Report of the National Survey to Assess

First Responder Deflection Programs in Response to the Opioid Crisis

FINAL REPORT

May 13, 2021

BJA's
Comprehensive
Opioid, Stimulant,
and Substance Abuse
Program

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1. Executive Summary

We are proud to share the Report of the National Survey to Assess Law Enforcement-led Diversion and First Responder Deflection Programs in Response to the Opioid Crisis.

This is a first-of-its-kind national, federally-funded survey specific to law enforcement-led diversion and first responder deflection (FRD) built on the five pathways of deflection.

This survey and report encompass what we believe to be the most comprehensive overview of the field and its role in responding to the opioid crisis—as well as how deflection/first responder deflection offers alternatives to law enforcement and first responders in their work.

The report first provides an *Introduction* to and history of the field and discusses how significantly diversion and first responder deflection are responses to the opioid crisis, which for a generation has left a significant mark on communities of all sizes and types across the United States. From there, the *Key Findings and Takeaways section* highlights major conclusions of the data gathered and analyzed, with embedded links to the relevant data addressed by each key finding. A *Conclusions section* spells out and projects how the critical findings of this report may apply to a range of policies and important issues in the justice system and related areas, including public health, public safety, and other sectors. Finally, the *Appendices* contain the charts, tables, and graphs created from the survey data, as well as the survey questionnaire.

Major findings include:

- **Most deflection programs were created and led by law enforcement agencies.** These programs typically were initiated at the local level for particular public health and public safety reasons. While most deflection programs are law enforcement-initiated, the localized nature of these programs is not yet aligned under a standardized model of protocols and common procedures by which they operate.
- **A wide variety of deflection programs—many based on early-adopter models like Quick Response Teams (QRT), Law Enforcement Assisted Diversion (LEAD), Civil Citation Network (CCN), and Angel—exist and generally are driven by local needs and priorities.** The different pathways for building and managing these programs generally focus on similar goals, such as linkage to treatment and services for substance use disorders (SUD).
- **Deflection programs operate through networks of collaboration and partnerships with a host of providers and agencies. Most respondents report that a dedicated program coordinator is responsible for managing day-to-day operations. Further, deflection programs rely on stakeholder-partners for broad governance and decision-making.** The partners who deliver the core deflection services include case managers, mental health and SUD treatment providers, peers, and a range of social services entities, as well as newly emerging jobs in the field such as deflection specialists. These partnerships—across the justice system, the treatment/recovery system, and the broader community itself —are critical to program sustainability and rely on stakeholder-partners for effective program management.

- **Substance use disorder treatment, including medication-assisted treatment (MAT), is the leading service to which deflection programs link.** Virtually all programs that responded to this survey provide linkage to SUD treatment, a critical element given the primacy of opioid use and overdose in driving development of FRD programs. Programs also increasingly collaborate to provide linkage to a range of outpatient and inpatient services (treatment- and non-treatment-related) consistent with community needs.
- **Recovery support services are involved in about 80 percent of deflection programs.** Roughly four of five programs that responded to the survey provide links or access to recovery support specialists, peer recovery coaches, or similar professionals including the newly emerging job title “deflection specialist”—an important element in encouraging program participation by clients.
- **Deflection programs—nearly 90 percent of those participating in the survey—proliferate in states that have expanded Medicaid through the Affordable Care Act, though funding for services tied to FRD programs is approximately equal between public and private sources.** Funding can be a limiting factor in accessing treatment and services. The significant presence of programs located in Medicaid expansion states illustrates the importance of having access to public as well as private resources.

We invite you to use and share this report with your colleagues.

2. Acknowledgements

We would like to thank all of the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) partners and members of the TASC Center for Health and Justice's National Survey Advisory Board for their assistance, insight, and contributions to all aspects of this survey.

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3. Introduction

The Opioid Crisis: A Catalyst for Police Innovation and the Birth of Deflection and Pre-Arrest Diversion

The opioid crisis—the dramatic rise in overdoses and deaths tied to a range of opioids—is a generation-long phenomenon. Drug overdoses have taken the lives of more than 750,000 Americans since 1999,[1] and about two-thirds of all drug overdose deaths from 1999 to 2018 were associated with opioids.[2]

Drug use, opioid use in particular, has contributed to a flattening of or decline in life expectancy, from 78.9 years in 2014 to 78.6 years in 2017, with overdose death rates rising in particular (with a related drop in life expectancy) in adults 35 to 44 years of age.[3] Over the past generation, death rates due to synthetic opioids other than methadone have increased the most dramatically, from 0.3 per 100,000 in 1999 to 9.9 per 100,000 in 2018, a rise of more than 3,000 percent. Overdose deaths from heroin increased by more than 400 percent during that time, and overdose deaths from natural and semisynthetic opioids like oxycodone increased by approximately 300 percent.[4]

The opioid crisis itself is typically characterized as having three "waves." The first included the increased prescription of opioids in the 1990s; the second began in approximately 2010, with significant increases in heroin-related overdose deaths; and the current wave began in approximately 2013, with a dramatic rise in overdose deaths tied to synthetic opioids (notably fentanyl), including those manufactured and sold illegally.

The number of opioid-related overdose deaths quadrupled from 1999 to 2015, accounting for approximately three of five drug-related deaths during that period. The second wave of the crisis saw a four-fold increase in heroin deaths in just five years, from 2010 to 2015.[5] In 2018-2019, opioid-related deaths approached 50,000, constituting about 70 percent of drug-related fatalities.[6]

The rise was particularly dramatic between 2017 and 2018, with double-digit growth in prescription opioid- and synthetic-opioid-involved deaths and notable increases in opioid- and heroin-related deaths. As the Key Findings and Takeaways section of this report indicates, both

[1] National Institute on Drug Abuse. STATCAST. Sept. 2019. Available at: https://www.cdc.gov/nchs/pressroom/podcasts/20190911/20190911.htm.
[2] Hedegaard H, Minino A, Warner M. (Jan. 2020). Drug overdose deaths in the United States, 1999-2018. U.S. Department of Health and Human Services, National Center for Health Statistics. NCHS Data Brief, #356. Available at: https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf.
[3] U.S. Department of Health and Human Services; National Center for Health Statistics. National Vital Statistics System, Mortality. https://www.cdc.gov/nchs/nvss/deaths.htm.
[4] Hedegaard H, Minino A, Warner M. (Jan. 2020). Drug overdose deaths in the United States, 1999-2018.
[5] O'Donnell JK, Gladden RM, Seth P. Trends in deaths involving heroin and synthetic opioids excluding methadone, and law enforcement drug product reports, by Census region - United States, 2006-2015. *MMWR Morb Mortal Wkly Rep.* 2017;66(34):897-903.
[6] National Institute on Drug Abuse. Overdose death rates. Available at https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates#:~:text=Opioid%2Dinvolved%20overdose%20deaths%20rose,in%202018%20with%2046%2C802%20deaths.

the initiation of FRD programs and the proximate causes for creating most of these programs are associated with significant increases in the number of fatal and nonfatal opioid overdoses. In this way, the opioid epidemic has both generated and accelerated the field of deflection and pre-arrest diversion. It is credible to posit that without the opioid crisis, the field would never have grown as rapidly as it did, as almost all the early deflection sites were established in response to opioids misuse and overdoses in the community.

The Evolution of Deflection and Pre-Arrest Diversion

Since the 1970s, the United States has supported and enforced policies that emphasize arresting and prosecuting individuals who traffic in and distribute illegal substances, as well as those who purchase and use such substances. However, spurred by the alarming number of fatal and near-fatal overdoses resulting from the opioid epidemic, law enforcement officials came to realize that they cannot arrest their way out of this problem and were compelled to devise alternative strategies. Since 2011, to better serve individuals who have substance use disorders (SUD), some law enforcement agencies began moving from an enforcement approach to a model that blends public safety and public health. A growing number of justice leaders now recognize addiction as a chronic, relapsing disease of the brain that often can better be addressed through treatment and prevention.[7] This movement by law enforcement toward a public health approach to address substance use disorders constitutes a paradigm shift that has led to the emergence of deflection, pre-arrest diversion, and FRD programs.

These programs are collaborative interventions connecting public safety (e.g., law enforcement, fire, and emergency medical services [EMS]) with public health systems to create community-based pathways to treatment and services for people who have SUD, mental health disorders (MHD), or co-occurring disorders. In partnership with SUD treatment providers, other service providers, peers, deflection specialists, and recovery personnel, these multidisciplinary programs help reduce overdoses through connection to community-based treatment and services. For law enforcement, deflection programs can enable individuals to receive referrals to services without fear of arrest if the individual does not accept deflection (in cases when law enforcement would have otherwise taken no action) or can serve in lieu of arrest when charges are present and an arrest would have otherwise occurred.

FRD programs have proliferated over the past decade,[8] with almost all the growth occurring since 2016 consistent with the third wave of the opioid crisis, as this report addresses in detail (see Exhibit 1).

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[7] Barbieri D, Taxman P. Diversion and alternatives to arrest: A qualitative understanding of police and substance users' perspective. *J Drug Issues*. 2019; 49(4):03-717. https://doi.org/10.1177/0022042619861273

[8] Charlier J, Reichert J. (2020). Introduction: Deflection - police-led responses to behavioral health challenges. *Journal for Advancing Justice*, *III 2020*: (Emerging best practices in law enforcement deflection and community supervision programs), 1-8.

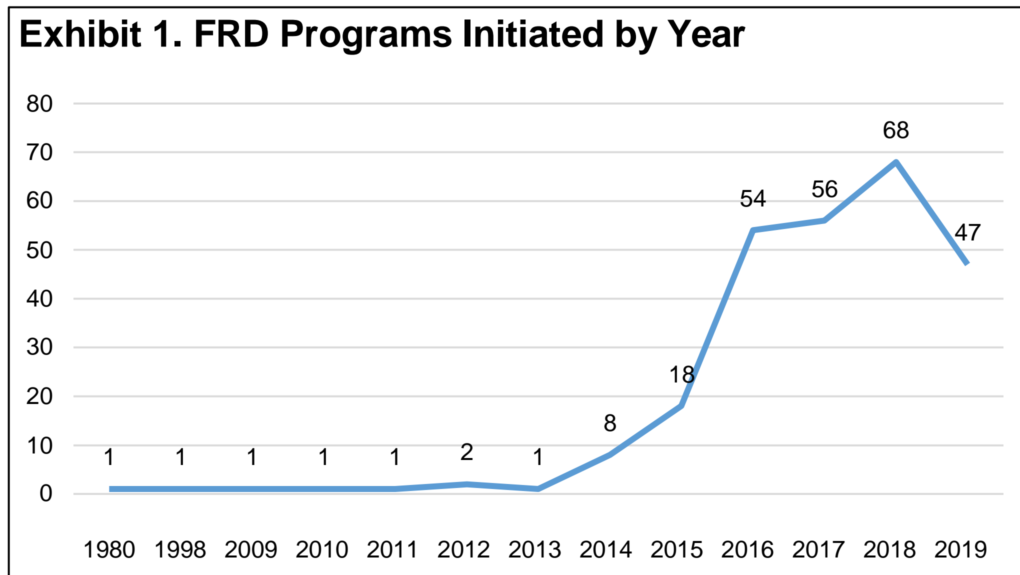

Exhibit 1. FRD Programs Initiated by Year

Although most FRD programs aim to address the effects of the opioid crisis by increasing linkages to treatment, they also have a variety of other objectives. Proponents of FRDs argue that these programs can advance a number of important outcomes, including:

- Reducing the stigma around SUD
- Improving community-law enforcement relations
- Facilitating more effective public safety interventions
- Addressing racial disparities in both the justice and treatment systems
- Improving outcomes for individuals with SUD and MHD
- Keeping families intact
- Shifting social service responsibilities from the justice system to the behavioral health and public health systems
- Creating cross-system collaborations between law enforcement and the behavioral health system that promote public safety and public health

Because deflection is still an evolving practice, research is necessary to determine best practices and whether these outcomes are achievable. This survey and the information it generated constitute an important first milestone for data gathering and analysis in this field.

What's in a Name?

It is important to differentiate among some of the terms commonly used in this document, specifically "deflection" and "pre-arrest diversion." Deflection and pre-arrest diversion are two sides of the same coin—i.e., they are complementary practices of a systems approach at the intersection of first responders, SUD and MHD treatment, recovery support, and community. These two practices, always taken together as a single coin, are simply referred to as the "field of deflection." This document will use the following definitions of "deflection" and "pre-arrest diversion:"

Deflection is the practice by which law enforcement or other first responders (i.e., fire and EMS) connect individuals to community-based treatment and/or services when arrest would not have been necessary or permitted, or *in lieu of taking no action* when issues of addiction, mental health, and/or other need are present. Deflection is performed without fear by the individual that if they do not "accept the deflection" they will subsequently be arrested.

Pre-arrest diversion is the practice by which law enforcement officers connect individuals who otherwise would have been eligible for criminal charges to community-based treatment and/or services in lieu of arrest, thereby *diverting* them from the justice system into the community. Some pre-arrest diversion programs have policies that mandate holding charges in abeyance until treatment or other requirements, such as restitution or community service, are completed, at which time the charges are dropped. Although pre-arrest diversion is facilitated by justice system stakeholders (usually police and sheriffs but sometimes prosecutors or a local government agency[9]), clients are diverted to community-based services.

Pre-arrest diversion programs should not be confused with prosecutorial diversion, which occurs after individuals have already been arrested and become involved in the justice system; in contrast, pre-arrest diversion occurs before the filing of charges.

According to the survey, almost 75 percent of FRD programs are led by law enforcement agencies, whereas 15 percent are led by fire and/or EMS departments. Prior to the emergence of deflection, law enforcement officers often had limited options when encountering individuals who had SUD, committed nuisance crimes, or were homeless—i.e., to arrest, advise/warn, or do nothing. Deflection and pre-arrest diversion programs provide law enforcement the option of connecting these individuals to community-based treatment and services. Likewise, fire and EMS personnel often respond to SUD-related medical emergencies, often for the same individuals, and, like law enforcement officers, before deflection, they had been limited to reversing overdoses with naloxone without being able to follow up or provide any outreach. Deflection programs allow first responders to reach out to individuals with SUD and other needs, as well as their families, to offer connections to substance use and mental health treatment, resources, wrap-around services, and, in some cases, naloxone.

This report will use "deflection" and "first responder deflection" ("FRD") to discuss the work of the agencies that responded to the survey to describe this evolving field of deflection.

The Five Pathways of First Responder Deflection

First responder deflection has grown and continues to grow as jurisdictions decide to adopt public health, rather than enforcement, responses for people affected by SUD, MHD, and other issues that drive criminal behavior. A number of "branded" models of FRD programs have

[9] See Yellow Line Project in Blue Earth County, Minnesota (*https://www.yellowlineproject.com/*) and the Goldilocks Project in Deschutes County, Oregon (*http://www.dcda.us/c5/deschutessafe/goldilocks/#:~:text=In%202017%2C%20the%20Deschutes%20County,drug%20crimes%20in%20Deschutes%20County*).

become familiar to public safety leaders, including the Police Assisted Addiction and Recovery Initiative (PAARI[10]), which was established to help law enforcement agencies replicate the Gloucester (Mass.) Angel program;[11] Quick Response Teams (QRT[12]); Civil Citation Network (CCN[13]); and the Law Enforcement Assisted Diversion (LEAD)[14] program. Many jurisdictions seeking to launch deflection programs looked to these brands to model their own efforts. But because what works in one jurisdiction—accounting for its size, demographics, treatment capacity, and other factors—may not work in another, simply copying an existing model may not be an effective approach. Further, adopting a branded approach can be a limiting factor in how that community thinks about deflection. Another reason why the "branded" approaches may not be the best way for the field to grow is that they represent only part of the range of deflection pathways available to a community.

In 2014, Treatment Alternatives for Safe Communities (TASC), Center for Health and Justice (CHJ) developed the first iteration of the five Pathways to Treatment, which offered different pathways for deflection that first responders could use to move someone from the justice system at the point of contact with law enforcement to community-based treatment. Each pathway has unique characteristics that make it appropriate to address particular problems such as SUD, OUD, MHD, homelessness, and other issues. Identifying and naming these pathways created a common language for practitioners to use in the new, emerging field of deflection.

The pathway(s) implemented by a community in a given FRD program should be informed by a problem-solution orientation, based on specific problems to be addressed in that community (e.g., substance use, mental health, housing instability, and others) and how available resources can be best aligned to serve the needs of the target population (e.g., treatment, recovery, stakeholder support, and so forth). Furthermore, FRD programs should fit each community's unique needs, because there is no one-size-fits-all approach. An important step in deciding which pathway is the best fit is to become familiar with all of five of them, which issues each one is meant to address, and how they function. Finally, each pathway is associated with different levels of investment needed to plan, implement, and operationalize it. In summary, identifying which elements of a pathway could be adapted and applied to suit a jurisdiction's particular needs is critical.

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[10] https://paariusa.org/
[11] https://paariusa.org/gloucester/
[12] https://qrtnational.com/
[13] https://civilcitation.net/
[14] https://www.leadbureau.org/

Exhibit 2 explains the five pathways, the targeted populations with which they are associated, and examples of established “brands”:

Exhibit 2. Five Pathways to Treatment

Pathway	Target Population & Brand
Self-Referral: An individual voluntarily initiates contact with a first responder agency (law enforcement, fire services, or EMS) for treatment referral. If the contact is initiated with a law enforcement agency, the individual makes the contact without fear of arrest.	Individuals with substance use disorders (SUD) PAARI (Gloucester, MA Angel Program)
Active Outreach: A first responder intentionally identifies or seeks out individuals with SUD to refer them to, or engage them in, treatment; a team consisting of a clinician and/or peer with lived experience often does the outreach.	Individuals with SUD PAARI (Arlington, MA, Outreach Program)
Naloxone Plus: A first responder and program partner (often a clinician or peer with lived experience) conduct outreach *specifically* to individuals who have experienced a recent overdose to engage them in and provide linkages to treatment.	Individuals with opioid use disorder (OUD) QRT and Drug Abuse Response Teams (DART)
First Responder/Officer Prevention: During routine activities such as patrol or response to a service call, a first responder conducts engagement and provides treatment referrals. [NOTE: if law enforcement is the first responder, no charges are filed or arrests made.]	Persons in crisis or with non-crisis mental health disorders and substance use disorders, or in situations involving homelessness, need, or prostitution LEAD
Officer Intervention (only applicable for law enforcement): During routine activities such as patrol or response to a service call, law enforcement engages and provides treatment referrals or issues (noncriminal) citations to report to a program. Charges are held in abeyance until treatment and/or a social service plan is successfully completed.	Persons in crisis or with non-crisis mental health disorders and substance use disorders, or in situations involving homelessness, need, or prostitution LEAD and Civil Citation (FL)

Collaboration between and among first responders and community-based behavioral health, treatment, and service providers is crucial to the success of deflection programs and facilitates the creation of these pathways. Each pathway is associated with specific elements that are implemented in different ways. Communities that initiate FRD often begin with a single pathway, and then add pathways as their programs evolve.

Contributions of this Report to Understanding Deflection

The data gleaned from this first-ever national, federally-funded survey specific to law enforcement-led diversion and first responder deflection built on the five pathways of deflection, give researchers a starting point for understanding how first responders have addressed the opioid crisis in the United States, whereas previously they could only speculate about such programs.[15] Analysis of these data reveals the nature and number of partnerships within FRD programs; examines reported gaps in treatment, recovery support, and wrap-around services; explores training needs for first responders to reduce barriers to implementation, reduce stigma, and encourage equity regarding who is deflected; and considers methods for encouraging sites to partner with researchers, collect data, and report on the programs' processes and outcomes.

One of the challenges to the emerging field is ensuring that research keeps pace with the growth of the field. Currently, only one of every six programs that responded to this survey conducts formal evaluation of its programs to assess and improve their performance. Still, at the national level, researchers are building a body of evidence-based practices that can inform and guide the development of new sites and improve existing sites' practices. This report will help to expand the knowledge base about FRD programs, and, we hope, spur further data collection efforts to help us understand if these programs are as beneficial as hoped, and how.

[15] The survey was targeted solely to programs that serve people with substance use disorders, especially opioid use disorders.

4. Methods

Organizational participants

Survey participants were representatives from law enforcement agencies, fire departments, and emergency medical services (EMS) departments who completed organizational surveys on behalf of their organizations. At no point in this process did we ask for any deflection program representatives' personal views of their agencies or for individual records of clients/suspects. To qualify for the study, an organization was required to operate a law enforcement, fire, or emergency medical services-led deflection program that served individuals with substance use disorders (SUD), primarily opioid use disorder (OUD). FRD programs are partnerships with treatment and/or service providers or other initiatives in place to directly connect individuals with an SUD to treatment or intervention services. Organizations without a deflection program were not eligible to participate in the study.

The survey was limited to programs that were created to serve individuals with OUD and other SUD (not including marijuana) and that have substantial law enforcement, fire services, or EMS engagement. Justice system FRD programs operated by prosecutors or the courts (drug courts, treatment courts, and others) were excluded. Likewise, programs with a primary focus on addressing homelessness, untreated mental health disorders, and/or public nuisance offenses were not within the scope of this survey. The survey aimed to collect information that will allow federal, state, and local stakeholders to better understand the operational nature of FRD programs that fall under one or more of the following five frameworks, also known as the five pathways for deflection:

- *Self-Referral:* An individual voluntarily initiates contact with a first responder (law enforcement, fire services, or EMS) for a treatment referral (without fear of arrest) and receives a warm handoff to treatment.
- *Active Outreach:* A first responder identifies or seeks out individuals in need of SUD treatment; the first responder then directly transfers the person to a treatment provider, who engages the individuals in treatment.
- *Naloxone Plus:* A first responder refers an individual to treatment as part of an overdose response.
- *First Responder/Officer Prevention:* During routine policing activities, law enforcement initiates treatment engagement, but no charges are filed or arrests made.
- *Officer Intervention:* During routine policing activities, law enforcement initiates treatment engagement; charges are held in abeyance or citations are issued, with a requirement that the individual complete a treatment plan, which can range from obtaining a clinical assessment to attendance in an appropriate treatment program to completion of a clinically appropriate treatment program.

Procedures of study

The research team at the National Opinion Research Center at the University of Chicago (NORC), along with CHJ staff, identified an initial group of 805 possible first responder

organizations thought to operate an FRD program. The team built on earlier work by CHJ that utilized nationally based listings already compiled by sources such as state entities that have compiled their own lists of eligible deflection programs. The team identified another 75 first responder organizations operating opioid deflection programs through outreach by first responder associations to their members (for a list of all partners and advisors, see *Acknowledgements)*. The total group of eligible respondents was 880 (805 + 75) organizations.

NORC conducted an automated check of the respondents' addresses using address management software (SmartMailer 7.0 by Pitney Bowes) to assess whether the roster contains a legitimate street address. If the address was missing some piece of information (e.g., ZIP code), NORC did an internet search to add the missing information (e.g., securing missing information from organizational websites). Any evidence that the contact information was no longer accurate (e.g., an address bounce-back) led us to do a search on the organization to secure up-to-date information. Once we cleaned the address list, we sent eligible organizational participants a voluntary survey to complete.

The development of the survey involved a number of stages. Initially an expert panel of 20 persons familiar with the operational models of law enforcement/FRD programs met with the Institute for Intergovernmental Relations (IIR), /CHJ, and the National Opinion Research Center (NORC) at the University of Chicago to draft the measures and definitions of deflection programs and frameworks. Then NORC subjected the survey to cognitive testing to learn how well candidate questions performed when working with opioid and SUD deflection programs during the fielding of the survey. We assessed both respondents' level of comprehension and their ability to provide accurate answers. NORC conducted cognitive interviews with a small sample of respondents (n = 15) to get their feedback on the survey. The cognitive interview covered the agency's experience with the survey, its perceptions of the survey administration, and its perspective on the strengths and weaknesses of each of the survey modalities. The respondent interviews also asked whether the agency had any suggestions for improvements to the survey, protocols, or related processes. A NORC staff member conducted the approximately 60-minute cognitive interview by phone. Based on the results of the cognitive testing and related comments from the expert panel, NORC modified the survey.

The survey took place over a nine-month period from January to September 2020. Informed consent was obtained from all participants before they were allowed to start the single cross-sectional survey. The survey took participants an average of approximately 30 to 40 minutes to complete. NORC used multiple modalities that included mail, phone, fax, web, or combinations thereof and made multiple initial contacts and follow-ups with the study participants. NORC used the industry-standard Dillman (2009)[16] approach for nonresponse follow-up.

The Dillman hierarchical approach begins with the least expensive contacting strategy and mode to complete the maximum number of interviews at minimal cost and transitions to more expensive contacts and modes to improve completion rates. In general, no statistical differences in survey responses by modality were identified. All participants first received a mailed invitation

[16] Dillman D, Phelps G, Tortora R, et al. *Response rate and measurement differences in mixed-mode surveys using mail, telephone, interactive voice response (IVR) and the Internet. Social Science Research.* 2009;38(1):1-18.

letter to complete the survey online via a secure server or by phone (via a toll-free at NORC's phone center). After one month, respondents who did not complete the survey received a reminder postcard to complete the survey online or by phone. At the same time, NORC began telephone prompting. Two weeks later, nonrespondents received a reminder letter (and an email reminder in cases where we had an email address for contact person in the organization), and phone prompting continued. At the two-month mark, a FedEx mailing was sent to the respondents in an Express Mail package, on the assumption that most people do not discard such packages without first viewing their contents.

Email, phone, and postcard reminders were used throughout the remaining study period, except for a few weeks in March 2020 during the COVID-19 pandemic lockdown period. During the lockdown, NORC staff could not enter their offices to continue the mail and phone work (a limited number of email reminders continued to some extent over this period). A month before the closing of the data collection period, "last chance" efforts were undertaken, all of which included a reminder to the participants about the pending closing of the data collection period. These last chance contacts have proven to be an effective methodology for NORC when conducting a variety of surveys, including organizational surveys.[17]

Data processing

NORC developed, tested, and implemented a phone- and web-based data collection tool that securely captured data, minimized respondent burden, and enhanced data quality. All survey transactions were secured through SSL encryption, and users could access the survey via unique logins and passwords. NORC collected high-quality phone and web data through intuitive design, a user-friendly interface, and real-time, automated checking of responses for numeric range and logic error. The phone and web survey also included several value-add features such as a "resume" feature that allowed a respondent to return to the survey at a later time without losing previously entered data, email links for support requests, a status bar to communicate progress, and the ability to print a copy of responses for participants' records.

NORC closely monitored survey item response rates during data collection. Even with a well-formatted questionnaire and concise instructions, some respondents will leave questionnaire items blank, refuse or answer "don't know" to critical questions, or give inconsistent information. The NORC system included a series of automated checks and prompts to reduce the amount of incomplete or inconsistent items. After data collection, NORC assessed all variables captured in the survey for completeness and accuracy and used internal consistency checks to identify problems indicative of inaccurate reporting; we found very few missing data. Most participants who completed the survey answered all survey items.

[17] Oudekerk B, Langton L, Warnken H, et al. Bureau of Justice Statistics. Building a national data collection on victim service providers: A pilot test. 2018. Available at: *https://www.ncjrs.gov/pdffiles1/bjs/grants/251524.pdf?ed2f26df2d9c416fbddddd2330a778c6=avuvtrorej-ayruvkko*.

