The Hard Work Done Every Day by Ohio Substance Use Deflection Teams:

Findings from the 2024 Deflection Inventory

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Contributors

Ellen Augspurger
Community Program Manager
Cordata Healthcare Innovations, Inc.

Mekal Banyasz, MPA
Research, Grants & Evaluation Manager
Criminal Justice Coordinating Center of Excellence
Department of Psychiatry
Northeast Ohio Medical University

Natalie Bonfine, Ph.D.
Associate Professor
Department of Psychiatry
Northeast Ohio Medical University

Jennifer Collins, Ph.D., MFT
Manager of Program Evaluation
Best Practices in Schizophrenia Treatment (BeST) Center
Department of Psychiatry
Northeast Ohio Medical University

Meelee Laura Kim, Ph.D.
Scientist, Institute for Behavioral Health,
Heller School for Social Policy and Management,
Brandeis University

Imari McGowan
Program Coordinator, Substance Use Deflection Initiative
Criminal Justice Coordinating Center of Excellence
Department of Psychiatry
Northeast Ohio Medical University

Dan Meloy
Cordata Healthcare Innovations, Inc.
Chief of Police and Director of Public Safety (Ret.)
Ohio Deflection Association (ODA), President

Ashley Morgan, M.Ed., LPCC-S, LICDC
Director, Substance Use Deflection Initiative
Criminal Justice Coordinating Center of Excellence
Department of Psychiatry
Northeast Ohio Medical University

Em Ribnik, Ph.D., LPCC-S,
Director
Criminal Justice Coordinating Center of Excellence
Department of Psychiatry
Northeast Ohio Medical University

Ruth Simera, M.Ed., LSW
Executive Director
Coordinating Centers of Excellence
Department of Psychiatry
Northeast Ohio Medical University

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Executive Summary

Ohio has been among the states most profoundly impacted by the nation's substance use crisis. While overdose deaths have declined moderately recently, the toll remains devastating. Fentanyl contamination, rising stimulant-related fatalities, doubling alcohol-related deaths, and the high availability of illicit substances continue to contribute to grave consequences for communities across the state. In response, Ohio's frontline workers have led innovative efforts to connect individuals to care rather than the criminal justice system, positioning the state as a national leader in deflection.

Deflection efforts in Ohio are still young but rapidly evolving. Teams vary widely in leadership, structure, funding, operations, and community context. Although earlier studies have examined Ohio deflection teams, this report represents the first comprehensive inventory of deflection efforts across the state, providing a detailed snapshot of the field.

Between January and August 2024, 64 semi-structured interviews were conducted with deflection teams from 58 counties. Areas of focus included team leadership, staffing, funding, response models, goals, and sustainability planning. The data were analyzed using descriptive statistics and thematic analysis to identify trends, variation, and common needs across teams.

Key Findings

The inventory revealed themes that illustrate both the strengths and ongoing challenges within Ohio's deflection landscape:

- **Diversity in Implementation:** Wide variation in practices and response models reflects local responsiveness but complicates the development of an evidence base and best practices.

- **Sustainability Concerns:** Most teams rely on short-term grants and lack internal infrastructure needed to maintain operations through leadership and staffing changes.

- **Varied Data Collection and Evaluation Capacity:** Variations in data collection, limited ability to track outcomes, and inconsistent definitions limit opportunities for continuous improvement and field-wide learning.

- **Gaps in Foundational Training**: Teams are committed to ongoing education but lack standardized core training resources.

- **Relationships Are Central to Deflection Success**: Trust, collaboration, and community partnerships are foundational to deflection success.

- **Innovation Remains Central to Deflection**: Teams continue to develop creative strategies tailored to emerging community needs.

Recommendations

As deflection efforts continue to evolve across Ohio, several strategies have emerged as essential for strengthening and sustaining this work:

- Pursue long-term, braided funding models that combine local, state, and federal resources.
- Standardize data collection practices to support consistent evaluation and shared learning.
- Support the ongoing development of best practices through evaluation, piloting innovations, synthesizing lessons, and spreading effective models.
- Establish a shared training foundation focused on key deflection competencies.
- Provide infrastructure guidance while preserving local flexibility.
- Build cross-sector partnerships to address risk and recovery needs.
- Recognize, evaluate, and scale innovative practices emerging across teams.
- Invest in leadership development and community engagement to build lasting support.

Conclusion and Next Steps

Ohio's deflection efforts reflect both remarkable progress and persistent challenges. Teams have grown in diversity, flexibility, and community impact but continue to face barriers related to funding, data, and infrastructure. As the field matures, continued investment in systems, training, and cross-team collaboration will be essential.

Deflection is ultimately about people: those served, and those doing the work. Supporting the future of deflection in Ohio means investing not only in programs, but in the people and partnerships that make this work possible.

Introduction

Purpose

Ohio faces a critical and ongoing substance use crisis, consistently ranking among the top ten states for overdose rates over the past decade (U.S. Centers for Disease Control and Prevention, 2024). In 2023 alone, 4,452 Ohioans died from unintentional overdoses, with fentanyl and its contamination in other substances such as cocaine and methamphetamine serving as major contributors to this crisis. Cocaine-related overdose deaths increased by 7% from 2022 to 2023, with fentanyl detected in 79% of these cases (Ohio Department of Health, 2024). The January 2024 Ohio Substance Abuse Monitoring (OSAM) Network noted increases in Bureau of Criminal Investigation cocaine case incidence across all regions of Ohio and fentanyl case incidence in most regions. Additionally, and across all regions, individuals who consume drugs reported high availability of methamphetamine and fentanyl, with most regions also indicating high availability of cocaine. OSAM consists of eight regions including Akron-Canton, Athens, Cincinnati, Cleveland, Columbus, Dayton, Toledo and Youngstown (Sherba et al., 2024). Nationally, over the past decade, the concentrations of fentanyl, methamphetamine, and cocaine detected in urine samples of individuals seeking treatment for substance use disorders have risen significantly (Huhn et al., 2024). These trends illustrate the rapid shifts in substance use patterns and the corresponding needs, emphasizing the critical urgency of adapting responses to the evolving substance use crisis.

Ohio has been a national leader in substance use response, establishing the concept of the Quick Response Team (QRT) in Colerain Township in 2013 (Ohio Deflection Association, 2023). Since then, deflection efforts, aimed at intercepting individuals with substance use disorders before they enter the criminal justice system, have expanded to cover more than 70% of the state's counties. By linking individuals to treatment, harm reduction, recovery services, and support systems, deflection teams promote early intervention, reduce harm and overdose risks, and foster community resilience.

Despite significant progress, deflection remains a relatively young field. Teams vary widely in their leadership, composition, structure, approaches, training, and sustainability. Much remains to be learned about their makeup, impact, and how best to support and advance their efforts. As Ohio started to take a step back and look at how to best strengthen and sustain the work, it became apparent that a centralized hub for coordination and technical assistance was needed. Northeast Ohio Medical University was approached to take on this role, building on its experience providing similar support for Crisis Intervention Team programs for the last twenty years through the Criminal Justice Coordinating Center of Excellence. As a result, the Substance Use Deflection Initiative (SUDI) was formed. This project was funded by American Rescue Plan Act funds through the Ohio Department of Public Safety's Office of Criminal Justice Services (OCJS).

The priority upon establishing the SUDI was to gain a comprehensive understanding of the current landscape of deflection efforts by conducting an inventory of deflection teams across Ohio. The findings in this report will guide the SUDI goals and strategic planning and help support and coordinate the deflection efforts throughout the state. Armed with this information, SUDI aims to establish a robust technical assistance and coordination center, promote the standardization of data collection and best practices, and work in partnership with Ohio teams and deflection stakeholders to cultivate a cohesive and effective deflection-based response to Ohio's substance use crisis.

Existing frameworks and models

Deflection efforts have become a cornerstone in combating substance use disorders, offering a proactive and community-centered approach to addressing substance use crises across the United States. The Police, Treatment, and Community Collaborative (PTACC) defines deflection as "an early, 'upstream' preventative approach to substance use and mental health that offers pathways for a community-based response to occur before an event such as an overdose, arrest, or mental health crisis" (2023). By integrating public safety and public health resources, deflection aims to connect individuals to recovery and treatment resources while bridging critical gaps between moments of crisis and access to long-term care.

The origins of substance use deflection and pre-arrest diversion can be traced to 2011 in Seattle, Washington, with the launch of the Law Enforcement Assisted Diversion (LEAD) program. LEAD was an innovative initiative that introduced pre-arrest booking diversion, harm reduction-focused case management, and system navigation (Collins et al., 2017).

In Ohio, deflection efforts gained momentum with the Colerain Township Quick Response Team Initiative, proposed in the fall of 2013. This marked a turning point as first responders sought to enhance their response to the opioid crisis and took the intervention from pre-booking to pre-arrest. Over the course of 18-months, first responders engaged in preparing for QRT implementation, prioritizing internal and external training, stigma reduction, and cultural change. Their efforts were guided by a Quick Response Team Logic Model developed collaboratively by the Colerain Township QRT. On July 15, 2015, Colerain Township's Fire/Emergency Medical Services (EMS) department and the Greater Cincinnati Addiction Services Council launched the first QRT shift focusing initially on what is now known as Naloxone Plus, one of the six pathways of deflection and pre-arrest diversion. This QRT continues to operate successfully (Ohio Deflection Association, 2023).

At the same time, in Lucas County, Ohio, Sheriff John Tharp implemented the Drug Abuse Response Team (DART) in response to the increasing numbers of individuals experiencing opioid withdrawal in their correctional center. The DART initiative granted officers discretion to connect individuals with treatment resources instead of arresting them during overdose incidents, primarily utilizing a Naloxone Plus deflection pathway (Lucas County DART, 2019).

