A Multi-Site Evaluation of Law Enforcement Deflection in the United States

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About This Report

This report describes the findings from a multi-site evaluation of law enforcement deflection in the United States. We use information collected from deflection programs in six sites, including information from program staff, administrative data, and program data, to describe how each program is implemented and to identify key program facilitators and barriers. For two of the six sites, we conducted outcome analyses to determine whether the model is effective in reducing drug-related deaths and overdoses, arrests, and treatment admissions. This report should be of interest to entities interested in deflection programs.

Justice Policy Program

RAND Social and Economic Well-Being is a division of the RAND Corporation that seeks to actively improve the health and social and economic well-being of populations and communities throughout the world. This research was conducted in the Justice Policy Program within RAND Social and Economic Well-Being. The program focuses on such topics as access to justice, policing, corrections, drug policy, and court system reform, as well as other policy concerns pertaining to public safety and criminal and civil justice. For more information, email justicepolicy@rand.org.

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Chapter 1. Introduction

In the past two decades, the United States has witnessed a substantial increase in drug overdose deaths involving opioids. Since 2016, overdose deaths involving opioids (of which the vast majority now involve illegally manufactured synthetic opioids, such as fentanyl) have been the most common form of accidental death in the United States, exceeding other causes, such as deaths involving vehicles or guns (Stein et al., forthcoming). Nearly 1 million Americans have died from drug overdoses since 1999, with more than 70 percent of these deaths tied to opioids (Centers for Disease Control and Prevention, 2022a); the Centers for Disease Control and Prevention (2022b) estimates that more than 107,000 Americans died from drug overdose in 2021 alone, with about three-quarters of these deaths tied to opioids.

Many law enforcement and first responder agencies (emergency medical technicians, firefighters, and paramedics) have adopted deflection as a front-line response to the large number of drug overdoses and deaths and the calls for service related to overdoses and co-occurring disorders, such as mental health disorders. Deflection programs aim to connect individuals with substance use disorder (SUD; not necessarily limited to opioids or one particular substance) who encounter the criminal justice system with treatment and other services according to the individual's needs.

Background

Deflection programs started growing in the United States after 2015, with the worsening of the overdose crisis (Charlier and Reichert, 2020). The total number of deflection programs currently operating in the United States is not known, although existing research suggests that the count is, at a minimum, in the hundreds. In 2020, the Bureau of Justice Assistance (BJA) commissioned a survey of deflection initiatives, reaching out to more than 600 initiatives known to be in operation at the time (National Survey to Assess First Responder Deflection Programs in Response to the Opioid Crisis, 2021). However, this is very likely an undercount, because the survey employed a convenience sample and did not attempt to survey a representative selection of U.S. police departments.

Irrespective of the pathway used, co-responders (peer support specialists, recovery coaches, social workers, behavioral health professionals, and others) are regular partners in deflection initiatives, consistent with the current focus in many communities on responding to calls for service through means other than law enforcement. Co-responders' close connection to law enforcement on these calls signals the need for a tailored, appropriate response to calls for service, as well as how deflection offers real potential for helping reduce the stigma associated with overdose and SUD.

In response to the emergence of various types of programs, Charlier and Reichert (2020) identified five deflection pathways (later expanded to six), which categorize programs according to the mechanisms through which they engage with their clients. Table 1.1 presents an overview of these pathways, along with existing exemplar programs for each pathway.

Table 1.1. Overview of Deflection Pathways

Pathway	Definition	Initiator of Contact	Initiation Location
Self-referral (also can be done by fire and emergency medical services [EMS] without law enforcement)	An individual voluntarily initiates contact with a first responder (a law enforcement, fire services, or EMS professional) seeking access to treatment—without fear of arrest—and receives a referral to a treatment provider.	Individual community member	Police department, fire station, EMS
Active outreach (also can be done by fire and EMS without law enforcement)	A law enforcement officer or other first responder identifies or seeks out an individual in need of substance use or mental health treatment (can include housing and other services), and a referral is made to a provider who engages them in treatment (and ideally case management services are also provided).	Police officer, often with outreach personnel	In the community
Naloxone-plus (also can be done by fire and EMS without law enforcement)	A law enforcement officer or other first responder engages an individual in treatment as part of an overdose response, preferably at the point of overdose or as close to the point of overdose as possible, such as at the emergency department.	Team with a combination of police, social worker, peer recovery specialist, faith-based leader	In the community, hospital (emergency department), residence
Officer prevention (also can be done in a co-responder approach)	A law enforcement officer, alone or as a member of a co-responder team, initiates treatment engagement (which can also be directly to a case manager first), but no criminal charges exist or are present, and hence no criminal charges can be filed. Officer prevention occurs as part of police patrol duties including “on view,” citizen “flag down,” or in response to a call for service.	Police officer and, if present in a co-responder approach, mental health, treatment, social worker, case manager, or peer	In the community, “on view,” in response to a call, on patrol
Officer intervention (law enforcement required, also can be done in a co-responder approach)	A law enforcement officer, alone or as a member of a co-responder team, initiates treatment engagement (which can also be directly to a case manager first), and either charges are filed and held in abeyance or a citation with treatment requirement is issued. Note: This is not the same as citation in lieu of arrest, as it involves some type of mandated treatment assessment or participation. Officer intervention occurs as part of police patrol duties including “on-view,” citizen “flag down,” or in response to a call for service.	Police officer and, if present in a co-responder approach, mental health, treatment, social worker, case manager, or peer	In the community, “on view,” in response to a call, on patrol

Pathway	Definition	Initiator of Contact	Initiation Location
Community referral	In response to service call, a community-based behavioral health team (crisis workers, clinicians, peer specialists, etc.) engages individuals to help de-escalate crises, mediate low-level conflicts, or provide to treatment, services, or to a case manager.	Community-based professionals/clinicians	In the community

SOURCES: Adapted from Charlier and Reichert, 2020; Ross, 2022.

As of late 2022, there has been little evaluation work done on deflection programs in the United States. With respect to deflection programs' outcomes, two literature reviews on deflection programs have been published so far, bringing together evidence from U.S. as well as international programs. Lindquist-Grantz et al. (2021) reviewed 31 studies (of which 24 were from the United States) and noted that (1) the majority of reviewed studies found reductions in recidivism and (2) nearly half (45 percent) reported reductions in substance use. More recently, Blais et al. (2022) reviewed 27 studies (of which 17 were from the United States) and found evidence that deflection programs can be effective in reducing crime and are promising with respect to improvements in health-related outcomes. However, an important limitation of these reviews is that the U.S. evidence came exclusively from pre-arrest diversion programs, such as Law Enforcement Assisted Diversion (LEAD), and thus could not comment on deflection programs that do not involve any criminal justice threat. This limitation is reflective of a large gap in existing literature: While pre-arrest diversion programs, such as LEAD, have been covered by a number of academic studies, considerably less is known about deflection programs where participation is truly voluntary. The very limited existing literature on these deflection programs largely focuses on program description, program participant description, or program implementation,[1] although broader literature on individual encounters with law enforcement in the context of SUD or mental health also speaks to issues relevant for deflection, such as the role of stigma.[2]

Deflection Today and the Self-Referral Pathway

The survey commissioned by BJA in 2021 found that the self-referral pathway is a common, popular approach to deflection, often the first pathway employed by deflection initiatives before they expand. The self-referral pathway—rooted in the Gloucester, Massachusetts, Angel initiative of the mid-2010s—is often the first pathway used by deflection programs, partly because it is relatively inexpensive and easy to start up. Because many self-referral initiatives are based in existing facilities, such as police/fire stations (sometimes known as *walk-in facilities* or

[1] See, e.g., Formica et al., 2021; Moore et al., 2021.

[2] See, e.g., Watson and Angell, 2013; Morabito and Socia, 2015.

safe stations), that are open 24/7 in welcoming environments, they typically are conveniently located within communities. And they offer rapid access to treatment and services for clients, making them a common starting point or linchpin for other pathways. Clients who enter self-referral facilities face no fear of arrest, which leads many to turn over drugs, drug paraphernalia, etc., upon entry. Other notable advantages of self-referral programs include the relative ease with which agencies can implement them and the quick turnaround time in which treatment and services (typically built around either [1] opioid use disorder [OUD] and overdose and/or [2] polysubstance use) can be initiated—both for clients and for their families and friends who may help facilitate their entry into treatment. In addition, unlike other pathways, which rely on dedicated officers, self-referral initiatives also can be implemented with limited resources. The main cost in self-referral operations often is officers' time spent assisting participants, which is relatively limited and arguably does not represent any new expenditure for the agency.

Research Aims

This report aims to help close the research gap discussed above and to contribute to the development of the evidence base underpinning voluntary deflection programs, given the ongoing interest of police departments to introduce deflection programs and to strengthen existing deflection practices. Specifically, we describe the implementation of six police-led self-referral deflection programs and the results of outcome analyses on two of those six programs. Specifically, we address the following research questions:

1. How have the deflection programs involved in this study been implemented, and how has the process been viewed by key stakeholders?
2. What factors have facilitated or hindered the implementation of these programs and the attainment of their objectives?
3. What are the most pressing practical considerations facing deflection programs and the communities they serve?
4. What is the impact of program adoption on overdose and crime rates in the county?

Chapter 2. Methods

In this chapter, we review the qualitative and quantitative methods that form this evaluation. The main goals of the qualitative portion of the evaluation are to describe the implementation process, including strengths and challenges. Our quantitative analyses, which rely on program and administrative data, aimed to understand who was served by the program and the impact the program had on outcomes. All components of the project were approved by the RAND Corporation's Institutional Review Board (IRB). This IRB review includes the approval of data sharing agreements and all data collection methods, including written consent for qualitative data collection.

Site Selection

During the initial months of the project, an advisory board was created to discuss the overall project goals and tasks; develop specific plans for the case studies, including brainstorming site selection criteria; and begin communication with sites. Board members included practitioners in the fields of substance use treatment, services for people who use drugs, and law enforcement officials. With the help of the advisory board, as well as the field-specific expertise held by Treatment Alternatives for Safe Communities (TASC) and Illinois Criminal Justice Information Authority (ICJIA), we were able to identify six sites that offer a range of program models, various levels of partnerships, levels of resources, police force sizes, and context (e.g., demographic characteristics, local SUD-related indicators). The sites were Bucks County, Pennsylvania; Everett, Washington; Fort Wayne, Indiana; Lake County, Illinois; Menominee Indian Tribe, Wisconsin; and Plymouth County, Massachusetts. These six sites were included in Phase 1 of the study, which revolved around examining the implementation of these programs and stakeholders' perspectives on the process. Phase 2 of the project included outcome analyses of two sites: Lake County, Illinois, and Plymouth County, Massachusetts. These sites were picked because of the availability of key outcome data and the length of program existence, which are both important for estimating the effects of these programs, as well as the maturity of the programs in question.

