Promising Practices Guide

A guide designed to help law enforcement and public safety partners develop and sustain deflection and diversion programs aimed to save lives and improve public safety.

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Presented by
The Police Assisted Addiction
and Recovery Initiative (PAARI)

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1. Introducing the Promising Practices Guide

Section A: Introduction

This guide is designed to help law enforcement, public safety, and public health partners develop and sustain deflection and pre-arrest diversion programs to help save lives and improve public safety. Substance use is a challenging and critical public health and safety crisis, as rates of fatal and non-fatal overdoses have reached historically high levels.[1] Law enforcement and public safety organizations are pivotal in addressing this public health crisis. Many police and public safety organizations are actively engaged in a dual approach; they are diligently responding to the enforcement demands precipitated by the opioid epidemic, while also facilitating access to treatment for individuals with substance use disorders. Furthermore, first responders are undertaking proactive initiatives to support and inform families and community groups that have been heavily impacted by this crisis. Their efforts are instrumental in the collective endeavor to mitigate the adverse effects of the opioid epidemic on society. Law enforcement and public safety agencies are important partners in any comprehensive effort to address this crisis.[2]

While enforcement of drug trafficking efforts is critical, exclusive reliance on traditional enforcement-led approaches, such as arrest, prosecution, incarceration for substance misuse, mental health, and other social issues, have been largely ineffective in saving lives and increasing community safety.[3] Law enforcement agencies increasingly view the problem from a public health lens. Agencies across the country have taken their long-standing dedication to helping their communities and begun to translate it into more effective, evidence-based practices, aimed at opening new doors to treatment and recovery for those using drugs.[4]

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[1] Merianne R. Spencer, Arialdi R. Miniño, and Margaret Warner, "Drug overdose deaths in the United States," NCHS Data Brief, no 457. (December 2022): 6, https://dx.doi.org/10.15620/cdc:122556.

[2] Substance Abuse and Mental Health Services Administration, *Connecting Communities to Substance Use Services: Practical Approaches for First Responders*, SAMHSA Publication No. PEP23-06-01-010, Rockville, MD: National Mental Health and Substance Use Policy Laboratory, 2023.

[3] United States Office of National Drug Control Policy, *National Drug Control Strategy*. 2022, https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf.

[4] "An Overview of Deflection and Pre-Arrest Diversion to Prevent Opioid Overdose," National Council for Mental Wellbeing, accessed December 11, 2023, https://www.thenationalcouncil.org/resources/an-overview-of-deflection-and-pre-arrest-diversion-to-prevent-opioid-overdose/?gad_source=1&gclid=CjwKCAjwvvmzBhA2EiwAtHVrb11kXESKeo92v_8KKdSNp2TQFpiM327V1KiWwNZlKDU8Hl3BxhTQIhoC0QcQAvD_BwE.

The Police Assisted Addiction and Recovery Initiative (PAARI) has worked closely with law enforcement from its creation. PAARI began with one of the earliest examples of a deflection program, Gloucester PD's Angel Initiative, and has since provided assistance and connection to law enforcement agencies that have implemented various deflection and diversion programs, including self-referral/officer-referral models, Quick Response Teams, co-responder models, post-overdose follow-ups, Hub situation tables, and more. The lessons we have learned from working with these agencies form the basis for this guide.

This Promising Practices Guide aims to help agencies adopt and implement deflection and diversion programs. Research shows positive outcomes in communities where law enforcement and public health partners have adopted deflection and diversion programs.[5] Persons engaged in these programs are showing increased treatment engagement, reduced recidivism, and less involvement with the criminal justice system.[6] Communities in Massachusetts that implemented one or more programs had a reduction in overdose deaths over time compared to similar communities that did not have these programs.[7] Individuals who received medication for their opioid use disorder were 50% less likely to die than similar individuals who did not receive medication treatment.[8]

The terminology around deflection and diversion programs can cause some initial confusion to practitioners in the field. This guide employs the "deflection and diversion" terms because they best reflect the range of programs that PAARI has helped agencies adopt.[9]

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[5] Jon Ross and Bruce Taylor, "Designed to Do Good: Key Findings on the Development and Operation of First Responder Deflection Programs," *Journal of Public Health Management and Practice*, 28 Suppl. 6 (November/December 2022): S296, https://doi.org/10.1097/PHH.0000000000001578; Aleksandra E. Zgierska et al., "Pre-arrest Diversion to Addiction Treatment by Law Enforcement: Protocol for the Community-Level Policing Initiative to Reduce Addiction-Related Harm, Including Crime," H*ealth Justice* 9, no. 9 (March 2021): 2, https://doi.org/10.1186/s40352-021-00134-w.

[6] Étienne Blais, Jonathan Brisson, François Gagnon, and Simon-Antoine Lemay, "Diverting People Who Use Drugs from the Criminal Justice System: A Systematic Review of Police-Based Diversion Measures," *International Journal of Drug Policy* 105 (2022), https://doi.org/10.1016/j.drugpo.2022.103697.

[7] Xuan Ziming et al., "Association of Implementation of Postoverdose Outreach Programs With Subsequent Opioid Overdose Deaths Among Massachusetts Municipalities," *JAMA Psychiatry* 80, no. 5 (May 2023): 476, https://doi.org/10.1001/jamapsychiatry.2023.0109.

[8] Thomas Santo Jr., et al., "Association of Opioid Agonist Treatment with All-Cause Mortality and Specific Causes of Death Among People with Opioid Dependence: A Systematic Review and Meta-Analysis," *JAMA Psychiatry* 78, no. 9 (September 2021): 984, https://doi.org/10.1001/jamapsychiatry.2021.0976.

[9] Shannon Magnuson, Amy Dezember, and Brian Lovins, "Examining the Impacts of Arrest Deflection Strategies on Jail Reduction Efforts," (Prima County, AZ: Safety and Justice Challenge), https://safetyandjusticechallenge.org /wp-content/uploads/2022/05/SJC-ISLG-DeflectionSynthesisReport.pdf.

The first section of the guide helps to differentiate various types of deflection and diversion programs that have been implemented in the field.

DEFLECTION

Deflection programs do not result in arrest and typically do not have criminal justice involvement beyond contact with officers in the field. Oftentimes an individual has not committed a criminal offense or has committed a lower level offense and an officer has no intention to arrest. Individuals voluntarily work with deflection team members to access treatment or other services. In deflection, there are no penalties for not engaging a treatment service or completing a program.

VS

DIVERSION

Diversion refers to approaches where potential clients are contacted during enforcement activities, where there is a potential for arrest (e.g., illegal possession). Some diversion programs include a formal arrest and booking, while others may occur pre-arrest. Ultimately, treatment initiation and compliance is court-ordered and participants must complete a required service/program to have their charges dismissed.

Section B: How to Use the Guide

The guide is organized in sections to provide a step-by-step way to help implement a deflection or pre-arrest diversion initiative. Each section discusses background information about key issues and concepts, and includes highlighted promising practice examples and recommendations. Most importantly, the “Deflection Planning Workbook” is designed to work alongside this digital guide. Each section has specific workbook questions to guide your internal program planning so you can begin taking specific steps towards program implementation. For example, you are first asked to assess any similar deflection or diversion programs already in place. Later, you will be guided through key decisions for developing policies and procedures. Completing each section of the guide and the accompanying "Deflection Planning Workbook" will help you develop a specific and detailed plan tailored to the unique requirements and situation of your community.

Local stakeholders, as discussed in the *Building Support for Deflection and Diversion Programs* section of this guide, should actively participate in the planning process. You are also encouraged to consult and follow your local and state laws/regulations when developing materials, such as policies and procedures for your program. Utilize the provided planning tools to organize your efforts, understanding that these plans may evolve. While thorough planning is crucial, it is the top priority to start your deflection and diversion programs to save lives and give support to community members with substance use disorders.

2. Components of Deflection & Diversion Programs

By reviewing this section of the guide first responders will be able to:

1. Distinguish between the different types of diversion and deflection programs implemented by police/public safety or in collaboration with police/public safety across the country.
2. Select the components of the program you wish to implement in your local agency.

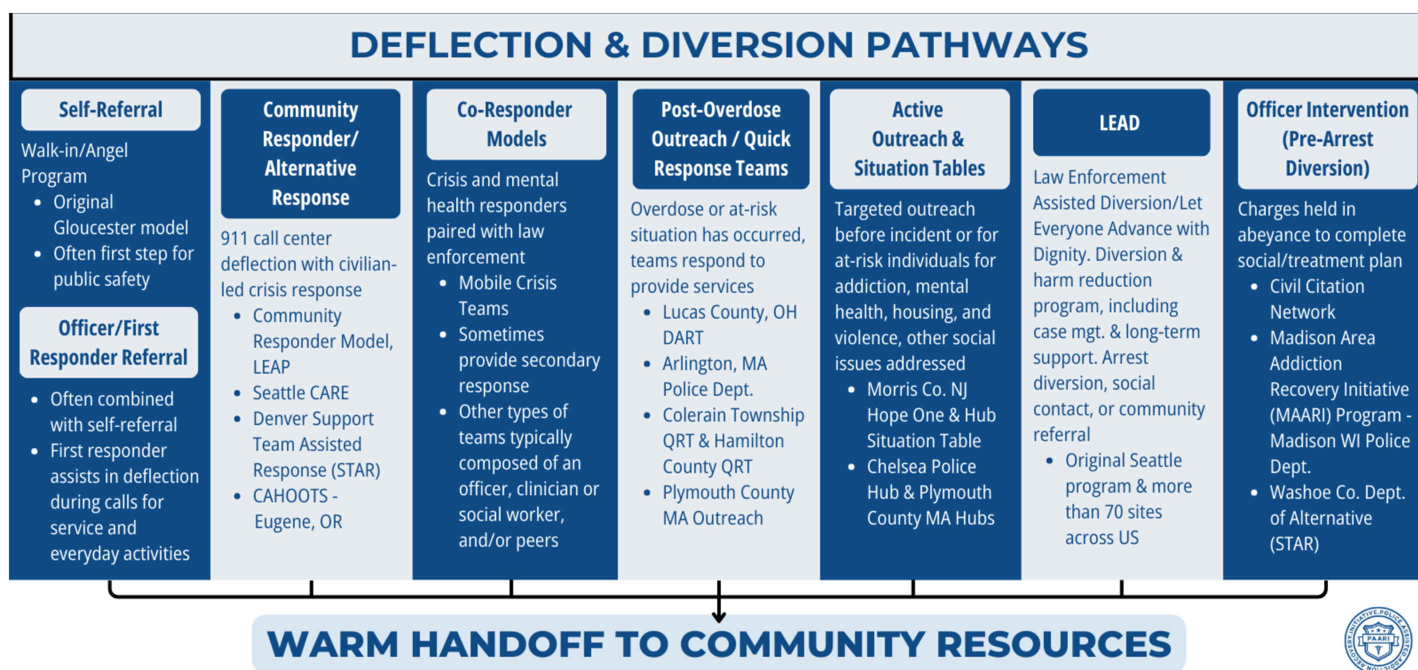
A comprehensive deflection and/or diversion model will include components that:

i) Link people who use drugs to treatment and harm reduction resources;

ii) Create new access opportunities through intake, outreach and true pre-arrest diversion; and

iii) Integrate critical support from community-based partners.

Section A: Types of Deflection and Diversion Programs



Self-Referral and Officer/First Responder-Referral. Self-referral programs work by creating police or community-based locations for individuals to voluntarily enter for navigation to treatment or other resources. Individuals can bring drugs or other illicit materials and will not face arrest or legal repercussions for any related

offenses. For example, the original Angel Initiative in Gloucester P.D., initially started with an intake program, where individuals came to the police department and program staff helped connect them directly to treatment services. Most self-referral models include other elements, such as first-responder/officer-referral. A first responder/officer-referral is when officers have the opportunity to connect to treatment or other resources from the field, during their regular duties. Examples of current Self-Referral and Officer/First-Responder Referral programs include Anne Arundel County, MD Safe Stations and Hope Not Handcuffs in Michigan and New York.

Community Responder. Community Responder Models divert specific 911 calls, such as those involving substance use, mental health, and homelessness, away from law enforcement, and instead, dispatch Community Responders to the scene. Examples include Eugene Orgeon's CAHOOTS Model, the Denver Support Team Assisted Response (STAR), and the Seattle Community Assisted Response & Engagement (CARE) Department. See also The Center for American Progress and the Law Enforcement Action Partnership's detailed guide for more information on the development of a Community Responder model.

Co-Response. Co-Response Models pair law enforcement with mental health clinicians to respond to calls-for-service that typically involve behavioral health crises. As substance use disorders or problematic substance use often co-occur with mental health disorders, these can be a powerful tool for communities addressing substance use.[10] By responding to these types of calls with clinicians, co-response models are effective at de-escalating tense situations, deflecting individuals away from criminal justice involvement, and connecting them to appropriate behavioral health services. One of the earliest examples of the co-response model is the Chapel Hill, North Carolina Crisis Unit. Additional examples of co-response models are the Boston Police Department/Boston Emergency Services Team and Tucson Police Department's Mental Health Support Team. For additional resources, the International Co-Responder Alliance is a non-profit organization dedicated to advancing co-responder programs across emergency services by providing networking, education, and resources to develop best practices and foster growth.

