



Bureau of Justice Assistance (BJA)

Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP)

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

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Active Outreach Pathway

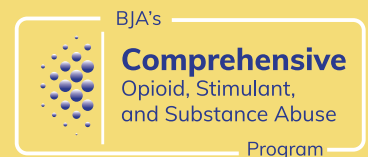
First responders are on the front lines of the battle against substance use disorders (SUDs), responding to calls for service involving individuals with SUDs and frequently responding to overdoses. To this end, a variety of law enforcement and fire/emergency medical services (EMS)-led deflection programs have emerged across the country. In partnership with SUD treatment providers, peers, and recovery personnel, these multidisciplinary programs are helping to reduce overdoses by facilitating connections to community-based treatment and services.

Law enforcement and first responder deflection programs provide pivotal opportunities to redirect individuals with SUDs, mental health disorders (MHDs), and co-occurring disorders away from placement in jails or emergency departments and, instead, connect them to community-based treatment for substance use, mental health services, recovery support, and housing and social services. These programs are referred to differently as “deflection,” “law enforcement/police-assisted diversion,” “crisis intervention,” “pre-arrest diversion,” or “pre-booking diversion.” Whereas in previous case studies, the practice was referred to as “first responder diversion,” in this case study and in forthcoming ones, it will be referred to as “deflection.” The philosophy behind all first responder

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

Six Pathways for Law Enforcement and First Responder Deflection to Treatment, Recovery, Housing, and Services

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



The **six pathways** to treatment through first responder deflection are described below. This brief focuses on the **Active Outreach Pathway**.

Each pathway is associated with specific elements that work in different ways. Communities providing first responder deflection often begin with a single pathway and then add pathways as their programs evolve. (For an example, see Case Study #2: Morris County, New Jersey [page 12], which started its first responder deflection efforts with Hope One, an active outreach program, and later created a self-referral program.) The pathway(s) implemented should be informed by a “problem-solution” orientation based on the specific problems to be addressed (e.g.,

substance use, mental health concerns, housing instability). This entails taking a holistic look at the problem, drawing in individuals or agencies that can help define it, and determining how to align resources (e.g., treatment, recovery support, stakeholder support) to meet the needs of the target population to be served. Also, deflection programs should be developed to fit the unique needs of each community. What works in one jurisdiction may not work in another. An important step in determining the most appropriate deflection pathway is to become familiar with all of the pathways, the problems that each pathway seeks to address, and how each pathway functions. Finally, each pathway requires different levels of investment for planning, implementation, and operationalization. In summary,

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

it is necessary to identify which elements of a pathway could be adapted and applied to suit the particular needs of a jurisdiction.

The Active Outreach Pathway

First responders—especially law enforcement officers—often know, as a result of their day-to-day activities, which individuals in their communities are suffering from SUDs and co-occurring MHDs. For years, officers have informally engaged in interventions to connect individuals to drug treatment and other services, but now a growing number of first responder agencies, through deflection programs, are formally encouraging their personnel to engage those individuals to help connect them to the treatment and community-based services they need.³ These officers often work hand in hand with peer recovery coaches, mental health professionals, and public health practitioners. Through this collaboration, they learn how to build trust and a positive connection with vulnerable members of their community and provide hope that recovery is possible.

To initiate the Active Outreach Pathway, no specific event or activity (criminal or otherwise) by the individual is required. First responders or multidisciplinary teams usually seek out individuals where they live, groups of

individuals where there are high overdose rates, or clusters of unsheltered individuals. When first responders encounter these individuals, they may offer linkages to treatment, resources to meet basic needs, and information about support services. First responders or multidisciplinary teams also often carry cards or brochures that contain information that can be used to contact them or service providers subsequently for referrals to treatment and other support services.

The Origin Story

In 2015, Arlington, Massachusetts, Police Chief Frederick Ryan listened to a plan by prosecutors and investigators to apprehend and arrest a drug dealer who had been connected to at least two overdose deaths. He realized that, while they knew the identities of the people who were purchasing drugs from this dealer, nothing was being done to get these individuals connected to services and provide them treatment for their SUDs. Recognizing this as a missed opportunity, Chief Ryan worked with an internal group that included command staff members, investigators, and the department's mental health clinician to outline a new strategy for police officers to directly influence the demand side of the opioid crisis.⁴

The resulting strategy, announced in June 2015, became known as the Arlington Opiate Outreach Initiative (Arlington Outreach). This initiative brought together law enforcement, health and human services, mental health and substance use professionals, service providers, and others to proactively reach out to people with SUDs to provide support and services to them and their families. Arlington Outreach was managed by the department's mental health clinician, who was designated as the outreach coordinator and facilitated all referrals.

Through the initiative, narcotics investigators would disclose the identities of a dealer's customers to the coordinator, who would then schedule a resource meeting with the individuals on the list as well as their family members. The aim was to

The sites highlighted in this case study are:

- ◀ Cumberland County, New Jersey—Operation Helping Hands: Recovery on Wheels.
- ◀ Morris County, New Jersey—Hope One.
- ◀ Philadelphia, Pennsylvania—Police Assisted Diversion Program's Outreach Co-Responder Team (PAD-OCT).
- ◀ The Rhode Island HOPE (Heroin – Opioid Prevention Effort) Initiative.
- ◀ Story County, Iowa—Alternatives Pre-/Post-Arrest Diversion Program.

persuade the customers to attend the resource meeting and engage in treatment.⁵

In addition, Arlington Outreach's strategy called for officers to operate under a community policing model and to proactively engage with residents who showed signs of SUDs. In these cases, officers were encouraged to refer those residents to the Arlington outreach coordinator, who would then offer services to them and their families.

Along with the Angel Initiative in Gloucester, Massachusetts, which had begun just a few weeks earlier, Arlington Outreach became a pillar of the [Police Assisted Addiction and Recovery Initiative \(PAARI\)](#)⁶ and an example for agencies that adopted the outreach model. PAARI is a nonprofit organization that provides resources to help law enforcement agencies nationwide create self-referral and active outreach programs. The Angel Initiative and Arlington Outreach helped start a paradigm shift in policing away from enforcement and toward collaboration with public health and community-based treatment providers to address the disease of addiction.⁷

How the Pathway Works

The goal of the Active Outreach Pathway is to identify and reach out to people with SUDs or who are at risk for SUDs before they have an overdose or are exposed to the justice system. Active outreach is a proactive form of deflection meant to prevent harm and justice system involvement. Active outreach programs, typically conducted by a multidisciplinary team of treatment professionals and service providers, can build relationships among stakeholders. Also, due to the positive nature of the contacts between the outreach team and community members, this pathway can help build trust among law enforcement and the community.

First responders engaging in active outreach must recognize addiction as a disease, so they can empathize with and best serve those with whom they are engaging and help reduce the stigma of addiction. (See Critical Elements, page 5.) To ensure that outreach is being conducted by first responders

with an appropriate level of knowledge, jurisdictions may enlist volunteers from their crisis intervention teams (CITs); hold special training for personnel who volunteer to perform the outreach; or utilize personnel with educational backgrounds in social work, psychology, or related fields.

Many active outreach programs, like the ones highlighted in this document, are initiated by a high-level justice system leader (e.g., a police chief, sheriff, district attorney, or director of public safety) or another reputable public safety stakeholder who can leverage resources and coordinate collaboration among the treatment and service provider agencies necessary to staff the program and serve clients. High-level officials can also rally first responder agencies to work with community-based treatment and service providers by bringing all stakeholders to the table and facilitating coordination. These officials advocate for the program to the public, and to local, state, and federal funders.

During outreach, first responders are most often accompanied or supported by a recovery specialist, licensed peer, other SUD treatment provider, or behavioral health specialist who helps engage individuals in discussions about treatment and makes connections to treatment and services. When the teams are deployed, team members usually wear shirts bearing the insignia of the program. First responders often wear these shirts along with their badges and firearms, instead of their uniforms. This makes first responders less distinguishable from the other members of the outreach team and may reduce the possibility that individuals feel intimidated by officers in uniform.

There are many types of active outreach programs, and they can vary based on a jurisdiction's size, goals, and needs. For example, mobile outreach teams can be deployed to different areas of a county daily or weekly based on the number of overdoses or reported drug use in the area or to meet the demand of community health needs. These mobile units often deploy teams that include a justice system representative who can help individuals navigate justice system obstacles, as well as treatment, behavioral health, and medical professionals who can provide screenings and

treatment resources. They also often carry naloxone kits and offer instructions on how to administer naloxone if someone is experiencing an overdose. Another outreach model features neighborhood-based teams comprising police officers and behavioral health specialists assigned to smaller or specific geographic areas. These teams use crime analysis data and information from community members to conduct outreach activities. The teams make themselves available to patrol officers who contact them when they encounter individuals with SUDs. In these cases, patrol officers facilitate a referral of these individuals to the outreach teams, who talk to the individuals about treatment and support services. This referral allows the patrol officers to continue their regular duties and gives the individual access to hands-on service engagement with a trained SUD professional. Still another model of outreach employs officers who have been specially trained in addiction science to conduct outreach to individuals who are at risk for overdose or criminal activity resulting from their SUDs. These officers may also focus their efforts on individuals with SUDs in the unsheltered community and offer to connect them to the program coordinator (or a case manager) who can conduct screening, help them obtain health insurance, and connect them to treatment and services.