Study design and participation rates

The project aimed to survey all the known law enforcement, fire, and emergency medical services organizations that led a deflection program at the time of data collection that serve individuals with SUD, primarily OUD. The intent was to build a first-ever national federally funded survey specific to law enforcement-led diversion and first responder deflection built on the five pathways of deflection that cover SUD/OUD. Because that there is no known list of the universe of all these types of programs, the team had to build one.

As discussed under the “Procedures of study” section above, 880 eligible first responder organizations believed to operate an opioid FRD program were identified. This list was informed by experts in the field and from existing lists of known programs, which were built on national listings already compiled by sources such as state-level entities that have compiled their own lists of eligible deflection programs. In addition, first responder organizations operating opioid FRD programs were identified through outreach by first responder associations to their membership. A limitation of this study is that NORC did not have the resources to survey every law enforcement, fire, and EMS organization in the United States to determine whether any programs were missing from the compiled list. Notwithstanding, the list collected for this survey is the most comprehensive current list of this type assembled. Also, as noted below, not everyone on the list completed the survey, but no sampling was done from this list and attempts were made to survey every eligible organization.

Of the 880 identified organizations, it was determined that 221 did not have an opioid FRD program (e.g., agency was permanently closed, agency management indicated that they no longer operated such a program, or the information was entirely wrong and not for a first responder organization but for another part of the justice system). As these 221 potential sites do not have deflection programs, they were excluded from the survey.

The final response rate was almost 50 percent (49 percent) for 321 completed surveys based on a denominator of 659 first responder organizations (880–221 = 659). Of the 321 completed surveys, 61 percent were law enforcement-only initiatives, 38 percent were mixed law enforcement and fire and/or emergency medical services, 0.3 percent were fire department-only initiatives, and 0.7 percent were emergency medical services-only initiatives. When factoring in partial survey respondents (91 incomplete responses), the response rate was 62.4 percent (n = 411/659). Where data are available from partial respondents on a particular item, the results are included in the tabulations and charts. The team encountered a number of challenges in collecting these data, as the bulk of data collection (from January 2020 to September 2020) occurred simultaneously with the emergence of the COVID-19 pandemic in the United States in March 2020. With many first responder organizations’ resources dedicated to responding to the pandemic and adapting their work accordingly, in some organizations relatively few staff remained available to complete our survey. It can reasonably be projected that if the pandemic had not occurred, more first responder organizations would have likely participated in the survey, raising the total response rate.

Measures

The survey did not collect client-level information on individuals served in the programs; rather, it asked about aggregate data mostly from 2018 or current at the time of data collection. It was intended that the information would be gathered to develop one of the few portraits of FRD programs created to serve individuals with SUD, primarily OUD, and to help federal, state, tribal, and local stakeholders better understand the operational nature of FRD efforts, programs, and initiatives. The survey included questions on the following topical areas (see the complete survey questionnaire in *Appendix E*):

Screening question on survey eligibility

The survey started with a screening question on survey eligibility. To qualify for the study, an organization needed to operate a law enforcement-, fire-, and emergency medical services-led deflection program that served individuals with SUD, primarily OUD. FRD programs are partnerships with treatment and/or service providers or other initiatives that directly connect individuals with an SUD to treatment or intervention services. Organizations without an FRD program were excluded from the study.

Background/demographic information on first responder organization assigned to survey

The survey asked the respondents a variety of background questions regarding: location of the program (U.S. Census region[18]); government units served by the program (city/village/township, county, region, tribal jurisdiction, or other government unit); type of community or communities served by the programs (urban, suburban, rural, tribal, or other); population size of community or communities served by the program; number of fatal opioid overdoses in 2018 in the community or communities served by the program; number of calls for service to the agency in the community or communities it served; and substances most frequently misused in the community or communities served.

Type of pathways/programs adopted by agencies

Survey respondents were asked to report on the type of deflection program operated by the participating first responder organizations and whether the organization has adopted a specific model or "brand" of deflection. Respondents were asked to identify the common types of marketing and other tools used by the programs, such as brochures, flyers, or handouts; business cards; memorandum of understanding (MOU) agreements; policies; outreach at community events; Health Insurance Portability and Accountability Act (HIPAA) consents; and social media presence.

Characteristics and features of deflection programs

Respondents were asked to report on whether the programs conduct outreach to the target population through an initial contact with the assistance of a treatment case manager, a co-

[18] The variable "region" is based on the U.S. Census definition, found at: *https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf*. States were coded as follows: Northeast: CT, ME, MA, NH, RI, VT, NJ, NY, PA; Midwest: IN, IL, MI, MN, MO, ND, OH, WI, IA, KS, NE, SD; South: DC, DE, FL, GA, MD, NC, SC, TX, VA, WV, AL, KY, MS, TN, AR, LA, OK; and West: AZ, CO, ID, NM, MT, OR, WA, UT, NV, WY, AK, CA, HI.

responding case manager, an emergency department, clinic, or other medical facility; or whether the initial contact occurs without the assistance of an FRD program. The co-responders were also defined. Data also were collected on referrals to treatment and/or services through the deflection programs and who can give those referrals. Respondents were asked to report on the staff and volunteer composition of the program, the number of years the program has existed, and factors responsible for the program's initiation, as well as on training for deflection program staff.

Background information on lead agency

Respondents were asked to report on which agency is leading (and where applicable, co-leading) the FRD program, its number of staff members, and its operating budget. These reports help provide a profile of the agencies that typically lead FRD programs.

Partnerships

The respondent reports with regard to partnerships explored the number of FRD program partners and the current types of interactions among the partners. Program partners were defined as collaborative service providers who are essential to the outcomes of the FRD program. For each partner, respondents were asked to identify the types of services provided and whether there is a formal agreement in place between each partner and the program. We asked respondents to report on whether the program has a dedicated stakeholder group (e.g., task force, advisory board, or steering committee) to provide oversight and direction to the program and how often this group meets.

Treatment, services and recovery

Respondents were asked to identify: 1) the number and type of services facilitated or offered; 2) which partner agencies made the referrals and delivered contacts; 3) services offered by how many staff and by what means, including funding amount and source; 4) eligibility screening and target population characteristics; 5) and training for FRD program participants. They were asked to identify: the number of referrals to treatment and/or services by the FRD program; whether the program tracks treatment attendance/participation for individuals referred through the program; whether it conducts outreach to individuals who do not attend their initial treatment and/or service referral; whether the program operates 24 hours per day, seven days per week; whether the program has an agreement with the treatment and service providers to prioritize intake appointments for individuals referred by the program; how clients are transported (if at all) to treatment and/or services; and how treatment and/or services are funded for individuals referred by the program.

Funding, data collection, performance measures, and formal evaluations associated with deflection programs

Respondents were asked to identify a number of items about the program budget funds used to start the program, funds currently used to operate the program, types of data collected about program participants and performance measures, and whether anyone has conducted a formal

evaluation of the program, as well as whether the deflection program is supported or associated with legislation.

Development of registry

As part of the survey, participants were asked to agree to take part in a public registry of deflection programs to share promising practices and trends in implementing them. The Bureau of Justice Assistance would operate the registry, which would contain some of the data from the survey—e.g., the name of the deflection program, program location (city and state), type of program the organization has been implementing, and number of years the program has been in place. Approximately 55 percent of the programs consented to the use of their information in a public registry, 19 percent wanted more information before deciding to consent, and 26 percent declined to agree to use the information in a public registry.

5. Key Findings and Takeaways

Characteristics of lead agency and community served by agency

*****Key finding: Deflection programs typically have been initiated and led by law enforcement departments in response to the opioid epidemic.***

FRD programs are widely distributed across all types of communities—urban, suburban, and rural, from large cities to small towns, in every region of the country. Law enforcement agencies created and lead almost three-quarters of all reporting programs (*see Chart B-1*) as part of their communities' response to rising opioid-related overdoses in many parts of the country (see *Introduction*). Fire/EMS agencies also have initiated and lead deflection programs but were represented in the survey on a smaller scale (*see Chart B-1*). As this field continues to evolve especially with a focus on non-law enforcement responses to calls for service in reaction to the civil unrest that occurred during the summer of 2020, future surveys may reflect a change in the representation of first responders leading these initiatives.

*****Key finding: Local needs and public health/safety priorities are the primary driver for developing first responder programs. These localized programs create a patchwork of deflection programs across the country, with varying protocols, procedures, and measurement standards.***

The dramatic growth and devastating effects of opioid misuse have directly influenced the number of FRD programs. This growth reflects the national scope of the opioid crisis across urban, suburban, and rural America and the need to prevent overdose deaths by emphasizing lifesaving care (e.g., naloxone administration) and keeping those who need treatment and services out of the justice system by facilitating their direct care and assistance through a diversity of partners.

The rise in FRD programs follows the rising national trend in opioid overdoses. Consistent with national trends (see *Introduction*), most FRD programs emerged during the third stage of the opioid epidemic, which began in approximately 2013. The initiation of these programs by respondents is consistent with the peak of the third wave of the opioid crisis between 2016 and 2019 *(see Table A-11)*, and generally in response to fatal and nonfatal opioid-related overdoses or a significant increase in opioid use in the community *(see Chart B-3)*.

The survey broke down distribution of respondent programs by region (*see Table A-1)* and identified several statistical relationships across the characteristics of the lead agencies, communities served, and FRD pathway used *(see Tables A-2 to A-8)*. Of the survey respondents, most (61 percent) FRD programs serve a community area defined as a city, village, or township. Approximately half (51 percent) report that they serve counties (which could include smaller municipal areas), with regional (10 percent) and tribal communities (<2 percent) comprising the rest *(see Table A-9)*. According to the survey findings, deflection programs are most frequently located in urban (48 percent) and suburban (56 percent) communities *(see Table A-10)*, with 41 percent located in rural areas. These findings suggest not only that

deflection program pathways vary by region and population size but that they are most commonly initiated and found at the local level.

In addition, approximately half of the programs reported opioids (55 percent) and heroin (46 percent) as among the top three most common substances used in their communities, with alcohol cited as the most frequent substance of use (74 percent) *(see Chart B-2)*. As the use of methamphetamines and other stimulants rises, first responders who want to direct their deflection initiatives to address this type of drug use may need to adapt their identification and screening methods for outreach, as overdoses may not occur as frequently for these substances unless combined with other synthetic opioids such as fentanyl.

Deflection program types

*****Key finding: The overwhelming number of FRD programs that participated in this survey were influenced by a specific model or "brand" of deflection. This indicates the strong influence that early-adopter FRD programs have had on other jurisdictions, especially within their regions of the country.***

These networks of deflection have helped other jurisdictions address the challenges in their own communities. However, communities may select specific FRD pathways based on proximity and familiarity with the early adopter, such as LEAD, PAARI, QRT, and Civil Citation programs, which form the basis of 78 percent of the programs participating in this survey *(see Table A-12)*.

The regional location of the FRD program was more strongly associated with the Officer Intervention pathways *(see Table A-1)*: Respondents who indicated that they operate Officer Intervention programs are more frequently based in the South and West (*see Tables A-2 to A-8*).

The most common program pathway used by survey respondents is Naloxone Plus, with 58 percent of programs doing this type of outreach *(see Table A-14)*. Significant numbers of programs use the First Responder/Officer Prevention pathway (55 percent), the Self-Referral pathway (53 percent), and/or the Active Outreach pathway (48 percent). The least common pathway was the Officer Intervention pathway (32 percent). Some organizations involved in the study used more than one pathway *(see Chart B-4)*. This approach increases the opportunities to connect individuals to treatment and services appropriate to their condition and treatment needs. Many operate multiple pathways. The "Other" category (n = 24) included programs that did not clearly fit into any of the survey's predefined pathways. Of the 24 agencies that identified with the "Other" pathway, 10 (42 percent) selected only the "Other" pathway and no other pathways *(see Chart B-4)*; four agencies selected one pathway in addition to "Other"; two selected two pathways in addition to "Other"; and the remainder selected three or more pathways in addition to "Other." This suggests that they may administer more than one FRD program or that the program(s) they administer may have elements that are not included in an existing pathway.

This area needs further examination. The five pathways of first responder deflection describe all known approaches to this work, including combinations of the five. If there is a jurisdiction

practicing deflection in a way that is not covered by the existing typology, this should be examined and added to the nomenclature. The agencies leading these programs may be unfamiliar with details about the pathways. These agencies, or the individuals submitting their survey responses, may not recognize their site(s) as fitting into an appropriate pathway.

***** Key finding: For all five deflection pathways, large numbers of FRD programs give all frontline staff deflection authority, suggesting that deflection is used as a broader policing practice in these agencies.***

Most programs place significant reliance on their frontline staff, with approximately 80 percent of them giving frontline staff deflection authority *(see Table A-17).* While this broad allowance of discretion in departments is encouraging, further findings listed below relate to a need for additional training and for more formalization of deflection practices through policy and procedures that could indicate a potential problem area for departments in the future if officers are not adequately prepared to perform deflection. These facts, coupled with the need for adequate treatment resources due to referrals that could be generated from a department that allows the majority of staff to perform deflection, should be considered by department leadership before authorizing deflection practices. Leadership should conduct a planning process that accounts for these issues to avoid putting the proverbial cart before the horse.

***** Key finding: The overwhelming majority of programs that perform outreach do in-person outreach to the location of the individual in the community.***

Fully 90 percent of programs participating in this survey that do outreach do so in person at the location of the individual being deflected *(see Table A-19)*. This highlights the importance of a personal approach to engagement in treatment and services versus the use of telephone outreach or material dissemination only. This face-to-face contact engages individuals in a conversation and enables relationships to develop between responders and community members. In contrast to other forms of enforcement, deflection offers extensive benefits, including greater success in treatment and service engagement, establishment of trust, and improved community-law enforcement relations.

*****Key Finding: Slightly more than half of the programs responding to this survey involve co-responders (predominantly peer support specialists/recovery coaches, clinical SUD treatment staff, case managers, and social workers), an important finding given the national spotlight now being focused on co-responders.***

Approximately half of respondents indicated that, during in-person outreach, their initial contact was completed with the assistance of a co-responder *(see Table A-18)*. Co-responders play an important role in deflection, and most (64 percent) are peer support specialists/recovery coaches, who may work as volunteers rather than as salaried members of the team *(see Table A-18)*. Moreover, because a large proportion (73 percent) of FRD program staff perform deflection activities *(see Table A-20)*, many trained individuals are available to perform this important function (other co-responders include behavioral health staff and volunteers). The development of outreach teams has allowed better relationships to develop among community partners, including first responders, behavioral health providers, and the recovery community.

Furthermore, when programs include co-responders in outreach, the majority (56 percent) travel to the response site with the first responder. Less frequently (35 percent), the co-responder arrives at the scene on his or her own but while the first responder is still present *(see Table A-18)*. This type of collaboration can increase support for the program as first responders learn from behavioral health and community partners. First responders bring their own unique perspectives on the community to the partnership, especially in cases where deflection teams ride to the response together.

For the Active Outreach and Naloxone Plus pathways, the most common type of initial contact was with a co-responding partner. For the two pathways that are driven by a law enforcement response (First Responder/Officer Prevention and Officer Intervention), the most common type of initial contact does not include a co-responder *(see Table A-21)*, which may have implications for training needs, such as training on substance use and mental health disorders, crisis intervention approaches, and naloxone administration.

In 2018, the range of referrals to treatment/services in 2018 was large, from zero to 2,500. The active outreach pathway was associated with the highest average number of referrals in 2018 (mean = 184), whereas the Officer Intervention pathway had fewer than 90 average referrals in 2018 (*see Table A-22,* Chart B-5 to B-6).

Finally, only 21 percent of respondents use volunteers as part of their outreach efforts (*see Table A-18)*, suggesting that there may be an untapped resource in communities served by deflection programs. Volunteers can be trained to do a variety of functions and in fact are a key component of PAARI's "Angel Programs;" volunteers also hold vital outreach roles in Quick Response Teams. Volunteers serve as force multipliers and assist in providing transportation, offer peer support to individuals throughout treatment/recovery, and serve as ambassadors by sharing program-related information, thereby lending it credibility. Using community volunteers can help reduce stigma about addiction, mental illness, and homelessness, and having them work directly with law enforcement creates bonds that enhance trust.

Key finding: More than half of FRD programs provide a personal introduction[19] to treatment case managers to assist in linkage to services, helping to overcome a significant barrier to getting treatment.

The type of outreach utilized by the majority of programs reflects research on successful case management and care coordination,[20] defined by increased program engagement and retention (*see Table A-20*). Nearly two-thirds (65 percent) of respondents also indicated that their programs provide some form of transportation assistance to a client's initial appointment *(see Chart B-7).* Navigating the behavioral health system is a complicated task, compounded by an individual's struggle with his or her SUD. The immediate engagement enabled by a personal introduction—potentially including transportation to the treatment or service provider (in addition

[19] Sometimes referred to as a "warm handoff."

[20] Treatment Alternatives for Safe Communities. TASC Specialized case management model. 2019. Available at: *https://www.tasc.org/TascBlog/images/documents/TASC-Clinical-Case-Mgt-Model.pdf*.

to facilitated contact between the program participant and treatment or service provider)—capitalizes on the momentum interest in receiving help can provide.

***** Key Finding: Many programs do not have specialized training that would help staff members who conduct deflection and outreach to increase their effectiveness.***

Only 34 percent of the programs have an FRD training curriculum, and of those, half offer four or fewer hours of training (see Chart B-8*)*, arguably an insufficient amount given the demands associated with FRD. The training offered in the vast majority of programs (91 percent) is in naloxone administration, reflecting a critical element central to most deflection programs *(see Table A-24)*. The second most common type of training (74 percent) is in crisis intervention, which has proven helpful in de-escalating and resolving tense situations for many first responder organizations (*see Table A-24*). Only 40 percent of programs that offer any training provide racial equity or gender equity training *(see Table A-24)*. Likewise, of those that provide any training, only 30 percent provide training on the neuroscience of addiction, something almost half (43 percent) of respondents identified as an area in which they would like additional training (*see Table A-24)*.

Deflection program partnerships

At their foundations, FRD programs are a collaborative effort among public safety, public health, and community-based behavioral health and social service systems, and the community. According to the survey, almost 75 percent of deflection programs (58.4 percent police department and 14.8 percent sheriff's office) are led by law enforcement (*see Chart B-1*). However, while law enforcement and other first responders may implement deflection programs, they do not provide treatment, case management, recovery support or other wrap-around services. These must be provided by agencies and organizations that partner with law enforcement to help individuals in need of treatment and other community-based services.

*****Key finding: Having multiple community-based service partners is a key element in the operation of deflection programs. These partners come from across the justice system and recovery community.***

All but three of the 233 programs that responded have at least two collaborative service partners. Almost half (46.4 percent) reported having at least three collaborative service providers, whereas another 26 percent reported having four to six partner service provider organizations (*see Chart B-9)*. These partnerships, which are essential to establishing networks of treatment and services for deflection programs, include community-based organizations and agencies that provide detoxification programs, substance use treatment, case management services, and recovery support, as well as complementary wrap-around services like housing, education, and job training *(see Table A-25*). This may even include providing transportation for clients, which 65 percent of programs do *(see Chart B-7*).

Although treatment providers, case managers, and service providers comprise a large percentage of the stakeholders who collaborate with first responders to implement deflection programs, other stakeholders also contribute to them. These stakeholders—prosecutors, judges, defenders, and community corrections agencies—often play key roles in obtaining buy-

in from individuals who can reduce barriers for justice-involved individuals who want to access treatment and services. For example, prosecutors can create policies on eligibility for program participation and for best using their staff to aid in deflection. Judges can help individuals with active warrants, and community corrections officers can be called on to address technical violations of probation or parole so that their clients can enter treatment. Moreover, including individuals who are in recovery, as well as those with lived experience, in recovery services and planning/implementation of related services may help build support and credibility in the recovery community.[21]

***** Key finding: Most FRD programs rely on a program coordinator to ensure the day-to-day work of the program runs smoothly and are guided by a stakeholder group that meets regularly to make important program decisions collaboratively.***

FRD programs bring together agencies and organizations that often have never worked together before and in some cases have a historical distrust or poor working relationship. For this reason, and to keep programs running smoothly, many FRD programs have found it beneficial to hire or appoint a program coordinator who can troubleshoot stakeholder concerns, identify resources, facilitate meetings, develop information-sharing systems, and streamline communication to keep the program moving forward. A majority of programs (149, or 64 percent out of 233 total) reported having a dedicated stakeholder group to provide oversight and direction to the deflection program. Of these 149, more than half (57 percent) meet monthly *(see Chart B-10)*, with another 27 percent meeting quarterly. Holding regular meetings of all partners to discuss challenges, review new data from analysis or research partners, and share success stories keeps lines of communication open and enhances trust among partners.

*****Key finding: More than half of respondents have agreements with their community-based partners regarding the services they will facilitate, but often these are not formalized in writing. In addition, agreements often do not clarify critical expectations regarding length of time to care, information to be exchanged, and metrics for success.***

Partnering with treatment providers is a necessary component of FRD because of the prevalence of drug use and mental health issues in populations most likely to be deflected. Therefore, having a partner that will accept referrals from first responders and engage with the individuals as rapidly as possible is critical to program participation. To this end, more than half (58 percent) of survey respondents indicate that they have some type of formal or informal agreement with their provider-partners to accept and prioritize referrals from the first responder agency's deflection efforts. Unfortunately, only a small minority of respondents (15 percent) indicated that they have a formal agreement such as a memorandum of agreement or contract specifying this arrangement *(see Table A-26)*. An oral agreement between partners may be all that is needed initially to get a program started, but first responders need assurance that referrals they make to their treatment partners will be received and executed on a timely basis.

[21] Bureau of Justice Assistance, Comprehensive Opioid, Stimulant, and Substance Abuse Program (2019). Peer Recovery Support Services Mentoring Initiative. https://www.cossapresources.org/Content/Documents/BriefingSheets/BJA_COAP_Peer_Recovery_Support_Services_Mentoring_Initiative.pdf

The less time it takes between initial contact and intake into community treatment services, the more likely an individual is to engage successfully with programming,[22] thereby decreasing the likelihood of that person's eventual involvement in the justice system (and of overdose). Timely treatment access is important, especially because many individuals with SUD may be ambivalent about seeking treatment. A formal agreement that specifies the expectations of both parties in deflection efforts can potentially lead to better standardization of the process and better outcomes for participants.

The lack of formal agreements in this area may be simply because the field of deflection is still young, with most sites having come into existence in the last three years in a field in which virtually every deflection site has been operational for no more than six years. Widespread protocols and procedures do not yet fully exist in the field.

Treatment, services and recovery

*****Key finding: Substance use treatment that includes access to medication-assisted treatment is the primary service referred by deflection programs.***

Given that FRD often targets individuals with an OUD, it is no surprise that the survey indicated that substance use treatment is the most frequent service provided by treatment partners in deflection programs. Fully 90 percent of respondents facilitate/provide links to SUD treatment, an essential service due to the range of SUDs (*see Table A-27*). Nearly three-quarters (73 percent) provide links to medication-assisted treatment (MAT), with approximately one-fourth facilitating one form of MAT. A little more than one in three links to two MATs, while 42 percent facilitate all three MATs (buprenorphine, methadone, and naltrexone) (*see Table A-28*).

Respondents indicated that their programs provide links to a range of inpatient and outpatient treatment services, including access to medications for OUD. Access to buprenorphine and methadone was offered at slightly higher proportions than naltrexone (68 percent versus 60 percent) (*see Table A-27)*; this may be because individuals referred from the community are more likely to be actively using opioids and therefore unable to start naltrexone until they have undergone a detoxification period of seven to 14 days.[23] This process contrasts with referral to MAT services from jails or prisons, where individuals are likely to have undergone detoxification and therefore would be eligible for induction onto naltrexone.

*****Key finding: Recovery support specialists play an important role in initial outreach to and continued engagement of individuals in deflection programs.***

Also noteworthy is the high number of respondents (79 percent) who reported having access to recovery support specialists or peer recovery coaches as part of their deflection efforts (see Table A-27). Providing access to recovery support specialists is critical in facilitating linkage to services following initial contact to maintain ongoing engagement with the client.[24]

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[22] Chun J, Guydish J, Silber E, Gleghorn, A. Drug treatment outcomes for persons on waiting lists. *Am J Drug Alcohol Abuse.* 2008;34(5):526-533. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2766557/*

[23] Alkernes, Inc. What is Vivitrol? Available at: *https://www.vivitrolhcp.com/what-is-vivitrol.*

[24] Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP). Expand peer support services and recovery housing: 2020. Available at: *https://www.cossapresources.org/Focus/PeerSupport*.

Part of this engagement involves conducting follow-up outreach to clients who did not attend their initial intake appointment; encouragingly, more than 65 percent of respondents indicated that they performed this function with a deflection team member (see Table A-26).

In addition, recovery support services can provide opportunities for positive prosocial outlets that can address a key criminogenic need, thereby helping reduce the likelihood of recidivism.[25] Despite the prevalent use of recovery support services, only approximately 30 percent of respondents cited FRD programs that address other critical needs such as employment, education, and food support as part of their services network (*see Table A-27*). It appears that sites would benefit from expanding their network of programs to include these valuable services to their clients to better ensure participation in treatment and long-term programming success.

*****Key Finding: Funding for deflection-related treatment is approximately equal between public and private sources, but regardless of the source of funding, nearly 90 percent of programs that responded to the survey are located in states that have expanded access to health care services through Medicaid via the Affordable Care Act.***

Treatment providers accept various funding sources to pay for the costs of treatment for clients. More than half (52 percent) indicated that they billed public insurance, either Medicare or Medicaid, to pay for clients' treatment *(see Chart B-11)*. The use of public insurance, particularly Medicaid, is notable in that the vast majority (88 percent) of respondents are from states that have expanded Medicaid under the Affordable Care Act, making this resource more readily available (see Table A-34).[26] Almost half (46 percent) of the respondents indicated that clients used private insurance as a payment source. Other sources included federal or state grants and client self-pay. The survey did not ask whether lack of client funding was a barrier to treatment access. Future surveys could explore the impact of lack of funding on both initiating and sustaining treatment for individuals who are not eligible for public funding and do not have private insurance.

Funding, data collection, performance measures, and formal evaluations associated with deflection programs

*****Key Finding: Local funding plays a significant role in both the startup and continuing operation of FRD programs.***

Funding of FRD programs, according to the survey findings, ranges across federal, state, and local sources, demonstrating that not only does the localized basis of deflection accommodate diverse funding sources (many from their own communities) but that these programs do not necessarily require large investments to start up or to sustain. Although two of every five

[25] Wooditch A, Tang LL, Taxman FS. Which criminogenic need changes are most important in promoting desistance from crime and substance use? *Crim Justice Behav*. 2014;41(3):276-299. Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4045616/*.

[26] 38 states and the District of Columbia have expanded Medicaid under the Affordable Care Act (ACA); of the 321 FRD programs identified in this survey, 283 are located in 31 of these states. In all, 38 FRD programs identified in this survey are located in eight of the 12 states that have not expanded Medicaid under the ACA. Data on Medicaid expansion states from KFF (2021). Status of state Medicaid expansion decisions: Interactive map. Available at: *https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.*

programs that responded to the survey have stand-alone budgets (some of them significant), approximately one of three used local funds to initiate their FRD program, and nearly half (45.8 percent) use local funds to operate it (*see Table A-29; Chart B-12 to B-14*). Many of these programs are launched and maintained/expanded with minimal contributions from local and state sources, demonstrating that programs reflect the customized, local nature of deflection.

