

Fentanyl Test Strip Kit Distribution Pilot Evaluation Report

Prepared for the Massachusetts Department of Public Health

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EXECUTIVE SUMMARY

Approved by the Massachusetts legislature, the 2020 state budget included appropriation 4512-0206 *Harm Reduction through Syringe Access*, encompassing several evidence-based harm reduction strategies, as recommended by the Harm Reduction Commission, including: expansion of new syringe service programs (SSPs), provision of naloxone post discharge from emergency departments, funding multiple mobile health units and safe observation and treatment spaces, and a pilot program of fentanyl test strips (FTS). The Police Assisted Addiction and Recovery Initiative (PAARI) implemented the FTS pilot. Brandeis was selected to evaluate the FTS pilot due to existing work with a range of drug checking activities across the state as part of the Overdose Data to Action CDC-funded efforts.

During the early weeks of COVID-19 in Massachusetts, PAARI distributed FTS kits to 11 police departments, six of which were selected for evaluation during the pilot (i.e. April 3 to June 30, 2020). Selection was based on (1) geography, (2) monthly number of reported nonfatal and fatal overdoses, and (3) proposed methods of FTS distribution. Pilot evaluation police departments were: Beverly, Chicopee, Lynn, Methuen, New Bedford and Taunton. A community-based mixed methods evaluation design was used to address the questions: *How was the FTS pilot implemented and how were program pilot partners and recipients affected?*

Process (quantitative) data focused on the: (a) number of kits distributed per contact, (b) number of contacts/referrals during pilot, (c) technical assistance requested and received, and (d) type and number of follow up services provided. A semi-structured interview protocol targeting key dimensions was employed with agency partners, recipients, and PAARI key informants. At the end of the pilot, all agency partners completed an anonymous online exit survey that assessed partners' opinions and knowledge regarding FTS, syringes, naloxone, and Massachusetts law relating to syringes and FTS.

A total of 320 kits were distributed during the pilot, primarily through either a police department-led or a community program-led distribution model. Only one evaluation site employed a hybrid police department and community led distribution model. Many of the community programs had previously provided FTS to community members, and thus were familiar with their use as an engagement and harm reduction tool. The highest volume of kits distributed and the greatest number of concomitant services and referrals provided was from community programs who received kits from police department partners and collaborated with police departments to distribute them locally. Metrics indicated that outreach and post overdose outreach were the primary modes of distribution for kits during the evaluation period. While distributing kits, both police department personnel and community partners made referrals to a variety of services. For every one kit distributed there was approximately one service or referral provided (1:1 ratio), suggesting a promising sign of project feasibility.

The qualitative data gathered revealed: (1) a group of professionally and/or personally motivated individuals committed to engaging people who use drugs (PWUDs) in a positive manner. (2) Police departments routinely used the term 'engagement' to articulate the role of kits in their outreach efforts with PWUDs which is largely due to PAARI message framing. (3) Although the commitment to distribute the kits was clear, police participants expressed concern for the added burden of such work during a pandemic. (4) To mitigate this burden, several departments strengthened existing relationships or forged new ones due to their common concern for their clients' health and general well-being. COVID-19 exposed the need for an emergency management planning framework for future similar endeavors.

The exit survey detected a heightened interest in harm reduction supply provision by police and community agency partners. At the pilot's end, a majority of participants indicated that they now consider FTS (89%), naloxone (94%), and sterile syringes (83%) as positive engagement and harm reduction tools for PWUDs. Almost none considered naloxone, sterile syringes, or FTS as drug paraphernalia. There was notable confusion and concern across many involved in the pilot that FTS may be misconstrued as drug paraphernalia under Massachusetts law (sec. 321). Future efforts would benefit from greater clarity in the law. Taken together, the pilot demonstrated feasibility and suggests that partnerships among police and community agencies may be a means of scaling up FTS distribution and other drug checking programming.

Background

For many years, diversion of some pharmaceutical fentanyl has occurred, including fentanyl patches. Recently fentanyl has been illicitly manufactured and introduced into the drug supply as an adulterant ultimately replacing heroin as an active main component substance of misuse.^{1,2,3,4,5} Since 2013, when illicitly manufactured fentanyl was introduced into the drug supply, fentanyl related deaths have greatly increased.^{6,7} Fentanyl can be synthesized covertly and inexpensively in clandestine labs.⁸ Illicit fentanyl is about 50 times more potent than heroin, is absorbed rapidly and has a relatively short duration of effect^{9,10} As the illicit drug market is unregulated, there is an increase in the possibility of receiving a product with unpredictable purity and dosage which can lead to overdose and death.^{11,12,13} In New England, illicit fentanyl has been found on its own as well as in heroin, cocaine, counterfeit pills, and other illicit substances.^{1,2,3,4,5,14,15,16} People who use drugs (PWUDs) report relying on smell, taste, color and word of mouth to determine fentanyl presence. However, these may not be effective ways to determine the presence of fentanyl¹⁷ and cannot reflect the amount of fentanyl in a drug.

Use of fentanyl test strips (FTS) has been shown to be a feasible and useful harm reduction tool linked to increased self-efficacy and behavior changes for safer use^{17,18,19,20,21,22} FTS are single use immunoassay tests that detect the presence of fentanyl and many common analogues, including carfentanil and acetyl fentanyl.²³ They are easy to use, inexpensive, require minimal sample prep and produce results within minutes.²³ At Vancouver Coastal Health, many locations offer fentanyl testing. At one site, clients who tested their drugs prior to consumption, and received a positive result were 10 times as likely to reduce their dose. Those who reduced their dose were 25 percent less likely to experience an overdose.^{24,25}

Green and colleagues compared FTS with Raman Spectroscopy (TruNarc device) and Fourier-transform infrared (FTIR) spectroscopy (Bruker Alpha device) to determine the efficacy of FTS in detecting fentanyl's presence and absence in street drug products.^{21,26} Among these three, the FTS had the lowest detection limit, highest sensitivity (ability to detect fentanyl when it was present) and highest specificity (ability to accurately report when fentanyl was not present), and were successful in detecting various fentanyl analogues.²¹ McCrae and colleagues in Canada compared the Bruker Alpha FTIR to FTS, and found that FTS are more consistently able to detect the presence of fentanyl in samples at lower concentrations, even as low as 1 percent.²⁷

FTS are intended for urine drug tests and although off-label use of FTS has not been approved by the US Food and Drug Administration, yet many Syringe Service Programs (SSPs) and other community initiatives in North America use and distribute FTS.^{28,29,30} Outside of a handful of small-scale or time-limited initiatives, there are no known examples of large-scale programs of police departments distributing FTS in the community.

Police officers have been part of a variety of novel harm reduction and recovery related initiatives, including equipping police with naloxone. More recent innovative programs include Seattle's Law Enforcement Assisted Diversion (LEAD) program, Gloucester Police Department's Angel Initiative, and the Hero Help program.^{31,32,33,34} As of March 2018, police departments in at least 41 states have implemented a naloxone distribution program.³⁵

Massachusetts is home to numerous town specific initiatives in response to the opioid epidemic, and police departments have been central partners in these efforts. For example, Quincy, MA Police Department, in partnership with the Department of Public Health, started an overdose reversal program in 2010. Patrol officers were trained how to recognize and reverse opioid overdoses and were given naloxone. In April 2016, 500 recorded overdoses were reversed.^{36,37} PAARI's role in creating and helping to spread these models have been foundational. As such, these programs have become models, spreading to other municipalities within the state, to other areas in the region and across the country.

Police also demonstrate a commitment to public health and public safety through partnerships with community programs and harm reduction organizations. Some of the best evidenced interventions for PWUDs are syringe service programs, which are effective at reducing risk behaviors of people who use inject drugs.^{38,39,40,41,42} While data indicate negative health outcomes for PWUDs are associated with high rates of policing and

enforcement of paraphernalia laws,^{43,44,45} more recent data suggest promising interventions designed for police and for minimizing drug-related harm.⁴⁶ In a similar vein, community-policing efforts that collaborate with community based programs, treatment programs, and harm reduction organizations may build additional synergies, especially during the opioid overdose crisis.