One feature common to most active outreach programs is their use of harm reduction strategies to address drug misuse by individuals. Harm reduction is an evidence-based approach that seeks to reduce the health and social harms associated with addiction and substance use, without necessarily requiring people who use substances to abstain or stop.⁸ One of the main principles of harm reduction, and one cited often by active outreach teams, calls for the nonjudgmental, noncoercive provision of services and resources for people who use drugs to assist them in reducing attendant harm.⁹ By offering services without judgment, team members can establish and nurture relationships that instill trust, reduce stigma, and may eventually result in a connection to treatment when the individual is ready for it.

The Ten Critical Elements of Active Outreach Initiatives

1. Identify the problem faced by the community.
2. Create a multidisciplinary planning group.
3. Hire a dedicated program coordinator.
4. Hold regular partner meetings.
5. Engage the larger community.
6. Be intentional when selecting personnel for outreach teams.
7. Train officers about addiction, trauma, and recovery, and project positive messaging to first responders about deflection.
8. Collect data and evaluate the program.
9. Create a feedback loop.
10. Conduct ongoing messaging to the community through the media.

Sometimes it takes weeks or months for individuals with SUDs to be ready to enter treatment, but, in the meantime, active outreach programs are a means to deliver basic needs to people, as well as information about available resources. The individual case studies in this document illustrate how outreach programs can connect people to behavioral health and medical treatment, as well as supportive housing and other wraparound services, and provide items such as identification cards, basic hygienic products, and naloxone.

Ten Critical Elements of Active Outreach Initiatives

The following are ten critical elements that have been identified through research or by practitioners during interviews. When implemented, they can help to create or enhance active outreach programs that are effective in connecting individuals with SUDs to treatment and services.

1. Identify the problem faced by the community.

If overdose rates in a locality are climbing among people with SUDs or the number of unsheltered individuals is rising, determine and address the underlying treatment and service needs of those individuals. To build relationships between first responders and the communities they serve, greater consideration should be placed on helping vulnerable members avoid arrest and trips to the emergency department by connecting them to community-based treatment or services.

2. Create a multidisciplinary planning group.

Collaborative partnerships are critical to implementing active outreach programs, and the support of each partner can be essential for securing funding, resources, community support, and referrals, as well as building treatment and service capacity.

Identify and build relationships with key partners—community-based treatment and behavioral health providers; elected and appointed officials; the local public health department; hospitals; prosecution and other justice system agencies; members of the broader community, such as the faith and recovery communities; and people who have lived experience with the challenges being addressed. It is important to keep group size manageable during the preliminary planning phase; it may then be expanded as the program is developed.

If the prosecutor's office or another justice system stakeholder initiates program planning, first responder agencies and behavioral health/treatment partners who will be staffing the teams should be brought into the planning process as early as possible. This is essential for garnering support and subsequent buy-in from frontline workers, such as patrol officers, fire department personnel, and EMS staff members who may be interacting with and making referrals for the program. In addition, it will help build trust among the

partner agencies, which is essential for the success of the program.

3. Hire a dedicated program coordinator.

The program coordinator troubleshoots stakeholders' concerns, works to identify resources, facilitates meetings, develops information sharing systems, and streamlines communication. First responder deflection programs consist of politically independent actors, so even if the program coordinator works for the agency that established the program and administers the funding, it is important that they be primarily concerned with the program itself and independent from all political and operational stakeholders.¹⁰

4. Hold regular partner meetings.

On an ongoing basis, the program coordinator should hold regular meetings with all partners to discuss any challenges and process issues, address individual situations that arise, review new data or trends from data analyses or research partner findings, and share success stories. This process keeps lines of communication open, enhances trust among partners, and facilitates better program operation.

5. Engage the larger community.

Buy-in from the larger community, including residents, local businesses, and other stakeholders, can provide program support while expanding the services network. During the planning and development phase, use public outreach (print media, social media, etc.) to inform the community about the program and encourage participation in public meetings. Listen to and engage residents in dialogue. Explain why the program was developed, the program's goals, and how it will benefit the community and offer to serve as a resource as questions arise. Faith-based and community service groups are often eager to contribute resources, time, or goods and services to outreach teams as part of their mission and should be identified and included as stakeholders.

Engaging community members from neighborhoods affected by crime and people impacted by or involved with the justice system, as well as individuals in recovery, can bring diverse perspectives that can enhance and sustain deflection efforts. By creating opportunities for community input, action, and engagement, authentic relationships between the community and other stakeholders can be established and strengthened.

After the program is implemented, consider holding regularly scheduled meetings about the program in and for the community, where community members can discuss program-related issues with agency officials who can address neighborhood concerns in real time, if possible. These meetings can help residents feel acknowledged and confident that their concerns are being heard, which helps to build trust between residents and program leaders. This is especially important in communities with a history of enforcement-centered approaches to addressing individuals with SUDs and provides an opportunity to inform community members of the changing role of law enforcement in addressing individuals with SUDs.

6. Be intentional when selecting personnel for outreach teams.

Outreach team members may include first responders, peer support specialists or recovery coaches, treatment providers, and other behavioral health professionals, as well as public health or community health practitioners, etc. It is essential to have core team members who are passionate about helping people and who collaborate well. Other considerations when selecting team members include the following:

- When choosing outreach team members, it is important to assess their experiences and connections to the community. Programs should prioritize training in crisis intervention or mental health first aid or educational backgrounds in social work, psychology, or a related field. First

responders with these backgrounds and credentials often are a good fit for active outreach teams.

- It is important to include team members who have lived experience with SUDs and MHDs and who can talk to potential clients about their own experiences with treatment and recovery. Individuals struggling with SUDs often see peer support specialists as the most credible members of the outreach team due to their shared experiences, and they feel most comfortable speaking with them. While other behavioral health providers usually are discouraged from sharing their personal experiences, peer workers need to be skilled in telling their recovery stories and using their lived experiences to inspire and support others living with similar conditions.¹¹
- Team members need to use active listening and motivational interviewing techniques during outreach. Making eye contact and affirming what an individual has said demonstrates empathy, confirms that the team member hears and cares about the person's story and challenges, and can help reduce stigma through a show of support.
- In addition to mindful listening, team members must listen for keywords and watch body language for an accurate understanding of what is being communicated.

7. Train officers about addiction, trauma, and recovery, and project positive messaging to first responders about deflection.

For any first responder deflection program to succeed, frontline personnel must support the program.

Knowledge of the following elements can provide officers with insight into and empathy for vulnerable populations and can reduce the stigma attached to individuals with SUDs and other behavioral health disorders:

- Training on the neuroscience of addiction to understand the chemical changes that occur in the

brain and how these changes are manifested in individuals' behaviors.

- Training on adverse childhood experiences (ACEs) and trauma to ensure that officers understand the impact of early trauma on developmental and life course outcomes. Training on ACEs and trauma can also inform outreach teams about the need to use empathic outreach techniques rather than overly assertive or intimidating behavior when approaching individuals.
- As highlighted above in Critical Element 6, priority should be placed on selecting personnel who demonstrate active listening skills. These skills should also be enhanced during outreach training through modules on motivational interviewing, screening and brief intervention techniques, and the use of a customer service orientation.
- Training for outreach teams should include all team members and employ a cross-training approach appropriate for the multidisciplinary nature of the team. The team should undergo training together and should engage in team exercises such as role-playing, scenario-based activities, and facilitated discussion to build rapport among team members.
- Understand that relapse is very often a part of the recovery process, which may result in an officer needing to divert an individual multiple times.

Command staff members should attend as many of the training sessions as possible to convey the importance of the program and their commitment to it. Programs should offer renewed training as more research becomes available, as new staff members join the agency, and to refresh prior educational efforts.

Command staff members should recognize deflection and outreach efforts when evaluating and considering the promotion of an officer. In this way, officers will be encouraged to see referral to treatment as a viable alternative to arrest with the possibility of leading to

positive outcomes for the individual, the community, and overall public safety.

8. Collect data and evaluate the program.

Research and data collection are vital for validating and improving any first responder deflection effort. Project coordinators should partner with a university or independent researcher as early as possible in the program planning phase. Research partners can help by assisting with program design, setting program goals, defining performance measures, creating data collection tools, developing evaluation procedures, and conducting data analyses. They can also help stakeholders track implementation of the program to ensure equity among communities; demonstrate the success of the program to policymakers, the media, and the community; apply for additional funding to sustain the program; and add to the knowledge base about first responder deflection.