***Key finding: Deflection programs generally do not collect standardized data metrics sufficient to gauge their programs' success.**

Survey participants track many forms of data relative to their programs' performance. For example, slightly more than half of the programs track fatal/nonfatal overdose data, an important factor because of the number of programs formed due to incidents of overdose in their communities *(see Table A-30*). But some respondents do not thoroughly track individuals who participate in their programs' services; a little more than half track participation, and three-quarters of these programs do so for more than 90 days, an impressive standard. Although 53 percent of respondents track participation, only half of those (27 percent) track participant completion of treatment, and only 40 percent track participation of referrals in recovery support *(see Table A-31)*. Although slightly more than half of these programs track participants who have reduced drug use, fewer than half track participant recidivism, employment/housing outcomes, and reduced substance use symptoms (*see Table A-32*).

In terms of sharing participation information with partners, 62 percent share aggregate participant information, and half (48.7 percent) share individual-level participant data (*see Table A-32*). Perhaps heightened formal development and sharing of consent documents and other legal/operational materials central to model program administration would boost important information sharing. Overall, tracking and analyzing participant/client engagement and sharing relevant participant information with program partners are key factors in improving outcomes, and the survey findings suggest that some programs could be more thorough to this end.

***Key finding: FRD programs' data on deflection clients' demographics are comparable to the national population but do not reflect the demographics of those currently in the justice system.**

Of those programs that collect data on deflection clients' race and ethnicity (slightly fewer than half), nearly three-quarters of their clients/participants are White (74.1%), while about 12 percent are Black and 8 percent are Latino. Yet Blacks in particular are placed in the justice system at numbers far higher than their population: Blacks comprised almost 13 percent of the total population, yet 27 percent of all arrests in 2019,[27] [28] while Latinos comprised 19 percent of the total population and 19 percent of all arrests *(see Chart B-15- B-16)*. These numbers are incompatible with data on SUD treatment, which indicate a greater need for and less

[27] Federal Bureau of Investigation (2019) Uniform Crime Report: Arrests by race and ethnicity. https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/topic-pages/tables/table-43
[28] United States Census (2021). Quick facts. Available at: https://www.census.gov/quickfacts/fact/table/US/RHI725219

participation in/completion of treatment by non-Whites.[29] By adding to and strengthening existing community-based treatment and service partnerships, deflection programs can reduce the disparities some groups face in the justice system, notably in terms of expanding access to SUD treatment.

*****Key Finding: Only one in six participating programs has conducted a formal evaluation of program effectiveness.***

Only one in six programs that responded has conducted a formal program evaluation *(see Table A-33)*. Independently conducted evaluations/audits of programs to assess performance and prescribe improvement are leading edge tools used across sectors, including among law enforcement/first responder organizations.[30] One such best practice involves partnerships between FRD programs and academic institutions for data gathering/analysis and outcomes measurement. Some initiatives, such as the National Institutes of Health-funded Justice Community Opioid Innovation Network (JCOIN), are conducting extensive evaluative research concerning best practices in evidence-based addiction treatment programs in the justice system.[31] FRD is a new, evolving initiative, so it is not surprising that only a small proportion of those participating in this survey have undergone formal program audits.

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[29] Mennis J, Stahler G. Racial and ethnic disparities in outpatient substance use disorder treatment episode completion for different substances. *J Subst Abuse Treat.* 2016;63:25-33. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0740547215003177.

[30] National Criminal Justice Reference Service, Office of Justice Programs, U.S. Department of Justice (2017). Evidence-based policing: Translating research into practice. https://www.ojp.gov/ncjrs/virtual-library/abstracts/evidence-based-policing-translating-research-practice.

[31] National Institutes of Health. Justice Community Opioid Innovation Network. Available at: https://heal.nih.gov/research/research-to-practice/jcoin.

6. Conclusion

The opioid epidemic has ravaged communities across the United States. As synthetic opioids began driving unprecedented numbers of overdose-related deaths, leaders in law enforcement and other first responder agencies began to change their approach to persons with SUD and substance use-related events. Traditional law enforcement approaches did not have a solution to the problem of overdoses, so the emergence of deflection as an innovative practice offered hope. Law enforcement departments accustomed to using arrest for drug-related offenses began to differentiate between individuals who manufacture and traffic in illegal substances and those who possess drugs for personal consumption and may suffer from the disease of addiction. Likewise, many fire and EMS personnel who were frequently tasked with responding to repeated overdoses by the same individuals—with no options other than naloxone administration or relying on emergency departments to address the problem—felt powerless to stop the cycle of addiction.

To combat the opioid crisis in their communities, law enforcement and first responders began to collaborate with public health, community-based treatment service providers, and other community organizations to intervene—at first to reverse an overdose, then proactively, as the field of deflection evolved, before substance use disorder or overdose led to fatality. In this way, the opioid epidemic in fact has helped to accelerate and catalyze the field, and without this unfolding tragedy, deflection potentially would never have formed, or certainly not as rapidly as it has, and continues to do so now into other arenas.

This paradigm shift toward deflection now holds promise for addressing a range of public health-related issues from substance use and mental health disorders to homelessness, domestic violence, child abuse and neglect, sex work, and nonviolent nuisance crimes related to poverty and distress. In hundreds of large and small communities across the United States—rural, urban, and suburban—FRD programs that include law enforcement, fire, and/or EMS can serve as models of collaboration and examples of “co-responder deflection,” or simply co-responders. The results of this survey show that, although law enforcement lead the majority of the programs that participated in the survey, all lead agencies work with multiple partner agencies to respond to their communities’ needs.

The survey also showed the need to provide greater training of law enforcement, first responders, and 9-1-1 dispatchers in areas important to deflection such as racial/gender equity training, the neuroscience of addiction, and motivational interviewing, among others. It also revealed a strong inclination within these agencies’ leadership to assess their communities’ needs and respond in thoughtful, appropriate ways that demonstrate a commitment to policing grounded in community needs. A sense of safety is more likely to exist in communities in which there are trust and good relations between citizens and law enforcement.

Successful FRD programs join public safety and public health/welfare organizations. The ability to link these functions is a unique characteristic of the field and a testament to the collaborations necessary for programs to thrive. Many communities that practice FRD have established partnerships that have led to successful outcomes for their citizens. For example, jurisdictions

facilitating the Active Outreach pathway create stakeholder partnerships that use a variety of means to identify at-risk individuals before they are exposed to the justice system or first responders due to an overdose. Thus, deflection acts to prevent future justice involvement and to facilitate earlier access to treatment. These collaborations also demonstrate how deflection is able to expand its capacity to meet a range of society's concerns and needs. However, because such a small proportion of programs conduct formal, third-party evaluation measures to validate their effectiveness, the field's ability to quantity the successes identified in this survey and replicate positive outcomes will rely on a much larger commitment to formal evaluation. As the sector grows and the demand for FRD programs from political leaders, citizens, and others in the law enforcement/first responder community increases, more programs will need to undergo formal, third-party evaluations to engender broader support for law enforcement/first responder initiatives, increase their programs' transparency, and incorporate empirically supported best practices to produce maximum effectiveness.

Deflection, as stated earlier, is therefore a "front-end" preventative approach designed to keep individuals out of jails and prisons, free up the justice system, allow law enforcement to focus on preventing and responding to the most serious crimes. By applying community-based solutions to community problems deflection keeps families intact and children with their parents.

Reframing the relationship between law enforcement and communities

In recent years, American society has had significant debates about the proper role of law enforcement. Although the overwhelming share of law enforcement-citizen encounters—tens of millions every year—involve no cause for arrest,[32] law enforcement officers still are called on at all hours to respond to issues for which, before FRD, they had few options to handle appropriately and effectively. To be clear, law enforcement agencies are the first and often only organizations contacted for many reasons, not the least of which is that they operate 24/7. Still, despite the growth in the expectations for their role, law enforcement officers typically are not properly equipped to address economic and social inequities, lack of investment or economic activity in communities, or factors that lead some individuals to pursue crime at the subsistence level (e.g., for personal needs only). Nevertheless, society asks and expects law enforcement to respond to the byproducts of these conditions. By providing these professionals with the necessary resources and training encompassed by deflection, we might see better responses to OUD/SUD needs.

The consensus that people want their communities to be safe and healthy lies at the foundation of the discussion about the proper role of law enforcement and their relationship with the communities they serve. The elements needed to build and maintain communities include education, job training, infrastructure, healthcare, community safety, and other factors. Government and the private sector involved in delivering these services need to understand how these functions are interdependent: public health is intricately linked to public safety, and

[32] Estimate based on U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (2015). Contacts between police and the public. Available at: *https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6406.*

economic activity is inherently aligned with health, which is associated with people's perception of their personal safety.[33]

Police chiefs and sheriffs, who manage by far the largest share of FRD programs, see every day the challenges their communities face. They have enormous influence to convene other stakeholders—such as behavioral health treatment and service providers, the faith and recovery communities, business leaders, and local government leaders—to the table to plan and develop these programs. Through such community-centered collaboration, deflection programs can provide tools to law enforcement and other first responders to effectively meet these challenges. FRD is not a cure-all for public safety, public health, or behavioral health, but it can make an important contribution to communities across America—and has been doing so for the past several years in the communities represented by those who responded to this survey. In this way, deflection is said to be reframing the relationship between law enforcement and community almost since its inception.

Responding to public pressure on law enforcement to be more accountable to issues of racial and social equity

The war on drugs and related policies have contributed to disproportionate shares of arrests and prosecution in, and disruption of, minority and Native communities, particularly Black communities, increasing the already prevalent economic, political, and social inequities that contribute to poor social determinants of health for many of them. Although deflection cannot address the root causes of social inequity because it is fundamentally about saving lives and getting people into recovery, it seeks to ensure equitable use and avoidance of racial disparities in its application.

Deflection, through the five pathways discussed in this survey, creates a third option beyond arrest or inaction for law enforcement to keep individuals out of the justice system and in the community. For persons with prior justice-system involvement, deflection can help provide a second chance by connecting them to community treatment and services, thereby helping prevent repeated justice system involvements. Clearly, broadening the information/data-gathering and program scope, and building trust in communities of color through FRD programs, are primary goals. Future success will require better understanding of how good data on race will drive the ways in which deflection programs target and serve those in their communities who can benefit from them.

Without proper oversight and correction, deflection, like any other intervention, program, or initiative, can be susceptible to bias in its use. Oversight requires precise knowledge of what is actually going on, which depends primarily on data collection and evaluation. Command and program staff then use the data and evaluation in decision-making and as a feedback/ correction loop. Data collection and analysis should include the demographics of individuals diverted to assess the program's equity. In addition to collecting data on individuals who *are* deflected, agencies must analyze the circumstances under which law enforcement officers did

[33] Dong B, White CM, Weisburd DL. Poor health and violent crime hot spots: Mitigating the undesirable co-occurrence through focused place-based interventions. *Am J Prev Med.* 2020;58(6):799-806.

not divert, as well as the response from treatment and other providers concerning who is accepted into the program and who is removed for noncompliance. This may require inclusion of a standardized system of measures in unified crime reporting to protect against program bias.

The practice of deflection is helping to create a new narrative regarding law enforcement and community encounters, as well as the stigma associated with mental health/substance use and treatment. Deflection also is helping to reframe the relationship between first responders and the communities they serve. FRD programs also can build trust between law enforcement and communities of color. Trust may not be easily developed in minority communities with longstanding perceptions of the role of traditional law enforcement; however, deflection offers an opportunity to “flip the script” and help create positive encounters and outcomes. To this point, most individuals in the law enforcement community, especially those involved in FRD, understand that the foundations of deflection (saving lives in response to overdoses, keeping those who have committed nonviolent crimes out of the justice system, and facilitating appropriate treatment and services in their communities) are now part of what is expected of first responders.

Deflection also removes from first responders the social burden of being required to take the lead in addressing non-crisis behavioral health issues (and, in many cases, doing so by themselves), something for which they are not properly trained or equipped. With the collaborative relationships inherent in deflection, law enforcement officers not only have a third option beyond arrest or inaction for many encounters, but can, along with first responders, save lives and facilitate treatment for citizens in collaboration with community-based co-responders and other professionals.

Reducing the size of the justice system and redirecting justice system budgets

FRD aligns public health and public safety through collaborations that emphasize connecting people to the treatment and services they need to avoid entering or returning to the justice system so they can remain in their communities and with their families. Deflection therefore can be seen as the “handle on the front door” of the justice system. For individuals who can be better served by community-based treatment and services, this reduces the reliance on scarce justice system resources—e.g., prosecution and corrections, probation and parole, and jail-based behavioral health resources. FRD also allows the justice system, particularly law enforcement, to devote labor and resources to individuals who pose a real risk to public safety.

Urban jails are among the largest providers of mental health treatment in the United States,[34] a discouraging reality on many levels. The justice system should not be the access point for entry to treatment—a disparity deflection aims to address. Even while incarcerated, many persons who need mental health services have no access to them. Further, when released from incarceration, their condition may be untreated or insufficiently treated. This can also be dangerous, especially for those with OUD. Indeed, the risk of overdose for formerly incarcerated

[34] States of incarceration. Why are correctional facilities the nation’s largest mental health care providers? 2021. Available at: *https://statesofincarceration.org/story/why-are-correctional-facilities-nation-s-largest-mental-health-care-providers.*

individuals is 12 times greater during the first two weeks after release than it is for those who use drugs in the general population.[35]

Moreover, behavioral health treatment offered in prisons is typically limited. Although approximately 40 percent of incarcerated individuals are diagnosed with a mental illness, only a small proportion of the prison population who need treatment actually receives it.[36] Furthermore, treatment done in chaotic, disruptive environments is less effective than it is in a community-based or home setting. Although initiatives such as Residential Substance Abuse Treatment (RSAT)[37] are highly effective, without community-based connections to care upon reentry, even the best jail- and prison-based programs have greatly diminished effectiveness.[38]

Deflection offers a direct solution to integrate public safety and public health. It is not the only, or even primary, solution to addressing behavioral health issues, but it can contribute to a comprehensive, systemic approach that increases the opportunities for intervention. This supports the argument in favor of funding a responsive public health approach rather than an enforcement approach, while recognizing law enforcement as a key referral source.

Future research needs

Although the key findings from this report will be beneficial to enhancing the understanding of deflection, this pioneering national scan has uncovered numerous additional areas for inquiry, as well as the need to continually update findings to measure the growth of deflection across the country. Some considerations for further surveys and research include:

- Continual scans of the field to better understand the number and types of programs.
- Focus on rural jurisdictions and the challenges they face in including access to treatment resources and funding for deflection programs.
- Examination of how deflection can avoid racial disparities and adopt practices that ensure that deflection is planned and administered equitably.
- Adaptations to deflection programs as primary drugs of use change from opioids to methamphetamines.
- Sustainability of programs initially funded by federal or state grants (e.g., some COSSAP site-based grantees).
- Review of the hybridization of the pathways by departments and standardization of these programs, including awareness of the development of potential new pathways beyond the five known ones.

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[35] Advocates for Human Potential RSAT training tool: Reentry strategies to reduce recidivism and sustain recovery. Available at: *Final-Re-entering-RSAT-Clients_9-27-19 (rsat-tta.com).*

[36] Prison Policy Initiative Policies and practices surrounding mental health. 2021. Available at: *https://www.prisonpolicy.org/research/mental_health/*.

[37] Bureau of Justice Assistance, U.S. Department of Justice. Residential substance abuse treatment for state prisoners (RSAT) program. 2021. Available at: *https://bja.ojp.gov/program/residential-substance-abuse-treatment-state-prisoners-rsat-program/overview.*

[38] Moore K, Hacker R, Oberleitner L, McKee SA. (2020). Reentry interventions that address substance use: A systematic review. *Psychol Serv.* 2020;17(1):93-101. Available at: *https://doi.org/10.1037/ser0000293.*

- Research on differences between/among deflection pathways that conduct outreach during crisis versus non-crisis situations.
- Research on the most effective pathways for initial engagement and long-term involvement in treatment services.
- Analysis of officers' and other first responders' perceptions of deflection and its impact on programs.
- Comparative research on the effectiveness of deflection versus other types of justice system diversion and the ideal candidates for deflection.
- Understanding how best to engage communities in creating and developing deflection initiatives.
- Assessment of how deflection can be adapted to best respond to and serve the needs of women, Native populations, and other minority communities.

1. Appendices

Appendix A: Tables

Unless otherwise noted, the denominator for all tables is (n =) 320 cases. In some tables the percentages do not add up to 100 percent because a respondent could provide more than one answer for each question.

We analyzed responses to provide a breakdown of programs by region (Table A-1) and to determine the statistical relationship between the region in which the deflection programs operate and the type of pathway used (Tables A-2 to A-8).

Using a chi-square test, we assessed whether there was an association between the region where the department was located and the type of pathway the department uses. Out of the five pathways (Naloxone Plus, First Responder/Officer Prevention, Self-Referral, Active Outreach, and Officer Intervention [plus "Other"]), only one was statistically significantly associated with region (nonsignificant pathways are shown in Tables A-3 to A-8).

Region was significantly associated with the first responder conducting outreach specifically to individuals who have experienced an Officer Intervention ($p = 0.017$).

Referencing Tables A-2 to A-8, the region in which the deflection program is located was more often associated with the Officer Intervention pathway (e.g., Midwest, 22 percent; South, 46 percent).

Table A-1. Distribution of deflection programs by region

Region	N	%
Northeast	116	36.1
Midwest	113	35.2
South	57	17.8
West	35	10.9

Table A-2a. Sample size for program pathway and region

	Northeast	Midwest	South	West	Total
Self-Referral	72	53	28	15	168
Active Outreach	63	45	29	16	153
Naloxone Plus	73	60	35	19	187
First Responder/Officer Prevention	73	53	33	16	175
Officer Intervention	38	25	26	12	101
Other	7	7	5	5	24
	326	243	156	83	808

Table A-2b. Proportion of cases for program pathway by region

	Northeast	Midwest	South	West
Self-Referral	22.1%	21.8%	17.9%	18.1%
Active Outreach	19.3%	18.5%	18.6%	19.3%
Naloxone Plus	22.4%	24.7%	22.4%	22.9%
Officer Intervention	11.7%	10.3%	16.7%	14.5%
First Responder/Officer Prevention	22.4%	21.8%	21.2%	19.3%
Other	2.1%	2.9%	3.2%	6.0%
Total	100.0%	100.0%	100.0%	100.0%

Table A-3. Self-referral pathway by region

Approximately 62 percent of programs based in the Northeast use the self-referral pathway; nearly half (49 percent) of those based in the South do so.

Table A-3. Self-referral pathway by region

	No	Yes	Total
Northeast	44	72	116
	37.9%	62.1%	100%
Midwest	60	53	113
	53.1%	46.9%	100%
South	29	28	57
	50.9%	49.1%	100%
West	19	15	34
	55.9%	44.1%	100%
Total	152	168	320

Pearson $chi^2 = 6.8976$; $p = 0.075$

Table A-4. Active Outreach pathway by region

Approximately 54 percent of programs based in the Northeast employ the Active Outreach Pathway, whereas 51 percent of those based in the South do so.

Table A-4. Active Outreach pathway by region

	No	Yes	Total
Northeast	53	63	116
	45.7%	54.3%	100%
Midwest	68	45	113
	60.2%	39.8%	100%
South	28	29	57
	49.1%	50.9%	100%
West	18	16	34
	52.9%	47.0%	100%
Total	167	153	320

Pearson $chi^2 = 5.0759$; $p = 0.166$

Table A-5. Naloxone Plus pathway by region

Programs based in the Northeast (63 percent) and South (61 percent) commonly use the Naloxone Plus pathway.

Table A-5. Naloxone Plus pathway by region

	No	Yes	Total
Northeast	43 37.1%	73 62.9%	116 100%
Midwest	53 46.9%	60 53.1%	113 100%
South	22 38.6%	35 61.4%	57 100%
West	15 44.1%	19 55.9%	34 100%
Total	133	187	320

Pearson $chi^2 = 2.5890$; $p = 0.459$

Table A-6. First Responder/Officer Prevention pathway by region

Approximately 63 percent of respondents in the Northeast employ First Responder/Officer Prevention programs. In the South, 58 percent of programs employ this pathway.

Table A-6. First Responder/Officer Prevention pathway by region

	No	Yes	Total
Northeast	43 37.1%	73 62.9%	116 100%
Midwest	60 53.1%	53 46.9%	113 100%
South	24 42.1%	33 57.9%	57 100%
West	18 52.9%	16 47.1%	34 100%
Total	145	175	320

Pearson $chi^2 = 6.9798$; $p = 0.073$

Table A-7. Officer Intervention pathway by region

Officer Intervention programs are most commonly applied in the South (46 percent) and West (35 percent).

Table A-7. Officer Intervention pathway by region

	No	Yes	Total
Northeast	78 67.2%	38 32.8%	116 100%
Midwest	88 77.9%	25 22.1%	113 100%
South	31 54.4%	26 45.6%	57 100%
West	22 64.7%	12 35.3%	34 100%
Total	219	101	320

Pearson $chi^2 = 10.1667$; $p = 0.017$

Table A-8. Other pathway by region

Of respondents that employ “Other” pathway, the largest proportion of those surveyed is located in the West (15 percent of respondents).

Table A-8. Other pathway by region

	No	Yes	Total
Northeast	109 94.0%	7 6.0%	116 100%
Midwest	106 93.8%	7 6.2%	113 100%
South	52 91.2%	5 1.6%	57 100%
West	29 85.3%	5 14.7%	34 100%
Total	296	24	320

Pearson $chi^2 = 3.3143$; $p = 0.346$

Table A-9. Community in which deflection programs are based

Of the survey respondents, most FRD programs serve a community area of a city/village/township (61 percent). The second most frequent community area, with a number of programs serving more than one area, is counties (51 percent)

Table A-9. Community in which deflection programs are based

	N	%
City/village/township	195	60.9
County	162	50.6
Region	38	11.9
Tribal jurisdiction	5	1.6
Other	12	3.8

Table A-10. Type of community with a deflection program

According to the results of the survey, deflection programs are most frequently located in urban and suburban areas, with approximately half of the programs diverting to these two types of communities. Of respondents, 41 percent are located in rural areas. Only 2.5 percent of respondents were from tribal communities.

Table A-10. Type of community with a deflection program*

Type of Community	N	%
Urban	153	47.7
Suburban	179	55.8
Rural	130	40.5
Tribal	8	2.5
Other	5	1.6

Table A-11. Number of years deflection program has existed

Most programs were initiated between 2016 and 2019, during the heart of the most recent wave of the opioid crisis.

Table A-11. Number of years deflection program has existed

Year program started (n = 374)	N	%
1980	1	0.36
1998	1	0.36
2009	1	0.36
2010	1	0.36
2011	1	0.36
2012	2	0.73
2013	1	0.36
2014	8	2.92
2015	18	6.57
2016	54	19.71
2017	56	20.44
2018	68	24.82
2019	47	17.15
2020	15	5.47

Table A-12. Specific model of deflection

The vast majority (78 percent) of the programs are based on a specific model of deflection. Between 20 percent and 30 percent followed one of these models: Police Assisted Addiction and Recovery model (PAARI), Quick Response Team (QRT), and Law Enforcement Assisted Diversion (LEAD).

Table A-12. Specific model of deflection

Program Model/Brand of Deflection Program (n = 274)	N	%
No specific program model used (generic)	60	21.9
Yes, adopted a specific program model*	214	78.1
Police Assisted Addiction and Recovery (PAARI)	61	28.9
Quick Response Team (QRT)	43	20.4
Law Enforcement Assisted Diversion (LEAD)	43	20.4
Civil citation (law enforcement)	1	0.5
Safe Stations (fire)	2	0.9
Community paramedics	6	2.8
Mobile integrated health-community paramedic/EMS	3	1.4
Other	52	24.6

* 211 of the 214 respondents who answered "yes" to this question answered a follow-up question on model/brand.

Table A-13. Program initiation and area served

	Urban	Suburban	Rural	Tribal	Other	Total
Address racial disparities in access to treatment	3.2%	2.5%	1.9%	6.5%	6.5%	2.7%
After learning about another department's program	11.1%	12.2%	11.4%	9.7%	9.7%	11.5%
As result of lawsuit	0.2%	0.1%	0.0%	0.0%	0.0%	0.1%
As result of public demands	4.0%	3.5%	4.4%	3.2%	6.5%	4.0%
At request of civic groups	5.5%	4.1%	4.1%	6.5%	9.7%	4.7%
At request of elected officials	4.2%	3.8%	4.2%	6.5%	0.0%	4.0%
Critical event led to initiation of program	3.9%	4.9%	3.9%	6.5%	9.7%	4.4%
Other	0.0%	0.1%	0.4%	3.2%	**16.1%**	0.5%
Response to increase in opioid use in community	**18.8%**	**19.9%**	**19.1%**	**16.1%**	12.9%	**19.1%**
Response to issues of law enforcement/community relations	7.4%	6.7%	6.4%	6.5%	3.2%	6.8%
Response to jail reduction efforts	5.9%	5.7%	6.9%	3.2%	6.5%	6.1%
Response to opioid-related overdoses	**19.0%**	19.4%	**19.5%**	**16.1%**	12.9%	**19.1%**
Response to other drug use in community	3.4%	3.5%	4.2%	6.5%	0.0%	3.6%
Stay current on new practices	13.6%	13.8%	13.5%	9.7%	6.5%	13.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 14. Program encounters

The most common program pathway used by the study organizations is Naloxone Plus with approximately 58 percent of programs doing this type of outreach, followed by First Responder/Officer Prevention (55 percent), Self-Referral (53 percent), and Active Outreach (48 percent). The least common program encounter is the Officer Intervention (31.6 percent).

The other category (n = 24) included programs that did not clearly fit into any of the predefined pathways in the survey, even if they might have had some elements associated with the predefined categories, which included mobile outreach vehicle programs and treatment navigation services offered through a hotline.

Of Officer Intervention programs, 80 percent included citable offenses, and 90 percent included misdemeanor offenses as eligible for deflection.

Table A-14. Program encounters

Program encounters (Check all that apply) N = 320		I	%
Self-Referral	Individual voluntarily initiates contact	168	52.5
Active Outreach	First responder intentionally identifies individuals to refer them to treatment	153	47.8
Naloxone Plus	First responder conducts outreach to individuals who have had a recent overdose	187	58.4
First Responder/Officer Prevention	First responder provides referrals during routine activity	175	54.7
Officer Intervention	Law enforcement provides referrals during routine activity but charge held in abeyance	101	31.6
	Offenses eligible for deflection	I	**%**
	Citable offenses	99	
	Yes	79	79.8
	No	20	20.2
	Misdemeanor offenses	101	
	Yes	91	90.1
	No	10	9.9
	Felony offenses	101	
	Yes	40	39.6
	No	61	60.4
Other		24	7.5

Table A-15. Program type and average number of full-time personnel
The size of the lead department was not significantly correlated with the type of pathway the department uses.

Table A-15. Program type and average number of full-time personnel

	Personnel size of the lead agency (full-time personnel)		
Pathway	**Mean**	**Std. Dev.**	**N**
Self-Referral	306.0	1227.3	123
Active Outreach	208.5	380.0	118
Naloxone Plus	244.1	642.2	142
First Responder/Officer Prevention	380.7	1345.7	122
Officer Intervention	197.7	391.1	74
Other	734.3	2889.2	20

Tables 16a and 16b. The type of pathway and source of funding that created the program
We performed a correlation analysis for categorical variables (Cramér's V, denoted as φ_c, giving a value between 0 and +1) to test whether there was an association between the type of pathway and the source of funding that was used to create the programs.

There is a statistically significant association between some types of funding sources and specific program pathways. Only federal funds and other funding were not associated with any type of program pathway. Table A-16b provides the raw percentages for each of the comparisons in Table A-16a.