[10] Melissa S. Morabito, et al., "Police Response to People With Mental Illnesses in a Major U.S. City: The Boston Experience With the Co-Responder Model," *Victims & Offenders* 13 no. 8 (November 2018): 1093-1105, https://doi.org/10.1080/15564886.2018.1514340.

Post-Overdose Outreach. A particular type of targeted outreach effort that is initiated by an overdose event, and is also known as Naloxone Plus. This can be done for survivors of non-fatal overdoses and their social network or the social network of individuals that fatally overdose. Plymouth County Outreach in Massachusetts is a model example of this kind of targeted outreach program, which utilizes officers and recovery coaches to respond within 72 hours of an overdose event. In Ohio, the Colerain Township Police Department partners with fire and emergency medical providers to engage in a Quick Response Team approach, while the Hamilton County Quick Response Team is a coordinated effort between law enforcement, public health, and community providers to provide post-overdose response, harm reduction resources, and proactive outreach to vulnerable populations.

Active Outreach. Active Outreach is when law enforcement agencies and their partners conduct community outreach to identify potential participants. This may include street outreach in locations where individuals with substance use disorder or with substance use disorder or co-occurring disease are using drugs or at-risk of overdose. Arlington P.D.'s Outreach Initiative is one of the leading early adopters of this model. Mobile Crisis Units, such as those operated by Morris County (NJ) Sheriff's Office and partners, are another example of this type of program.

Hub/Situation Tables. The Hub/Situation Table Model, first developed in Saskatchewan, Canada, in 2011, provides a proactive, collaborative approach to supporting individuals facing acute risks related to substance use, mental health, and other challenges. By addressing these risks early, the model enhances community safety while reducing reliance on emergency services. In weekly meetings, police, social service providers, and other partners identify individuals or families in need and develop a multidisciplinary response plan using a structured four-filter process. This ensures swift connections to treatment, harm reduction, and support resources while maintaining confidentiality through strict de-identification protocols. First adapted in the U.S. by the Chelsea Police Department (MA), the model has since been replicated in cities nationwide.

Officer Intervention (Pre-arrest Diversion). Pre-arrest *diversion* initiatives offer alternative options for individuals who have committed a minor offense because of

their substance use.[11] Individuals are often redirected to treatment and recovery resources, rather than going through the usual arrest and court process.[12] With a pre-arrest diversion program in place, officers often have discretion and protocols to refer individuals to treatment or for support, but the charges are held in abeyance until some course of treatment or restitution is completed. Civil Citation Network and the Wisconsin-based Madison Area Addiction and Recovery Initiative (MARI) are examples of pre-arrest diversion.

Section B: Goals of Deflection and Diversion Programs

Regardless of the type of model used, deflection and diversion programs are aimed to:

Create *new* points of access to treatment, harm reduction services, and other social resources. Due to the high number of routine interactions with people who use drugs, often through enforcement activities and responding to calls-for-service, law enforcement agencies are in a unique position to be a critical point of access to treatment and harm reduction that has been previously underutilized in public health and safety responses to substance use.

Save lives and reduce the harms of substance use by connecting individuals to treatment and other resources. Removing barriers and increasing access to treatment, recovery supports, and harm reduction strategies, such as distributing Naloxone, fentanyl testing kits, or connecting people with recovery coaches/care navigators, can help save lives and reduce the harms associated with substance use.[13]

Deflect and divert people away from the criminal justice system for offenses related to substance use. Arrest is a substantial deprivation of liberty, and even when no further action is taken (e.g., booking, prosecution), it has significant

[11] Greg Frost, "Pre-Arrest Diversion: An Effective Model Ready for Widespread Adoption," Safety & Justice Challenge, November 23, 2020, https://safetyandjusticechallenge.org/blog/pre-arrest-diversion-effective-model-ready-widespread-adoption/.

[12] International Association of Chiefs of Police, Building Healthier Communities: A Guide to Enhancing Police Engagement through Community Partnerships (2021), https://www.theiacp.org/sites/default/files/243806_IACP_CPE_Building_Healthier_Communities_p2.pdf.

[13] National Institute on Drug Abuse, "Naloxone for Opioid Overdose: Life-saving Science," *U.S. Department of Health and Human Services*, (March 2017) https://nida.nih.gov/publications/naloxone-opioid-overdose-life-saving-science; Nicholas C. Peiper et al., "Fentanyl Test Strips as an Opioid Overdose Prevention Strategy: Findings from a Syringe Services Program in the Southeastern United States," *International Journal of Drug Policy* 63, (January 2019): 125, https://doi.org10.1016/j.drugpo.2018.08.007.

consequences for individuals and costs for communities.[14] **Deflection and diversion programs create new access** to treatment and other resources that can reduce recidivism and move people out of further justice-system processing and incarceration.

Create partnerships between public health and public safety entities to address other social issues in the community, for example:, housing insecurity, poverty, food insecurity, mental health, domestic abuse, etc.

[14] Amanda Geller et al., “Aggressive Policing and the Mental Health of Young Urban Men,” *American Journal of Public Health* 104, no. 12 (December 2014): 2321, https://doi.org/10.2105/AJPH.2014.302046; Ram Sundaresh et al., “Exposure to the US Criminal Legal System and Well-Being: A 2018 Cross-Sectional Study,” *American Journal of Public Health* 110, no. S1 (January 2020): S116, https://doi.org/10.2105/AJPH.2019.305414.

3. Building Support for Deflection and Diversion Programs

By reviewing this section of the guide first responders will be able to:

1. Explain the evidence on the benefits of diversion and deflection programs to community stakeholders and agency personnel;
2. Develop strategies for building support for your local diversion and deflection implementation efforts; and
3. Use examples to develop presentations and other materials to communicate the benefits of diversion and deflection programs.

All new initiatives require support of policymakers, community stakeholders, and the organizations carrying out the implementation efforts. PAARI has supported police and public safety agencies with technical assistance throughout the country, who are not only new, but seek to reimagine the way police address the challenge of substance use in their communities. From police chiefs to front-line personnel and from policy makers to community organizations, these approaches have been initiated and championed by individuals with various roles and responsibilities. Regardless of your role, there are several ways to build support for implementation within your community.

Section A: Promote the Evidence on Effectiveness

First responders can build support by promoting the key evaluation study findings that demonstrate the effectiveness of deflection and diversion programs:

> **Save Lives and Reduce Harms of Substance Use.** Research has shown that when individuals participate in evidence-based treatment, they are less likely to die from substance use.[15] For example, a review of medication for opioid use disorder (MOUDs) studies, found that MOUD access leads to a reduction in both overall mortality and overdose mortality.[16] Community-level evaluation of Massachusetts agencies that adopted a post-overdose outreach program found a 6% reduction in fatal overdose rate *annually* for each year of the program relative to communities

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[15] Marc R. Larochelle et al., "Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study," *Annals of Internal Medicine* 169, no. 3 (June 2018): 137-145, https://doi.org:10/7326/M17-3107.

[16] Jun Ma et al., "Effects of Medication-Assisted Treatment on Mortality Among Opioids Users: A Systematic Review and Meta-Analysis," *Molecular Psychiatry* 24, (June 2018): 1868-1883, https://doi.org/10.1038/s41380-018-0094-5.

with non-adopting agencies.[17] Compared to 2020, Plymouth County Outreach (MA) reported an 18% reduction in overdose deaths and Anne Arundel County (MD) Safe Stations reported an 18% decrease in all overdoses and nearly a 30% decrease in overdose deaths in 2021.[18,19] Similarly, in 2024, Hamilton County, Ohio, which has had an active Quick Response Team since 2018, reported a 52% reduction in overdoses since its peak in 2017.[20]

Connect People to Treatment and Provide Other Resources. Intake models have seen high volumes of people seeking services. For example:

- In the first year (2015-2016) of the Angel Program, initiated by Gloucester PD, 376 people sought assistance (31 per month), and about 95% of those were referred to treatment.[21]
- In the first two years of *The Champion Plan* in Brockton P.D., 92% of 818 intakes (34 per month) were successfully enrolled in treatment at a facility or in the community.[22]
- A Way Out (AWO) program in Lake County, IL connected 758 people to treatment in little over 4.5 years of operation across multiple police departments (14 per month).[23]

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[17] Xuan et.al., "Association of Implementation of Postoverdose Outreach Programs," 468-477.
[18] John Guilfoil, "Plymouth County Outreach Advisory Board Releases Statement on 2021 Annual Report," Plymouth County Outreach, Plymouth County Outreach, March 24, 2022, https://plymouthcountyoutreach.org/plymouth-county-outreach-advisory-board-releases-statement-on-2021-annual-report/
[19] Anne Arundel County and Annapolis Police Departments, *Opioid-Related Data: Anne Arundel County, Including City of Annapolis as of December 31, 2022*, https://www.aahealth.org/sites/default/files/2023-07/ORD-12-31-22.pdf.
[20] Hamilton County Addiction Response Coalition. (2024). *Annual report: State of the addiction crisis*. https://bit.ly/3Yj0oO4.
[21] Davida M. Schiff et al., "A Police-Led Addiction Treatment Referral Program in Gloucester, MA: Implementation and Participants' Experiences," *Journal of Substance Abuse Treatment* 82, (September 2017): 45-46, http://dx.doi.org/10.1016/j.jsat.2017.09.003.
[22] Sean P. Varano, Pamela Kelley, and Nicholas Makhlouta, "The City of Brockton's 'Champion plan': The Role of Police Departments in Facilitating Access to Treatment, *International Journal of Offender Therapy and Comparative Criminology* 63, no. 15-16 (2019): 2630-2653, https://doi.org/10.1177/0306624X19866127.
[23] Reichert, Jessica, Lily Gleicher, and Sharyn Adams. "A Preliminary Outcome Evaluation of Lake County's Police Referral to Substance Use Disorder Treatment Program. Illinois Criminal Justice Information Authority. May 30, 2021.
https://icjia.illinois.gov/researchhub/articles/a-preliminary-outcome-evaluation-of-lake-county-illinois-police-referral-to-substance-use-disorder-treatment-program.

- Between April 2017 and December 2018, Anne Arundel County (MD) Safe Stations program connected 70% of 5,131 eligible people to treatment.[24]

Post-overdose follow-up can navigate a high percentage of successful contacts to treatment. For example:

- 54% of individuals engaged by Tempe (AZ) PD's post-overdose engagement program staff accepted referral or services, including community- or institutional-based treatment.[25]
- Plymouth County Outreach (MA) made 809 home visits in 2021 with 74% of individuals accepting services in the comfort of their own homes even after many had declined services at the hospital.[26]

Reduce Justice System Involvement and Associated Costs for Individuals. A systematic review of deflection/diversion initiatives showed that these programs are effective in preventing future offending and contact with the criminal justice system.[27] Deflection and pre-arrest diversion programs not only directly reduce justice system involvement for the offense that initiated the contact (and would have led to arrest under enforcement-focused approaches), but they also reduce the likelihood of subsequent arrest after participation.[28] Each arrest, prosecution, and incarceration avoids harms associated with these experiences.

Evaluations of the LEAD program in Seattle found that 6-months after participants entered the program, the likelihood of recidivism for participants decreased by 57% relative to the comparison group of non-participants.[29] In addition, Anne Arundel County (MD) reported declines in robberies (-25%), aggravated assaults (-15%), thefts (-22%), burglaries (-37%), and thefts from automobiles (-28%); compared to

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[24] Steve Thomas, Jennifer Corbin, and George S. Everly, "Anne Arundel County Safe Stations," *Crisis, Stress, and Human Resilience: An International Journal* 4, no. 4 (June 2023): 216, https://www.crisisjournal.org/article/77943-anne-arundel-county- safe-stations.

[25] Michael D. White et al., "Moving Beyond Narcan: A Police, Social Service, and Researcher Collaborative Response to the Opioid Crisis," *American Journal of Criminal Justice* 46, no. 4 (July 2021): 636, https://doi.org/10.1007/s12103-021-09625-w.

[26] Plymouth County Outreach. (2021). *In the community: Making an impact.* https://plymouthcountyoutreach.org/in-the-community/

[27] Etienne Blais et al., "Diverting People who use Drugs from the Criminal Justice System: A Systematic Review of Police-Based Diversion Measures, *International Journal of Drug Policy* 105 (July 2022), https://doi.org/10.1016/j.drugpo.2022.103697.

[28] Zgierska et al., "Pre-Arrest Diversion to Addiction Treatment," 8.

[29] Susan E. Collins, Heather S. Lonczak, and Seema L. Clifasefi, "Seattle's Law Enforcement Assisted Diversion (LEAD): Program Effects on Recidivism Outcomes," *Evaluation and Program Planning* 64 (October 2017): 49-56, https://doi.org/10.1016/j.evalprogplan.2017.05.008.

before and after implementing Safe Stations throughout the county.[30] Moreover, the Tucson Police Department's deflection program has shown to be more effective in reducing the frequency of illegal drug use compared to traditional arrest.[31]

Save Economic Resources Compared to Standard Enforcement Approaches. According to the National Institute of Drug Addiction (NIDA), treatment is far less costly than incarceration; the average cost per year for an individual to be incarcerated is $24,000, compared to receiving substance use treatment for *only* $4,700 per year. [32] Research specific to diversion programs found that operational costs are not prohibitive and decrease after initial start up. For example, the LEAD program in Seattle demonstrates that average costs of the program (which includes part of district attorney time in the pre-booking diversion process) was less than $11,000 per year per participant or about $900 per month per participant. These costs decreased to about $530 after 2.5 years of adoption.[33] These costs are far lower than typical costs associated with arrest, prosecution, and, especially, supervision or incarceration. One study found that treatment would save over $17,500 in the societal costs of crime, which includes justice-system expenditures, in a 6-month period in California.[34]

A 2022 evaluation of the Tucson Police Department's Deflection Program showed a cost savings of $13.40 in personnel costs per incident and less personnel time used for deflection programs compared to traditional arrest. Moreover, Tucson Police projected that their jail and justice system expense savings for the project exceeded $640,000 compared to traditional arrest processes.[35]

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[30] Lt. Steve Thomas, Jennifer Corbin, and George S. Everly, "Anne Arundel County Safe Stations," *Crisis, Stress, and Human Resilience: An International Journal* 4, no. 4 (June 2023): 216, https://www.crisisjournal.org/article/77943-anne-arundel-county- safe-stations.