In March of 2020, the coronavirus pandemic drastically changed both public health and public safety responses and capacities. As public health and harm reduction service providers continued their essential services in amended fashion, so too did police officers and other first responders. Some of the expanded duties of police at this time included enforcing social distancing and shelter-in-place orders.⁴⁷ Many Massachusetts municipal police department employees tested positive for COVID-19 throughout the pandemic.⁴² In mid-April, about 250 officers across Massachusetts tested positive for COVID-19, including 15% of officers in Taunton (a pilot site).⁴⁸ More than half of pilot sites sustained high infection rates during the pilot period. Adjustments that Massachusetts police departments made included: no longer having roll call, shift changes, suspending in-person meetings and roll-call, wearing personal protective equipment for any interaction with the public, and staying physically distant from other police officers.^{43,49}

Some departments gave verbal warnings instead of arresting and taking people into custody.⁴² Other departments closed their front desks and encouraged people to report incidents online or over the phone.⁴⁴ Many Massachusetts municipalities previously conducting post-overdose outreach or in-person outreach activities were suspended or amended to phone or web contact only with overdose survivors and their families. Overdose emergency calls were still responded to by emergency medical services and police, though calls for 911 were fewer during this time. In sum, police departments engaged as they could in limited contact activities with people to slow the spread of COVID-19 while still seeking ways to reduce overdose and support people with substance use disorder.⁴²

Police Assisted Addiction and Recovery Initiative

The Police Assisted Addiction and Recovery Initiative (PAARI) is a nonprofit headquartered in Boston, Massachusetts. The organization provides training, support, and resources regarding non-arrest pathways to treatment and recovery to police departments across the United States. PAARI started in June 2015 to further assist police departments to prevent and reduce overdose deaths and increase access to treatment and recovery. PAARI works with nearly 600 police departments in 34 states to provide technical assistance, coaching, tools, seed grants, and placing AmeriCorps recovery coaches in local departments.

PAARI led the FTS kit distribution pilot implementation. Following a request for application period, PAARI selected 11 sites to receive the test strip kits. PAARI provided initial orientation to the project, training on fentanyl safety, use of FTS, and metric tracking and safe outreach visit roll calls. PAARI also conducted regular check-ins and fostered a learning community among the evaluation and pilot partners through peer-enhanced communications and support. The 11 police departments selected were:

- Beverly Police Department
- Chicopee Police Department
- Edgartown Police Department
- Holyoke Police Department
- Ipswich Police Department
- Lynn Police Department
- Methuen Police Department
- New Bedford Police Department
- Taunton Police Department
- Whitman Police Department
- Winthrop Police Department

With input from community partners, Brandeis University, and the state department of public health, PAARI prepared a series of technical assistance videos on how to distribute the kits (e.g., a home visit, an outdoor visit, and adaptations during the COVID-19 pandemic, Appendix 1) and fentanyl safety awareness. Throughout

the pilot, PAARI provided support and technical assistance to all pilot sites. PAARI held a midpoint and endpoint convening to gather all police departments and interested community partners to share pilot successes and challenges in implementing the project. The 11 departments continued group-based emails to allow for open discussion about the pilot and learn from peers. PAARI sent weekly “tips” to all 11 departments to help support implementation challenges, remind about upcoming deadlines, examples of social media posts and ease the process of replenishing kit supplies.

The initial kits contained three fentanyl test strips, a brochure on how to use the test strips, a COVID-19 safety handout, a card on how to obtain naloxone from the pharmacy, a card on the Massachusetts Substance Use Helpline and a card on how to contact a PAARI recovery coach. Participating departments were encouraged to further tailor the kits to supplement their standard outreach efforts.

Program Evaluation

The Brandeis team worked with PAARI to select six police departments for the evaluation portion of the pilot. The agencies were selected based on geographic considerations, overdose volume and proposed methods kit distribution. The six evaluation departments were: Beverly, Chicopee, Lynn, Methuen, New Bedford and Taunton Police Departments.

During the pilot, each evaluation site provided monthly reports, which included: the number of kits distributed, the manner in which they were distributed (via outreach or other manners), and any services provided or referrals given at the time of the test strip kits distribution on a monthly basis. In the middle of the pilot, Dixie cups were added into the kits based on concern about potential FTS false positives in the presence of methamphetamine in order to encourage people to use more water with the FTS for a valid result. Masks and hand sanitizer were also added to the kits mid-pilot in response to the COVID-19 pandemic.

Initially, police departments were planning to distribute kits during post overdose outreach visits, and other related community programs or events. However, much of this was not possible due to COVID-19. Therefore, many departments connected with local community partners, including SSPs, treatment programs, community health centers and hospitals to assist in kit distribution

This community-based process evaluation employed a mixed methods research design. Pre-COVID-19, we proposed measuring program success through process data and semi-structured interview data with agency partners and kit recipients. Due to COVID-19 interview data of recipients was sparse and any observational data collected was limited to a one-time event per site and was not possible until late June 2020 when most of our police partners re-opened thereby allowing civilians including research personnel access.

While traditional in-person data collection was not possible throughout the three-month pilot period, the Brandeis evaluation team, using a semi-structured interview guide, conducted virtual interviews via Zoom with police and community partner pilot participants and FTS recipients. The team conducted at least one on-site observation in each pilot community in order to document site differences, barriers, and/or facilitators. Data collection spanned from March 17, 2020 through July 31, 2020. Eligible interview participants received compensation of \$50 in the form of cash, an Amazon gift card or PayPal payment.

The figure below provides a general timeline of the project as it progressed alongside Massachusetts state COVID-19 milestones.

Massachusetts COVID-19 Milestones

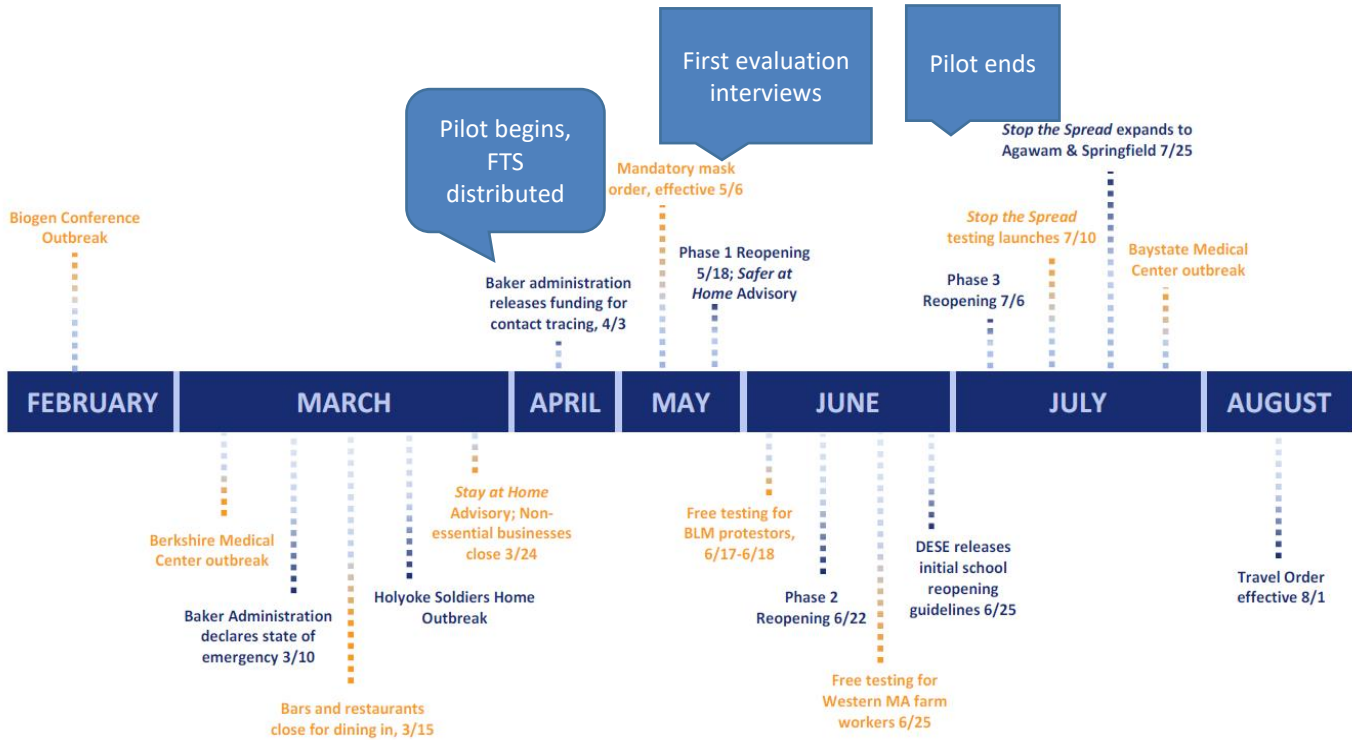


Image created by the Public Health Institute of Western MA (PHIWM); Milestones compiled by the Academic Public Health Volunteer Corps and PHIWM Updated 8/4/2020. Note: Timeline does not include every milestone or event of importance to COVID-19.

All interviews were audio-recorded and professionally transcribed. Each transcription was then reviewed against its audio recording, and corrected when necessary, by two Brandeis team members. Microsoft Word was used to sort and structure each of the transcripts by using the following: (1) text-formatting features, (2) find-and-replace function, and (3) annotating text, i.e. track-change function for memoing and deductive coding. Microsoft Word because of the size of the interview database and the delimited scope of the analysis^{50,51}.

