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Law Enforcement and First Responder Deflection
Pathways to Deflection Case Studies Series

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First Responder and Officer Referral Pathway

First responders are on the front lines of the battle against substance use disorder (SUD), responding to calls for service involving individuals with or affected by SUD. These calls frequently include overdose incidents. In response, a variety of law enforcement-, fire-services, and emergency medical services (EMS)-led responses have emerged across the country. Implemented in partnership with SUD treatment providers, peers, and recovery personnel, these multidisciplinary programs are helping to reduce overdoses by facilitating connections to community-based treatment and services.

Law enforcement and first responder deflection programs provide pivotal opportunities to redirect individuals with SUDs, mental health disorders (MHDs), and co-occurring disorders away from placement in jails or emergency departments and, instead, connect them to community-based substance misuse treatment, mental health services, and recovery support as well as support services, such as housing and food assistance. These programs may be known by different names across jurisdictions, including law enforcement/police-assisted diversion, crisis intervention, pre-arrest diversion, deflection, or pre-booking diversion. In this case study, law enforcement- and fire-service/EMS-led responses will be referred to as "first responder deflection." The philosophy behind all first responder deflection

programs is based on peer-reviewed science affirming that addiction is a treatable, chronic disease of the brain,[1] not a moral failing, and that to stop the drug-seeking behaviors that accompany addiction, the disease itself must be treated.

Six Pathways of Deflection to Treatment, Services, and Recovery

There are six frameworks or pathways[2] of deflection, each of which addresses specific public health and public safety challenges faced by communities. These six approaches to connecting people to treatment are referred to as pathways because, in contrast to justice system interventions in which individuals are mandated to attend treatment, first responders and community response teams are instead offering access, or pathways, to community-based treatment and resources through proactive outreach and support to individuals in need. The spectrum of the six pathways offers an alternative to traditional enforcement methods of responding to individuals coping with SUDs, MHDs, or co-occurring disorders that may necessitate contact with law enforcement officers or other first responders.

The six pathways to treatment through first responder deflection are described below. This brief focuses on the First Responder and Officer Referral Pathway.

Pathway	Target Population
Self-referral: An individual voluntarily initiates contact with a first responder agency (law enforcement, fire services, or EMS) for a treatment referral. If the contact is initiated with a law enforcement agency, the individual makes contact without fear of arrest.	Individuals with SUDs
Active Outreach: A first responder intentionally identifies or seeks out individuals with SUD to refer the individuals to or engage them in treatment; outreach is often conducted by a team consisting of a clinician and/or a peer with lived experience.	Individuals in crisis or with non-crisis MHDs and/or SUDs, or who are experiencing homelessness
Naloxone Plus: A first responder and a program partner (often a clinician or peer with lived experience) conduct outreach specifically to individuals who have recently experienced an opioid overdose to engage them in and provide linkages to treatment.	Individuals with opioid use disorder (OUD)
First Responder and Officer Referral: As a preventative measure, during routine activities such as patrol or response to a service call, a first responder engages individuals and provides referrals to treatment or to a case manager. (Note: If a law enforcement officer is the first responder, no charges are filed or arrests made.)	Individuals in crisis or with non-crisis MHDs and/or SUDs, or in situations involving homelessness, theft, or prostitution
Officer Intervention: During routine activities such as patrol or response to a service call, in which charges otherwise would be filed, law enforcement officers provide referrals to treatment or to a case manager or issue non-criminal citations to report to a program. Charges are held in abeyance until treatment and/or a social service plan is successfully completed.	Individuals in crisis or with non-crisis MHDs and/or SUDs, or in situations involving homelessness, theft, or prostitution
Community Response: In response to a call for service, a team comprising community-based behavioral health professionals (e.g., crisis workers, clinicians, peer specialists), and/or other credible messengers—individuals with lived experience—sometimes in partnership with medical professionals, engages individuals to help de-escalate crises, mediate low-level conflicts, or address quality-of-life issues by providing a referral to treatment, services, or to a case manager.	Individuals in crisis or with non-crisis MHDs and/or SUDs, or in situations involving homelessness or low-level conflicts

Each pathway is associated with specific criteria and works in different ways. Communities providing first responder deflection often begin with a single pathway and then add pathways as their programs evolve. For example, see Case Study #1: Longmont, Colorado (page 11), where deflection efforts started with the Angel Initiative (a self-referral program) and later evolved to a law enforcement assisted diversion (LEAD) program (an officer referral program).

The pathway(s) implemented should be informed by a "problem-solution" orientation, based on the specific problems to be addressed (e.g., substance use, crisis response, housing instability). This entails taking a holistic approach to the problem, drawing in individuals or agencies who can help define it, and determining how to align resources to meet the needs of the target population to be served (e.g., treatment, recovery, social services).

What's in a Name?

The terms "deflection" and "pre-arrest diversion" are sometimes used interchangeably because both practices are at the intersection of first responders, treatment and service providers, recovery support, and communities affected by substance misuse. But it is important to differentiate between them:

Deflection is the practice by which law enforcement or other first responders connect individuals to community-based treatment and/or services when arrest is not necessary or in lieu of taking no action when issues of addiction, mental health, and/or need are present.

Pre-arrest diversion is the practice by which law enforcement officers connect individuals who otherwise would have been eligible for 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 but sometimes prosecutors or a local government agency), 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.

Deflection programs should be developed to fit the unique needs of each community; what works in one jurisdiction may not work in another. An important step in determining the most appropriate deflection pathway is to be familiar with all the pathways, the problems that each pathway seeks to address, and how each pathway functions.

Finally, each pathway requires different levels of investment and collaboration for planning, implementation, and operationalization. In summary, it is necessary to identify which elements of a pathway could be adapted and applied to suit the particular needs of a jurisdiction.

The First Responder and Officer Referral Pathway

Every day, law enforcement officers and other first responders encounter individuals suffering from the effects of SUDs and mental health conditions, homelessness, or poverty. These effects can include disruptive behavior, overdoses, medical conditions, or criminal behavior stemming from these conditions. Often, first responders are not equipped or trained to address addiction or mental illness and, as a result, have few options for helping these individuals. Emergency medical personnel might learn about an individual's SUD while engaging them for another medical emergency but have no means of providing assistance. When law enforcement officers encounter individuals who have not committed an offense but need treatment and services, options are often limited to arrest,

transport to an emergency department, or taking no action. Without the proper tools, such as linkages to social services that deflection programs offer, an officer may charge people who have unmet behavioral health needs with a misdemeanor if the officer thinks that no appropriate alternatives are available.[3]

Community-based treatment and service providers are trained to address substance use and mental health challenges and to provide services to people needing assistance and support. Partnering with these organizations reduces the burden on first responders while enabling them to connect vulnerable individuals to treatment and services. First responder and officer referral programs also enhance public safety by giving first responders tools that help to reduce recidivism and prevent further criminal activity linked to unmet behavioral health needs, especially SUD.[4, 5] This enables more effective utilization of public safety resources.

Studies show that arrest and incarceration, even for a short time, can result in a number of collateral consequences. These may include fines and fees, housing instability, unemployment or underemployment, loss of government benefits, educational deficits, and reduced economic mobility. Justice system involvement also can increase a person's risk of engaging in crime.[6] For people with SUDs and mental health conditions, jail can be even more detrimental. They may be taken off Medicaid as a result of being taken into police custody, and if they do not receive the care or treatment they need in custody, they are likely to reoffend upon release into their communities.[7] First responder and officer referral programs can help break this cycle of justice system involvement by deflecting people with behavioral health needs away from the justice system into community-based treatment and services to address the underlying reasons for their behaviors.

The First Responder and Officer Referral Pathway is a collaborative, community-based alternative to involvement in the justice system. Successful implementation requires strong multisector partnerships that include elected and appointed officials from municipal and county governments; justice system and public safety stakeholders; public health, mental health, and drug treatment professionals; service providers; housing organizations; school systems; businesses; and additional stakeholders the community, including, but not limited to the faith community, the recovery community, civic organizations, and residents of neighborhoods impacted by the drug crisis and justice system involvement.

As the name implies, first responder and officer referral programs can be utilized by all first responders, but the majority (approximately 75 percent) of existing programs have been implemented by or in concert with law enforcement agencies.[6] Recently, new programs have emerged, led by non-law enforcement first responders such as fire services and EMS to respond to behavioral health issues in instances where there is no threat to public safety. Often these programs use a "co-responder" team, typically staffed by a combination of a mental health professional; a firefighter, emergency medical technician, or paramedic; and a peer support specialist. While responding to any number of calls for service, first responders, including law enforcement officers, can contact these designated co-responder teams to help facilitate linkages to community-based services. These teams may also be dispatched by 9-1-1 (or in some communities, 9-8-8) operators to respond to certain calls for service. Having a dedicated co-responder team can help free up law enforcement and other emergency response systems to handle other crises in the community. In doing so, they also help individuals avoid justice system involvement, as well as costly hospital stays.

For instance, San Francisco, California, has a street crisis response team that is made up of a community paramedic, a mental health clinician, and a peer specialist. The team can be contacted either by community members calling 9-1-1 or by other first responders. Trained in harm reduction and crisis de-escalation principles, this team follows up after each call it responds to and connects individuals with community-based resources and services.[9]

Similarly, many communities implement programs in the Active Outreach Pathway.[10] These programs are implemented by first responder agencies, usually including specially trained law enforcement officers, who work side by side with behavioral health and peer specialists to conduct proactive outreach to individuals in the community in need of treatment and services. These programs enable first responders, including patrol officers, to call on active outreach teams to assist individuals they encounter who are in need. Once outreach team members arrive, the first responders can return to their routine activities. This example demonstrates the fluidity between the pathways: the officers or other first responders are able to make referrals to treatment and services because of the availability of the outreach teams.

How the Pathway Works: First responder and officer referral programs begin when first responders, while engaged in routine activities (i.e., calls for service, patrol, or "on view"), encounter individuals who would benefit from linkages to treatment, services, or case management. In the case of an encounter with a law enforcement officer, the individual must be eligible for deflection based on the priorities, policies, and procedures of that program before the officer can refer the individual to the program. Many first responder and officer referral programs designate a broad array of eligible offenses conducted by people with unmet behavioral health needs and experiencing chronic homelessness.

After first responders decide to refer eligible individuals to the program, they provide them with information about the program and then ask whether the individuals are interested in participating. If individuals are interested, the first responders may either call a co-responder team or a case manager to meet them in the field for a warm handoff.[11] First responders might also transport individuals to a central location for intake into the program, or collect information from individuals to send to the case manager for later follow-up. According to case study interviews, a warm handoff of an individual to a case manager improves the

chance that the individual will participate in the program. Some people referred to the program may not have permanent addresses, making it difficult for case managers to locate them for initial or further engagement. While a warm handoff is not always possible or practical, the sooner a case manager can meet with an individual after referral to determine needs, explain the program, and begin to build a relationship, the more likely an individual is to engage in the treatment and services the program offers. Providing individuals the choice of engaging in the program is a critical component. Research shows that evidence-based treatment and services work best for people with SUDs when entry into those interventions is voluntary.[12]

Case management is central to most programs in the First Responder and Officer Referral Pathway, and case managers can play several important roles in successful program implementation. Case managers can conduct screenings and assessments of program participants to create client-centered, trauma-informed care plans that address the participants' immediate and long-term needs. They can coordinate linkages to appropriate treatment and services; communicate on behalf of their clients to justice system partners; and arrange for clients' transportation to appointments or meetings. Because of the work they do, it is important for case managers to build trusting relationships with program participants, who often take the lead in prioritizing the treatment and services in which they will engage. In addition, case managers also build and maintain relationships with program partners, including law enforcement officers, and help educate them about the program and the status of the participants.