Implementation Process

Document Review

We requested program documentation from the six sites participating in the study. This included, where available, annual reports, budgetary documentation, program policies and procedures, and any other documents pertaining to the operation of the programs. These

documents were reviewed by members of the research team and triangulated with insights from stakeholder interviews (discussed below).

Stakeholder Interviews

We conducted 41 interviews with representatives of the six deflection initiatives, covering several distinct stakeholder groups (see Table 2.1). Most of the interviews took place in 2020–2021 as part of the general wave of interviews; however, three interviews were conducted in 2022 to follow up with individual sites on the implementation of planned initiatives and to check for accuracy of data.

Table 2.1. Overview of Stakeholder Interviews by Type

Stakeholder Group	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Total
Criminal justice	4	3	1	3	2	1	14
Treatment provider		1	1	2		2	6
Non-treatment provider (e.g., harm reduction, housing)	1	1	2	1		1	6
Non-provider (e.g., local policy maker)		1				1	2
Program staff (e.g., program administrator)	1		2	4	5		12
Multiple						1	1
Total	6	6	6	10	7	6	41

Program leadership served as the first port of call with respect to identifying suitable interviewees, and additional individuals were recruited via a snowballing approach. The interviews were semistructured, following a standardized interview topic guide, albeit tailored to various stakeholder types, while allowing for a discussion of unanticipated topics (see the appendix). The topic guide was developed iteratively by the research team and incorporated feedback from the project's advisory board. The topic guide covered the following domains: local program environment and nature of the substance use challenge in the area, program history, program description and procedures, program goals, eligibility, treatment and other services offered, funding, collaborative partnerships, reflections on implementation and achievements, and data. Interviews were facilitated by at least two members of the research team, with one serving as the lead interviewer and the other as the notetaker. With the permission of interviewees, each conversation was audio-recorded and professionally transcribed. Interviews were conducted over videoconferencing or telephone and generally lasted between 45 and 60 minutes.

In addition to the stakeholder interviews, the original research plan also envisaged undertaking site visits to each site. However, these plans were abandoned with the onset of the COVID-19 pandemic.

Analysis Plan

Interview recordings were professionally transcribed. These transcripts, along with research team's notes where recordings were not available ($n = 2$ interviews), served as the basis for the analysis. Data from interviews were analyzed by researchers using standard thematic analysis approaches in Dedoose, a qualitative analysis software (Boyatzis, 1998; Clarke, Braun, and Hayfield, 2015). As the first step, researchers developed a codebook based on the review of the entire corpus of the transcripts. Owing to the semistructured character of interviews, the parent codes largely followed the interview topic guide and served as the organizing structure for child codes emerging from the transcripts. Two members of the research team independently coded a subset of transcripts and discussed areas of convergence and divergence. They subsequently amended the codebook accordingly. This process was repeated until a degree of "good" agreement was achieved (defined as Cohen's kappa of 0.7). Next, researchers independently coded the remainder of the transcripts. Material included in each code served as the basis for the formulation of key findings.

Outcome Analyses

Administrative Data

As discussed above, we conducted outcome analyses in two of the six sites: Lake County, Illinois, and Plymouth, Massachusetts. To be clear, we were not able to conduct individual analyses; instead we tested the impact of program adoption on overdose and crime rates in the county.

We examined seven outcomes that may indicate the success of a deflection program. For our Lake County, Illinois, analyses, counts of all drug-related deaths, opioid-related deaths, and all drug overdoses were obtained from the Illinois Department of Public Health. Our arrest data are from the Illinois State Police, and counts of Medicaid treatment admissions are from the Illinois Department of Health and Human Services. Table 2.2 displays summary statistics for our outcome indicators. Note that the numbers are average rates per person per quarter and are multiplied by 1,000 for clarity. For example, on average, the number of opioid deaths in Lake County each quarter was 0.00002 per person living in the county.

Table 2.2. Descriptive Statistics of Outcome Indicators in the Lake County Analysis

	Other IL Counties	Lake County
Opioid death rate[a]	0.02	0.02
	(0.03)	(0.01)
All drug overdose rate[a]	0.70	0.50
	(0.32)	(0.09)
Opioid overdose rate[a]	0.16	0.11
	(0.12)	(0.04)
Property arrest rate[a]	11.49	8.99
	(7.41)	(2.68)
Drug arrest rate[a]	9.58	5.34
	(6.93)	(1.84)
DUI arrests rate[a]	8.80	8.50
	(8.01)	(2.21)
Serious property arrests rate[a]	1.02	0.80
	(0.68)	(0.24)
Serious drug arrests rate[a]	0.84	0.45
	(0.64)	(0.16)
Serious DUI arrests rate[a]	0.74	0.75
	(0.72)	(0.20)
Medicaid treatment admissions rate[a]	0.83	0.29
	(1.21)	(0.22)
Observations	4,386	51

SOURCES: Data from the Illinois Department of Public Health, Illinois State Police, and the Illinois Department of Health and Human Services, as described in the text.
NOTE: DUI = driving under the influence. Mean quarterly statistics from 2008 through 2020; standard deviation in parentheses. All figures are rates calculated as a ratio of quarterly counts divided by the county's population and can be interpreted as the rate per person.
[a] Figures have been multiplied by 1,000 for clarity.

The covariate variables used to create the synthetic control groups were gathered from the 2014 American Community Survey (ACS; U.S. Census Bureau, undated), and counts of substance abuse disorder treatment sites are from the Mental Health and Addiction Treatment Tracking Repository (Cantor et al., 2022). Table 2.3 summarizes covariate data for Lake County and for the remaining counties in Illinois.

Table 2.3. Covariant Data for the Lake County Analysis

	Other IL Counties	Lake County
Population	120,596	704,294
	(532965)	
Percentage of population 15–19 years old	6.56	8.10
	(1.16)	
Percentage of population 20–24 years old	6.46	6.40
	(2.63)	
Percentage of population Asian	1.41	7.60
	(1.91)	
Percentage of population Black	5.88	7.80
	(7.35)	
Gini index	0.43	0.48
	(0.03)	
Percent of population Hispanic	4.43	20.50
	(5.30)	
Median household income	49,487	77,873
	(9672)	
Percentage of population moved counties[a]	3.97	2.10
	(2.33)	
Percentage of population moved states[a]	1.44	2.90
	(0.75)	
Percentage of population moved within county[a]	6.93	7.20
	(2.42)	
Per capita income	39,973	68,199
	(5783)	
Population density	183.2	1,588.3
	(625.5)	
Percentage of population below poverty line	10.06	7.20
	(3.54)	
Unemployment rate	5.23	6.10
	(1.35)	
Observations	101	1
Count of SUD treatment sites (2005–2020)[b]	8.60	35.62
	(33.41)	(3.93)

SOURCES: Data from the 2014 ACS (U.S. Census Bureau, undated) and the Mental Health and Addiction Treatment Tracking Repository (Cantor et al., 2022), as described in the text.
[a] Figures have been multiplied by 1,000 for clarity.
[b] Yearly average.

Our Plymouth, Massachusetts, analysis examines a similar set of outcomes. Opioid-related medical incidents and deaths were gathered from the Massachusetts Emergency Medical Services and Department of Public Health, respectively. Arrest data are from the Massachusetts crime statistics dashboard (Massachusetts Crime Statistics, undated), and SUD treatment admissions data are from the Bureau of Substance Addiction Services at the Massachusetts Department of Public Health. Table 2.4 displays summary statistics for our outcome indicators. Note that the numbers are average rates per person per quarter and are multiplied by 1,000 for

clarity, with the exception of opioid-related deaths, which is a yearly rate. For example, on average, the number of opioid-related deaths in Plymouth County each year was 0.00019 per person living in the county.

Table 2.4. Descriptive Statistics of Outcome Indicators in Plymouth County Analysis

	Plymouth County	Other MA Counties
Opioid-related medical incident rate[a]	0.85	0.75
	(0.16)	(0.32)
Opioid related death rate[a,b]	0.19	0.16
	(0.12)	(0.11)
Property arrests rate[a]	6.43	7.31
	(1.47)	(3.96)
Drug arrests rate[a]	0.47	0.55
	(0.14)	(0.37)
DUI arrests rate[a]	0.41	0.51
	(0.07)	(0.51)
All SUD treatment admissions rate[a]	1.99	1.88
	(0.16)	(1.52)
All opioid treatment admissions rate[a]	0.99	0.94
	(0.21)	(0.84)
Observations	60	780

SOURCES: Data from Massachusetts Emergency Medical Services, the Massachusetts Department of Public Health, and the Massachusetts crime statistics dashboard (Massachusetts Crime Statistics, undated), as described in the text.
NOTE: Mean quarterly statistics from 2008–2020; standard deviation in parentheses. All figures are rates calculated as a ratio of quarterly counts divided by the county's population and can be interpreted as the rate per person.
[a] Figures have been multiplied by 1000 for clarity.
[b] Because of data limitations, the opioid death rate is based on yearly, not quarterly counts.

The covariate variables used to create the synthetic control groups were gathered from the 2014 ACS. Table 2.5 summarizes covariate data for Plymouth County and for the remaining counties in Massachusetts.

Table 2.5. Descriptive Statistics of Covariates in Plymouth County Analysis

	Plymouth County	Other MA Counties
Population	506,513	481,237.2 (450,055.9)
Percentage of population 15–19 years old	6.900	6.892 (1.568)
Percentage of population 20–24 years old	5.800	7.085 (2.971)
Percentage of population Asian	1.700	4.531 (3.589)
Percent of population Black	9.900	7.092 (6.495)
Gini index	0.441	0.467 (0.0237)
Percentage of population Hispanic	3.400	8.477 (7.168)
Median household income	75,816	64,866.2 (13,166.3)
Percentage of population moved counties[a]	2.900	2.569 (1.270)
Percentage of population moved states[a]	1.100	2.262 (0.810)
Percentage of population moved within county[a]	5.700	6.908 (2.294)
Per capita income	56,571	61,033.8 (18,017.7)
Population density	768.5	1717.3 (3,532.2)
Percentage of population below poverty line	5.500	8.700 (3.404)
Unemployment rate	6	5.246 (1.300)
Observations	1	13

SOURCE: Data from the 2014 American Community Survey (U.S. Census Bureau, undated).
NOTE: Mean coefficients; standard deviation in parentheses.
[a] The ACS asks this question if the respondent was living in the same place one year prior to survey.