A semi-structured interview guide was used with each interview participant. The interview protocol for pilot partners covered the following areas: (1) experience supporting public health and public safety efforts, with overdose, and in providing harm reduction tools including FTS, (2) perceptions and familiarity specifically with FTS, (3) FTS implementation and distribution, and (4) COVID-19 impacts: community, recipients, general crime, and drug supply. The interview protocol for FTS recipients varied slightly: (1) experience with overdose, harm reduction, with other community agencies, and in using FTS, (2) familiarity in receiving and using FTS, (3) FTS implementation and distribution including secondary exchange, and (4) COVID-19: community, personal, crime, and drug supply. The follow up interviews with PAARI leadership team key informants focused on the following critical areas: (1) reflections on the FTS pilot and forecasting its future, (3) police reform, (4) racial and ethnic diversity, and (5) kit distribution and Massachusetts Law Section 321.

A Textual Analysis (TA) framework was used to identify, contextualize, and report the most saliently semantic themes hereinafter⁵². The scope of the textual analysis was informed by the following general research questions: *How was the FTS kit pilot distribution program implemented and how were program pilot partners and recipients affected?*

At the end of the pilot, all participants completed an anonymous online exit survey that assessed their opinions and knowledge regarding FTS, syringes, naloxone/Narcan, drug paraphernalia and Massachusetts law relating to syringes and FTS. Response requests were sent to the survey to 33 people who participated in the pilot.

RESULTS

The six evaluated departments demonstrated high variability in the types of kit distribution they undertook during the pilot. The primary kit distribution channel consisted of PAARI distributing kits to participating police departments, who then provided them to community program partners. The goal of this simple distribution chain was to ensure potential kit recipients in a target city had multiple opportunities for obtaining a kit. However, COVID-19 triggered a significant reset of such efforts across all sites. None of the evaluation sites dropped out of the pilot; all adapted on some level to embrace a distribution pattern.

Police Department-led Kit Distribution

Of the six evaluation sites, three locations—half of the evaluation sites—planned for or resulted in a police-led kit distribution approach, that is, there was no or limited community partnering in these programmatic models during the pilot period. Chicopee Police Department had intended to partner with community programs but experienced substantial logistical challenges in doing so. New Bedford Police Department partnered with community programs from the outset but was delayed in coordination of activities. Methuen Police Department did not plan for, or partner with community programs at all, opting to distribute FTS entirely through their department's civilian staff. Observation during site visits and interview data collection indicated important programmatic nuances in the pilot implementation during the pandemic.

Chicopee Police Department was forced to scale back all non-essential police services, including street outreach and post overdose outreach. Such programming was not deemed an essential service by the police department and continued activity occurred at substantial physical and social distancing; the number of outreach visits and referrals remained low. While partnerships with community programs were planned and attempted, the Chicopee Police Department experienced hurdles in launching their pilot with community partners. However, there was some modest distribution by police officers throughout the pilot period.

The New Bedford Police Department pilot site experienced significant delays in kit distribution during the evaluation period. While largely due to the city's persistent community COVID-19 infection rates, local community programs were not able to obtain any kits from the police department for the better part of the pilot period. Many of the New Bedford Police Department's community-based outreach activities were forced to scale back all non-essential police services, including street outreach. Street outreach was not deemed an essential service of the officers by the police department. However, as the police were the single source for all kits in this pilot project and FTS were not delivered prior to stay-at-home orders and staff quarantine, it was the middle of June 2020 before the project was reinvigorated and kit distribution expanded. Consequently, limited community program provision and distribution occurred during the pilot, despite initial intentions to engage them.



Essex County Outreach
April 15 at 2:57 PM · 🌐

Essex County Community Engagement Specialists continue to assist those in the community during these stressful times of COVID-19.

As part of the P.A.A.R.I.'s three-month pilot project, made possible by a \$150,000 grant from the Massachusetts Department of Public Health, this past week, Methuen CARES Initiative Program has distributed (9) Fentanyl Test Strip Kits as an engagement tool for individuals at risk of opioid use.

Of these 9 kits, (3)where post overdoses, (2) street outreach, (4) calls into CARES requesting kits since seeing previous posts. We will remain in contact with these individuals/family members as our goal is to open the conversation with those struggling with addiction and offer appropriate treatment as needed.

The GOAL of this pilot program is to engage with individuals to help prevent opioid overdose deaths. If you or a loved one is in need of assistance, or for more information about Rapid Response Test Strip Kits, please contact any of the participating police departments:

Beverly - # 978-992-1212
Ipswich - # 978-356-4343
Lynn - # 781-595-2000
Methuen - # 978-701-7782 & # 978-701-8195



CARES - Community Addiction Resource Engagement Services

April 15 at 2:42 PM · 🌐

Community Engagement Specialists continue to assist those in the community during these stressful times of COVID-19.

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If you or a loved one is in need of assistance, or for more information about Fentanyl Test Strip Kits, please contact us:

978-701-7782
978-701-8195

WE ARE IN THIS TOGETHER!
<https://vimeo.com/401361892>

Figure 1. Example social media posting from Methuen Police Department

There was a robust amount of kit distribution through the Methuen Police Department due to strong extant programming by this group. Although Methuen police partners scaled back to only essential policing services, provision of limited outreach services was conducted by civilian staff. While in-person outreach and visits were not conducted, the police department civilian staff in Methuen made effective use of social media (a communication mode previously employed by this particular department) by promoting the kit pilot distribution program and providing follow up contact information for prospective recipients, see Figure 1. For example, both Essex County Outreach and Community Addiction Resources Engagement Services (CARES) Facebook pages were used to alert recipients and social network members of this service. Following this department's communication, PAARI prepared social media posts, sample blog templates, and readily usable content for departments to adopt. While well poised to do so, this innovation did not disseminate further to other pilot department sites during the short pilot period.

Community-Led Kit Distribution

Prior to the pandemic, Lynn and Beverly Police Departments had each planned to work collaboratively with local harm reduction agencies to provide FTS in the community, but planned for primary distribution through community program collaborators. Both police departments have long-standing relationships with community partners, and therefore, the expanded programming with community partners was a natural point of synergy. Specifically, distribution was provided through local community program partners Healthy Streets (Lynn pilot site) and ONESTOP Harm Reduction Program (Beverly pilot site). Both community programs continued to provide outreach and related services during the state's COVID-19 stay-at-home orders. In addition to traditional outreach services, Healthy Streets made effective use of social media by promoting the kit pilot distribution program, providing follow up contact information for prospective recipients, and providing training on the proper use of the strips, and recipient marketing. Figure 2 shows social media posts related to kits made by Healthy Streets. Social media posting is an ongoing means of communication to the community used by Health Streets before and throughout COVID-19 and was not an innovation of this pilot.

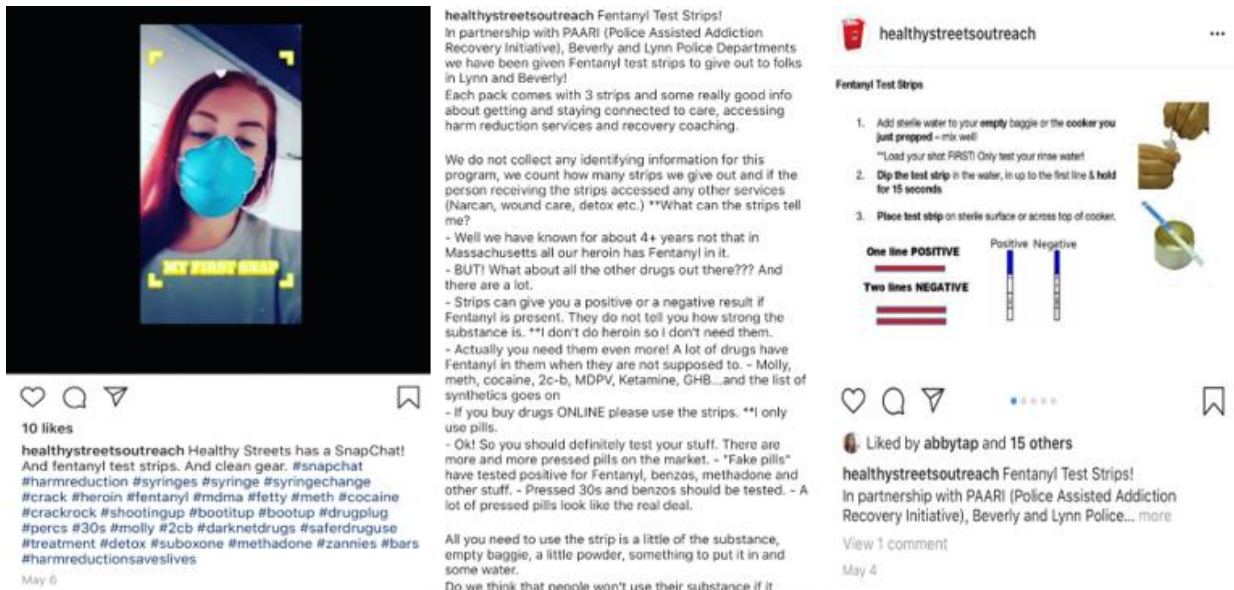


Figure 2. Example social media posting from Health Streets Lynn

Police Department and Community-led Kit Distribution

Kit distribution in the city of Taunton was unique for two reasons; (1) modified outreach efforts by police partners continued throughout the COVID-19 quarantine and (2) new community program partners were identified, equipped with FTS, and distribution commenced there. Taunton Police Department extended new partnerships to several medical, treatment (opioid treatment program), and social support service sites as part of this pilot.