One feature common to most first responder and officer referral programs is the use of harm reduction principles to guide their interactions with program participants. Harm reduction refers to a set of public health strategies and principles centered on reducing the negative outcomes associated with harmful behavior regardless of whether a person chooses to stop that behavior or not. In its most fundamental application, services that reduce harm are

designed to save lives. Harm reduction practices endeavor to "meet people where they're at, but don't leave them there" by providing services and supports to maximize individuals' well-being. For people who use drugs, harm reduction measures can include providing them with clean syringes, naloxone, and fentanyl test strips and linking them to evidence-based treatment, such as medications for opioid use disorder (MOUD). As illustrated by the case studies in this document, the practice of harm reduction also includes providing nonjudgmental and noncoercive services to program participants, empowering them to be the primary agents of their treatment and service plans, and ensuring that their voices are heard.[13]

Origin Story: The most ubiquitous of the first responder and officer referral programs (and the foundational model of all the sites in this case study) is LEAD. Established in 2011 in Seattle, Washington, the original LEAD model was designed as a post-arrest/pre-booking diversion program that enabled officers to exercise their discretion to redirect people engaged in low-level offenses, such as drug possession or sex work, to community-based services instead of jail. At the suggestion of police officers tasked with implementing LEAD, entry to the program was expanded to include social-contact referrals, allowing officers to refer to LEAD eligible individuals who were not being charged with an offense, but would benefit from the program because of behavioral health or other needs. The program expanded again in 2020 in response to the racial justice movement with a component called "Let Everyone Advance with Dignity." This element of LEAD allows community partners and, in some jurisdictions, community members, to refer people to the program.

LEAD was the first program of its kind. In addition to being designed for people with SUDs suspected of committing drug-related offenses, it was rooted in harm reduction principles, which removed the requirement of abstinence and participation in treatment as requirements of the program. Evaluations of the program indicated that compared to individuals in control groups, LEAD

participants had a 60 percent lower chance of arrest during the 6 months subsequent to entry into the program, as well as positive results over the longer term: a 58 percent lower chance of arrest and a 39 percent lower chance of being charged with a felony. These differences in arrest and felony charge rates for LEAD participants versus individuals in the control group indicate that participating in LEAD has a positive effect on reducing recidivism. In addition, evaluation results suggest that LEAD has a greater effect on recidivism than some other justice system approaches, including therapeutic courts.[14]

Since 2011, LEAD has been widely replicated nationally. In 2016, the LEAD National Support Bureau was founded to provide training, technical assistance, and strategic guidance to jurisdictions that wanted to create their own programs. The bureau is staffed by a team of LEAD practitioners who developed and implemented LEAD initiatives both in Seattle and across the country. As of 2022, there are 52 programs in 21 states. In addition, there are numerous other jurisdictions exploring or developing LEAD programs.[15]

Ten Critical Elements of First Responder and Officer Referral Programs

1. Clearly identify the problem or issue faced by the community and its associated causes.

2. Create a multidisciplinary planning group.

3. Hire a dedicated program manager to coordinate all aspects of the initiative.

4. Hold regular partner meetings.

5. Engage the larger community.

6. Train first responders and officers about addiction, trauma, and recovery.

7. Have at least one partner agency provide case management services.

8. Collect data and evaluate the program.

9. Create a feedback loop.

10. Support from first responders—especially law enforcement officers—is critical to the success of first responder and officer referral programs.

The following are ten critical elements that have been identified through research or by practitioners in the field. When implemented, these elements can help to create or enhance first responder and officer referral programs that are effective in connecting individuals with unmet SUD and/or behavioral health needs to treatment and services.

1. Clearly identify the issue faced by the community and associated causes.

Before building a deflection response, determine and address the underlying causes of the issues faced, and consider the specific treatment and service needs of those individuals. For example, if overdose rates in a locality are climbing among people with SUD or the number of unsheltered individuals is rising, determine and address the underlying treatment and service

needs of those individuals. If the goal is to reduce recidivism caused by unmet behavioral health needs, greater consideration should be given to helping vulnerable individuals avoid arrest or re-arrest by connecting them to community-based treatment or services. Collect data that demonstrate the significance of the issue, provide baseline information, and can assist with goal setting.

2. Create a multidisciplinary planning group.

Collaborative partnerships and relationship building are critical to implementing first responder and officer referral programs. The support of each partner is essential for securing funding, resources, community support, and referrals, as well as building treatment and service capacities.

At the outset of the planning process, leaders from each of the stakeholder agencies who have operational decision-making authority should come together as a multidisciplinary planning committee. Key partners may include leaders from law enforcement and other first responder agencies; community-based treatment and behavioral health providers; service providers; elected and appointed officials; the local public health department; hospitals; prosecutors; and other justice system stakeholders. Community representatives might include local business leaders, faith and recovery communities, and people who have lived experience with the challenges being addressed. This executive-level committee should examine the nature of the problem and help determine the program's objectives and design.[16] It is important to keep the group size manageable during the preliminary planning phase; it may then be expanded as the program is developed.

If an agency or organization other than law enforcement initiates the program, it is essential that law enforcement leaders, as well as other justice system partners (e.g., prosecutors, public defenders, and judges), be invited into the planning process as early as possible. Getting law enforcement input into

program planning and policy development is essential for garnering support from agency leadership and subsequent buy-in from frontline officers who will be tasked with making referrals to the program. (The same is true for other first responder organizations responsible for implementing the program.) In addition, bringing law enforcement (and other appropriate first responder agencies) to the table early in the process will help build relationships and engender trust among the partner agencies, which is essential for the success of the program.

3. Hire a dedicated program manager to coordinate all aspects of the initiative.

The program manager administers the day-to-day work of the program and is essential to maintaining the continuity of the program by ensuring that it is being implemented as planned and by holding regularly scheduled partner meetings to maintain and expand the collaborative nature of the program. The program manager troubleshoots stakeholders' concerns, works to identify resources, facilitates meetings, oversees development of information sharing and data collection systems, and streamlines communication. First responder deflection and pre-arrest diversion programs consist of politically independent actors, so even if the program manager works for the agency that established the program and administers the funding, it is important that they be primarily concerned with the program itself and independent from all political and operational stakeholders.[17]

4. Hold regular partner meetings.

On an ongoing basis, the program manager should hold regular meetings with all partners to discuss program-related challenges and troubleshoot issues, address individual situations that arise, review new data or trends from data analyses or research partner findings, and share success stories. Meetings also can be used to communicate problems identified by the community so everyone is working toward the

same positive outcomes. Meeting regularly facilitates relationship-building, enhances trust among partners, and allows for easier communication regarding shifts in vision, operations, or protocols. Deflection program partners should consider establishing subcommittees to address the specific needs of the program. For instance, LEAD programs are encouraged to have three governing bodies that work in tandem to manage and implement the program: a policy coordinating group, an operations work group, and a community leadership team. Each of these bodies is charged with specific responsibilities and has different internal structures.[18, 19]

5. Engage the larger community.

Buy-in from the larger community, including residents, local businesses, the faith community, and other stakeholders, can provide program support while expanding the services network. During the planning and development phase, use public outlets (print media, social media, etc.) to inform the community about the program and encourage participation in public meetings. Listen to and engage residents in dialogue. Explain why the program was developed, its goals, and how it will benefit the community, and offer to serve as a resource as questions arise. Examples of engagement may include outreach efforts to the community, like setting up booths at community events, speaking at civic group meetings, or providing brochures to schools, libraries, and local businesses.

When possible, include local business owners and members of the local Chamber of Commerce or similar groups in the community leadership team or other advisory body. Shoplifting and loitering are common among individuals with problematic drug and alcohol use; educating the business community about, and involving business owners in, your program demonstrates to them that program goals include the improvement of public safety for residents and business owners and facilitates buy-in for situations in which a police officer chooses not to arrest an individual for shoplifting or a similar crime. Support

from this critical sector can greatly influence support from local elected officials.

Many LEAD sites use the community leadership team as a mechanism for involving the community in the implementation of LEAD. Typically, the community leadership team is led by a community engagement coordinator, who also has a seat on the policy control group and the operations work group, and is employed by a community-based organization that has good standing within the community.

6. Train first responders and officers about addiction, trauma, and recovery.

In order for programs in the First Responder and Officer Referral Pathway to succeed, first responders and officers must be willing to implement the program. Training on the following elements can provide first responders with insight into and empathy for vulnerable populations and can reduce the stigma attached to substance misuse and other behavioral health disorders.

- The neuroscience of addiction, to understand the chemical changes that occur in the brain and how these changes are manifested in individuals' behavior.

- Adverse childhood experiences (ACEs) and other types of trauma, to ensure that first responders understand the impact of early trauma on development and life course outcomes and employ empathic outreach techniques during encounters with vulnerable individuals.

- The realities of recovery and the fact that relapse is often part of the recovery process, which may result in a first responder needing to deflect the same individual multiple times.

Command staff members should attend the trainings to convey their commitment to the program. Programs should offer training on a recurring basis to refresh prior education efforts.

7. Have at least one partner agency provide case management services.

It is important that program leaders take great care when selecting, contracting with, and overseeing a case management agency. The latter should be an agency that will work closely with the program manager and other program partners, including first responders; train its client-facing staff in evidence-based methods; and adhere to the policies of the program. Agencies should strongly consider hiring case managers with lived experience with SUD, MHD, the justice system, or other shared experiences of those the program serves. Peer case managers bring valuable perspectives that make them particularly qualified to weave the threads of relationship and trust into effective outreach, engagement, and sustained connection.

8. Collect data and evaluate the program.

Data collection and evaluation are vital for validating and improving any first responder deflection effort. Project managers should partner with a university or independent researcher/program evaluator during program planning to determine program goals and objectives, establish how data will be collected, and plan process and outcome evaluations. Collecting data on and evaluating first responder deflection programs can help stakeholders track implementation of the program to ensure fidelity to the model and equitable treatment among communities; demonstrate program impact to policymakers, the media, and the community; apply for additional funding to sustain the program; and add to the knowledge base about first responder deflection.

9. Create a feedback loop.

It is essential that stakeholder agencies, organizations, first responders, and community members learn about the outcomes of individuals who have benefited from the program. When a program is being implemented successfully, hearing about or from an individual

who has experienced positive outcomes reinforces the benefits of the program and incentivizes first responders to continue implementing it and the community to continue supporting it.

In addition, the results of program-related research and data analysis should be shared with all program partners and stakeholders. It is important to celebrate positive outcomes and use negative outcomes to drive necessary programmatic modifications. Finally, line-level personnel should have the opportunity to offer input to the program manager or other program leaders.

10. **Support from first responders—especially law enforcement officers—is critical to the success of first responder and officer referral programs.**

These programs rely on the initiative and discretion of first responders and line officers for referrals. They must be equal partners in the program and invited to conversations about enhancing it. Command-level support is equally critical; if law enforcement leaders recognize deflection efforts when conducting performance evaluations and consider deflection attempts in the same manner as traffic enforcement or community engagement—that is, as a performance metric—officers will view referrals to treatment as a valued law enforcement tool that can lead to positive outcomes for the individual, the community, and overall public safety. Incentivizing referrals through commendations, public recognition, and training opportunities for those officers who actively engage in deflection can also be valuable.

The following sites are highlighted in this case document:

1. **Longmont, Colorado**—Longmont LEAD
2. **Bel Air, Maryland**—Bel Air LEAD
3. **Bernalillo County, New Mexico**—Bernalillo County Let Everyone Advance with Dignity (LEAD)
4. **Hamilton County, Ohio**—Hamilton County LEAD
5. **Lancaster County, South Carolina**—Lancaster County LEAD

Longmont, Colorado— Longmont LEAD

About Longmont

Longmont (population 98,711)[20] is a suburban community located in Boulder County, Colorado, approximately 33 miles northwest of Denver, the state capitol. With more than 1,500 acres of parks and open space and proximity to Rocky Mountain National Park, Longmont is a perfect destination for outdoor enthusiasts.