Analysis Plan

With one county implementing each program, we use the synthetic control method (SCM) to estimate the impact of program adoption on overdose and crime rates in the county. Let Y_{jt} be the outcome of interest (nonfatal overdose rate, fatal overdose rate, driving under the influence (DUI) arrest rates, property crime rates, and drug possession arrests) for deflection program j of $J+1$ at time t, with deflection program $j=1$. The synthetic control estimator models the effect of the deflection intervention at time T_0 on the treatment group using a linear combination of optimally chosen units as a synthetic control. For the post-intervention period, the synthetic control estimator measures the causal effect as $Y_{1t} - \sum_{j=2}^{J+1} w_j^* Y_{jt}$, where w_j^* is a vector of optimally chosen weights between zero and one that together sum to one. In this case, the estimator identifies counties that have the most similar trends to the treated unit, and weights them to more closely approximate the pre-treatment trend for the treated unit. The goal is to have no difference between the treated unit and the synthetic control unit in the pre-treatment period.

Matching variables, X_1 and X_0, are predictors of post-intervention outcomes and unaffected by the intervention. The weights are chosen to minimize the norm, $||X_1 - X_0 W||$, such that each weight is greater than or equal to zero and the sum of all weights equals one. We may have unmeasured factors affecting post-deflection crime, as well as heterogeneity in the effect of these unobserved factors and probably observed factors. If the number of pre-intervention periods is large enough, then matching on pre-intervention outcomes should control for this because we would expect the unobservables and observables to be similar for groups matched over a long time. Indeed, we use every lag of the dependent variable as predictors in our specifications. The covariates used in these analyses include the variables in Table 2.3 and Table 2.5, as well as the lag of the dependent variable for each observation in the pre-treatment period.

We estimate effects using the *synth* program in STATA version 17.0 (Abadie, Diamond, and Hainmueller, 2020). The program begins by calculating the weights for each control unit, and then the outcome of the synthetic control unit, as well as the root mean squared prediction error (RMSPE) based on differences between the treatment and synthetic control units in the pretreatment period. Because RMSPE is relative to the scale of the outcome rather than a standardized scale, we also calculate an absolute standardized mean deviation (ASMD) to test balance between the treated and synthetic control units (Parast et al., 2021). The effect of the program is then estimated by comparing the actual values of the dependent variable for the treatment unit to the corresponding values of the synthetic control. We also use a joint test of *p*-values to assess whether the overall effect of the intervention was significant. We also examine estimates for each post-intervention period because this study estimates community-level effects of an intervention that increased the number of people treated over time. Therefore, we test the effects over time.

Chapter 3. Process Findings

Model Descriptions

The programs included in this study differed on a wide array of key features, which are summarized in Table 3.1. These features represent key decision points that jurisdictions interested in running deflection programs face.

Table 3.1. Summary Overview of Main Program Characteristics

Feature	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6
Geographical coverage	City	County	Tribal Area	County	County	City
Number of agencies involved	One	40 agencies	One	28 agencies	19 agencies	One
Deflection pathways utilized	Active outreach (main) Self-referral	Self-referral (main) Post-overdose outreach (some agencies) Active outreach (some agencies)	Officer Prevention (main) Self-referral	Post-overdose (original) Self-referral Active outreach	Self-referral (original) Self-referral Post-overdose (some agencies) Active outreach (some agencies)	Active outreach (main) Self-referral
Substances covered	All SUD	All SUD	All SUD	All	All SUD	Alcohol use disorder not covered
Law enforcement officers involved	Dedicated outreach team in uniforms	All officers (in uniforms)	All officers (in uniforms)	Dedicated plainclothes officers in an unmarked cruiser	All officers (in uniforms)	Dedicated plainclothes officers in unmarked cars
Other individuals interacting with participants	Social workers in bulletproof vests	Recovery coaches in aftercare	Crisis workers riding with law enforcement officers; wraparound workers	Recovery coaches in plain clothes, community outreach specialist	Navigators	Peer recovery coaches (not present during law enforcement officer outreach)
End of police involvement	Ends with connection to services; minimal case management done by the social worker	Relationship ends with transport and handoff	Crisis support workers hand case over to peer supports at treatment center	Ends with connection to care/handoff	Ends once a person leaves the station; navigators' involvement ends with connection to services	Connection with peer recovery coaches

The principal characteristic of each deflection program is the **pathway** through which it engages with clients. In line with the original focus of the funding award, the self-referral pathway was present in each site, although with important differences. In two sites (Site 2 and Site 5), self-referral was the original pathway and has remained the main source of clients. In both sites, the self-referral mechanism was very similar: Members of the public were invited to seek help in any participating police station (all departments in the county in Site 2 and approximately half of departments in the county in Site 5). Both sites that originally started with the self-referral pathway later added new pathways—post-overdose and active outreach in both sites and officer prevention in Site 5—albeit with more limited geographical coverage. By contrast, the other four sites originally started with another pathway (active outreach in Site 1 and Site 6, officer prevention in Site 3, post-overdose in Site 4), and self-referral was added later. Notably, in none of these four sites was the addition of self-referral a formal planned decision. Rather, as a rule of thumb, as local residents' familiarity with the original pathway and the existence of the program grew, interested individuals or their families and friends began contacting the program with the intention to self-refer. And because the programs already had a deflection process in place, allowing community members to self-refer represented a relatively small and inexpensive change to the program.

The original design of the program was also related to the question **whether to use dedicated police officers** and, if so, how they should identify themselves. Both original self-referral sites (Site 2 and Site 5) involved all officers in the participating departments. This is unsurprising, because potential clients may present themselves at a station at any time and so any officer must be able to receive them. By contrast, programs running primarily other pathways generally relied on dedicated officers. Site 1 (active outreach) established a dedicated outreach team, clearly marked in uniforms. Site 4 (post-overdose) and Site 6 (active outreach) used dedicated plainclothes officers in unmarked cruisers. The only exception to this pattern was Site 3 (officer prevention), which involved all officers in outreach duties, although stakeholders we interviewed pointed out that the number of referrals made varied across officers. In the three sites that added self-referral pathways following the implementation and relied on dedicated deflection teams, all police officers might still be marginally involved in the program if interested clients show up at the police station or call the departments' general phone number and the dedicated officers are not available. In such instances, the receiving officers would typically take the clients' details for further outreach by the dedicated team. Most often, however, potential clients would self-refer directly to the dedicated team on the basis of previously distributed information materials or based on word-of-mouth referrals.

In addition to police officers, all six sites made **use of other non–law enforcement personnel** in interactions with clients. Again, some notable differences emerged across the sites, primarily whether these nonpolice individuals were present during the initial contact with the potential client. Three sites used nonpolice personnel already during outreach to potential clients. In Site 1, officers on the outreach team were joined by social workers. Similarly, Site 3 had crisis

workers ride with officers during responses to calls for service and Site 4 had recovery coaches ride with officers during post-overdose visits. By contrast, Site 6, which also relied on active outreach, only connected clients with peer recovery coaches once they accepted the connection. Site 4 also introduced a pathway not involving law enforcement officers at all by hiring a community outreach specialist tasked with reaching out to potential clients in hotspot locations. Lastly, the two self-referral-driven sites (Site 2 and Site 5) also incorporated nonpolice specialists, albeit in a different manner. Site 5 worked with navigators who would come to police stations to facilitate the intake and engagement of clients once a person has presented to a police station. Site 2 worked with recovery coaches, but only as an aftercare service, and did not use any nonpolice personnel before handoff to service providers.

As a general rule, in all six sites **the role of police officers ended** after the client left the station or was transported and handed over to an outside provider—typically, though not exclusively, a provider who would conduct an assessment of the client. In all six sites, some form of follow-up and continuous engagement with clients existed; however, police officers were never part of that.

A further important consideration for deflection programs, and self-referral programs in particular, is the question of **outstanding warrants** potential clients may have or their ongoing criminal justice system involvement. Stakeholders from all six sites recognized this as a potential issue and described processes in place intended to help individuals with unresolved criminal histories. Police interviewees from two sites explicitly noted that their programs will overlook some minor delinquency. Further, stakeholders in all six sites mentioned that their programs will work with potential clients to help clear out any issues—for example, by helping set up court dates to vacate existing warrants, reaching out to other counties and states to get help with out-of-county or out-of-state warrants, or working with the district attorney on deferred prosecution. In another example, outreach officers in Site 6 explicitly avoided doing outreach at addresses with known outstanding warrants, and in Site 1 they did not always check for warrants before engaging individuals. However, despite these processes' ability to improve the situation of some individuals, two potentially important gaps remain, particularly for self-referral programs that require individuals to be willing to present themselves to the police on their own volition. First, the extent to which deflection programs are able or willing to help resolve individuals' prior criminal justice involvement is not clear or clearly communicated. Interviewees from two sites explicitly pointed out that some prior warrants (such as those for serious crimes) will not be cleared, which means that facing a criminal sanction remains the only option for some potential participants. Elsewhere, interviewees described the process of dealing with prior warrants as being on a "case-by-case basis," which may not confer the level of guarantee a potential client may be seeking. Second, in two sites with multiple participating police departments (Site 4 and Site 5), stakeholders noted that the practice of addressing prior warrants may differ across agencies. This again may not be consistent with the level of assurances and transparency potential clients may need in order to come forward.

Reflections on Expectations and Results

When discussing expectations from the deflection programs, interviewees generally mentioned four types of expected outcomes.[3] First, the principal objective was to address harms stemming from substance use and the opioid crisis. Second, interviewees described a growing perception that a new policing approach was needed to deal with drug-related issues and viewed deflection programs as a departure from a traditional arrest-based approach. A third, and related, objective was to reduce the impacts of the opioid crisis on law enforcement personnel, citing such issues as respondent fatigue and increased demands on law enforcement stemming from drug use and crime linked to drug use. And fourth, to a more limited extent, some stakeholders also spoke of the need to respond to public concerns about drug-related public nuisances.

Overall, stakeholder perspectives suggested that deflection programs achieved progress toward all of the aforementioned objectives. Interviewees from all sites were able to offer anecdotal examples of positive linkages with treatment and other services effected thanks to the program, even if rigorous data of programs' impacts in this domain were not available. Further, the majority of interviewees agreed that deflection programs resulted in a change in policing practice toward a less enforcement-focused and more supportive approach. To illustrate, multiple law enforcement interviewees spoke of the realization that "one cannot arrest their way" out of the problem, as well as of the fact that police departments have the means to, and frequently are the only ones able to, provide assistance to people who use drugs and experience an urgent need for support services. Relatedly, multiple interviewees highlighted increasing acceptance of deflection principles among police officers and law enforcement agencies. Lastly, with respect to community perspectives, some interviewees suggested that deflection programs contributed to a reduction in community stigma surrounding drug use and, simultaneously, contributed to a change in how members of the community, including some people who use drugs, viewed the police. A related overarching observation made in all six sites was that the deflection programs enjoyed community support, or at a minimum did not face meaningful opposition.