Meanwhile, in Gloucester, Massachusetts, the Gloucester Police Department launched the ANGEL Initiative in June 2015. This innovative program allowed community members to self-refer to the police station 24/7, where they could access treatment resources without fear of arrest (Schiff et al., 2016).

Current Research

Existing research highlights not only the effectiveness of deflection but also the diverse ways teams are organized and operate in practice. Initial evaluations of Seattle's LEAD program demonstrated effectiveness in reducing recidivism and engaging individuals in case management services (Collins et al., 2017). In an evaluation of the ANGEL Initiative, 94% of individuals presenting at the police department were provided with a direct link to treatment, exceeding hospital-based initiatives intended to provide immediate access to care (Schiff et al., 2016).

In 2021, the Treatment Alternatives for Safe Communities (TASC) Center for Health and Justice completed the *National Survey to Assess First Responder Deflection Programs*, providing a comprehensive overview of

deflection initiatives nationwide and highlighting key operational and structural characteristics. The survey found that most deflection programs are led by law enforcement (LE) agencies, often in collaboration with treatment providers and social service organizations. Sixty-one percent of teams were made up of LE representatives only and 38% included only LE and Fire/EMS professionals. Many deflection programs have expanded beyond the initial Naloxone Plus pathway to engage individuals using other substances or seeking services through self-referral. Challenges related to response efficiency, such as funding constraints, data collection inconsistencies, and staffing limitations, were common themes across programs.

In 2022, Firesheets et al. conducted a review of Ohio QRTs incorporating quantitative data from 22 QRTs and qualitative insights from 35 counties. The study examined professional representation, operational capacity, population served, deflection pathways, and response times across the teams. The analysis showed that LE was represented on most QRTs, with 27% of teams including three key partners: LE, Fire/EMS, and treatment providers. Additionally, 25% of teams were composed of LE and treatment providers, while 10% were LE only teams. The study highlighted that several QRTs have broadened their focus beyond opioid overdoses to address individuals using other substances or those who have not experienced an overdose. Expanded approaches included proactive outreach and self-referral pathways. While many QRTs aimed to respond within 72 hours of an incident, delays in accessing referral information and limited staffing capacity often prevented teams from meeting this goal.

A 2023 study, the Multi-Site Evaluation of Law Enforcement Deflection in the United States, included a quantitative analysis at two sites and qualitative evaluation across six sites (Labriola et al., 2023). The evaluation highlighted that many deflection teams began with a singular pathway, such as self-referral, and gradually expanded to include additional pathways, complex multidisciplinary teams, and interventions. Programs often evolved to collaborate with other deflection and pre-arrest diversion initiatives in their communities. Teams noted that deflection has contributed to a shift in police responses to substance use, decreased stigma, and increased community buy-in.

In Ohio, QRT was among the earliest strategies adopted and continues to play a significant role in community-based deflection strategies. These teams work to reduce overdose deaths, increase treatment engagement, expand access to harm reduction services and support, and build trust within affected communities. The findings in this report, based on interviews with approximately 64 QRTs and other deflection teams statewide, provide a snapshot of how teams operate.

Methods

CJ CCoE staff began by collaborating with state partners to develop a contact list of all Ohio teams that self-identified their work as deflection. We made direct contact by phone and when necessary were redirected or referred to primary deflection team members. We prioritized the attendance of working team members over individuals who performed administrative oversight, while ultimately allowing teams to determine who should represent them. We made sure to coordinate schedules to ensure attendance of all members of the team. We were not able to contact all of Ohio's teams. While seven of the teams known to us did not participate, we made attempts to include their participation while respecting non-responses as non-interest. Our timeline was ample in that we had 8 months to contact unresponsive teams.

Once contact was made and interview scheduled, we conducted mixed methods research by holding one semi-structured two-hour interview with each of the 64 teams. This process was semi-structured in that

one staff person set the stage using a script and then asked a predetermined set of 54 questions. A second staff person assisted by note-taking and summarizing responses to each question and asked for and provided clarifying information as needed. Interviews were recorded for note-taking reference, ensuring that responses and summaries maintained accuracy. Interview questions covered multi-facets of teams generally including their identity, financial and political support, services provided to clients, formal and informal structures, professions involved in outreach, intended versus actual populations for service, methods of referrals, methods of engagement, service settings, barriers and criteria to providing services, resources offered, formal and informal structural support, methods of collaboration and communication with communities, data collection practices and tools, and their approaches to community awareness and promotion of services. Participants could ask and answer questions as they desired, and conversation was encouraged throughout.

Information gathered through this process was provided to teams in summary and later verified with them for accuracy. Our data collection and cleaning process was iterative, in that we allowed the data to show us what was arising from interview discussions, categorizing, and then conducting analysis. The data was analyzed in Excel and transformed into descriptive statistics for charts and graphs, and for select questions, thematic analysis.

Timeline

The development of the inventory questions began in Autumn of 2023; a collaboration of CJ CCoE staff in consultation with state partners directly involved with teams. Inventory interviews commenced in January 2024 and continued through August 2024, culminating in interviews with 64 teams across 58 counties. Follow-up with teams occurred throughout the interview process and extended into November 2024. Data analysis began in November 2024 and continued into early 2025.

Inventory Findings

When describing deflection, it is common to hear "if you have seen one QRT, you have seen one QRT." This illustrates the vast diversity among communities and teams. In this inventory, aspects of identity, structure, sustainability, operations, referrals, services, and measures of success were examined and, in many cases, supported this expression. Diversity is a theme throughout the findings.

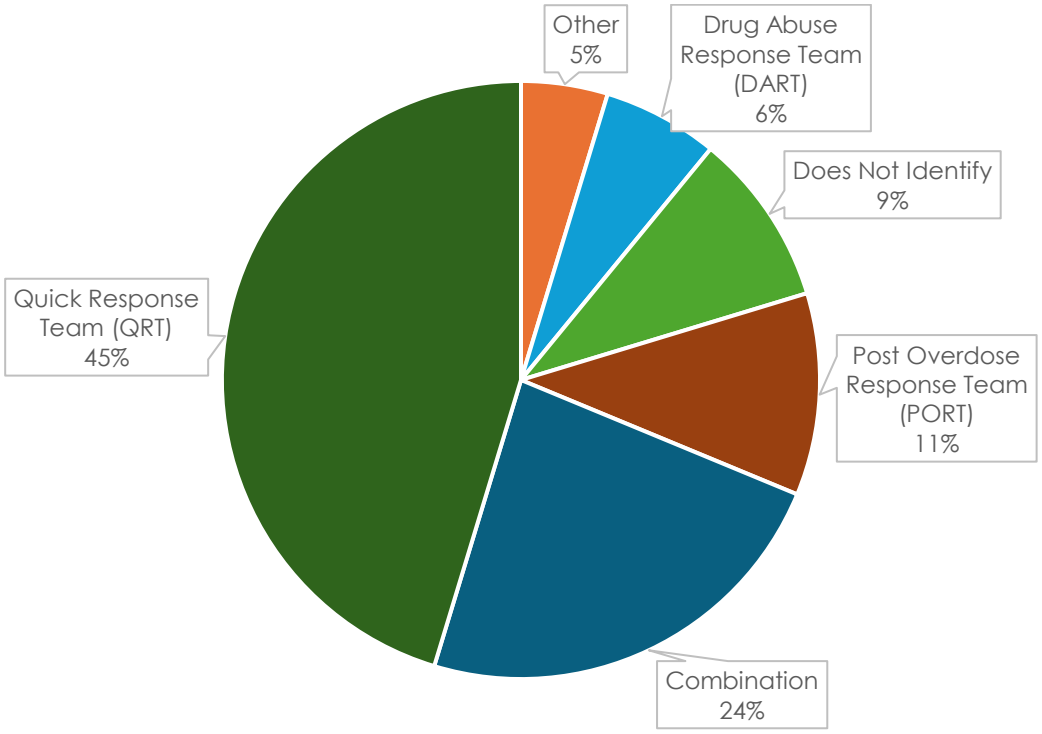
Team Identity and Structure

Previous studies of deflection teams have shown that most are led by LE and include LE officers as part of their core staff. Typically, these teams are composed of a combination of first responders and behavioral health (BH) professionals. While Ohio teams followed this general pattern, they also demonstrated a lot of diversity in leadership and team composition, suggesting a broader and more adaptive approach to deflection.

Team Identity

While there are many models for substance use response, most Ohio teams identified as QRTs. Other teams identified as combination, Post Overdose Response Teams, DART, or specialized models. See **Figure 1** for a full distribution of team identities.

Figure 1. Team Identity Among Ohio Deflection Programs (N=64)

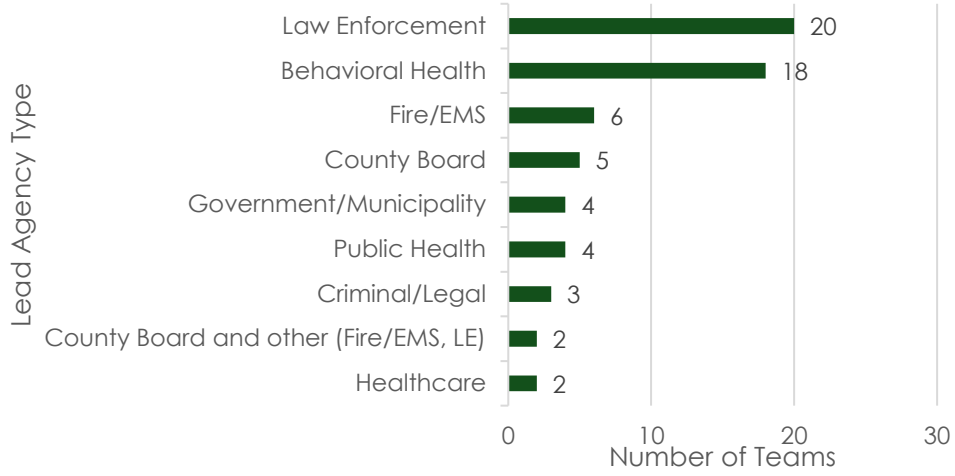


Note. This figure illustrates the percentage of teams identifying as QRT, PORT, DART, hybrid, or other specialized approaches.