In addition to its natural beauty, several things make Longmont unique, including the city's commitment to equity, innovation, and inclusion. Another relevant feature is that Longmont Police Services and Fire Services are divisions within the Longmont Public Safety Department, which also houses the Support Services Division and Community Health and Resilience, the newest division of the Public Safety Department. Having all these services within a single agency promotes teamwork, problem solving, and interdependent relationships and has reduced barriers to information sharing among divisions.[21, 22]

In Colorado, the rate of fatal methamphetamine overdoses increased significantly during the latter part of the 2010s. Prior to 2011, the statewide fatal methamphetamine overdose rate was less than 1 per 100,000 residents. That rate increased to 2.5 per 100,000 residents in 2015, 3.5 in 2016, and 5.2 in 2017.[23] In addition, from 2013 to 2017 the admittance rate for methamphetamine use doubled at one of the state's largest treatment centers, the Arapahoe House.[24]

In 2017, to curb overdose and substance misuse rates, the City of Longmont launched its Angel Initiative. This self-referral program encourages people who have SUD to go to a police station to ask for assistance in accessing treatment.

The Angel Initiative helped pave the way for the adoption of alternative responses in Longmont to address SUD and led to the implementation of a LEAD program in July 2018. These programs aimed to enhance the city's comprehensive behavioral health response system.[25]

How Longmont LEAD Began

The idea for Longmont LEAD emerged through the observations and actions of key actors in the community. Mike Butler, Longmont Public Safety Chief, found that his officers consistently ran into the same individuals struggling with SUDs. He realized that arresting these individuals was not helping them overcome their SUDs or decreasing the number of calls for service, so he began exploring alternatives to arrest that included options for enhancing access to treatment. In 2017, the state announced it would fund four LEAD pilot programs through the Marijuana Tax Cash Fund. Deputy Chief of Police Jeff Satur, accompanied by representatives from the Boulder County Public Health Department and harm reduction stakeholder groups, traveled to Santa Fe, New Mexico, to learn about Santa Fe LEAD.

Upon Deputy Chief Satur's return to Longmont, Chief Butler charged Assistant Public Safety Chief Dan Eamon with applying for state funding to launch the Longmont LEAD Program. The application was successful. Deputy Chief Satur began laying a foundation with the Patrol Division for the adoption of LEAD as a diversion tool. At the same time, Assistant Chief Eamon and his team began conducting informational interviews with other LEAD programs and harm reduction programs to help guide program development. One of the lessons learned through these conversations that stood out to Assistant Chief Eamon was that most LEAD programs contract with external service providers for case management services, which made it difficult for the programs to stay flexible and adaptable, as they had little control over the policies and practices of external contractors. This led the Longmont LEAD team to decide to bring case management in-house rather than contracting with an outside service provider. Since this is

not a traditional model, Assistant Chief Eamon had to make the case to stakeholders and department heads as to why it made sense to bring the case managers into the Public Safety Department. Because of his proactive outreach, the program launched with in-house case management in July 2018.

Program Development

The development of Longmont LEAD was guided and facilitated by the LEAD steering committee, which acts as a kind of board of directors and serves in an advisory and advocacy capacity. The steering committee is composed of executive-level representatives from Boulder County Public Health, the Boulder County District Attorney's Office, the Boulder County Office of the Colorado State Public Defender, UCHealth Longs Peak Hospital, as well as the Longmont Municipal Court Judge and the Assistant Chief of the Longmont Public Safety Department. As Longmont LEAD was being developed, the steering committee provided guidance and insight on policies and procedures. The current role of the steering committee is to provide support and advocacy in removing any systemic barriers the program may face.

A second body, the LEAD operational working group, originated from the LEAD model and consists of representatives from partner organizations that provide treatment and services for LEAD participants. When the Longmont LEAD team first established its operational working group, it invited these organizations to join to learn about the program, participate in coordination of care, and advocate for individual program participants. LEAD case managers soon learned that rather than trying to facilitate care for individual participants, it was more useful to engage this group in solving systemic challenges that were affecting all participants, sharing agency updates, discussing resources available in the community, and staying current on the evolution of community-based programs. The operational working group still sometimes discussed individual program participants but realized that focusing on

enhancing the service provider system was another way to help all participants.

The Longmont LEAD Program began in July 2018 with a team of three: a program manager, a case manager supervisor, and a case manager, all of whom worked within the Longmont Public Safety Department. Like many other new programs, Longmont LEAD went through some growing pains and experienced turnover within the case management team in its first 6 months. However, by late 2019, the program had a strong foundation. According to Michelle Webb, Manager of Public Safety Diversion Programs, much of the credit for this belongs to Emily Van Doren, who was hired in 2018 as the case management supervisor. She has been critical to building a culture of professional development and support among Longmont's case management team, which also supports the city's Crisis, Outreach, Response and Engagement (CORE) Initiative; Community Health Program; and Angel Initiative.

Because case management is central to supporting the LEAD program, Ms. Van Doren focuses on hiring case managers who understand and share the program's philosophy of harm reduction (i.e., meeting people with SUD where they are at as opposed to insisting they immediately engage in treatment).[26] An integral part of knowing how to meet people where they are at is to understand what it is like to experience something similar in one's own life. Ms. Van Doren and her team believe this is such a fundamental part of the case manager's job that they decided to exclusively hire case managers who had life experiences similar to those of their clients. Members of the Longmont LEAD case management team have a range of lived experience: family members with SUDs or mental health conditions, their own struggles with SUD or mental health conditions, or experience receiving services within multiple systems (such as the justice system, child protection, or sheltering services). The ability to share life experiences can foster meaningful relationships between the case manager and the client and reduce the power

imbalance commonly found in the service provider/service user relationship. It can also contribute to an improved sense of hope, empowerment, and social inclusion for those accessing services and reduce the sense of isolation and stigma associated with SUDs, mental health conditions, and use of services.[27]

During the hiring process, to ensure that candidates understand what their daily work will be like, applicants shadow a case manager for a day. After they are hired, as part of their onboarding process, they go on a ride-along with a Longmont patrol officer. Building relationships with patrol officers, who make the majority of the referrals that the LEAD program receives, is an important aspect of being a case manager, so it is vital to begin relationship building with officers during the orientation process.

Ms. Van Doren developed comprehensive onboarding training for incoming case managers. The training includes information on the LEAD model, harm reduction techniques, case management, recovery coaching, motivational interviewing, and trauma-informed care. In addition to this preliminary training, Longmont's case management team has adopted a culture of continuous professional development that keeps its members up to date on best practices in their field, which includes in-service training sessions and training sponsored by other social service agencies or national organizations.

The case management team, which comprises a range of entry-level to experienced case managers, also engages in weekly meetings that include instruction or a presentation led by a fellow team member on a relevant topic of their choice. Team meetings also include conversations about ethics, during which team members present ethical dilemmas that they have dealt with and discussions on lessons learned from certain cases. As part of a monthly book club, the team chooses books on topics that will expand the team members' job skills. They divide the books into sections and meet once a month to discuss the section they read. Through these conversations and the training that team members provide each other, the case managers

have developed a learning community and supportive relationships. According to Ms. Webb, there is an ethos of kindness and compassion for people that begins with colleagues and extends to the clients they work with. While LEAD began with only one case manager, the program has since expanded to include seven peer case managers, and no turnover has occurred within the team for almost 3 years.

When LEAD began, the Angel Initiative and a restorative justice program were already in place, so police in Longmont were familiar with the concept of diversion and did not need formal training on alternative forms of response to SUD. However, once LEAD launched, Ms. Van Doren, the program manager, a patrol officer who is assigned to Longmont's co-responder team, and the deputy chief of public safety went to briefings (or "roll calls") and walked patrol officers through the brief referral form. They also hosted staff members from the LEAD National Support Bureau, who provided training about the LEAD model. About 3 months after LEAD launched, the program manager and Ms. Van Doren circled back with police to share updates about the program and answer questions that officers had about referrals.

To enhance officer support for the program, the case management team takes steps to update Longmont officers on the progress of individuals whom officers refer to the program. When LEAD first launched, case managers distributed a weekly newsletter updating officers on the progress of individual participants; as the number of participants increased, the team shifted to sending a monthly list of program participants with the case managers they are assigned to in case an officer wanted to follow up with a specific participant. Also, case managers update referring officers about positive outcomes as well as challenges that occur throughout the participants' engagement with the case management team. The team also works to engage with officers by inviting them to members' offices for coffee and holding social events for them. These activities help build relationships with officers and demonstrate the value of referrals to the program. The

case management team recognizes that relationships need to be cultivated and nurtured, even when a solid foundation is already established. Team members consistently evolve their ideas and practices to maintain rapport with patrol officers, understanding that, like any relationship, it requires them to be dynamic and responsive.

How Longmont LEAD Works

When Longmont police officers encounter individuals suspected of offenses associated with SUD, officers may use their discretion to refer those individuals to the LEAD program. The goal of the program is not to rely solely on arrest and incarceration but instead to connect individuals struggling with SUD to the intensive case management services offered by LEAD.

Longmont LEAD is a voluntary program, so prospective clients can decide whether to enter the program. When individuals elect to enter the program, case managers initiate contact within 24 business hours of receiving the referral (or first thing Monday morning, if referrals are made over the weekend). When making initial contact with participants, case managers greet them with enthusiasm to set the tone for the client's experience in the program. During the first meeting, the case manager explains how the LEAD program works and answers any questions the client has. The case manager and the client work together to fill out a "shared expectations form," which helps establish an equal power dynamic between them and demonstrates to the client that they have a strong voice in determining how their needs will be addressed through the program. The case manager then helps the client identify personal goals, which do not have to center around SUD and can involve services that case managers coordinate with community partners to address unemployment, housing, or mental health services or to obtain an identification card.

After clients identify the goals they want to address, case managers allow clients to set the pace of engagement. Some meet with case managers several times a week, while others meet every other week. Case managers also use

assertive outreach, where they regularly check in with clients whom they have not heard from in a while. Case managers have a process that helps them determine when to stop initiating outreach to participants whose behavior indicates that they are not ready to participate in the program. When this happens, case managers still let clients know they are welcome to return whenever they want to re-engage.

Case managers collect demographic data, including information on housing status, substance use, personal relationships, employment status, education, and other elements, that help the case manager understand clients' immediate needs. This information is also used by program administrators and evaluators to assess program implementation.

Each case manager has a caseload of roughly 20 clients to whom they provide the support needed for the clients to reach their goals. This may include providing their clients transportation to medical or mental health appointments, coordinating care with external community partners, linking to housing resources or employment services, assisting with applying for eligible benefits and health insurance, and building life skills aligned with the client's goals.[28] There is no expiration date attached to a client's participation in the program. The case manager assists the client until the client no longer needs or wants assistance.

> "It's a beautiful outcome when a participant's life becomes what they hoped it would; it's just as meaningful to have someone beside you along the way, regardless of outcome. Our case managers build strong human connections with participants amidst a participant's own doubt and worry; the difference is, they don't need to brave it alone."
>
> —Emily Van Doren, Case Management Supervisor, Longmont Public Safety Department

System Impact

Important goals of Longmont LEAD are to decrease client contact with the justice system and decrease emergency trips to the hospital. A study released in 2020 involving 133 LEAD participants showed a 59 percent reduction in the number of illegal incidents after first contact with LEAD case managers. Further, there was a 50 percent reduction in the arrest rate after first contact with LEAD, 33 percent of participants were not arrested again, and 32 percent did not receive another summons after first contact. The report also indicated that there was a 25 percent reduction in trips to the emergency room, especially for clients who received peer counseling.

Other system impacts are more subtle. The number of officer referrals to LEAD has increased as officers have learned about program successes. From 2019 to 2020, officer referrals to Longmont LEAD increased by 20.5 percent (from 78 to 94), and as of mid-November 2021, the 98 referrals made by officers had exceeded the 2020 total. In addition, many people in the recovery community have begun to develop a rapport with police officers who referred them to the program, resulting in a change in the relationship between the recovery community and the police.

> "Our staff approaches each and every individual with the goal of building a relationship. That relationship is profoundly beneficial in many ways. Relationships build trust, lead to less use-of-force incidents, create an openness among public safety staff to learning about and understanding the chronic disease of addiction, and break down past barriers to care."
>
> —Dan Eamon, Assistant Public Safety Director, Longmont Public Safety Department

Lessons Learned

◂ The principles of harm reduction should guide the work at every level. These principles apply not only to working with clients; they guide case managers' relationships with law enforcement personnel, compelling them to listen to officers' concerns about the program.

