Designed to Do Good: Key Findings on the Development and Operation of First Responder Deflection Programs

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ABSTRACT

Opioids and drug overdoses have claimed more than 750 000 American lives since the late 1990s. Overdoses since the mid-2010s have risen dramatically, due to synthetic opioids such as fentanyl whose lethality is disproportionately greater than street drugs of earlier decades. Until recently, most police and other first responders lacked resources beyond arrest to respond to overdoses and other nonviolent crimes. Largely in response to the opioid crisis and synthetic opioid-related overdoses, first responder deflection (FRD) has emerged as an alternative. First responder deflection has enabled first responders across the United States to save lives by training them to administer naloxone, a medication that blocks opioid receptors after overdose, then linking these individuals to community-based treatment and services. Consequently, FRD has helped keep many citizens out of the justice system entirely, giving them a chance to rebuild their lives and become productive members of their communities. To this end, TASC's Center for Health and Justice and National Opinion Research Center at The University of Chicago collaborated on a national FRD survey encompassing a comprehensive overview of the field and its role in responding to the opioid crisis. The findings reveal how FRD offers alternatives to traditional policing, including its role in advancing racial and social equity by aligning public health and public safety for those who otherwise might enter the justice system. This article will discuss the methodology, key findings, and policy implications of this national survey (encompassing more than 300 active FRD programs). We will present results on the development of FRDs and how they operate. Results will cover the extensive involvement of law enforcement agencies in initiating FRD initiatives; the role of non–first responder partners in providing treatment and services through FRD; and the scope of Medication-Assisted Treatment in these programs, among other important findings.

KEY WORDS: criminal justice deflection, first responder deflection, law enforcement, opioid crisis, opioids, prearrest deflection, prearrest diversion, racial equity

The opioid crisis and the rapid growth of drug overdoses and overdose deaths that accompany it present a significant challenge, particularly for those in the law enforcement/first responder sectors. Availability of synthetic opioids such as fentanyl, far more lethal than what had previously been available, poses a particularly daunting, ever-expanding threat.[1] The widespread presence of these drugs contributes to burgeoning numbers of overdoses and overdose-related deaths, including an increase of more than 3000% in synthetic opioid-related deaths (nonmethadone) from 1999 to 2018.[2] More than 841 000 Americans have died from a drug overdose since 1999.[3] Moreover, synthetic opioids alone are now involved in more than 85% of opioid-related deaths and nearly two-thirds of all overdose deaths.[4] There are at least 61 million encounters between citizens and police each year, with only about 15% of those resulting in arrest or prosecution[5] and the remainder involving police taking essentially no action. The sheer volume of fatal and nonfatal overdoses presented challenges that demanded alternatives to these options than first responders, police in particular, had previously followed.

From these circumstances, consistent with the "third wave" of the opioid crisis in the mid-2010s (the first wave consisting of prescription of opioids in the late 1990s, the second in 2010 with rapid

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increases in heroin-related overdose deaths),[6] came such a response, now commonly known as deflection (or first responder deflection [FRD]).* First coined in 2015,[7] the term "deflection" refers to collaborations aligning public safety organizations with community-based public health systems and providers to establish pathways by which first responders can facilitate treatment, housing/other services, and recovery to individuals they encounter† —in most cases without fear of arrest, or in others in lieu of arrest when charges exist and an arrest otherwise would have ensued. Through these programs, individuals are "deflected" from ever entering the justice system, emphasizing substance use disorder (SUD)/mental health treatment and services over enforcement. Because deflection proved a viable, locally driven alternative for many police and other first responders (as opposed to arrest or taking no action), especially as the third wave of synthetic opioids entered the scene, these programs grew quickly and exponentially.