Implementation Lessons

Interviewees were also invited to reflect on lessons from the implementation process. Thinking about implementation facilitators, three items were featured most prominently.[4] First, the most frequently mentioned facilitator was the importance of partnerships and cooperation mechanisms between key stakeholders. Second, and related, interviewees also stressed the contribution of high-profile champions, who were seen as instrumental in generating support and

[3] This section presents a brief summary of a discussion in an in-progress paper by Jirka Taylor and colleagues, about stakeholder perspectives on the implementation of the six police-led deflection programs we evaluated.

[4] This section presents a brief summary of a discussion in an in-progress paper by Jirka Taylor and colleagues, about stakeholder perspectives on the implementation of the six police-led deflection programs we evaluated.

buy-in for the program and making it a reality. And third, the involvement of people with lived experience was also highlighted by interviewees as an important building block and contributor towards successful implementation.

Alongside implementation facilitators, interviewees also commented on perceived barriers to a more effective implementation of police-led deflection programs. The most frequently mentioned issue was the persistence of stigma pertaining to substance use, coming predominantly in three forms: (1) continued stigma among law enforcement officers, (2) continued stigma among health care professionals, and (3) effects of community stigma resulting in lower support for services for people who use drugs and in lower willingness of people who use drugs to seek help. A second major barrier highlighted by interviewees was continued distrust of the police, which is an important impediment for programs that invite people who use drugs to either seek help from at a minimum accept help from the police. And third, corresponding to the perceived importance of partnerships, several interviewees spoke of either experienced or potential issues with maintaining effective partnerships over time. In addition to these barriers directly impacting the operation of police-led deflection programs, numerous interviewees also pointed out that broader challenges pertaining to service provision for people who use drugs also indirectly affect deflection programs by impacting the likelihood of a participant's successful connection with an appropriate service. In this regard, two issues loomed large: (1) insufficient treatment capacity in the local area and (2) issues pertaining to insurance and cost of treatment.

Chapter 4. Pressing Practice Issues

In addition to reflections on the implementation process presented in the previous chapter, this project also led to the identification of a number of pressing practice issues facing deflection programs. This chapter contains a brief discussion of these issues, drawing on insights from the six deflection programs in this study as well as on evidence from other studies on deflection and related topics, such as services for people who use drugs, substance use, and law enforcement and SUD/mental health.[5]

Coordination and Exchange of Information

As discussed earlier, with increasing maturity, individual programs expand to include additional pathways and linkages to new providers. These expansions take place alongside the proliferation of various diversion initiatives operated by other criminal justice agencies, and often bring an increasing interest in addressing issues beyond the original remit of opioid use or substance use more broadly. These trends result in increasingly complex environments for stakeholders and coordination needs.

As discussed earlier, interviewees uniformly highlighted strong local partnerships as the most important facilitator of successful implementation. Coordination in a more complex environment is more likely to require dedicated staff, making it more difficult to implement deflection operations with limited new resources. Relatedly, more sophisticated record management systems and databases may be required for successful administration, again making programs more reliant on new sources of funding. To illustrate, interviewees in one of the sites relying on external grants to support its deflection initiatives viewed the potential loss of the initiative's information system as the main threat associated with the funding's discontinuation. This is particularly important as deflection programs face the challenge of data sharing and coordination across multiple systems and professions.

Connection to Services

The primary motivation of deflection is to facilitate connection to services for people who would benefit from such linkage, typically because they would otherwise be arrested/prosecuted for an offense and/or have fallen through the cracks of the health care system—individuals who, in many communities, are disproportionately ethnic or racial minorities. Accordingly, in some initiatives, the role of the leading first responder agency is concluded at the

[5] This chapter presents a brief summary of a discussion of an in-progress paper by Jon Ross and colleagues.

moment the participant is connected with treatment or other services through a warm handoff to a treatment or services partner. In other cases, the involvement of the deflection initiative continues after the linkage has been made—for instance, in the form of periodic follow-ups, often because the law enforcement agency responsible for the transfer of the individual to treatment or services has an interest in the individual's status, including the potential that the individual will not be the source of a call for service in the future. The latter approach is in line with a desire to minimize the well-known risk that a program participant can get lost at various points on their journey, such as handovers between various providers (Stein et al., forthcoming). Still, no predominant approach appears to exist among deflection initiatives, so the question of who takes ownership of assisting the participant in their journey through the systems and guides them so that they do not fall between various system cracks continues to apply. This represents a significant expansion of a deflection initiative's responsibilities, which the program likely would not have the capacity to take absent new resources, nor may the leading agency be interested in taking on these duties. Relatedly, particularly for deflection initiatives led by law enforcement agencies, the participants themselves or partner agencies may prefer to limit the involvement of a criminal justice agency after the connection with services is made.

Reducing Stigma

Perspectives from stakeholders suggest that deflection initiatives have been instrumental in reducing stigma associated with SUD, among both police officers as well as the general public. Despite this observation, stigma was consistently highlighted as one of the main barriers to greater program effectiveness. It is not surprising that stigma would represent a major challenge for deflection initiatives, particularly those led by law enforcement. Depending on the pathway, deflection relies on the willingness of program participants to voluntarily come forward and seek help at the station or accept help following an interaction with a police officer. This in turn requires some degree of trust, which may be unrealistic to expect among some potential participants.

Some deflection operations' features may mitigate some negative impacts of stigma and a lack of trust in the police. As discussed above, numerous programs employ nonpolice personnel (often in conjunction with law enforcement), who represent an alternative point of contact for potential participants to reach out to. Representatives of more mature programs also highlighted word of mouth among people who use drugs as an important buy-in and trust-building mechanism. Fire department–led programs represent another option to avoid issues surrounding law enforcement and stigma, although fire department–led programs currently account for a relatively small fraction of deflection practice.

A corollary to this discussion is that the pernicious impacts of stigma, experience with discriminatory practices, and the quality of police-community relations vary across communities. Consequently, it is conceivable that the potential benefits of deflection are not distributed

equitably across communities, and some groups of individuals are more likely to stand to benefit from participating in deflection. Indeed, one of the challenges noted by interviewees is reaching out to and encouraging participation from hitherto less participating groups, such as communities of color.

Barriers to Access to Treatment and Other Services

Deflection initiatives are also indirectly affected by issues related to service provision in their communities. This objective is difficult to achieve if existing services are difficult to access. For that reason, deflection stands to benefit from policy interventions aiming to improve access to services. In addition to the possible connection between the presence of deflection initiatives and Medicaid expansion, other interventions have been discussed at length in existing literature (e.g., Christie et al., 2017; Commission on Combating Synthetic Opioid Trafficking, 2022; Saloner et al., 2018) and do not need revisiting at length here, although based on existing data, two particular areas merit special mention.

The first area involves provider capacity and the ability of providers to accept deflection clients. Owing to their working relationships with treatment providers and their knowledge of local service provision, deflection initiatives may be more likely to find a place for new participants. However, this ability is still limited by the existing treatment capacity in deflection programs' communities, necessitating in some instances looking for treatment and services in more distant locations. Thus, deflection initiatives would be indirect beneficiaries of policy interventions to increase SUD treatment capacity, such as restricting various relaxations on medications for opioid use disorder (MOUD) prescribing. Importantly, provider capacity issues are not limited to SUD treatment but extend to other domains. In line with observations made in existing literature, chief issues among these include housing and transportation, alongside other wraparound services and health determinants (Timko et al., 2016; Frazer, McConnell, and Jansson, 2019; Gressler et al., 2019).

Knowledge Gaps and Learning

Given the relatively recent development of deflection, it is not surprising that the knowledge base underpinning this area is very much in development. A great share of the existing literature has focused on the description of existing deflection provisions, with the aim of understanding the variability across existing programs, their origins, and their implementation, and of creating a typology of existing programs (e.g., Charlier and Reichert, 2020; Formica et al., 2021). The evidence base is comparatively less developed with respect to understanding the results and impacts of deflection. The few evaluations that exist primarily draw on pre-arrest diversion programs, such as LEAD (e.g., Lindquist-Grantz et al., 2021), and do not largely comment on the effectiveness of programs not involving any threat of criminal sanctions.

In this regard, evaluating the impact of individual deflection programs in a way that extends beyond procedural indicators, such as the number of connections to treatment made, is rendered difficult by a number of factors. To illustrate, some deflection operations are relatively small and do not see a large number of participants. This makes it difficult to design a well-powered evaluation. The attribution of any observed effects to the deflection initiative is also often complicated. In some contexts, deflection initiatives may not be aware of individual positive cases where participants do not engage with services immediately after their encounter with deflection, but the interaction may have nevertheless facilitated their decision to seek help later in their lives. Further, contamination is a serious concern because it is possible that other interventions operating in the area contributed to successful outcomes. Finding a suitable comparison group is also difficult as the exposure to deflection is not random; for instance, treatment entrants not utilizing the deflection program may differ on important unobservable characteristics, such as motivation. Population-level studies may be a solution to the counterfactual problem but still face the challenges mentioned above, such as statistical power and attribution.

For that reason, many important questions remain unanswered. For instance, while anecdotal evidence of successfully deflected participants and interviewee perspectives of deflection programs' contributions toward a range of positive outcomes are available, uncertainty exists around the magnitude and breadth of true impacts of deflection. Further, evidence is lacking on what design features in such areas as pathways, lead agency, and partnership models are associated with a greater likelihood of effectiveness and of mitigating the practice and policy issues discussed above.

Chapter 5. Outcome Findings

Police diversion, or deflection, programs are proposed as a way of improving community-level outcomes in terms of lowering crime and reducing problems related to substance use and mental health (Charlier, undated). Based on our understanding of deflection efforts, several possible outcomes are of interest. First, because deflection programs attempt to provide connection and warm hand-offs to treatment, admissions to substance use treatment providers may increase. Second, increased access to and engagement with substance use treatment and other services may reduce drug overdoses or fatal drug overdoses. We also analyzed the impact of these programs on three types of crimes: DUI, property crime (burglary, theft or larceny, and motor vehicle theft), and drug possession. There are several reasons for analyzing these specific crimes. First, the extent to which officers have discretion for making an arrest differs by crime type. For DUI, given the danger of releasing someone, officers have very little, if any, option to arrest someone or not once an individual has been stopped and there is suspicion of use. Thus, arrests for DUI are less discretionary and less likely to be affected by changes in police practice that result from deflection. For drug possession, however, officers have some discretion to consider the context, and whether investigating for drug use is needed for public safety. Certainly, in a jurisdiction with a drug deflection program, we might expect officers to exercise their discretion not to arrest for drugs and may instead offer the individual a chance to participate in the program. Second, the program hypothesizes that an important number of property crimes are due to drug use, in line with the idea that some individuals with drug use disorders commit a significant number of acquisitive crimes to pay for drugs. To test this theory, we estimate the effect of the programs on arrest rates at the county level.