- It has been valuable to case managers to learn how officers perceive and utilize their services. This knowledge has helped case managers understand where case management services fit on the continuum of public safety services.

- The case management team's confidence in its members' expertise and openness to feedback from seasoned officers allowed the team to integrate new perspectives and build trust within its department.

◂ At the start of implementation, Longmont LEAD team members had unrealistic expectations about the amount of time it would take for a harm reduction program to create change, and what measuring harm reduction would entail. They thought they would have promising data within 6 to 12 months. Then they learned that behavior change takes time. They are working on building a program performance measurement system that will accurately reflect such changes.

◂ The Longmont LEAD team was eager to begin implementation and started accepting clients as soon as its new case management supervisor was hired, even though it had the option of waiting for several months. In hindsight, team members stated that they would have benefited from using that time to build a stronger foundation before accepting clients. Taking time to create routines and collaborate with partner organizations makes it easier to ensure that the program runs smoothly.

◂ After determining the long-term vision for the deflection program, program planners should ask for all the resources necessary to achieve that vision

instead of requesting what seems feasible. They should let stakeholders know what it will take to achieve programmatic goals rather than making small and repeated requests for resources needed in the short term.

‹ Case management supervisors should provide job candidates with realistic employment expectations to prevent high turnover rates and better prepare them for their roles. In the first year of Longmont LEAD, there was significant turnover among case managers. The leadership team learned that departing case managers misunderstood what their day-to-day work would entail, so the team changed aspects of the hiring process. Now, candidates who make it past the first interview shadow a case manager to experience a typical day. This has helped in the long-term retention of case managers.

‹ Program managers should staff the program with individuals who want to help shape the program, understand and care about the community, think of their work as something that gives their life meaning, and who are willing to listen to all the voices in the community, including clients, patrol officers, treatment and service providers, business leaders, and people in recovery. Finding the right program staff is crucial to implementing a successful, sustainable, and inclusive program.

‹ Program managers should identify program goals and objectives, which are the foundation for identifying and prioritizing measurements, data points and data collection efforts. While a system might be capable of tracking hundreds of data points, prioritizing performance measurement will help guide data collection efforts.

About Bel Air

Bel Air (population 10,661)[30] is located in northeast Maryland and is the county seat of Harford County, which is a part of the Baltimore-Columbia-Towson Metropolitan Statistical Area. Harford County borders the Chesapeake Bay to the southeast; Baltimore County, Maryland, to the west; and Pennsylvania to the north. Bel Air residents are able to access drugs that come into the county from cities such as Baltimore, Maryland; Wilmington, Delaware; and Philadelphia, Pennsylvania. These cities are on the Interstate 95 corridor, which is considered a drug trafficking pipeline.[31]

From 2007 to 2012, the number of fatal opioid-related overdoses that occurred in Harford County fluctuated from year to year, without an aggregated trend. In 2007, there were 24 fatal opioid-related overdoses in the county; from 2008 to 2014 the number ranged from 28 (in 2009 and 2011) to 38 (in 2010 and 2014).[32] The annual number of fatal overdoses increased after 2014, reaching 45 in 2015, 76 in 2016, and 93 in 2017. The surge in overdoses was primarily attributed to fentanyl, which was involved in fewer than 5 overdoses in 2014, but in 2017 accounted for 73 of the 101 fatal overdoses in Harford County.[33]

Before LEAD: Bel Air's DART Program

In 2017, there were 32 opioid overdoses in Bel Air, 5 of which were fatal.[34] During an especially disturbing incident, an officer responded to the home of a young overdose victim and was met by the siblings of the deceased who were hysterical with grief. This incident spurred Bel Air Police Department (BAPD) Chief Charles A. Moore to create

the BAPD's Drug Abatement Response Team (DART). This program eventually evolved into the Bel Air LEAD Program.

Chief Moore originally believed that the best way to hold people accountable for breaking the law was to arrest them and put them in jail, but seeing how the number of overdoses was affecting both the quality of life in the community and officer morale, he began to reassess the traditional response to individuals with SUDs. After researching potential options for new programming, attending seminars on the opioid crisis, and conferring with practitioners from other localities similarly experiencing rising numbers of overdoses, he concluded that any solution for Bel Air would have to entail teamwork among experts in both public health and law enforcement.

Chief Moore learned about the DART program being implemented by the Cumberland, Maryland, Police Department in collaboration with behavioral health partners, and in January 2018, the BAPD launched the Bel Air DART. For treatment and support services, the BAPD partnered with Family and Children's Services (now called Springboard Community Services), the Harford County Office of Drug Control Policy, the Harford County Health Department, Addiction Connections Resources, the Maryland Opioid Operational Command Center, the Maryland Overdose Response Program, the Maryland Department of Parole and Probation, Harford County Social Services, and the Maryland Governor's Office of Crime Prevention, Youth, and Victim Services. Under the DART program, when officers responded to the scene of non-fatal overdoses, they had the option to ask overdose survivors for permission to refer them for intervention services. If those individuals agreed to receive services, the DART reached out to them within 48 hours to conduct post-overdose peer support interventions. The DART included a uniformed officer and a case manager.

How Bel Air LEAD Began

In May 2019, Chief Moore was contacted by representatives from the Governor's Office of Crime Prevention, Youth, and Victim Services and Harford County's State's Attorney's

Office to discuss expanding upon DART—a program that focused solely on overdose response—to create a LEAD program that would incorporate principles of harm reduction and trauma-informed policing. They explained that the goals of LEAD are to intervene with individuals before they suffer an overdose and to assist participants in accessing services to meet additional needs, like those related to homelessness and MHD. Following this conversation, Chief Moore decided to implement LEAD, and the program officially launched in Bel Air in February 2021.

Under the new LEAD program, BAPD officers can connect individuals they encounter in the field to treatment and other services as needed. There are two types of referrals: social contact referrals and stop referrals.

When officers encounter an individual with unmet behavioral health needs, they have the discretion to initiate a social contact referral. For example, individuals who experience an overdose and who would previously have been served by DART are eligible to receive social contact referrals. Officers can also provide social contact referrals to individuals experiencing homelessness or who have mental health or substance use disorders, and to family members of overdose victims. In addition, officers have the discretion to make stop referrals in lieu of arrest for individuals who commit low-level offenses related to their SUDs or other untreated MHDs. This case study focuses on social contact referrals.

The LEAD National Support Bureau recommends that each LEAD program establish three guiding bodies to encourage group decision-making among organizational and community stakeholders: a policy coordinating group, which is made up of higher-level leadership from the stakeholder organizations; an operational work group, which is composed of case managers, treatment and service providers, and sometimes referring officers; and a community leadership team, which features people with lived experience, faith leaders, and representatives from the business and nonprofit sectors, as well as other community

members who are tapped into the needs of the community. Establishing all three groups ensures that all voices are heard and can help attract additional support for the program within various sectors of the community.

When the Bel Air LEAD Program launched, Springboard Community Services assumed case management responsibilities and the remaining partners, who were already working together to implement DART, transitioned into implementation of the LEAD program. Joined by representatives from the Harford County State's Attorney's Office and Public Defender's Office, as well as the Klein Family Harford Crisis Center and the Harford Office on Mental Health's mobile crisis team (now Harford Crisis Response), leaders from the original partner organizations established an operational work group. This body, which met every 2 weeks, took on the role of a traditional LEAD operational work group, which is to review each client's service plan and provide support to case managers. The same individuals also acted as the policy coordinating group, which discusses and guides program development and management issues. As Bel Air LEAD evolved, program leaders formalized the structure of the program, establishing a separate, standalone policy coordinating group at the end of 2021 and a community leadership team in early 2022.

Bel Air LEAD relies on police officers to make referrals to the program. To encourage officer participation, leaders of the program invited a representative from the Maryland Governor's Office on Crime Prevention, Youth, and Victim Services to explain how and why LEAD started in Seattle and to describe the success it has had there and in other jurisdictions around the country. To help officers understand the role of trauma in addiction and reduce the stigma associated with SUD and MHD, staff members from several partner agencies conducted training on ACEs, harm reduction, and trauma-informed policing. Many officers were eager to try a new response to the problem of individuals whom they were arresting multiple times, because officers previously had no other options. They were also happy to participate in a program that helped them connect people in need, such as unsheltered individuals and

those with MHDs, to services in the community. The chief gained additional support from officers by explaining how making a referral to LEAD can save officers time and effort by reducing the amount of arrest-related paperwork, the number of court appearances, and repeat calls for service. In addition, Chief Moore tapped into the department's informal leaders to elicit support from officers.

Recently, the case management team at Springboard Community Services began sharing the success of Bel Air LEAD with officers through a newsletter, which has helped to increase officer engagement in the program. The newsletter shares data on the number of referrals, discharges, and clients who have obtained housing, employment, or other positive outcomes. Providing information about the impact that LEAD has on clients resulted in referrals from officers who had never made referrals to the program before.

In November 2021, the BAPD hired a former chief sergeant from the department, Richard "Chip" Carter, to fill the position of LEAD executive officer. Sergeant Carter, who has more than 40 years of law enforcement experience, understands trauma-informed policing and harm reduction principles and is well respected by the agency's officers because of his experience and his effectiveness as an administrative officer.

The LEAD executive officer attends the meetings of all three leadership groups, serves as the main liaison with Springboard Community Services and the LEAD case manager, and works with Harford Crisis Response. The executive officer also can help patrol officers with referrals.

Sometimes, patrol officers encounter individuals who they know would benefit from LEAD referrals, but who do not want to participate nor cooperate in the referral process. Those incidents are documented on an activity sheet and the LEAD executive officer may be called out to assist with those referrals so patrol officers can resume their duties. The LEAD executive officer is able to take time to explain in more detail what the program entails, provide information on the benefits of participating, and answer any questions

that potential participants have. Meeting with individuals can put them at ease and convince them to participate in LEAD. In addition to meeting with new referrals when requested, the executive officer checks in with clients who have become disengaged from the program to ensure that no one falls through the cracks.

As the program coordinator, the Sergeant Carter has made Bel Air LEAD more efficient and become the face of the program. Having the executive officer located within the police department demonstrates the BAPD's genuine commitment to LEAD and the philosophies it stands for.

How Bel Air LEAD Works

Once officers decide to make a social contact referral, they provide verbal and written information about the LEAD program and ask whether the individual is interested in receiving services. If the individual agrees to receive services, they must sign a consent form. The officer then contacts the LEAD case manager, who meets the officer in the field to engage with the individual. Depending on the time of day, if the case manager is not available, the individual is linked with Harford Crisis Response, and if necessary, additional support is made available from the Klein Family Harford Crisis Center, which operates an urgent care walk-in center for immediate assessment/care coordination.

Once individuals enter LEAD, the Springboard Community Services case manager meets with them to conduct comprehensive assessments of their needs. Based on the most pressing needs, the case manager works with clients to help them identify their goals and objectives. This process is a partnership between the case manager and clients and results in a personalized service plan. Clients may identify a need for housing, medical or dental care, or for documentation such as birth certificates or identification cards. In addition, the case manager can provide access to mental health and SUD treatment, food services, and more. Sometimes, Springboard Community Services refers clients to one of the other project partners' services and make

internal referrals for therapy and treatment available through its own clinicians.

For some, a service plan goal may simply entail getting the client to meet with the case manager on a regular basis. If the case manager has not seen a client in a while and wants to reengage with them, or cannot find a client, the relationships that the case manager has with officers come into play. Officers often have good rapport with the people they referred and, in some cases, assist with treatment planning. Referring officers can often help the case manager find clients who have disengaged from the program.

The case manager checks in with clients every 30 to 60 days to adjust their plans as needed. The operational work group also regularly assesses clients' progress through the program to see if any changes to service plans are necessary. While LEAD is meant to be a long-term program and clients are encouraged to continue meeting with their case manager for up to a year, program data indicate that clients participate in Bel Air LEAD for an average of roughly 6 months. Bel Air LEAD follows a harm reduction model, and clients guide their own treatment plan. LEAD clients—even stop referrals, who must participate in the initial assessment and a follow-up contact with a case manager—are free to decline SUD or mental health treatment if they are not interested. If the case manager encounters challenges in the care of a client or does not know which services to employ, they can leverage the diverse expertise of operational work group members to support their work.