Demographics of Kit Implementation/Distribution Partners

From April 3, 2020 through June 30, 2020, a total of 22 individuals from police and community programs participated in implementing the pilot project and distributed kits. Police department partners were all white, mostly male, with a median age of 44, had a median overall time on the job of 18.5 years, and most had bachelor degrees of greater. The community program teams were mostly white, primarily female, slightly younger (median age of 40), less experiences in their job (median experience of 5.5 years) and tended to have less education. Community program interviewees had a median of 2.25 years of experience collaborating with police. In both cohorts, nearly all of those interviewed personally knew someone who has experienced an opioid overdose or who has an opioid use disorder (Table 1).

Pandemic response and supports, including training and guidance, differed substantially between community programs and police departments. While all sites had access to PPE, community-based programs were more likely to have adopted COVID-19 related guidance and supports from agencies like MDPH compared with their police partners. This may be due to community-based programs regularly partnering with BSAS and BIDLs for naloxone distribution, SSP, or other service provision. Consequently, community programs commonly employed procedures such as “clean rooms” for supply preparation, organizing staff into cohorts, symptom checks and attestations, and could more readily isolate and replace staff in the field to ensure continuity of service delivery. Lacking clear guidance and support from state and municipal health departments, police departments may have been more reluctant to continue to provide community-based programming like in-person outreach and post overdose outreach services.

Table 1. Demographics (N=22) of pilot project implementing partners

	n (%)	
Role	Police department partner(n=10)	Community program partner(n=12)
Gender		
Male	6(60.0)	1(8.3)
Female	4(40.0)	9(75.0)
Gender conforming or non-binary	0	2(16.7)
Race		
Multi-racial	0	1(8.3)
Other	0	1(8.3)
White	10(100.0)	10(83.3)
Hispanic/Latinx		
Yes	1(10.0)	2(16.7)
No	9(90.0)	10(83.3)
Age	median=44.5	Median=40.5
26-35	1(10.0)	2(16.7)
36-45	5(50)	6(50.0)
46+	4(40.0)	4(33.3)
Education		
High school graduate or GED	1(10.0)	1(8.3)
Some college	0	4(33.3)
College graduate	5(50.0)	4(33.3)
Advanced degree	4(40.0)	3(25)
Harm reduction or public health experience		
Yes	5(50.0)	8(66.7)
No	5(50.0)	4(33.3)
Length of time at job, in years median (range)	18.5 years (1 week-32 years)	5.5 (6 months-25 years)
Length of time collaborating with PD in years, median (range)	--	2.25 years (1 week-20 years)
Know someone with OUD or has experienced overdose		
Yes	9(90.0)	12(100)
No	1(10.0)	0

During the evaluation period, from April 3, 2020 – June 30, 2020, a total of 320 kits were distributed across six communities. Many original distribution approaches were not possible due to COVID-19. Consequently, departments adjusted and leaned more heavily upon various local community partners, including syringe service providers, community health centers, treatment programs, and hospitals, to assist in kit distribution. Some departments adjusted by developing new partnerships for the pilot as a consequence of the pandemic (see Table 2, asterisked programs).

Table 2. Fentanyl Test Strip Kits Distributed April-June 2020 by pilot programs

Evaluation Sites	April	May	June	Total Kits Distributed
Law Enforcement Department				
Beverly	0	0	0	0
Chicopee	2	0	10	12
Lynn	0	0	2	2
Methuen	29	20	15	64
New Bedford	NA	NA	14	14
Taunton	4	7	9	20
Total	35	27	50	112
Community Program				
Beverly Hospital*	0	0	4	4
Beverly: Healthy Streets	1	3	0	4
Beverly: One Stop	10	17	14	41
Chicopee: Tapestry	NA	NA	0	0
Lynn: Healthy Streets	13	37	14	64
New Bedford: Seven Hills	NA	NA	2	2
New Bedford: Anchor Ministries	NA	NA	0	0
New Bedford: Fishing Partnership	NA	NA	0	0
New Bedford: Stepping Stone	NA	NA	5	5
New Bedford: New Recovery Center	NA	NA	0	0
Taunton: Column Health*	0	2	0	2
Taunton: Habit OPCO*	4	35	16	55
Taunton: Manet*	NA	NA	11	11

Taunton: Stepping Stone*	0	2	3	5
Taunton: Seven Hills	0	3	0	3
Taunton: SSTAR*	0	6	6	12
Total	28	105	75	208
			Grand Total	320

Outreach services (including post-overdose) by police and community program members continued during the pilot period despite the pandemic. Outreach by police was the mechanism that distributed the most FTS. Outreach activities by police is best defined—and redefined during COVID-19--by example, as one department member explained:

Because of the coronavirus we have been handing them [FTS] out to people who we are familiar with when we see them out in the community, mostly known narcotic distribution and consumption areas. By doing this we are able to limit the interaction time with people, in most cases they already know who we are and the services we provide. We have given some basic instruction to people who have never used them before. We use social distancing and also all involved use PPE. We again limit the time of the conversation. All of the interactions are done in the community. We have not yet gone back to doing outreach/follow ups at people's homes due to COVID.

For community partners, visits to their local site (i.e., brick and mortar location or mobile unit site) were the more fruitful kit distribution pathway. In one case, services were adapted to run out of a parked UHAUL truck and other programs continued to operate from their offices and mobile sites. The fact that FTS recipients honored an outreach request and visited a community program or police department partner highlights the strength of informal relationships between community program and police members and the community they serve.

Table 3. Method of Fentanyl Test Strip Distribution April-June 2020

	Law Enforcement Partner	Community Partner	Both
Hospital visit	0	4	4
Post overdose Outreach	43	2	45
Outreach	49	45	94
Recipient visit to fixed location	16	146	161
Phone Contact	4	0	4

In total, there were 318 total referrals and services provided to FTS recipients during the pilot period. Police departments made 93 referrals, ninety three percent of which occurred in June during the Massachusetts re-opening phase. Community program partners made 225 referrals, representing a broader variety and higher

volume of referrals than the police partners. The North Shore area (Beverly, Lynn) had the greatest volume of referral requests (see Table 4), primarily driven by referrals and services provided by community partners there.

Table 4. Referrals/Services Provided February-June 2020*

Evaluation Sites	April	May	June	Total Referrals
Beverly	0	0	0	0
Chicopee	2	0	4	6
Lynn	0	0	25	25
Methuen	1	0	0	1
New Bedford	NA	NA	36	36
Taunton	4	3	18	25
Total police referrals and services	7	7	83	93
Beverly Hospital	0	0	1	1
Beverly: Healthy Streets	3	3	2	8
Beverly: One Stop	12	24	20	56
Chicopee: Tapestry	NA	NA	0	0
Lynn: Healthy Streets	27	71	18	116
New Bedford: Seven Hills	NA	NA	7	7
New Bedford: Anchor Ministries	NA	NA	0	0
New Bedford: Fishing Partnership	NA	NA	0	0
New Bedford: Stepping Stone	NA	NA	15	15
New Bedford: New Recovery Center	NA	NA	0	0
Taunton: Column Health	0	0	0	0
Taunton: Habit OPCO	0	0	0	0
Taunton: Manet	NA	NA	22	11
Taunton: Stepping Stone	0	0	0	0
Taunton: Seven Hills	0	0	0	0
Taunton: SSTAR	0	0	0	0
Total partner referrals and services	42	98	85	225
Grand total	49	105	168	318

*If a site did not provide any data, the cell is populated with NA. If a site reported no referrals to services during these months, the cell is populated with a zero.

While distributing kits, both police department personnel and community partners made referrals to services. Pilot programs were focused on engaging test strip recipients with services. Referrals to services were a desired outcome directly related to engagement. The approximate 1 to 1 ratio of kits to referrals suggests a promising sign of project impact. Some services, such as harm reduction services, were on-site. Other service referrals were in a variety of forms, ranging from the provision of information and a phone number to a “warm handoff” where the client was personally escorted to the service (Table 5).

Table 5. Types of Referrals/Services Provided

Types of Referrals and Services	Police department Partner	Community Partner	Total
Provision of Harm Reduction Services*	20	149	169
Drug Treatment	23	29	41
Counseling	26	1	27
Wound Care	2	15	17
Meals/Food	3	10	13
Housing	10	2	12
Medical	1	4	5
Financial	3	0	3
HIV/HVC Testing	0	14	3
ID Support	3	0	3
Legal	2	0	2
Drug Checking	0	1	1
Referrals to MH Services	0	0	0
Employment	0	0	0
Total	93	225	318

*Provision of harm reduction services includes provision of Narcan/naloxone.