[31] Josephine Korchmaros, et al., *Costs, Cost Savings, and Effectiveness of a Police-led Pre-Arrest Deflection Program*, Tucson, AZ - University of Arizona: Southwest Institute for Research on Women, 2022.

[32] National Institute on Drug Abuse, "Principles of Drug Addiction Treatment: A Research-Based Guide (3rd Eds.)," *U.S. Department of Health and Human Services*, (January 2024) https://archives.nida.nih.gov/sites/default/files/podat-3rdEd-508.pdf.

[33] Susan E. Collins, Heather S. Lonczak, and Seema L. Clifasefi, "Seattle's Law Enforcement Assisted Diversion (LEAD): Program Effects on Criminal Justice and Legal System Utilization and Costs," *Journal of Experimental Criminology* 15, no. 2 (March 2019): 201-211, https://doi.org/10.1007/s11292-019-09352-7.

[34] Emanuel Krebs et al., "The Costs of Crime During and After Publicly Funded Treatment for Opioid Use Disorders: A Population-Level Study for the State of California." *Addiction* 112, no. 5 (May 2017): 838-851, https://doi.org/10.1111/add.13729.

[35] Korchmaros et al., "Costs, Cost Savings, and Effectiveness," 2.

Section B: Promote the Benefits to the Organization

Adoption of innovative practices can come from leadership or key champions within the organization and in response to evolving external contexts (e.g., public attitudes, peer agency, professional associations). Those seeking to champion the model within their organizations should highlight that, in addition to evidence of effectiveness, **adopting deflection and diversion programs**:

> **Aligns with Public Support for Addressing Community Substance Use Challenges with Treatment Rather Than Enforcement and Incarceration.** A national survey in 2017 found that 65% of respondents preferred getting an offender into a treatment program for individuals found in possession of opioids instead of serving time in jail.[36] Survey research from Virginia shows that 80% of respondents supported the expansion of community-based treatment programs being provided in their respective communities over arrest.[37] Regardless of the community you serve, support is high for alternatives to enforcement-only approaches.

> **Can Help to Build Trust Among Communities Particularly Impacted by Disparate Treatment in Arrest, Prosecution and Incarceration.** People of color are disproportionately affected by enforcement-only approaches to substance use and related behaviors due in-part to socioeconomic inequality.[38] Creating deflection and diversion programs that are applied equitably and equally in communities can greatly repair the harms associated with enforcement and may improve perceptions of trust. (*See* "*Building Successful Partnerships Between Law Enforcement and Public Health Agencies to Address Opioid Use*").

> **Places the Agency in Line with a Large and Growing Group of Police Agencies Adopting Deflection and Diversion Programs.** A national survey in 2020, sponsored by Bureau of Justice Assistance, identified 659 first-responder deflection programs that included at least one deflection or diversion program.[39] Most (82%) of

[36] Amy Cook and Henry H. Brownstein, "Public Opinion and Public Policy: Heroin and Other Opioids.," *Criminal Justice Policy Review* 30, no. 8 (November 2017): 1163-1185, https://doi.org/10.1177/0887403417740186.

[37] Amy Kyle Cook and Nicola Worcman, "Confronting the Opioid Epidemic: Public Opinion Toward the Expansion of Treatment Services in Virginia," *Health & Justice* 7, no. 1 (July 2019): 4-5, https://doi.org/10.1186/s40352-019-0095-8.

[38] Marc Mauer and Nazgol Ghandnoosh, *Incorporating Racial Equity into Criminal Justice Reform*, Washington, D.C.: The Sentencing Project, 2014.

[39] NORC at the University of Chicago, Center for Health and Justice at TASC, and BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program, *Report of the National Survey to Assess First Responder Defection Programs in Response to the Opioid Crisis*, 2021.

these programs were adopted between 2016 and 2019 (the last full year studied).[40] The adopting agencies are supported by major federal and state justice agencies and major foundations through policy guidance and funding.

Section C: Promote the Ease of Implementation

Although resources and coordination are necessary to implement novel deflection and diversion programs, agencies of all types, sizes, and regional locations have done so successfully. Those seeking to implement should recognize and promote the idea that **implementation is not overly challenging**, by emphasizing:

Funding and Implementation Supports are Available. The Bureau of Justice Assistance-sponsored survey found that programs were supported by a variety of funding sources, including federal and state grants.[41] Over $50 billion in Opioid Settlement Funding or Opioid Abatement Funding is newly available over the next 18 years due to civil case settlements involving pharmaceutical companies found responsible for contributing to the opioid epidemic (learn more on our website).[42] Technical assistance from PAARI and other organizations, including PAARI's State-by-State Opioid Settlement Fund Guide, and guidance from peer-agencies can assist with overcoming challenges of implementation. For additional information on funding sources see this resource available on PAARI's website, which is updated regularly.

Potential Partners (Public Health, Social Work And Community-Based Organizations) Support the Model and Are Ready to Do So in Many Communities. Promoting pathways to treatment is part of the core mission of these kinds of organizations and many of them have partnered with law enforcement agencies throughout the country. The multidisciplinary collaborations done within HUB Models in many sites, including PAARI's HUB in Plymouth County, MA, are excellent examples of willingness of local service providers and community organizations to work together on complex problems.

Timelines From Formulation to Implementation Can Be Relatively Quick. Intake programs can begin navigating individuals to treatment within months as was seen in several early adopters of the model.[43] For example, a process evaluation of a

[40] Ibid, 7.
[41] Ibid, 39.
[42] National Academy for State Health Policy. (n.d.). *State opioid settlement spending tracker.* https://nashp.org/state-tracker/state-opioid-settlement-spending-decisions/
[43] Zgierska et al., "Pre-Arrest Diversion to Addiction Treatment," 5-6.

program run by Madison Police Department in Wisconsin determined that development started in October 2016, and began diverting people by September 2017.

Leadership Support and Training Can Help Officer Buy-In and Engagement with Deflection Efforts. In many communities, first responders are supportive of deflection and diversion efforts that improve outcomes for individuals with substance use disorders, mental illness, and other social issues. For example, one study, completed in 2021, found that after a LEAD training, 72% of the officers were likely/extremely likely to divert within the model; less than 6% were unlikely/extremely unlikely to divert.[44] Additionally, process evaluations of the Tempe, AZ program describe officers as supportive of the program.[45]

PAARI has heard of the shifting mindset among law enforcement personnel many times. Leadership and training is critical to the engagement of officers and personnel in deflection programs:

- Hear Chief Bosse of the Georgetown, PD (KY) talk about his own personal and professional growth and the impact of his department's program on officers: *https://vimeo.com/713701141#t=16m10s&share=copy*
- Hear Lt. Jeremiah Nicastro from Gloucester, PD discuss the rewarding experience of truly helping people through alternatives to arrest: *https://vimeo.com/713726113#t=7m43s&share=copy*
- Hear from Chief Steven D'Agata discussing the importance leadership and buy-in to support his deflection initiative: https://vimeo.com/1062904142/415cb9ccc8?share=copy

Resources Can Be Disseminated to all Programs with Similar Aims and Personnel. Many police departments and their community partners have adopted multiple deflection and diversion initiatives that address behavioral health challenges, including a Co-Response model and utilizing Mobile Crisis Units. These examples can integrate easily with substance use deflection and diversion programs because they share similar aims and protocols. Agencies also have programming

[44] Lonnie Schaible, Lauren Grant, and Stephanie Ames, "The Impact of Police Attitudes Towards Offenders on Law-Enforcement Assisted Diversion Decisions," *Police Quarterly* 24, no. 2 (September 2020): 205-232, https://doi.org/10.1177/109861112096071.
[45] White et al., "Moving Beyond Narcan," 633-634.

staff already in place that can help to initiate implementation, coordinate early efforts, and secure funding. One example includes programs developed by the non-profit "Face Addiction Now" in Michigan. Their early deflection program, Hope Not Handcuffs, started as a single walk-in model program, but quickly branched out into additional programs that include harm reduction, post-overdose response, naloxone training, and recovery coaching.

4. Determining the Populations of Focus

By reviewing this section of the guide, first responders will be able to:

1. Understand the important challenges and promising practices that other programs have used to decide who their deflection and diversion programs will serve;
2. Recognize the public health principles that guide delivery of services within deflection and diversion to a wide range of individuals who use drugs;
3. Consider issues with inclusion and exclusion criteria for each component of your deflection and diversion program.

One of the first key decisions deflection and diversion program implementers must make, is to define the population that will be eligible for participation. Two principles guide this determination.

1. Deflection and diversion programs seek to provide services to the broadest population of individuals at risk for drug abuse. The initial emphasis for programs had been opioid use, but now, most programs address all substances, including alcohol, mental health disorders, co-occurring disorders, and other social issues.
2. All individuals are deserving of services. **There is no public health justification for excluding individuals based on criminal history or other justice-system statuses.**

Section A: Define Eligibility Requirements & Populations of Focus

Program parameters should be the least restrictive to ensure all pathways are available for individuals needing help with problematic substance use, even though many deflection and diversion programs define eligibility parameters depending on the pathway to resources. For example, a post-overdose follow-up program will narrow the population to those that have experienced a recent non-fatal overdose. An intake program will have the broadest target population because it aims to create pathways to treatment for most individuals with substance use disorders that contact program sites for assistance. Certain street outreach programs might focus on areas known to have populations of people who use drugs with a different set of criteria for inclusion. Overtime, many programs incorporate multiple pathways to broaden their reach.

Section B: Select Exclusion Criteria

Program developers also frequently specify **exclusion criteria** for various components of the model. Exclusion criteria are often based on organizational capacity, real or perceived

demands of local policymakers, state regulations, or external funding requirements. Several characteristics are often debated in the context of program implementation, including existing warrant status, offense types committed at point of contact, if applicable, other existing supervision status (e.g., parole or probation), and criminal history prior to point of contact. There is little guidance about the appropriateness of these criteria for program success.

Section C: Warrant Status

One important area to consider is the practice around warrant checking; a policy which can have substantial implications for connecting people to treatment through deflection and diversion programs. A 2019 survey of Massachusetts Police Departments found that 57% of post-overdose outreach programs checked warrants prior to outreach. Of this majority, 19.6% of post-overdose outreach was performed without addressing warrants, 15.9% was delayed until warrants were cleared, 8.0% ended in arrest of the survivor, 7.2% took a situational approach, and 6.5% ended up not performing outreach.[46] Ultimately, warrant checks can cause barriers to providing services for overdose survivors. Warrant checking and police participation should be established at the discretion of each program and/or on a case-by-case basis. If warrants are to be checked, there should be a clearly defined and communicated procedure that officers take.

> ***Promising Practice Recommendation:*** Avoid including warrant status as exclusion criteria, particularly for intake, outreach, and overdose follow-ups. Checking warrants may be more appropriate for pre-arrest diversion, and the practice is virtually unavoidable in most post-arrest diversion procedures.
>
> ***Promising Practice Recommendation:*** If you are required to check warrants due to state or local policy, have a process in place that allows for discretion from higher ranking staff or one that would allow the local court to re-docket cases when possible.
>
> - The Hope Not Handcuffs program procedures explicitly state that the warrants "may" affect eligibility and that shift supervisors have the discretion to allow participation based on several factors.

[46] Marco E. Tori et al., "Warrant Checking Practices by Post-Overdose Outreach Programs in Massachusetts: A Mixed-Methods Study, *International Journal of Drug Policy* 100 (February 2022), https://doi.org/10.1016/j.drugpo.2021.103483.

- The Safe Passage program in Illinois had a process in place for officers to contact the state's attorney, which resulted in most of the existing warrants being vacated.
- The Plymouth County Outreach program has recovery coaches conduct follow ups by phone in the event that a warrant exists, ensuring that individuals with warrants have the opportunity to clear up their warrants or have access to services the same way an individual without a warrant would.

Section D: Offense Types at Point of Contact

Individuals might be in possession of drugs or drug paraphernalia when they arrive at an intake site or when contacted through outreach activities in public or private spaces. Intake and outreach programs should minimize barriers to access treatment and recovery and should not exclude individuals who are voluntarily seeking resources, while in possession of drugs or drug paraphernalia. However, implementing agencies must decide on the appropriateness of diversion for certain offenses in addition to drug possession when conducting enforcement activities and pre-arrest diversion practices.