9. Create a feedback loop.

It is essential that stakeholder agencies, organizations, first responders, and community members learn about the outcomes of individuals who have benefited from the program. After a program has been implemented successfully, hearing about or from an individual who is in treatment or recovery reinforces the benefits of the program and provides incentives to first responders to continue implementing it. Hearing that an individual is experiencing positive outcomes resulting from a team's outreach efforts can be more powerful than the results of a program evaluation. Situations that have less-than-positive outcomes can also be discussed during program and stakeholder meetings to consider what could have been done differently, other needs the program has not met, and changes that can be made. These are the stories that numerical data do not capture but still have a significant impact on program success.

10. Conduct ongoing messaging to the community through the media.

Develop messaging for local media at all stages of program planning and implementation to highlight the goals and successes of the program and to celebrate milestones. Invite media representatives to join the outreach team at community events or celebrations and offer interviews with program officials from each key stakeholder organization. Positive media coverage can broaden awareness of the program and help engage the community to garner support, which can lead to program expansion and sustainability.

Programs that use mobile outreach should use their program website and social media platforms, as well as those of their partners and stakeholders, to publish calendars and lists of locations where their teams will be deployed in the community.

Active Outreach Case Study #1: Cumberland County, New Jersey

Operation Helping Hands (OHH):
Recovery on Wheels (ROW)

FY 2021 COSSAP Grantee

About Cumberland County

Cumberland County (population 153,602)¹² is a coastal area located on the southern tip of New Jersey, bordering Delaware Bay to the south and Atlantic County and Cape May to the east. The county is centrally located among some of the major cities in the region. By car, New York and Baltimore are two hours away, and a trip to Philadelphia takes 45 minutes. Cumberland County's long history of agricultural commerce earned it the nickname the "Garden Spot of the Garden State."

From 2015 to 2018, fatal overdose rates (primarily attributed to opioids) and naloxone administration rates in Cumberland County increased alarmingly. Cumberland County experienced 38 fatal overdoses in 2015 and 112 fatal overdoses in 2018, an increase of nearly 295 percent.^{13, 14} The two substances leading this surge were heroin, which accounted for 16 of the overdoses in 2015 and 42 of the overdoses in 2018 (a 263% increase), and fentanyl, which accounted for 10 of the overdoses in 2015 and 94 of the overdoses in 2018 (a 940% increase). Similarly, the number of naloxone administrations performed by law enforcement and EMS rose from 178 in 2015 to 688 in 2018, an increase of nearly 387 percent.¹⁵

How Recovery on Wheels Began

Due to escalating harm related to substance misuse, Cumberland County Prosecutor Jennifer Webb-McRae rallied local law enforcement agencies, other county departments, and SUD treatment providers to consider programming that would facilitate access to treatment for residents suffering from SUDs. In 2017, the Cumberland

County Department of Human Services (CCDHS), Division of Alcohol and Drug Abuse Services and the Cumberland County Prosecutor's Office (CCPO) joined with the Southwest Council, a local nonprofit organization focused on substance misuse prevention, to launch Cumberland CARES (Compassionate Addiction Recovery Equals Success). The program trained CARES recovery coaches to staff a hotline 24 hours a day, 7 days a week, to connect individuals with SUDs to treatment services.¹⁶

In 2019, the CCPO was funded to join the statewide Operation Helping Hands (OHH). OHH was created by Attorney General Gurbir S. Grewal during his tenure as the Bergen County, New Jersey, Prosecutor in 2016. Under the Bergen County OHH model, when law enforcement officers detained individuals they suspected were using drugs, officers gave those individuals the opportunity to engage in treatment and recovery services instead of arrest.¹⁷ However, when this program was implemented in Cumberland County, only a few of those individuals who were arrested agreed to enter into treatment. In addition, OHH program administrators found that the people who entered the program so that their charges would be dropped were often not complying with the program's terms, and there was a high rate of recidivism. Simultaneously, as word of the program spread, individuals desperate for treatment began voluntarily requesting to be placed into the program. Practitioners found that those individuals who willingly entered the OHH program had higher treatment placement rates, lower attrition rates, and better outcomes than those who entered the program to have their charges dropped.

Recognizing the value of offering voluntary access to treatment and drawing upon the resources from both Cumberland CARES and OHH, the CCPO collaborated with the Cumberland County Sheriff's Office (CCSO), CCDHS, and the Cumberland County Department of Health to launch a mobile outreach unit in August 2019 called [Recovery on Wheels \(ROW\)](#). The CCPO paid to retrofit a retired fleet bus provided by the county's Office of Aging & Community Services. The program also hired recovery

coaches trained by Cumberland CARES to staff the mobile outreach unit. CCDHS supervises the recovery coaches, and the Cumberland County Department of Health provides on-site community nurses to attend to medical needs such as Hepatitis A or influenza vaccinations and health screenings. The CCSO maintains the bus, provides fuel, and supplies a driver. ROW can reach underserved Cumberland County residents by meeting them where they are and providing services directly to those who need them most.

"We changed our focus from trying to end a social ill through criminal justice tactics to working to prevent it. And all of us involved in the effort—law enforcement, the county, and other stakeholders—also realized we could be more effective through collaboration than we could individually."

– Special Agent Matthew Rudd, CCPO

ROW benefits from the fact that the Cumberland County Prosecutor serves as the county's chief law enforcement officer and can coordinate programming through the municipal police chiefs across the county through directives or requests. The involvement of the prosecutor proved instrumental in coordinating ROW programming across county departments and expanding the program to create more touchpoints, or opportunities for contact, with individuals with SUDs. This has been a significant lesson learned: the more opportunities offered to connect individuals with SUD to SUD treatment, the higher the cumulative response and effectiveness. Another advantage for OHH and ROW is that the prosecutor is appointed by the New Jersey Governor for a term of five years, which lends stability and sustainability to the program.

How Recovery on Wheels Works

ROW provides mobile outreach once a week during daytime hours to various sites in Cumberland County. To notify the public of the location where ROW will be each week, stakeholder groups and partner organizations publish a list of locations the bus will visit over the next 60 days on their websites and social media platforms.

Individuals seeking SUD treatment, often brought by family members or friends, visit ROW, where they connect with a recovery coach for intake to screen their needs and receive appropriate treatment placement within 48 hours; they are often transported to an appointment directly from the ROW site. Beyond SUD treatment, visitors to ROW can get health screenings and services from an on-staff community nurse, a naloxone kit with guidance about needle use and medication disposal, referrals to social service providers, and temporary identification cards for accessing SUD treatment services.¹⁸ ROW administrators also write letters of recommendation to defense attorneys to present to the court in cases in which a participant who is accessing treatment has pending criminal charges.

“Some of our credibility [comes from the fact] that we continue to rise in our success rate. In fact, we have a 100 percent success rate in placement for someone who wants to go to treatment the same day or day after,” said Special Agent Rudd of the CPPO.

System Impact

Between the launch of ROW in August 2019 and March 2022 (with a short hiatus during the emergence of the COVID-19 pandemic), the mobile outreach unit was deployed over 100 times and connected more than 130 people with SUD treatment services. As success bred more success, the program’s popularity expanded outside of Cumberland County. Individuals with SUDs traveled from other localities to visit the mobile outreach unit due to growing awareness of the program. New partners and treatment providers have expressed interest in contributing

to or collaborating with the program. The U.S. Census Bureau, Volunteers of America, local food banks, and homeless outreach groups have asked to come on-site or to have the bus park near their locations, and several counties also participating in OHH have asked for guidance on how to replicate ROW in their locations.

Practitioners consistently work to expand access to treatment services and increase the number of touchpoints with individuals suffering from SUDs. This includes intentionally dedicating one trip per month to rural areas in Cumberland County to reach isolated individuals who lack access to SUD and health services. In addition, after receiving a \$62,000 expansion grant from the New Jersey Office of the Attorney General, the county added a component to its outreach efforts, Knock and Talk, which enables OHH to connect with individuals whose lives were saved by naloxone administered by first responders. The Knock and Talk program also received support from the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP), which helped start the effort by connecting OHH administrators with a mentor site in West Virginia to benefit from their successes and lessons learned.

CCPO Special Agent Rudd works with the area’s High Intensity Drug Trafficking Areas (HIDTA) program to compile a list of Cumberland County residents who have recently experienced an overdose. Once a week, just before the scheduled ROW outing, a team composed of a CCSO officer and a recovery coach visits those individuals through the Knock and Talk program. Whereas the mobile outreach unit functions during the day, the Knock and Talk team members go out during the early evening after normal work hours, to increase the likelihood of contacting identified individuals or their family members. When the team members make contact, they tell the individual or their family members about available treatment options and that coaches are on standby to assist them in their recovery. According to Special Agent Rudd, “By and large, the overdose survivors and their families have been

very receptive and appreciative of [Knock and Talk team] visits.” After the visit, team members transfer their notes from the meeting to the coaches at the county-run Capital Recovery Center, who then follow up via phone to continue supporting and encouraging the individuals whom the Knock and Talk team contacted. Since the program’s launch in August 2020, 1,115 contact attempts were made with an approximately 20 percent rate of success; the 223 successful contacts resulted in some form of support, ranging from treatment placement and social services to job readiness or placement. As a new COSSAP grantee, the CCPO has plans to expand the program, including implementing a pre-indictment deflection component to provide even more pathways for those seeking recovery.