Agency Leads

Teams have varied oversight, with LE, BH organizations, and Fire/EMS-led teams emerging as most common. A full breakdown of lead agencies is shown in **Figure 2**. This variety highlights the adaptability of deflection initiatives and demonstrates how teams are built around the unique needs and resources of their respective communities.

Figure 2. Lead Agency(ies) for Teams (N=64)



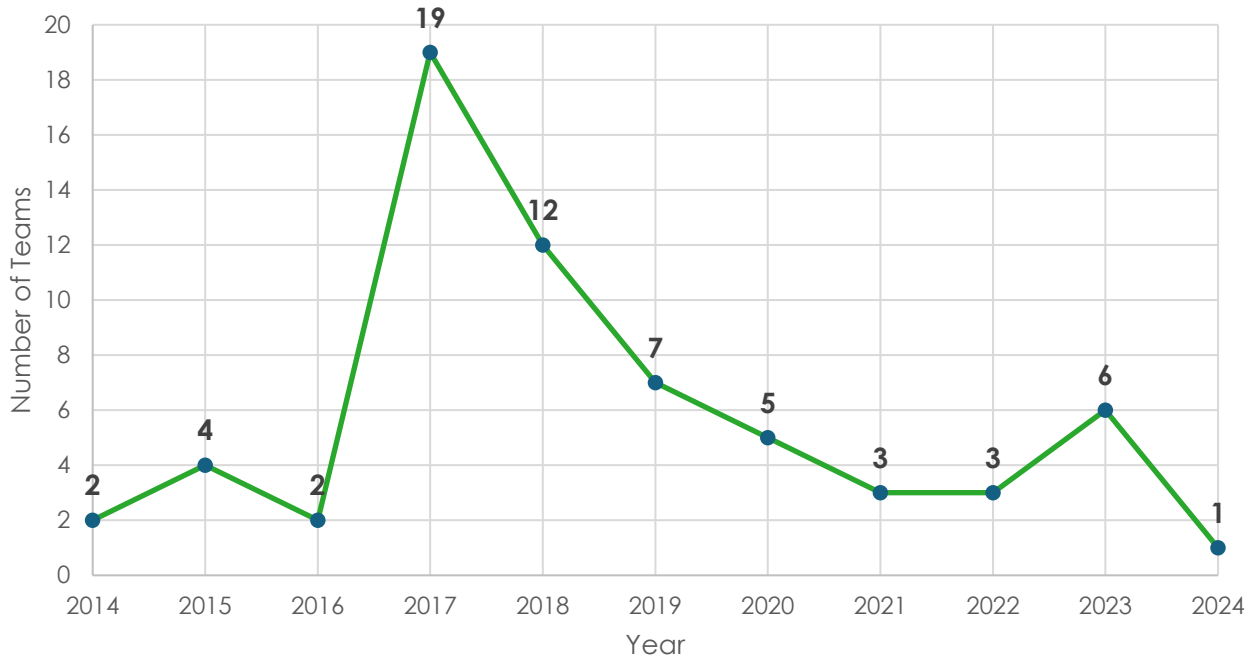
Note. This figure shows the number of teams led by LE, BH, Fire/EMS, county board, public health, government/municipal, criminal/legal, and healthcare organizations.

Looking at geography, teams led by BH and public health (PH) organizations are most commonly found in rural communities, while those led by Fire/EMS, government/municipal agencies, and healthcare (HC) systems are more prevalent in urban areas. LE led teams are evenly distributed across rural, partially rural, and urban communities although Appalachian communities are the least likely to have them.

Team Longevity

QRTs originated in Ohio more than a decade ago, with the oldest team operating for more than a decade. On average, teams in this inventory have been in operation for six years, reflecting a period of significant growth that began in 2017, when funding and support for deflection efforts expanded statewide. In 2017, the Ohio Attorney General's Office (AGO) offered grant opportunities for QRTs, DARTS, and other similar interventions, alongside the launch of Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP). By 2019, additional counties received support through the Medication Assisted Treatment–Prescription Drug and Opioid Addiction (MAT-PDOA) grant. At the time of writing, the most recently established team had been operating for less than a year (0.7 years), showing the ongoing growth of Ohio's deflection landscape.

Figure 3. Number of Ohio Deflection Teams Implemented by Year (N=64)



Note. This figure shows the number of new deflection teams that were implemented in Ohio each year between the years of 2014-2024.

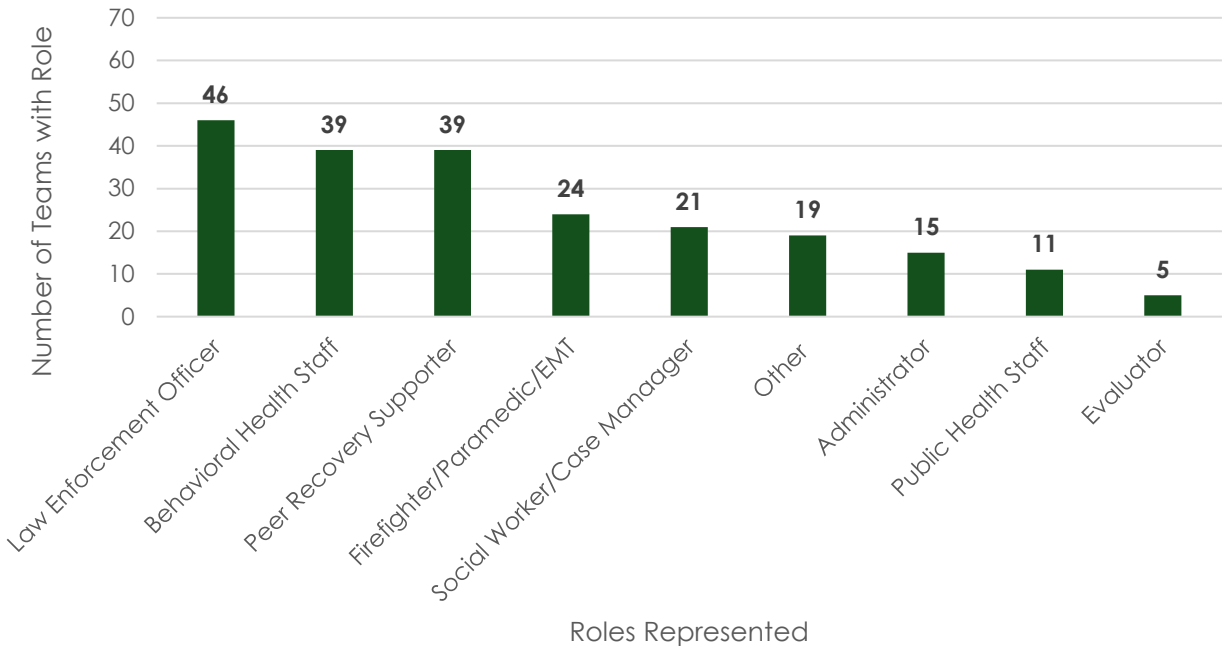
Comparing longevity by team lead, PH and Board/Other-led teams tend to have been established most recently. The presence of more recently established PH-led teams aligns with a broader trend of increasing PH involvement in deflection. Regionally[1], teams in Southeast Ohio tend to be newer on average, while those in Northeast and Southwest Ohio tend to have more longevity.

Composition by Profession

Deflection team composition varies widely across Ohio. As shown in **Figure 4**, common roles include LE officers, peer recovery supporters (PRS), and treatment providers, with other professionals contributing based on community needs and resources. Each profession brings unique expertise and community connections.

[1] Regions referenced in the inventory results reflect the regional designations established by the Ohio Deflection Association. See Appendix B for a regional map.

Figure 4. Professional Roles Represented on Ohio Deflection Teams (N=64)



Note. This figure displays the number of teams that include various professional roles. Other includes nurses, probation officers, and clergy. More than one role may be represented on a team.

When examining team composition by lead agency, several patterns emerge:

- Fire/EMS personnel are less commonly found on BH led teams, though they are consistently present on teams led by government/municipalities and county board/others.
- PRS are universally found on PH, government/municipality, board, and county board/other led teams but less frequently represented on Fire/EMS led teams.
- In addition to BH led teams, BH providers are universally included on teams led by PH agencies, criminal/legal systems, and HC organizations.

This pattern may reflect opportunities for relationship development between sectors to strengthen interdisciplinary collaboration, support role integration, and build on one another's strengths.

Geographically, we also see variation in roles:

- Fire/EMS personnel are more frequently found on teams operating in urban communities.
- PH staff, BH providers, and PRS are more commonly represented on teams serving rural communities.

This may reflect geographical differences in resource availability. In rural communities, Fire/EMS departments may operate with limited or volunteer staffing, while PH, BH, and peer support systems are often adapted to extend service reach based on community need.

Staffing Levels and Capacity

Approximately half of all deflection teams have at least one full-time staff member. This highlights community investment and underscores the importance of having dedicated personnel to effectively support the work. However, the remaining 50% of teams rely on members who are juggling multiple roles across already demanding professions such as LE, PRS, and treatment services. It is important to consider whether this multitasking strains individual capacity and whether it poses challenges to team efficiency and sustainability.