In-kind donations were negatively associated with the First Responder/Officer Prevention pathway and were the least likely to be used for this type of pathway. In contrast, local funds were positively associated with Active Outreach. Philanthropic funds are negatively associated with the Naloxone Plus pathway. State funds are positively associated with the First Responder/Officer Prevention pathway.

Table A-16a. Types of funds used to start the program

	Federal	In-kind donations (e.g., staff time)	Local	Philanthropic	State	Other	No outside funds used to start program	Total
Self-Referral	18%	11%	25%	5%	21%	9%	12%	100%
Active Outreach	17%	10%	29%	5%	22%	9%	8%	100%
Naloxone Plus	20%	10%	27%	4%	23%	9%	8%	100%
First Responder/Officer Prevention	18%	10%	26%	5%	23%	8%	10%	100%
Officer Intervention	21%	6%	24%	4%	25%	6%	13%	100%
Other	20%	8%	28%	8%	25%	13%	0%	100%

Table A-16b. Correlations between funding sources used to start program and program type

		Federal	In-kind donations	Local	Philanthropic	State	Other	No outside funds
Self-Referral	Corr	-0.0195	0.0539	0	-0.037	0.0059	0.04	-0.0124
	p	0.728	0.3357	0.991	0.5088	0.9167	0.42	0.8248
Active Outreach	Corr	0.005	0.0186	**0.1455****	-0.0104	0.0777	0.08	**-0.1388***
	p	0.9288	0.7393	0.009	0.8525	0.1647	0.17	0.0128
Naloxone Plus	Corr	0.073	-0.0116	0.073	**-0.1196****	0.0868	0.05	**-0.168****
	p	0.192	0.8358	0.19	0.0321	0.1205	0.42	0.0025
First Responder/Officer Prevention	Corr	0.0135	0.0184	0.074	-0.0258	**0.1325****	0.03	-0.0825
	p	0.8092	0.7424	0.188	0.6453	0.0176	0.6	0.1404
Officer Intervention	Corr	0.0645	**-0.114***	-0.018	-0.0396	0.0899	-0.06	0.0059
	p	0.249	0.0412	0.743	0.4799	0.108	0.29	0.9168
Other	Corr	0.0576	-0.01	0.071	0.0543	0.0885	0.09	**-0.1264***
	p	0.3039	0.8587	0.203	0.3322	0.1134	0.09	0.0235

Note: * p < .05, ** p < .01, *** p <.001

Table A-17. Program pathway and staff deflection authority
For all the program pathways, between 79 percent and 86 percent of the programs give all frontline staff deflection authority. Programs in which all frontline staff have deflection authority were most common for the Self-Referral pathway (85 percent), whereas the First Responder/Officer Prevention pathway had the lowest rate (79 percent).

Table A-17. Program pathway and staff deflection authority

	Yes	No	Total
Self-Referral	128	23	151
	84.8%	15.2%	100%
Active Outreach	114	23	137
	83.2%	16.8%	100%
Naloxone Plus	136	33	169
	80.5%	19.5%	100%
First Responder/Officer Prevention	77	21	98
	78.6%	21.4%	100%
Officer Intervention	132	26	158
	83.5%	16.5%	100%
Other	19	3	22
	86.4%	13.6%	100%

Table A-18. Initial contact to the target population

Approximately half of responding programs perform outreach to the target population (program participants) through initial contact with the assistance of a treatment case manager (56 percent) and through initial contact with the assistance of a co-responding case manager (51 percent). Only 10 percent of the programs perform initial contact with the assistance of an emergency department, clinic, or other medical facility, making it the least common type of program contact.

When programs perform an initial contact with a co-responding treatment case manager, the co-responder usually rides along with the first responder (56 percent of programs). Approximately one-third of the time, the co-responder arrives on his or her own at the scene while the first responder is still present (35 percent). Rarely do co-responders arrive at the scene on their own after the first responder has left (9.5 percent).

Most co-responders are peer support specialists/recovery coaches (64 percent). About one-third of the co-responders are case managers and social workers. Volunteers make up approximately 20 percent of program co-responders, and clinical SUD treatment staff make up 43 percent.

Table A-18. Initial contact to the target population in program

Program contact (Check all that apply) N = 307	**N**	**%**
Initial contact without the assistance of a treatment case manager	172	56.0
Initial contact with the assistance of co-responding case manager	157	51.1
Initial contact with assistance of a medical facility	34	11.1
Treatment case managers perform initial contact without assistance of first responder DEFLECTION/FIRST RESPONDER	70	22.8
Other	30	9.8
Assistance of co-responding treatment case manager (Check all that apply) N = 147		
Arrives on own at the scene while first responder still present	51	34.7
Arrives on own at the scene after first responder has left	14	9.5
Rides along with the first responder	82	55.8
Who are the co-responders (Check all that apply) N = 141		
Case managers	42	29.8
Child welfare workers/family welfare worker	9	6.4
Clinical mental health staff	0	0
Clinical substance use disorder treatment staff	61	43.3
Peer support specialists/recovery coaches	90	63.8
Social workers	42	29.8
Volunteers	30	21.3
Other	9	6.4

Table A-19. Types of encounters between law enforcement, fire, or EMS agencies and people with substance use disorders

The vast majority of deflection programs conduct physical outreach to program participants (90 percent), Other methods of outreach frequently used include electronic outreach (phone, text, email) and dissemination of materials during calls for service (68 percent and 52 percent, respectively).

Table A-19. Types of encounters between law enforcement, fire or EMS agencies and people with substance use disorders

Program outreach (Check all that apply) N = 210	N	%
Electronic outreach (phone, text, email)	109	51.9
Physical outreach to their known location	189	90.0
Dissemination of materials during calls for service	142	67.6
Other	29	13.8

Table A-20. Referral to treatment and/or services

The majority of deflection programs provide written information—e.g., cards, flyers, brochures, or handouts about treatment—as a method to refer individuals to treatment programs (60 percent) and by providing a personal introduction to treatment case managers for assessment (58 percent). In 73 percent of reporting programs, all frontline staff have the authority to divert individuals to treatment.

Table A-20. Referral to treatment and/or services

How individuals are referred to treatment through deflection program N = 300	N	%
Receive general written information about treatment	179	59.7
Receive written referral to treatment provider	62	20.7
Receive treatment appointment by program for specific date/time	95	31.7
Receive personal introduction to treatment case managers for assessment	175	58.3
Other	50	16.7
All frontline staff given authority to divert individuals to treatment N = 320		
Yes	234	73.1
No	58	18.1
Do not know	38	11.9

Table A-21. Initial contact to target population by program pathway

For all of the program pathways, the two most common types of initial contact are contradictory, with between 29 percent and 39 percent performing initial contact *with* the assistance of a co-responding case manager and 29 percent to 39 percent performing initial contact *without* the assistance of a co-responding case manager. The least common type of initial contact for all the program pathways is initial contact with the assistance of a medical facility.

Table A-21. Initial contact to target population by program pathway

	Initial contact w/ co-responding manager	Initial contact w/ medical facility	Initial contact w/o manager	Other method	Treatment managers w/o deflection first responder	Total
Self-Referral	93 33.9%	26 9.5%	90 32.8%	17 6.2%	48 17.5%	274 100%
Active Outreach	100 36.8%	23 8.5%	91 33.5%	16 5.9%	42 15.4%	272 100%
Naloxone Plus	123 38.9%	29 9.2%	93 29.4%	16 5.1%	55 17.4%	316 100%
Officer Intervention	47 27.8%	13 7.7%	65 38.5%	16 9.5%	28 16.6%	169 100%
First Responder/Officer Prevention	97 33.7%	23 8.0%	102 35.4%	15 5.2%	51 17.7%	288 100%
Other	11 29.7%	1 2.7%	13 35.1%	2 5.4%	10 27.0%	37 100%

Table A-22: Total number of referrals to treatment/services by pathway in 2018

The Active Outreach pathway is associated with the highest average number of referrals in 2018 (mean = 184) compared to the "other" pathway and the Officer Intervention pathway, both of which had fewer than 90 average referrals in 2018.

Table A-22: Total number of referrals to treatment/services by pathway in 2018

Type of program	Mean	Std. Dev.	Min	Max	N
Active Outreach	184.2	344.4	0	2500	72
Naloxone Plus	158.8	326.9	0	2500	85
First Responder/Officer Prevention	141.3	320.1	0	2500	83
Self-Referral	127.9	196.7	0	1000	82
Officer Intervention	89.2	174.7	0	1000	49
Other	85.3	89.9	0	300	11

Table A-23. Referral type by program pathway

For all the program pathways, the most common types of referral are receiving general written information and receiving a personal introduction by the program to treatment/recovery/peer/case managers for assessment and/or coordination of treatment planning.

Table A-23. Referral type by program pathway

	Receive general written information	Receive written referral to treatment	Receive treatment appointment for specific date	Receive personal introduction	Other	Total
Self-Referral	110	34	57	104	21	326
	30.7%	10.4%	17.5%	31.9%	6.4%	100%
Active Outreach	105	40	60	101	27	333
	31.5%	12.0%	18.0%	30.3%	8.1%	100%
Naloxone Plus	121	46	70	119	31	387
	31.3%	11.9%	18.1%	30.7%	8.0%	100%
Officer Intervention	55	24	33	63	13	188
	29.3%	12.8%	17.6%	33.5%	6.9%	100%
First Responder/Officer Prevention	116	43	63	108	23	353
	32.9%	12.2%	17.8%	30.6%	6.5%	100%
Other	9	4	7	13	7	40
	22.5%	10.0%	17.5%	32.5%	17.5%	100%

Table A-24. Training for deflection program staff

The overwhelming majority of programs have received naloxone administration training (91 percent). The second most common type of training is crisis intervention training (74 percent). Only 40 percent of programs offer racial equity training or gender equity training, and fewer (30 percent) of the programs provide training on the neuroscience of addiction.

Table A-24. Training for deflection program staff

Have staff received any of the following training N = 300	N	%	Need the following training to better meet needs of community	N	%
Cognitive behavioral treatment			Cognitive behavioral treatment		
Yes	83	27.7	Yes	25/45	55.6
Crisis intervention team training			Crisis intervention team training		
Yes	222	74.0	Yes	58/95	61.1
Cultural awareness			Cultural awareness		
Yes	183	61.0	Yes	94/203	46.3
Gender equity			Gender equity		
Yes	101	33.7	Yes	118/223	52.9
Harm minimization training			Harm minimization training		
Yes	111	37.0	Yes	96/222	43.2
Mental health treatment training			Mental health treatment training		
Yes	202	67.3	Yes	104/245	42.5
Motivational interviewing			Motivational interviewing		
Yes	92	30.7	Yes	98/232	42.2
Naloxone administration training			Naloxone administration training		
Yes	273	91.0	Yes	104/182	57.1
Racial equity			Racial equity		
Yes	120	40.0	Yes	68/116	58.6
Recovery support services			Recovery support services		
Yes	139	46.3	Yes	81/175	46.3
SBIRT*			SBIRT*		
Yes	71	23.7	Yes	67/135	49.6
Addiction neuroscience			Addiction neuroscience		
Yes	93	31.0	Yes	84/196	42.9
Staff safety			Staff safety		
Yes	141	47.0	Yes	94/216	43.5
Substance use treatment training			Substance use treatment training		
Yes	132	44.0	Yes	88/177	49.7
Other			Other		
Yes	23	7.7	Yes	86/254	33.9

* Screen, brief intervention, and referral to treatment

Table A-25. Services and partners

To facilitate services essential to the outcomes of their programs, FRD programs most often reported partnering with providers of treatment, case management, and recovery support services. Deflection programs led by agencies other than first responders also reported collaborating with law enforcement, EMS, and combined fire/EMS to provide outreach and referral or co-response services.

Table A-25. Services and partners

Service Partner	% (Programs with Partners Providing Service)*	Average Number of (Known) Partners/Program**	N (Total Partners Providing Services)***
Treatment provider	16.8%	2.4	395
Case management	16.5%	1.9	298
Recovery support services	16.0%	1.8	283
Law enforcement (police/sheriff)	10.7%	2.3	241
Other partner not mentioned above	7.2%	1.7	122
Other justice	7.1%	1.7	114
Civic group	6.0%	1.5	89
Housing support	5.9%	1.7	99
EMS	4.1%	1.4	54
Combined fire/EMS	3.8%	1.3	47
Vocational/education	3.8%	1.9	69
Fire dept. (non-EMS)	2.0%	1.1	20
	100%		

* Proportion based on the number of programs with ≥1 partner providing the service.

** Each partner could be assigned multiple service types.

*** A program could report multiple partners, but ≤20 for this item; hence, these are only "known partners."

Table A-26. Treatment/services for those referred through the deflection program

Approximately 52 percent of programs track treatment attendance and/or participation for individuals referred through the program. Approximately 65 percent of programs conduct outreach to individuals who do not attend their initial treatment and/or service referral. Approximately 53 percent of programs operate 24 hours per day. Approximately 60 percent of programs operate seven days per week. Approximately 58 percent of programs have some sort of agreement with their treatment and service providers to prioritize intake appointments for individuals referred by the program: 14.9 percent have a formal agreement, and 42.7 percent have an informal agreement.

Table A-26. Treatment/services for persons referred through the deflection program

	N	%
Yes, track treatment attendance	134	51.9
Yes, conduct outreach to persons not attending their initial treatment referral	157	65.4
Yes, programs operate 24 hours per day	152	53.0
Yes, programs operate seven days per week	172	60.1
Yes, formal agreement with providers to prioritize intake for program referrals	45	14.9

Yes, informal agreement with providers to prioritize intake for program referrals	129	42.7

Table A-27. Treatment services by treatment partner

As seen in Table A-27, when treatment partners provide substance use treatment, more than 70 percent of the programs provide inpatient withdrawal management, intensive outpatient treatment, medication-assisted treatment (MAT), and outpatient treatment. The most common type of substance use treatment is outpatient (87 percent), and the least common is partial hospitalization programming (38 percent). When using MAT, approximately 60 percent of treatments include buprenorphine, methadone, and naltrexone; there is no type of MAT that is the most common—both buprenorphine and methadone are equally likely to be used.

Table A-27. Treatment services by treatment partner (n = 282)

	N	%
Substance use treatment	254	90.1
Mental health assessment/treatment	223	79.1
Peer support or recovery coaching	222	78.7
Assistance with benefits applications	156	55.3
Family counseling	155	55
Harm minimization	154	54.6
Transportation assistance	151	53.4
Housing support services	142	50.4
Education	106	37.6
Food and nutrition	104	36.9
Employment	92	32.6
Family reunification	68	24.1
Vocational training	55	19.5
Traditional/cultural healing	32	11.3
Other	20	7.1
Types of substance use treatment provided by treatment partner N = 254	**N**	**%**
Outpatient	220	86.6
Inpatient withdrawal management (detox)	196	77.2
Intensive outpatient	189	74.4
Medication-assisted treatment (MAT)	185	72.8
Residential	143	56.3
Partial hospitalization program	97	38.2
Which medication-assisted treatment offered N = 184	**N**	**%**
Buprenorphine (Subutex, Suboxone)	125	67.9
Methadone (Dolophine, Methadose)	122	66.3
Naltrexone (Vivitrol)	110	59.8
None of the above	21	11.4

Table A-28. Type of medication-assisted treatment facilitate

Approximately one-fourth of the study agencies (37/163 [23 percent]) provide links to treatment to only one form of MAT, whether this is buprenorphine only, methadone only, or naltrexone only. Approximately 36 percent (n = 58 agencies) provide links to treatment to two MATs, and 42 percent (n = 68 agencies) link to all three MATs.

Table A-28. Type of medication-assisted treatment offered (n = 163)

Type of medication-assisted treatment offered	Freq
Only buprenorphine	9
Only methadone	24
Only naltrexone	4
Buprenorphine and methadone only	20
Buprenorphine and naltrexone only	28
Methadone and naltrexone only	10
All three	68

Table A-29. Ongoing source of funding by pathway

Only “federal funds,” “local funds,” and “no outside funds” were associated with any type of program pathway. Federal funds were positively associated with Active Outreach, meaning that the use of federal funds as an ongoing source of support increases the likelihood of active outreach as a pathway. Local funds were positively associated with both Active Outreach and First Responder/Officer Prevention. Use of no outside funds as ongoing support was negatively associated with Naloxone Plus and First Responder/Officer Prevention (for statistical analysis, see *Table A-13* above).

Federal funds are most commonly used as an ongoing source of support for Naloxone Plus (23 percent); they are the least common for First Responder/Officer Prevention (13.1 percent). Local funds are most commonly used as ongoing support for both Self-Referral (28 percent) and Active Outreach (28 percent), and the least commonly used for Officer Intervention (12 percent).

Table A-29. Ongoing source of funding by pathway

	Self-Referral	Active Outreach	Naloxone Plus	First Responder/ Officer Prevention	Officer Intervention	Other	Total
Federal	62	63	74	67	42	13	321
	19.3%	19.6%	23.1%	20.9%	13.1%	4.0%	100%
In-kind donations	31	26	29	27	12	3	128
	24.2%	20.3%	22.7%	21.1%	9.4%	2.3%	100%
Local	76	76	84	84	45	11	376
	27.5%	27.5%	22.3%	22.3%	12.0%	2.9%	100%
Philanthropic	14	10	13	12	10	3	62
	22.6%	16.1%	21.0%	19.4%	16.1%	4.8%	100%
State	59	57	69	65	37	12	299
	19.7%	19.1%	23.1%	22.0%	12.4%	4.0%	100%
Other	21	18	25	21	7	5	97
	21.6%	18.6%	25.8%	21.6%	7.2%	5.2%	100%
No outside funds were used	18	15	15	15	17	1	81
	22.2%	18.5%	18.5%	18.5%	21.0%	1.2%	100%

Table A-30. Tracking of overdose data

Slightly more than half of programs track fatal and nonfatal overdoses, as well as naloxone administration; many fewer track distribution of naloxone kits and emergency room visits related to overdose.

Table A-30. Tracking of overdose data (check all that apply) n = 300

	N	%
Number of fatal overdoses	155	51.7
Number of nonfatal overdoses	155	51.7
Number of naloxone administrations by a law enforcement, fire, or EMS agency	151	50.3
Number of naloxone kits distributed by program	87	29.0
Number of emergency room/department visits for overdoses	16	5.3
Do not know	102	34.0

Table A-31. Tracking of participation in services

Slightly more than half of programs that responded track how many individuals receive treatment or services; many fewer track those involved in recovery support, those who complete treatment, and the length of participation in treatment or services.

Table A-31. Tracking of participation in services (check all that apply) (n = 300)

	N	%
Number of individuals who participate in treatment and/services	160	53.3
Number of individuals who participate in recovery support	123	41.0
Number of individuals who complete treatment phases	81	27.0
Length of participation in treatment and/or services	80	26.7
Do not know	137	45.7

Table A-32. Tracking of participant outcome data and sharing data

Slightly more than half of programs that responded to the survey track clients who have reduced drug use. Other participant outcome data are much less commonly tracked.

Table A-32. Tracking of participant outcome data and sharing data (check all that apply) (N = 299)

	N	%
Number of individuals who have reduced drug use	50	53.5
Number of individuals who are arrested during program	59	45.8
Number of individuals who have reduced substance use symptoms	45	41.1
Number of individuals who obtain employment	38	27.1
Type of housing participants live in	40	26.8
Number of individuals who are arrested post program	0	0.0
Number of individuals who become incarcerated during program for a new offense	0	0.0
Number of individuals who are incarcerated post program for a new offense	0	0.0
Other	14	0.0
Do not know	198	0.0
Program shares aggregate participation information	121	62.1%
Program shares identifiable individual-level participant data	96	48.7%

Table A-33. Conducted a formal program evaluation

Relatively few programs conduct a formal program evaluation.

Table A-33. Conducted a formal program evaluation

	N	%
Yes	38	16.7
No	189	83.3
Total*	227	100

*72 additional respondents selected “Do not know” (not included here)

Table A-34. Of the sites in the study, 88%[39] are located in Medicaid expansion states (nonexpansion sites are noted with an asterisk).

Table A-34. Distribution of deflection programs by Affordable Care Act-adopting states

State	N	%	39 states with surveys
Alabama*	1	0.31	1
Alaska	2	0.62	2
Arizona	5	1.56	3
California	6	1.87	4
Colorado	4	1.25	5
Delaware	2	0.62	6
Florida*	3	0.93	7
Georgia*	4	1.25	8
Hawaii	2	0.62	9
Illinois	13	4.05	10
Indiana	5	1.56	11
Iowa	2	0.62	12
Kentucky	7	2.18	13
Louisiana	2	0.62	14
Maine	9	2.8	15
Maryland	6	1.87	16
Massachusetts	62	19.31	17
Michigan	34	10.59	18
Minnesota	1	0.31	19
Missouri	2	0.62	20
Nebraska	1	0.31	21
Nevada	1	0.31	22
New Hampshire	5	1.56	23
New Jersey	7	2.18	24
New Mexico	2	0.62	25
New York	19	5.92	26
North Carolina*	13	4.05	27
Ohio	45	14.02	28
Oregon	6	1.87	29
Pennsylvania	11	3.43	30
Rhode Island	1	0.31	31
South Carolina*	4	1.25	32
Tennessee*	1	0.31	33
Texas*	2	0.62	34
Vermont	2	0.62	35
Virginia	3	0.93	36
Washington	7	2.18	37
West Virginia	9	2.8	38
Wisconsin*	10	3.12	39

* 8 states that did not expand Medicaid for ACA (four other states did not expand but they were not in the study)

[39] 38 states and the District of Columbia have expanded Medicaid under the Affordable Care Act (ACA); of the 321 FRD programs identified in this survey, 283 are located in 31 of these states. In all, 38 FRD programs identified in this survey are located in eight of the 12 states that have not expanded Medicaid under the ACA.

Appendix B: Charts

Unless otherwise noted, the denominator for all charts is (n =) 320 cases. In some charts, the percentages do not add up to 100 percent because a respondent could provide more than one answer for each question.

Chart B-1. Lead Agency for Deflection Program
Law enforcement agencies, including law enforcement departments and sheriff's offices, made up 73 percent of deflection program respondents. Fire and EMS departments made up 15 percent.

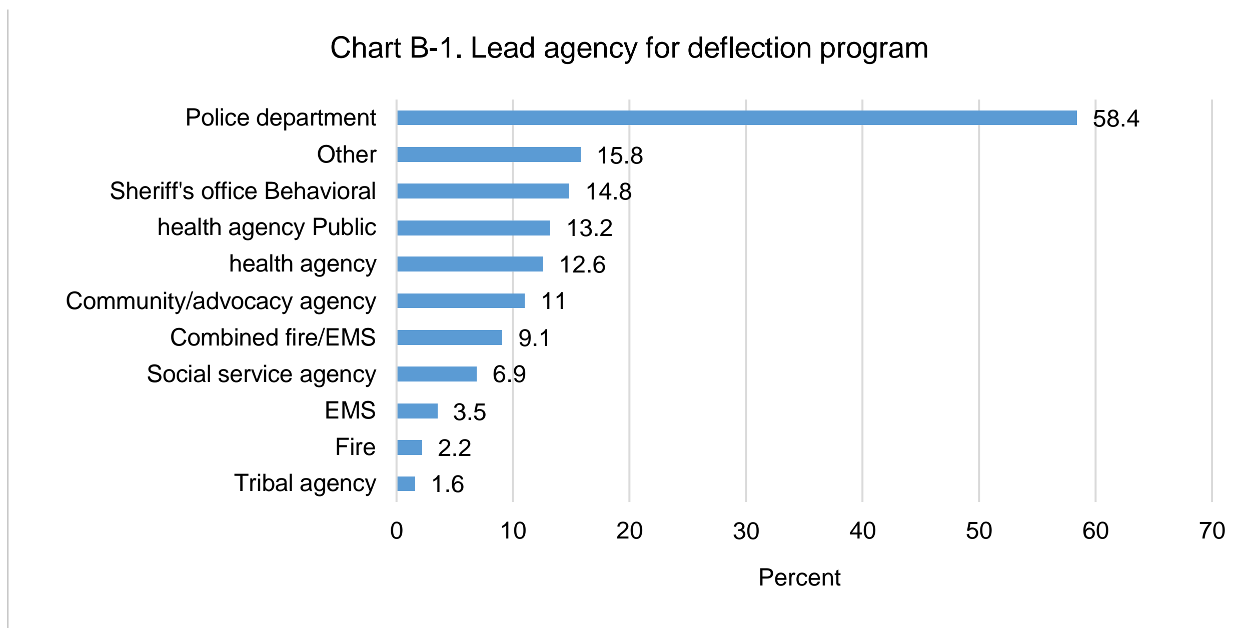


Chart B-2. Most frequently misused substances
The most frequently misused substances in deflection programs' communities was alcohol (74 percent), followed by opioids (55 percent), marijuana (48), and heroin (46 percent). The next most frequently misused was methamphetamines (35 percent).