With this significant growth of deflection programs, and to gauge the partnerships they have developed, services they facilitate, pathways to treatment and recovery they employ, and programs' funding sources (including public programs such as Medicaid), training offerings, and evaluation practices, the Bureau of Justice Assistance's Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP, formerly COAP) commissioned a survey and report from TASC's Center for Health and Justice (CHJ) and the National Opinion Research Center (NORC) at The University of Chicago. (CHJ is a provider of training and technical assistance to the COSSAP program[8]; NORC is an independent research institution specializing in social science and public opinion research.) The purpose of the work was to conduct the first-ever national, federally funded survey and report specific to law enforcement–led deflection and FRD built on the 5 pathways of deflection.‡ This article summarizes key findings from that report, providing context and perspective on NORC's quantitative findings using other empirical sources where available.[9]

The goal of the study was to provide a comprehensive overview of the field of deflection and its role in responding to the opioid crisis—as well as how deflection/first responder diversion offers alternatives to law enforcement and first responders in their work.

Methodology

Sampling frame and participants

The study was designed to be a census survey of all the known law enforcement, fire, and emergency medical services (EMS) organizations that led FRD programs at the time of data collection that serve individuals with SUD, primarily opioid use disorder (OUD). Given that there is no known list of the universe of all these types of programs, our team had to build this list. The study team started with a list of 880 eligible first responder organizations thought to operate an opioid FRD program. This list was informed by experts in the field and from state lists assembled of known programs, building upon nationally based listings already compiled by sources such as state-level entities that have compiled their own lists of eligible programs. We also identified first responder organizations operating opioid programs through outreach to FRD membership organizations. Of 880 identified organizations, 221 were determined to not have an opioid FRD program (eg, the agency was permanently closed, agency management indicated that it no longer operated such a program, or the information was wrong and not for a first responder organization but another part of the justice system) and were excluded from the survey. Our final sample was 321 FRD organizations out of 659 first responder organizations ($880 - 221 = 659$; $321/659 = 48.7\%$).

Survey participants were representatives from law enforcement agencies, fire departments, and EMS departments who completed surveys on behalf of their organizations and reported on a specific deflection program. In line with the study criteria denoted previously, justice system FRD programs operated by prosecutors or courts (drug courts, treatment courts, etc) were excluded.

Survey development

The development of the survey involved a number of stages. Initially, an expert panel of 20 persons familiar with the operational models of law enforcement/FRD programs met with the Institute for Intergovernmental Research (IIR), a COSSAP partner; CHJ; and with survey methodology experts from NORC to draft the measures and definitions of deflection programs and frameworks. Then, NORC subjected the survey to cognitive testing to learn how well candidate

*In many jurisdictions, these programs may be known as prearrest diversion, deflection, prebooking diversion, coresponder programs, law enforcement/police-assisted diversion, and crisis intervention. In this article, law enforcement and fire/EMS-led responses will be referred to as "deflection" or "FRD."

†These pathways are known as Self-Referral, Active Outreach, Naloxone Plus, Officer Prevention Referral, and Officer Intervention Referral. More information can be found at Bureau of Justice Assistance (nd). Law enforcement/first responder diversion. Comprehensive Opioid Abuse Program: https://www.cossapresources.org/Learning/PeerToPeer/Diversion

‡The report can be found here: https://www.cossapresources.org/Content/Documents/Articles/CHJTASC_Nation_Survey_Report.pdf.

questions performed when working with OUD/SUD deflection programs during the fielding of the survey. Cognitive testing is an applied approach to identifying problems in survey questionnaires by doing an interview with someone resembling a study participant to assess their comprehension of the survey items by using verbal probing techniques, as well as "think-aloud," to elicit thinking about each question.[10] National Opinion Research Center conducted these cognitive interviews with a small sample of respondents (n = 15) to get their feedback on the survey. Based on the results of the cognitive testing and related comments from the expert panel, NORC modified the survey. The survey included 44 items of closed-ended questions based on response options developed in consultation with substantive experts in FRD deflection programs and survey design experts from NORC. The operationalization of the items is covered in the "Measures" section.

Procedures

The survey took place over a 9-month period from January to September 2020. Informed consent was obtained electronically from all participants before they were allowed to start the single cross-sectional survey through checking a "yes" box to a consent statement. The survey took participants an average of approximately 30 to 40 minutes to complete whether done online via Web survey or by phone with a NORC interviewer. We did not observe statistical differences in survey response by modality.