Lessons Learned

- ◀ Deflection programs should be capable of adapting to the context of the community. For example, OHH practitioners found more success in connecting individuals who accessed the program voluntarily for treatment rather than in place of arrest. Consequently, program practitioners created ROW to increase voluntary access to the program.
- ◀ As the county’s lead law enforcement officer, the Cumberland County Prosecutor is in a unique position to coordinate and steer programs. Her ability to generate multidepartmental, countywide collaboration proved instrumental in obtaining support from law enforcement, appointing program staff, and creating momentum for a coalition to help sustain the program. Federal and state agencies, other county departments, local businesses, and community groups responded to ROW’s early success by contributing financial support, expanding the program’s capacity to reach more individuals over time.
- ◀ Practitioners can enhance SUD deflection programs by adding more touchpoints for people with SUDs. For example, the addition of the Knock and Talk program enabled ROW to provide new opportunities to recovery staff members to reach out to additional people and for people with SUD to connect with treatment.

- ◀ Identifying partners with shared goals is the best place to start, especially if an agency is unsure about where to begin. Collaborating with partners builds momentum, offers more accountability, and enables the program to overcome more obstacles than one organization acting alone. Identifying partners requires assessing current community readiness to launch an SUD deflection program.
- ◀ Making data-driven decisions requires collecting and analyzing data, so be prepared to put in the necessary work when constructing a programmatic plan. The resulting program will have an evaluative component already built in, allowing for an efficient and accurate assessment of what is working and what needs adjusting.

Active Outreach Case Study #2: Morris County, New Jersey

Hope One

FY 2018 COAP* Grantee

*COAP was the Comprehensive Opioid Abuse Program, predecessor to COSSAP.

About Morris County

Morris County (population 510,981)¹⁹ is located in northern New Jersey and encompasses 39 distinct municipalities. The county is primarily suburban, but it also includes outdoor recreational areas and many rivers and lakes. It is roughly 30 miles west of New York City and is considered part of the New York metropolitan area.

Like many areas across the country, Morris County continues to be impacted by the opioid epidemic. In 2013, there were 46 overdose deaths in Morris County. In contrast, the number of overdose deaths in 2017 was 89. The increased prevalence of fentanyl and fentanyl analogs proved a significant factor in the rise in overdose deaths. In 2013, there was only one fatal overdose incident involving fentanyl, while in 2017, the number rose to 42.²⁰

Program Development

When James M. Gannon was sworn into office as the sheriff of Morris County on January 2, 2017, one of his focus areas was combating illegal drugs such as heroin.²¹ Noting a spike in fatal overdoses and speaking with affected residents along the campaign trail, Sheriff Gannon witnessed the scope of the drug problem in Morris County and the toll it was taking on the community. Upon entering office, he was determined to create a program to enhance access to treatment for people with SUD. Drawing upon the bookmobile model, Sheriff Gannon sought to create a mobile unit to bring services and resources directly to community residents struggling with SUDs or MHDs. Within 100 days, the concept became the active outreach program

known as Hope One, which officially launched on April 3, 2017.

Sheriff Gannon relied on collaboration among the Morris County Sheriff's Office's (MCSO) Community Outreach and Planning Section (COPS), the Morris County Department of Human Services (MCDHS), the Mental Health Association of Essex and Morris (MHA), and the Center for Addiction Recovery Education and Success (CARES) to develop and launch Hope One.

The first Hope One vehicle was a police tactical operation van that Sheriff Gannon helped repurpose into a mobile recovery access center. Sheriff Gannon used roughly \$17,000 of drug forfeiture money to retrofit the inside of the van to serve as a meeting space for prospective clients and interested parties. The program's name was advertised on the outside of the van as well as the telephone number for a recovery support hotline and a "stigma-free" logo indicating that it was a judgment-free zone.

The Hope One team comprises Corporal Erica Valvano, a member of the MCSO COPS and the coordinator of Hope One; Officer Chelsea Whiting; Albert Shurdom, a mental health advocate and professional from MHA, who serves as the program's case manager; and Caroline Bailey, a CARES-certified peer recovery specialist. At first, the program had no outside funding, just a shared commitment among the participating agencies to help the community. However, as the program began to receive recognition from Morris County officials and other county agencies, the MCDHS stepped in and provided funding for MHA and CARES to staff the vehicle for two days per week.

How Hope One Works

At first, Hope One was deployed into the community every Monday and Thursday. Hope One practitioners thought that Monday would be ideal, because it is the first day following the weekend, and Monday morning hangovers might spur individuals' willingness to access treatment. Thursdays were chosen because of the high number of overdose incidents that occurred on that day. As the program evolved and its

value became clear to stakeholders, Hope One increased the number of deployments to four days per week, serving the community Monday through Thursday.

“There is no secret that across America and beyond, this opioid epidemic was happening, and we wanted to make a difference. So, what do we need to do? We need to focus on the at-risk population, and the second and final piece is bringing services to them. That’s it; it’s not complicated.”

—James M. Gannon, Sheriff, Morris County, New Jersey

Hope One team members are not only strategic about when they deploy, but where. The Hope One team examines naloxone utilization data and overdose data when identifying areas for outreach. Also, recognizing the link between substance misuse and retail theft, the team often sets up outside stores that have experienced high rates of theft.

Before Hope One makes an outreach visit, the team takes steps to market the event to residents. The calendar of outreach events is promoted on county websites as well as on social media platforms. On-site, the Hope One team takes steps to attract passersby, such as by offering free refreshments outside the van. One team member reported that the Hope One staff members sometimes are compelled to engage the public proactively to promote naloxone, its purpose, and the fact that it is available for free. This activity not only helps alert people to Hope One’s presence but also serves to destigmatize issues and dispel myths related to SUDs. Hope One team members also distribute brochures from the van to help connect individuals to life-changing services. Moreover, if the individual is not ready to receive help at that time, the team reassures the client that when they are ready, the team will be there to help.

When a prospective client visits the Hope One mobile outreach unit, a team member sits down to talk with the individual to learn more about them and their needs. If the person voices concern over an SUD, Ms. Bailey, the peer recovery specialist, takes over as the lead of the conversation. Alternatively, if the prospective client is more interested in resources or treatment related to mental health, Mr. Shurdom, the mental health advocate, takes the lead. The Hope One team seeks to empower clients by listening carefully to them, helping them identify and set their own goals, and then providing assistance to help the clients meet those goals. It is a client-driven process rather than a practitioner-driven process. If the client is interested in accessing treatment service, the team member asks if the client has any preference about where they want to go. For her part, Ms. Bailey is well acquainted with local treatment providers from her own experiences with addiction and her subsequent work and uses her knowledge to educate the individual on options across multiple pathways to recovery.

The Hope One mobile outreach unit provides a variety of services and referrals to SUD and mental health treatment services across multiple access points. Among the most popular services—and according to Sheriff Gannon, the most important—is the support the mobile outreach unit provides individuals in obtaining identification cards from the MCSO. Without proper identification, people cannot access treatment or services; apply for a job, food stamps, or housing; or even borrow a library book. The Hope One team has provided identification cards to more than 900 people. Team members also provide toiletries, new socks, and other basic items. The state-of-the-art van also provides a charging station where unsheltered individuals can charge their mobile devices. The team can make referrals to other service providers who provide housing assistance, as well as case management and mentoring services for families experiencing homelessness. They also offer training on how to administer naloxone and provide naloxone kits after the training.

Depending on capacity, the lapse in time from initial contact to the client entering treatment can range from 30 minutes to 2 days. When treatment space is available immediately, the Hope One team uses an auxiliary van to transport the client from the mobile outreach unit to the treatment center. If the client must wait 24 to 48 hours to access treatment, or if an individual is not yet ready to seek treatment, Hope One staff members, through CARES, offer the person access to the program's telephone recovery support system. With this system, peer recovery coaches follow up on a pre-determined schedule set by the client. The telephone recovery support system can assist clients in the short term to get through the waiting period before accessing treatment and can also assist in the long term. Recovery coaches call clients regularly and leave voicemail messages to let them know that the recovery coach will be there if the client needs anything or is ready to seek treatment. Many times, months later, clients contact recovery coaches to voice gratitude for the support they received and to share that they are now ready to access treatment.

System Impact

From its inception on April 3, 2017, through March 15, 2022, the Hope One mobile outreach unit contacted 26,881 people. These contacts resulted in 129 connections to recovery resources, 122 connections to SUD treatment centers, 54 connections to family support services, 270 connections to mental health services, and 5,068 naloxone training sessions. The program received reports from 93 people stating that they had successfully used the naloxone provided by Hope One to reverse or try to reverse an opioid overdose.