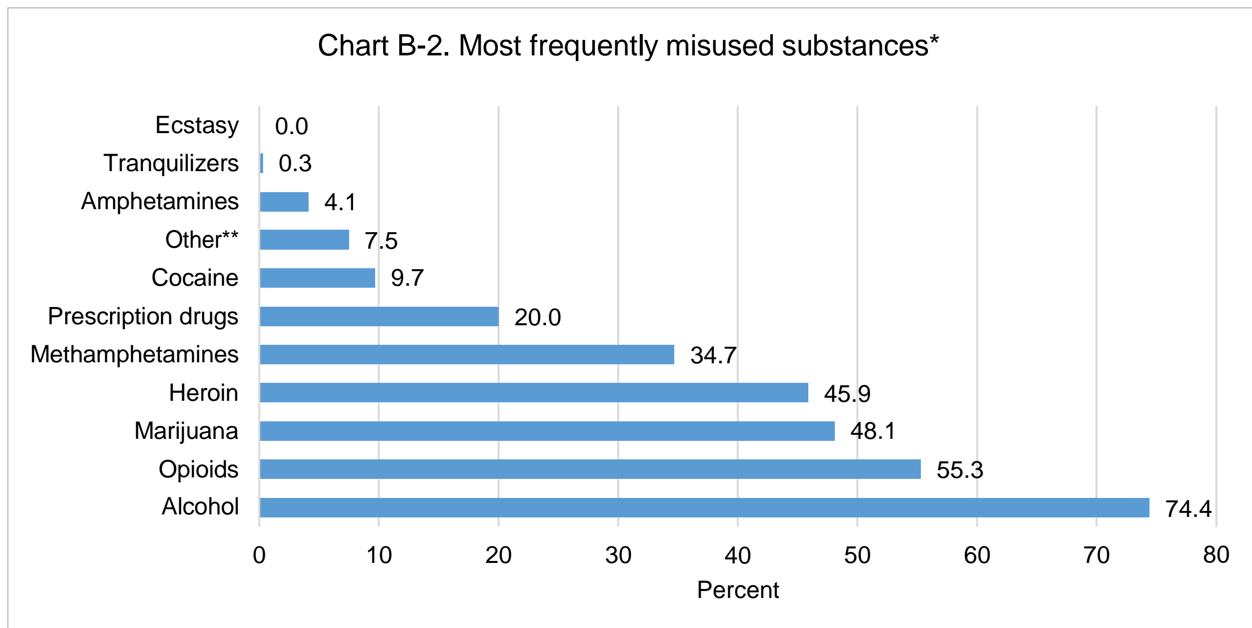
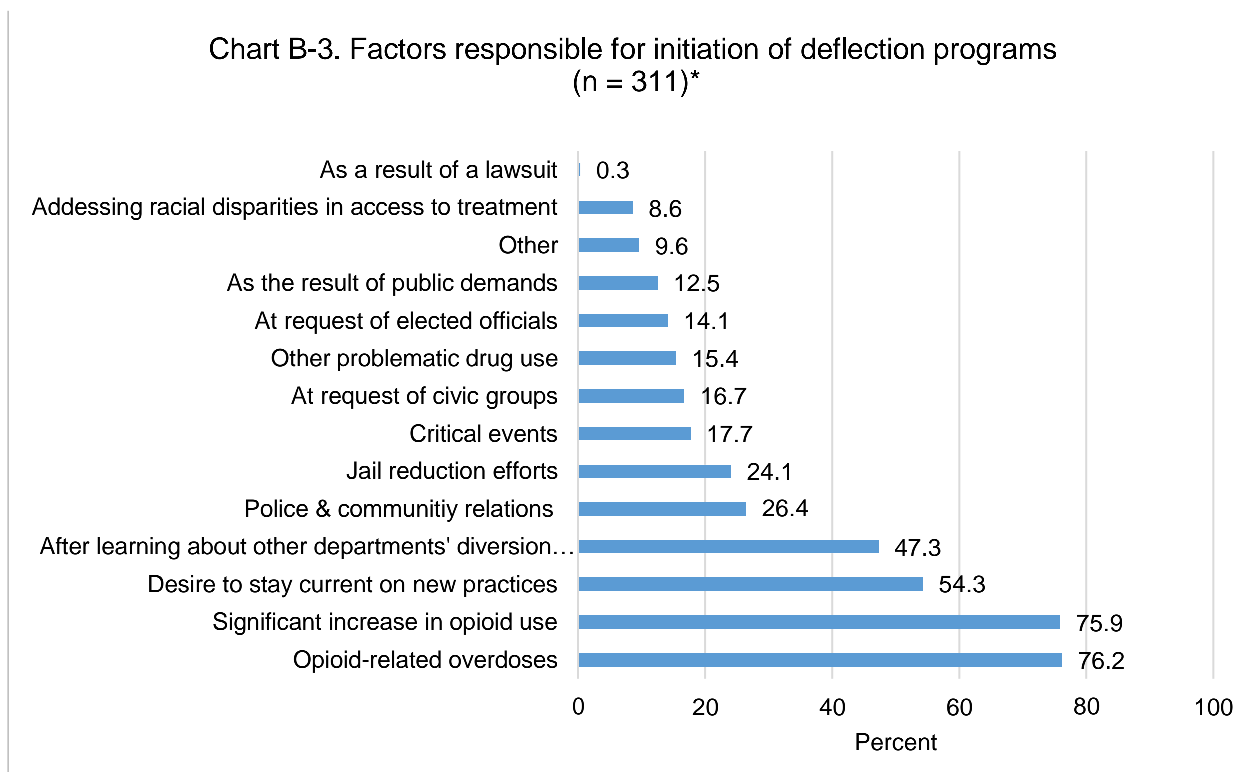


Chart B-3. Factors responsible for initiation of deflection programs

The majority of the programs reported that, among multiple factors that contributed to their initiation, they began in response to opioid-related overdoses (76 percent) or to a significant increase in opioid use in the community (76 percent). Approximately half of the programs reported that they initiated the FRD program to stay current on new practices and innovations (54 percent) and after learning about other departments' deflection programs (47 percent).



* Respondents could provide multiple answers (n = 1242).

Chart B-4. Did organizations that identified with the "Other" pathway (n = 24) select any other pathways?

For the 24 agencies that identified with the "Other" pathway, 10 agencies (42 percent) selected only the "Other" pathway and no other pathways, and two respondents that selected "Other" also checked all pathway types.

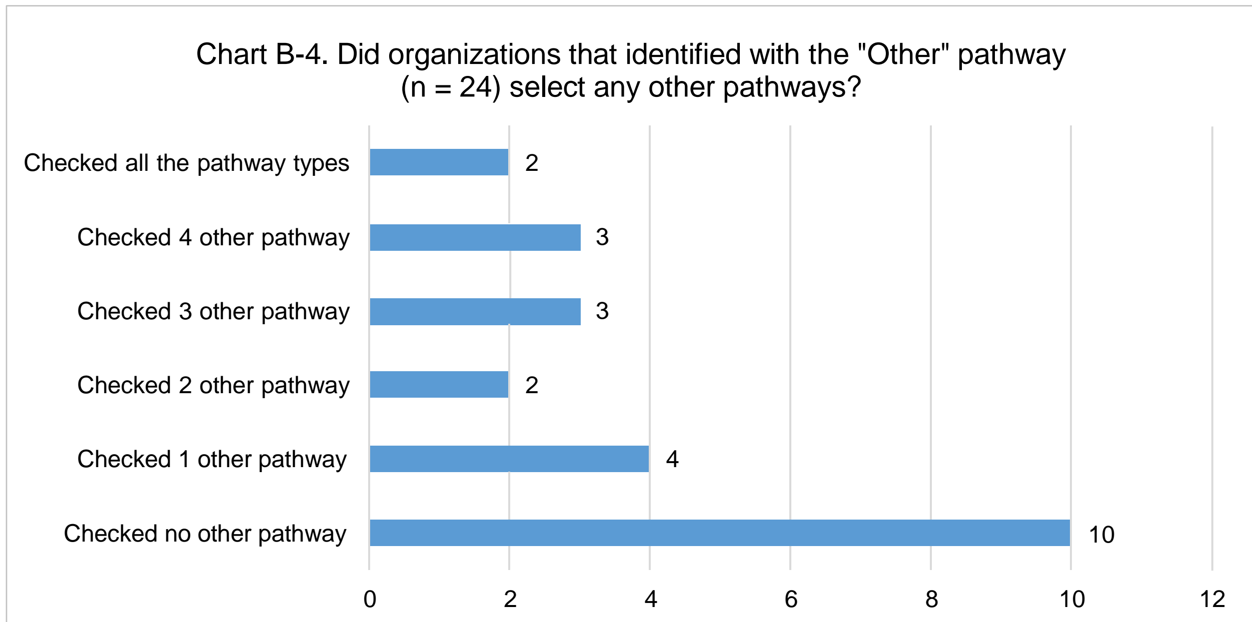


Chart B-5. Total number of referrals to treatment/services since inception

Most programs have had <500 referrals to treatment and services since their inception.

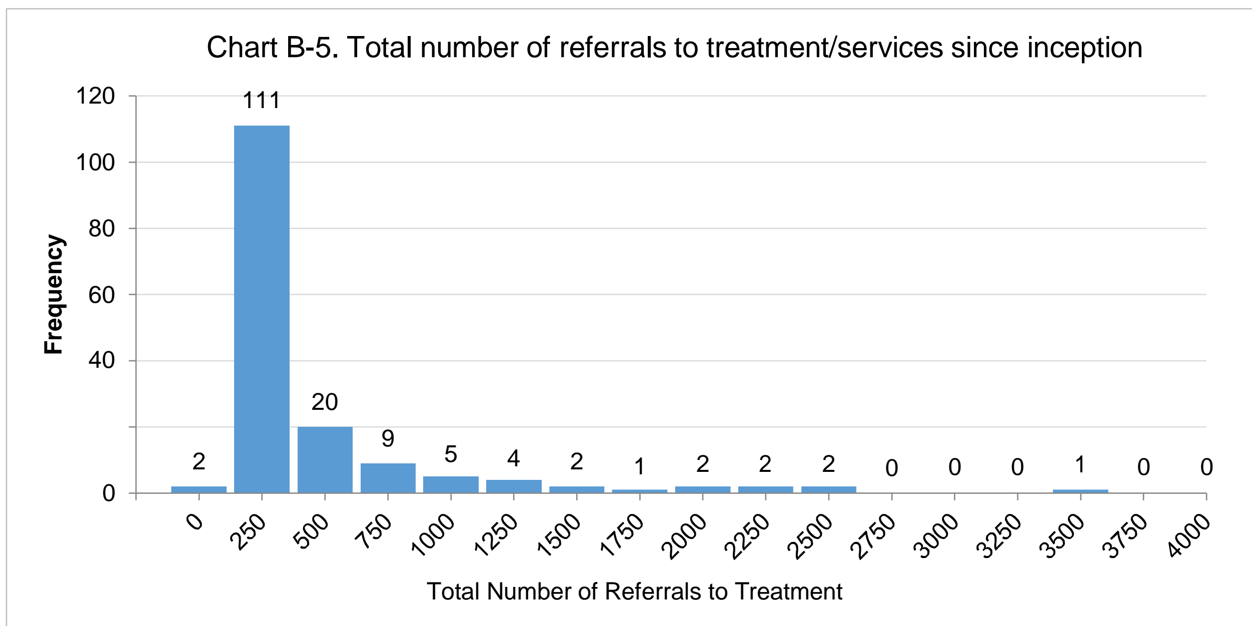


Chart B-6. Total number of referrals to treatment/services in 2018

Most programs had <500 referrals to treatment and services in 2018.

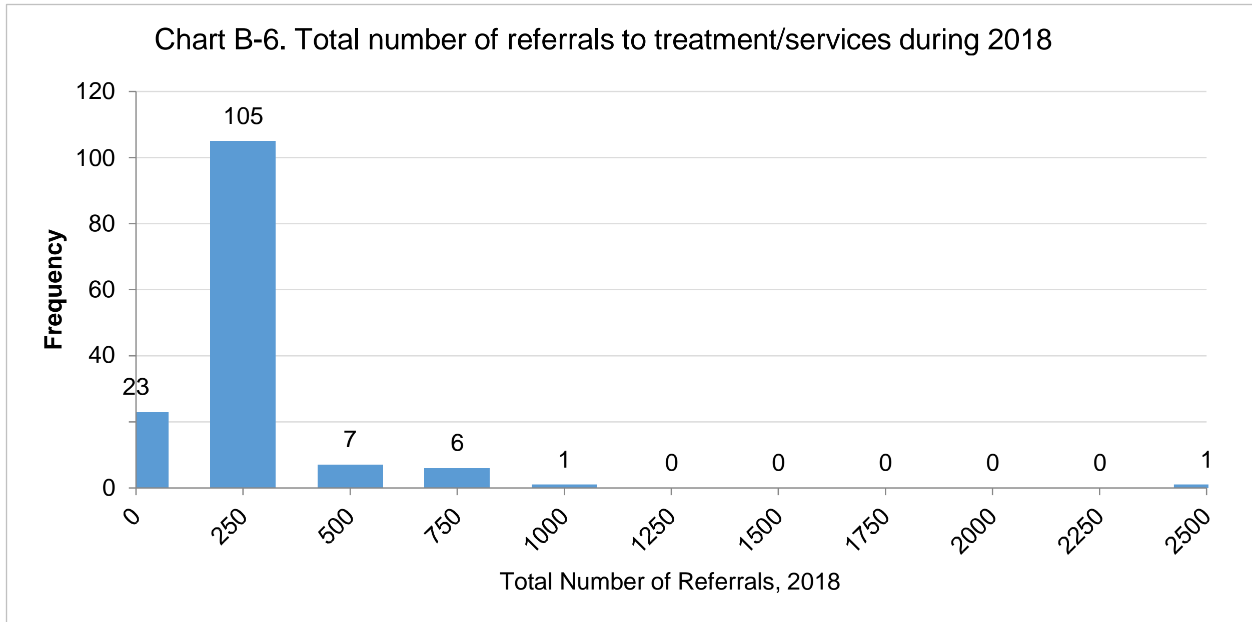


Chart B-7. How clients are transported to treatment and services

Of deflection programs responding to the survey, 65 percent provide transportation to treatment and services for clients (including 25 percent who allow clients to provide their own transportation). Fewer than one-fifth do not provide any form of transportation for their clients.

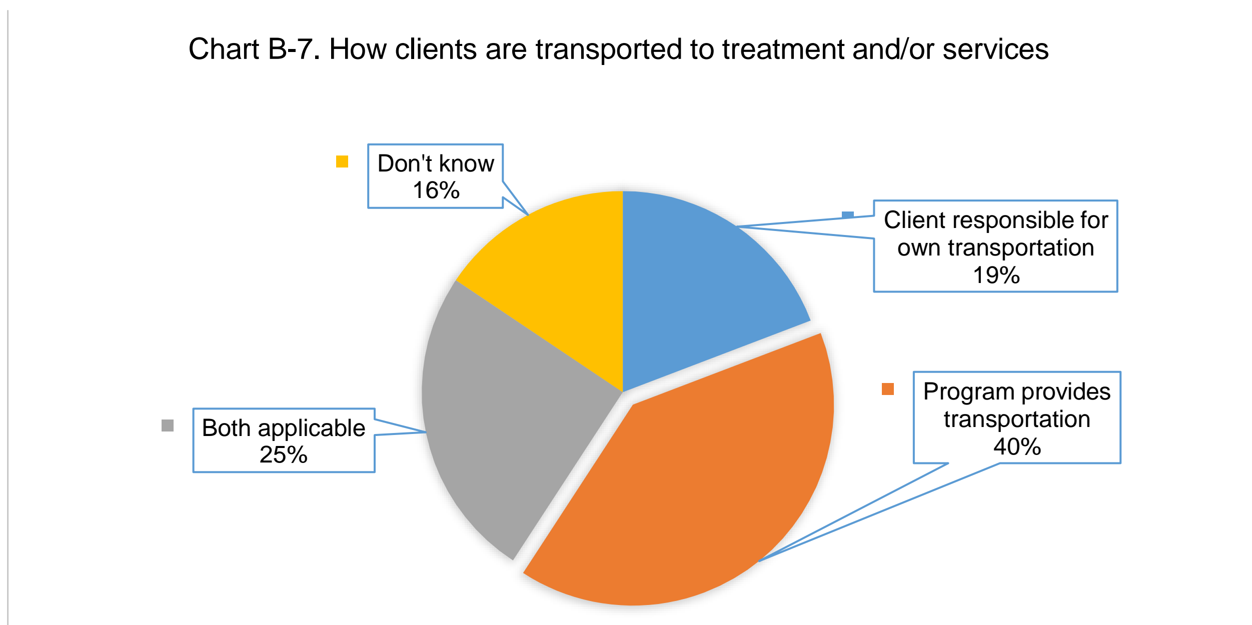


Chart B-8. Deflection training curriculum

Only 34 percent of FRD programs have a deflection-oriented training curriculum. The length of the training curriculum ranges from one to 678 hours, but half the cases (the median) receive four or fewer hours of training.

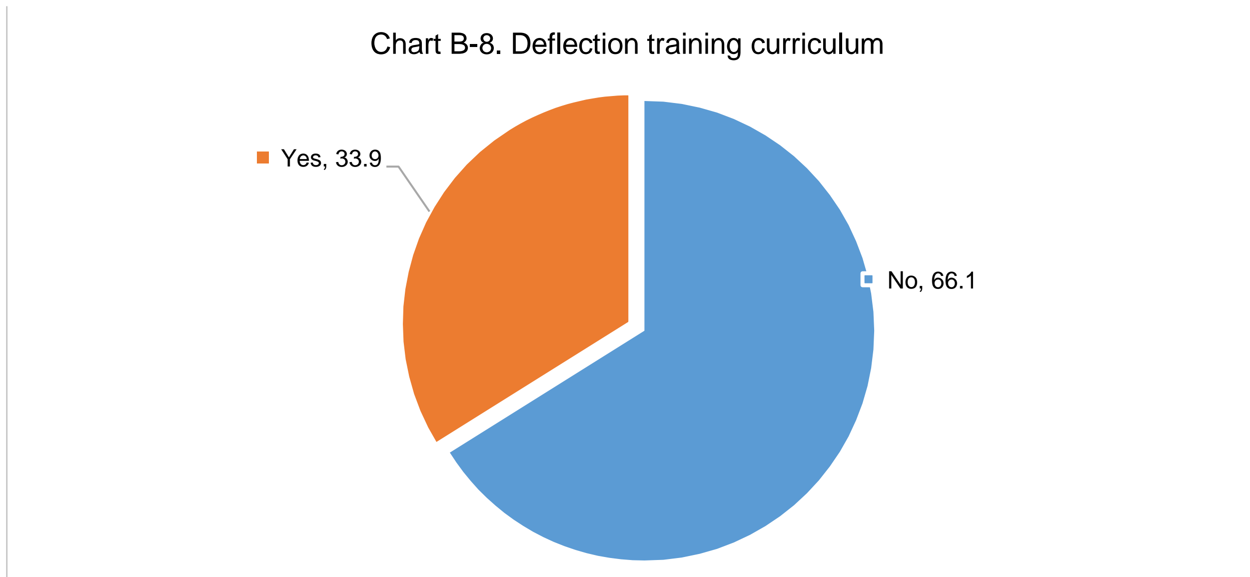


Chart B-9. Agencies/organizational partners involved in the program (n = 233)

Almost half of the of programs (46.4 percent) responding to the survey reported having one to three collaborative service providers, while another 26 percent reported having four to six partner service provider organizations essential to the outcomes of the deflection program. The remaining 28 percent have seven or more partners.

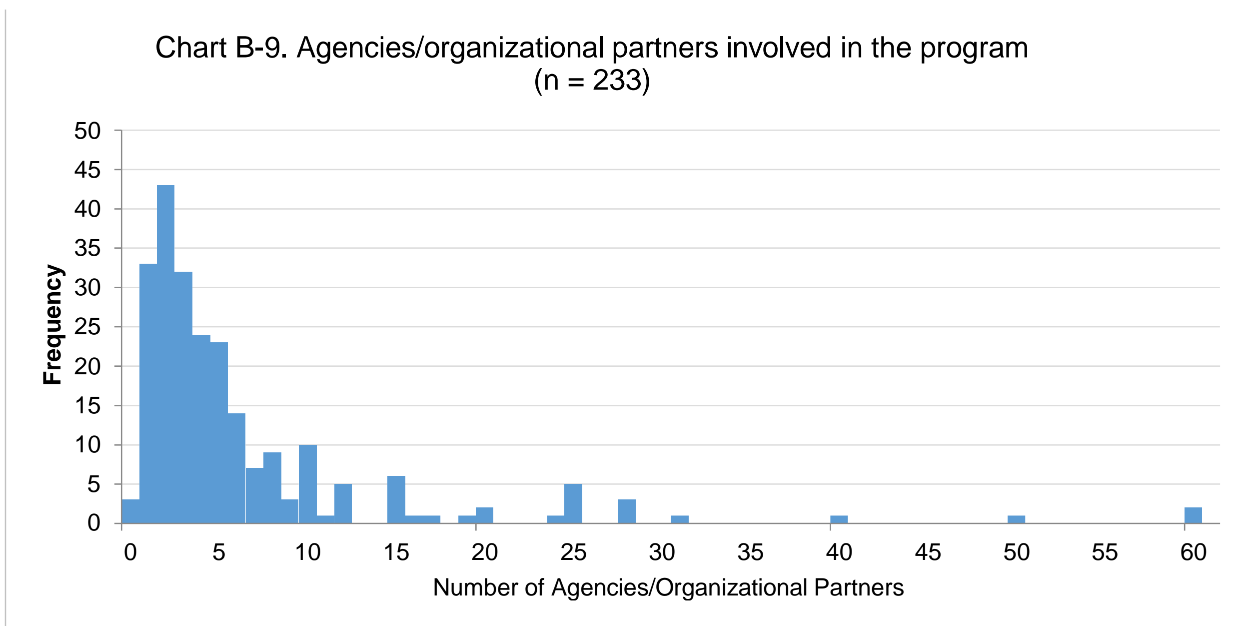


Chart B-10. Stakeholder meetings (n = 149)

Of those surveyed, 64 percent (149 in all) reported that they maintain a dedicated stakeholder group to coordinate and provide direction to deflection program activities. Of these programs, more than two-thirds hold stakeholder meetings at least monthly; all hold stakeholder meetings at least annually.

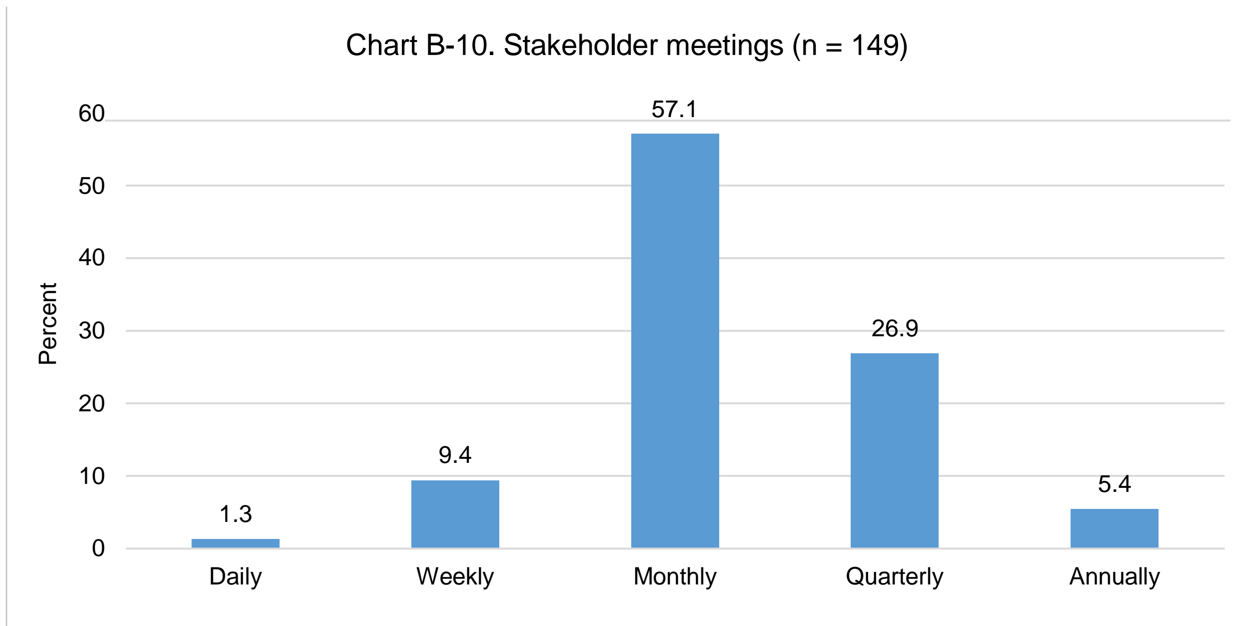


Chart B-11. Typical funding source of SUD treatment/services

As seen in Chart B-11, programs most often reported that, for individuals referred by the program, SUD treatment and/or services typically were funded by Medicaid or Medicare. Approximately 52 percent of programs reported this funding as typical. Other frequently reported typical funders of treatment included private insurance (reported as typical by 46 percent of respondents), federal grant funds (reported as typical by 35 percent of respondents), and state grant funds (reported as typical by 34 percent of respondents).

Chart B-11. Typical funding source of substance use disorder treatment/services (n = 302)

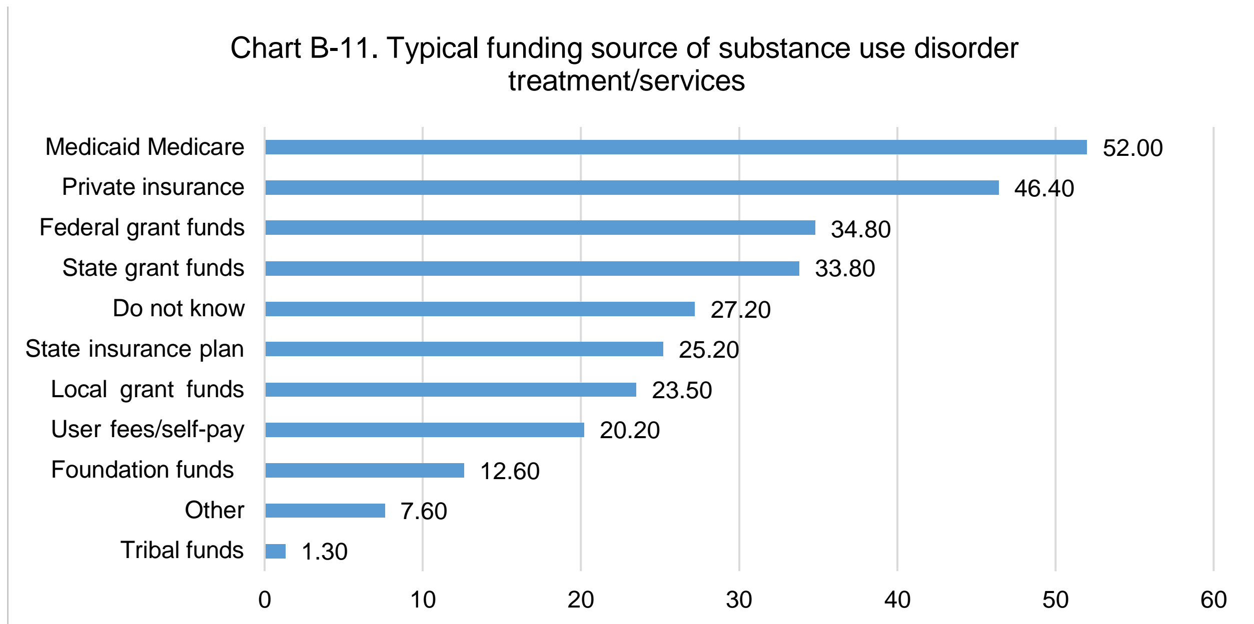


Chart B-12. Program has stand-alone budget

Approximately 40 percent of programs have a stand-alone budget dedicated to their deflection program (separate from their agency's overall budget).

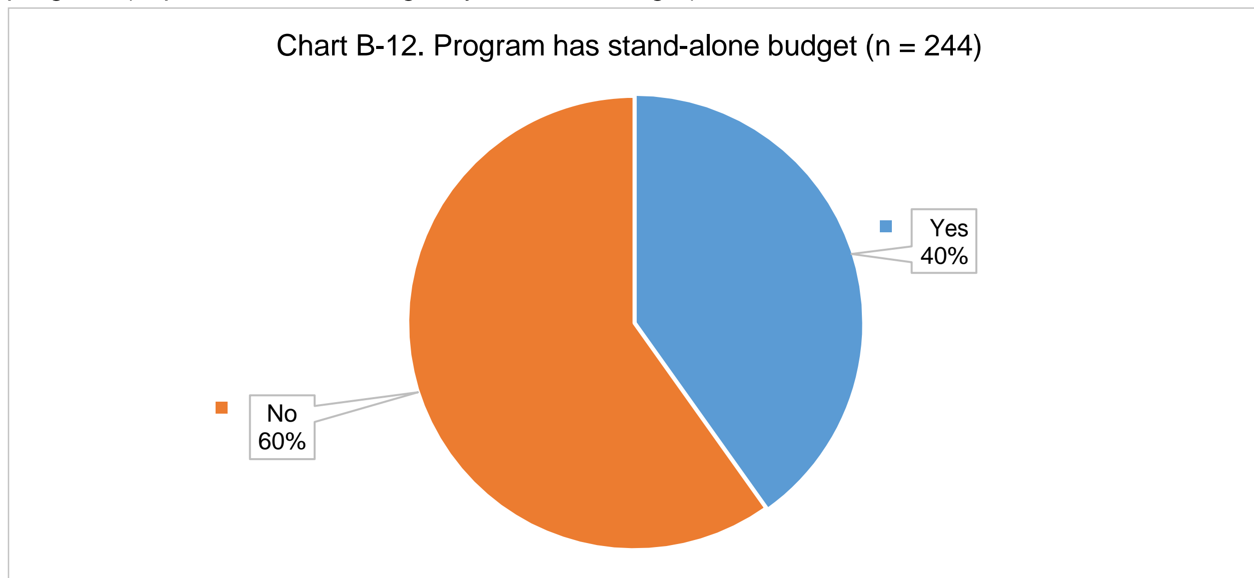


Chart B-13. Types of funds used to start program

Agencies often used multiple funding sources to start their deflection programs (therefore, numbers do not add up to 100 percent). The most common types of funds used to start the program were local funds (36 percent). Approximately 30 percent of the programs used state funds to start the program, and 26 percent of the programs used federal funds. Only 8 percent of the programs used philanthropic funds to start the program, making it the least commonly used type of funds.