By comparing the actual arrest and overdose patterns for two counties adopting deflection programs with the estimated synthetic controls in the post-program period, we derive quarter-by-quarter estimates for the impact of these two deflection programs in the four years (Lake County) and three years (Plymouth County) following program adoption.[6]

Analyzing the Impact of Deflection on Community-Level Crime and Overdoses

With one county implementing each program, we used the synthetic control method (SCM) to estimate the impact of program adoption on overdose and crime rates in the county. We then estimated the effect of the program by comparing the actual values of the dependent variable for

[6] This chapter represents a brief summary of an in-progress paper by Samuel Peterson about the county-level effects of police deflection on key outcomes.

the treatment unit to the corresponding values of the synthetic control. We also used a joint test of *p*-values to assess whether the overall effect of the intervention was significant. We also examined estimates for each post-intervention period because this study estimates community-level effects of an intervention that increased the number of people treated over time. Therefore, we tested the effects over time.

Results

Here, we present synthetic control results for Lake County, Illinois, and Plymouth County, Massachusetts, across seven outcomes: treatment admissions, nonfatal overdoses, fatal overdoses, fatal opioid overdoses, property crime arrests, DUI arrests, and drug offense arrests.

SCM Results for Lake County

In our first set of synthetic control models, we examined the public health outcomes of treatment admissions, nonfatal overdoses, fatal overdoses, and fatal opioid overdoses (Table 5.1). The treatment admissions results suggest a poor fitting synthetic control group, meaning significance testing is not interpreted. Next, the nonfatal drug overdoses synthetic control model shows moderate fit, as indicated by the ASMD max value that is higher than recommended. Nevertheless, the ASMD mean is at an appropriate level (Hunt, 2021; Parast et al., 2021). Therefore, we interpret the results with caution, but note that there appear to be consistently negative effects starting at the seventh quarter after the start of the program, or almost two years later. Next, the synthetic control model results for fatal overdoses shows a better fit of the synthetic control in the pretreatment period, and fairly similar findings, although with some fluctuation (two periods are positive and significant). Last, the fatal opioid overdoses model has a similar synthetic control fit to the nonfatal overdoses model, but it provides the most consistent evidence of a significant reduction relative to the synthetic control, with most post-treatment observations being negative and significant as well as a significant joint *p*-value.

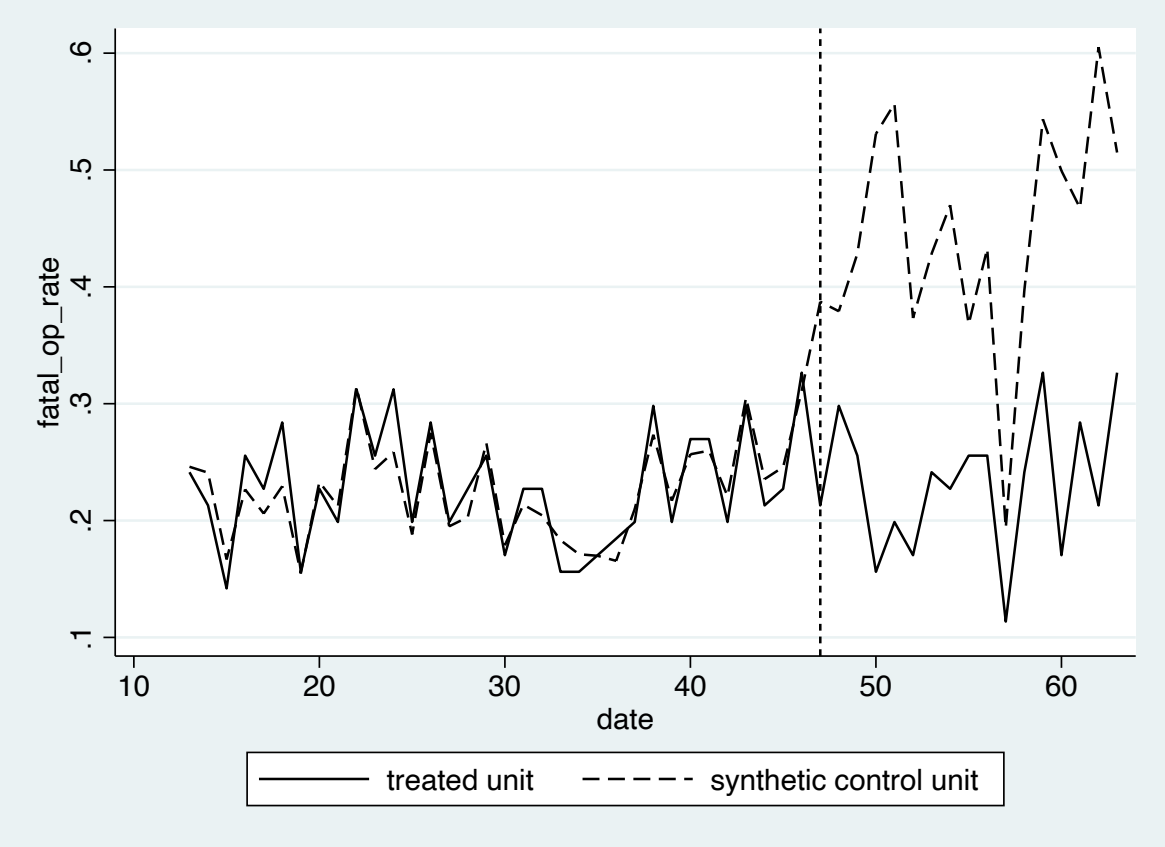
Table 5.1. SCM Estimates of Health Outcomes for Lake County

	Treatment Admissions		Nonfatal Overdoses		Fatal Overdoses		Fatal Opioid Overdoses	
	Est	Pvals std.	Est	Pvals std.	Est	Pvals std.	Est	Pvals std.
Post Q1	–1.58	0.00	0.35	0.23	–0.22	0.00	–0.17	0.01
Post Q2	–2.41	0.00	–0.18	0.53	0.11	0.03	–0.08	0.10
Post Q3	–3.33	0.00	–0.59	0.14	0.01	0.86	–0.17	0.02
Post Q4	–3.42	0.11	–0.85	0.12	–0.31	0.00	–0.37	0.01
Post Q5	–3.64	0.05	–0.38	0.38	–0.10	0.05	–0.36	0.01
Post Q6	–3.76	0.05	–0.09	0.76	–0.06	0.22	–0.20	0.03
Post Q7	–3.95	0.05	–1.03	0.04	0.13	0.02	–0.19	0.01
Post Q8	–1.34	0.11	–1.34	0.04	–0.11	0.02	–0.24	0.01
Post Q9	–0.84	0.24	–0.98	0.04	–0.09	0.06	–0.11	0.08
Post Q10	–0.87	0.18	–0.70	0.05	–0.06	0.10	–0.18	0.06
Post Q11	–0.64	0.32	–0.87	0.03	–0.11	0.03	–0.08	0.16
Post Q12	–1.01	0.16	–1.38	0.04	–0.05	0.21	–0.16	0.05
Post Q13	–1.22	0.13	–1.57	0.03	–0.15	0.05	–0.22	0.02
Post Q14	–1.11	0.11	–1.23	0.01	–0.11	0.02	–0.33	0.02
Post Q15	–0.65	0.32	–1.13	0.03	–0.07	0.09	–0.18	0.01
Post Q16	–1.28	0.08	–1.35	0.04	–0.14	0.02	–0.39	0.01
Post Q17	–0.84	0.21	–1.82	0.01	0.00	0.92	–0.19	0.06
RMSPE			0.184		0.019		0.019	
ASMD mean			0.063		0.043		0.066	
ASMD max			0.282		0.207		0.271	
Pval joint std			0.041		0.035		0.023	
Pval joint std adj.			0.053		0.046		0.034	

NOTE: Est = estimate of treatment effect; Pvals std. = standardized *p*-value from placebo tests; Q = quarter.

Figure 5.1 displays the treatment and synthetic control unit trends for fatal opioid overdoses over time. As shown, the pre-intervention match quality is adequate, and the post-intervention differences are immediate and sustained during the post-intervention period. The total fatal overdose and nonfatal overdose charts are fairly similar.

Figure 5.1. Treated Unit and Synthetic Control Unit Trends Pre- and Post-Intervention in Lake County



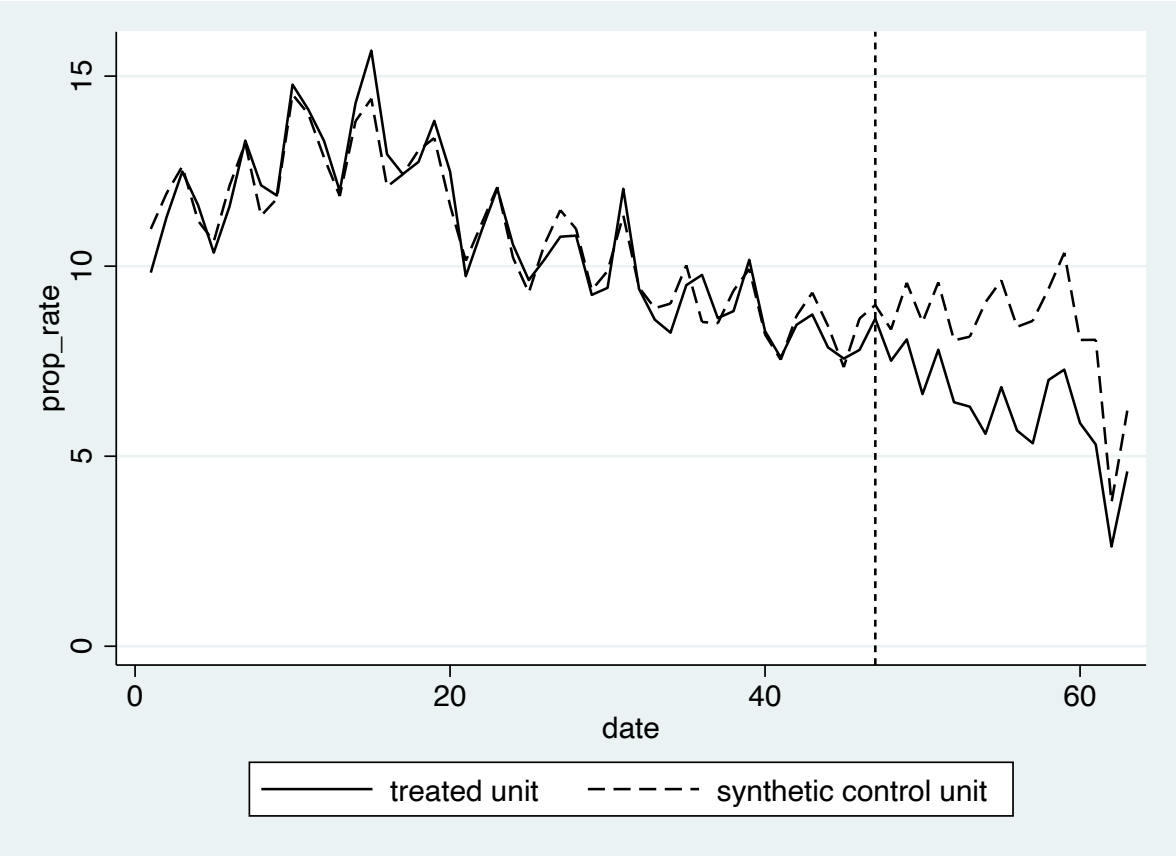
Next, the synthetic control results for property crime arrests show mostly negative and significant effects for Lake County, and the joint *p*-value estimate is less than 0.05 (Table 5.2). The pre-treatment fit of the synthetic control group is adequate given the ASMD mean and max. DUI arrests and drug arrests show little evidence of significant change after the start of the deflection program in Lake County.