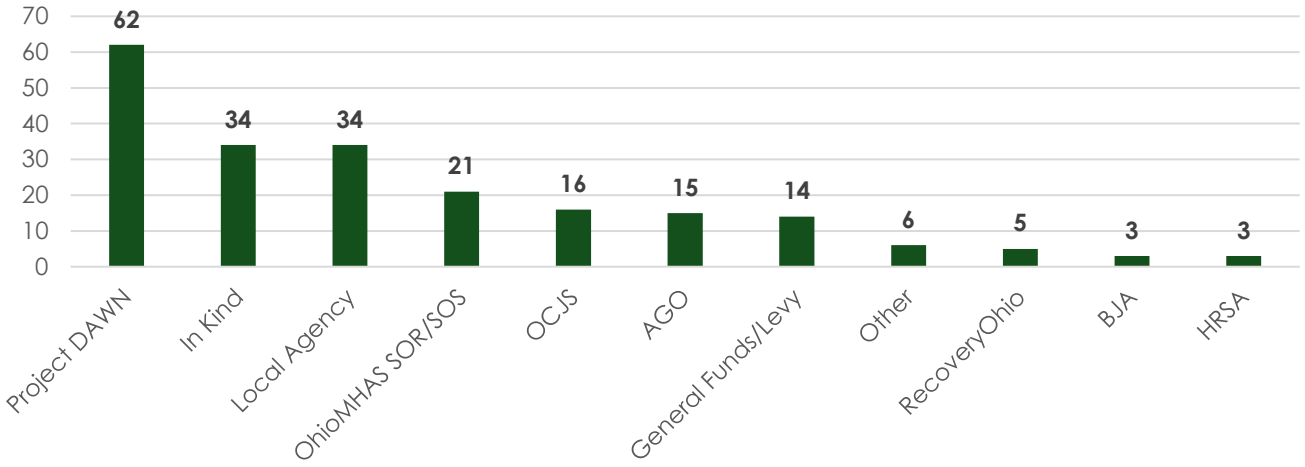
Furthermore, 25% of teams report having at least one unfilled position, reflecting broader workforce challenges within the field. These vacancies can hinder the teams' ability to meet community needs, exacerbating the burden on existing staff, and potentially compromising the quality and consistency of services provided.

Funding and Sustainability

Funding Sources

Deflection teams in Ohio are supported by a mix of dedicated and in-kind funding sources. As shown in **Figure 5**, most teams (94%) reported having dedicated funding, with the majority of that support coming from grants, often administered through state agencies using federal dollars. In-kind contributions, reportedly used by 61% of teams, supplement grant-specific funding and typically include staff time, transportation, materials, or training resources. While this braided approach enables flexibility, reliance on short-term grants and in-kind support can create instability and pose challenges to sustainability.

Figure 5. Funding Sources for Ohio Deflection Teams (N=64)



Note. This figure shows the number of teams receiving funding through state-administered grants, local levy or general funds, direct federal awards, and in-kind contributions. Teams may receive funding from multiple sources. Abbreviated funders are defined below.
Funding Source Key:

- *OhioMHAS SOR/SOS – Ohio Department of Mental Health and Addiction Services, State Opioid Response / State Opioid and Stimulant Response*
- *OCJS – Office of Criminal Justice Services*

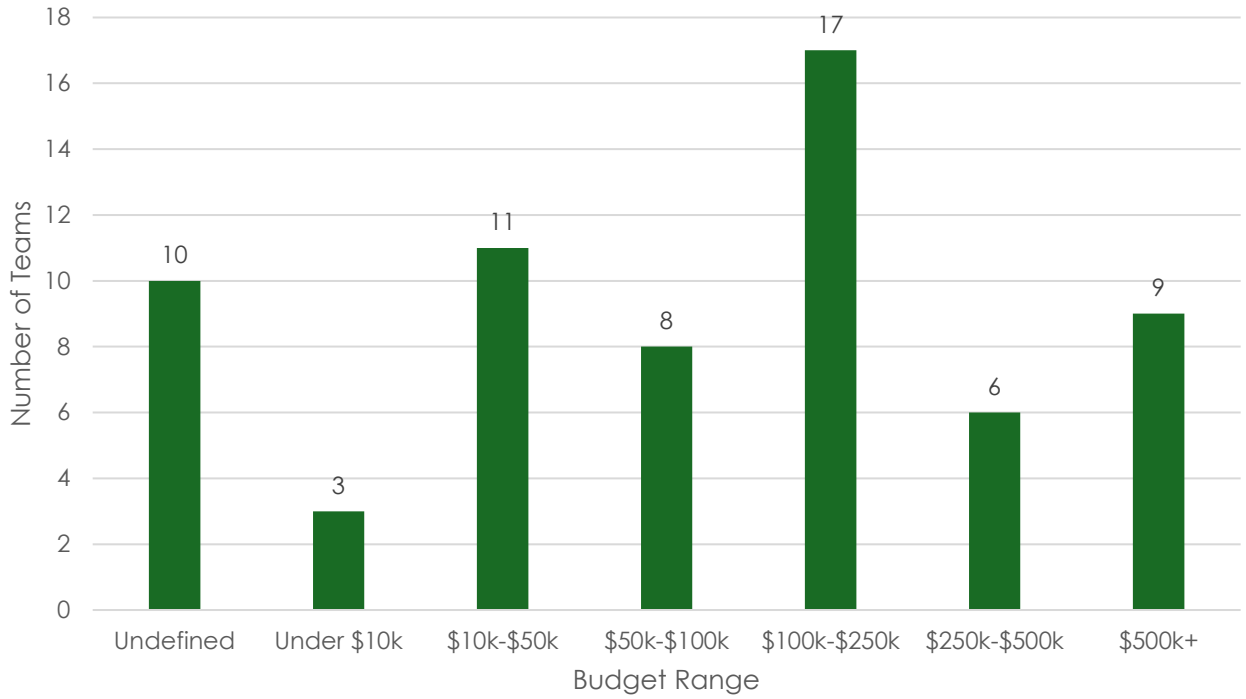
- *AGO – Ohio Attorney General's Office*
- *BJA – Bureau of Justice Assistance*
- *HRSA – Health Resources and Services Administration*

Looking at lead agency influence on funding streams, Fire/EMS led teams received general fund or levy support approximately 50% of the time. Teams led by BH agencies often received State Opioid and Stimulant Response (SOS) funding. LE, criminal/legal, and government/municipality led teams more often had access to funding from the AGO. Among PH led teams, 75% reported receiving funds from OCJS. This suggests that collaborative, multidisciplinary approaches could expand access to a broader range of funding sources by aligning with multiple agency priorities and eligibility pathways.

Budget Ranges

Deflection team budgets varied widely, reflecting differences in funding sources, community and leadership support, team capacity, and access to or proficiency in grant writing. The most reported budget range was $100,000–$250,000. Surprisingly, nearly 1 in 5 teams report budgets under $50k, raising concerns around sustainability and reach. It should be noted that some teams were unable to provide exact figures or estimates. When possible, follow up was conducted to clarify.

Figure 6. Annual Budget Ranges Among Ohio Deflection Teams (N=64)



Note. This figure shows distribution of reported annual budgets across deflection teams.

Report findings show disparities in team budgets across Ohio regions and population density. Central Ohio teams have the highest median budgets and represent a balanced mix of rural, urban, and partially rural communities. In contrast, teams in Northeast and Northwest Ohio operate with lower median budgets, despite Northeast Ohio having the fewest rural teams and Southeast Ohio having the most. Urban teams

across the state have a significantly higher median budget ($235,000) compared to rural teams ($76,000), with partially rural teams falling in between at $105,000. This suggests that both geography and population density influence team funding levels.

These findings highlight potential inequities in access to resources and opportunities. Further exploration into the root causes, such as population, risk, economic conditions, fundraising capacity, and access to grants, could inform targeted support strategies. Initiatives such as funding programs for rural teams, resource-sharing partnerships between regions, and tailored training on financial sustainability could help address these gaps.

Support Systems

While securing funding is critical, sustainability also depends on strong support systems and champions who can advocate for and sustain deflection efforts over time. The majority of teams reported receiving support through guidance and championing efforts. Champions play a critical role in fostering trust and momentum for deflection work, helping teams establish a strong foundation and achieve success. Most teams felt they had a reliable source of guidance when needed, often in the form of an individual within their team, organizational leadership, or a BH professional in their community. In some cases, agencies such as mental health and recovery boards were specifically mentioned as trusted resources for teams seeking answers or direction. Teams identified champions across various sectors, including:

- Local leaders
- HC professionals
- LE officers
- Mental health and recovery boards
- Coalitions
- PH organizations
- BH providers

All teams funded staffing, with some also covering travel, vehicles, naloxone, and training. Few budgeted for evaluation or overhead.

Health care–led teams had the highest budgets; board- and public health–led teams the lowest.

Even teams with <$10K showed strong harm reduction access, while teams with >$1M had expanded capacity, diverse funding, and broader deflection options.

These findings highlight that champions can emerge from diverse sectors, tailored to the unique needs and resources of their communities.

Sustainability Planning and Challenges

When asked, 97% of teams reported sustainability plans, sharing a variety of strategies aimed at ensuring long-term viability. These plans focus on securing funding, strengthening community partnerships, and building internal capacity. Many teams prioritized pursuing grant opportunities, such as DART, COSSUP, and opioid settlement funds, while also exploring alternative funding streams like Medicaid billing, levy support, and in-kind contributions. Community integration emerged as a critical element, with teams

fostering strong relationships with hospitals, Fire/EMS, LE, and treatment providers to enhance visibility and value. Internally, efforts included leadership development, staff training, process standardization, and obtaining accreditation or credentialing to bolster credibility and diversify funding options. Despite challenges and uncertainties surrounding long-term funding, teams remain committed to demonstrating their impact through data collection, sharing success stories, and tailoring services to meet community needs, ensuring their programs continue to thrive and make a meaningful impact.

Operational Capacity and Practices

Hours and Flexibility

Many deflection teams (66%) report having set hours for their operations, meaning they work a specific schedule, with weekdays being the most common. Teams without set hours typically operate on an as-needed basis. Among these, Tuesday through Thursday are the most frequently cited days, accounting for nearly half of the reported operational schedules. Fewer than 10% of teams provide weekend responses.