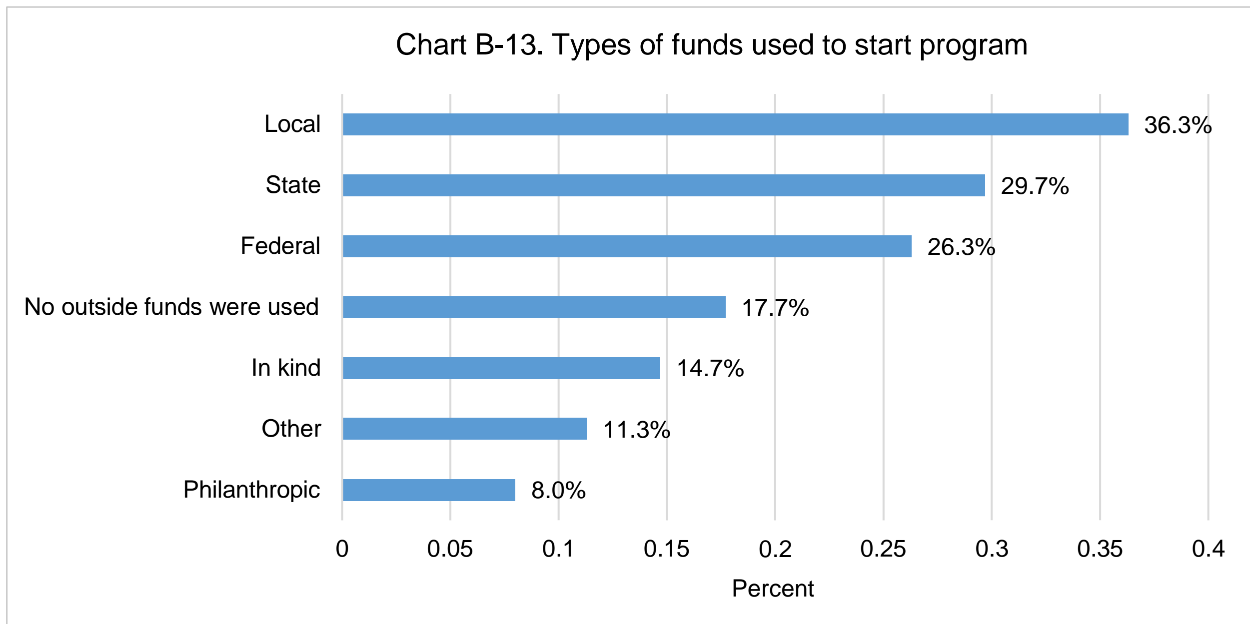


Chart B-14. Types of funds currently used to operate program

The most common types of funds used to operate the program were local funds (46 percent). Approximately 38 percent of the programs use federal funds to operate their FRD program today, and 35 percent of the programs used state funds. Although more programs used state funds rather than federal funds to start a program, more programs seemed to use federal funds rather than state funds to currently operate it. Only 9 percent of the programs used philanthropic funds to operate the program, making it the least commonly used type of funds.

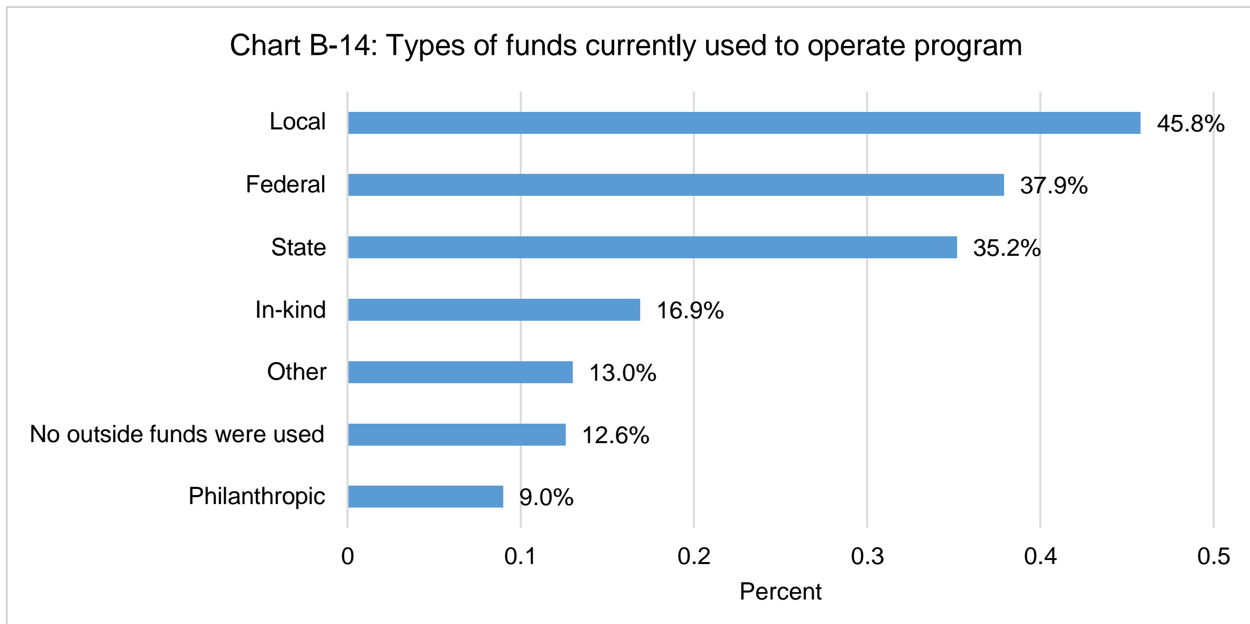


Chart B-15. Type of demographic data collected by deflection program (n = 301)

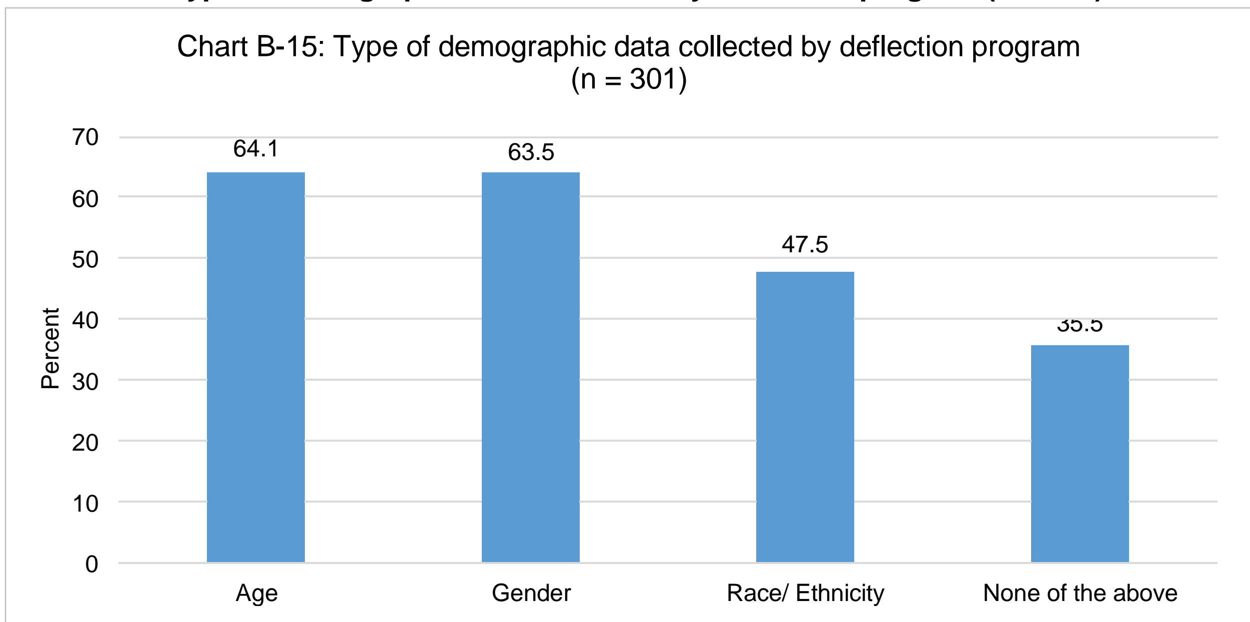
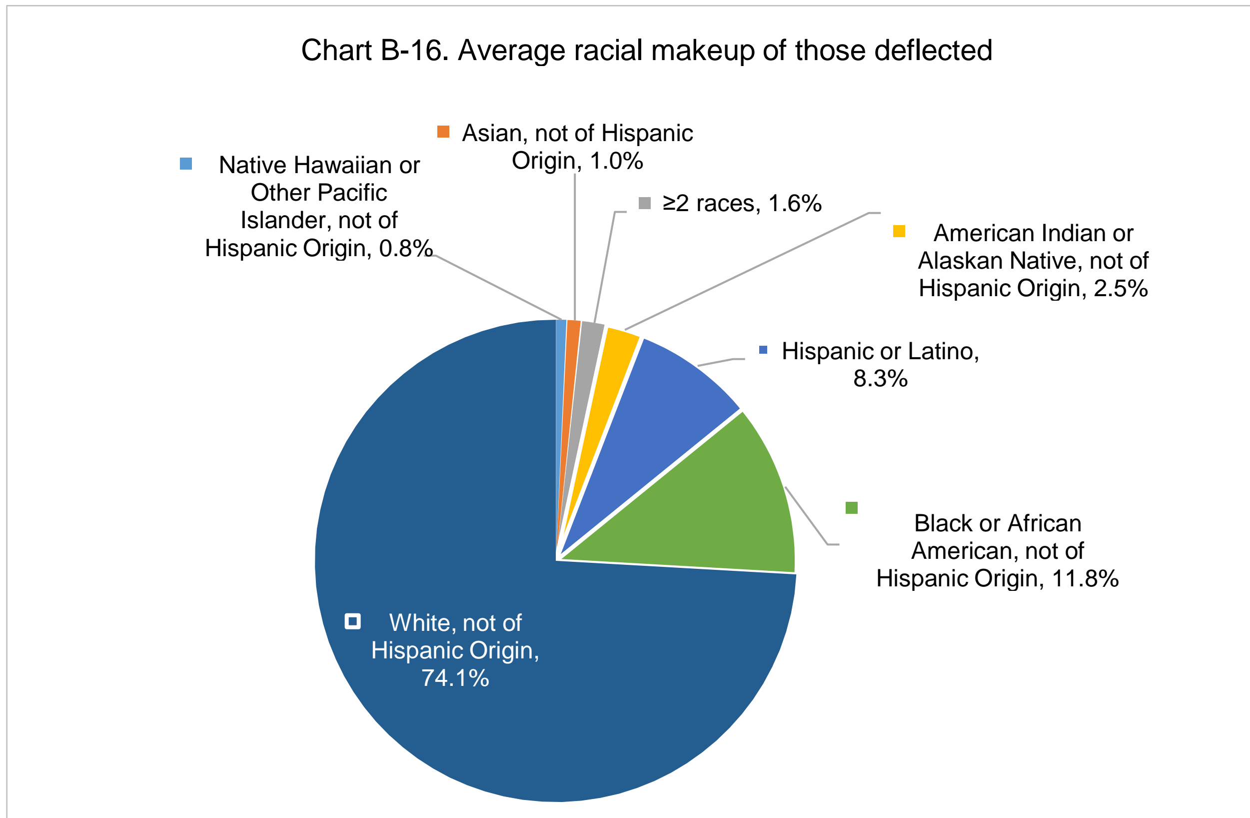


Chart B-16. Average racial makeup of those deflected



Appendix C: Additional Tables

Unless otherwise noted, the denominator for all tables is (n =) 320 cases. In some tables, the percentages do not add up to 100 percent because a respondent could provide more than one answer for each question.

Tables in this section include data collected in the survey but not referenced in the Key Findings and Takeaways Section (Section 5).

Table C-1. Population size of community serviced by deflection program

Population size	N	%
< 5,000	12	4.4
5,000-9,999	6	2.2
10,000-99,999	138	50.7
100,000-499,999	76	27.9
> 500,000	49	14.7

*Two respondents reported that the population size was one, which was not a valid response; these were coded as missing.

Table C-2. Fatal opioid overdoses in 2018*

Table 2	N	Median	Mean	SD	Range
Fatal opioid overdose by population size	216	11	56.8	131.2	2 - 840
<5,000	9	1	5.4	14.1	3 - 43
5,000-9,999	5	1	2.2	2.2	1 - 5
10,000-99,999	99	5	21.6	87.1	1 - 793
100,000-499,999	52	38.5	75.7	137.5	1 - 840
> 500,000	25	121	179.4	164.3	2 - 683
Nonfatal opioid overdose by population size	211	65	393.5	983.4	2 - 9,000
<5,000	9	7	48.9	115.9	1 - 356
5,000-9,999	5	10	13.2	11.6	2 - 26
10,000-99,999	99	33	120.4	504.8	3 - 5,000
100,000-499,999	52	265.5	454.4	495.9	4 - 1906
> 500,000	24	744.5	1474.6	2013.0	3 - 9,000

*Respondents were asked to answer this question with 2018 data or with the most recent data they had available.

Table C-3. Staff and volunteer composition of deflection program

	N	Median	Mean	SD	Range
Full-time staff	236	2.0	15.2	51.8	0 - 535
Part-time staff	237	2.0	18.2	56.6	0 - 350
Volunteer staff	226	0.0	2.0	6.6	0 - 50

Table C-4. Lead agency's organizational total operating budget in 2018 (n = 211)

	N	%
Under $250,000	26	12.3
$250,000 - 1 million	30	14.2
1 - 10 million	88	41.7
10 - 20 million	23	10.9
20 - 40 million	11	5.2
40 - 60 million	7	3.3
60 - 100 million	14	6.6
Over 100 million	12	5.7

Table C-5. Personnel size of lead agency

	N	Median
Total full-time personnel	220	64
Total part-time personnel	185	2
Total volunteer personnel	180	0

Table C-6. Budget size of lead agency

N	Mean	SD	Range
65	$644,430	$1,756,545	$10,000 - $14,000,000

Table C-7. Characteristics of participant referrals (n = 300)

	N	%
Number of program referrals by gender	96	32.0
Number of program referrals by race and ethnicity	75	25.0
Number of program referrals by sexual minority	23	7.7
Do not know	199	66.3

Table C-8. Tracking of sources of program referrals (Check all that apply) (n = 300)

	N	%
Number of referrals from specific districts, locations, or areas of your community	86	28.7
Number of program referrals from specific agencies	85	28.3
Number of referrals from specific individuals (e.g., officer/firefighter/ paramedic/EMTs)	77	25.7
Other referral data indicators	7	2.3
Do not know	167	55.7

Table C-9. Length of participation in treatment and/or services, tracking attendance in treatment and/or outcomes

	N	%
≤30 days	1	1.5
≤60 days	4	6.0
≤90 days	10	14.9
>90 days	52	77.6
Total	67	100

Table C-10. Program initiation factor by region

	Northeast	Midwest	South	West	Total
Address racial disparities in access to treatment	8 1.8%	8 1.8%	8 3.5%	6 4.8%	30 2.4%
After learning about other department's program	55 12.2%	45 10.3%	31 13.4%	16 12.8%	147 11.8%
As result of lawsuit	0 0.0%	0 0.0%	0 0.0%	1 0.8%	1 0.1%
As result of public demands	16 3.5%	12 2.8%	7 3.0%	4 3.2%	39 3.1%
At request of civic groups	17 3.8%	26 6.0%	5 2.2%	4 3.2%	52 4.2%
At request of elected officials	11 2.4%	16 3.7%	8 3.5%	9 7.2%	44 3.5%
Critical event led to initiation of program	21 4.7%	21 4.8%	10 4.3%	3 2.4%	55 4.4%
Other	9 2.0%	5 1.1%	7 3.0%	6 4.8%	27 2.2%
Response to increase in opioid use in community	91 20.2%	90 20.7%	41 17.7%	14 11.2%	236 19.0%
Response to issues of law enforcement/community relations	28 6.2%	31 7.1%	13 5.6%	10 8.0%	82 6.6%
Response to jail reduction efforts	23 5.1%	21 4.8%	18 7.8%	13 10.4%	75 6.0%
Response to opioid-related overdoses	95 21.1%	86 19.8%	42 18.2%	14 11.2%	237 19.1%
Response to other drug use in community	15 3.3%	16 3.7%	11 4.8%	6 4.8%	48 3.9%
Stay current on new practices	62 13.7%	58 13.3%	30 13.0%	19 15.2%	169 13.6%
N	451	435	231	125	1242
%	100%	100%	100%	100%	100%

Table C-11. Program Pathway and population size

	<5,000	5,000-9,999	10,000-99,999	100,000-499,999	>500,000	Total
Self-Referral	21.7%	0.0%	21.1%	20.5%	20.7%	20.5%
	5	0	72	43	23	143
Active Outreach	8.7%	18.2%	17.6%	21.0%	21.6%	18.9%
	2	2	60	44	24	132
Naloxone Plus	17.4%	18.2%	21.4%	**27.1%**	**22.5%**	**23.1%**
	4	2	73	57	25	161
Officer Intervention	21.7%	18.2%	15.0%	10.5%	9.9%	13.2%
	5	2	51	22	11	92
First Responder/Officer Prevention	**26.1%**	**36.4%**	**21.4%**	19.0%	21.6%	21.1%
	6	4	73	40	24	147
Other	4.3%	9.1%	3.5%	1.9%	3.6%	3.2%
Total %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total N	23	11	330	207	108	

Table C-12. Program pathway and program options

	Self-Referral	Active Outreach	Naloxone Plus	Officer Intervention	First Responder/Officer Prevention	Other	Total
Yes, track treatment attendance	74	78	92	60	72	11	387
	19.%	20.2%	23.8%	15.5%	18.6%	2.8%	100%
Yes, conduct outreach to those not attending their initial treatment/service referral	86	95	108	62	90	13	454
	18.9%	20.9%	23.8%	13.7%	19.8%	2.9%	100%
Yes, programs operate 24 hours/day	92	66	80	55	97	9	399
	23.1%	16.5%	20.1%	13.8%	24.3%	2.3%	100%
Yes, programs operate 7 days/week	101	76	93	60	107	11	448
	22.5%	17.0%	20.8%	13.4%	23.9%	2.5%	100%
Yes, formal agreement with providers to prioritize intake for program referrals	27	21	30	13	25	2	118
	22.9%	17.8%	25.4%	11.0%	21.2%	1.7%	100%
Yes, informal agreement with providers to prioritize intake for program referrals	67	62	74	38	75	11	327
	20.5%	19.0%	22.6%	11.6%	22.9%	3.4%	100%

Table C-13. Population size and program initiation factor

	<5,000	5,000-9,999	10,000-99,999	100,000-499,999	>500,000
Address racial disparities in access to treatment	4.3%	4.1%	1.8%	2.1%	6.3%
After learning about other department's program	15.2%	8.8%	13.2%	11.7%	12.5%
As result of lawsuit	0.0%	0.7%	0.0%	0.0%	0.0%
As result of public demands	0.0%	4.7%	1.9%	3.8%	3.1%
At request of civic groups	2.2%	4.7%	3.5%	5.2%	9.4%
At request of elected officials	4.3%	5.4%	2.3%	4.8%	0.0%
Critical event led to initiation of program	4.3%	2.7%	4.5%	4.8%	3.1%
Other	0.0%	0.7%	0.2%	0.3%	3.1%
Response to increase in opioid use in community	15.2%	**19.6%**	**20.8%**	**19.6%**	12.5%
Response to issues of law enforcement/community relations	8.7%	9.5%	6.4%	4.8%	3.1%
Response to jail reduction efforts	6.5%	4.7%	6.2%	8.2%	6.3%
Response to opioid-related overdoses	**19.6%**	18.9%	20.2%	18.9%	**18.8%**
Response to other drug use in community	6.5%	2.0%	4.7%	2.4%	6.3%
Stay current on new practices	13.0%	13.5%	14.2%	13.4%	15.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Table C-14. Substance used and program pathway

	Self-Referral	Active Outreach	Naloxone Plus	First Responder/ Officer Prevention	Officer Intervention	Other	Total
Alcohol	26.2%	23.3%	24.4%	25.3%	24.4%	27.8%	24.9%
Amphetamines	1.2%	2.0%	1.8%	1.0%	1.7%	1.4%	1.5%
Cocaine	3.0%	4.1%	3.6%	3.6%	3.3%	1.4%	3.5%
Heroin	14.9%	16.6%	14.6%	15.0%	17.8%	16.7%	15.6%
Marijuana	16.7%	13.1%	13.7%	15.4%	14.9%	12.5%	14.7%
Methamphetamines	8.3%	11.1%	11.9%	10.7%	12.5%	15.3%	10.9%
Opioids	19.0%	21.6%	21.0%	18.5%	18.2%	16.7%	19.7%
Prescription drugs	7.3%	5.2%	5.7%	6.9%	5.0%	5.6%	6.1%
Tranquillizers	0.0%	0.0%	0.2%	0.2%	0.0%	0.0%	0.1%
Other substance	3.4%	3.1%	3.0%	3.4%	2.3%	2.8%	3.1%
Totals	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table C-15. Program age and program documentation (n= 320 with respondents allowed to provide more than one answer for each question)

Program Document Type	Average Age of Program (years)	N
Program documentation		
MOUs and/or agreements	3.1	164
Policies	3.1	156
HIPAA consents	3.0	92
No documents	3.3	20
Community outreach		
Brochure, flyer, or handout	3.4	215
Outreach at community event	3.5	165
Business cards	3.3	140
Social media	3.3	111
Other	3.2	11

Table C-16. Program age and training curriculum

Has training curriculum	Average age of program (years)	N
Yes	3.3	77
No	3.1	152

Table C-17. Program age and meeting frequency

Meeting Frequency	Average age of program (years)	N
Annually	2.7	8
Daily	2.7	2
Monthly	2.9	77
Quarterly	3.2	38
Weekly	2.8	13

Table 18. Program pathway and written formal agreements with partners

Program Pathway	% of Programs with Formal Agreements	N (Total Formal Agreements)	Average Formal Agreements per Program
Naloxone Plus	24.5%	375	3.5
First Responder/Officer Prevention	20.3%	315	3.6
Active Outreach	19.6%	325	3.8
Self-Referral	18.7%	302	3.7
Officer Intervention	13.6%	202	3.4
Other	3.2%	49	3.5
	100.0%		

Table C-19. Program pathway and average number of partners

Program Pathway	Average Number of Partners	N*
Self-Referral	7.9	124
Active Outreach	7.5	123
Naloxone Plus	6.6	153
Officer Intervention	6.3	81
First Responder/Officer Prevention	6.7	129
Other	7.2	20

*Includes only programs with pathways

Table C-20. Co-responder type by program pathway

	Case Managers	Child/ Family Welfare Worker	Clinical Mental Health Staff	Clinical Substance Use Disorder Treatment Staff	Other	Peer Support Specialists	Social Workers	Volunteers	Total
Self-Referral	22	6	0	37	4	55	31	21	176
	12.5%	3.4%	0%	21.0%	2.3%	31.3%	17.6%	11.9%	100%
Active Outreach	32	6	0	42	5	64	31	15	195
	16.4%	3.1%	0%	21.5%	2.6%	32.8%	15.9%	7.7%	100%
Naloxone Plus	35	8	0	53	8	77	38	21	240
	14.6%	3.3%	0%	22.1%	3.3%	32.1%	15.8%	8.8%	100%
Officer Intervention	21	4	0	20	4	27	17	8	101
	20.8%	4.0%	0%	19.8%	4.0%	26.7%	16.8%	7.9%	100%
First Responder/Officer Prevention	30	9	0	41	6	59	34	21	200
	15.0%	4.5%	0%	20.5%	3.0%	29.5%	17.0%	10.5%	100%
Other	3	0	0	3	2	8	2	1	19
	15.8%	0%	0%	15.8%	10.5%	42.1%	10.5%	5.3%	100%

Table C-21. Number of full-time staff for each program pathway

	N	Mean	Median	Standard Deviation	Range
Self-Referral	128	14.8	2	45.7	0 - 400
Active Outreach	124	16.8	2.5	62.9	0 - 535
Naloxone Plus	151	15.3	2	52.8	0 - 535
First Responder/Officer Prevention	128	18.3	3	55.5	0 - 535
Officer Intervention	80	12.0	2	29.7	0 - 175
Other	18	35.2	3	63.8	0 - 200

Table C-22. Number of part-time staff for each program pathway

	N	Mean	Median	Standard Deviation	Range
Self-Referral	129	22.6	2	61.4	0 - 350
Active Outreach	121	21.7	3	58.9	0 - 350
Naloxone Plus	154	23.1	2.5	68.8	0 - 500
First Responder/Officer Prevention	132	18.7	3	54.9	0 - 350
Officer Intervention	75	19.0	2	49.7	0 - 300
Other	17	17.2	2	40.9	0 - 166

Table C-23. Number of volunteer staff for each program pathway

	N	Mean	Median	Standard Deviation	Range
Self-Referral	116	2.6	0	7.6	0 - 50
Active Outreach	117	2.2	0	7.0	0 - 50
Naloxone Plus	143	2.1	0	7.0	0 - 50
First Responder/Officer Prevention	124	2.0	0	6.8	0 - 50
Officer Intervention	72	1.7	0	6.1	0 - 50
Other	17	1.4	0	2.1	0 - 7

Table C-24. Use of informal agreement with providers to prioritize intake for referrals by pathways

Type of program	# Yes, informal agreement with providers to prioritize intake for program referrals			+ no
	n	%	n	%
Self-Referral	67	20.5%	101	21.0%
Active Outreach	62	19.0%	91	18.9%
Naloxone Plus	74	22.6%	113	23.5%
First Responder/Officer Prevention	75	22.9%	100	20.8%
Officer Intervention	38	11.6%	63	13.1%
Other	11	3.4%	13	2.7%
	327	100.0%	481	100.0%

Appendix D: Additional Charts

Unless otherwise noted, the denominator for all charts is (n =) 320 cases. In some charts, the percentages do not add up to 100 percent because a respondent could provide more than one answer for each question.

Charts in this section include data collected in the survey but not referenced in the Key Findings and Takeaways Section (Section 5).