Beyond its current efforts, the Hope One team is enhancing its outreach to people with SUD. Supported by a \$332,000 grant to the MCSO from BJA, Sheriff Gannon started a PAARI program, which led to the creation of two additional pathways to deflection—first responder and officer referral and self-referral. Through PAARI, 22 active police departments in Morris County provide an alternative to

arrest for people with SUD. Now, officers can call a certified peer recovery specialist when they meet someone who needs assistance with an SUD, thus diverting eligible individuals away from the justice system and into treatment. Also, through PAARI, individuals with SUD can walk into any of the 22 participating law enforcement agencies in Morris County and get connected to treatment services without fear of arrest. In September 2020, the Hope One team began conducting outreach to individuals in homeless encampments, continuing the program's mission of bringing services directly to those in need.²²

Hope One inspired the creation of another new program, Hope Hub, which was established to serve clients with complex needs and at elevated levels of risk. Through Hope Hub, which is coordinated by Officer Whiting, Hope One practitioners convene a multidisciplinary panel comprising representatives from law enforcement, social services, mental health services, health care, treatment, and recovery to strategize about how to help individuals and families who could benefit from a variety of wraparound services. The panel helps determine which services would best assist an individual and then works to determine if that individual's situation requires a welfare visit or an intervention.

Recognizing Hope One's value, many jurisdictions outside Morris County have adopted or are seeking to adopt the Hope One model. Although Hope One was developed in a suburban environment, police departments in rural and urban localities have successfully applied its framework locally. The City of Newark, New Jersey, launched Hope One Newark in December 2018. By April 2019, Hope One Newark made more than 450 contacts, completed 68 referrals to drug treatment programs, and performed 20 naloxone training sessions.²³ Other counties in New Jersey that have adopted the Hope One model include Passaic, Burlington, Monmouth, Hunterdon, Cape May, and Atlantic with several more about to launch soon. In addition, Yonkers, New York, explored adopting the model.

Hope One gained further recognition when it received the International Association of Chiefs of Police (IACP)/Security Industry Association Michael Shanahan Leadership in Public/Private Cooperation Award at the IACP Annual Conference and Exposition in October 2019.²⁴ Hope One continues to help residents with SUD and assist other localities in launching their own Hope One programming locally.

Lessons Learned

- ◀ Having a law enforcement leader such as Sheriff Gannon implement and champion Hope One has built support for the program among stakeholders including service providers, partner agencies, policymakers, and benefactors. He gives the Hope One team ample autonomy and provides cover if they run into challenges or barriers. Sheriff Gannon also works to secure funding for the program.
- ◀ It is important to assess available local resources before launching a program such as Hope One. Collaboration with behavioral health, SUD treatment, and other treatment and service providers who are committed to the program is one of the keys to Hope One's success.
- ◀ Hope One benefits from the experience and knowledge of team members who have lived experience with SUD and mental health issues. Participants are more likely to trust recovery coaches and clinicians who have been in their shoes and can speak from experience about treatment and recovery.
- ◀ It is essential to have core team members who are passionate about helping people and who collaborate well. Hope One team members go out of their way to reach out to individuals and families who need their services and often talk about how much they love their jobs.
- ◀ Listening to potential clients is paramount. When people approach the van, they may need only one type of help or a whole array of services. By listening for keywords, team members can determine individuals' needs and consider appropriate responses.

Active Outreach Case Study #3: Philadelphia, Pennsylvania

Police-Assisted Diversion Program's Outreach Co-Responder Team

About Philadelphia

Philadelphia (population 1,619,355)²⁵ is the largest city in Pennsylvania and the sixth most populous city in the United States.²⁶ Philadelphia borders Camden, New Jersey, to the east, and its immediate proximity to Interstate 95 allows for easy access to other major cities such as New York City to the north and Wilmington, Delaware; Baltimore, Maryland; and Washington, DC, to the south. Philadelphia is home to well-known universities, such as Temple, Drexel, and the University of Pennsylvania, and has a vibrant art scene and several professional sports teams.

In contrast to these attributes, Philadelphia also features some of the most prolific and long-standing drug hotspots in the United States. With some variance year by year, the annual citywide rate of unintentional overdose deaths grew from 387 in 2010 to 907 in 2016 and peaked at 1,217 in 2017. Opioids were the primary driver of this alarming increase in overdose deaths. The number of opioid-related overdose deaths was 297 in 2010, 752 in 2016, and 1,074 in 2017.²⁷ The increasing prominence of fentanyl and fentanyl analogs in heroin supplies drastically increases the risk of overdose and results through a quicker onset of withdrawal symptoms and cravings after use, as fentanyl provides a more intense but shorter high than heroin alone.

In North Philadelphia, a section of neighborhoods known colloquially as the "Badlands" is home to an abundance of drug markets and drug activity. Included in this area is the Kensington neighborhood, which has a well-known and established open-air drug market that attracts both residents and individuals who travel from the suburbs or out of state. Due to the availability of drugs, specifically opioids, many unsheltered individuals with SUDs congregate and live in the area to allow for easy access.

To combat the opioid crisis, the Philadelphia Police Department (PPD) collaborates with city departments, community groups, and treatment providers on several programs to improve the accessibility to and availability of treatment services. This case study focuses on the PPD's Police-Assisted Diversion (PAD) Program's Outreach Co-Responder Team (OCT).

Philadelphia's History of Deflection and Community-based Programming

The PAD OCT Team represents a step forward in the evolution of deflection and community-oriented programming in Philadelphia. The original Philadelphia PAD program was created in 2017 through a partnership among the PPD, the Managing Director's Office of Criminal Justice, the Defender Association of Philadelphia, the Office of the District Attorney, the Department of Behavioral Health, the Pennsylvania Recovery Organization Alliance, Prevention Point Philadelphia, and the Salvation Army. PAD was part of an effort to address Philadelphia's exceptionally high rates of fatal overdose, poverty, and incarceration. It enabled officers to offer individuals access to treatment services in lieu of arrest (termed "stop referrals"). In two pilot zones, officers could perform stop referrals in cases involving retail theft or minor drug activity; citywide, officers could use stop referrals in response to charges stemming from prostitution. PAD also allowed for "social referrals" which enabled community members to enroll in the PAD program themselves, independent of any criminal charge or investigation.

In 2017, the PPD also launched the East Service Detail (ESD), a specially trained unit composed of two problem-solving officers, to serve the Kensington neighborhood specifically. Officers assigned to the ESD were tasked with going into the community to directly interface with people experiencing homelessness or SUDs and connect them to services. ESD officers do not perform enforcement activities and do not respond to calls for service. Instead, their responsibilities include building rapport and relationships with those in need, responding to quality-of-life issues, assisting patrol officers by de-escalating situations, and

facilitating warm handoffs to service providers so that patrol officers can return to their duties. To be selected for the ESD, officers must express a passion for helping individuals in the community, have a preexisting connection to the area, and be bilingual in order to communicate with Spanish-speaking residents. These requirements are designed to help instill trust in the ESD among members of the community.

In October 2018, Mayor Jim Kenney signed an executive order creating the Philadelphia Resilience Project, which brought together 35 city agencies and departments to address the unsheltered population, quality-of-life issues, and the prevalence of opioid overdoses. As a result of this new initiative, PAD began servicing the Kensington and Fairhill neighborhoods. Since its inception, the ESD has expanded to 12 officers covering three shifts and offering services 24 hours a day, Monday through Friday.

PAD Outreach Co-Responder Team: How It Began and How It Works

In March 2019, as part of the Philadelphia Resilience Project strategy, Philadelphia's Managing Director's Office of Criminal Justice coordinated a partnership between the PAD program and the ESD that was launched as the PAD-OCT in the Kensington and Fairhill neighborhoods. Peer recovery specialists from Merakey, a behavioral health nonprofit organization, were embedded in the ESD and began accompanying its officers to facilitate health interventions through targeted outreach. In the field, the co-responder team discusses treatment options with individuals, connects them with services, and provides transportation directly to treatment facilities. Pairing peer recovery specialists with the ESD was intended to strengthen the ESD's impact in the target area by enhancing its ability to assist people with SUDs and to provide them access to treatment services.

The OCT works with a wide network of community-based treatment providers. When developing the list of treatment provider partners, practitioners solicited input directly from community members and individuals with lived experience.

Prospective providers had to be willing to partner with the PPD, support a peer-based recovery model, and provide services during the PAD hours of operation Monday through Friday. In addition, although the OCT's overarching priority is to connect people with SUDs to treatment services, providers also have to be willing to meet people where they are in an authentic way to provide support in the moment, while also building rapport for additional future support. This approach led the OCT to partner with harm reduction groups such as Prevention Point Philadelphia.

Complementary to the ESD's purpose, the OCT's objective is to build rapport and trust with the community—specifically with individuals struggling with SUD—and respond to requests for help. If the OCT encounters an individual who is interested in accessing treatment services, the outreach team promptly connects that person with treatment services. Due to the preexisting relationships between the PAD program and local treatment providers dating back to the launch of PAD in 2017, providers prioritize individuals referred to them by the OCT and reserve space for such clients.