Table 5.2. SCM Estimates of Crime Outcomes for Lake County

	Property Crime Arrests		DUI Arrests		Drug Arrests	
	Est	**Pvals std.**	**Est**	**Pvals std.**	**Est**	**Pvals std.**
Post Q1	–0.36	0.63	–0.34	0.68	–1.16	0.15
Post Q2	–0.82	0.24	–0.33	0.68	–0.04	0.95
Post Q3	–1.49	0.06	0.10	0.91	–0.37	0.67
Post Q4	–1.89	0.01	–1.02	0.22	0.76	0.33
Post Q5	–1.77	0.08	–0.55	0.51	–1.09	0.21
Post Q6	–1.63	0.05	0.54	0.48	–0.58	0.45
Post Q7	–1.84	0.07	–0.83	0.30	–1.30	0.17
Post Q8	–3.46	0.00	–0.26	0.78	–1.74	0.09
Post Q9	–2.81	0.02	0.18	0.91	–1.99	0.09
Post Q10	–2.73	0.01	1.13	0.21	–1.26	0.22
Post Q11	–3.22	0.00	0.30	0.64	–2.51	0.03
Post Q12	–2.40	0.02	0.81	0.36	–2.43	0.06
Post Q13	–3.07	0.00	1.12	0.23	–2.24	0.07
Post Q14	–2.19	0.02	1.21	0.22	–1.56	0.07
Post Q15	–2.76	0.00	1.78	0.11	–2.17	0.06
Post Q16	–1.16	0.17	0.91	0.24	–1.09	0.22
Post Q17	–1.60	0.20	1.16	0.22	–2.27	0.05
RMSPE	0.531		0.551		0.448	
ASMD mean	0.059		0.055		0.067	
ASMD max	0.171		0.197		0.199	
Pval joint std	0.000		0.333		0.092	
Pval joint std adj.	0.011		0.341		0.102	

Figure 5.2 shows the treated and synthetic unit trends over time for property crime arrests in Lake County. Here, there is a pre-intervention gradual decrease in property crime arrests, which continues for the treated unit in the post-intervention period but changes to a slight increase in the synthetic control unit.

Figure 5.2. Treated Unit and Synthetic Control Unit Trends for Property Crime Arrests in Lake County



SCM Results for Plymouth County

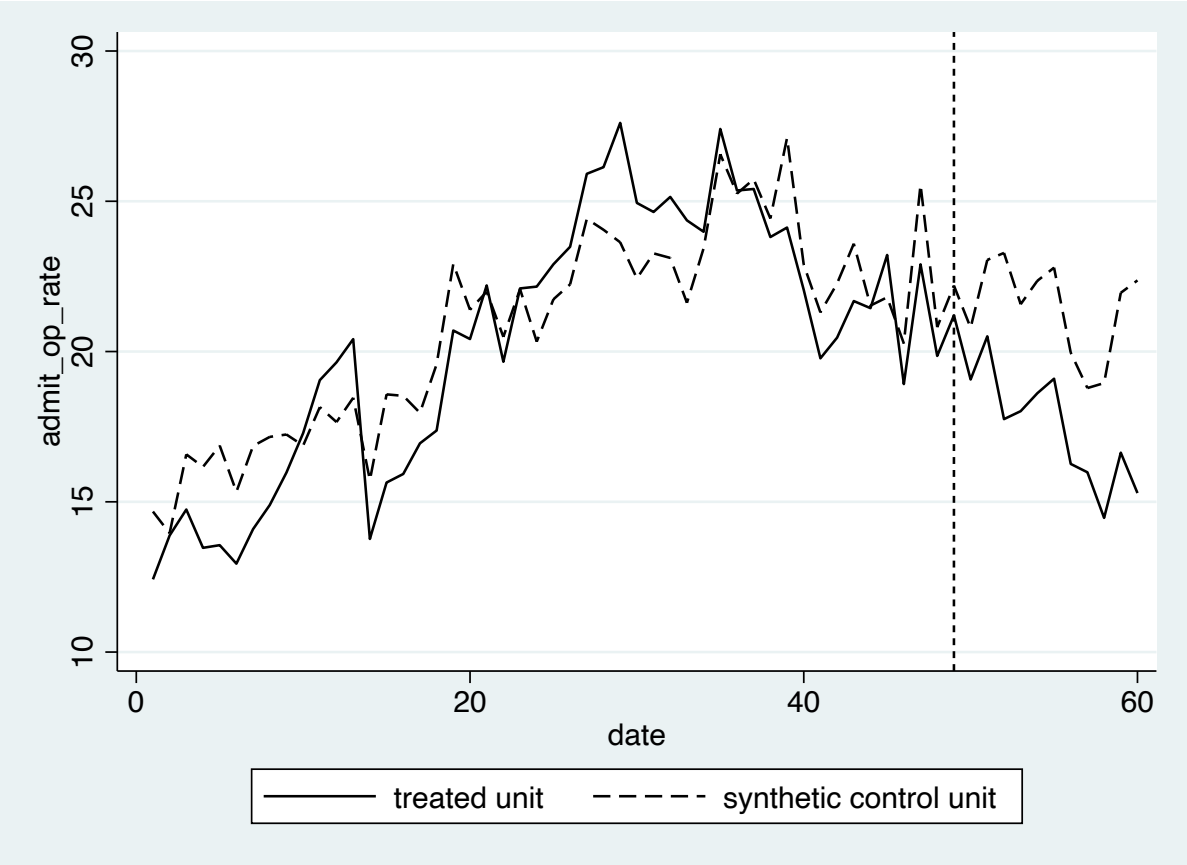
Next, we examined the effects of the deflection program in Plymouth County, Massachusetts. Given limited data quality, the only health outcomes we were able to analyze are quarterly treatment admissions and yearly fatal overdoses (Table 5.3). The synthetic control estimate in the pre-treatment period for fatal overdoses was not an adequate fit to the pre-treatment trend in the treatment county. Given that the yearly data only contain three post-treatment observations, better data are needed for overdoses across Massachusetts.

Table 5.3. SCM Estimates of Health Outcomes for Plymouth County

	Treatment Admissions		Treatment Admissions—Opioids			Fatal Opioid Overdoses (yearly)	
	Est	**Pvals std.**	**Est**	**Pvals std.**		**Est**	**Pvals std.**
Post Q1	2.83	0.27	–0.99	0.64	Post Y1	0.581	0.27
Post Q2	–0.24	1.00	–1.72	0.45	Post Y2	–0.557	0.46
Post Q3	1.03	0.82	–2.54	0.55	Post Y3	–0.202	0.91
Post Q4	–6.17	0.00	–5.53	0.00			
Post Q5	–3.13	0.45	–3.56	0.27			
Post Q6	–3.31	0.36	–3.74	0.18			
Post Q7	–2.16	0.64	–3.70	0.36			
Post Q8	–2.16	0.45	–3.70	0.09			
Post Q9	–0.97	0.82	–2.80	0.27			
Post Q10	–6.44	0.00	–4.48	0.09			
Post Q11	–7.45	0.00	–5.32	0.09			
Post Q12	–11.65	0.09	–7.08	0.00			
RMSPE	2.56		1.869			0.201	
Pval joint std	0.091		0.091			0.636	
Pval joint std adj.	0.167		0.167			0.667	

Figure 5.3 depicts the treated unit and synthetic control unit trends for Plymouth County treatment admissions for opioid use. As shown, and relative to the Lake County findings, there is a much poorer fit between the synthetic control unit and the treated unit for the pre-intervention period in Plymouth County. Additionally, the number of treatment admissions for opioid use in the treated unit actually decreased after the intervention, and appears to be part of a pre-treatment downward trend in admissions. Comparing this decrease to the synthetic control unit is not recommended because of the poor pre-treatment fit.

Figure 5.3. Treated Unit and Synthetic Control Unit Trends for Treatment Admissions for Opioid Use in Plymouth County



Finally, although the effects for property crime and drug arrests show that arrests generally decreased after the start of deflection, the joint *p*-value estimate is not less than the 0.05 level (Table 5.4). Only the first quarter after the start of Plymouth's deflection program is significant. The estimates for DUI arrests are all positive, but only one is significant. Thus, there is no evidence that the Plymouth County deflection program had any impact on these crimes.

Table 5.4. SCM Estimates of Crime Outcomes for Plymouth County

	Property Crime Arrests		DUI Arrests		Drug Arrests	
	Est	**Pvals std.**	**Est**	**Pvals std.**	**Est**	**Pvals std.**
Post Q1	–5.26	0.00	1.13	0.18	0.05	1.00
Post Q2	–5.87	0.18	1.12	0.00	–0.35	0.91
Post Q3	–4.64	0.45	0.12	1.00	–0.50	0.55
Post Q4	–0.08	1.00	0.62	0.45	0.66	0.45
Post Q5	–6.03	0.36	0.48	0.36	–0.14	0.82
Post Q6	–3.90	0.64	1.12	0.18	–0.20	0.73
Post Q7	0.12	1.00	0.32	0.91	–0.96	0.18
Post Q8	1.06	0.91	0.24	0.91	–0.11	0.91
Post Q9	6.71	0.09	0.55	0.82	–0.55	0.55
Post Q10	–0.96	0.73	0.94	0.27	–0.22	0.73
Post Q11	–7.33	0.09	0.11	1.00	–0.10	0.91
Post Q12	–2.86	0.73	0.63	0.82	–0.31	0.82
RMSPE	5.25		0.671		0.866	
Pval joint std	0.545		0.545		0.910	
Pval joint std adj.	0.583		0.583		0.917	

Summary of Results

Overall, the findings in Lake County are suggestive of improved overdose outcomes, particularly fatal opioid overdoses. Additionally, property crime arrests likely decreased after the start of the county's deflection program. Drug arrests also decreased in Lake County, but these estimates were not significant. Admissions data for Lake County were limited to only Medicaid data and did not produce useful estimates. Next, the results for Plymouth County are mostly null. This is likely due to the low number of comparison units. Additionally, the data availability for health outcomes in Massachusetts was poor. We were not able to obtain quarterly fatal and nonfatal overdoses and opioid overdoses at the county level from the state health department, which are arguably the most important outcomes for deflection programs. Lastly, we did obtain quality treatment admissions data for Massachusetts, but these data revealed that treatment admissions slightly decreased after the start of the Plymouth County deflection program, while overdose deaths also declined during this period.