Chart D-1. Region

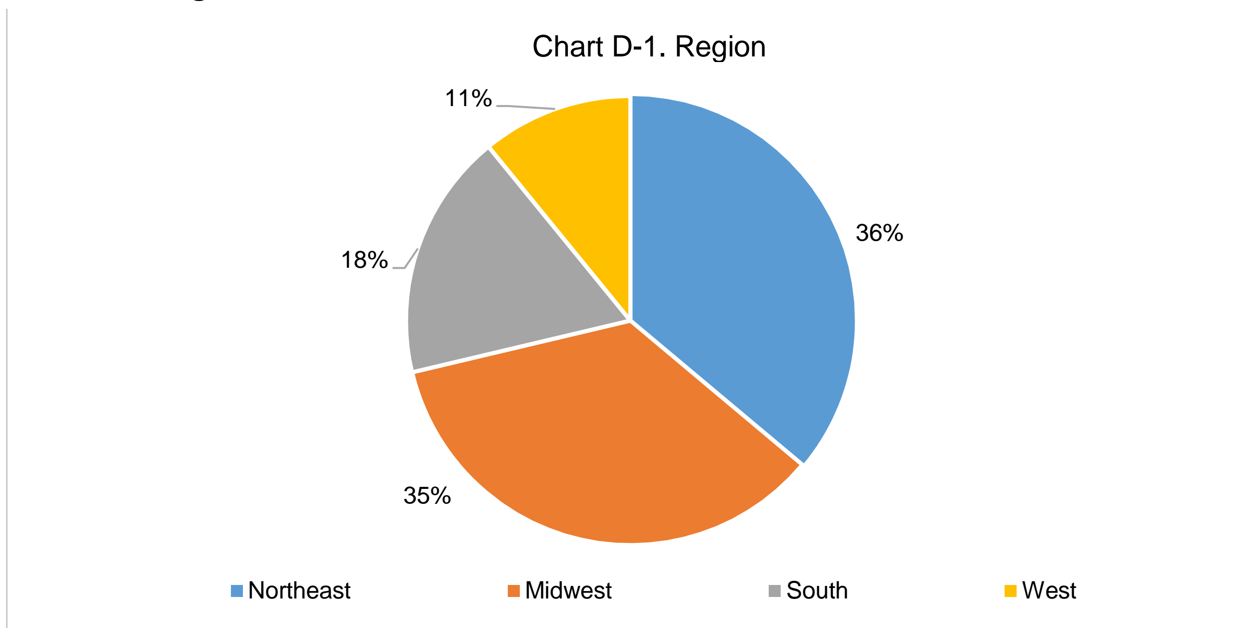


Chart D-2. Community in which deflection program is based

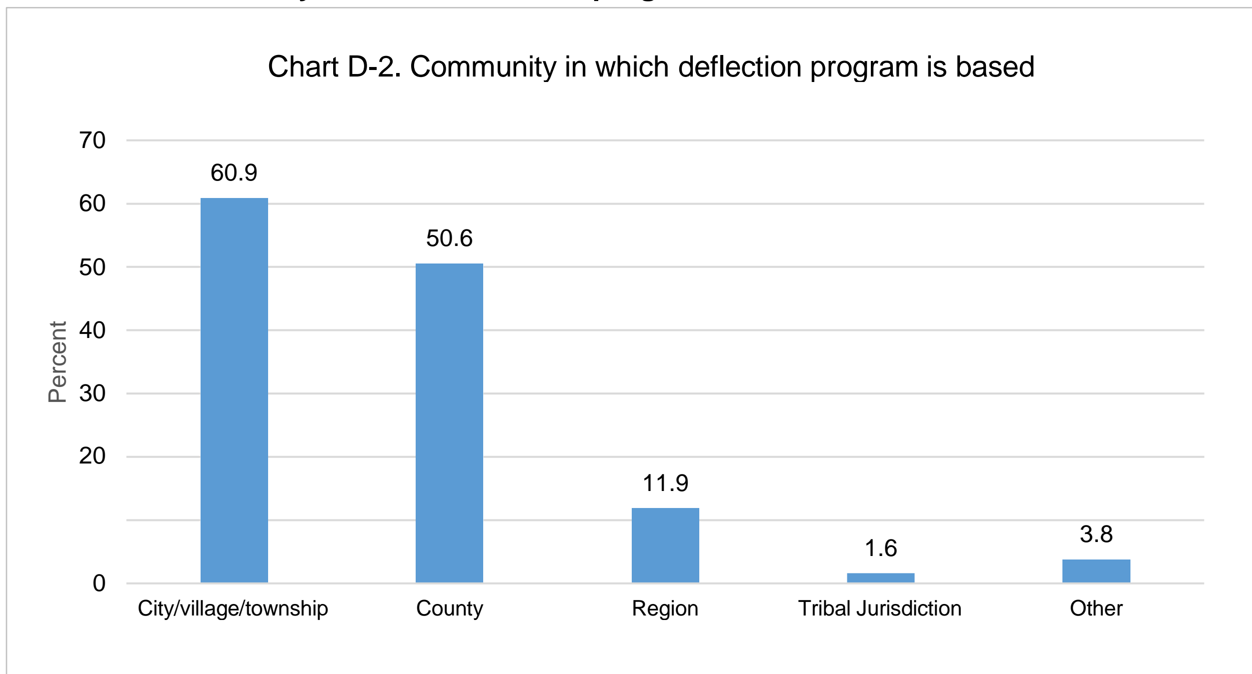


Chart D-3. Where deflection programs take place

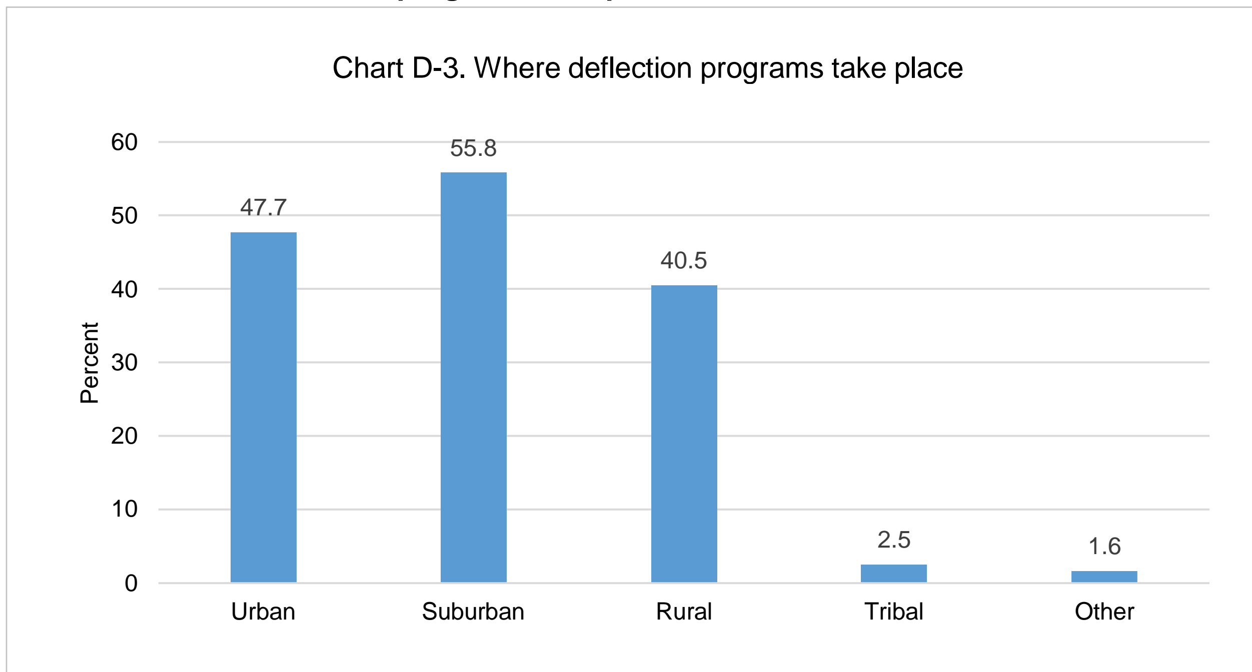


Chart D-4. Program documentation and community outreach (n = 320)

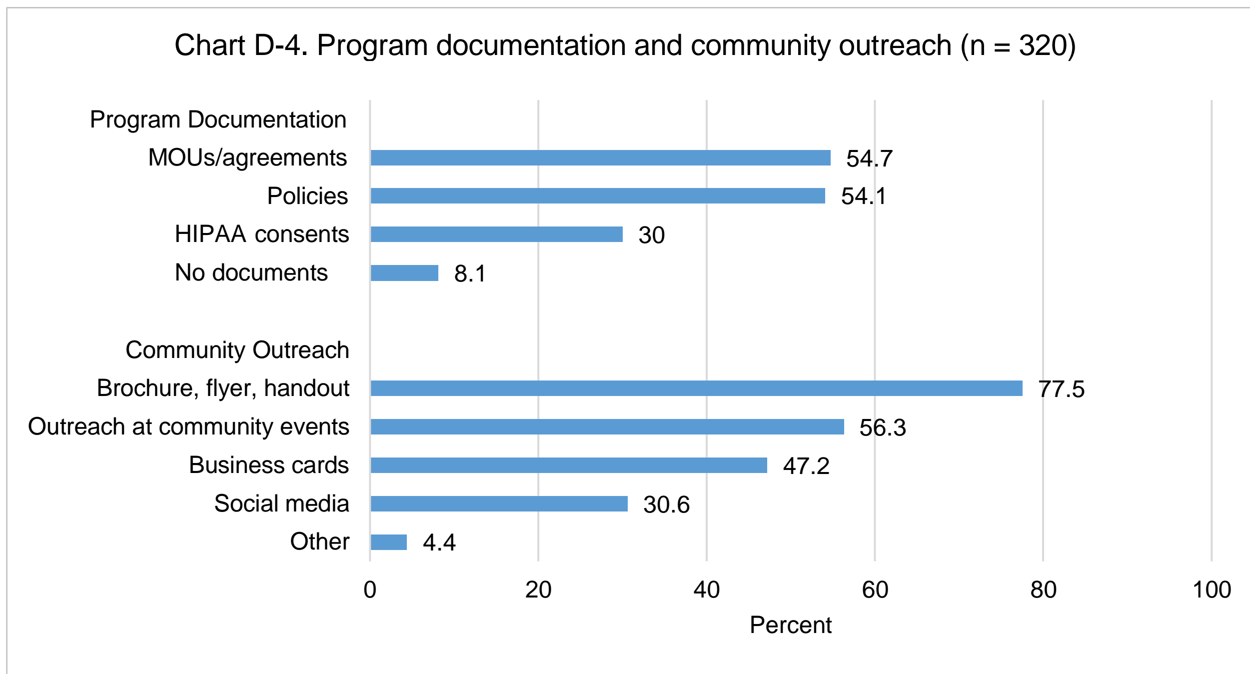
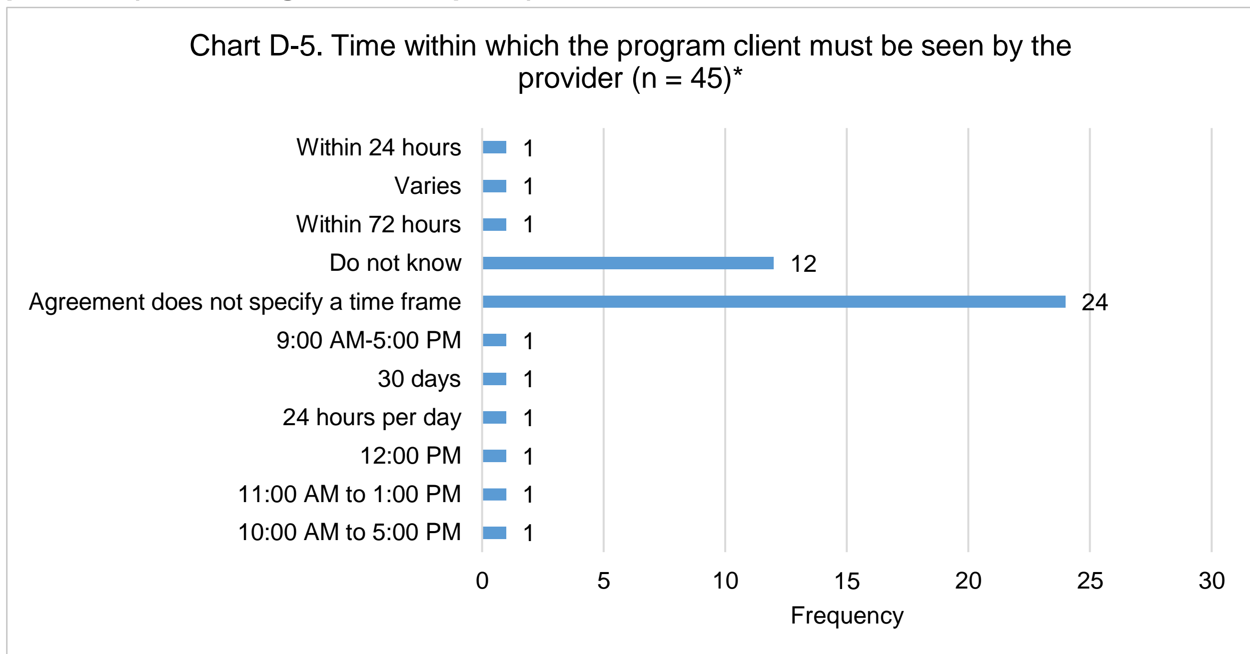


Chart D-5. Agreed-upon time within which the program client must be seen by the provider (if formal agreement in place)



* Denominator is for just those providers who indicated they have a formal agreement with their providers to prioritize intake appointments.

Chart D-6. Program shares aggregate participation information

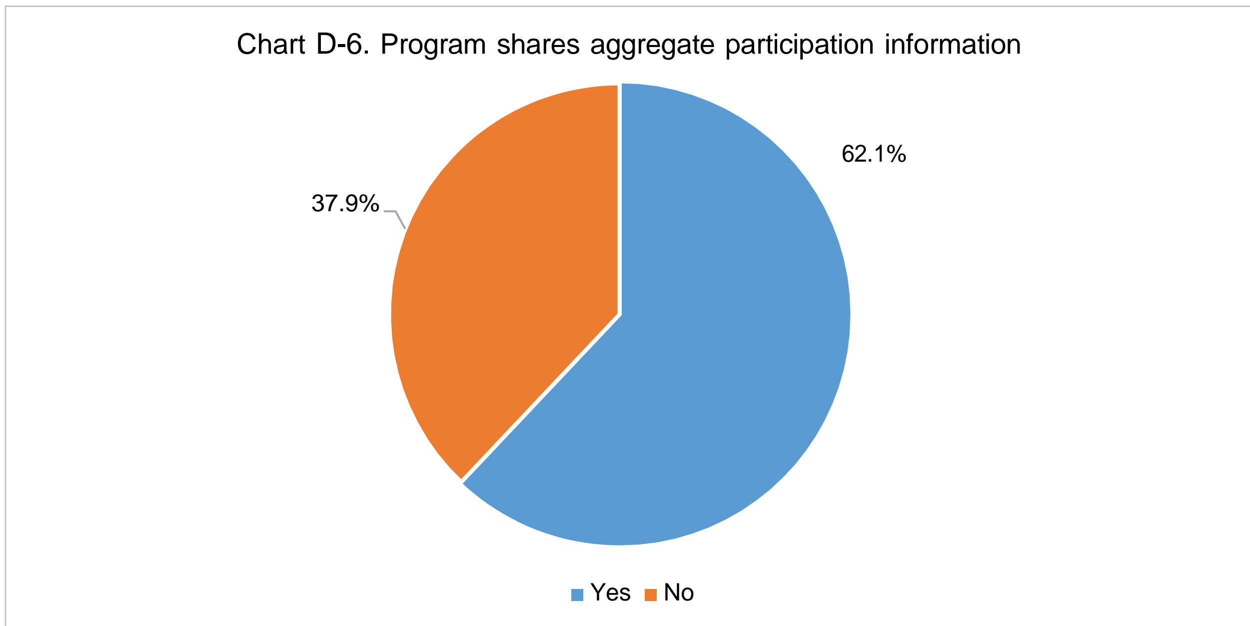


Chart D-7. Program shares identifiable individual-level participant data

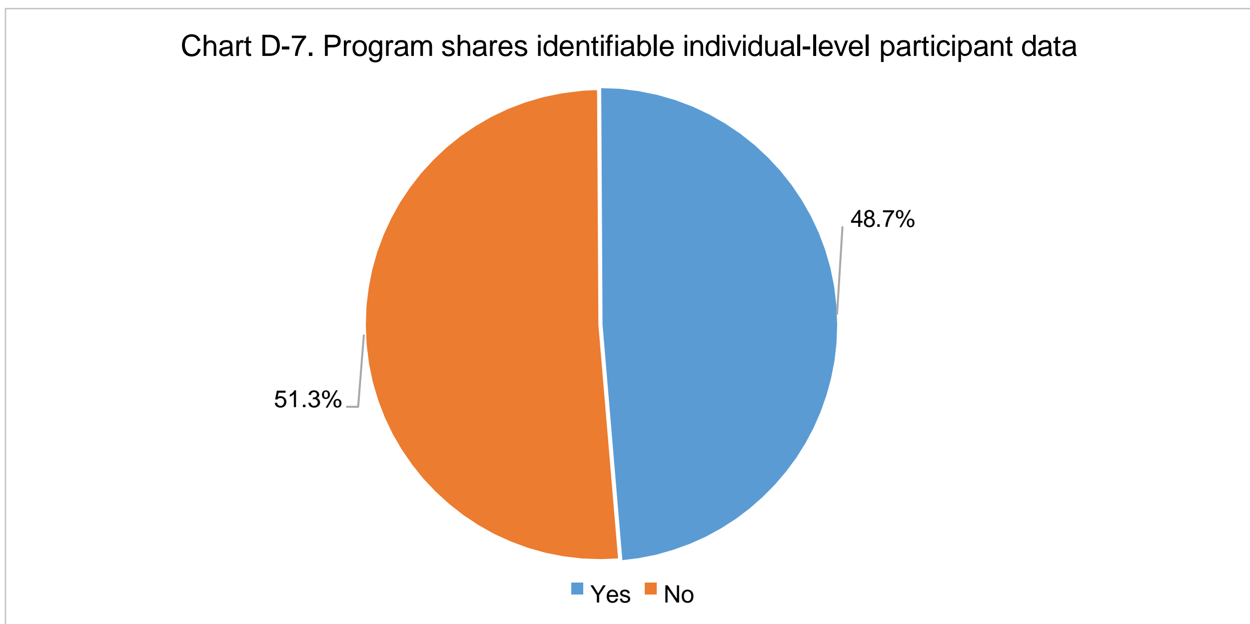


Chart D-8. Deflection program supported or associated with legislation

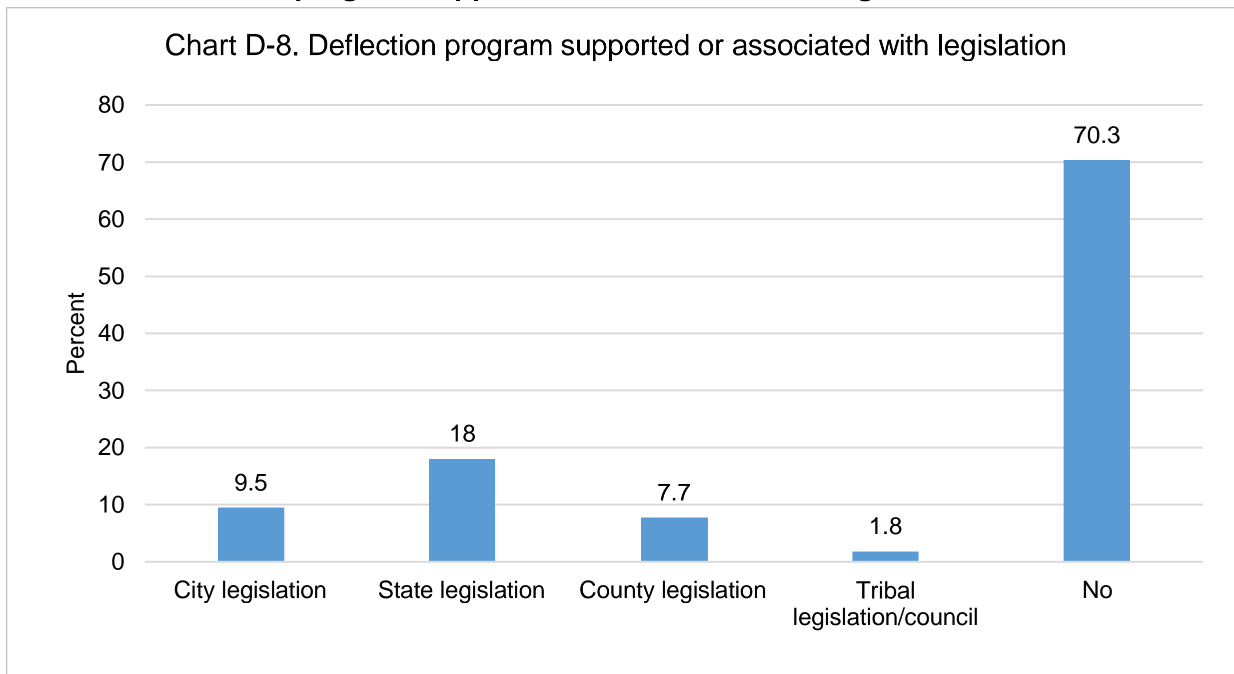


Chart D-9. Program pathway and total number of partners

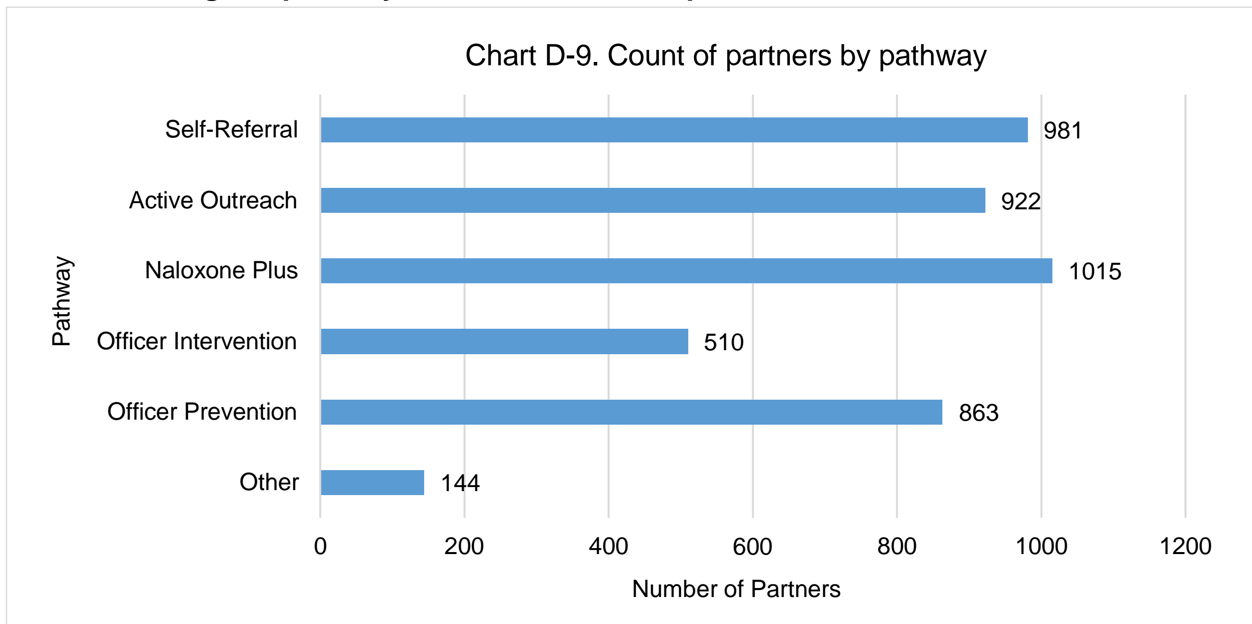


Chart D-10. Type of co-responder assistance by program pathway

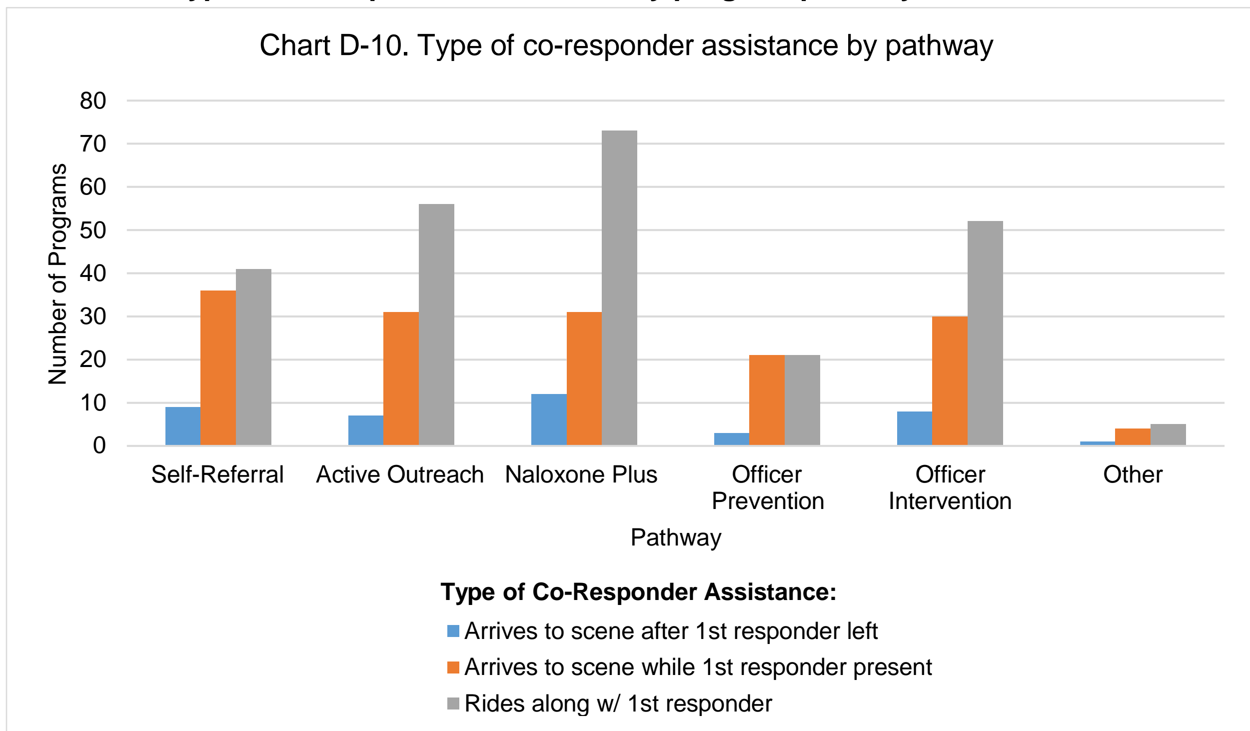
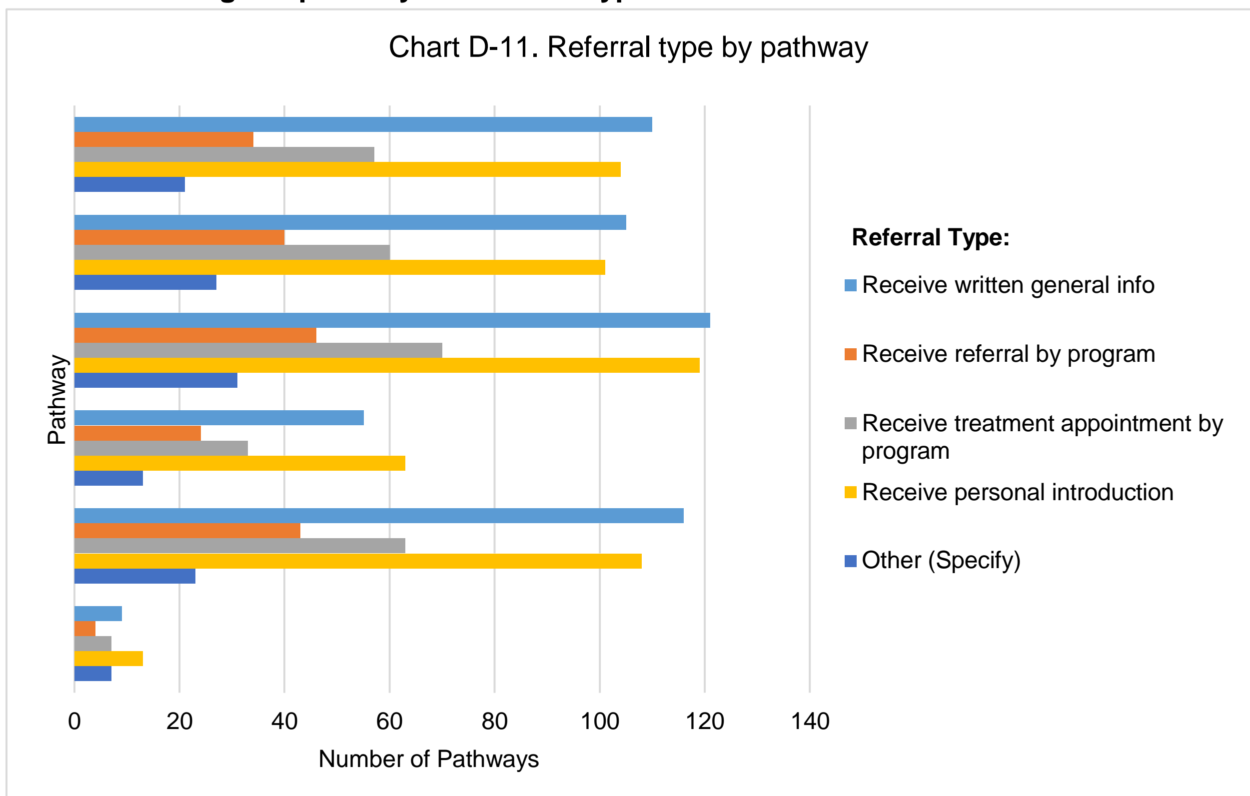


Chart D-11. Program pathway and referral type

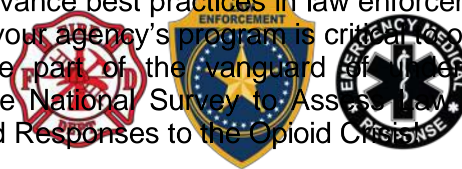


Appendix E. Survey Questionnaire

National Survey to Assess Law Enforcement-led Diversion Programs and Fire/EMS-led Responses to the Opioid Crisis

This survey is designed to collect information on law enforcement, fire, and emergency medical services (EMS)-led diversion programs that serve individuals with substance use disorders (SUD), primarily opioid use disorder (OUD). The information gathered will help federal, state, tribal, and local stakeholders better understand the operational nature of law enforcement/fire/EMS-led diversion efforts, programs, and initiatives. Based on survey responses, a summary report detailing various operational methods across diversion programs and highlighting key aspects of programs will be produced and widely disseminated.