Of the 318 total requests for referrals made, the most were for (1) provision of harm reduction services followed by (2) drug treatment, and (3) general counseling. A secondary group of referrals made were for (a) wound care, (b) meals/food, and (c) housing.

Qualitative Results: Key Themes

A number of key themes emerged from the qualitative data collected during the evaluation: *motivation, conceptualizing FTS as a tool, impact and opportunity during COVID-19, collaborations, contextualizing factors for potential recipients, and modifications to the pilot intervention.*

Motivation

As a group, program pilot partners were both experienced and highly motivated, both professionally and personally. Police officers talked about developing empathy, and having a stake in community policing, with one discussing the impact of having children,

...[LAUGH] having kids...made me a little bit softer, and, you know, having more empathy for people. And...you know, thinking back when I was younger in my career and I would arrest people and they'd be calling on the phone, begging their parents for... bail money and the parents would come to down to bail out their kid for the 100th time, I, of course knowing everything would say, "I can't believe you're bailing your kid out." And more than a couple would look at me and say, "You obviously don't have kids." And then...once I had kids, I started looking, like I said, at people with more empathy and... trying to treat people the way I would want my kids to be treated later in life if they had developed a... mental health issue or a substance abuse issue.

Another expressed passion for the work, saying

I've never taken a promotional exam. I love what I do. I've been doing this stuff with mental health. I'm a big mental health guy and maybe six or seven years ago started to get into the opiates and, you know, the folks that are having issues with it to try to help them. So always had a passion for folks with special needs and folks that have some weaknesses. And so that was something I had been a guy that I liked making my arrests. I liked helping people certainly. But I liked getting drugs off the street and dealing with the people that were doing that. And this was a whole 180 where I'm working with these, not so much the drug dealers because I still would like to get them off. But working with people who have the issues with opioids and other drugs, including as you guys probably know better than me, the mental health aspect of it, how it's just is so co-occurring and how it's always, you know, partnered up with it many, many times.

Many community partners were motivated to participate by a recognition of need either through their work, or from their lived experience. One community partner reported their involvement as a matter of faith, saying,

Okay, sure. So, I was actually living in [another state], and I got involved with a volunteer group out there that would go out at night, and I talked to women who were being exploited on the streets. And we would hand out food and, you know, toiletry kits. And it was a faith-based ministry, we would pray with them if they wanted to. And we actually saw a lot of success with women coming off the street through that program.... And I kept thinking, like, where is this happening where people aren't addressing it? And specifically, as a person of faith, where is the church not addressing it? And so, I had lived in [CITY] before, and I just kept thinking back to the women that I would see on the streets... And so, my husband and I talked about it a while and we decided to move back to start a street outreach ministry for the women that are in [CITY].

Several other community partners came to this work through lived experience with drugs or overdose. One reported that,

Oh, I... hmm. I have some lived experience and decided I wanted to get into some... I needed a job, and I got into working at an adolescent residential facility back in [STATE], where I'm from, and really enjoyed some aspects of that. I ended up transferring within the same organization to the detox unit that they had and really just really enjoyed helping people make some kind of positive change in the relationship I was building with people that use drugs. And so, I started volunteering at the needle exchange harm reduction agency, what have you, that's located in [CITY], Michigan.

Still, other community partners came to this work through personal experience with the impact of overdose in the community, with one saying

Yeah, so, you know, that's how I began to show some interest on that. And then, you know, years later, I fostered a five-year-old whose father was an active user and mother passed away. So, he was with us for a very long time, and he struggled with opiates, you know, himself. So multiple overdoses on that. And then a friend of mine, the same thing, he fatal overdosed, you know, on opiates about, I don't know, 10 years ago.

So, when I really started getting involved, really dedicating, was in 2007 when I had a lot of my friends, you know, having their children overdose. And, you know, and myself, where I was, you know, struggling to keep [NAME], which was my foster kid at that time, safe, you know, and so he wouldn't overdose, so I connected really well with a lot of the parents that their kids were struggling, and this was middle-class, white, you know, going to private schools, athletic kids, you know, those were the ones that really got affected in 2007 while I was going through that myself.

Conceptualizing FTS as a tool

Police officers implementing the pilot program considered the FTS kits an important adjunct tool for engagement. For example, as one police partner expressed;

And you know, then [PAARI leadership] explained to me, "[NAME], it's really not so much [LAUGH] to make sure it's fentanyl or not. It's-it's the engagement. It's to get there and talk to 'em." And I said, "Well, if it's an engagement thing, [PAARI Leadership], then, of course, we'll be-we'll be glad to do it." Yeah, no. I have...no skepticism now. I-I just see it as an engagement program. I mean, if-if somebody is taking the time to test, you know, that's-that's great. You know? That's great. Maybe they won't take a pill that they think is...Adderall [LAUGH] and have it be pressed fentanyl, you know? If that's what they do, that's what they do, that's great. It'll probably save their life. But, you know, as... as an engagement tool, I think it's great, you know, if you can t-talk-stop and talk to somebody for a couple of minutes. And even if they throw the strip away behind your back when you walk away, then at least you talked to them and you maybe might have planted that seed.

Another police partner reported similar reasons to use it kits as an engagement tool saying,

And it's like, you try to explain to them, like, listen, people are pressing the pills now. They're making them out of Fentanyl. And you think you're getting Xanax, or whatever, but you're really getting just pure Fentanyl. So, to be able to give those people test strips and say, look, just shave a little off and test it, and that way you know. If you're just taking Xanax, take your Xanax and that's fine. That way, you're not taking Fentanyl without knowing and stuff like that, because, like I said, I don't know how many calls we've gone to where people say, I don't do that stuff. I do pills, that's it. Well, it's there. I don't think you took it on purpose. I think it's an accident. But these will help you in that regard. So, I think it's a great tool to be able to give to people, to keep themselves safe. So, hopefully we can keep it going forward.

Even when confronted with trepidation, kits kept the conversation moving:

Yes. So, one mom was scared. She goes, "I don't know if I wanna give it to him, 'cause now I'm giving him permission to use drugs. And I says, "You know, walk that through. What if he buys drugs and he passes away? That's gonna weigh heavy on you." And she said, "You're right. Like, I can't control his outcome in regards to using or not using, but I can give him a prevention method which is handing him this kit."

In general, community partners supported the concept of the police distributing FTS, especially to clients who were "opiate-naïve" or to clients who weren't necessarily engaged with existing harm reduction programs

I mean, I think any time you can distribute them, especially to people who might be, like I said, opiate naïve. It's good. I think the police might run across people who are, you know, primarily like I said, cocaine users, recreational cocaine users, alcohol users that use cocaine.

Some community partners with extensive experience partnering with the police conceptualized the pilot as part of ongoing and united team efforts:

I have always been a fan of our law enforcement. I was so proud to be a part of the outreach team and I think that it's amazing. They're showing our community that they want to help folks. Not only arrest. I mean it's building, you know, relationships in the community. It gives folks just yet another option. I think it's fantastic and I'm just so proud to be part of a team who we're all for the common goal, you know?

Other community partners questioned whether there was enough trust with the police to distribute FTS because of their role in also enforcing drug laws. This role confusion was noted by several community partners. One community program staff member discussed the potential for “self-incrimination”, saying

I don't think the trust is there for the police to really handle that sort of thing. I mean if you're going to grab one, essentially, I guess it would feel like you're already incriminating yourself, saying that you have a bag on you, that you're ready to use, that there is some paraphernalia on you.

Another community partner noted self-incrimination as a potential problem but also suggested a way to resolve role confusion (a challenge not uncommon in policing and public health work⁵³), that is, for police to stop arresting people for simple possession saying

*I just think it's kind of a weird... not a bad, but a strange message. Like, what you do is illegal and anything you do to get that drug, or if I catch you using that drug or that drug is in your pocket, I'm arresting you. Like, it's such a weird thing for me to think about. Like...
...you know, if I catch you outside this train station next time and you have a loaded needle full of dope, I'm not gonna be like, "Hey, use this strip before you shoot that bag."
I'm gonna fuckin' arrest you for trespassing and possession of class A. Like, I don't know. It's weird.*

Later saying:

Yeah, and I get the idea of the [FTS] intervention and, like, trying to tell people, like, "Hey, we know you're using. We want you to be safe. We want you to stay alive," but I feel like it's also not... I don't know. I feel like it's not really fair. Like, I feel like if you hand them a fentanyl test strip, you should also be making the commitment that you're never going to arrest anyone for possession. Like, it just doesn't seem fair. And I know that a lot of other resources come in the packages, but ultimately, the selling point is the strip, so...