In addition to building rapport and connecting individuals to treatment services, the OCT provides short-term stabilization support around people's most basic needs, such as access to food and shelter. Outreach team members provide SUD assessments and transportation to crisis response centers and emergency shelters. Harm reduction service providers offer access to identification cards, clean socks, and clean water. If an individual is not interested in accessing formal treatment services but asks for help from the OCT, practitioners view this as progress. By consistently showing up in the community, building rapport with individuals with SUDs, and following through on requests for help, the OCT makes it clear that when an individual is ready to enter treatment, the team will be there to facilitate the linkage.

“You need to meet people's immediate needs, providing what we call ‘short-term stabilization around the means of survival.’ [The outreach teams] can help [clients] figure out basic things like where their next meal is coming from, where they can get clean clothes, and where they can use the bathroom. From there, you build rapport so that folks feel comfortable to come back when they want to . . . [to] address more of their complex unmet health needs.”

—Kurtis August, Deputy Director of Diversion and Deflection, Philadelphia's Managing Director's Office of Criminal Justice

The OCT performs outreach to known drug or overdose hotspots daily. In addition, the team encourages community members to share information about other locations that need attention or individuals who would benefit from outreach. Quality-of-life calls from neighborhood residents help team members identify areas for outreach. The OCT also receives leads during a weekly “huddle” convened by the Philadelphia Opioid Response Unit every Tuesday morning on the corner of F Street and Allegheny Avenue, which is a hub for drug activity. Members of this multidisciplinary team—composed of supervisors from the Opioid Response Unit, personnel from the Managing Director's Office of Criminal Justice, police, representatives from the homeless outreach team and homeless shelters, and other service providers—attend the huddle and make themselves available so that the weekly meeting becomes a platform for community engagement.

The huddle empowers community members to speak directly to officials who can address their concerns in real-time, including OCT members. Team members then share this information with district captains, who communicate

with the ESD and other appropriate teams to recommend places and people to target for outreach. While the huddle takes place outside, anyone who wants to talk specifically about particular problems can have a private conversation with officials in a nearby office space. Residents can expect that by attending the huddle they will get help in real time from officials who will immediately engage in outreach to those in need.

System Impact

In some parts of Philadelphia, greater trust needs to be built between law enforcement officers and the community. When officers are active in the community through non-enforcement activities and focus on building relationships and responding to requests for services, the officers promote a new dynamic. Traditionally, people who misuse substances would not think to turn to the police for help. However, the OCT aims to create relationships and build trust so that people who misuse substances and need support look to the PAD-OCT as a viable and trusted source of assistance. By allowing residents to provide input for law enforcement outreach efforts, and then following through on residents' requests, the PPD promotes cooperation between itself and the community.

Programs such as PAD and the OCT promote efficiency by saving patrol officers time. Instead of spending hours processing paperwork and evidence for the arrest of a low-level offender with an SUD, officers can spend 20 minutes facilitating a warm handoff to a behavioral health specialist who can connect that person to treatment and long-term support, which reduces the likelihood of repeat encounters with law enforcement for the same issue. Aside from drug use, Philadelphia is also in the midst of a gun violence epidemic, and programs like PAD and the OCT enable patrol officers to focus their time and resources on serving as consistent, uniformed presence in the community to deter violent crime.

There is still room to improve trust between law enforcement and community members in the Kensington and Fairhill neighborhoods. Kurt August, Deputy Director for the Managing Director's Office of Criminal Justice, said, "We've moved the mountain an inch, but there's a lot more to do in terms of really making the kind of structural quality of life-related improvements that [these] neighborhood[s] need to see." The East Service Detail and the PAD-OCT program are steps in the right direction.

Lessons Learned

- ◀ Strong public support from municipal and police leaders gave the OCT political legitimacy and credibility that garnered organizational buy-in for the program model.
- ◀ Having weekly public "huddles" and allowing community members to directly interface with OCT members, municipal leaders, and service providers has proven invaluable. These meetings facilitate collaborative problem-solving, build community engagement, strengthen rapport between law enforcement and community members, help direct OCT members where they are most needed, and help residents feel acknowledged and confident that their concerns and service issues will be addressed.
- ◀ To develop the required array of service providers, program administrators must dedicate time and effort to build structured, trusting relationships between a diverse network of behavioral health providers.
- ◀ Police leaders should carefully select officers to perform community outreach like that conducted by the ESD.
 - When making personnel decisions, it is important to assess officers' backgrounds. Officers with experience in behavioral health or educational experiences in social work, psychology, or related fields should be prioritized.
 - Officers should be able to communicate with and be culturally responsive to residents of the community they serve. If focus areas have large Spanish-speaking populations, officers should be able to understand and speak Spanish.

- Officers should have a connection to the area they serve, whether they have family members who reside there, have lived there themselves, or have existing positive relationships with residents.

Active Outreach Case Study #4: Rhode Island

The Rhode Island HOPE (Heroin – Opioid Prevention Effort) Initiative

(FY 2018 COAP Grantee)

About Rhode Island

Rhode Island (population 1,097,379)²⁸ is the smallest state in terms of geographic area (1,033 square miles),²⁹ but it has been disproportionately affected by the opioid crisis. In 2013, there were approximately 200 fatal opioid overdoses, and Rhode Island had the highest rate of illicit substance misuse nationally, as well as the highest rate of overdose incidents involving any substance in all of New England.³⁰ From 2013 to 2016, the number of fatal overdose incidents and fatal opioid-related overdose incidents continued to increase, peaking in 2016. The annual number of fatal opioid overdoses began to gradually decrease after 2016, from 314 in 2016 to 271 in 2018.³¹ Even so, in 2018, Rhode Island had the 11th-highest rate of total fatal overdoses per 100,000 residents in the country and the 8th-highest rate of fatal opioid overdoses per 100,000 residents.³²

Program History

In response to the prevalence of opioid misuse and the number of fatal overdoses, in 2014, the Rhode Island State Police (RISP) used federal drug forfeiture money to equip troopers with 300 naloxone kits to use in the field.³³ The RISP also offered naloxone kits to police departments in all 39 jurisdictions in Rhode Island.

In 2017, Colonel Ann Assumpico of the RISP assigned Captain Matthew C. Moynihan to explore other options for combating the opioid crisis in Rhode Island. Captain Moynihan brought many years of experience working with narcotics enforcement and with various law enforcement agencies in task force models to combat crime and address emerging problems. Captain Moynihan was assigned to

then-Governor Gina M. Raimondo's Overdose Prevention and Intervention Task Force and collaborated with other leaders in state government to develop innovative approaches to combat the rising overdose rates in the state.

As a law enforcement representative to the task force, Captain Moynihan's early thoughts centered around enforcement activities, especially targeting fentanyl drug trafficking organizations. However, he soon realized that narcotics enforcement had always been a top priority in the state, and that continuing to dedicate efforts and resources to this strategy alone would not work, as evidenced by the fact that overdoses still continued to occur at an alarming pace. Captain Moynihan decided to develop a statewide program that would focus equal attention and resources on the demand for opioids by reaching out to individuals struggling with OUD and connecting them to treatment. His determination spurred the RISP to develop the Rhode Island HOPE (Heroin – Opioid Prevention Effort) Initiative, which officially launched in 2018. The program is groundbreaking in that it is the first statewide law enforcement-led program that performs active outreach to people with OUD.

How the Rhode Island HOPE Initiative Began

As Captain Moynihan considered approaches for launching a co-responder active outreach program, he came across an article on a program called Plymouth County Outreach in the IACP's *Police Chief* magazine.³⁴ Plymouth County Outreach is a countywide outreach program in neighboring Massachusetts. The article reinforced what Captain Moynihan believed would be critical to Rhode Island's success in combating the opioid epidemic—a multijurisdictional approach that ensured that individuals receive services whether they overdosed in their hometown, the municipality where they purchased the drugs, or someplace in between.

After speaking with the Plymouth County practitioners and drawing upon their experience, Captain Moynihan reached out to Kelley Research Associates, a research firm working

with Plymouth County Outreach, to partner with the Rhode Island HOPE Initiative. He believed experienced researchers would be key partners who could help the Rhode Island HOPE project management team develop the program's design; establish goals, identify objectives, and define performance measures; create data collection tools and technologies; develop evaluation procedures; conduct continuous data analysis to assess achievements of the program; and provide regular and ongoing feedback for program staff members regarding process and outcome measures.

The RISP coordinated the implementation of the Rhode Island HOPE Initiative in partnership with the Rhode Island Department of Health (RIDH); Governor Raimondo's Overdose Prevention and Intervention Task Force; the Executive Office of Health and Human Services; and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals. After Captain Moynihan met with executive directors from the two largest treatment providers in the state, CODAC Behavioral Healthcare and the Providence Center, both came on board as early programmatic partners. These providers offered a wealth of knowledge about OUD and its treatment, and the HOPE Initiative sourced its clinical staff from these providers. As the initiative evolves, it continues to expand its network of community-based treatment providers to diversify its offering of treatment resources.