Survey design

National Opinion Research Center used multiple modalities including mail, phone, fax, Web, or combinations thereof to research study participants and made multiple initial contacts and follow-ups with study participants. National Opinion Research Center used the Dillman et al approach for nonresponse follow-up.[11] All participants first received a mailed invitation letter to complete the survey online via a secure server or by phone (via a toll-free NORC's phone center). After 1 month, the respondents who did not complete the survey received a reminder postcard to complete the survey online or by phone. At the same time, NORC began telephone prompting. Two weeks later, nonrespondents received a reminder letter (and an email reminder in cases in which we had an email address for contact person in the organization) and phone prompting continued. At the 2-month mark, we sent a FedEx mailing to the respondents. We used an Express Mail package on the assumption that most people do not discard such packages without first viewing their contents. We used email, phone, and postcard reminders throughout the remaining study period.

Measures

The survey did not collect client-level information on individuals served in the programs; rather, it asked about aggregate program data mostly from 2018 or current at the time of data collection.

Background/demographic information on first responder organizations

The survey asked the respondents background questions regarding location of the program; government units served by the program; type of community or communities served by the programs (urban, suburban, rural, tribal, or other); and population size of community served by the program.

Type of pathways/programs

Survey respondents were asked to report on the type of deflection program operated by the participating first responder organizations and whether the organization has adopted a specific model or "brand" of deflection.

Characteristics and features of deflection programs

Respondents reported on whether the programs conduct outreach to the target population through an initial contact with the assistance of a treatment case manager, a coresponding case manager, an emergency department, clinic, or other medical facility; or whether the initial contact occurs without the assistance of an FRD program. Data were also collected on referrals to treatment and/or services through the deflection programs and who can give those referrals. Respondents were asked to report on the staff and volunteer composition of the program and background on the FRD program.

Partnerships

The respondent reports with regard to partnerships explored the number of FRD program partners and the interactions among the partners. For each partner, the respondents were asked to identify the types of services provided and whether there is a formal agreement in place between each partner and the program.

Treatment, services, and recovery

The respondents were asked to identify (1) the number and type of services facilitated or offered; (2)

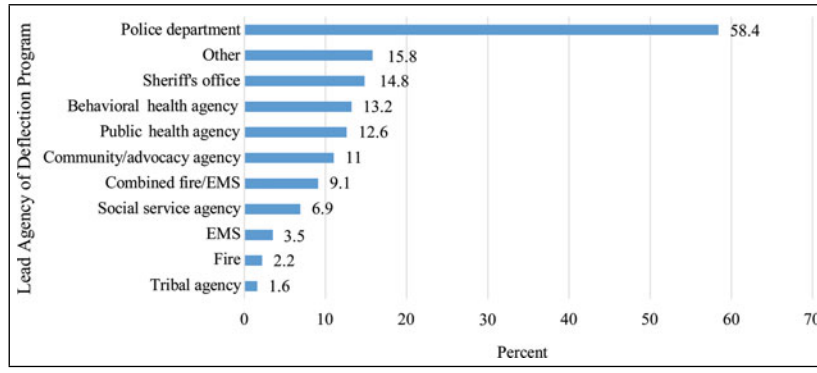

FIGURE 1 Lead Agency for Deflection Program
Abbreviation: EMS, emergency medical services. This figure is available in color online (www.JPHMP.com).

which partner agencies made the referrals and delivered contacts; (3) services offered by how many staff and by what means, including funding amount and source; (4) eligibility screening and target population characteristics; (5) and training for FRD program participants. They were asked to identify the number of referrals to treatment and/or services by the FRD program.

Analytic plan

Descriptive statistics such as frequencies were computed for each study variable and cross tabulations were calculated for specific variables of substantive interest. All data were analyzed using STATA 16.[12]

Results

Program initiation

Of the 321 completed surveys, 61% of the participating organizations were law enforcement-only organizations, 38% were mixed law enforcement and fire and/or EMS, 0.3% were fire department-only organizations, and 0.7% were EMS-only organizations.