Chapter 6. Conclusion

In response to the overwhelming harms caused by the overdose crisis, communities across the country have adopted deflection as a front-line response to the opioid crisis. Deflection programs aim to connect individuals with SUD who encounter the criminal justice system with treatment and other services according to the individuals' needs.

This report aims to contribute to the development of evidence base underpinning voluntary deflection programs, given the ongoing interest of police departments to introduce deflection programs and to strengthen existing deflection practice. Specifically, this report describes the implementation of six police-led deflection programs, examines stakeholder perspectives on this process, and identifies transferrable lessons for other sites interested in a similar course of action. In addition, this project discerns the effectiveness of the police deflection programs in two of the sites.

Key Findings

Implementation Findings

The data show that deflection programs in the United States can take many shapes and forms. In Chapter 1 of this report, we discuss the various deflection pathways. This is in line with the results of the BJA survey (National Survey to Assess First Responder Deflection Programs in Response to the Opioid Crisis, 2021). There are clear decisions leaders of deflection programs need to make in terms of how to operationalize and structure their programs to best suit the needs of their communities.

The findings from this report, in conjunction with the BJA survey, indicate that there are some trends emerging across the field of deflection practice:

- gradual incorporation of additional pathways
- overall move toward greater complexity and breadth of service provision, including the coexistence of other diversion programs in the area
- a move toward the professionalization of deflection (e.g., needing own staff, formulation of best practices).

Qualitatively, perspectives from stakeholders suggest positive results in terms of (1) individual participant journeys, (2) change in policing practice and views, (3) reductions in stigma, and (4) stakeholder and community buy-in. Facilitators of implementation can also be identified, primarily as strong partnerships and champions. Barriers include persistence of stigma, distrust of police, and challenges pertaining to services for people who use drugs writ large, such as treatment capacity and payment methods.

Outcome Analyses

With regard to the outcome analyses, the data clearly show that Lake County saw improvements in overdoses, particularly fatal opioid overdoses after the beginning of its deflection program. These effects are fairly consistent over time. While we would have expected treatment admissions to increase as a result of deflection programs starting, this does not appear to be the case, although the data we had for Illinois were not complete (Medicaid only), and trends suggest evidence of other factors affecting treatment admissions levels. From the data, it does not appear to affect crime in a clear way, although property crime arrests in Lake County were reduced. It does not appear that drug arrests declined, although it must be acknowledged that there were statewide and local initiatives and policies that could have affected the estimates.

Limitations

There are a few limitations of the study that need to be mentioned. Owing to the recent emergence of deflection as a practice, this project has attempted to scope a rapidly developing field. Because of limited resources, we were not able to collect the perspective of people who were currently using drugs or were involved with a deflection program. Also, this study has been ongoing since 2019, and COVID-19 disrupted some of the key data collection activities, especially site visits.

This study included a small sample size: We were only able to look at six sites qualitatively and conduct the outcome analyses in two programs in two states. There are a multitude of variations in programs across the country, and we were unable to test what program components matter or matter most. While an effort was made to capture perspectives from a wide range of stakeholder types and a variety of local contexts, it is necessary to view those perspectives as coming from a limited number of sources. It is possible that different perspectives would have been offered in different programs.

For the outcome analyses, we lacked knowledge about other concurrent deflection programs in other counties or other large initiatives within or across counties that may have affected outcomes. Other concurrent efforts in control counties would have the impact of diminishing our ability to observe effects, while concurrent efforts in the treatment county would confound any observed effects.

There was poor data coverage in Massachusetts and poor treatment data in Illinois. Because analyses are county-level, these findings are unable to say whether program participants were more successful than nonparticipants. Moreover, there is a question of whether these programs are large enough for county-level effects to be observed. Finally, some of these outcomes are fairly rare at the county level quarter-to-quarter.

Concluding Thoughts

Despite its relative newness, the field of deflection is becoming a distinct professional practice, incorporating different ways of policing for many law enforcement entities involved in deflection, alongside a collaborative organizational and governance model. Deflection is emerging as a practice unto itself, with most programs relying on dedicated staff to manage the daily operations of the initiative.

Overall, deflection operations have emerged and evolved in communities responding to specific, often urgent, needs through development of treatment and services partnerships. Because this is a sector still in its early stages, a great deal of work is underway to assess promising practices and established models of deflection to translate them into best practices and foundational tools of deflection and disseminate them across the sector. The organic expansion of deflection, alongside the government and industry resources and sharing of practices by deflection advocates, adds to both the knowledge we have of the field and the gaps that must be addressed to sustain the practice of deflection in the United States and its potential impacts. These include expanding community-based treatment and services for individuals to help them lead productive lives in their communities; reducing the population of the justice system, especially among individuals who have committed nonviolent offenses; increasing partnership and restoring trust between first responders (law enforcement in particular) and the communities they serve; and addressing racial, ethnic, and social inequities marked by, among others, disproportionate enforcement in many minority communities and those with lower socioeconomic standing.

Appendix. Interview Instrument

Deflection Site Interview Protocol

Note: This interview guide is designed to be used with staff from all stakeholder agencies. Specific questions may be omitted if determined to be not relevant for a given party. Note that because a given party will not be asked all of these sets of questions, the sum of the projected time for each of these sets of questions exceeds the estimated interview time length of 45–50 minutes for a given party. We distinguish the following types of stakeholders:

- **Law enforcement:** Representatives of the agency running the deflection program
- **Treatment provider/Recovery Supports:** Representatives of agencies providing substance use treatment services or recovery support services to people who use drugs or alcohol in the jurisdiction of the deflection program
- **Non-Treatment provider:** Representatives of agencies providing non-treatment/non-recovery support services (e.g., housing, social welfare, harm reduction) to people who use drugs or alcohol in the jurisdiction of the deflection program
- **Non-provider:** Other stakeholders in the jurisdiction of the deflection program who do not directly provide any services to people who use drugs (e.g., policymakers, community organizations, community schools and faith leaders).

Introduction, Local Context

Name of the deflection program: _____

Introduction/Demographics (Law Enforcement, Treatment Provider, Non-Treatment Provider, Non-Provider)

1. What is your official title?

Program Environment (Law Enforcement, Treatment Provider, Non-Treatment Provider, Non-Provider)

2. How would you describe the substance use problem in [JURISDICTION]? [prompts: drugs used, people affected—age, gender, SES, trends over time, differences among populations]
3. What services are available to people with substance use disorder in [JURISDICTION]? [prompts: treatment services—MAT/non-MAT, wraparound services, harm reduction—naloxone/SSP, drug court, gender-specific services and differences, age-appropriate education support, services for children and families] What are the biggest gaps?
4. What are the biggest obstacles to people who use drugs accessing services they need in [JURISDICTION]? [prompts: lack of availability/capacity, financial, lack of awareness, stigma, lack of trust, fear of loss of job, of consequences to family members, fear of losing children, belief "they can do it on their own"]

Program Background

Program History (Law Enforcement, Treatment Provider, Non-Treatment Provider, Non-Provider)

5. What date did your program start?
6. *[if applicable]* How long you have been involved with the deflection program?
7. *[if applicable] [non-law enforcement only]* Why did you consider partnering with a police department regarding this deflection program?
8. Why was the program opened and which stakeholders provided the impetus?
9. Was there any opposition to the program? [prompts: How was it presented/accepted by the community, [partner organizations, and key stakeholders]? If well accepted and supported, did that include representative numbers of community residents across races and socio-economic populations in your community?
10. Was there a formal or an informal planning team? Was your organization involved in the planning of the program? If so, could you please describe the process and who was involved? [prompts: Who conceived the idea? How was it presented/accepted by the community, partner organizations, and key stakeholders? How did implementation planning go and what were the key planning mechanisms? Was there a person representing people in recovery and/or family members? Representatives of treatment organizations/recovery community organizations?]
11. Did you ever receive funding to help implement the program?
12. How has the program changed over time?

Overall Program Information (Law Enforcement)

13. What is the coverage area (city(ies), county(ies)? Do you allow individuals outside of the coverage area to participate in the program?
14. What is your organization's role in the deflection program?
15. What is your specific role or involvement in the deflection program?
16. To date, how many people has the program served?
17. On average, approximately how many people seek your deflection program each month? [breakdown by gender, race/ethnicity]
18. Can an individual go through your deflection program more than once? How many times? How many representing clients has the program had?
19. How do you select officers involved in the program? Do you have your entire department trained or only certain officers? How many officers do you have for your deflection initiative? Are they reflective of the population of the community?

Program Goals **(Law Enforcement, Treatment Provider, Non-Treatment Provider, Non-Provider)**

20. What are the main goals of the deflection program?
21. Are some goals more realistic or achievable than others?

Program Flow

Eligibility/Initial Contact (Law Enforcement)

22. Can you please describe your program--what it would look like from initial contact all the way through? prompts:
    a. What happens when an individual presents themselves at the station?
    b. Who provides the initial intake for program eligibility?
    c. What are the options for subsequent referral of the individual? Who decides on next steps?
    d. How does the hand-off to the next agency look? Who is involved? Are peer workers involved?
    e. How often does a family member accompany the individual? What information/support are family members provided with (e.g., referrals to support services)?
23. If children are involved, how is that situation handled? What are your deflection program eligibility requirements? [prompt: Is there any flexibility in the requirement?]
24. How long does it take from the time of identification of a deflection client to complete the warm-handoff to treatment?

Intake (Treatment Provider, Non-Treatment Provider)

25. Could you describe the process of receiving clients via the deflection program? [prompts: At what stage of their involvement with the program would they reach your organization? do they come directly from the police department? Do they come via another agency? How does the handoff from the previous agency look like?]
26. Are there notable differences between clients coming through the deflection program and other clients? [prompts: severity/needs, drug use patterns, previous treatment experience]
27. How quickly is your organization able to take in an individual going through the deflection program?
28. Is there a procedural difference in terms of accessing your services depending on whether a client comes through the deflection program or not? [prompts: Is there a difference in waiting times? Is there a difference in eligibility for your services? Is there a difference in costs/insurance coverage or your reimbursements?]