Bel Air LEAD is partially funded by the Maryland Governor's Office of Crime Prevention, Youth, and Victim Services, which is a COSSAP grantee. (This document includes references to grantees that received funding from two COSSUP predecessor programs: the Comprehensive Opioid, Stimulant, and Substance Abuse Program [COSSAP] and the Comprehensive Opioid Abuse Program [COAP].) Springboard Community Services receives funding to assist with costs associated with case management services, and the BAPD used the funding to hire the LEAD executive officer.

System Impact

The launch of both DART and Bel Air LEAD impacted the culture of the BAPD by shifting its approach to dealing with SUD and MHD. While some officers, like their leaders, were ready to participate in a new approach to addressing repeat offenders with behavioral health issues, others have become more supportive of LEAD as the program continues to achieve success. Representatives from Bel Air LEAD's behavioral health partners and the Harford County State's Attorney's Office also credit Chief Moore for his leadership and promotion of the program. He focused on the benefits of collaborating with behavioral health practitioners to address the underlying trauma that leads to SUD, MHD, and other negative outcomes and has encouraged his officers to see referrals to case management as a better option than solely relying on arrest.

> "I do think that the difference from a behavioral health perspective is the level of engagement that the officers have when they're looking at a prevention pathway. Sometimes when they're dealing with someone, they immediately talk to them about housing and food—things you don't think a police officer is going to talk to someone about, and they get to know the individual. So, we see through these social referrals that officers recognize that if this intervention does not happen for this person, their behavior could result in something more serious later."
>
> —Ernestina Simmons, Chief Program Officer, Springboard Community Services

In the first year of operation in Bel Air, 90 percent of LEAD participants were successful in avoiding new criminal charges during their enrollment. In the quarter ending June 2021, 67 percent of discharged clients were successfully connected to housing, employment, SUD treatment, and mental health services. Also, as of June 2021, LEAD's case management team had trained 57 individuals to administer naloxone.

The Maryland Attorney General's Office is hoping to convince law enforcement agencies and leaders from other municipalities to join LEAD by showcasing the success of the program. In addition, team members are currently assessing the viability of developing a naloxone leave-behind program, which would allow police to leave overdose response kits with individuals who experience overdose.

Lessons Learned

◀ Officers must be given discretion to make referrals to LEAD. To obtain support, program leaders should educate officers about the goals of the program and its success in other jurisdictions and provide training on trauma and harm reduction. Chief Moore also informed his officers about the harm that arrest and involvement in the justice system can cause individuals, especially first-time offenders; the benefits of connecting individuals to case management, treatment, and support services; and the ease of making referrals versus making arrests.

◀ It is important for the case management team to reach out to and get to know officers. The relationships formed between case managers and officers as they work together on the program build trust and enhance officer buy-in to the program. The case manager from Springboard Community Services not only attended LEAD training sessions with BAPD officers but also spends time at the department, goes on ride-alongs, and conducts joint community visits to clients who have disengaged from the program. The team at Springboard Community Services also keeps officers apprised of program success through a quarterly newsletter, which further encourages buy-in.

◀ It is important to keep case managers' caseloads at a manageable level so they can successfully meet client needs. Having smaller caseloads allows case managers to give sufficient time and attention to each

client, increasing the likelihood of program success. Also, the case management team assumed that social referral clients would have fewer needs and require less attention from case managers than stop referral clients, but it learned that their needs were just as intensive.

◄ Having a formal structure in place to implement LEAD is important. When Bel Air LEAD first transitioned from the DART program, the same partners continued to work together and maintained the same structure. Therefore, the DART program's main decision-making body became LEAD's operational work group. Program practitioners report that it would have been helpful to form the policy coordinating group and the community leadership team before launching LEAD. Those two groups are now established and fulfilling their defined roles.

◄ The Bel Air LEAD team found value in having a robust local 24-hour mental health system of care that includes a mobile crisis team. Harford Crisis Response provides backup if the LEAD case manager is unavailable to meet officers and potential participants in the field, and the Klein Family Harford Crisis Center has the capacity to address the treatment needs of clients with MHD or who are undergoing a mental health crisis.

About Bernalillo County

Bernalillo County (population 662,564)[35] is located in central New Mexico and offers beautiful geographical features, from the Sandia-Manzano Mountains in the east, to the Volcanic Cliffs of the West Mesa. Although it is the third-smallest county in New Mexico by geographic area, Bernalillo has the highest population in the state, and its county seat, Albuquerque, is the state's largest city.

From 1990 to 2017, New Mexico's annual fatal overdose rate consistently exceeded the national rate.[36] This continued in 2018, when New Mexico's fatal overdose rate was 26.7 per 100,000 residents,[37] while the national rate was 20.7.[38] Bernalillo County had more fatal overdoses than any other county in the state from 2011 to 2015.[39]

In 2019, the Bernalillo County Department of Behavioral Health Services launched Bernalillo County's LEAD program to assist individuals in Bernalillo County suffering from SUDs by enhancing their access to treatment services. Before the LEAD program was established, Bernalillo County offered individuals pre-prosecution diversion and the opportunity to participate in specialty courts. Both of these programs were offered after an individual was arrested and had entered the justice system. LEAD was created to expand the county's existing diversion programs and to divert non-violent individuals with SUD or mental illness away from the justice system and into community-based services.[40] LEAD also aimed to decrease the strain on the justice system and EMS services by diverting high-frequency utilizers of multiple systems to treatment and services. The LEAD program has two components: a law enforcement diversion program,

which allows for referrals in lieu of arrest (an example of the Officer Intervention Pathway), and a social referral program in cases in which there are no pending arrests. This is an example of the First Responder and Officer Referral Pathway, and the focus of this case study.

> "What we've been doing for the last 20 to 40 years, since the war on drugs started, isn't working. There has been a 700 percent increase in incarceration, but a zero percent decrease in drug use, and that's a huge problem."
>
> —Glenn St. Onge, Bernalillo County LEAD Program Manager

How Bernalillo County LEAD Began

Before the LEAD program launched, Bernalillo County already had crisis response teams that the program could rely on, including the Albuquerque Police Department's Crisis Intervention Unit, Bernalillo County's Mobile Crisis Team, and the county's Fire Mobile Crisis Team, which pairs a paramedic with a behavioral health clinician for a non-law enforcement crisis response. In 2018, drawing upon the example of the Santa Fe LEAD Program, representatives from the Department of Behavioral Health Services began to explore how to launch LEAD in Bernalillo County. They identified project partners and funding sources and worked on program development. Community stakeholders were supportive of the LEAD model, as it prioritizes client-developed goals and harm reduction over total abstinence. This was also attractive to the District Attorney's Office and the Office of the Public Defender, since most of the existing diversion programs were abstinence-based and LEAD offered an alternative approach. The District Attorney's Office, the Office of the Public Defender, the Albuquerque Police Department (APD), and the Bernalillo County Sheriff's Office (BCSO) signed on as initial project partners and met biweekly to develop Bernalillo LEAD. In addition, the Santa Fe LEAD team continued to act in an advisory role.

The Bernalillo County LEAD team initially sought funding through the Department of Behavioral Health Services and received $250,000 to hire three case managers. These case managers work out of the Department of Behavioral Health Services' Comprehensive Assessment and Recovery through Excellence (CARE) campus, which houses several programs for people with SUDs, including detoxification and treatment, inebriation intervention, inpatient SUD treatment, and supportive aftercare. As case managers perform intake assessments, their proximity to the services on the campus promotes speedy referrals and systemic collaboration.

Program Development/Program Expansion

In 2020, the New Mexico Department of Human Services received grant funding from COSSAP to support New Mexico's six LEAD sites, including Bernalillo County. COSSAP funding allowed Bernalillo County to hire a LEAD program manager, expand programmatic training for the APD and the BCSO, and expand services to allow for community referrals. In addition, in 2020, Bernalillo County received a MacArthur Foundation grant of $20,000 to fund the purchase of phones and forms of identification for program participants.

The funding provided by COSSAP helped the Bernalillo County LEAD team overcome a major obstacle that it faced during the first 2 years of the program—a lack of law enforcement referrals. On average, the program only received one to four referrals per month. To increase referrals, the Bernalillo County LEAD team hired Glenn St. Onge, a former APD lieutenant who retired in 2016, for the project manager position. This proved to be a turning point for the program.

Having worked at the APD for 20 years, Lieutenant St. Onge had credibility with APD department heads, many of whom previously worked under him, and he was able to earn their support for the program. Lieutenant St. Onge took an active role in the law enforcement training sessions, and worked with retired Police Chief Patrick Gallagher, formerly of the

Truth or Consequences, New Mexico, Police Department, to develop training on the LEAD program, which they began to provide to APD officers and BCSO deputies in spring 2021. The training they developed was accredited by the New Mexico Department of Public Safety to be used by any department in the state developing or enhancing its own LEAD program. Officers also can use the training to earn continuing education credits. Further, Lieutenant St. Onge began going into the field with officers and deputies to show them how to refer someone to the program and addressed their concerns about the practice of diverting people to LEAD rather than arresting them.

Lieutenant St. Onge made two additional changes to the LEAD program that increased law enforcement support for the program. First, he arranged for the LEAD case managers to ride along with police officers in the field, which helped them build working relationships and trust. The second change applies to the law enforcement diversion component of the LEAD program, which mandates that officers hold charges in abeyance while individuals participate in the LEAD program. This was a heavy administrative burden for officers and deputies, so Lieutenant St. Onge appointed LEAD liaisons—one each at the APD and the BCSO—who were responsible for holding the charges for every participant diverted through their agency and making sure each participant was compliant with the program. These changes and the new training program increased officer and deputy buy-in to the program, and the number of referrals increased from fewer than 5 per month to roughly 20 per month.

As the program evolved, a stakeholder group—the policy coordinating committee—emerged to guide program development and help implement programmatic activities. Composed of representatives from the District Attorney's Office, the Department of Behavioral Health Services, the Office of the Public Defender, the APD, and the BCSO, the policy coordinating committee meets every other week to coordinate services for clients, provide support for case managers, and address policy issues.

"In trainings I ask officers, 'Who here has ever had a case dismissed for dope?' And everybody raises their hands. Then I ask, 'Was it worth it for the criminal justice system, for the client, and for your time?' That's when they begin to understand the value of the program."

—Lieutenant Glenn St. Onge, LEAD Program Manager, Bernalillo County Department of Behavioral Health Services

How Bernalillo County LEAD Works

For the officer prevention component of the Bernalillo County LEAD program, when a law enforcement officer encounters a person in the field who they feel might benefit from LEAD, the officer will make a social referral to the program. If the individual wants to participate, the officer will contact the case manager to make a warm handoff and conduct intake in the field. If the case manager is unable to meet the officer in the field, the officer will transport the individual directly to the CARE campus or file an electronic referral that goes to the case manager, who typically follows up with the client for an in-person consultation within 72 hours. While the case manager performs an initial intake assessment with a client, the District Attorney's Office runs a formal background check on the client to confirm program eligibility. Officers who refer individuals to LEAD are informed about whether that person contacted a case manager and, in the case of the law enforcement diversion component of LEAD, whether charges will have to be filed. In addition, the officer is informed about whether the individual was accepted into the program and, if so, is invited to biweekly case management meetings to discuss the client's status and progress. Keeping officers informed about the status of individuals they refer to the program enhances their buy-in to the program and encourages their involvement in the referral process.

In the program's early stages, prospective clients were ineligible for entry if they had been found guilty of any violent felonies or crimes against children in the previous 10 years. However, officers and deputies reported to program staff that this standard eliminated many potential clients who might benefit from the program. To be more inclusive, the Bernalillo County LEAD team shifted its eligibility requirement to consider only the previous 3 years of prospective clients' criminal records.