Impact and opportunity during COVID-19

The COVID-19 pandemic greatly affected the FTS distribution pilot and all partners articulated challenges in implementation of the pilot. Preceded by a training and introduction to the evaluation, kits were mailed on March 31, 2020 to all sites and the pilot started on April 3, 2020, just after the state of Massachusetts announced stay-at-home orders on March 24, 2020. Despite the pandemic, distribution of the kits started and continued throughout the state's stay-at-home orders, with greater reliance upon community partners' capacities. For example,

When [NAME] was out there. We didn't know what to expect from the beginning to be honest with you. Especially where it just kind of like, came upon the same time that there was so much, you know, we just didn't know what to expect, because of COVID, you know, hitting us. As far as the restrictions that we actually had on the department as a whole and with the community and whatnot. And then when we heard about the test strips, we were like, "Well, how is this gonna really work?" And, you know, our team really just kind of like, took it and ran with it as far as that goes. You know, as you saw, [NAME]'s out there. She's out there on her website, you know, that's associated with the police department. As far as what they do advertising, "This is what we're doing." They took the kit and they obviously put in their contact information. Again, all the literature that they have. "Hey, we're here for you." Things like that. So, we were limited in the outreach, but we took the necessary precautions. And I remember telling [NAME] and [NAME], obviously the Sergeant here, because of COVID obviously, all the precautions that we need to use as far as the masks, gloves, you know, everything else that went with it.

While many police departments altered plans and shifted kit distribution to their community partners, some continued limited outreach efforts in hopes of connecting with people they had been supporting and working with.

Well, the whole process of doing some outreach stuff, I was kind of tasked to kind of oversee it, and I was supposed to have a team that's supposed to go out and try to do, like, follow-ups. But unfortunately, because of everything that's been going on, that's kind of not happened, so I've kind of tried to, when I could, just try to do a little bit of community outreach through the phone, to see if I can make contact with people to see if I can offer 'em anything, you know, services, 'cause they really weren't allowing us to, you know, go out to houses.

Police departments conducting post overdose outreach or community outreach received limited guidance from MDPH on how to safely continue this work during the pandemic (and did not adopt MDPH guidance directed towards treatment programs which covered topics such as cohorting and quarantine management, creating duplication and managing project teams in field, adaptations to harm reduction protocols and naloxone administration, clean room safety, PPE and decontamination for COVID-19 exposure prevention and management, screening, quarantine, isolation, and treatment protocols). One webinar was held addressing some elements of this in spring 2020 but did not result in common guidance. PAARI provided focused police department technical assistance and supports on adapting FTS messaging and procedures, however, these did not include the BSAS or BIDLS guidance on providing essential public health services. In addition, police departments—including those carrying out post overdose outreach or community outreach prior to the pandemic—did not appear to organize as a peer group, either informally or formally. PAARI's efforts during this time focused on bringing together the departments for the pilot to form a peer group and supporting their adaptations to coronavirus challenges as best they could. Despite these helpful efforts, the lack of guidance received by law enforcement on these topics from the state and the absence of information exchange across departments during this time was in sharp contrast to the community programs. Many of the community programs greatly benefited from initial and ongoing guidance from state agencies, formal coalitions for peer supports and exchange of best practices, and informal exchanges between networked partners. Incorporating best practices like cohorting, clean rooms, protocols for isolation and quarantine, routinizing PPE and decontamination activities, physically altering their space and base of operations, installing handwashing and hand sanitizing stations in places where outreach or congregations occurred, and other safety processes during this time were more readily adopted into the community programs, making the provision of kits more clearly part of the essential services they offered.

The shift of police outreach activities at this time was also noted by community partners. One community partner reported that the change was not because the police departments did not want to distribute FTS, but rather an adaptation to community partners with experience in harm reduction. The partner's expectation was that after the pandemic, the police department would return to distributing kits, saying

And part of the reason for that is 'cause they're not going out and doing overdose follow-ups during COVID. The Police Department gave us all their strips because of COVID. Outside vendors weren't allowed into the station. They kind of shut [redacted] the Behavioral Health Unit out of the station. But we've remained in contact with those folks, so I think once they come back, they'll have some of the strips that they can distribute too, but for now... And I don't think that's a reflection on the department.

Community partners also saw the opportunity to take part in the pilot, and provide additional services to their clients,

Yes, because they were having trouble getting some participants for the pilot, and it was time-limited, 'cause they said, oh, it's going to end in June and we need some quick participation, and everyone's closed because of COVID. So [police officer] reached out to me and explained about the program, and I was like, oh, absolutely. We're open and our patients could absolutely use that service, so we jumped on it.

Collaborations

One unexpected result of the pilot due to COVID-19 was the strengthening of existing partnerships between community programs and police departments and the creation of new ones. Police officers were acutely aware of the value of relationships with community agencies, as one officer stated:

I tell you, I couldn't do what we do without the groups that we work with, without [COMMUNITY ORGANIZATION] and without [COMMUNITY ORGANIZATION]...I mean, I think I said it on the last Zoom call, but they've been outstanding. They have done basically all the leg work for us and, you know, they are the ones that have the connections in the community. And they have been the ones that have, kind of, like, introduced us into that community.

Another acknowledged the burden of program implementation that fell on community organizations because of COVID-19, saying

Yeah...you know, we had all the best intentions, 'cause we have our behavioral health unit, you know, the case manager and the clinicians and stuff, and who were-who have a good relationship with [COMMUNITY ORGANIZATION]. So, when originally applied through PAARI, it wasn't just the [CITY] PD, it was [COMMUNITY ORGANIZATION] as well, 'cause we knew that's how most of our overdose follow up was done. You know, the officers do the referrals, but the follow up with the victims...you know, was through the behavioral health unit. And that was our plan, and then, of course, you know, COVID kicked and the behavioral health unit had to leave the station so, all of our actual outreach to the overdose victims, the people we had planned to give the fentanyl strips to initially, has-has pretty much fallen on the [COMMUNITY ORGANIZATION].

Some community partners became involved in the intervention because they had existing relationships with the police, while other community connections evolved serendipitously. One community program reported police officers reaching out to them because of the pilot project, saying

I don't know. It was probably about a month ago. A [police officer], in the Community Impact Unit for [CITY], asked if we were interested in providing these to people that we see inpatient or wherever I see them and we jumped on the idea.

Another community partner had been recruited by a police officer to distribute FTS strips over the course of a usual interaction with the outreach work team. The community program interviewee recounted the story, saying

So I have three outreach workers there that have been doing some more street outreach for homeless. And, of course, come in contact with people who inject as well. So on Monday, they ran into the police officer that is part of this project and he said, oh, can you give out test strips. And we're like, yeah. And can you give out ours? So my outreach worker called me and said, [NAME], can I take these fentanyl test strips? I'm like wait a minute. Let me talk to him, see what he's talking about and like what are we getting ourselves into. I didn't know about this project until Monday. Why are the police giving out, and how, especially the [CITY] Police, giving out fentanyl test strips?.....But so when he called and the sergeant, and I'm blanking on his name right now, called, I called him Monday and he told me he was doing this project with Brandeis and I said, oh, all right, fentanyl test strips, Brandeis so it must [NAME]. So I emailed [Brandeis name] and said are you doing this?....So this is all kind of new.

Whether these collaborations evolved due to pandemic-related strains, from police department openness to new connections or both, the fact remains that new partnerships were formed through the pilot. Still, one police officer felt that giving FTS directly to the community partners might be a better approach, saying,

Yeah. I mean, I think it would be very beneficial to the other organizations within the community that I do in the outreach work for them to get the strips directly than it is be in a room for three months, being locked in. No one can go into that room until that officer is back. I mean, if we want this program, the fentanyl test strip program to be successful, we have to learn from our past mistakes. And what I've seen in [CITY] is if it just sits in a box, the room, I mean, it's not getting out to the community, so why not just directly send it to the organizations that are already going out so that for them just to pass it out. I mean, PAARI has a relationship with some of the organizations in [CITY]. So I would assume I would believe that they would be open to that. I know, I think [NAME] would.

Contextualizing factors for potential recipients

Potential kit recipients were also deeply affected by the COVID-19 pandemic. Community partners who adapted their services and remained open during the stay-at-home order observed many impacts of COVID-19. It was in this context that community programs continued to rethink how and kits when distribution of FTS kits would occur. One community partner reported the impact of the libraries closing saying:

I had to like basically like beg to get them to put in some port-o-potties and handwashing stations because, you know, they lost all their... another thing that affected, I mean, not only drug using population but the homeless drug using population, but you know, they lost access to bathroom facilities and sanitation facilities and places to charge their phone and you know.