> ***Promising Practice Recommendation:*** Avoid overly restrictive exclusion criteria around offenses committed during the contact. For example, possession of illegal substances or paraphernalia offenses should **not** be added to exclusion criteria for any deflection components of your comprehensive model. This ensures a more inclusive and effective approach, addressing underlying issues and promoting harm reduction within the framework of diversion.
>
> Assess the offense types added to exclusion criteria with data from existing sources. Existing pre-implementation arrest data is a window into determining how exclusion criteria will affect the number of people eligible for deflection and diversion programs.
>
> Build discretion into your exclusion criteria based on offense type criteria. For example, the MARI program in Madison, WI, allows exceptions with approval from higher-level staff. For more information, refer to the policy and procedure section.

5. Developing Policies & Procedures

By reviewing this section of the guide, first responders will be able to:

1. Comprehend each type of deflection and diversion program's key procedural steps and central issues that must be included in policies.
2. Develop written sections that can be included in your local program's policy and procedures, recognizing the importance of local laws, policies and priorities.

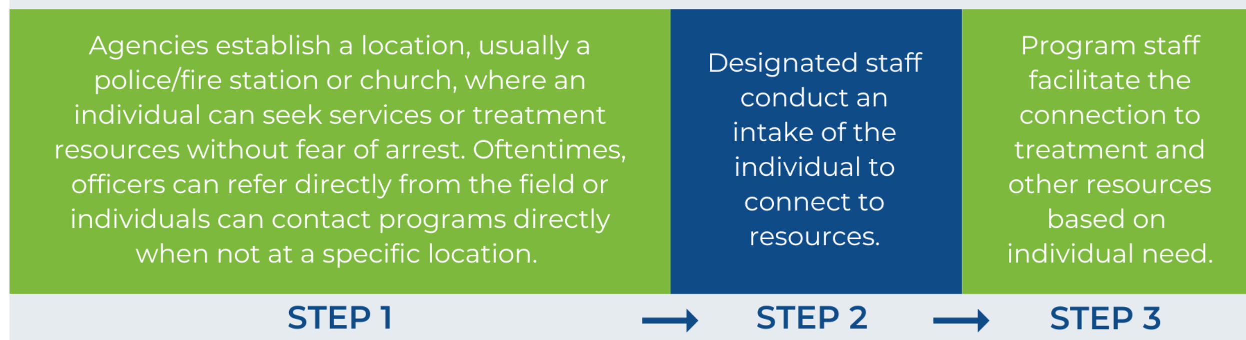
The policies and procedures that you develop for your deflection and diversion programs will be used to fit specific components that you are implementing. This section is set up to guide you on procedures for intake, outreach, and diversion programs. For each section, there are key issues or decisions that must be discussed with partners and stakeholders.

Section A: Self-Referral & Officer-Referral Program Procedures

Self-referral and officer-referral are some of the easiest ways to begin connecting people who use drugs to treatment and other services. The first example of this type of program was the Angel Initiative adopted by Gloucester Police Department in Massachusetts. This program created new opportunities for treatment by establishing a partnership with treatment providers and setting up procedures to receive individuals seeking help.

The basic steps of intake and officer-referral programs are straightforward:

1. Agencies establish a location, usually a police department, fire station or church, where an individual can come in to seek services or treatment **without the fear of being arrested**. Oftentimes, people can call directly to a hotline or use an online form for resources when not at a specific walk-in location. Officers are also able to refer directly to program staff/resource partners from the field.
2. Designated staff conduct an intake of the individual to connect them to resources.
3. Program staff or volunteers then navigate the individual to treatment programs and other services they may need.



Key Issues & Promising Practice Recommendations:

Establish Treatment And Recovery Pathways Before The Start Of Any Program. Direct connection to community resources is critical to program success.

> ***Promising Practice Recommendation:*** Direct connections to treatment and recovery resources (harm reduction, detox, inpatient, outpatient, telehealth, counseling, co-occurring -serious mental health disorders, recovery residences, etc.) should be developed before launching. Basic needs resources, such as housing, food, and finding employment , are critical to include in the list of resources. The list of resources and connections to care will expand as the program grows and more resources are identified.

Establish Key Staff And Engage Persons With Lived Experience. Many programs include persons with lived experience (paid), volunteers with or without lived experience (unpaid), and/or clinicians and social workers working with law enforcement to help people access resources.

> ***Promising Practice Recommendation:*** The key to these public health and public safety relationships is a warm handoff to recovery resources and support through the recovery process. Persons with lived experience (peers) can provide vital support for participants throughout the process.[47] Peer personnel can be embedded directly with law enforcement or contracted with an outside agency to provide support.

[47] Alan B. McGuire, "Emergency Department-Based Peer Support for Opioid Use Disorder: Emergent Functions and Forms," *Journal of Substance Abuse Treatment* 108 (January 2020): 2. https://doi.org/10.1016/j.jsat.2019.06.013.

Some programs use a combination of trained volunteers and a hotline staffed by peers or have Mobile Crisis Units (CIT officer, care coordinator, and/or clinician) that respond to a call in the field or when there is a designated walk-in location. (*See Hope Not Handcuffs NY and Anne Arundel County*)

Most Angel Initiatives Are Not Solely Focusing On Self-Referral And Have More People Referred To Treatment When They Provide A Variety Of Entry Points Into Recovery.

Promising Practice Recommendation: Most programs find that Angel Initiatives/Walk-In Models are more effective when officers are able to refer people to the program in the normal course of their duties. In addition to officer referrals, some programs broaden their scope to include post-overdose outreach (teams refer people to treatment and resources after they have overdosed), active outreach (teams actively seek out individuals who use drugs, have co-occurring mental illness, and/or at risk for overdose and refer to treatment), or Hub Situation Tables (multiple community service organizations and first responder organizations meet to develop interventions for persons at risk for overdose or other issues that lead to increases in hospitalization, suicide, arrest, etc.).

No-Arrest Policy. Individuals seeking assistance by showing up at intake sites, such as police departments, may be in possession of drugs. This type of program's intent is clearly to aid without any threat of arrest.

Promising Practice Recommendation: Make clear in all documentation promoting the program, policy and procedures, that arrest is not a possibility for anyone that seeks assistance. The purpose of these programs is to connect persons in need to treatment and recovery resources. These programs are voluntary and are not to be used for enforcement and intelligence gathering purposes. Special considerations on active warrants should be clear in the program description. A good example of this practice is the Hope Not Handcuffs program that includes explicit guidance in their procedures prohibiting the gathering of intelligence.

Section B: Post-Overdose Follow-up Outreach Procedures

Post-overdose follow-up has been implemented in various ways. It is a critical part of deflection and diversion programs because it seeks to engage individuals that have experienced an overdose and are at high risk for subsequent overdose and other harms. The overdose event brings these individuals to the attention of emergency medical

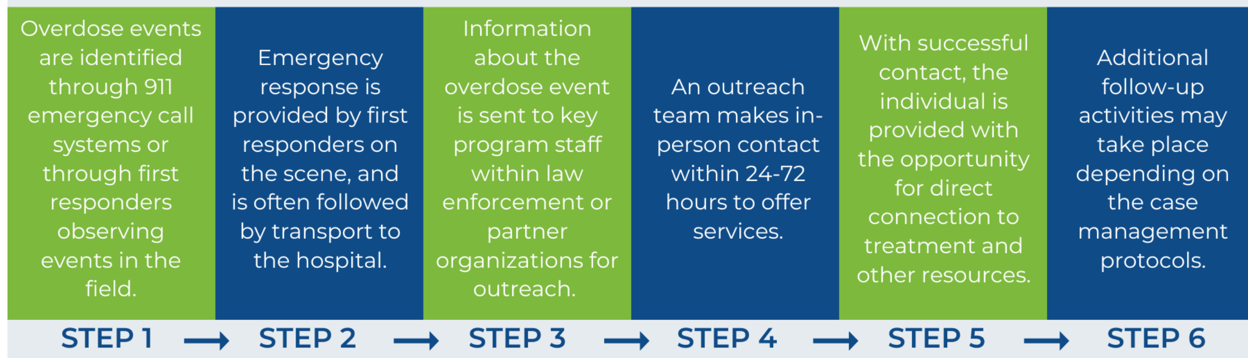
providers and police, which is a critical time for helping navigate people towards treatment.[48]

Police agencies are an essential part of post-overdose outreach because they often initiate the process. Overdoses are frequently reported through the 911 emergency systems operated by local law enforcement agencies or are observed directly by officers on patrol in public spaces. In agencies where officers are already equipped and trained to use Naloxone, the medical response they provide as first responders can be vital to a person's survival. Agencies implementing post-overdose follow-up programs must craft specific procedures that occur once an emergency response has concluded, and the follow-up process can be initiated.

The basic steps of an overdose follow-up response are straightforward:

1. Overdose events are identified through 911 emergency call systems or through first responders observing events in the field.
2. Emergency response is provided by first responders on the scene, and is often followed by transport to the hospital.
3. Information about the overdose event, including individual's contact information, is sent to key program staff within the law enforcement or partner organizations for outreach.
4. An outreach team, often consisting of police/public safety personnel, civilian clinicians, people with lived experience, or partner organization staff, conducts follow-up outreach through in-person visits or by phone. The contact usually occurs within 24 - 72 hours after the initial event.
5. With successful contact, the outreach team offers resources and direct connections to treatment.
6. Additional follow-up activities may take place depending on the case management protocols.

[48] Bradley Ray et al., "Post-Overdose Follow-Up in the Community with Peer Recovery Specialists: The Lake Superior Diversion and Substance Use Response Team," *Drug and Alcohol Dependence Reports* 6 (March 2023): 3. https://doi.org/10.1016/j.dadr.2023.100139.



Key Issues & Promising Practice Recommendations:

Medical Information Privacy. Protecting privacy for people who overdose is a concern. While police do not have the kinds of legal constraints on sharing 911 or other police data with any partners involved in the response, medical providers do have legal barriers to sharing protected information, for example substance use disorder or mental health related information. Additional guidance on privacy regulations in public health and public safety partnerships is here.

> The county-wide Plymouth County Outreach program is a model example of sharing information between partners within their Critical Information Management System (CIMS). Program staff have set up extensive protocols that describe access, information to be shared, training on the system, security, and other details.
>
> Hamilton County (OH) Quick Response Team and LEAD programs utilize a Cordata data platform to record clients' demographics, contact information, dates and outcomes of communications with clients and other parties, and case management. The system is secure and limited to key team members.

Legal Violations. During an overdose event, the person that overdosed and those around the individual may be in violation of drug laws based on their possession of drugs and paraphernalia. As discussed in the target population section, there is no public health justification for seeking arrest of the individual that overdosed or those who are present at the time of overdose. Arrest in these instances is antithetical to deflection programs. Many states have adopted Good Samaritan Laws - or laws that offer immunity to individuals experiencing an overdose or bystanders - to promote seeking emergency medical assistance. Check this resource to find the laws in your state as you develop your policy.

Multiple Outreach Attempts. Sometimes, individuals and/or their families/friends are unable to be reached during first, second, or even third attempts of outreach. Many departments conduct multiple outreach visits in person or by phone before deciding to discontinue their efforts. If an individual cannot be located at the address listed in the most recent report, some agencies will comb through other reports to find other known addresses for the individual, or they will try reaching out to other parties listed in the report to see if they might know where an individual can be located.

Outreach in Uniform and Marked Cruisers or in Plain Clothes and Unmarked Cruisers. The intention behind post-overdose outreach is to offer services and resources to individuals who are at heightened risk of subsequent overdose and other harms. Although there is no evidence that uniformed officers or marked cruisers can negatively affect the outreach event, some departments have opted to have officers in plain clothes and in unmarked cruisers. Officers accompanying outreach workers or clinicians may be dressed in plain clothes and drive in unmarked cruisers, both so individuals feel more comfortable, and so that undue attention is not drawn to citizens receiving help, potentially revealing that they are using drugs to their neighbors. Nonetheless, many outreach teams and Quick Response Teams respond in uniform and marked cruisers and have successful engagement with the community.

Secondary Outreach. The focus of most outreach models is the individual that overdosed. However, in one community, family members and third parties administered a dose of nasal naloxone to a person overdosing before first responders arrived on the scene in 26% of overdose cases.[49] Therefore, many implementing agencies do extend outreach to others around the individual who are also at risk for harms associated with drug use.[50] Research shows the social proximity to an overdose is also associated with increased risk for an overdose.[51] This makes extending outreach to individuals around those a valuable opportunity to offer harm reduction services and connection to treatment. This is not only because an individual's opioid tolerance can become rapidly reduced within just a few days

[49] Pamela Kelley and Sean Varano, *Plymouth County Outreach: 2021 Annual Report*, Kelley Research Associates, 2022.
[50] Scott W. Formica et al., "Characteristics of Post-Overdose Public Health-Public Safety Outreach in Massachusetts," *Drug and Alcohol Dependence* 219 (February 2021), https://doi.org/10.1016/j.drugalcdep.2020.108499.
[51] Abby E. Rudolph, April M. Young, and Jennifer R. Havens, "Using Network and Spatial Data to Better Target Overdose Prevention Strategies in Rural Appalachia," *Journal of Urban Health* 96 (February 2019): 27-71, https://doi.org/10.1007/s11524-018-00328-y; Bradley Ray et al., "Spatiotemporal Analysis Exploring the Effect of Law Enforcement Drug Market Disruptions on Overdose, Indianapolis, Indiana, 2020–2021," *American Journal of Public Health* 113, no. 7 (July 2023): 753-756. https://doi.org/10.2105/AJPH.2023.307291.

without intake, but individuals may also obtain drugs from an unknown source whose supply is more potent with fentanyl or other drug mixtures.