The policy coordinating committee also helps assess whether a prospective client is a good match for the LEAD program. If an individual is accepted into the program, a case manager works with the individual to identify goals. While some diversion programs prioritize an abstinence-based approach, LEAD prioritizes harm reduction and giving clients agency in selecting their goals. Needs vary across clients but commonly relate to detoxification, treatment, and recovery services; medical services; housing and employment services; and childcare, other social support services, and acquiring forms of identifications. Some of these services are readily available at the CARE campus, whereas others are offered in the broader community. Case managers meet with clients at least once a week to help them work toward their goals until the client elects to leave the program or seek services elsewhere. Barring outrageous or violent behavior, clients are rarely removed from the program. If clients stop participating in treatment or services, or decide to leave the program, they may reenter it later if they want to.

System Impact

Bernalillo County LEAD gained traction in 2020 when the program hired a program manager. Leaders are waiting for the results of a soon-to-be-released evaluation to gauge system impact. Their goal is to create a culture shift in the justice system away from punishment and incarceration and toward treatment and intervention.

Bernalillo County and the City of Albuquerque have long supported programming that diverts people away from the criminal justice system. In addition to offering SUD and mental health diversion programs, the county and the city have established a variety of specialty courts, including a drug court, mental health court, young adult court, behavior health court, and driving while intoxicated court. Launching the Bernalillo County LEAD program was a logical next step in expanding the county's offering of diversion programs.

Since its inception, the LEAD program has allowed for both social referrals and referrals in lieu of arrest. Like the LEAD National Support Bureau and the flagship LEAD program in Seattle, the Bernalillo County LEAD Program is adding a "Let Everyone Advance with Dignity" component to its program, which allows for referrals from community partners as well as from sworn law enforcement officers. Since the program is located on the CARE Campus, Bernalillo County LEAD team members are working to increase referrals from the other services located on the campus. In addition, the Bernalillo County LEAD team is working to establish a post-arrest diversion component.

Lessons Learned

◄ To maximize efficiency and effectiveness, the Bernalillo County LEAD Program needed a full-time program manager. When the program first started, there was only enough funding to hire case managers. Additional funding from the COSSAP grant enabled the county to hire a program manager to coordinate program activities, including administrative responsibilities and training. This allowed case managers to focus on their clients rather than on day-to-day administrative and liaison duties.

◄ It is highly beneficial for a law enforcement-driven program to have a program manager with a background in law enforcement and an understanding of the program and its goals. Hiring a program manager with law enforcement experience for the LEAD program was critical to enhancing buy-in from the program's law enforcement partners. The program manager's understanding of officer attitudes helped overcome

officers' and deputies' reluctance to divert people to LEAD, and the hands-on training that the program manager provided led to a significant increase in the number of law enforcement referrals. The LEAD team also devised the following strategies to keep officers in the loop regarding the individuals they refer to LEAD, which helped garner support for the program:

- After an officer brings an individual to the CARE campus or implements a warm handoff to a case manager, the case manager fills out a disposition form that lets the officer know the outcome of the referral.

- Once an officer diverts an individual to LEAD, that officer is invited to participate in biweekly case management meetings to discuss the client's status and progress.

◄ The Bernalillo County LEAD Program manager suggested designating LEAD liaisons within the APD and the BCSO. These are detectives who, in addition to their day-to-day responsibilities, assist with follow-up in cases of diversion in lieu of arrest. Having programmatic liaisons responsible for keeping track of the dispositions of these cases, instead of the referring officers, makes diversion an easier lift and more attractive to use as an alternative to arrest.

◄ LEAD program staff members emphasized the importance of having case managers in the field, working hand in hand with the officers. The growth of relationships between officers and case managers has fueled greater cooperation and given each group a better sense of the other's role in the project.

Hamilton County, Ohio— Hamilton County LEAD

About Hamilton County

Hamilton County is situated at the southernmost tip of Ohio, bordering Kentucky and Indiana. The United States Census Bureau estimates that as of July 1, 2021, 826,139 residents lived in the county,[41] which boasts professional football, baseball, and soccer teams as well as numerous theaters and more than 100 art galleries. Cincinnati is the county seat and the largest city in Hamilton County, which is the cultural center of the region. Cincinnati is home to the headquarters of multiple Fortune 500 companies and several universities, including the University of Cincinnati and Xavier University.

Cincinnati is also the location of the Hamilton County Justice Center, which serves as the county jail. The jail was initially designed to house 840 incarcerated people but overcrowding has been a long-standing issue. In 2017, the jail population peaked at more than 1,600, and as of November 2019, there were more than 1,300 incarcerated people housed in the facility.[42] Overcrowding can be partially attributed to the rate at which offenders recidivate. In the mid-2010s, the rate of recidivism in Hamilton County was about 33 percent.[43] Since 2015, the Hamilton County Addiction Response Coalition (HC ARC) has pursued a number of evidence-based policies and programs to improve outcomes for people, particularly those with SUDs. The HC ARC partners with the Hamilton County Office of Reentry to provide support to individuals released from state and local corrections and address the recidivism rate. HC ARC, which is under the direction of Hamilton County Administration and the Board of County Commissioners, is a collaborative coalition of law enforcement, public health, community leaders, first responders, treatment providers,

peer recovery specialists, and elected and administrative officials in local, state, and federal governments.

Considering that a large percentage of the jail population were individuals who had been arrested and incarcerated multiple times for charges related to SUDs, mental health conditions, homelessness, or poverty, officials from Hamilton County and the City of Cincinnati decided to try a proactive approach to drive down the jail population.[44] In 2018, HC ARC applied for funding to launch a LEAD program to address these issues. The goals of the program are to improve public safety by reducing the number of people entering the justice system for issues related to SUDs, MHDs, homelessness, and poverty, and to strengthen community-police relations.

Like many other LEAD programs, Hamilton County LEAD allows for both arrest diversion, to connect individuals to case managers in lieu of arrest, and social contact referrals for individuals who have not committed an offense. This case study will focus on the latter.

How Hamilton County LEAD Began

The idea for Hamilton County LEAD originated from local participation in the 2018 Police, Treatment, and Community Collaborative (PTACC) training conference on pre-arrest diversion and deflection. A team of practitioners and officials from the county, including representatives from HC ARC, the Hamilton County Heroin Task Force, Interact for Health, and the Cincinnati City Council, were in attendance. There, they met with leaders of the LEAD National Support Bureau and learned how LEAD can help communities connect residents struggling with issues such as mental illness, SUDs, homelessness, and poverty with much-needed quality-of-life services.

To support the creation of the LEAD program, HC ARC applied for funding from the FY2018 COAP, predecessor to COSSAP. Although the Bureau of Justice Assistance awarded funding to the county in October 2018, staffing issues delayed the launch of the program until October

2019, when Meagan Gosney was hired to manage Hamilton County LEAD. On her first day, she convened the first meeting of the program's policy control working group (PCWG), the governing body of the LEAD initiative.

The PCWG consists of representatives from various stakeholders at the city (the City Manager's Office, the City Solicitor's Office, the Mayor's Office, the City Council, and the Cincinnati Police Department), county (HC ARC, the County Administrator's Office, the Board of County Commissioners, the Hamilton County Office of Reentry, and the Hamilton County Prosecutor's Office), and state (the Ohio Justice and Policy Center) levels, as well as from the University of Cincinnati. During the planning phase, which lasted from October 2019 to January 2020, the PCWG met monthly to develop foundational components of the LEAD program, including eligibility requirements, memoranda of understanding, and standard operating procedures for law enforcement officers. The Cincinnati Police Department was heavily involved in establishing the policies and protocols to help build the LEAD program. By February 2020, the group finalized a plan for implementing LEAD and hired a case manager and a screening and outreach coordinator. After the program launched, the PCWG began meeting quarterly to review and improve referral and diversion protocols, determine geographic areas of operation, and provide guidance to the LEAD case management team.

Before implementing LEAD, representatives from the PCWG began to partner with community-based agencies and organizations that focus on mental health, SUD treatment, and homelessness to educate providers about the pilot and establish clear and simple referral pathways for future participants. These initial partnerships led to the development of an operations work group (OWG), composed of clinicians, officers, and service providers who work directly with participants. This group works with and advises the case management team. In addition to the LEAD case management team, the OWG is currently composed of the LEAD program manager, personnel from the three participating police departments (City of Cincinnati Central

Business District and District 1; Colerain Township, Ohio, and City of Norwood, Ohio), a representative from the Hamilton County Prosecutor's Office, representatives from the treatment community, and the project's research partners at the University of Cincinnati. The OWG meets weekly to discuss the admittance of new participants into the program, as well as provide and receive updates on current LEAD participants. Treatment providers and law enforcement officers alike utilize OWG meetings to update case managers on current activities of LEAD participants at their respective agencies.

Hamilton County LEAD is unique in that case management services are provided by the county's Office of Reentry. Trina Jackson, Director of the Office of Reentry and Case Management Supervisor for LEAD, explained that the case management services provided by LEAD are an extension of services already provided by the Office of Reentry to participants navigating the reentry process. Ms. Jackson, Sheryl Miles (LEAD case manager), and a screening and outreach coordinator constitute the LEAD case management team.

Despite having the case management team in place, the launch of the Hamilton County LEAD pilot was delayed because of the COVID-19 pandemic. The LEAD pilot, which was set to launch in March 2020, finally launched in July 2020 with the involvement of the Cincinnati Police Department's Central Business District and District 1. In spring 2021, Hamilton County LEAD expanded to include the City of Norwood and Colerain Township, with the support of their respective Police Departments.

Law enforcement buy-in is critical to the success of Hamilton County LEAD because, unlike some LEAD programs that accept referrals from the community, all Hamilton County LEAD referrals come from police. The first step to getting that support was engaging with police leaders. Fortunately, the program had police support from the beginning. The commander of the Hamilton County Heroin Task Force, Captain Tom Fallon, was part of the team that first learned about and then helped plan the LEAD program.

Maintaining support from law enforcement officers is an ongoing process. Although representatives from the LEAD National Support Bureau conducted numerous trainings for law enforcement, the LEAD case manager continuously educates officers about the program and provides information about LEAD to new officers. The LEAD case management team attends roll calls, goes on ride-alongs and walk-alongs, grabs lunch or coffee with officers, and looks for other opportunities to interact informally with officers to discuss the program.

These activities provide opportunities for one-on-one conversations, not only to educate officers about the program, but to help build trusting relationships. Relationship building is crucial because the harm reduction philosophy, which is central to the LEAD program, does not always align with techniques police officers were trained in to respond to people with SUDs. Being able to meet in informal situations and provide consistent messaging about harm reduction can help officers understand the harm reduction philosophy and its benefits. Further, officers often become more focused on making referrals when Ms. Miles joins them in doing a ride-along, going out of their way to locate individuals they know would benefit from the program.

> "Officers get to know people in the community who need services; they know them by first names and know where to find these folks. A ride-along can become a brainstorming session for them."
>
> —Sheryl Miles, LEAD Case Manager,
> Hamilton County Officer of Reentry

Officers who refer individuals to LEAD are kept in the loop about their progress, which helps maintain their support for the program. As previously mentioned, referring law

enforcement officers are invited to OWG meetings, where they can explain why they made a referral as well as receive updates on participants' status. Also, Ms. Miles might let an officer know that a participant has not been showing up for appointments and attempt to get their last known location information from the officer. Officers might also attend meetings to inform the OWG about environmental changes in the community, such as a new homeless encampment, so that Ms. Miles can do a walk-along in the area.

How Hamilton County LEAD Works

Law enforcement officers can use their discretion to make social contact referrals for individuals who have frequent contact with the police, but not because of criminal offenses, which are handled through arrest diversions. When officers identify an opportunity to make a social contact referral, they tell the individual about the LEAD program. If the individual is interested in receiving assistance, officers complete the referral form and contact Ms. Miles. If she is available, she will meet the officer and individual immediately and begin the screening process. Otherwise, the officer forwards the referral by email and Ms. Miles follows up with the individual to provide detailed information about the program and complete an initial screening form. The form, which confirms the individual's interest and consent to participate in the program, then goes to the OWG for review.