To fund the program and promote the growth of its infrastructure and capacity, Captain Moynihan applied for and received a COAP grant in 2018. The HOPE Initiative also received funding through the RIDH's State Opioid Response program.

The HOPE Initiative's clinical staff is composed of six full-time peer recovery coaches and three full-time SUD and mental health master's degree-level clinicians. Program staff also include a supervisor for the clinical team, a supervisor for the police officers, and Captain Moynihan, who now serves as the initiative's director.

The HOPE Initiative has provided programmatic training to more than 250 police officers from local departments across the state who can assist with outreach. This 8-hour training includes a presentation from an RIDH official, a peer recovery coach, and HOPE Initiative staff members. Former professional basketball player Chris Herren has made presentations about his own experience with SUD, law enforcement, and recovery during some of these training sessions. The collaboration with and engagement of local police departments is crucial to the HOPE Initiative because the program relies on their knowledge of their community to help make outreach visits successful. Local law enforcement officers can work for the HOPE Initiative (under the auspices of the RISP) while not on duty at their departments and are paid at their regular overtime rate when assigned to the program. When working for the HOPE Initiative, police officers wear HOPE Initiative-branded business-casual attire (as do the clinicians), and the team arrives at each outreach visit in an unmarked SUV. While officers' badges are always visible and officers are armed, the message is clear: this may be a police officer knocking on the door, but the officer is there to offer help and not to investigate a crime or make an arrest.

One of the first steps in developing the initiative was finding a method for identifying individuals at risk of overdose or struggling with OUD. Recognizing that police often are already aware of these individuals through encounters in the field, the initiative created a database model using software that consolidates information from individual police department databases and computer-aided dispatch (CAD) databases across the state. This automated system performs a database search every ten seconds; flags entries that contain keywords such as "opioid," "unresponsive," and "naloxone"; then alerts HOPE Initiative team members of the incident. Identifiable information from police incident reports (i.e., the individual's name, address, and details of the overdose) is transferred to the Rhode Island HOPE Initiative team, and the individual is added to its outreach list. Technology has been a critical element of the initiative's success: the team integrated its alert system

with a case management platform, the HOPE Initiative Case Management System (CMS), which was created with guidance from Kelley Research Associates and is considered the backbone of the program. The CMS is also connected to the Overdose Detection Mapping Application Program (ODMAP) and allows for immediate transfer of data into the ODMAP database.

How the HOPE Initiative Works

When HOPE Initiative staff members identify an at-risk individual, they contact the individual's local police department and engage one of the trained officers to act as the outreach team's law enforcement representative. Within 72 hours of identification, program practitioners begin case management, and an outreach team, comprising a police officer and a clinical practitioner or a peer recovery coach from the HOPE Initiative, visits the at-risk individual.

Once the outreach team members make contact, they explain the purpose of their visit and offer their support. Their message is, "We are here to help." If the individual is interested in accessing treatment, the outreach team works with the client to assess treatment options and facilitate a warm handoff to a treatment provider. If the individual is not interested in treatment, the team discusses harm reduction techniques and offers naloxone. Even if the individual refuses treatment, case management continues, and practitioners perform weekly, or even daily, follow-up check-ins with the individual. For individuals who accept treatment, the initiative's clinical staff members follow up once treatment is complete. The level of contact is left to the discretion of the clinical team.

"What we drive home over and over again is that the doorstep encounter is really about building relationships, so when the individual is ready, we are on speed dial. They know who to call."

—Captain Matthew Moynihan, RISP

The HOPE Initiative's Other Avenues to Treatment and Recovery Resources

The Rhode Island HOPE Initiative offers other avenues to treatment and recovery resources beyond its active outreach efforts. The initiative hosts a telephone hotline and a confidential online referral form.³⁵ Individuals interested in using the HOPE Initiative's services can also make a self-referral to get connected to treatment and recovery resources. Friends and family members can use these avenues to express concerns over a friend's or loved one's substance use and initiate active outreach via the HOPE Initiative.

Program practitioners also work with individuals who have OUD and are reentering the community after serving time in jail or prison. In 2016, Rhode Island began screening all incoming inmates for SUD and started offering all three medication-assisted treatment options (buprenorphine, methadone, and naltrexone) to inmates who suffer from OUD. Studies have shown that individuals are at a higher risk for an overdose within the first seven days after their release from incarceration.³⁶ To prevent these post-release overdoses, HOPE Initiative staff members work with willing inmates to establish a relationship before their release. The HOPE Initiative may provide a ride home and help the individual access recovery services, find housing, or obtain government identification. The HOPE Initiative clinician has daily contact with the individual for the first seven days to help the client stay on course. By assisting at this critical time, the HOPE Initiative can establish trust with the goal of preventing an overdose or future criminal activity. After the initial post-release period, the individual is added to the HOPE Initiative's caseload, and a clinician connects with them at prescribed program intervals.

HOPE Initiative practitioners continually work on expanding avenues for individuals to access treatment and recovery resources. However, they also recognize that friends and family members need access to support services too. In 2019, the HOPE Initiative partnered with the Herren Project, an organization founded by Chris Herren that focuses on

SUD prevention, treatment, and recovery, to create a virtual support group for family members of the initiative's clients.³⁷

System Impact

The HOPE Initiative is a crucial component of Rhode Island's response to the opioid crisis, but it is also helping build trust between police officers and the residents they serve. Having local police officers on outreach teams promotes community policing by encouraging officers to develop rapport and relationships with at-risk individuals. The HOPE Initiative also benefits police departments across the state by giving smaller departments access to statewide resources.³⁸ Whereas many departments were unreceptive to the naloxone program in 2014, more recently, the HOPE Initiative has prompted some of those departments to reconsider and equip their officers with naloxone to respond to opioid overdoses.

The Rhode Island HOPE Initiative is the first statewide active outreach program of its kind and serves as a model that other states can adapt to launch their own statewide active outreach programs. In the two years since its inception, the Rhode Island HOPE Initiative has proven successful in connecting at-risk Rhode Islanders to treatment services, and the model could be used to help residents in additional states.

"The HOPE initiative doesn't give up on people. Whether it's the first, fifth, or twentieth time, we don't give up. Even if someone overdoses a couple times, they can contact us, and we'll be there to help them."

—Captain Matthew Moynihan, RISP

Lessons Learned

- ◀ Collaborative partnerships are critical to program success, and the buy-in of each partner has been essential for securing program funding, community support, and referrals. It is essential to find people who can champion the program in each of the stakeholder organizations. These individuals play a crucial role in encouraging stakeholder interest and participation in programming.
- ◀ The HOPE Initiative benefited immensely from the involvement of treatment providers as early collaborators. Treatment providers offered an understanding of OUD and its treatment that other practitioners drew upon when developing the initiative's model.
- ◀ Early participation by research partners can help program administrators by assisting with program design, setting program goals, defining performance measures, creating data collection tools, developing evaluation procedures, and conducting data analysis. A research partner can also assist with reporting requirements for funders and the local project team.
- ◀ The multijurisdictional approach of the HOPE Initiative facilitates information sharing across police departments throughout the state and has created more opportunities for departments to work together.

Active Outreach Case Study #5: Story County, Iowa

Alternatives Pre-/Post-Arrest Diversion Program

FY 2019 COAP Grantee

About Story County

Story County (population 100,337)³⁹ is located in central Iowa, approximately 40 miles north of the state capital of Des Moines. The county encompasses 4 unincorporated towns, 16 townships, and 15 incorporated cities. The city of Ames is the largest municipality in the county and is the home of Iowa State University, which had an enrollment of almost 32,000 students in 2020.⁴⁰

Most justice system deflection programs for individuals with SUD are created in response to high rates of opioid misuse and opioid overdose, but in Story County, the primary concern is the trend of increased use of methamphetamine. Since 2017, arrests and hospitalizations due to methamphetamine use have increased, both in Story County and in the rest of Iowa.⁴¹ While opioid misuse creates challenges in Story County, it has not caused the widespread devastation seen in other communities.

How Alternatives Began

In 2018, the Story County Attorney's Office, led by Latifah Faisal, Director of Special Projects, attempted to launch a mental health court; however, a moratorium on specialty courts mandated by the Iowa Supreme Court halted these plans. When Ms. Faisal learned that the Iowa Governor's Office of Drug Control Policy (ODCP) was applying for a COSSAP grant from BJA, she refocused her attention on applying for funding through ODCP to launch a deflection program. Story County Attorney Timothy Meals was committed to helping residents with SUD. He recognized the value of its preexisting partnerships with several Story County stakeholders and felt confident that those partners would participate in and

support the new program. One such partnership, with the Ames Police Department (APD), proved critical in the planning stages of the program.

After BJA approved ODCP's grant application, Story County became one of the three counties in Iowa selected to pilot an arrest deflection program. Ms. Faisal and Commander Geoff Huff (now chief of police in Ames) took advantage of the training and technical assistance (TTA) provided by COSSAP and worked with TASC's Center for Health and Justice (CHJ) to actualize their idea. Another important member of this planning team was Tyler Lennon, Service Coordinator with Story County Community Services/ Central Iowa Community Services (the county mental health department). During the planning process, team members were joined by Linda Hanson, who was hired by the Story County Attorney's Office to serve as coordinator of the new program.