When there is a drug market disruption, like a large illicit drug seizure, there is a unique opportunity to provide outreach and engagement to people who are most vulnerable to overdose. PAARI developed a Public Safety Action Guide: Addressing Overdoses After Drug Seizures, adapted from procedures that the CDC's Opioid Rapid Response Program (ORRP) employs in the aftermath of a legal drug market disruption (i.e. a prescriber's license is revoked), to address heightened risks of overdoses after an illicit opioid seizure.

Section C: Hub/Situation Table Procedures

The Hub/Situation Table Model was first implemented in Saskatchewan, Canada in 2011. "The main objective of the Hub is to provide an integrated response to at-risk, marginalized and vulnerable populations proactively, based on an understanding of composite risk factors, while improving community safety and well-being."[52] This model seeks to meet the needs of people in the community "upstream" to reduce calls to emergency medical providers and police. In this model, weekly meetings occur where first responders or treatment providers can present individuals or families they have engaged with who need services across several risk factors. Providers at the meeting then come together through a four-filter process to create a quick and direct plan to connect that individual or family to resources. This presentation of the individual or family presents all de-identifiable information to preserve the dignity and confidentiality of the person(s) needing support. Participants who plan to take part in this model must be specifically trained to ensure the integrity of the four filter process.

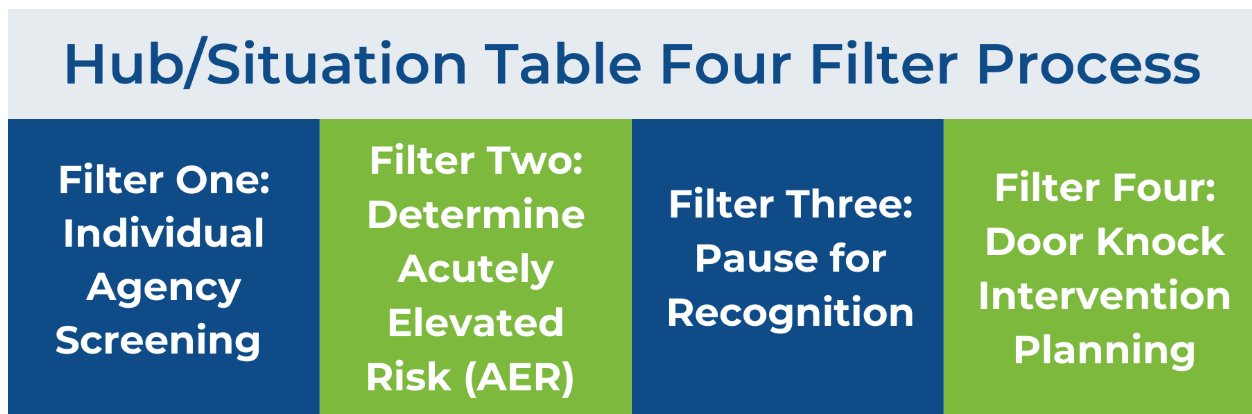
The following section outlines the **four-filter process**:

1. **Filter One: Individual Agency Screening**
    a. An individual agency/department reviews the situation of a person and/or family and determines if it meets the criteria for the situation table and if they have already expended all efforts to mitigate the situation alone.
2. **Filter Two: Determine Acutely Elevated Risk (AER)**
    a. Agency from filter one presents de-identified information to preserve confidentiality
    b. Meeting attendees determine if the situation meets the criteria for an AER:
        i. Significant interest at stake

[52] Abeba Taddese, *"Saskatchewan, Canada: The Hub Model for Community Safety"* Results for America, July 2017, https://results4america.org/wp-content/uploads/2017/07/LandscapeCS_Canada_4.pdf.

    ii. Probability of harm occurring
    iii. Severe intensity of harm
    iv. Multidisciplinary nature of elevated risk
3. **Filter Three: Pause for Recognition**
    a. Determine which agencies are already involved with the individual/family through accessing their respective data systems
    b. Determine which additional agencies are needed to meet the needs of the individual/family
4. **Filter Four: Door Knock Intervention Planning**
    a. Agencies that have recognition or can offer the services needed to support the needs of the situation opt into a smaller conversation to discuss the intervention plan
    b. An intervention plan is made by selecting which agencies will engage with the individual and/or family within 24-48 hours to offer immediate connection to assistance

Although it is not included in the four-filter process, the lead agency will be responsible for providing a brief, de-identified update on the situation at the next meeting. The report should include only the situation number and focus solely on confirming or editing the table data. A determination is made through consensus of the group whether or not a situation has been resolved (Acutely Elevated Risk reduced) or another discussion/ intervention is needed to provide support and mitigate the challenges faced. If the situation is resolved, the lead agency will continue to monitor the situation outside of the table and ask for further assistance from the table if necessary.[53]



[53] Global Network for Community Safety e-Learning Portal, *Authorized Mentor Development Program (AMDP)*, Global Network, accessed April 30, 2025, internal training program.

Key Issues & Promising Practice Recommendations:

Medical Information Privacy. Protecting the privacy of people's medical information is a concern. While police do not have the kinds of legal constraints on sharing 911 or other police data with any partners involved in the response, medical providers do have legal barriers to sharing protected information, for example SUD or mental health related information.

> ***Promising Practice Recommendation:*** With the Hub/Situation Table Model, there is an explicit requirement for non-disclosure agreements that partners sign to only take notes and be involved with situations that relate to the services provided by their respective agency/department. In addition, individual agencies determine if/when they disclose recognition of an individual based on the limits of their respective legal and ethical requirements. The Hub/Situation Table does **not** record or share any personal identifiable information, and, instead, connects agencies who can share that information with each other to ensure anonymity.

Collaboration Between Multiple Agencies. Collaboration in human services involves professionals from different disciplines working together toward a common goal. It includes sharing resources, adapting practices, and strengthening collective capacity. Collaboration benefits both service providers and clients across sectors such as mental health, social work, education, addiction, policing, and corrections. These benefits include increased support for key issues, closing service gaps, strengthening agency capacity, improving service delivery, and enhancing community resilience and understanding.[54]

> ***Promising Practice Recommendation:*** Tap into existing coalitions with various organizational partnerships already developed. Educate and encourage these organizations to participate in the Hub/Situation Table Model. Effective collaboration requires structured support at both practical and systemic levels. To facilitate this, tools, training, and ongoing support are essential. Regularly requesting feedback from organizations and departments, tracking resource gaps using de-identified data, and disseminating educational resources for new table members will assist in maintaining relationships and offering essential services.

Data Collection and Ongoing Growth. The final element of the Hub/Situation Table model is data collection, which serves multiple purposes, including identifying systemic

[54] Chad Nilson, A Statistical Snapshot of Youth at Risk *and Youth Offending in Canada*, Public Safety Canada, 2016, last modified August 9, 2022, https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2016-r001/index-en.aspx.

issues, supporting discussions, ensuring privacy, enabling evaluation, and aiding in model replication. To assist Hub/Situation Table members, Nilson, Winterberger, and Young developed guides outlining the benefits of systematic data collection, key variables to track, and best practices for conducting data-friendly meetings.[55] These resources provide guidance for Table Chairs, participants, and data-recorders.

> ***Promising Practice Recommendation:*** In Plymouth County, Massachusetts, new partnerships are periodically added to meet the gaps in services, thus improving the outcomes of the table situations. As an example, Plymouth County Hub/Situation Table noted that housing had been a factor in 64.3% of the situations presented.[56] Due to this, the coordinator connected and trained participants from the region's shelter/housing support provider. As a result, more individuals are able to gain access to the resources from this provider.

Section D: Pre-Arrest Diversion Procedures

Pre-Arrest diversion programs in policing vary a good deal–in part because of confusion between types of diversion. In particular, the procedures for pre-arrest diversion programs must create a pathway for treatment that happens prior to any arrest decision. Typically in pre-arrest diversion, officers identify eligible participants during routine enforcement activities and can choose to offer program participation instead of arrest. Participants often must report to a treatment facility or case manager for assessment and follow a prescribed treatment plan to avoid charges. Failure to follow recommended plans can result in the original charges being filed.[57] We emphasize here the steps for best practices in pre-arrest diversion following evidence-based examples from the field.

The basic steps of a pre-arrest diversion work as follows:

1. Officers identify individuals in violation of the law, but who also have signs of substance use during calls for service/patrol activities.
2. Officers gather information to determine potential eligibility for diversion.
3. Officers document information about the offense in an incident report, a civil citation, or summons issued to the individual.
4. The individual is then given the opportunity to engage in the diversion process.

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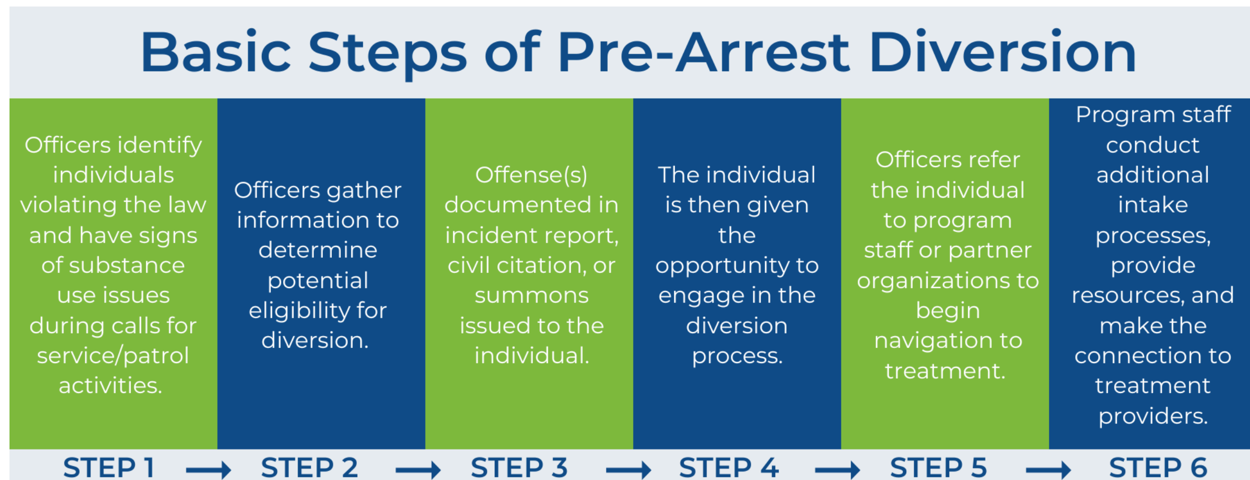
[55] Nilson, *A Statistical Snapshot*, 2016.
[56] Plymouth County HUB, 2022, "The Plymouth County HUB Data and Findings Report," Unpublished Report, https://drive.google.com/file/d/1QlIYHePVbdWBGP35no0-Eu_tOlbqaRXD/view.
[57] Bureau of Justice Administration, *Law Enforcement and First Responder Diversion, Pathways to Diversion Case Studies Series,* https://www.cossup.org/Content/Documents/Articles/Pathways_to_Diversion_Case_Studies_Series_Officer_Intervention.pdf.

5. Officers refer the individual to program staff or partner organizations to begin navigation to treatment.
6. Program staff conduct additional intake processes, provide resources, and make the connection to treatment providers.



Key Issues & Promising Practice Recommendations:

Direct Navigation to Program & Treatment. Process evaluations of diversion programs and previous program guidance emphasizes the importance of immediate connection to case managers and treatment providers.[58] This process is typically described as a ***"warm handoff."*** For example, officers divert the person to a case manager, who then can involve treatment providers and other recovery resources. Delays related to treatment and recovery resource connection, travel, and other barriers can reduce the likelihood of engagement in treatment. [59]

Promising Practice Recommendations:

1. Dedicate program staff that are available at all times of day to receive referrals from officers and continue the program process.

2. Establish opportunities to provide for travel from contact location to relevant staff or vice versa.

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[58] Dina Perrone, Aili Malm, and Erica Jovanna Magana, "Harm Reduction Policing: An Evaluation of Law Enforcement Assisted Diversion (LEAD) in San Francisco," *Police Quarterly* 25, no. 1 (2022): 10. https://doi.org/10.1177/10986111211037585.
[59] Mary Ann Priester et al., "Treatment Access Barriers and Disparities Among Individuals with Co-Occurring Mental Health and Substance Use Disorders: An Integrative Literature Review," *Journal of Substance Abuse Treatment* 61 (February 2016): 48. https://doi.org/10.1016/j.jsat.2015.09.006.

Conditions to Maintaining Diversion Status. In pre-arrest, and more frequently, in post-arrest diversion programs, there can be explicit conditions for maintaining diversion status. Since some form of arrest information is documented and "held in abeyance," police and/or prosecutors can reinitiate the legal process if conditions are violated. For example, the LEAD program in New Bedford, MA generally requires individuals to complete the intake process within seven days, unless participants are engaged with program staff and explain why they need an extension. MARI program in Madison, WI, requires individuals to a) adhere to treatment and b) not re-offend for 6-months before the arrest is voided. Implementers must consider the implications of such conditions.