Response timeframes

Most teams (95%) have established response expectations, with most aiming to respond within a week. The 24–72-hour window is the most common response timeframe, although a smaller number of teams have the capacity to respond in less than 24 hours. Less frequently, teams operate on an as-needed basis or have response times extending beyond a week.

When evaluating operational hours and response time, it may be valuable for teams to assess when the majority of their referrals occur to ensure schedules align with when teams are likely to experience the most activity. However, referrals do not always occur at or near the moment of crisis. Many teams report receiving referrals that are delayed and responding to those referrals in batches at designated times. This raises important questions about whether existing referral and engagement structures support a timely, person-centered response.

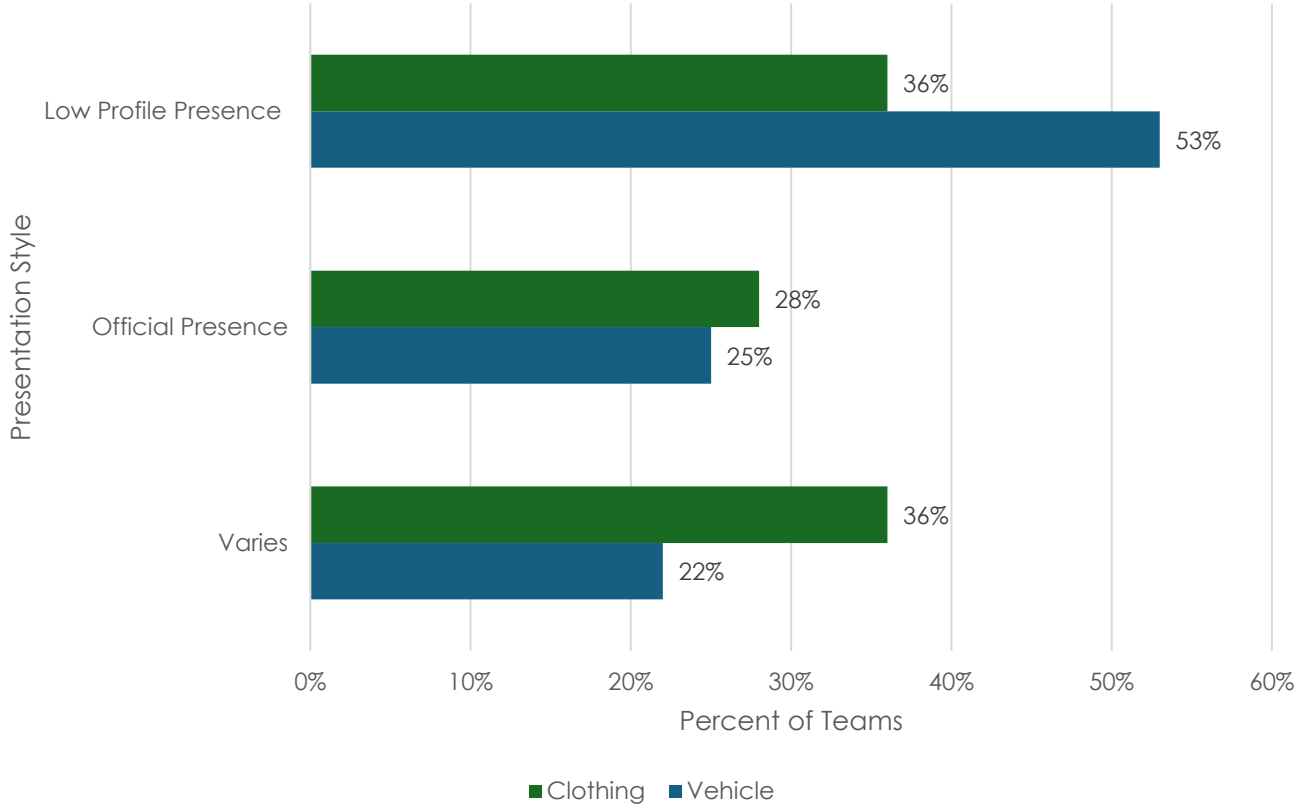
While evidence shows that individuals with opioid use disorder who receive follow up within seven days of an emergency room visit are less likely to have a fatal or non-fatal overdose within the following six months, there has been limited exploration of deflection-specific timelines to begin to clarify best practices (Cunningham et al., 2022). A deeper understanding of how and when teams engage referrals and the logistical or philosophical reasons for delayed engagement could inform effective approaches. Further evaluation is needed to strengthen understanding and improve practice across the field.

Appearance and Visibility

Across Ohio, deflection teams have made intentional decisions to ensure their appearance aligns with community norms to reduce barriers to engagement. Teams reported that how they present themselves, through attire and vehicle type, can have an impact on successful outreach. In some communities, the presence of first responders in uniforms and marked vehicles was perceived as intimidating and stigmatizing, particularly where there is heightened caution around LE. To reduce perceived stigma and foster trust, many teams chose to wear plain clothes and use unmarked vehicles during outreach.

However, other teams found that a visible, uniformed presence could *improve* community relationships. For example, LE officers using uniforms and marked vehicles reported that this visibility helped reframe their presence as one of care and support, challenging negative stereotypes and strengthening public trust.

Figure 7. Outreach Presentation Styles Reported by Ohio Deflection Teams (N=64)



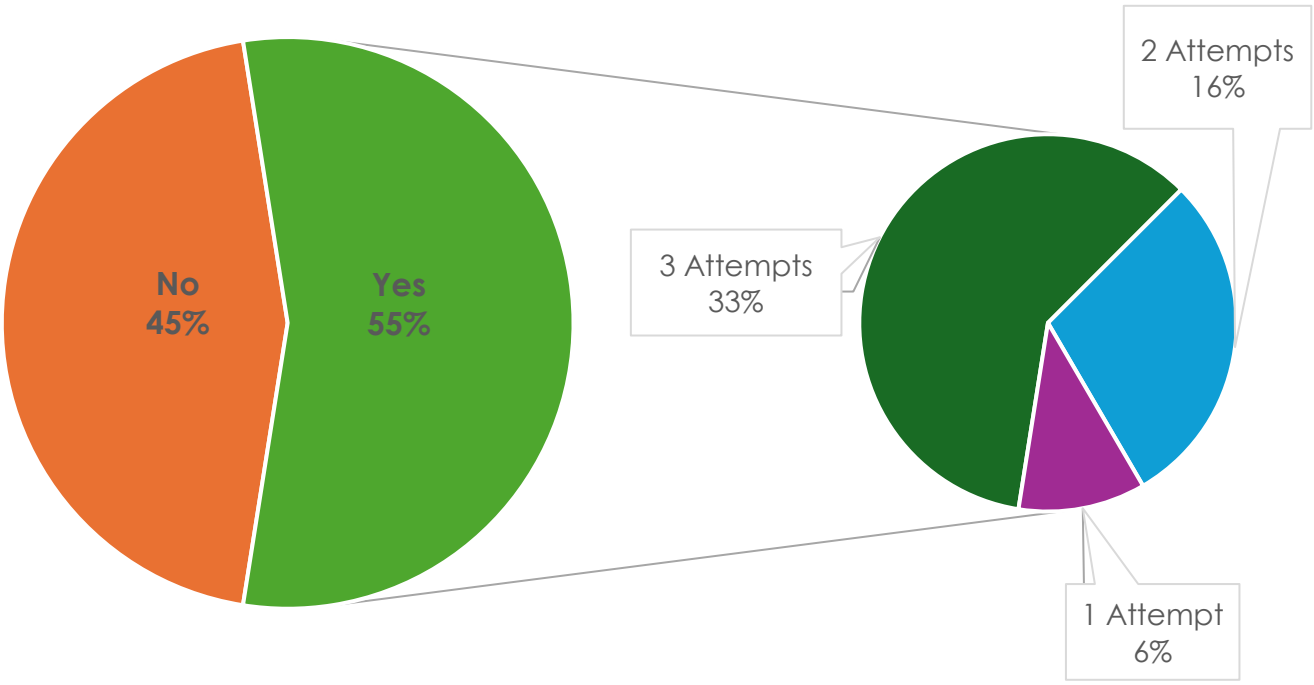
Note. This figure shows the percentage of teams that reported using low profile (plain clothes or unmarked vehicles), official (uniforms or marked vehicles), or situationally adapted (varied) approaches to clothing and vehicle use during community response.

Presentation style was also influenced by team lead and composition. PH led teams and those with PH staff tended to prioritize low-profile outreach, most commonly going out in unmarked vehicles and plain clothes. Fire/EMS led teams most commonly did outreach in uniform and marked vehicles, signaling to the community a health focused response and ensuring visibility.

Outreach Attempts

Teams typically receive referrals from a variety of sources following an overdose event and aim to contact the individual to offer support, make referrals, and provide follow-up care. However, locating individuals or successfully making contact can be challenging for many reasons, including unstable housing, disconnected phones, or reluctance to engage. Teams are fairly evenly divided on whether they establish a set number of initial contact attempts before closing a client record due to lack of response, with 55% implementing this practice and 45% not doing so. Of those teams, 60% reported making three attempts before closing a case, 29% reported making two attempts, and 11% reported making one attempt. This highlights the absence of a standardized approach to outreach attempts.

Figure 8. Set Outreach Attempts and Frequency (N=64)



Note: This chart shows the percentage of teams that report using a set number of outreach attempts when responding to an individual. Among the 55% that set a defined limit, the breakdown of how many attempts is illustrated.

Special Circumstances

In addition to initial outreach attempts, teams also navigate situational factors that may limit engagement opportunities, such as active warrants or safety concerns. During this portion of the inventory, teams were asked *"Are there any limits to the attempts you make when contacting referrals for the first time? If yes, then what are the limits in place?"* This question was intended to gather information about the number of outreach attempts. However, several teams spontaneously referenced limitations based on outstanding warrants and histories of violence.