Program Services

Treatment-Related Questions (Law Enforcement)

29. Who or what organization assesses an individual for level of care/treatment required?
30. How many treatment providers do you have working agreements with related to the deflection program?
    a. What services do these provide? What are the possible treatment pathways and recovery support pathways available to the program's clients?
    b. Do you have written documents or Memorandum of Understandings (MOUs) between the police department and provider(s)?

c. Are there services that are not available to the program's clients? If so, why not? [prompts: not available in the area/provider does not participate]
d. Are there local providers not participating in the program? If so, why did they opt not to take part?

31. What happens if a person does not complete the treatment program? [Does it include following up with impacted family members?]
32. What is your policy on personal possession of drugs and drug paraphernalia for deflection? What is your policy if they are obviously under the influence of alcohol or other intoxicants?

Collaborative Partnerships (Law Enforcement)

33. Other than treatment providers, what other organizations or agencies do you collaborate with for the deflection program, if any?
34. What services do these partners provide? [prompts: for individuals going through the program, families, children/teens]
35. How did the partnership(s) develop?
36. What partners, if any, are missing? Why are they missing?
37. Has the partnership led to any of the following:

- Additional resources?
- Improved relationships among partners?
- Greater communication between partners?
- Enhanced streamlining of the program?
- Anything else?

Services (Treatment Provider, Non-Treatment Provider)

38. *[treatment only]* What substance use treatment services do you provide within your organization? [prompts: Is your organization abstinence-only? Do you provide MAT? If yes, which ones? Do you provide Naloxone? Are any of your services gender-responsive or gender-specific? Do you provide education and support for impacted family members, including children?]
39. *[non-treatment only]* What services do you provide within your organization? [prompts: community supervision, prevention, harm reduction, housing, welfare, legal advice, other?] Are any of your services gender-responsive or gender-specific? Do you provide education and support for impacted family members, including children?]
40. Do you coordinate provision of services with other organizations? If so, how? What are the partnership arrangements you have in place?
41. *[treatment only]* What assessment or tools are used to create an individual's treatment plan? Do you also assess the needs of the family members?
42. *[non-treatment only]* What assessment or tools do you use to assess individual's needs?
43. Is there a difference between the range of services offered/provided to deflection program clients and others?
44. What happens to your clients once they have completed your services? [prompts: Under what condition do they stop receiving your services? Are they referred on to another agency? If so, how does the handoff work? Do they continue receiving any services? Are

they discharged without any follow-up? Is there a difference in this aspect between deflection and non-deflection clients?]

Recovery, Case Management (Treatment Provider, Non-Treatment Provider)

45. Do you use peers / recovery specialists?
46. Who performs your case management? What happens to case management support after the person has completed treatment?
47. *[treatment providers only]* For how long will you work with a person who has been deflected after they have completed treatment?
48. Do you work with the families of those deflected? How?

Funding

Funding and Resource Questions (Law Enforcement)

49. How long can a case take? [prompt: Let's think about the fastest, slowest, and typical individual who comes in]
50. Did you need to add staff or use overtime to cover the time for these cases?
51. What are the costs of the program? [prompts: staff costs, treatment costs, gas to drive to treatment]
52. Do you get any funding for the program?
    a. Where from?
    b. How much?
    c. What do the funds cover related to the program?
53. How much do you know about the current state of solicitations for funding of deflection programs?
    a. Have you seen solicitations for deflection program funding?
    b. Have you applied to any of those solicitations for program funding?
54. Do you get funding support from any local, state, or national associations?
    a. If so, which associations?
    b. If so, what does the funding cover?
55. What do you believe are resources/areas that are lacking with regard to your deflection program?
56. Have you, or an outside entity, trained police officers on the deflection program?
    a. If so, how many?
    b. How long is the training?
    c. What information is provided in the training?
    d. Do you include information that addresses the multi-generational transmission of addiction within families—and the trauma it engenders?
57. Have you, or an outside entity, trained civilian staff on the program?
    a. If so, how many?
    b. How long is the training?
    c. What information is provided in the training?

58. Have you, or an outside entity, trained police officers on substance use disorders?
    a. If so, how many?
    b. How long is the training?
    c. What information is provided in the training?
59. Do you have a program coordinator or other administrative staff that are paid for this deflection program?
60. Do you use volunteers? If so, how?
61. Do you advertise the program? How, could you please explain what you do to bring awareness to the deflection program? What are the costs of the promotion?

Throughput, Costs, Resources (Treatment Provider, Non-Treatment Provider)

62. To date, how many people has your organization served from the deflection program? [prompts: How big a proportion of your clientele are individuals coming through the deflection program? Does this differ by gender? Has the deflection program resulted in an increase in the demand for your services?]
63. On your organization's end, what are the costs associated with being part of the deflection program? [prompt: are there any additional costs? Are there costs you would have incurred anyway]
64. On your organization's end, do you currently receive funding for those who go through the deflection program?
    a. If yes, where from?
    b. If yes, how much?
    c. If yes, what do the funds cover?
65. Does your organization take individuals without insurance?
66. Does your organization take individuals on Medicare or Medicaid?
67. Does your organization allow for a sliding scale for payment of services?
68. Do you help individuals enroll in health insurance if they enter without insurance?
69. Do you believe the capacity of your organization to provide services is sufficient to meet the current need for services?
    a. If not, what level of resources do you think would be necessary to help you meet the need?
70. Do you advertise the program? How, could you please explain what you do to bring awareness to the deflection program? What are the costs of the promotion?

Results/Reflections

Input/Feedback on Deflection Program (Law Enforcement)

71. To what extent is the deflection program accepted by…
    a. Your police agency leadership?
    b. Other police officers?
    c. Community members?
    d. Other criminal justice professionals (e.g., corrections, courts)
    e. Local policymakers

f. Treatment providers
g. Other service providers
h. Family members
i. People who use drugs

[prompt: can group them into most accepted, least accepted groups]

72. Does your department meet with partner organization on a regular basis to monitor progress, discuss the program, program goals, successes, challenges, or other program related issues? If so, could you describe the mechanism? How is the report distributed?
73. How do you let the community/public know about the deflection program?
74. What, if any, comments have you heard about the deflection program from partners or people in the community?
75. What criticisms, if any, have you heard about the deflection program from partners or people in the community?
76. What, if any, comments have you heard from clients and/or their family members/loved ones about the deflection program?
77. What do you think has been the biggest impact of the deflection program?
78. What are the limitations of the deflection program?
79. In retrospect, what, if anything, should have been done or should be changed regarding your deflection program? What, if anything, would you change now?
80. What advice or lessons learned would you give to other jurisdictions who would like to start a deflection program? How replicable is the program to other jurisdictions? [prompt: is there anything specific about the program in [JURISDICTION] that would prevent its replication elsewhere? This might be specific partnerships for example]
81. What do you believe the future holds for the deflection program? How sustainable is the program? [prompts: financially, in terms of stakeholder support, etc.?

Data and Follow-Ups (Law Enforcement)

82. Is data collected by the police department regarding the deflection program?
    a. If so, what data is collected?
    b. If so, how is data collected?
83. How satisfied are you with data collection and performance monitoring protocols?
84. Do you create regular performance reports of any kind? [prompt: monthly updates on number of participants, number referred to treatment, number of direct hand-offs to treatment provider, etc.] To whom are they distributed?
85. Interest in participating in a future impact evaluation of your program?
    a. If yes, would you be willing to share case-level data?
    b. Would it be feasible for us to conduct baseline interviews with participants?
    c. Ideas about a comparison group? [prompt: is there anything random about who gets deflected and who doesn't? Or an interesting cutoff point (like days when deflection is possible or assessment score)]
    d. (List of types of information maintained in program's database)
86. Do you, or other deflection program staff, follow-up with participants' progress after a warm hand-off is made to treatment?

a. If yes, who follows up?
b. If yes, how frequently do these follow-ups occur?
c. If yes, what happens when a follow-up indicates the individual is still struggling with substance use or other mental health concerns?

87. Is information regarding deflection program participants shared between the treatment provider and the program coordinator (if applicable)? Is information regarding deflection program participants shared between the treatment provider and police?
88. Is an authorization for release of information form used to allow the police department to follow up with participants? (ask to share)

    a. If not, do treatment providers share aggregate information regarding individuals who enter through your program?

89. Have you had any external research conducted on your deflection program?

    a. If yes, by who?
    b. If yes, what stage is the research currently at and/or what were the findings?

Data and Evaluation (Treatment Providers, Non-Treatment Providers)

90. What data and outcomes do you track on your clients?
91. Is information regarding deflection program participants' progress in treatment relayed to the program coordinator or police officer/department/any other organization involved in the service chain?

    a. If so, who receives it?
    b. If so, is it individual or aggregate information? How is information provided to the program coordinator or police officer/department?
    c. If so, is there an authorization for release of information signed by the individual for release of individual information?
    d. Do you or any other organization/institution collect information on/follow up with individuals who no longer receive your services? If so, what information and how?
    e. Do you follow up with family members? Did they have any recovery support?

92. Have the outcomes of your organization been evaluated?

    a. If yes, what were the findings? Who evaluated?
    b. If no, why not? Is this something your organization is open to?

93. Do you maintain a database tracking participants?
94. How satisfied are you with data collection and performance monitoring protocols? Do you create regular performance reports of any kind? Are you interested in participating in a future impact evaluation of your program?

    a. If yes, would you be willing to share case-level data?
    b. Would it be feasible for us to conduct baseline interviews with participants?
    c. Ideas about a comparison group?
    d. (List of types of information maintained in program's database)

Impact/Final Comments (Treatment Provider, Non-Treatment Provider, Non-Provider)

95. Does your organization meet with partners on a regular basis to monitor progress, discuss the program, program goals, successes, challenges, or other program related issues? If so, could you describe the mechanism?
96. In your opinion, what, if any, are the benefits/added value of the deflection program? [prompt: What difference does it make and why? Why do you think so? Are there any data supporting this view?]
97. Are there any downsides/risks to having the deflection program in place? [prompts: opportunity costs of the program, increase in demand for services that cannot be met, etc.]
98. From the perspective of your organization, how could the functioning of the deflection program be further improved?
99. How replicable is the program to other jurisdictions? [prompt: is there anything specific about the program in [JURISDICTION] that would prevent its replication elsewhere?]
100. How sustainable is the program? [prompts: financially, in terms of stakeholder support, etc.]
101. Any other questions or comments you'd like to share about the deflection program?

Abbreviations

ACS	American Community Survey
ASMD	absolute standardized mean deviation
BJA	Bureau of Justice Assistance
COVID-19	coronavirus disease 2019
DUI	driving under the influence
Est	estimate of treatment effect
ICJIA	Illinois Criminal Justice Information Authority
LEAD	Law Enforcement Assisted Diversion
OUD	opioid use disorder
Pvals std.	standardized *p*-value from placebo tests
RMSPE	root mean squared prediction error
SCM	synthetic control method
SUD	substance use disorder
TASC	Treatment Alternatives for Safe Communities

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