Promising Practice Recommendations:

1. *Create minimal standards for treatment participation as a condition of the diversion status.* Conditions are inherently coercive and if arrest is imposed, it ultimately leads to the harms associated with justice-system processes and incarceration. Treatment is unlikely within jail or prison and reentry after incarceration places people who use drugs at heightened risk for overdose.[60]
2. *Creating opportunities for re-engagement in treatment processes is central to pre-arrest diversion programs.* Program staff can document information about the potential arresting offense and program progress through case management data, which then can be included as part of the intake assessment. According to studies, approximately 40-60% of individuals with a substance use disorder will relapse at some point in their recovery journey, increasing their risk of being caught possessing drugs and/or committing crimes related to their drug use.[61] Individuals who have substance use disorders will have periods where they are engaged in treatment followed by periods where they return to using.[62] Having this information on hand can help foster meaningful treatment re-engagement discussions after a relapse.

Potential for Net Widening. Net widening is a potential unintended consequence for any diversion program, especially post-arrest diversion. Net widening is well known in diversion research and refers to the idea of imposing a higher level of involvement or sanctions than

[60] Grant Victor et al., " Jail and Overdose: Assessing the Community Impact of Incarceration on Overdose," *Addiction* 117, no. 2 (February 2022): 433-441, https://doi.org/10.1111/add.15640.
[61] National Institute on Drug Abuse, "Treatment and Recovery," *Drugs, Brains, and Behavior: The Science of Addition*, (July 2011).
http://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery.
[62] Ibid.

would typically be the case in an effort to provide alternatives.[63] For example, in post-arrest diversion programs, officers might respond to incentives created by program adoption to engage in *more* arrests of people who use drugs than would normally be the case in their routine discretionary decisions. This often results in the unintended consequences of greater exposure to arrest, prosecution, and incarceration for individuals and higher criminal justice-related costs.

Promising Practice Recommendations:

1. Monitor arrest data for unintended increases. Increasing frequency of arrests for offenses that would be eligible for diversion may be a sign that officers are engaging in behaviors consistent with net widening and reducing the effectiveness of the program.
2. Wherever possible, emphasize the use of pre-arrest diversion, rather than post-arrest diversion. The arrest experience has negative consequences for people who use drugs.
3. Differentiate the target populations for pre-arrest and post-arrest procedures such that individuals that are ineligible for a pre-arrest diversion due to the offense at contact might be eligible for a post-arrest diversion. One aim of pre-arrest is to avoid arrest for individuals eligible and likely to be arrested; the goal of post-arrest is to avoid the adjudication process. Because the post-arrest diversion takes place at a more significant decision point (e.g., booking and potential prosecution), agencies may see it as more appropriate to have individuals with more serious offenses diverted at this point than through pre-arrest.

Officer Engagement with Program Practices. Pre-arrest (and post-arrest) diversion programs rely in most circumstances on patrol officers initiating the process. Departments can develop buy-in and support from officers in a variety of ways, including training and awareness efforts, but they can also promote engagement through policy and protocol.

Promising Practice Recommendations:

1. Regular review of arrest reports made for eligible offenses to determine if the case might have been appropriate for diversion. New Bedford P.D. 's protocol explicitly calls for district attorneys receiving arrest reports of

[63] Robin S. Engel et al., “Alternatives to Arrest,” *The Power to Arrest* (Switzerland: Springer, 2019), 75-122, https://doi.org/10.1007/978-3-030-17054-7_4.

potentially eligible cases to refer them back to the department for assessment of program participation.

2. Build appropriate diversion activities into the performance evaluation of officers. The evaluation should not be based on frequency metrics alone to avoid creating incentives for net widening and should also include an examination of the diversions relative to arrest levels and their appropriateness for the program.
3. Consider having regular meetings or a feedback loop that updates officers on the follow-up status of individuals they deflect or divert to help with buy-in and connection to the program.[64] Not only will semi-regular meetings update officers on a participants' status, but it will also allow them the chance to offer feedback about the program to leadership. A review of Seattle's LEAD program found that police officer buy-in and participation in that program was significantly improved when officers felt that they had a voice in the program and could give their input.[65]

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[64] Kurt August et al. "Law Enforcement and First Responder Deflection Pathways to Deflection Case Studies Series," Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP), Bureau of Justice Assistance (BJA), December, 2022, LINK

[65] Katherine Beckett, *Seattle's Law Enforcement Assisted Diversion Program: Lessons Learned From the First Two Years*, Law, Societies & Justice Program and Department of Sociology - University of Washington: Ford Foundation, 2014.

6. Building Effective Partnerships

By reviewing this section of the guide first responders will be able to:

1. Understand the nature and importance of partnerships to the successful implementation of deflection and diversion programs.
2. Develop strategies to build effective partnerships with community partners and other agencies.

Partnerships are critical to any type of deflection or diversion program. Collaborative, multi-disciplinary responses to complex problems are superior to responses that can be delivered by a single organization. Adopting police agencies are often supported by public health workers, social workers, and other government or community-based organizations. Building effective partnerships to support this model takes effort and intention.

Section A: Resources for Partnership and Support Building

Before you continue reading, it could be helpful to review this PAARI presentation on developing buy-in internally and externally for your program:
https://vimeo.com/1074051678/31c16e4482?share=copy

Additionally, this Checklist For Obtaining Officer Support For Deflection Or Pre-Arrest Diversion Programs by the International Chiefs of Police Association (IACP), BJA, the Comprehensive Opioid, Stimulant, and Substance Use Program, and the Center for Health and Justice at TASC is a great guide to help when navigating a support strategy for your programs.

Section B: Partnership Considerations

Partnerships can be challenging where there is goal incongruity, distrust, and competition for resources. Program developers can overcome these challenges by i) keeping focus on shared goals, ii) make competing outlooks transparent, iii) frequent and respectful communication, and iv) setting clear boundaries through formal policy, procedures, and agreements (e.g., Memorandums of Understanding [MOU]).

- Template from the Bureau of Justice Assistance (BJA) of MOU between law enforcement and behavioral health agencies
- Example MOU from the Carmel Fire Department and the Hamilton County Council on Alcohol and Other Drugs
- Example MOU for Civil Citation programs

Let Local Partners Know About Your Work. To engage potential community partners, they first need to be aware of your program. Since only one in five citizens interact with their local police department each year,[66] proactive outreach is essential to ensure community awareness.

- Market your program by creating a downloadable brochure, distributing business cards while on patrol, putting up yard signs or billboards, handing out stickers, adding decals to patrol vehicles, or tabling at local events.
- Publicly announce your program's launch and share milestones and success stories through press releases and pitching local media outlets.
- Maintain an online presence, whether through a dedicated webpage or social media accounts that include information about your program's history, how it works, who is eligible for services, and key contact details.

Emphasize Common Goals. Partner organizations share the broad goal of promoting public safety. They agree specifically that the key goals are to save lives and reduce harms associated with drug use, including behavioral health outcomes like committing crimes or risky health practices. These goals should be recognized in all partner interactions and made clear in written statements and other materials.

Be Open About Competing Outlooks. Health care providers have an obligation to provide care. Police agencies have law enforcement as part of their core mission, in addition to broader public safety mandates. Public health workers, social workers, and other community-based organizations have other priorities. These institutional outlooks are unavoidable, but their impact as a barrier to partnership and implementation can be minimized with awareness. Being open means, among other things, preparing staff central to partnerships about competing outlooks and priorities.

Communicate Early, Often and With Respect. Distrust and conflicts can exist because of prior experiences between organizations and will be detrimental to implementation. There is no easy solution to these barriers. Agreeing to meet regularly and setting expectations that implementation will be done respectfully, is key to building trust between organizations and resolving disputes.

- Hear Captain Sandlin of the Kentucky State Police discuss conducting a community forum to foster partnerships and receive input from a range of

[66] Susannah N. Tapp, PhD, and Elizabeth J. Davis, *Compendium of Federal Justice Statistics, 2020* (Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, November 2022), https://bjs.ojp.gov/media/document/cbpp20.pdf.

stakeholders right from the start of their statewide program: https://vimeo.com/713726113#t=14m25s&share=copy

- Lt. Nicastro of Gloucester PD (MA) emphasizes the importance of bringing partners in regularly to talk to staff throughout all levels of the organization: https://vimeo.com/713726113#t=29m10s&share=copy

Clarify Boundaries and Responsibilities. Partnerships are more formalized organizational structures rather than loose collaborations. Partnerships function well when boundaries are set in written policy statements and agreements. Specific roles and responsibilities need to be outlined, including who will do what and what are the requirements for commitment of resources. See *Section B* of this Chapter for example Memorandums of Understanding.

Equity and Inclusion. Deflection and diversion program development should include diverse community stakeholder collaboration. Law enforcement/public safety, mental health and recovery/treatment service providers, and persons with lived experience are critical to have at the table. Consider what other groups should be involved including but not limited to: health care providers; harm reduction organizations; public health workers; first responders and emergency management organizations (including fire, EMS, and dispatch centers); prosecutors, public defenders, judges, reentry services; recovery community members, housing, and homeless outreach providers; elected officials; faith-based organizations; legal aid services; schools and higher learning institutions; and transportation providers.[67]

[67]Shannon Mace, KC Wu, and Margaret Jaco Manecke, *An Overview of Deflection and Pre-Arrest Diversion to Prevent Opioid Overdose*, National Council for Mental Wellbeing, 2021.

7. Staffing & Training Key Positions

By reviewing this section of the guide first responders will be able to:

1. Recognize how the key roles of program coordination, case management, and outreach are central to delivering services within deflection and diversion programs.
2. Identify training components and offerings to support deflection and diversion implementation and staffing.

Program staffing will depend on program size and resources needed and available. Many programs have started with very few dedicated staff (e.g., a point person within the department and several volunteers) and have evolved as they built capacity and secured more resources. An important point to recognize is that agencies can get started with minimal staff and then build towards a more fully staffed program over time. There are three critical roles that are necessary to set up to operate and develop deflection programs: Program Coordination, Case Management, and Outreach and Support.

Section A: Program Coordination and Case Management

Program coordination staff work to organize the overall efforts of the deflection programs. They are crucial to partnership building, data management, and decision making in a deflection effort.[68] Duties may entail supervising individuals engaged in delivering direct services, such as case managers, building and maintaining partnerships with other organizations, promoting community-wide events, developing materials (e.g., protocols, outreach brochures) and coordinating training. In regional or other multi-jurisdictional sites, program coordinators organize efforts across these agencies. They are integral to building the capacity of the programs over the long term, including securing funding sources and creating processes to institutionalize programs.

Many sites have a dedicated non-law enforcement program manager to coordinate the deflection activities. In other examples, individuals that coordinate other initiatives within the department that require similar skills staff the program manager role. Law enforcement officers or public safety personnel in management positions also play this role, especially when their positions are dedicated to implementation and management of community-based initiatives. A final example is a coordinator role provided by a partner provider agency that has dedicated time to support the partnership.

[68] Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) and Treatment Alternatives for Safe Communities (TASC), *Critical Elements of Successful First Responder Diversion Programs* (Bureau of Justice, 2020), https://www.cossup.org/Content/Documents/Articles/CHJ_TASC_Critical_Elements.pdf.

Section B: Outreach and Support

First responder agencies with deflection programs often hire social services personnel, recovery coaches, peer supports and/or outreach workers, or utilize volunteers to handle outreach and support efforts. In other circumstances, partnerships with external agencies can provide departments with these workers. These staff/volunteers work closely with specific participants in the deflection program. Depending on the kind of deflection program, they may conduct outreach (with or without officers during post-overdose outreach or during street outreach at local hot-spot locations), provide intake assessments, navigate individuals to treatment, provide harm reduction resources, monitor progress through the treatment and programming, and offer guidance to individuals in recovery.

Promising Practice Recommendations:

1. PAARI has an ongoing Partner Spotlight Webinar series that highlights various deflection and diversion programs across the country. These webinars provide great insight into how teams operate and how they are staffed and trained.
2. PAARI's "Best Practices for Embedding a Social Worker Within Your Police Department" shares helpful tips for both social workers and police departments, breaks down how social workers can make a difference in public safety, and includes sample policies and extra resources to get started.
3. SAMHSA's "Connecting Communities to Substance Use Services: Practical Approaches for First Responders" also highlights the different types of teams and staffing, in addition to various training and support recommendations.

Section C: Training for Program Staff and Officers

Comprehensive training is critical to successful deflection and diversion programs. Effective training ensures that all staff involved, from law enforcement officers to outreach workers and program coordinator, are well-prepared to handle the complexities and sensitivities of these initiatives.

Promising Practice Recommendations:

1. *Substance Use Disorder Awareness & Language.* Training on the nature of substance use disorders, including understanding addiction as a chronic disease, the effects of different substances, and recognizing signs of

overdose. This training helps staff approach individuals with empathy and knowledge.

a. PAARI is trained to deliver "Responding to Addiction Training" through the Addiction Police Council. This training program discusses information on addiction science, treatment, recovery, self-care, and resources. This training aims to increase addiction knowledge, develop community support skills, and promote professional well-being through topics like addiction science, evidence-based treatment, wellness, and engagement strategies.
b. The National Council for Mental Wellbeing's Mental Health First Aid (MHFA) training is like a basic first aid course, but for mental health. Instead of learning how to help someone with a physical injury, you learn how to recognize the signs and symptoms of a mental health crisis or substance use issue. There is also a specific course for First Responders who encounter individuals with mental health and/or substance use crises.