Specifically, 27% of teams (17 out of 64) mentioned considerations related to active warrants, such as conducting a warrant check prior to outreach and deciding whether to proceed based on the result. Of those, 29% (representing 8% of all teams interviewed) reported that they would still conduct outreach, even when a warrant was present, suggesting discretion based on context. Additionally, 16% of teams brought up histories of violence as a limitation.

While the number of teams referencing these scenarios was relatively small, it brought an awareness of these potential limitations of responding to people using substances who have histories with the criminal justice system. Some LE officers are using discretion to proceed when appropriate. Others may choose to adapt by not including LE during outreach in these scenarios. While legal status and safety concerns are not always a barrier to engagement, these complexities justify further exploration, especially considering individuals with warrants or histories of violence who may still benefit from intervention. Understanding how to safely and effectively link them to treatment and support services could help expand the impact of deflection programs.

Deflection Pathways and Referral Sources

Pathways of Deflection and Pre-Arrest Diversion

Individuals with substance use disorder or who are experiencing a substance use crisis often interact with LE and other first responders, presenting opportunities for harm reduction, treatment referral, and recovery supports. PTACC defines six pathways of deflection and pre-arrest diversion, which provide frameworks to address PH and safety challenges related to substance use (2022). These six pathways, outlined in **Figure 9**, are distinct from traditional criminal justice interventions. They empower officers and other community responders to connect people to treatment, recovery supports, harm reduction, and basic needs.

Figure 9. The Six Pathways of Deflection and Pre-Arrest Diversion

THE SIX PATHWAYS OF DEFLECTION AND PRE-ARREST DIVERSION

There are six frameworks or ***pathways*** of deflection and pre-arrest diversion, each of which uses a different approach to address specific public health and public safety challenges faced by communities. These six approaches are referred to as "pathways" because, in contrast to justice system interventions, which mandate that individuals attend treatment, programs in these pathways enable first repsonders (law enforcement, fire, and emergency medical services) and community response teams to offer access, or *pathways*, to community-based treatment and resources to support individuals in need.

The six pathways are described below:

PATHWAY	TARGET POPULATION
Self-Referral • An individual voluntarily initiates contact with a first responder agency (law enforcement, fire, or EMS) for a referral to treatment and services. If the contact is initiated with a law enforcement agency, the individual makes contact without fear of arrest.	Individuals with substance use disorder (SUD)
Active Outreach • A first responder intentionally identifies or seeks out individuals with SUD to refer them to or engage them in treatment and services; outreach is often done by a team consisting of a behavioral health professional and/or peer with lived experience.	Individuals in crisis or with non-crisis mental health disorders (MHD) and/or SUD, or are homeless
Naloxone Plus • A first responder and program partner (often a behavioral health professional or peer with lived experience) conduct outreach *specifically* to individuals who have recently experienced an opioid overdose to engage them in and provide linkages to treatment and services.	Individuals with opioid use disorder
First Responder and Officer Referral • As a preventative approach, during routine activities such as patrol or response to a service call, a first responder engages individuals and provides a referral to treatment, services, 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 MHD and/or SUD, 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 otherwise would be filed, law enforcement provides a referral to treatment, services, or to a case manager, or issues 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 MHD and/or SUD, 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.

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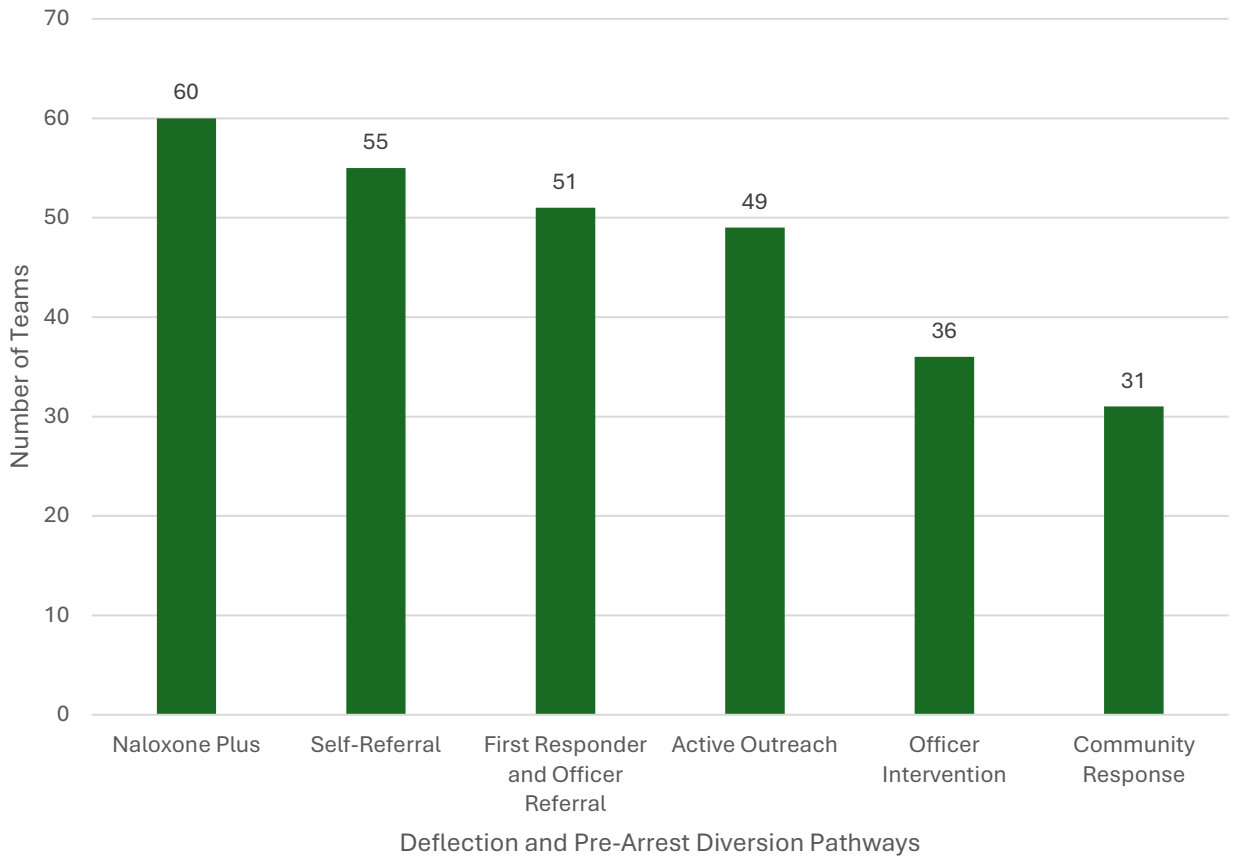
All six deflection pathways are utilized by teams in Ohio. While some teams were initially unfamiliar with the terminology, most were able to identify where their practices aligned after definitions were shared during the interview process. As shown in **Figure 10**, Naloxone Plus is the most commonly used pathway (94%), which aligns with the prominence of QRTs in Ohio, the state's first and most widespread deflection model.

Self-referral is also widely used (86%), and in Ohio, this pathway often includes individuals voluntarily initiating contact with PH or BH teams, particularly in programs without LE involvement.

Community Response is the least commonly used pathway (48%), though its presence reflects a growing national trend to reduce reliance on traditional first responders by dispatching alternative personnel such as social workers, clinicians, or peers.

Figure 10. Use of Deflection Pathways Among Ohio Teams (N=64)



Note: This figure shows deflection and pre-arrest diversion pathways used by teams. Multiple pathways may be used by one team.

Pathway utilization varied by team lead and composition:

Self-Referral	• Common for all teams regardless of lead • Universally implemented by board/other, HC, criminal/legal, PH, county board, and fire/EMS led teams
Active Outreach	• Utilized by only half of HC and Fire/EMS-led teams • Universally implemented by county board/other and criminal/legal led teams
Naloxone Plus	• Common for all teams regardless of lead • Universally implemented by board/other, HC, criminal/legal, PH, and LE led teams
First Responder and Officer Referral	• Most common pathway reported by BH led teams • Least common pathway reported by PH led teams or those with PH staff • Not utilized by HC led teams • Universally implemented by board/other and criminal/legal led teams
Officer Intervention	• Least common pathway reported by board/other, county board, PH, fire/EMS, and BH led teams • Most common among teams with LE staff • Least common among teams with PRS • Universally implemented by criminal/legal led teams
Community Response	• Least common pathway reported by criminal/legal, LE, and BH led teams • Universally implemented by board/other led teams

Referral Sources

Understanding the pathways teams use to engage individuals is closely tied to the sources from which referrals originate. As shown in **Figure 11**, teams reported a wide range of referral sources. Referrals from the criminal justice system were the most common, with police reports cited by 75% of teams. The frequency highlights the opportunity for deflection teams to intervene early within the Sequential Intercept Model (SIM), a framework outlining intercepts along the criminal justice continuum where individuals can be diverted from deeper involvement in the criminal justice system. Teams are also increasingly embedded at later intercept points, including courts, probation, and jails, where they help connect individuals to treatment and recovery pathways while attempting to reduce further criminal justice system involvement. These efforts are critical for addressing the heightened risk of overdose among individuals involved in or recently released from detention settings. This trend also reflects growing collaboration and trust between deflection teams and criminal justice system partners, along with decreasing stigma around substance use disorder.