Law enforcement agencies (including police and sheriff's offices) created and lead almost three-quarters of all reporting programs as part of their communities' response to rising opioid-related overdoses around the United States (see Figure 1), which helped spur rapid development of deflection programs during the second half of 2010, as indicated in Figure 2. Fire/EMS agencies (separately or jointly) comprise about 15%.

Deflection programs as collaborations

Deflection initiatives, by definition and practice, are partnerships among public safety, public health, and community-based behavioral health and social service systems, and the community, with multiple partners being critical to their operation. In addition to the predominantly law enforcement–based entities that lead

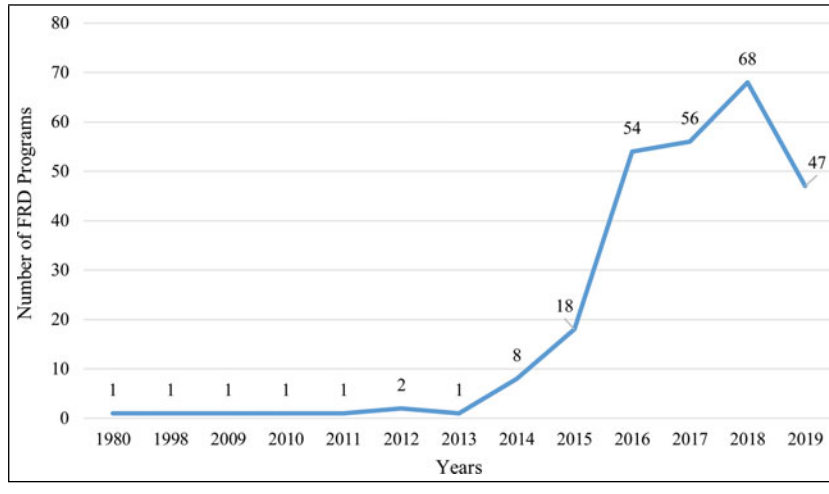

FIGURE 2 FRD Programs Initiated by Year
Abbreviation: FRD, first responder deflection. This figure is available in color online (www.JPHMP.com).

deflection programs, treatment, case management, recovery support, and other wrap-around services are provided by agencies and organizations that partner with law enforcement to help individuals in need of treatment and other community-based services. All but 3 of the 233 programs that responded have at least 2 collaborative service partners. Almost half (46.4%) reported having at least 3 collaborative service providers; 26% reported having 4 to 6 partner service provider organizations. These partnerships include community-based organizations and agencies that provide detoxification programs, SUD treatment, case management services, and recovery support, as well as housing, education, job training, and other supportive services. Justice community partners such as judges, community corrections officers, and others are partners in many FRDs.

Coresponder involvement

Slightly more than half of the programs involve coresponder deflection approaches (peer support specialists/recovery coaches, clinical SUD treatment staff, case managers, and social workers) for initial contact; nearly 80% employ peer support specialists/recovery coaches in their program. About half of respondents noted that, during in-person outreach, their initial contact was completed with the assistance of a coresponder. Coresponders' role as deflection partners comes through their direct work with peer support specialists/recovery coaches, whose lived experience within the communities they serve often contributes to treatment/recovery and their initial outreach to and continued engagement of individuals in deflection programs. Nearly 4 in 5 respondents (79%) reported having access to recovery support specialists/peer recovery coaches as part of their deflection efforts. Despite the prevalent use of recovery support services, only approximately 30% of respondents cited FRD programs that address other critical needs such as employment, education, and food support as part of their network.

Personal introductions to treatment case managers

Most programs provide a personal introduction, also known as a "warm handoff," to treatment case managers to assist in linkage to services, helping overcome a significant barrier to treatment. The outreach utilized by these programs reflects research on successful case management and care coordination (eg, increased program engagement and retention). Nearly two-thirds (65%) of respondents also indicated that their programs provide some form of transportation assistance to a client's initial appointment.