The OWG reviews all referrals for safety concerns, for treatment history, and to identify potential services based on the participant's needs. Clinicians from three OWG member organizations—Mental Health Access Point, Greater Cincinnati Behavioral Health Services, and the Addiction Services Council—review information about potential participants with the LEAD case management team to inform them about services that those individuals have received or are receiving, their levels of engagement, and gaps in their treatment or services. If a potential participant received services or treatment from one of these agencies, the LEAD case manager can confer with the individual's current or former case manager to coordinate care. The OWG approves or denies individuals' referrals to LEAD based on whether they are LEAD-eligible (for arrest diversion) or a good fit for the program (for social contact referrals). After approval, the OWG serves as a sounding board for treatment decisions.

After individuals are accepted to the program, Ms. Miles meets with them at LEAD headquarters or one of the program's satellite offices. She works with the individuals to complete the LEAD Intake and Needs Assessment (LINA) to determine their top three areas of need (e.g., treatment, shelter, employment) and provide a detailed account of the barriers the participant has faced accessing services for those needs. The LINA is the program's comprehensive psychosocial assessment. Participants have 30 days from the point of OWG acceptance to complete the LINA. Once the LINA is complete, Ms. Miles and the LEAD participant work together to build an individualized service plan (ISP), which identifies goals established by the participant, and the activities they will engage in to meet those goals. Ms. Miles helps to hold participants accountable as they work on their immediate goals, and when those are accomplished, she works with them to update their service plan with new goals.

Hamilton County LEAD utilizes the HC ARC's vast directory of treatment and service provider partners to refer participants. Recovery supports include shelters and permanent housing for individuals experiencing homelessness, both residential and intensive outpatient SUD treatment, and mental health agencies that can provide treatment and ensure that participants have the medications they need. Ms. Miles also makes sure that participants' transportation needs are met so they can make treatment and other appointments and have a level of independence.

There is no procedure for discharging someone from the program or ending services. Grounded in the harm reduction philosophy, LEAD participants ultimately direct their own treatment and service plans with guidance and encouragement from their case manager. LEAD case managers are prepared to be involved in participants' lives until participants no longer see a benefit. Each participant

has the discretion to end their involvement with the program, and many do withdraw or sometimes go missing and return at a later date.

Since its launch in July 2020, Hamilton County LEAD has utilized Cordata Healthcare Innovations' deflection system as its workload management tool to manage, monitor, and enhance LEAD programming and to collect the data required to measure its progress toward meeting COSSAP objectives. LEAD's case management team works with Cordata Healthcare Innovations' LEAD Division, which records participant demographic and contact information, dates, and outcomes of communications with participants and other parties (family members, treatment providers), harm reduction supply distribution (naloxone, fentanyl test strips, Deterra bags), and relevant case management information such as participant support systems and individual needs.

Inbound referrals from law enforcement officers are uploaded to the Cordata dashboard by the LEAD screening and outreach coordinator. The system tracks participants' progress from their initial needs screenings to their LINA and ISPs, through 30-, 60-, and 90-day updates, and each interaction they have with their case managers. The system also collects data on the gender, race, and age of participants, which are compared to calls for service data in each participating jurisdiction to ensure that LEAD is being implemented equitably. The system also allows case managers to update participants' status and track their progress in relation to the case management team's goals and activities. Access to the platform is secure, limited to key team members of the LEAD program, and managed by HC ARC, and the platform is easily accessible in the field via tablet or laptop computer. Data are collected in real time and can be reported on a monthly or quarterly basis as needed. Importantly, the evaluation team can access a wide variety of data not only to examine program efforts and participant outcomes but also to explore potential delivery mechanisms for the program, such as frequency of contact with Hamilton County LEAD or types of outbound referrals.

System Impact

From July 2020 to April 2022, LEAD received 100 total referrals, of which 94 percent were social contact referrals. Of the total referrals, 72 percent of the participants successfully completed an intake assessment. Of the participants who completed an intake assessment, 76 percent are receiving ongoing case management services, 24 percent decided to withdraw from services voluntarily, and 5 percent successfully completed case management services. The average time from referral to first contact is 19 days. This timeframe accounts for officer referral; OWG review and acceptance; the case manager locating the participant based on known locations, addresses, and active phone numbers or social media; and initiating LEAD documentation (Immediate Needs Screening, LINA, ISP, etc.). The average time from referral to first service (outbound referral to recovery supports) is 58 days. This timeframe accounts for officer referral, OWG review and acceptance, the case manager locating the participant, LEAD documentation, and completing the documentation to initiate a service plan for appropriate referral and connection to services.

An immediate impact is felt by those who participate in LEAD. Ms. Miles has received positive feedback about LEAD from officers who say they have not seen certain people on the street for long periods of time whom they used to see every day. Some LEAD participants credit the officers who referred them for their good fortune. For example, in a testimonial collected for a May 2021 community symposium on Hamilton County LEAD sponsored by the Ohio Justice Policy Council, a 51-year-old LEAD participant credited his referring officer for saving his life: "He could have put me in jail because I had a beer sitting next to me, but he gave me a chance."

A 41-year-old participant who was struggling with housing, health, and justice system issues due to his SUD, mental illness, and isolation caused by the COVID-19 pandemic was referred to LEAD and began taking classes at the

Recovery Center of Hamilton County, which provided a new level of support for him. Because of his participation and dedication to the classes, which included information on wellness, computer literacy, and art, the Recovery Center offered him a volunteer position with the possibility of full employment in a year, giving him new sense of purpose. He reported, "I feel the LEAD program can be beneficial to all that participate. The case managers have answered any questions or concerns I've had. They inspired me, motivated me, raised my self-esteem, and have given me hope for the future. It's my opinion that LEAD should be used all throughout the country."

Another participant was able to access mental health services, complete two of their five goals, access food assistance services, and begin the process of finding information about their birth parents. The participant said that "since being in the program, my interaction with the police has decreased due to me being involved in mental health services and the support from LEAD staff. I think LEAD is a positive program for individuals dealing with mental health and other issues such as homelessness and substance abuse." These testimonials are often shared with officers, local stakeholders, and city and community counselors to demonstrate the value of the LEAD program.

Lessons Learned

◄ Hamilton County LEAD team members emphasized that the power of relationship building cannot be overemphasized. Building relationships with everyone from partners to law enforcement officers to participants has been critical to their program's development and implementation.

◄ Police leaders in the Cincinnati Police Department were part of the PCWG that helped develop LEAD, but frontline officers did not have the opportunity to provide input to the program. Allowing front-line officers input into how the structure or processes of LEAD were developed may have mitigated some of the challenges with officer buy-in to the program.

◄ Buy-in from law enforcement agencies has to start at the top with individuals in leadership roles. Law enforcement leaders needed to see the value in the LEAD model, so Hamilton County administrators and elected officials spent a lot of time early on engaging with captains and chiefs to garner their support.

◄ Frequent engagement with officers in both formal (e.g., roll calls, ride-alongs, walk-alongs) and informal (e.g., lunches, coffee breaks) settings has helped to cultivate officer buy-in to LEAD and the philosophy of harm reduction. The LEAD case management team emphasized the importance of using those opportunities to communicate enthusiasm for harm reduction or to advocate for a participant, which can help an officer see that person in a new way. Case managers also suggested explaining how harm reduction supports officer safety.

◄ Having officers engage with residents outside the scope of enforcement can strengthen community-police relations. Programs like LEAD promote relationship building with community members, local stakeholders, and businesses.

◄ Programs like LEAD must consider how they will measure success. Hamilton County LEAD team members suggested not getting discouraged by the end results for participants but instead recognizing the value of small victories that are pivotal to each participant's progress. Focusing on the latter can demonstrate the value of LEAD in the lives of its participants.

Lancaster County, South Carolina—Lancaster County LEAD

COSSAP FY2018 and FY2020 Grantee

About Lancaster County

Lancaster County (population 103,966)[45] is located in the Piedmont Region of northcentral South Carolina, bordering North Carolina. The county is a part of the Charlotte-Concord-Gastonia, North Carolina-South Carolina (NC-SC) Metropolitan Statistical Area, and its county seat is the city of Lancaster. With Interstate 77 close by, residents of Lancaster can easily access major cities such as Charlotte, North Carolina, which is about 45 miles to the north, or Columbia, South Carolina, which is approximately 60 miles to the south.

Over the latter half of the 2010s, the annual number of fatal overdoses significantly increased in Lancaster County. In 2015 and 2016, there were fewer than 10 fatal overdoses annually, but in 2017, the county experienced 24 fatal overdoses; after a steep reduction in 2018 (14 overdose fatalities), the number of fatal overdoses in 2019 surged to 35. The rising number of fatal overdoses was primarily attributed to opioids. Whereas there were 4 fatal opioid overdoses in 2015, there were 23 in 2017 and 32 in 2019.[46] People in Lancaster County with SUDs are now facing an additional emerging issue—the presence of adulterated illicit pills, which are often cut with ingredients that make them more lethal. Not only are people unaware of what they are ingesting, but the mixture of substances in these pills can negate naloxone's life-saving effects in cases of overdose.[47]

To help residents struggling with issues like SUD and MHD and to reduce the strain on the county's justice system capacity, the Lancaster County Sheriff's Office launched

South Carolina's first LEAD program in May 2019. Through LEAD, case managers connect residents with community-based organizations that use a harm reduction approach to combat behaviors that might lead to future criminal offenses based on their SUDs or MHDs.[48]

Like most LEAD programs, Lancaster County LEAD allows for both stop referrals, in which diversion is offered in place of arrest, and social contact referrals, in which law enforcement officers and community members can refer people to LEAD who are facing issues related to SUD, mental health, or poverty and are at risk of involvement in the justice system. This study highlights the Officer Referral Pathway and focuses on social contact referrals.

How Lancaster County LEAD Began

Before the launch of Lancaster County's LEAD program, the Lancaster County Sheriff's Office's (LCSO) Narcotics Division focused on arresting and incarcerating individuals who use illicit drugs, which was straining the capacity of the jail. In late 2017, Lancaster County Sheriff Barry S. Faile attended a conference where one of the speakers argued that law enforcement cannot continue to arrest its way out of the drug problem and then discussed using pre-arrest diversion and deflection programs to address the problem. Sheriff Faile took what he learned at the conference back to Lancaster County and began to consider how his department could better serve individuals with SUDs. The county already had a drug court, but he was interested in developing a way to help people before they received charges. Sheriff Faile looked to the LEAD initiative as a possible solution, and from these efforts, Lancaster County LEAD was born.

The development of Lancaster County LEAD benefited from a pre-existing and long-standing stakeholder group called the Coalition for Healthy Youth. The Coalition for Healthy Youth is funded by a Drug-Free Communities grant from the Centers for Disease Control and Prevention and aims to identify community needs and community resources through inter-organizational collaboration. When Lancaster County

LEAD launched, it relied upon partnerships that already existed through the Coalition for Healthy Youth. Counseling Services of Lancaster provides case management services, access to medication-assisted treatment, and outpatient services. Additional project partners include the Lancaster Police Department, Lancaster County Emergency Medical Services, the 6th Circuit Solicitor Office, Plexus (a medical care provider), local treatment centers, transitional housing providers, and several community partners that the program uses to enhance its outreach efforts. While Lancaster County lacks extensive treatment and transitional housing providers, the LEAD program can access a network of treatment and service providers in neighboring counties through the Coalition for Healthy Youth, which continuously adds partner agencies. It is this network of resources that has enabled the development of Lancaster County's Operation Significant Impact programs, which, in addition to LEAD, include a Byrne Criminal Justice Innovation (BCJI) project that helps police identify "hot spots" of crime tied to drug use, and the COSSAP first responder-led naloxone plus program, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).[49]

The Lancaster County Sheriff, case managers, designated evaluator Dr. Paul McKenzie, and representatives from the LCSO, the Lancaster Police Department, Counseling Services of Lancaster, and other treatment providers joined together to form an advisory committee, which met monthly to develop Lancaster County LEAD. As the program progressed, the group evolved into the project's operational work group, which meets biweekly and reviews clients' progress through the program.