2. *Program-Specific Protocols and Procedures.* Detailed training on the specific protocols and procedures of the deflection and diversion program, ensuring consistent application and adherence to best practices.
   a. JCOIN's 90-minute "First Responder Deflection: A Warm-Handoff to Services in the Community" training gives a great basic overview of first-responder deflection programs
   b. Operation 2 Save Lives/QRT National by Cordata offers a two-day Deflection Academy Training, which equips participants to understand and implement deflection pathways to engage at-risk individuals, focusing on overdose response and addressing co-occurring mental health needs, trauma, and family support. Additionally, they are the only authorized mentors/trainers for Hub/Situation Tables in the United States.
   c. Crisis Intervention Team (CIT) training is a great foundational course for multidisciplinary teams. The CIT model aims to improve officer responses to mental health crises through specialized training to de-escalate crises, understand mental health issues, and divert individuals to treatment rather than the criminal justice system.
   d. The Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) Support Bureau has specific toolkits and training available for organizations implementing a LEAD diversion program.

The LEAD Support website has a step-by-step guide for implementing LEAD programming, including fact sheets and logic models.

   e. The Connecticut Community for Addiction Recovery (CCAR) has specific certified training for Recovery Coaches. Courses include the Recovery Coach Academy, Ethical Considerations for Recovery Coaches, and more.

3. *Harm Reduction Strategies.* Education on harm reduction principles, including the distribution and use of Naloxone, safe needle exchange programs, and fentanyl test strips. This training equips staff with practical tools to prevent overdoses and other harms.
   a. JCOIN and Addiction Policy Forum offers a "Fentanyl Facts and Overdose Risk" course to help criminal legal system professionals better understand the dangers of fentanyl. The course shares practical, evidence-based information aimed at reducing overdose deaths and supporting more informed, compassionate responses to people at risk in justice settings.
   b. PAARI's Fentanyl Safety Roll Call Video gives law enforcement and first responders a quick, easy-to-follow rundown on staying safe around fentanyl. It covers what to look out for, how to protect yourself, and what to do in an overdose situation.
   c. PAARI's "Xylazine 101" and "Xylazine Wound Care" videos break down what first responders need to know about xylazine, a dangerous drug showing up more often in the supply. These short videos explain what xylazine is, the risks it poses, and how to respond safely and effectively.
4. *Trauma-Informed Care*: Training on the principles of trauma-informed care, which emphasizes understanding and responding to the impact of trauma on individuals. This approach is essential for building trust and rapport with participants.
   a. The Systems Mapping and Training Center at Policy Research Associates delivers a "How Being Trauma Informed Improves Criminal Justice Responses" training aimed to teach criminal legal system professionals about trauma and its impact on behavior. The training focuses on increasing safety, reducing recidivism, and supporting the recovery of people with criminal legal system involvement.

    b. The National Child Traumatic Stress Network has many free resources and training materials related to vicarious trauma, trauma-informed care, and specific lessons related to children and caregivers.
5. *Motivational Interviewing and De-escalation Techniques.* Training in communication skills, including motivational interviewing (MI) to encourage individuals to seek treatment and de-escalation techniques to manage potentially volatile situations. Here are a few online options and trainers available for MI:
    a. Motivational Interviewing Network of Trainers (MINT) has an online database of motivational interviewing trainers and courses available.
    b. Psychwire has multiple Motivational Interviewing (MI) modules from the founders of MI and expert trainers.
6. *Legal and Ethical Considerations.* Consider training on privacy laws (e.g., HIPAA, 42 CFR Part 2), confidentiality requirements, and ethical guidelines related to data sharing and participant interactions. The following resources can help provide a foundation for understanding confidentiality in these programs, but it is always recommended to consult legal professionals for guidance with your specific program.
    a. Center of Excellence for Protected Health Information (CoE PHI) has a document on "Navigating Confidentiality in First Responder Deflection" and a 2024 webinar on 42 CFR Part 2 Final Rule from 2024

By investing in comprehensive training, agencies can ensure that their staff is well-prepared, knowledgeable, and compassionate, ultimately leading to more effective and successful deflection and diversion programs.

8. Collecting Data for Management, Monitoring & Evaluation

By reviewing this section of the guide, first responders will be able to:

1. Understand the importance of collecting data for management, monitoring and evaluation of deflection and diversion programs.
2. Develop strategies for using available data sources to manage and monitor local programs.

Data collection is completed for several purposes: 1) case management, 2) program monitoring, and 3) evaluating effectiveness. *Case management* involves collecting data about individual participants and activities so that program staff can identify participants, track progress and participation throughout the program, make informed decisions about participants, and share information with relevant partners as needed. *Program monitoring* helps program staff and management assess how well the program is working and identify opportunities for improvement. Program monitoring takes place on an ongoing basis as the program is being administered and can involve reviewing outputs/activities and client-level outcomes. *Impact or outcome evaluations* examine the effectiveness of a program on key *outcomes* after sufficient time has elapsed following program participation or adoption. Collecting data is an essential part of program implementation because it is necessary for operating the program, revising on an ongoing basis, and ultimately demonstrating the effectiveness of the program.

In all cases, program planning and implementation activities should include strategies for collecting data on participants, program outputs/activities, and key outcomes. While many practitioners report measuring performance indicators, studies have shown that few organizations conduct formal evaluations due to limited capacity. This is often due to challenges in transferring knowledge into practice and insufficient staff expertise and the complexity of evaluating human change processes.[69] Still, practitioners can help to initiate data collection efforts to support evaluation efforts that might come later. Fully designing an impact evaluation is beyond the scope of this guide so we focus on the measurement of key outputs and outcomes that will be useful to monitoring and demonstrating the

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[69] Sarah Carnochan, Michael Samples, Megan Myers, and Michael J. Austin, "Performance Measurement Challenges in Nonprofit Human Service Organizations," *Nonprofit and Voluntary Sector Quarterly* 43, no. 6 (2013): 1014–1032, https://doi.org/10.1177/0899764013508009; J. Bradley Cousins, Catherine Elliott, Courtney Amo, Isabelle Bourgeois, Jill Anne Chouinard, Swee Goh, and Robert Lahey, "Organizational Capacity to Do and Use Evaluation: Results of a Pan-Canadian Survey of Evaluators," *Canadian Journal of Program Evaluation* 23 (2008): 1–35, https://doi.org/10.3138/cjpe.0023.002.

potential effect of the program; for sites that are interested in more robust evaluation, research partners can enhance ongoing evaluation activities by helping first responders to develop evaluation methodologies or measurement strategies.

Section A: Data Sources for Program Monitoring & Evaluation

Three main sources of information are available to program staff to monitor and prepare for evaluation of the program:

Law Enforcement 911 Emergency Call Data And Incident-Based Data. These data are integrated into routine first responder practice in most communities and can be used to measure key outputs (e.g., field contacts) and outcomes (e.g., overdose events). Often data is available for long periods prior to adoption of a deflection program, allowing program staff to monitor changes before and after the adoption of new practices. Agencies frequently have some capacity to prepare and analyze these data. When using 911 emergency call data or incident-based reports, it is important to understand the context of these data; there are cautions about the accuracy of certain measures due to officer reporting decisions in the field. This data also does not measure all the output and outcome measures that would be important to monitoring and evaluation, but can be a very useful supplement to programmatic data.

Program-Specific Case Management Data. Case management data includes information about specific program participants that is collected as part of the day-to-day operations of the deflection program. This often includes information about participant characteristics (i.e., demographics, referral information) and programmatic decision-points or activities. Case management systems vary in terms of their complexity (e.g., simple spreadsheets to relational databases) and the scope of information they collect. While the primary purpose of case management data is to help program staff and supervision to manage decisions about participants, the data collected through case management is a critical source of information that can be used to measure program outputs and outcomes for both monitoring and evaluations.

NOTE: Depending on the program structure, some case management data may be subject to privacy protections under HIPAA or CFR42 Part 2. When creating a first responder deflection or diversion program, leadership should consider how to most effectively protect sensitive information, and also how this will affect reporting and evaluation in the program.

Original Data Collection Activities, Including Surveys Or Interviews, Usually Performed By External Researchers. The advantage of these sources is that they can be designed to measure program-specific outputs and outcomes that are not collected through other sources. For example, interviews with participants can collect information about drug use – a key outcome measure – that police data or even case management data would not capture. In contrast to incident-based data or case management data, original data collection activities do not need to occur in an ongoing way but can be administered for a short time to gather specific information and then discontinued. Researchers can help design strategies to collect information in ways that produce reliable and valid measures and involve a lower burden for program staff and participants. We do not focus on providing guidance around this source of information because it necessitates research partners and is less useful for ongoing program monitoring.

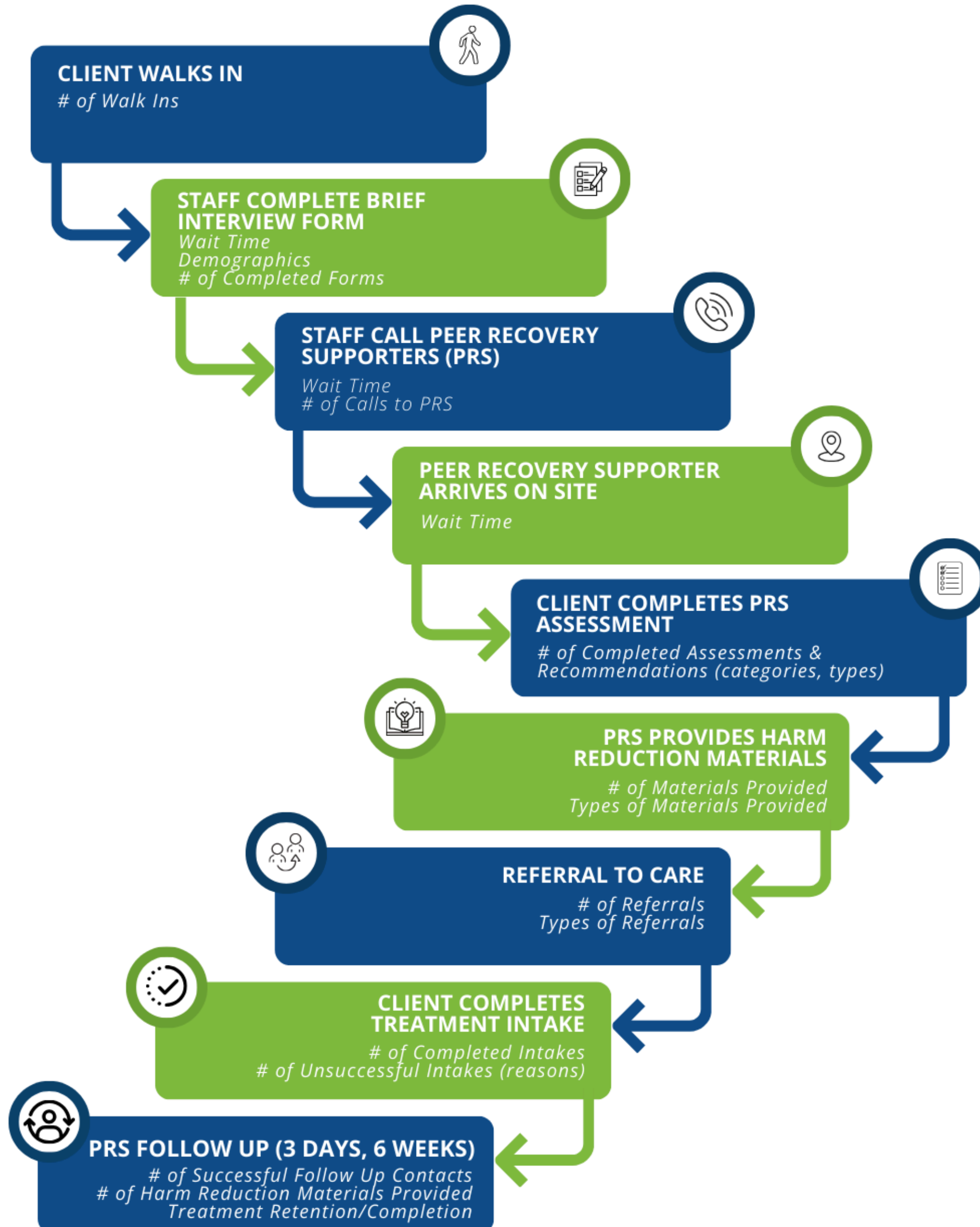
Section B: Measuring Key Outcomes & Outputs

Outcome measures are tied to the program's specific goals. Deflection and diversion programs often seek to reduce overdoses, justice-system involvement, and criminal behavior. Program staff can measure these outcomes through police or program management data. When monitoring diversion and deflection model outcomes, most will be measured at either the individual-level or the aggregate-/community-level over a set observation period. For example, the number of overdose events can be tracked through self-report (individual participants) or emergency calls for service (community). Similarly, program staff can record how often an individual is arrested, or look at overall arrest rates in a community or target area; for example, a program might report the number or rate of arrests per population for all participants in the program or for implementation sites.

Next, another essential part of program monitoring and evaluation is measuring outputs. Outputs are measures of the specific activities or services the program provides. Although there is variation in the specific kinds of activities and outputs that deflection and diversion implementers will engage in, deflection initiatives are commonly seeking to engage people in the program (e.g., number of referrals, number of contacts), deliver resources (e.g., number of Naloxone kits distributed, number of test kits distributed), provide services (e.g., number of recovery coaching sessions), refer them to treatment providers, and guide them through program steps or stages. Most of these activities are client-based and therefore outputs are often derived from case-management data.