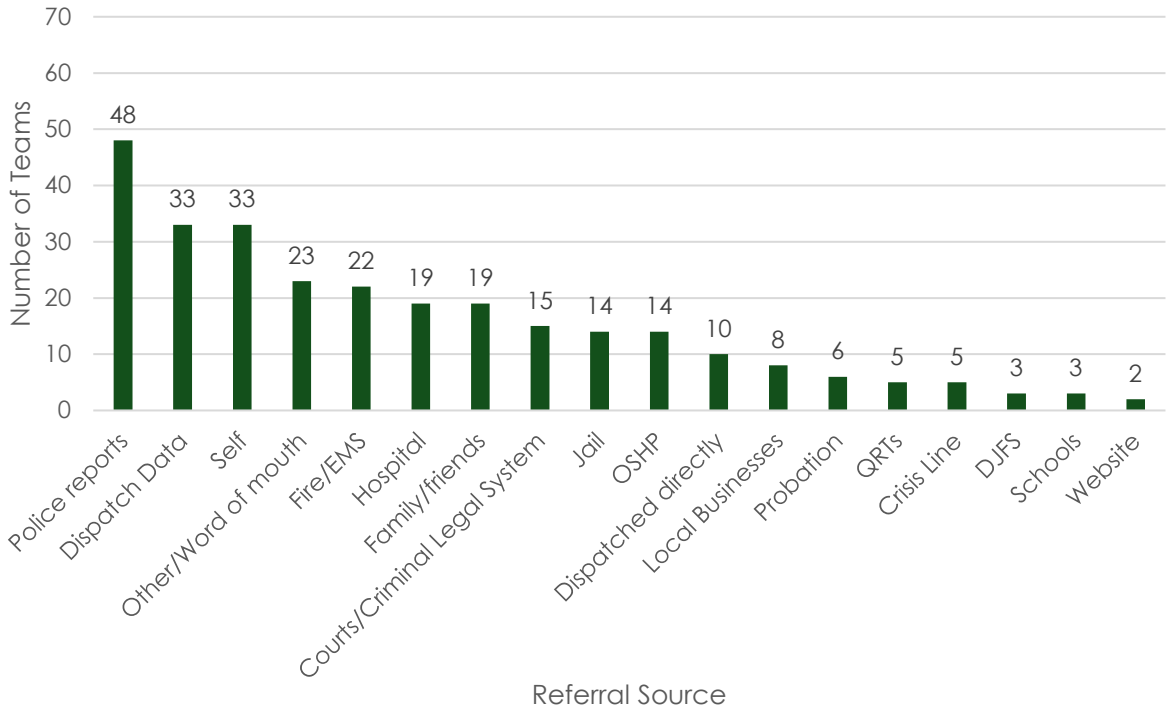
Community-based referrals were also prominent, with self-referral cited as the second most common source. The prevalence of self-referrals and community-driven sources such as family, friends, and word of mouth stresses the importance of empowering families and communities to support recovery. Family and community involvement are critical to recovery, and earlier intervention leads to better outcomes for both individuals with substance use disorders and their loved ones (Lander, Howsare, & Byrne, 2013). These findings highlight the value of maintaining relationships with PRS on deflection teams or bridging

individuals to peer and family navigator services. They also speak to the effectiveness of and ongoing need for community events, outreach campaigns, and partnerships with local organizations. Such efforts can raise awareness of deflection initiatives and increase understanding of recovery, harm reduction, and treatment options, while reducing stigma.

Some teams reported receiving referrals from health care and emergency response systems. Emergency dispatch data, cited by 51% of teams, underscores the critical connection between deflection teams and emergency responders. Referrals from Fire/EMS and hospitals further reflect the frequent interaction between individuals with substance use disorders and HC or crisis response systems. These findings point to key opportunities to strengthen partnerships with emergency departments, establish warm handoffs to deflection teams, improve data sharing and coordination, and reduce response times. Additionally, ongoing education and training for first responders and HC providers can help foster a culture of compassion when responding to individuals in substance use crisis.

The least common referrals were from youth-oriented systems, such as schools and the Department of Job and Family Services (DJFS). Despite the far-reaching impact of substance use on children and families, these referral pathways remain underutilized. Schools and child welfare agencies offer critical opportunities to identify and intervene with at-risk youth and families. Deflection teams could strengthen partnerships with school counselors and educators to recognize signs of substance use or family instability and provide timely referrals. In Ohio, where parental substance use contributes to one of the highest rates of foster care entries related to substance use in the nation, DJFS caseworkers could be uniquely positioned to assess family needs and connect them to deflection teams or evidence-based programs such as Ohio START (Sobriety, Treatment, and Reducing Trauma) (Health Policy Institute of Ohio, 2019).

Figure 11. Referral Sources Reported by Ohio Deflection Teams (N=64)



Note. This figure shows the variety of referral sources reported by Ohio deflection teams. Teams may receive referrals from multiple sources.

Referral sources also varied based on lead agency type. Community-based referrals, such as self-referrals and those from family, friends, or word of mouth were the most highly adopted and accessible across all teams. Criminal justice referrals, including police reports and dispatch data, were also consistently utilized, highlighting the importance of strong relationships between deflection teams and LE, who often serve as an initial point of contact and maintain access to real time data.
In contrast, HC and emergency response referrals (from hospitals and Fire/EMS) were least utilized. This may reflect challenges related to cross systems collaboration, including privacy regulations such as the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2, as well as deflection traditionally being taken up by LE. However, it also highlights an opportunity for expanded access to individuals using substances, as EMS providers and hospitals are often at the center of acute and crisis care.

Lead Agency Type	Referrals			
	Top Sources	Criminal/ Legal	Community-Based	Healthcare/ Emergency Response
Law Enforcement	✓ Police Reports ✓ Dispatch Data	High	Moderate	Low
Behavioral Health	✓ Police Reports ✓ Dispatch Data	High	Moderate	Low to Moderate
Fire/EMS	✓ Fire/EMS ✓ Self-Referral	Moderate	High	Moderate
County Board	✓ Word of mouth ✓ Police Reports	High	High	Moderate
Public Health	✓ Word of Mouth	Moderate	High	Moderate
Government/ Municipality	✓ Self-Referral	Moderate	High	Moderate
Criminal/Legal	✓ Police Reports ✓ Self-Referral ✓ Word of Mouth	High	High	Moderate
Healthcare	✓ Hospital ✓ Word of Mouth	Moderate	High	High
Board/Other	✓ Hospital ✓ Self-Referral	Moderate	Moderate	High

Services and Engagement

Population Served

As shown in **Figure 12**, deflection teams have expanded their focus over time in response to evolving trends in substance use, overdoses, funding, stigma, and available resources. The inventory explored differences between the populations teams initially expected to serve and those they currently serve.

Initially, 55% of teams focused solely on individuals who had overdosed on opioids. Today, just 5% maintain that narrow focus, while 92% now respond to overdoses regardless of substance type—a shift likely influenced by the growing prevalence of stimulant-related overdoses involving cocaine or methamphetamine contaminated with opioids.

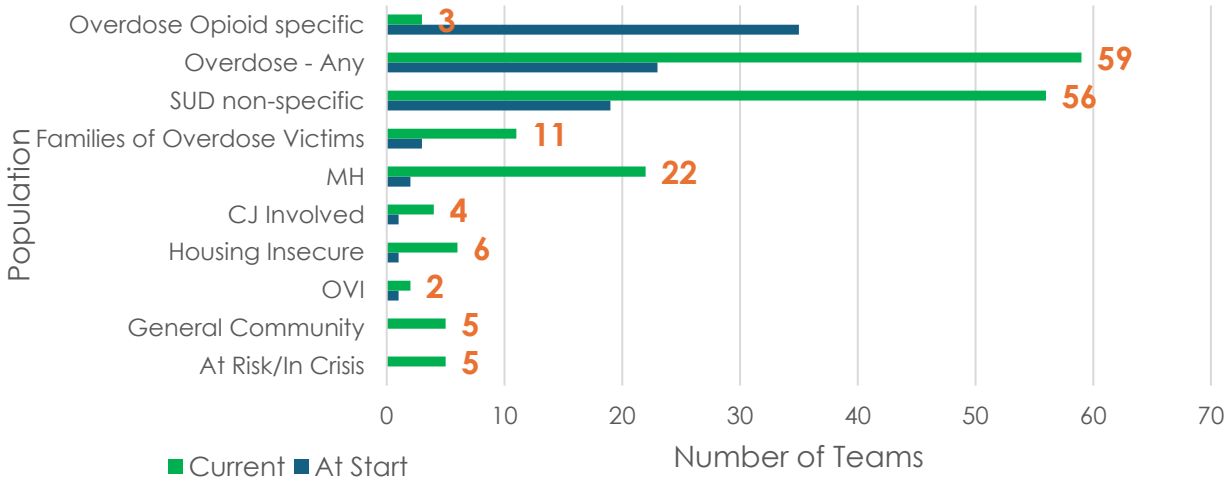
The scope of services for individuals with substance use concerns beyond overdose has also grown significantly. At inception, only 30% of teams served individuals with non-overdose-related SUD needs. Currently, 87% support individuals with any SUD-related concerns, without requiring an overdose event to trigger a referral.

Addressing mental health needs has emerged as another key trend. While just 3% of teams anticipated engaging individuals with mental health challenges, 34% now report doing so in practice.

Support for families has similarly expanded. Just 5% of teams initially expected to serve family members of individuals who experienced an overdose, compared to 17% who currently engage with and support the broader family system affected by substance use.

Overall, 72% of teams indicated that the populations they serve today differ from what they originally expected. These changes reflect the evolving deflection landscape and the need for teams to remain responsive to the complex, shifting needs of their communities.

Figure 12. Populations Served by Ohio Deflection Teams at Program Start Compared to Current Practice (N=64)



Note. This figure compares the populations deflection teams initially expected to serve with those they currently support. Teams may serve multiple populations.