Thank you for participating in this study, which is designed to improve understanding of the expanding field of law enforcement/fire/EMS-led diversion programs. Individual responses will remain confidential, and the information provided will be aggregated across participants to provide a national summary report. Our findings will be shared with your jurisdiction and can be used to assist with securing resources for your program. We will also disseminate reports – without identifying individual agencies or personnel – to the broader first responder community to advance best practices in law enforcement/fire/EMS-led diversion programs. Participation by your agency's program is critical to our collective success. Have your agency's program be part of the vanguard of understanding these innovative programs- participate in the National Survey to Assess Law Enforcement-led Diversion Programs and Fire/EMS-led Responses to the Opioid Crisis!



SECTION I. – CONTACT INFORMATION FOR PERSON COMPLETING SURVEY

Your Name:______________________________________Job Title:
____
Agency Name:
____
Address:
____
City:____State:__________Zip Code:
____
Main Phone:_____________________________________Direct Line___________________________
Email:
____
Alternate Point of Contact Name:____________________Phone:
___________________________Alternate point of Contact Email:
____
Name of Law Enforcement/Fire/EMS-led Diversion Program (if applicable):
____
Name of Law Enforcement/Fire/EMS-led Diversion Program Manager/Director:
____
Law Enforcement/Fire/EMS-led Diversion Program Website (URL):
____

Does my organization qualify to take the survey?

When encountering people with problematic substance use in your community, does your organization (i.e. law enforcement, fire department, or emergency medical services) have one or more diversion programs for individuals with substance use disorders? Law enforcement/fire/EMS-led diversion programs are partnerships with treatment and/or service providers or other initiatives in place to directly connect individuals with a substance use disorder to treatment or intervention services. Here in after we will use the abbreviation "LE/F/EMS diversion" to refer to Law Enforcement-led Diversion Programs and Fire/EMS-led Responses to the Opioid Crisis. **(Mark one answer).**

- Yes (Continue with the survey)
- No (Message: Thank you for your interest in our project. The survey is designed for first responder organizations with formalized LE/F/EMS diversion programs. We encourage you to learn more about LE/F/EMS diversion programs and how you can start one in your community. For more information or technical assistance, please click on the following link [https://www.coapresources.org/).

SECTION II. BACKGROUND INFORMATION ON COMMUNITY OF PROGRAM

The next set of questions are about the jurisdiction or community where your LE/F/EMS diversion program operates.
Please note that estimates are acceptable in informing your responses throughout this survey.

1. **Is the community where you divert individuals to treatment and/or services a city, county or region? (Check all that apply and write the name of the community (ies). If more than one, please list all)**
   City/Village/Township__________________(list as many as apply, up to 10)
   County______________________________(list as many as apply, up to 10)
   Region______________________________(list as many as apply, up to 10)
   Tribal Jurisdiction______________________(list as many as apply, up to 10) Other_______________________________(list as many as apply, up to 10)

2. **Is your community where the LE/F/EMS diversion program takes place urban, suburban, rural, or tribal? (Check all that apply)?**
   Urban
   Suburban
   Rural
   Tribal
   Other _______

3. **How many zip codes are included in your service area where your LE/F/EMS diversion program operates? _________________**

4. **What are the 10 largest zip codes included in your service area where your LE/F/EMS diversion program operates?**

5. **What was the size of the population of your community where the LE/F/EMS diversion program takes place in 2018? For example, if your community includes two counties, please report the total of both counties combined. (Select 'Don't Know' if you do not have an estimate)**

If you do not have ready access to this information, it can be found by searching for your city on the US Census website at https://www.census.gov/quickfacts.

6. **What was the approximate number of <u>fatal</u> opioid overdoses and the approximate number of <u>non-fatal</u> opioid overdoses in your community where the LE/F/EMS diversion program takes place in 2018? (Select 'Don't Know' if you do not have an estimate)**

   If you do not have 2018 data, answer this question with the most recent data you have available and note the year of the data in this box:
   Fatal overdoses [Can enter up to 7 digits+ Don't Know]
   Non-fatal overdoses [Can enter up to 7 digits+ Don't Know]

7. **Indicate the total number of service calls for all types in 2018 in your community where the LE/F/EMS diversion program takes place: (Select 'Don't Know' if you do not have an estimate)**
   Law Enforcement [Can enter up to 7 digits+ N/A + Don't Know]
   Standalone Fire Dept. Operation: [Can enter up to 7 digits+ N/A + Don't Know]
   Standalone EMS Operation: [Can enter up to 7 digits+ N/A + Don't Know]
   Joint Fire/EMS Operation: [Can enter up to 7 digits+ N/A+ Don't Know]

8. **Currently, what are the top three substances used in your community?**
   Alcohol
   Amphetamines
   Cocaine
   Ecstasy
   Heroin
   Marijuana or hashish (cannabis)
   Methamphetamines (e.g., crystal meth)
   Opioids
   Prescription drugs
   Tranquillizers or sedatives
   Other (Specify) ___________________

(New screen with selected drugs) Rate the TOP THREE WITH A NUMBER.

SECTION III: PROGRAM

9. Which best describes the types of encounters between law enforcement, fire or EMS agencies and people with problematic substance use for your program? (Check all that apply):

An individual voluntarily initiates contact with a first responder agency for a treatment referral; if the contact is initiated with a law enforcement agency, the individual makes the contact without fear of arrest.

A first responder intentionally identifies or seeks an individual(s) to refer or engage them with treatment and not for the purposes of criminal investigation.

[If option is checked on web survey, Q. will show up on next screen] How is outreach to your target population conducted by your program? (Check all that apply)

By electronic outreach, such as phone, text, or e-mail contact
By physical outreach to their known location
By dissemination of materials on the program during calls for service

Other____

A first responder or program partner conducts outreach *specifically* to individuals who have experienced a recent overdose to engage and provide a linkage to treatment.

[If option is checked on web survey, Q. will show up on next screen] How is outreach to your target population conducted by your program? (Check all that apply)

By electronic outreach, such as phone, text, or e-mail contact
By physical outreach to their known location
By dissemination of materials on the program during calls for service

Other____

A first responder conducts engagement and provides treatment referrals during routine activities (e.g., patrol, response to a service call). NOTE: If law enforcement is the first responder, no charges are filed, or arrests made.

(Only applicable for law enforcement led diversion) The law enforcement agency engages and provides treatment referrals during routine activities (e.g., patrol) but the charge are held in abeyance or citations are issued that may include a requirement for completion of an assessment for treatment or completion of a treatment plan.

[If option is checked on web survey, Q. will show up on next screen]
[Only applicable for law enforcement diversion]
What offenses are eligible for diversion (do not include prosecutorial, court, probation, parole, jail or any other type of justice diversion in your response)?
(Check all that apply):

Citationable offenses?
Yes
No

Misdemeanor offenses?
Yes
No

Felony offenses?

Yes- please list

No

Other ____.

10. Is your program based on a specific model LE/F/EMS diversion (some examples: Police Assisted Addiction and Recovery Initiative [PAARI], Quick Response Team [QRT], Law Enforcement Assisted Diversion [LEAD], or Civil Citation (Police), Safe Stations (Fire), Community Paramedics or Mobile Integrated Health-Community Paramedic/EMS)?

Yes

[If option is checked on web survey, Q. will show up on next screen] If yes, what is the name of the model?

Police Assisted Addiction and Recovery Initiative [PAARI]

Quick Response Team [QRT]

Law Enforcement Assisted Diversion [LEAD]

Civil Citation (Police)

Safe Stations (Fire)

Community Paramedics

Mobile Integrated Health-Community Paramedic/EMS

Other (Specify):______________________________

No

11. Does your LE/F/EMS diversion program have any of the following documentation or materials on your program? Check all that apply and please upload using the upload button at the bottom of this question. *(if you chose to upload you will have an option to make this a public or private document for use by the research team only)*

Brochure, flyer, or handout

Business cards

HIPAA consents

MOUs and/or agreements

Outreach at community events

Policies

Social media.

[If option is checked on web survey, Q. will show up on next screen] If yes, please list URL or social media page handle/identifier:

- Facebook________________________________
- YouTube_________________________________
- Twitter _________________________________
- Instagram_______________________________
- Other (specify)___________________________

Other____

Upload button (if you chose to upload you will have an option to select the type of document and to make this a public or private document for

12. **Who performs the initial contact to the target population in your program? (Check all that apply):**
    - LE/F/EMS diversion perform the initial contact without the assistance of a treatment/recovery/peer/case manager.
    - LE/F/EMS diversion perform the initial contact with the assistance of a co-responding treatment/recovery/peer/case manager:
        - **[If option is checked on web survey, Q. will show up on next screen]**
        - Who arrives on their own to the scene while the first responder is still present.
        - Who arrives on their own to the scene after the first responder has left.
        - Who rides along with the first responder.

        [If option is checked on web survey, Q. will show up on next screen]
        Answer ONLY if you are using a co-responding treatment/recovery/peer/case manager in the question above: **If using any of the co-responder approaches above from the last question, your co-responders are (Check all that apply):**
        - Case Managers
        - Child welfare worker/Family welfare worker
        - Clinical mental health staff
        - Clinical substance use disorder treatment staff
        - Peer support specialists and/or recovery coaches
        - Social Workers
        - Volunteers (including peer, recovery, community, and faith-community)
        - Other ____
    - LE/F/EMS diversion perform the initial contact with the assistance of a hospital, ER/ED, or other medical facility.
    - Treatment/recovery/peer/case managers perform initial contact without the assistance of a law enforcement, fire or EMS agency.
    - Other method in which a law enforcement, fire or EMS agency performs the initial contact:______________________

13. **How are individuals referred to treatment and/or services through your LE/F/EMS diversion program? (Check all that apply)**
    - Individuals receive general written information (e.g., card, flyer, brochure or handout) about treatment and/or services resources.
    - Individuals receive a written referral to a treatment and/or service provider by the program.
    - Individuals receive a treatment and/or service appointment by the program for a specific date and time.
    - Individuals receive a "personal introduction"** by the program to treatment/recovery/peer/case managers for assessment and/or coordination of treatment planning.
    - Other (specify): ____

[**In a personal introduction, a law enforcement, fire or EMS agency facilitates contact between an individual and a substance use disorder or mental health treatment provider for assessment and coordination of treatment planning. *On the web survey, "personal introduction" will be a clickable box to receive this message.]*

14. **Have all frontline staff of your agency been given the authority to divert individuals to at least some treatment and/or services as part of your diversion program?**
    Yes
    No
    Don't know

15. **What is the staff and volunteer composition of your LE/F/EMS diversion program? Please list all staff and volunteers, including allocated staff from your partner organizations.**

Instructions: If you have one person on the program who is a full-time staff member but works part-time on the program, mark them as a one part-time staff member. If every member of your department (e.g., all officers) are able to refer to your program, they would *all* qualify as being part of your program's composition. *Select 'Do not know' if you do not have an estimate.*

- **What is the total number of paid staff dedicated full time to the program?** [Range 0-99,999 + Don't Know]
- **What are the titles of the positions for staff dedicated full-time to the program?______________________**(Write in Title, if multiple people with same title, only write title once, add up to 20 spots)
- **[Q shown on new screen on web survey] Excluding full-time staff, what is the total number of staff dedicated less than full time to the program (supports the program in addition to regular agency duties)?** [Range 0-99,999 + Don't Know]]
- **What is the total number of volunteer staff who work on the program at least one hour per month?** [Range 0-99,999]

Use the following text box if you feel you need to add an explanation for any of the above staffing numbers

16. **Indicate the month and year your program began offering services:** M M___Y __Y Y Y .

Check this box if you do not know the month ☐

Check this box if you do not know the year ☐

17. To the best of your knowledge, were any of the following factors responsible for the initiation of your LE/F/EMS diversion program? (Check all that apply)

A desire to stay current on new practices/innovations
Addressing racial disparities in access to treatment and/or services for opioid use disorder
After learning about other department's LE/F/EMS diversion program
As the result of a lawsuit
As the result of public demands/public pressure
At request of elected officials
At the request of civic/community groups
Critical event(s) led to the initiation of the program
In response to a significant increase in opioid use in your community
In response to issues of police and community relations
In response to jail reduction efforts in your community
In response to opioid-related overdoses (fatal and non-fatal)
In response to other problematic drug use in the community (specify drug(s))
____
Other (specify) ____)
Other (specify) ____)
Other (specify) ____)

18. **(Note: A is asked on Screen 1 and B is asked on Screen 2 with programmed logic, presented in grid form here for logic clarity)**

	A. Have staff associated with your LE/F/EMS diversion program receive any of the following training?		**IF A= NO, B. In the previous question, you indicated you did not receive this training. However, is this type of training needed by your program to better meet the needs of your community?**	
	Yes	No	Yes	No
Cognitive Behavioral Treatment (CBT)				
Crisis Intervention Team (CIT) training				
Cultural awareness				
Gender equity				
Harm minimization training				
Mental health treatment training				
Motivational Interviewing (MI)				
Naloxone administration training				
Racial equity				
Recovery Support Services				
SBIRT (Screen, Brief Intervention, and Referral to Treatment)				
Science of Drug Use and Addiction (addiction neuroscience)				
Staff safety				
Substance use treatment training				
Other (specify) ________________				
Other (specify) ________________				
Other (specify) __________________				

19. **Does the program have a** LE/F/EMS diversion **training curriculum?**

Yes

[If option is checked on web survey, Q. will show up on next screen]

If yes, what is the length of time to complete the curriculum?________hrs.

No

SECTION IV: BACKGROUND INFORMATION ON LEAD AGENCY

NOTE these questions are now expressly on your **lead agency and are not about your law enforcement/fire/EMS-led diversion program. We are asking these questions because we want to know the profile of agencies that tend to lead law enforcement/fire/EMS-led diversion programs. **

20. Who is the lead agency for the LE/F/EMS diversion program? If you have a co-lead(s), check all that apply.

Sheriff's department
Police department
EMS
Fire
Combined fire/EMS
Community/advocacy agency
Social service agency
Behavioral health agency
City, county, or state public health agency
Tribal agency
Other (specify):_____
Other (specify):__________________
Other (specify):__________________

21. What is the lead agency's/organization's approximate total operating budget in 2018? If you have co-leads, select an answer that corresponds to the largest of the co-leads for the program.

Under $250,000
$250,000- 1 million
$1 -10 million
$10-20 million
$20-40 million
$40-60 million
$60-100 million
Over $100 million
Do not know

22. What is the personnel size of the lead agency (if applicable, count sworn and non-sworn personnel)? If you have co-leads, select an answer that corresponds to the largest of the co-leads for the program. (Select 'Don't Know' if you do not have an estimate)

a. Total full time personnel: [Can enter up to 6 digits + Don't Know]
b. Total part-time personnel: [Can enter up to 6 digits + Don't Know]
c. Total volunteer personnel: [Can enter up to 6 digits + Don't Know]

SECTION V: PARTNERSHIPS

**Note: The next set of questions are about your LE/F/EMS diversion program's agency partners and the current set of interactions among the partners. Program partners are defined as collaborative service providers who are essential to the outcomes of the law enforcement/fire/EMS-led diversion program. **

23. **How many agency or organizational partners are involved in your program? For example, if you are a fire department and have a treatment partner and a social service agency partner you would answer '2' for this question. (Select 'Don't Know' if you do not have an estimate)**

24. **For each of your partners, please list the organizations' name and identify the types of services provided by the partner (mark all that apply). Also, please indicate if you have a written formal agreement in place between each partner for your law enforcement/fire/EMS-led diversion program.**

    Begin by listing the name of the first partner here. On the following 2 screens, you will be asked to identify the types of services provided by the first partner and to indicate if you have a written formal agreement in place with the first partner.

    This process will repeat for the second partner and you will continue repeating this process through the rest of the number of partners you indicated on the previous page.

    (Note: grid presented in paper copy for clarity, web survey will have separate screens for name, type of services, and written formal agreement questions.)

	Type of Service Provided by Partner (Check all that apply)	Written formal agreement (e.g., memorandum of understanding or data use agreement) with this partner and the program?
Name of partner	Case management partner (e.g., provider of office based or community outreach linkage to services)	Yes No
	Civic group partner (e.g., community advocacy or alliance groups)	
	Combined Fire/EMS	
	Emergency medical service partner (e.g., paramedics or community paramedics) (Non-Fire)	
	Fire department partner (Non-EMS)	
	Housing partner (e.g., provider of short-term or long-term housing placement)	
	Law enforcement partner (e.g., police or sheriff)	
	Other justice partner (e.g., prosecutor, public defense, other court parties)	

	Recovery support services partner (e.g., provider of post treatment recovery services, such as peer support specialists and recovery coaches, AA/NA)	
	Treatment provider partner (e.g., clinical provider for outpatient, inpatient, medication assisted treatment [MAT] services)	
	Vocational/education partner (e.g., college or community based job skills training)	
	Other partner not mentioned above (e.g., faith community, emergency room/center)	
Name of partner	(same as above)	Yes No
Name of partner	(same as above)	Yes No
Name of partner	(same as above)	Yes No
Name of partner	(same as above)	Yes No

25. Does the program have a dedicated stakeholder group (e.g., task force, advisory board, or steering committee) to provide oversight and direction to your LE/F/EMS diversion program?

Yes

[If option is checked on web survey, Q. will show up on next screen]

If yes, how often do they meet? If you have more than 1 group, think of the one that meets most often.

Daily
Weekly
Monthly
Quarterly
Annually

No

SECTION VI: TREATMENT, SERVICES, AND RECOVERY

26. What treatment and/or recovery support services do your treatment partner(s) provide to participants referred through your LE/F/EMS diversion program? (Check all that apply) Assistance with benefits applications

Education (e.g., GED)
Employment
Family Counseling
Family reunification
Food and nutrition
Harm minimization
Housing support services
Mental health assessment and/or treatment
Peer support or recovery coaching
Substance use treatment go to 27
Traditional/Cultural healing
Transportation assistance
Vocational training
Other (Specify):____________________

[If option is checked on web survey, Q. will show up on next screen]

27. If yes to substance use treatment, which types are provided by your treatment partner(s)?

Inpatient Withdrawal Management (Detoxification)
Intensive Outpatient
Medication-assisted treatment (MAT)
Outpatient
Partial Hospitalization Program (PHP)
Residential

[If Medication-assisted treatment (MAT) option is checked on web survey, Q. will show up on next screen]

Which MAT medications are offered?

Buprenorphine
Methadone
Naltrexone
None of the above

28. Indicate the total number of <u>referrals to treatment and/or services</u> by your LE/F/EMS diversion program and partners <u>since inception.</u> We are looking for the total number of referrals, including repeat referrals, NOT an unduplicated count.: (Select 'Don't Know' if you do not have an estimate)

Please indicate the total number of referrals to treatment and/or other services during <u>2018.</u> If this is the same number as above, enter it again here. (Select 'Don't Know' if you do not have an estimate)

29. **Do you track treatment attendance/participation for individuals referred through your program?**
    Yes
    No
    Don't know

30. **Does your program conduct outreach to individuals who do not attend their initial treatment and/or service referral?** Yes
    No
    Don't know

31. **Does your program operate 24-hours per day?** Yes
    No
    Don't know
32. **Does your program operate seven days per week?** Yes
    No
    Don't know
33. **Do you have an agreement with your treatment and service providers to prioritize intake appointments for individuals referred by your program?**
    Yes- Formal agreement
    [If option is checked on web survey, Q. will show up on next screen]
    If yes, does this agreement specify a time within which the program client must be seen by the provider. Entire time frame in text box
    Yes- Informal agreement
    No

34. **How are clients transported to treatment and/or services? (Check all that apply)**
    Client gets there himself or herself
    Program does transportation
    Do not know

35. **How are substance use disorder treatment and/or services typically funded for individuals referred by your program? (Check all that apply)**
    Federal grant funds
    Foundation funds
    Local grant funds
    Medicaid/Medicare
    Private insurance
    State grant funds
    State insurance plan
    Tribal funds
    User fees/Self-pay
    Other (Specify):____
    Don't know

SECTION VII: FUNDING, DATA, LEGISLATION, AND POLICIES

36. **Does your program have a standalone budget dedicated to your LE/F/EMS diversion program that is separate from agency budget(s)?**
    Yes

[If option is checked on web survey, Q. will show up on next screen]
If yes, what is the approximate budget for your program?
$________________________
No

37. What types of funds were used to <u>start</u> your program? (Check all that apply)
Federal
In-kind donations (e.g., staff time)
Local Philanthropic
State
Other ______________________
No outside funds were used to start the program.

38. What types of funds are currently used to <u>operate</u> your program? (Check all that apply)
Federal
In-kind donations (e.g., staff time)
Local
Philanthropic
State
Other ______________________
No outside funds are currently used to operate the program

39. Does your program collect any of the following data on participants? (check all that apply)
Gender
Age
Race/Ethnicity
[If option is checked on web survey, Q. will show up on next screen]
If yes, what is the racial make-up of those diverted by your program?
a. White, not of Hispanic Origin ____%
b. Black or African American, not of Hispanic Origin ____%
c. Hispanic or Latino ____%
d. American Indian or Alaskan Native, not of Hispanic Origin ____%
e. Asian, not of Hispanic Origin ____%
f. Native Hawaiian or Other Pacific Islander, not of Hispanic Origin ____%
g. Two or more races ____%
h. Not known ____%

None of the above

40. Does your program track any of the following performance measures? (Check all that apply)

Characteristics of participant referrals

Number of program referrals by gender
Number of program referrals by race and ethnicity
Number of program referrals by sexual minority (includes gender identity and sexual orientation)
Do not know

Sources of program referrals

Number of referrals from specific districts, locations, or areas of your community
Number of program referrals from specific agencies
Number of referrals from specific individuals (e.g., officer/firefighter/paramedic/EMTs)
Other referral data indicators:______________________________
Do not know

Overdose data

Number of naloxone administrations by a law enforcement, fire or EMS agency
Number of Naloxone kits distributed by program
Number of fatal overdoses
Number of non-fatal overdoses
Number of emergency room/department visits for overdoses
Do not know

Participation in services

Number of individuals who participate in treatment and/or services
Number of individuals who participate in recovery support services
Length of participation in treatment and/or services

[If option is checked on web survey, Q. will show up on next screen]
If yes, how long do you track attendance in treatment and/or services?

- 30 days or less
- 60 days or less
- 90 days or less
- More than 90 days
- Do not know

Number of individuals who complete treatment phases
Do not know

Participant Outcomes

Number of individuals who have reduced drug use
Number of individuals who have reduced substance use symptoms
Types of housing participants live in
Number of individuals who obtain employment
Number of individuals who are arrested during program
Number of individuals who are arrested post program
Number of individuals who become incarcerated during program for a new offense
Number of individuals who are incarcerated post program for a new offense

Other:______________________________

___
Do not know

41. **Have you conducted a formal program evaluation?**
    Yes
    [If option is checked on web survey, Q. will show up on next screen] If yes, please upload your executive summary or shareable findings here.

    Upload button (if you chose to upload you will have an option to make this a public or private document for use by the research team only)

    No
    Do not know

42. **Does your program share <ins>aggregate participation information</ins> with your LE/F/EMS diversion program partners for the <ins>running the program</ins>? (e.g., guiding program operations, evaluating program components, etc.)**
    Yes
    No
    Do not know

43. **Does your program share <ins>identifiable individual-level participant data</ins> among program partners <ins>for work with individual program participants</ins>? (e.g., to guide the development of individual treatment plans)**
    Yes
    No
    Do not know

44. **Is your LE/F/EMS diversion program supported or associated with legislation?**
    Yes, city legislation
    [If option is checked on web survey, Q. will show up on next screen] If yes, city legislation name
    ____
    Yes, state legislation
    [If option is checked on web survey, Q. will show up on next screen] If yes, state legislation name
    ____
    Yes, county legislation
    [If option is checked on web survey, Q. will show up on next screen] If yes, county legislation name
    ____
    Yes, tribal legislation/council

[If option is checked on web survey, Q. will show up on next screen] If yes, tribal legislation name/council

____

No
Don't Know

SECTION VIII: CONSENT TO JOIN REGISTRY

We are creating a public registry of LE/F/EMS diversion programs for sharing promising practices and trends in LE/F/EMS diversion programs. The registry would contain the name of your program, the location of your program (city and state) and the type of program you have been implementing, and number of years the program has been in place. Would you provide your consent for us to include this limited information in the public registry?

Yes
No
Need more information

Thank you for participating in this research! The survey has now ended.
We appreciate you spending time on the survey and please know that we will work to provide the results of this study to the organizational participants as rapidly as possible.