To identify key outputs and outcomes, we recommend drafting a client flow diagram, which will help identify specific opportunities for reporting or monitoring. Below, we provide a

simple client flow diagram for a Self-Referral Program (the client flow is **bold**, and examples of data points that could be used for evaluation are below in *italics*):



Section C: Practical Uses for Data

To better understand data collection efforts, it is helpful to see how the data can be used in practical ways. Deflection and diversion programs and published process evaluations give good examples of how data can be used to monitor programs. A few example questions will illustrate the straightforward process of 1) question or problem; 2) data collection; 3) analysis; 4) dissemination; and 5) action for change.

> **Example 1.** *How well does the program connect people to treatment?* Through case management data, program staff will know the number intakes, referrals, and enrollments in treatment. They can therefore assess, on an ongoing basis, the percentage of referrals that have been enrolled in treatment. Staff can further examine this metric across different groups, sites, or other distinctions that are meaningful to program staff. These results can be shared with partner organizations. If connections are lower than expected, or decreasing over time, or varying across subpopulations, program staff can use that information to advocate for improvements.

> **Example 2.** *How well does the program utilize diversion for individuals that have committed eligible offenses?* Police data on arrests can be linked to program management data to determine the percentage of arrests that have a referral. An agency that arrests 60 people for possession offenses during a given timeframe and makes 30 referrals to program case management staff, has a referral rate of eligible individuals of 50%. Program staff can assess how well this meets expectations, changes over time, or varies across areas of the city or site. This data can be shared with managers across the department and external partners. They can act to create awareness of the referral process or reinforce expectations through supervisors.

Section D: Additional Resources for Data Collection

- PAARI convened experienced researchers and evaluators from the field of deflection, and PAARI partners, to develop and recommend a set of standards for programmatic data collection. PAARI's "Standards for Deflection Data Collection" guide is a great resource to review.
- The Wisconsin Deflection Initiative developed a comprehensive guide on Deflection Performance Measures to provide suggested quantitative measures as a framework to measure progress and success of deflection initiatives.
- The Police Treatment and Community Collaborative (PTACC) has recommended core measures for deflection and pre-arrest diversion.

9. Equity Considerations

By reviewing this section of the guide, first responders will be able to:

1. Recognize the disproportionate impact of the War on Drugs and the opioid epidemic on racial and ethnic minorities.
2. Develop strategies to address barriers to treatment and access, and work towards rebuilding trust with communities of color through deflection and diversion programs.

Any guide proposing best practices around deflection and diversion programs would be incomplete without dedicating discussion to the disproportionate impacts the War on Drugs and the opioid epidemic have had on racial and ethnic minorities. For example, in the year 2020, overdose death rates in older Black men were at rates nearly seven times higher than those in older white men. Additionally, overdose death rates for younger American Indian and Alaska Native (AI/AN) women were nearly two times those of younger white women, and in counties with higher amounts of income inequality, overdose death rates for Black individuals were more than two times higher than in counties with less income inequality.[70] Though tragic, research has shown that racial and ethnic minority groups have barriers to effective substance use treatment often due to lower socioeconomic status, lower employment opportunities, unstable housing, unreliable transportation, and a lack of adequate health insurance[71]. All of these barriers are then exacerbated by distrust of the healthcare system, stigma, and bias.[72] Despite African Americans and white Americans having similar rates of drug use, African Americans are imprisoned for drug charges at six (6) times the rate of white Americans. Further,while only making up 5% of illicit drug users, African Americans make up 29% of those arrested and 33% of those incarcerated for drug offenses.[73]

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[70] Mbabazi Kariisa et al., "Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020," *Morbidity and Mortality Weekly Report* 71, no. 29 (July 2022): 943-944. http://dx.doi.org/10.15585/mmwr.mm7129e2.

[71] Benjamin Saloner and Beth Lê Cook, "Blacks and Hispanics Are Less Likely Than Whites to Complete Addiction Treatment, Largely Due to Socioeconomic Factors," *Health Affairs* 32, no. 1 (2013): 135–145, https://doi.org/10.1377/hlthaff.2011.0983.

[72] "Drug Overdose Deaths Rise, Disparities Widen," Centers for Disease Control and Prevention, accessed July 21, 2024, https://www.cdc.gov/vitalsigns/overdose-death-disparities/index.html.; Substance Abuse and Mental Health Services Administration: The Opioid Crisis and the Black/African American Population: An Urgent Issue. Publication No. PEP20-05-02-001. Office of Behavioral Health Equity. Substance Abuse and Mental Health Services Administration, 2020.

[73] "Criminal Justice Fact Sheet," NAACP, accessed July 21, 2024, https://naacp.org/resources/criminal-justice-fact-sheet.

Importantly, deflection and diversion initiatives that are intentional about their approaches can help to remedy some of these disproportionate impacts that will not only improve health outcomes and diminish harmful criminal justice involvement, but will also help to rebuild relationships and trust with both at-risk groups and the community at large. Though this section of the guide will not be exhaustive in its recommendations, it will provide some concepts that should inform decision-makers on how to structure programs to make sure they are serving all members of the community equitably.

Section A: Address Barriers To Treatment And Access

A community that has a high capacity to provide care does not always produce equal health outcomes across a community. For example, in communities with high capacities to provide care, Black and AI/AN people had steeper death rates than the general population.[74] Though adequate resources may exist in a community, barriers like lack of housing, transportation, childcare, and insurance can prevent individuals from accessing treatment and services when they need it.

Promising Practice Recommendations:

1. Utilize Situation Tables. This model considers individuals on a holistic basis and works to address any number of issues an individual may have, including common barriers to seeking and accessing treatment such as housing, insurance coverage, and food insecurity. Invite trusted community leaders to these meetings to expand reach (more below).
2. Create partnerships with trusted community leaders and figures. In Communities of Color, these may be religious leaders from church and faith-based groups, Indigenous leaders, prominent figures from barber shops and beauty salons, etc. who may know those who need assistance within the community.[75,76] Partnering with them and integrating them into the care continuum can help individuals access needed resources.

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[74] "Achieving Equity Around Overdoses," Centers for Disease Control and Prevention, July 21, 2024, https://www.cdc.gov/overdose-prevention/health-equity/achieving-health-equity-around-overdoses.html.

[75] Ronald G. Victor et al., "A Cluster- Randomized Trial of Blood-Pressure Reduction in Black Barbershops," *New England Journal of Medicine* 378, no. 14 (April 2018): 1297, https://doi.org/10.1056/NEJMoa1717250

[76] Laura A Linnan and Yvonne Owens Ferguson, "Beauty Salons: A Promising Health Promotion Setting for Reaching and Promoting Health Among African American Women," *Health Education and Behavior* 34, no. 3 (June 2007): 517-530, https://doi.org/10.1177/1090198106295531.

3. Conduct community-led needs assessments that incorporate minority voices. These can help identify gaps in services and resources that act as barriers to entering into treatment and recovery for the entire community.
4. Create policies and systems that diminish biases in the field that lead to criminal justice involvement instead of treatment and recovery options. For example, allow for post-arrest diversion of individuals that have been arrested due to low-level crimes related to drug use by law enforcement administrative staff or the District Attorney's Office.
5. Increase access to buprenorphine. Buprenorphone is generally a less stigmatizing treatment compared to methadone, especially in Communities of Color.[77] Fostering partnerships with appropriate agencies that can provide these treatments, using mobile units, and reducing barriers like transportation and inadequate health insurance coverage, can help link people with this effective treatment option that is minimally accessible in low-income and minority communities.
6. Utilize Mobile Outreach Units. Mobile units can bridge the gaps in access to treatment that exist for at-risk communities. By meeting community members where they are, both physically and figuratively, trust and goodwill can be built when they are provided with linkages to resources and treatment through genuine interactions that show care and compassion.[78,79]
7. Consider incorporating language justice principles. In 2019, the U.S. Census Bureau conducted the American Community Survey which found that nearly thirteen percent of people in the United States over the age of five speak English "less than well," with six percent who speak English "not at all."[80] In order for all community members to receive equitable access to resources provided by their outreach programs, departments should consider adopting effective language justice programs like the one implemented by the Portland Police Bureau.

[77] Substance Abuse and Mental Health Services Administration, "The Opioid Crisis."
[78] Victor et al., "A Cluster- Randomized Trial," 1297-1298.
[79] Linnan and Ferguson, "Beauty Salons," 517-530.
[80] Sandy Dietrich and Erik Hernandez, *Language Use in the United States: 2019, American Community Survey Reports*, United States Census Bureau, 2022.

Section B: Rebuilding Trust Between Law Enforcement and Communities of Color

As a result of harmful past policies like the Anti-Drug Abuse Act of 1986 that disproportionately incarcerated People of Color, genuine fears exist, particularly among Black/ African American men, that seeking treatment for substance use disorder may result in severe sentencing and incarceration.[81,82] This fear is in addition to a growing distrust in police generally, with nearly half of Black American adults (and two-thirds of Black men) having reported that they felt unfairly stopped by police due to their race.[83] Law enforcement can take steps that will hopefully alleviate these fears and rebuild trust over time.

Promising Practice Recommendations:

1. *Engage in activities and outreach that prioritize relationship-building.* Reaching out to minority communities, whether through post-overdose programs, mobile unit visits, street outreach, etc., and focusing on positive interactions without criminal justice system involvement, can build rapport and trust. Time and dedication to improving these relationships through deflection and diversion programming can, over time, demonstrate law enforcement's commitment to helping minority communities.
2. *Use diverse peer recovery supports.* Peer recovery coaches can help build trust between law enforcement and people who use drugs. Additionally, they have been shown to be effective in helping people access treatment because of shared experiences.[84,85] Boston's Project RECOVER uses peer recovery coaches of diverse backgrounds to help individuals connect with them on a deeper level and provide them access treatment and resources with cultural awareness.[86]
3. Diversify the police force. A recent study has shown that diversifying police forces can lead to better outcomes for minorities, with Black and Hispanic officers making far fewer arrests and stops than white officers, especially

[81] Keturah James and Ayana Jordan, "The Opioid Crisis in Black Communities," *Journal of Law Medicine, and Ethics* 46, no. 2 (January 2021): 404-421, https:// doi.org/10.1177/1073110518782949
[82] Carl L. Hart and Malaki Z. Hart, "Opioid Crisis: Another Mechanism Used to Perpetuate American Racism," *Cultural Diversity and Ethnic Minority Psychology* 25, no. 1 (January 2019): 6, https://doi.org/10.1037/cdp0000260.
[83] "Trust in America: Do Americans trust the police?" Pew Research Center, accessed July 21, 2024, https://www.pewresearch.org/2022/01/05/trust-in-america-do-americans-trust-the-police/.
[84] Victor et al., "A Cluster- Randomized Trial"
[85] Linnan and Ferguson, "Beauty Salons," 517-530.
[86] Clinical Addiction Research & Education (CARE) Unit, "Project RECOVER," Boston University Medical Campus, accessed April 9, 2025, https://www.bumc.bu.edu/care/research-studies/project-recover/

against Black civilians.[87] Although that study applies to arrests and stops, the benefits of a diverse police force and being able to enter Communities of Color with officers who look like the people they are trying to serve can help to diminish unnecessary arrests and help build community trust.

4. Re-imagine first responders in communities. Community Responder Models discussed Section II should be considered when developing a deflection response in your community. Also, training and equipping trusted members of communities with naloxone can save lives. These groups may include Indigenous leaders, faith-based organizations, religious leaders, community health workers, and family members. For example, the African American Engagement Workgroup in Hamilton County, OH engages the faith -based community, harm reduction resources, and community partners to provide tailored support for the youth and adult African American community to reduce stigma of addiction and connect with recovery resources.[88]

   You can learn more about the efforts of the Hamilton County, OH African American Outreach team in this PAARI Spotlight Series: https://vimeo.com/868486700?share=copy#t=2369.122

Section C: Use Data To Analyze Patterns That May Reveal Inequities

In 2020, overdose deaths increased by 44% for Black Americans and by 39% for American Indian and Alaska Native (AI/AN) people compared to rates from 2019.[89] As discussed previously, Black Americans make up a significantly larger portion of those incarcerated for drug-related crimes, despite having similar rates of drug use as white Americans. Data can help determine not only when particular groups within communities need more targeted intervention, but also patterns of racial bias in policing, if and when they arise.

Promising Practice Recommendations:

1. Document, monitor, and report the racial makeup of your program participants. We recommend that deflection initiatives document the race of program participants (among other demographic information), and regularly

[87] Bocar A. Bar et al., "The Role of Officer Race and Gender in Police-Civilian Interactions in Chicago," *Science* 371, no. 6530 (February 2021): 696-702, https://doi.org/10.1126/science.abd8694.
[88] Hamilton County Addiction Response Coalition. (2024). Annual report: State of the addiction crisis. https://bit.ly/3Yj0oO4
[89] Centers for Disease Control and Prevention, "Achieving Equity Around Overdoses."

review this information. To understand whether your program is equitable, you can compare your program demographics to local census data (overall population), to overdose fatality demographics (for a post-overdose follow up program), or to jail demographics (for other deflection programs).

2. Utilize data to compare fatal and non-fatal overdoses with specific community demographics and develop interventions accordingly. For example, if your community is 10% Black, and yet, Black members of your community make up 20% of fatal overdoses, they are fatally overdosing at disproportionate rates and further inventions should be examined.
3. Utilize data to examine criminal justice involvement by race and determine patterns. For example, determine if there are any patterns or differences related to diversion and deflection from the criminal justice system among at-risk and minority group groups in your community.

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