And they didn't want to do it, but it's like, they have the port-o-potty there, but they've been locking it at nights and on weekends

In addition, the FTS pilot took place amidst new and concerning surges in community drug-related harm. Specifically, harm reduction programs reported seeing surprising reoccurrences and relapse to drug use among people who had been stable, that they attributed to COVID-19 stress. These are opportunities for naloxone and kit provision, with one provider saying,

So we've had a shocking number of people, way more than usual, drop out of treatment unexpectedly during Covid. And I think, and I'd have to do a deeper dive, but I know anecdotally, a number of them are related to patients who got Covid take homes and weren't really ready for them, you know. Or they kind of bombed, or maybe they had those take homes and then they got them suspended and they got, you know, kind of a case of the F-it's and walked out of treatment and said, screw this. You know, I'm not coming back, even though it was working very well for them. And again, they didn't earn those take homes, and they could have gotten them back probably if they just stayed the course, right?

Later saying

I don't know, but what our assumption was, as staff, was that the drugs might be harder to get for patients. But anecdotally, they've told us no, it's fine. Like they're still easy to get. Now they did say like for someone who already has the hookup, if you will, that's very easy for them to continue and maintain, right? For someone who is maybe new to the area, or new to drug use, or something like that, that might be more difficult for them. I will say, we have seen a lot of people relapse that were previously sober during like Covid times.

Modifications to pilot intervention

Police and community program partners used their harm reduction experience, and their knowledge of the clients they serve to modify and target the kits in the field. PAARI encouraged the departments to modify the kits to better suit the needs of the community. One police officer spoke about the kit being a bit overwhelming for people in the street, saying

I think it's a little overwhelming to those on the street in regards to having to take the cup and add the water and everything, so, I think if it was a simpler form, it would be great. For those parents that took it to bring to their house, there was great feedback on it. To give to their individuals... Yeah, that were in need. But I think the community of those that are on the street, I think we might be overwhelming them [with the kits].

Expressing similar concerns, some community programs reported modifying the kits. Primarily, programs reported including their own card or information about how to contact the community partner organization. There were some specific modifications and included materials that programs reported as problematic, as discussed below.

Modification: The inclusion of Dixie cups was confusing to some people.

Per MDPH and literature-based recommendations to do so, PAARI modified the kit to include Dixie cups as new information suggested that drug samples, especially stimulants, needed to be diluted in about a third of a cup of water for accurate test results. While some programs understood why the cups were there, the message about dilution was inconsistently communicated. When asked why the cups were included, one community partner was able to say why, saying

He said that the cups were because some people were getting a false positive because they did not put enough water in a cup to do the testing, so they included a couple of cups to like fill with water for a more accurate test, I suppose.

While others objected to the bulkiness of the cups in the packages.

Oh, it's so people can use it to test drugs. Clients don't need that, so it's bulky, you know, when you're giving out a package, you want it to be where they can put it in their pocket, their backpack, you know?

Modification: Too much paper and bulkiness

Other community partners noted that there was a lot of **paper** in the kits with one saying

I mean, I think there's a lot of paper in them also, which is some of it is really useful and I think some of it could probably be reduced down to the basics.

Another also noted this, and described consequences of including too much paper, saying

I look at those bags, and I'm like, "Whoa, that's gonna get you in trouble," because of our own experience of giving out information and health information, and it ending up in the street as, like, drug trash and us getting in trouble from law enforcement for giving out stuff and creating litter.

Another community partner repackaged the kits into small bags and added other materials,

We add water, like, sterile water. Usually, we'll add, like, a cooker. What else do we add? Something with instructions on it, and some other, like, of our material so that they know how to contact us. But, yeah, I know that we'd like to repackage them more just because they're a little bit bulky, which it maybe seems like a silly complaint.

Community partners went on to report on other strategies, in addition to repackaging the kits into smaller packages, to target the kits to specific groups.

Modification: Targeting distribution of kits to stimulant users

Many of the community partners selectively distributed the kits to people who use stimulants (PWUS), reporting that opioid users knew there was fentanyl in their drugs, and often declined to take a kit. One community partner described why targeting PWUS with test strips was likely to reduce overdoses among this population saying,

If we were a program that was not a [treatment program] that worked with cocaine users and we're targeting cocaine users to test their cocaine that might accidentally or potentially laced with fentanyl, I think you could maybe prevent a lot of overdose deaths there. You will capture some for sure, and there will be some overlap, or maybe it's distributing it to the OTP's and then they distribute it [fentanyl test strips] to their cocaine abusing friends, you know, and things like that, you know. 'Cause it's like there's not really a lot of programs. There's no detox for cocaine. You can't go inpatient to like detox off cocaine, you know. There's not a ton of treatment options out there for that.

Another reinforced the importance of test strips for PWUS saying,

But I think they're [FTS] super useful still when it comes to people who are using stimulants or pills, especially people who are not used to using opioids or that's not really what they're going for, because I think for those individuals it can be really, really dangerous to suddenly end up with a high dose of a potent opioid with no tolerance, you know, so...

A community partner reported that FTS were part of safety planning as clients switch from opioids to stimulants,

But we did have some people that were still newer. I've seen a lot of people switch, that their drug of choice was heroin and then fentanyl then move away from fentanyl when it first came on the scene because they were very nervous about a lot of different things and so they switched to using stimulants. And then the test strips did come in handy for that during that transition when they stopped using an opioid and started using primarily stimulants. Yeah, I mean, it was all really safety planning on their part to switch substances too.

Another community program noted that for opioid users, the additional knowledge that FTS could provide was a few years too late, as fentanyl is ubiquitous in the current supply of opioid drugs.

Some people have denied taking them [fentanyl test strips]. They don't want them. They're like, "I know. I don't do other drugs. I just do dope, and then that's fentanyl, and I'm not gonna waste my time." So, that's the interesting piece, and the kind of the sad piece is, like, we're in this time now where people don't want them, and we had all those years where people were begging us....

Modification: Kit information needed in other languages, especially Spanish

The kits as distributed contained only information in English and the need for translated materials was noted by both police and community partners. One police officer noted the need for Spanish and Portuguese materials in the kit, saying

I was actually thinking, 'cause I was in that training, I think it was Monday and they were saying they were making a Spanish one. But I definitely think in [CITY] area, we definitely need a Spanish and Portuguese one 'cause we have that both populations here.

A community partner discussed the need for information to support PWUD living there who identify as being from the Central American community:

Yeah, for sure. I'd say... Well, the area where we are too. So we're like in the north, they call it the near-north end, and there's a large Central American community there as well. So..... No, I think definitely Spanish. Even, you know, maybe K'iche'. I don't know. I know that's a harder language.

Another community partner tied the need for Spanish instructions to the demographic profile of the city saying,

Oh yeah...I mean that's... you know, in [CITY] it's about, you know, 50 percent of the population is Puerto Rican descent and I can't remember, I think about half of them, Spanish is their primary language.

Finally, one evaluator conducted an observation at a harm reduction site. A woman who only spoke Spanish came to the site seeking harm reduction supplies. She picked up several items but the provider did not give her a kit because the woman did not speak English, and nobody spoke Spanish well enough to give her instructions on using the FTS. Provision of instructions in Spanish, and other languages, is a critical modification that should be made to the kits.

Secondary distribution

PAARI's decision to include three test strips (versus one or two) in each kit resulted in secondary distribution of test strips to other and potentially higher risk individuals, as was intended. Secondary distribution can be used as a strategy to expand the reach of public health and harm reduction tools like FTS. One community partner reported an incident of secondary distribution, saying,

I heard back from one patient who said that they were giving it to a friend, like a friend who's not in treatment with us and would it be okay if they gave it to them. And I said, sure, you know, 'cause they said, oh, they mentioned it to a friend who is using and has concerns about, you know, what's in these street drugs, 'cause I always tell patients, you know, it's not like it's FDA approved. You never know what's in there when you're using street drugs. And so she was very excited to be able to give it to a friend of hers who wasn't in treatment and didn't have access to the resources that she does being in treatment.

While we were unable to extensively interview kit recipients due to the COVID-19 pandemic, we did talk to two kit recipients. One recipient spoke about teaching people how to use strips. In an account of one incident, the recipient asked a friend what drug he was using, and went on to describe the incident:

He was like, well, you know, I don't know for sure, but it is coke. Why would it be? I said, all right, so I got something for you... I want you to, 'cause you're not too sure.... I pulled it out and... he goes what is that. I said, well, so let me just explain to you what it is...

So I'm gonna do this with a little bit of water, you know, so I said I'm gonna show you. He says, no, you're gonna go... 'Cause it was just like a little bit. Right. So he said, you're not going to ruin my shit,

my stuff, you know what I'm saying? I said, listen. If you take this part 'cause you don't even know what you're dealing with. All right, so...

Whatever, long story short, I put a little water with it up to this line, where I put a line at, put a little water in it, and I took the strip out. As soon as the strip was out, he's like, what is that? Like a test, like a drug tester or whatever have you, right. So I said, no, it's not a drug test. It's just to let you know that powder, it's cut with fentanyl and then it shows there's fentanyl in it. And he was like, no, you-you're lying. I said, no, honest to god, it lets you know, like he asked if I had used it before. I told him, yeah. But I would just like it was my first time using it when I was showing him. Right. So I told him, yeah. So-and then I dip it in and then it was no fentanyl in it, in his cocaine. 'Cause the... the strip didn't... It just had color, but it didn't show the fentanyl strip line...