- ◀ The Story County Alternatives Pre-/Post-Arrest Diversion Program (Alternatives), which officially launched in the summer of 2020, offers low-level, non-violent offenders, or individuals at risk of becoming involved in the justice system who suffer from SUD, the opportunity to access SUD treatment to interrupt the cycle of addiction. The program features three primary components: active outreach, which engages individuals who are at risk of justice system involvement due to their substance use; pre-arrest law enforcement deflection, for individuals with SUD who would be eligible for charges if not diverted; and post-arrest prosecutor deflection.⁴² The active outreach component is the subject of this case study.

Guided Program Planning and Development

After receiving COSSAP funding through ODCP, the Story County Alternatives team reached out to CHJ, the TTA provider for first responder-led deflection initiatives under COSSAP, to help plan its program.⁴³ CHJ guided the Alternatives team members through their Solutions Action Plan, a tool used to help teams identify specific problems

they want their program to address, determine the specific results they want to achieve, set goals and objectives to achieve those results, and identify the partners with whom they will need to collaborate to reach the identified goals. Alternatives team members reported that the Solutions Action Plan tool made them think about and answer questions they had not considered before. After the team completed the Solutions Action Plan, they invited Julie Saxton, the mental health advocate for the APD, to give her feedback on the plan, which generated additional valuable ideas.

The Alternatives team, Dr. Monic Behnken from Iowa State University and Youth Standing Strong outreach coordinator Denise Denton, applied for and received a Sequential Intercept Model (SIM) Mapping⁴⁴ training grant through the Substance Abuse and Mental Health Services Administration (SAMHSA). Over several weeks, a team from Policy Research, Inc. (PRI) facilitated a SIM workshop in Story County. The training helped county stakeholders, who were already collaborating on mental health outreach, to identify existing resources within the community and gaps in service so they could better address the needs of individuals with MHDs and SUDs.⁴⁵ This training helped stakeholders develop a customized local map of treatment resources and an action plan to address gaps in services.

Alternatives also received guidance from a COSSAP mentor site, the "A Way Out" program in Lake County, Illinois. While A Way Out is a self-referral deflection program and functions differently than Alternatives, it still offered useful information to the Alternatives team, and the two groups began to collaborate on programmatic ideas. This guidance proved instrumental in turning the idea for the Alternatives program, through planning, into a reality.

The team developed a working group to champion the project and lead the planning and implementation of Alternatives. In addition to the core Alternatives team members, this group includes Story County Attorney Timothy Meals, Julie Saxton, and Nathan Hostetter, a local defense attorney. As the program expands, the

Alternatives working group hopes to add members, including representatives from mental health and SUD treatment providers.⁴⁶

The working group members plan to build a larger advisory board, which will work to review changes to policies and procedures, recommend course corrections, and provide oversight to the program.

Story County has a history of launching progressive justice system programs, and Alternatives benefited from pre-existing relationships between local mental health providers and law enforcement agencies. Alternatives has a similar design to Story County's mental health advocacy program. In 2012, the APD hired a retired detective to serve as a mental health advocate. Ms. Saxton took over the position in 2015. Her duties include performing daily scans of calls for service and police report data, identifying incidents related to mental health issues, and serving as a liaison to service providers. She sends a daily email to local mental health providers to inform them of these incidents in case the providers are already working with any of the identified individuals. If so, the treatment provider can check in on the client. Many of these treatment providers also provide SUD-related services and were excited to learn more about the Alternatives program and discuss ways they could further support it.

Alternatives also benefited from the APD's existing Safe Neighborhoods Team, created in January 2011 to strengthen the relationship between the police department and community members. This team, which includes four full-time police officers and a police sergeant, focuses on quality-of-life issues and concentrates on problem-solving in areas with high volumes of calls for service.^{47, 48}

The Safe Neighborhoods Team was already working with The Bridge Home to conduct active outreach to the homeless community and is responsible for identifying individuals in the broader community as candidates for mental health treatment. This made the officers on the team

a perfect fit for rolling out the Alternatives program. The Alternatives program will soon benefit from the participation of additional officers; Alternatives team members are training more officers on addiction science, Alternatives program guidelines, and outcomes for individuals referred to the program. According to Chief Huff, the program is empowering officers to use deflection to treatment providers as a resource instead of arrest:

“Officers on the Safe Neighborhoods Team encounter the same people all the time—those who have mental health problems and SUD—and generally know where to find them. Some of [these people] are homeless and the team does active outreach rather than waiting for contact with police to happen.”

—Police Chief Geoff Huff, APD

How Alternatives Works

Two primary methods are used to identify at-risk individuals for Alternatives' outreach efforts. First, while performing her daily assessment of calls for service and police reports, Ms. Saxton confers with Ms. Hanson, the Alternatives project coordinator, about any calls related to mental health and SUD issues, and together they decide how to assign follow-up activities. Second, members of the Safe Neighborhoods Team make referrals to Ms. Hanson when they encounter individuals struggling with SUDs. In addition, community partners can make referrals, and individuals with SUDs can self-refer.

Once an individual is identified for the program's outreach efforts, Ms. Hanson contacts them and sets up a meeting where she gathers information and identifies services that may benefit the individual. For example, she assists participants with signing up for health insurance, links individuals experiencing homelessness to The Bridge Home,

sets up doctor appointments to address medical concerns, and arranges SUD evaluations with treatment providers. The team is working on recovery support strategies, and the program will soon have support from peer specialists. In addition, Ms. Hanson informs program graduates that they can call upon her for ongoing recovery support.

Systems Impact

Alternatives is starting to make an impact on the number of frequent utilizers encountered by police or who require emergency medical attention. Launching the program during the COVID-19 pandemic has proven challenging. From August 2020 to March 2022, 152 referrals were made to the program. Alternatives connected 66 of these individuals to SUD treatment, and 21 of the individuals have completed treatment. In addition, there is a very low rate of recidivism and overdose among program participants.

For example, Ken (an alias) had six charges for public intoxication in the year preceding his participation in the Alternatives program, and he had experienced chronic homelessness for more than two decades. Since entering Alternatives, he has reduced his alcoholic intake significantly, has only received a single charge for trespassing, and, through The Bridge Home's services, has qualified for rapid rehousing. He is currently seeking a home; when he finds one, he will receive support for the first three months, including rent and case management services. Due to his reduced alcohol use, he is hopeful that he will find a home and be able to maintain a full-time job.

Brenda (also an alias) was married with children and had a professional career when she entered the Alternatives program. She was charged with fifth-degree theft after shoplifting while intoxicated and was at risk of losing her employment. As a result of her participation in Alternatives, she quit drinking, her charges were dismissed, and she is no longer at risk of losing her job.

Although Alternatives is a young program, it continues to demonstrate its potential to help transform the lives of many other Story County residents like Ken and Brenda.

Lessons Learned

- ◀ Having the support and participation of law enforcement, both at the rank-and-file and leadership levels, was essential in developing and implementing the Alternatives program.
- ◀ Building relationships with stakeholder groups is crucial to garnering support for programs like Alternatives. Such relationships foster interagency cooperation to achieve project goals. Alternatives benefited from existing collaborations with several mental health and SUD treatment providers, as well as providers of wraparound services such as housing.
- ◀ Team members have to listen to each other, be open-minded, and be willing to consider all options available before making decisions about program planning and implementation.
- ◀ Starting the Alternatives program during the COVID-19 pandemic necessitated virtual meetings and training sessions, which do not allow for the same level of informal conversation between participants as in-person training. The Alternatives team members realized they were fortunate to have preexisting relationships with their collaborators, which they credit for success in addressing issues that came up while building the program and conducting training virtually.
- ◀ Those interested in starting programs like Alternatives should consider creating a data strategy to inform every stage of planning and implementing their program. The data strategy should include plans to collect, analyze, use, and share program data. Although Story County has not faced high rates of opioid overdose, data indicate that an average of 40 percent of people who were booked in Story County's jails in 2020 had at least one substance-related charge, which illustrated the need for SUD deflection programming. Data can also reveal progress toward stated project goals and the impact of the program on the community.

- ◀ When launching programs such as Alternatives, it is important to have a core group of stakeholders to champion the program who know they may face adversity but will be persistent and flexible enough to accept setbacks without giving up on program development. When Ms. Faisal was thwarted in her initial attempts to start a mental health court, she pivoted, built consensus with the core team to focus on alternatives to arrest for SUD, and successfully applied for ODCP (pass-through COSSAP) funding for Alternatives.
- ◀ Do not reinvent the wheel. The Alternatives program is similar to the existing APD's mental health advocate program; in fact, the two program coordinators share information to maximize outreach. When developing or enhancing a program, take advantage of any TTA that becomes available, including mentoring opportunities.

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