Services facilitated by deflection programs

The SUD treatment that includes access to Medication-Assisted Treatment (MAT) is the primary service referred by deflection programs. Medication-Assisted Treatment include buprenorphine, methadone, and naltrexone. Fully 90% of respondents facilitate/provide links to SUD treatment, an essential service due to the range of SUDs. Nearly three-quarters (73%) provide links to MAT, with approximately one-fourth facilitating 1 form of MAT (see Table 1). Slightly more than one-third link to 2 MATs, while 42% facilitate all 3 MATs. Respondents indicated that their programs provide links to a range of inpatient and outpatient treatment services, including access to medications for OUD.

TABLE 1
Treatment Services (n = 282)

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

Deflection programs and public funding

Nearly 90% of FRD programs responding to the survey are located in states that have expanded Medicaid access through the Affordable Care Act. The expansion of health care services through the Affordable Care Act seems to align with the rise of FRDs, particularly those responding to the study, 88% of which are in Affordable Care Act expansion states (see Table 2). This helps account for the finding that more than half of FRD program treatment providers reported that they bill public insurance (Medicaid/Medicare).

Training and deflection programs

Among survey respondents, only about a third have formal training aligned with deflection. Most FRD initiatives that provide training offer critical components central to deflection practice: naloxone administration (91%) and crisis intervention for de-escalation practices (74%). Less common areas of training include racial/gender equity (40%) and the neuroscience of addiction (30%).

Formal evaluation of program

Only 1 in 6 respondents (17% of 227 total) has conducted a formal program evaluation or audit.

Discussion

The survey results paint a picture of the state of deflection as practiced by several hundred active programs that responded to the survey. It suggests, for one, that law enforcement entities (police in particular) involved in deflection are applying deflection as a new approach to overdoses. This outreach is made possible by programs' partnerships with multiple community-based service, treatment, and recovery providers, many of them new to collaboration with law enforcement agencies. Deflection has emerged in an environment that seeks alternatives to traditional police-driven enforcement of drug possession/drug use and other offenses, particularly in response to mental health and SUD-related calls. To this point, deflection—particularly when initiated by law enforcement—appears to be addressing a range of public safety, public health, and social demands.

This response particularly seems relevant when seen through the lens of the survey's findings around the wide use of coresponders, the recovery support specialists/coaches, and others whose role in linking individuals referred by first responders in deflection programs to treatment and services is associated with

TABLE 2
Distribution of Deflection Programs by Affordable Care Act–Adopting States[a]

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

[a] Thirty-eight states and the District of Columbia have expanded Medicaid under the Affordable Care Act (ACA); of the 321 FRD programs identified in this survey, 283 are located in 31 of these states. In all, 38 FRD programs identified in this survey are located in 8 of the 12 states that have not expanded Medicaid under the ACA.

[b] Eight states that did not expand Medicaid for ACA (4 other states did not expand but they were not in the study).

Implications for Policy & Practice

- The role of overdoses and overdose deaths in the origin and development of deflection initiatives—particularly the large share of programs founded and led by law enforcement entities—illustrates the impact of the opioid crisis on how many police and first responder agencies have come to view their roles. This marks a shift from an enforcement/arrest approach to one that emphasizes, in many cases, treatment and recovery.

positive outcomes tied to treatment participation, reduced recidivism, and other benefits.[13] Although we can speculate that deflection programs' facilitation of these services will produce outcomes similar to what is seen throughout the literature, the field is new, and that assessment is ongoing (including in other articles in this journal). To this end, the relatively low rate of responding programs that have conducted a formal program evaluation reveals not only the relative newness of the field but that key elements—such as leading-edge best practices to assess program performance, validate outcomes, and recommend improvements—need to be incorporated across the field to advance and sustain its contributions. Extensive efforts to this end are underway through the COSSAP initiative and other programs, and their expansion would seem to further contribute to the field's growth. Furthermore, the low numbers of programs that have developed and provide formal training suggest another area in which adoption of certain best practices is critical to advancing the field.

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