This respondent recounted another incident with a friend, who used an FTS on an alleged Percocet pill,

And she was just like, even when she was rubbing her hand on it, it was like the white was coming off on her hand. So she was like, ah, this ain't perc. Perc don't usually do this, right. So she goes, all right, so [person's name] gave me this freaking rapid thing. So, she used it and she used it. They gave her a fentanyl pill instead of a Percocet pill.

[Q: Yeah. Did she take the pill anyway?]

No, she didn't take it.

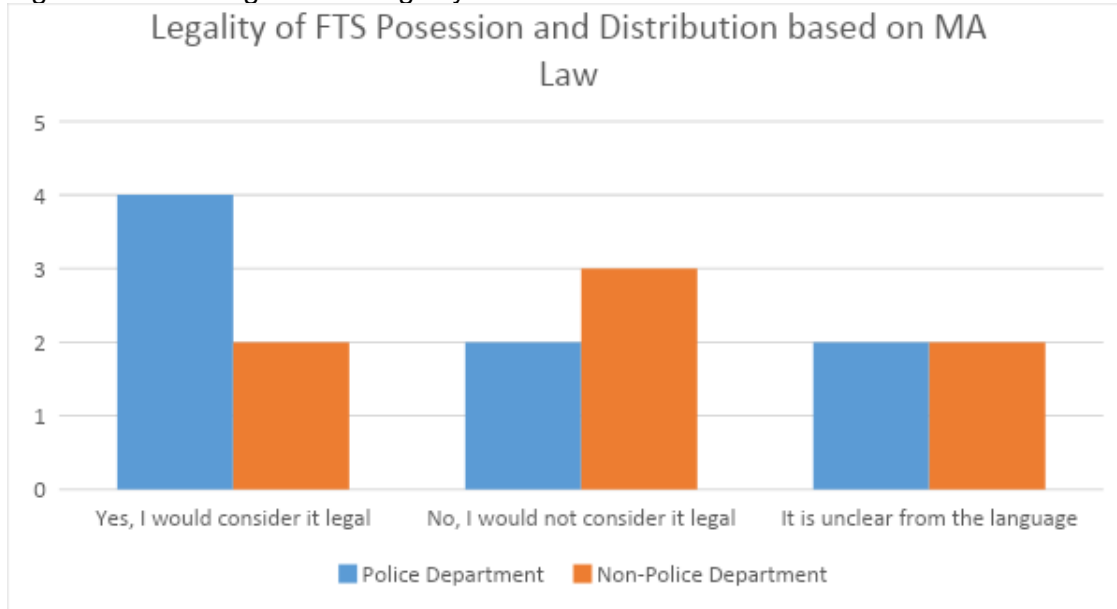
Exit Survey Results

We received 18 complete responses and 5 partially completed responses (70% response rate): eight community programs and 10 police department responded. Street outreach (n=14) and post overdose outreach (n=14) were the main pathways through which respondents intended to distribute kits, followed by distribution through a collaboration with a community program (n=10). Currently many respondents distribute naloxone through street outreach (n=10) and post overdose outreach (n=11) and through collaboration with another agency (n=9).

Importantly, participation in the pilot led to expanded community and police department interest in harm reduction supply provision. These included two police department respondents who indicated that they do not currently distribute naloxone but would like to start. One police department respondent and one community program respondent reported that they do not currently distribute sterile syringes but would like to start. In addition, four police departments and one community partner indicated that they would like to start distributing personal syringe disposal units, joining the six other respondents who do so already. Overall the respondents considered kits, sterile syringes, and naloxone good harm reduction and engagement tools. Almost all respondents disagreed that naloxone, sterile syringes, or kits are classified as drug paraphernalia.

Interestingly, as shown in Figure 3, after reviewing the text of the Massachusetts law Section 321 that defines drug paraphernalia, there appeared to be more confusion on the matter. More police department respondents considered the possession and distribution of FTS to be legal, compared to community program respondents. More community programs were concerned that the possession and distribution of FTS were not legal. More than one police department and community program partner found the language to be unclear. A majority of respondents endorsed changing the law to improve clarity: 15 of 17 indicated that the law should be amended to allow people to possess and distribute FTS.

Figure 3. Knowledge of the Legality of FTS Possession and Distribution Based on MA Law



Vision and Rationale: Discussion

The pilot distribution program was implemented with an objective of creating an opportunity with the FTS kits to engage people who use drugs and their social networks and provide awareness of local supporting services in order to create additional pathways and linkages to services. As one PAARI key informant shared,

Well...the pilot was asking could this be used as an engagement tool. Just another thing to talk about. To elongate the first contact. And to add to that contact some piece of empathy to the circumstance of the person. To send the message 'yeah, we care about you in a number of ways. To keep you safe, and this is just one of those ways.' But we had no expectation that we were going to be discovering fentanyl that people didn't know about.

In 90 days and during a Massachusetts stay-at-home orders and suspension of all non-essential services, FTS pilot partners distributed **320 kits** leading to **318 referrals for supporting services such as harm reduction, drug treatment, general counseling, wound care, meals/food, and housing**. Regardless of the pandemic, people who use drugs and their social networks needed services and FTS pilot partners strived to meet those needs.

FTS pilot partners were forced to rethink traditional outreach models, of which this program was predicated on. A critical concept underscored by the pandemic, is the definition of “essential service”. For police departments involved in the pilot, the pandemic forced them to revert to policing services that minimized personal contact with the public at large. As a result, most police departments disengaged from in-person outreach efforts, adapted as they could to remote telephonic measures and brief materials drop-offs, and shifting in-person services to those of community program partners who fulfilled them instead, as part of the community partner’s “essential service” provision. Nevertheless, police departments remained committed to community engagement, some suspending all such work and others adapting outreach functions to non-contact methods. With PAARI’s central involvement in this pilot project, there was infrastructure for cataloguing how departments adopted FTS into police department led outreach efforts and that fit alongside ongoing PAARI efforts to provide technical assistance to police doing outreach work in the community. A PAARI leadership key informant noted:

We have been documenting how police departments responded. The variety of tools they created or repurposed to maintain contact with people. We've developed new telephone outreach protocols for the [PAARI supported police department] recovery coaches. Recovery coaches themselves have been

resilient. And learned how to stay in contact by phone. So, these lessons are being documented. I think that we're distributing this documentation to our members in Massachusetts, and around the country. We're documenting the conversations among the departments about the techniques that they've been experimenting with.

Similarly, community partners gathered with state, local, academic and professional supports to generate and disseminate best practices during COVID-19. These adaptations are part of the story of the pandemic, and also central to this pilot project.

Conclusion

The pilot program demonstrated feasibility and proof of concept that police departments can effectively distribute the kits to people at risk of witnessing or experiencing an overdose. This pilot has shown that these agencies can perform this task both on their own and, more productively, by leveraging existing and new community partnerships. During the three-month pilot, there were over 300 kits (approximately 900 individual strips) provided and nearly 300 referrals to a range of services, supplies and supports that included SUD care options and other basic health and social support needs. This approximate 1 to 1 ratio of kits to referrals suggests a promising sign of project impact. In order to implement the pilot and maintain commitments to overdose prevention, engagement, and linkage to services, police departments demonstrated flexibility and resilience. Community partners demonstrated creativity, flexibility, and a willingness to collaborate with police on the pilot in order to better serve the needs of their clients and the chance to reach PWUD who are not involved with harm reduction services. The COVID-19 pandemic clearly exposed the need for an emergency management planning framework for future interventions for PWUD, and for the service and police departments who care for and interact with them. The lack of clarity on the legal status of FTS and drug checking more generally undermines the potential of this engagement and harm reduction tool for both police department and community partners. The pilot showed FTS as one, promising engagement tool set within the broader landscape of overdose awareness and as a complement to more comprehensive strategies for drug checking interventions.

Appendix 1

Roll Call Video Links

Outreach Visit Amid COVID-19

<https://vimeo.com/432306046>

FTS Training – Home Visit

<https://vimeo.com/401360827>

FTS Training – Outdoor Visit

<https://vimeo.com/401361892>

Fentanyl Safety Training

<https://vimeo.com/432306286>

Appendix 2

Key Dates

Upon funding notification, early March: Request for applications went out March 6th, 2020

March 20, 2020: Announcement of accepted sites

March 27, 2020: Orientation and Training Session

March 31, 2020: FTS sent to all pilot sites

April 3, 2020: Pilot began

May 14, 2020: Midpoint check in with sites

May 27, 2020: First qualitative interview

June 30, 2020: Pilot ended. End of pilot convening with pilot sites

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