Lancaster County LEAD's goal was to model the program on the LEAD programs in Seattle and in Albany, New York. In August 2019, project staff members visited Seattle LEAD to learn more about its program model and practices. When Lancaster County was ready to launch its LEAD program in December 2019, representatives from the LEAD National Support Bureau, which provides training and technical assistance to LEAD programs across the country, traveled

to Lancaster County to train the LCSO deputies and project staff.

To plan and implement LEAD, the LCSO applied for and was awarded a Bureau of Justice Assistance (BJA) grant that funded the program from October 2018 to July 2021. While the advisory committee was eager to plan Lancaster County's LEAD program, the process, which started in spring 2019, took more time than expected. The first challenge arose as the committee was drafting the policies and procedures for their LEAD program. The LCSO is accredited by the Commission on Accreditation for Law Enforcement Agencies (CALEA), which facilitates an agency's pursuit of professional excellence by requiring that programs develop a comprehensive, uniform set of written directives. Consequently, it took several months to write policies and procedures for Lancaster County LEAD that were consistent with CALEA's strict standards. Also, it was difficult for the team to scale down the program it had learned about in urban Seattle to fit the needs and resource capacity of rural Lancaster County.

The final hurdle to fully implementing the program was finding the right deputy to fill the project coordinator position funded by the grant. In April 2019, Deputy Max Adams was hired as the LEAD project coordinator. In that role, he worked to get the policies and procedures written and approved, and helped initiate program implementation. When Deputy Adams was promoted and transferred to the Patrol Division, Deputy Neina Small assumed the role of project coordinator and worked with officers to increase the number of referrals. In June 2021, Lancaster County enhanced its LEAD program with funding from a new COSSAP grant, which enabled the program to hire a civilian to serve as project coordinator. When LaNisha Stover-Blair assumed the role of project coordinator, she began handling administrative duties related to the program and some case management duties, such as following up with clients who go inactive or graduate from the program. This allowed Deputy Small to move into a community liaison position. In this role,

Deputy Small meets with individuals who have been referred to LEAD by deputies or police officers, provides in-field training to officers to promote support of the program, and champions the program to law enforcement and the community.

Like most LEAD programs, Lancaster County LEAD relies upon law enforcement officers to refer individuals they encounter in the field. Before LEAD launched, there was a lot of stigma attached to people with SUD by Lancaster County law enforcement officers. Many officers thought that individuals who used drugs should be incarcerated and held accountable for breaking the law. In addition, since arrests are often viewed as an effective way to hold people accountable for their actions, deputies and officers were resistant to referring individuals to LEAD instead of making an arrest. However, ongoing support from leadership, especially Sheriff Faile and Deputy Small, resulted in officers viewing the ability to refer to the LEAD program as a valuable additional resource. Deputy Small's field training support enhanced officer engagement in LEAD and helped solidify Lancaster County LEAD as a valuable tool for officers. She assured deputies and officers that they would receive credit for making referrals, just as they would for making arrests. Although the LEAD program is not uniformly utilized by officers in Lancaster County, support among law enforcement is high and LEAD programming has significantly reduced the stigma associated with SUD in the county's law enforcement agencies.[50]

While law enforcement agency support was necessary for implementation, Lancaster County LEAD also worked to gain support for the program from community partners. The program team created informational brochures to distribute to local businesses and at community events to promote LEAD. These brochures include information about how members of the community can make social contact referrals for family members and friends who are dealing with SUD, MHD, or homelessness, and who could benefit from LEAD programming. The brochures also educate business owners

about the benefits of LEAD so that they might be more amenable to deflection and empowered to make their own social contact referrals.

How Lancaster County LEAD Works

When law enforcement officers encounter individuals who would benefit from participating in LEAD, they have the discretion to refer those individuals to the program. If individuals are interested in accessing LEAD, deputies or officers check their criminal histories to ensure eligibility for the program and then conduct initial screenings. An individual may be ineligible to enter the program if they are under 18, have exploited minors, have recently been convicted of a violent crime, are a registered sex offender, or live outside of Lancaster County. Deputy Small has some discretion to determine program eligibility and can seek additional input from command staff.

After screening individuals, officers call Deputy Small, who meets potential LEAD clients to discern their needs and tell them about the program. If an encounter happens in the evening or on a weekend, officers provide written information about the program to the individual and then email a form with information about the referral to Deputy Small, who follows up the next business day. If individuals decide to participate in LEAD, Deputy Small works with them to fill out an initial intake form, which provides information on their background and any immediate needs, such as housing or detoxification. She then performs a warm handoff to Ms. Stover-Blair. Deputy Small also conducts intakes for social contact referrals from the community; case management is handled by Counseling Services of Lancaster, with follow-up from Ms. Stover Blair.

Case managers work with new clients to fill out a comprehensive assessment and establish personalized goals. Lancaster County LEAD offers access to a variety of services based on clients' needs, such as counseling, detoxification, in-patient and outpatient mental health or SUD treatment, and transitional housing. If clients need transportation to an appointment or meeting, they can

access a ride service that is operated by the Lancaster County Council on Aging for residents of the county (regardless of age). The operational work group supports the work of LEAD case managers when asked, and any officers who diverted individuals to the program are invited to participate in operational work group meetings to hear updates about people they diverted or to share any information they might have about a participant's status.

Through the duration of the client's participation in Lancaster County LEAD, the case manager works with them to monitor their progress toward their goals. When clients decide to participate, they consent to have case managers follow up with them for 1 year on a frequency determined by each client's needs. When clients near the end of the year, their case managers inform them that their time in the program is expiring and asks whether they would like to continue to take advantage of case management and LEAD services. Clients who opt to remain in the program can decide to meet with their case managers on the same schedules or change their schedules. Clients who decide to discontinue their participation with the program are put on a list of "inactive contacts," maintained by case managers. This list includes social contact referrals who declined LEAD programming or individuals who ceased attending treatment services. LEAD team members reach out to inactive contacts every month to check in and see whether they are interested in engaging/reengaging in treatment or services.

> "We now know that we're not going to be able to arrest ourselves out of this opioid crisis. We also know that we're making a positive difference, a significant impact by going out, helping these folks, and trying to get them immediate treatment. By helping opioid abusers, we're also eliminating crime like burglaries, larcenies, and domestic offenses."
>
> —Barry Faile, Sheriff, Lancaster County, South Carolina

System Impact

The most immediate impact of Lancaster County LEAD is that it introduced the principle of harm reduction to Lancaster County law enforcement agencies and behavioral health providers. The idea of linking people to treatment instead of arresting them was a paradigm shift for law enforcement officers, many of whom have also accepted LEAD's practice of letting clients determine their own level of involvement in the program. Approximately 12 months after officers were trained on the goals and practices of the LEAD program (November and December 2019) and began to implement the program, officers were surveyed about their impressions of the program. Of the 75 officers who responded, 80 percent indicated that they believed that LEAD made some positive contributions to the community and 94 percent reported that case managers were responsive and helpful when the officer made a referral.[51]

Implementation of Lancaster County LEAD is also reducing costs and strain on the justice system. According to an evaluation of the program, the average cost to the county of processing a drug-related charge is almost $5,200. In contrast, the cost of diverting an individual to treatment and services averages out to roughly $1,400, for an average savings of $3,717 per case.[52] In addition, an examination by the LEAD team showed that active clients experienced a 71 percent reduction in the number of contacts they had with law enforcement officers after entering the program.

Lancaster County LEAD falls under the umbrella of the county's Operation Significant Impact project (see page 32), which uses an innovative team approach to combat addiction, conflict, and crime in Lancaster County. Drawing upon partnerships developed through the Coalition for Healthy Youth, Operation Significant Impact uses inter-organizational relationships to enhance a systems-wide response to these issues. Further, these programs can lean on one another to strengthen their impact. Many of the same stakeholders involved in LEAD's advisory committee are also involved in the First Responder Quick Response

Team's (QRT) advisory committee, and project partners can promote cross-program collaboration.

Operation Significant Impact gained statewide recognition when it was awarded the 2021 Barrett Lawrimore Memorial Award by the South Carolina Association of Counties.[53] This award recognizes innovative regional partnerships in South Carolina and their capacity to "achieve impressive results and offer new ideas for other counties to consider."[54]

Lessons Learned

‹ When Lancaster County LEAD started, team leaders decided that a deputy should serve as the project coordinator responsible for administrative and operational tasks, including meeting and following up with clients, coordinating stakeholder meetings, attending community events, and working with law enforcement officers to implement the program. When additional funding became available, the team hired a civilian as the project coordinator and assigned a deputy as the community liaison for the program. Being able to hand off administrative responsibilities for the program but continue to coordinate closely with the project coordinator on the status of clients allows the deputy to spend more time in the field meeting officers and potential clients for warm handoffs, responding to calls for service, and championing the program alongside other law enforcement officers. Team leaders reported that they would have written two positions—project coordinator and community liaison—into the grant from the beginning if they had known the importance of coordinating between law enforcement agencies and behavioral health providers to successfully administer the program.

‹ LEAD programs rely on deputies and other police officers to participate in and refer people to the program. Therefore, it is essential to have a well-respected champion within law enforcement to encourage officer support for LEAD. Lancaster County LEAD has a strong advocate in Sheriff Faile, who started

the program. In addition, Deputy Small talked to officers about the benefits of the program, told them it would reduce the number of repeated calls for service, and reassured them that they would continue to have the discretion to make referrals to Lancaster County LEAD and that diverting individuals would count toward advancement in the department as much as making an arrest.

‹ When a community is starting a new program, it is helpful to have a mentor site that is similar in size and type to that community. When team members from Lancaster County LEAD made a site visit to the original LEAD program in Seattle, they were impressed by the program and eager to launch it in Lancaster County. However, when they tried to export that model to their small, rural county, they realized that Lancaster County had very different challenges and resources than Seattle. In retrospect, team members reported that they would have learned more from the LEAD programs in West Virginia, where the communities and political climate are similar to Lancaster County.

‹ It takes an enormous amount of collaboration among public safety, public health, and other community stakeholders to implement LEAD programs. Because of the lack of local SUD treatment providers and services, rural diversion and deflection programs should consider partnering with treatment and service providers in neighboring counties. Lancaster County LEAD benefits from the Coalition for Healthy Youth, whose stakeholder agencies and organizations are within or in proximity to the county.

Acknowledgements

About TASC's CHJ

TASC's CHJ is a national training and technical assistance (TTA) agency focused on creating strategies that reduce crime, justice system involvement, and recidivism by addressing substance use and mental health conditions among people who come in contact with law enforcement and other first responders, as well as the justice system. CHJ is grounded in the practical, on-the-ground experience of TASC, which, for more than 45 years, has served as a bridge

between justice systems and community-based treatment by offering specialized case management services.

CHJ helps COSSAP grantees implement evidence-based, systemic solutions at the front end of the justice system to respond to the substance use that often underlies criminal justice involvement. CHJ helps build integrated criminal justice, behavioral health, and community treatment and service capacities by assisting first responders in developing pathways to treatment for individuals at risk for illicit substance use and misuse. CHJ offers online resources and in-person TTA engagements customized to the needs of specific jurisdictions with the goals of connecting and maximizing the treatment resources of the community to improve public health and safety. Learn more about CHJ at www.centerforhealthandjustice.org.

Endnotes

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Learn more about the IACP at **www.theIACP.org**.

Visit the Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) Resource Center at **www.cossup.org**.

About the IACP

The International Association of Chiefs of Police (IACP) is the world's largest and most influential professional association for police leaders. With more than 32,000 members in more than 170 countries, the IACP is a recognized leader in global policing. Since 1893, the association has been speaking out on behalf of law enforcement and advancing leadership and professionalism in policing worldwide.

The IACP is known for its commitment to shaping the future of the police profession. Through timely research, programming, and unparalleled training opportunities, the IACP is preparing current and emerging police leaders—and the agencies and communities they serve—to succeed in addressing the most pressing issues, threats, and challenges of the day.

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