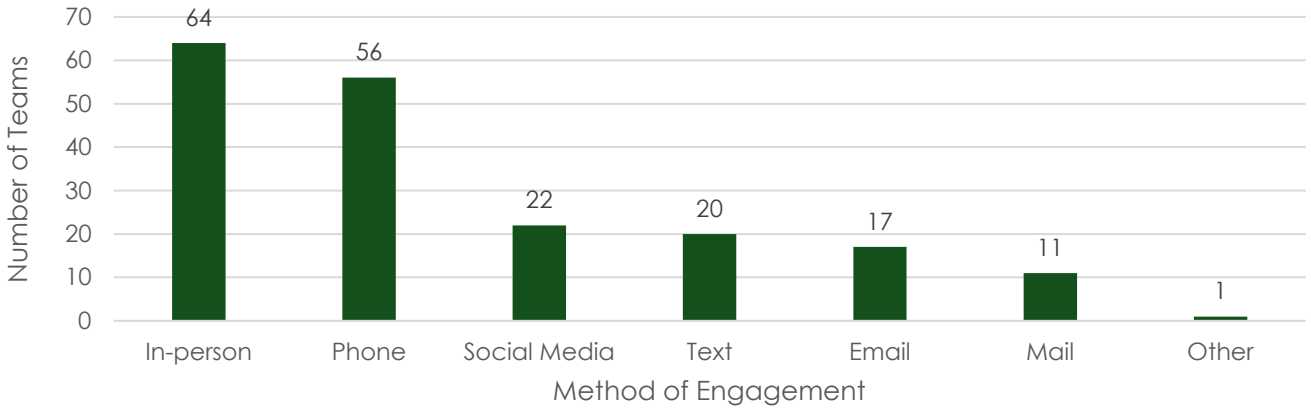
Initial Contact

As shown in **Figure 13**, engagement methods vary across deflection teams, reflecting a range of strategies used for both initial contact and ongoing connection with individuals served. In-person engagement was universally reported by all teams (100%), with phone calls also widely utilized (87%) for both outreach and follow-up. Teams also reported using social media (34%), text messaging (31%), and email (26%)—offering important alternatives to in-person or phone contact for individuals who are difficult to locate,

uncomfortable with phone calls, or lack reliable access to a phone outside of Wi-Fi zones. Additionally, 17% of teams used mail as a form of outreach, particularly in situations where in-person contact was not possible due to location challenges, active warrants, or safety concerns.

Teams reported varying levels of success with different methods. While some found social media effective for reaching individuals, others encountered limited success or restrictions on use. Further exploration into the effectiveness of each engagement strategy may help optimize outreach approaches and improve linkage to care across deflection programs.

Figure 13. Methods of Engagement Used by Ohio Deflection Teams (N=64)



Note. This figure shows the variety of methods teams use to engage individuals. Teams often employ multiple strategies of engagement.

Ongoing Engagement and Interaction

While most teams (83%) continue to connect with individuals after initial contact, ongoing engagement with clients varies significantly and is largely client-led, tailored to individual needs, and dependent on the client's willingness to engage. Many teams prioritize building trust and rapport, adjusting their level of interaction based on the client's stage of change, or their readiness to consider or engage in treatment, and overall interest in recovery support. Follow-ups can range from daily or weekly check-ins to occasional interactions over months or even years. Teams often provide resources, support with transportation, and connection to treatment, but many cease follow-ups if clients refuse services or become unresponsive.

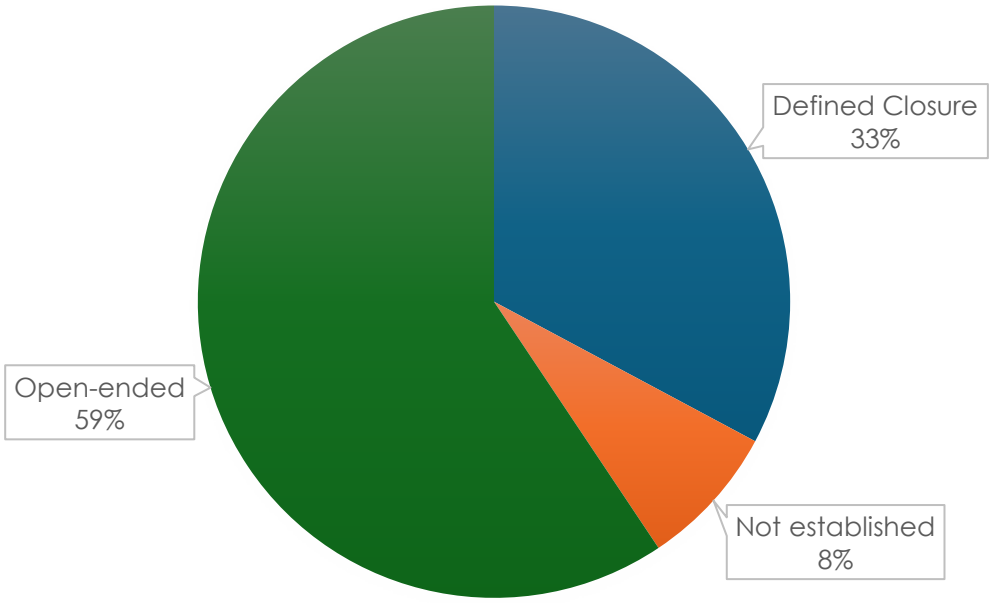
Several teams emphasize the importance of addressing not only the client's immediate needs but also broader challenges such as social support, housing, and food security. Constraints like staffing shortages, stigma, and limited resources sometimes impact a team's ability to maintain consistent follow-ups. Some teams employ structured timelines, such as 30-, 60-, and 90-day follow-ups.

Service Conclusion

As shown in **Figure 14,** the majority of teams maintain an open-ended relationship with individuals, allowing services to continue indefinitely based on the client's needs and preferences. This approach is used universally among PH led teams. In contrast, approximately one-third of teams operate with a defined discharge timeline, with Fire/EMS-led teams being the most likely to have established parameters. A smaller portion of teams are still in the process of developing formal guidelines for case closure. Case

closeout practices are predominantly client-led, emphasizing flexibility and respect for individual autonomy and recovery pathway. Most teams allow clients to determine when to end services, with cases typically remaining open until clients are connected to treatment, achieve stability, or explicitly decline further engagement. Common criteria for closure include successful linkage to recovery programs, refusal of services, inaccessibility, or fulfillment of the client's immediate needs. Many teams also maintain an open-door policy, enabling clients to re-engage with services as needed.

Figure 14. Case Closure Practices Among Ohio Deflection Teams (N=64)



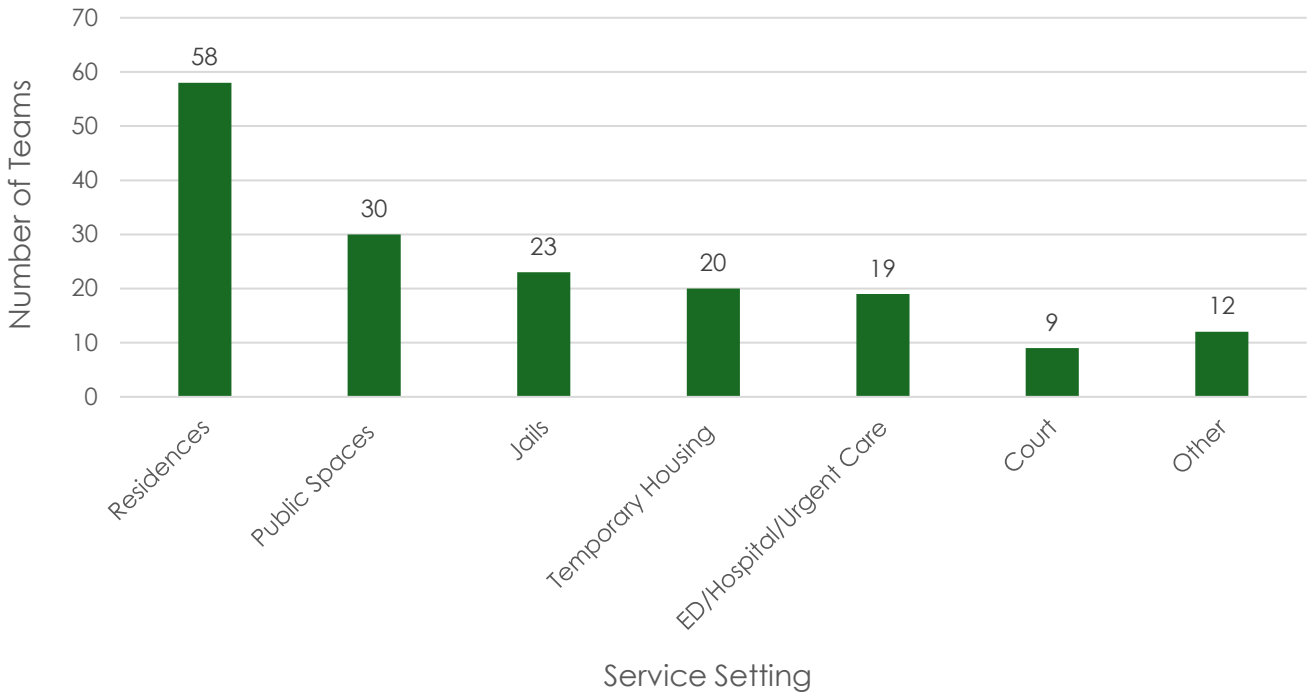
Note. This figure shows how teams structure case closure practices.

Service Settings

The diversity in team referrals, geographical contexts, and available resources has resulted in a wide variety of service settings for deflection teams, illustrated in **Figure 15**. This variety illustrates the underlying value held by the field of deflection to meet people where they are.

These findings reflect the adaptability and responsiveness of deflection teams, which evolve based on the unique needs and resources of their communities. While the primary role of a deflection team is to focus on early intercepts, their services are increasingly extending into later intercept points, likely because persons with substance use disorders are at a higher risk of criminal justice system involvement. Teams providing services in court settings were more commonly found in urban communities, while services in jails occurred exclusively in rural communities. The geographical variation may highlight how communities access and utilize resources available to them.

Figure 15. Service Settings for Ohio Deflection Teams (N=64)



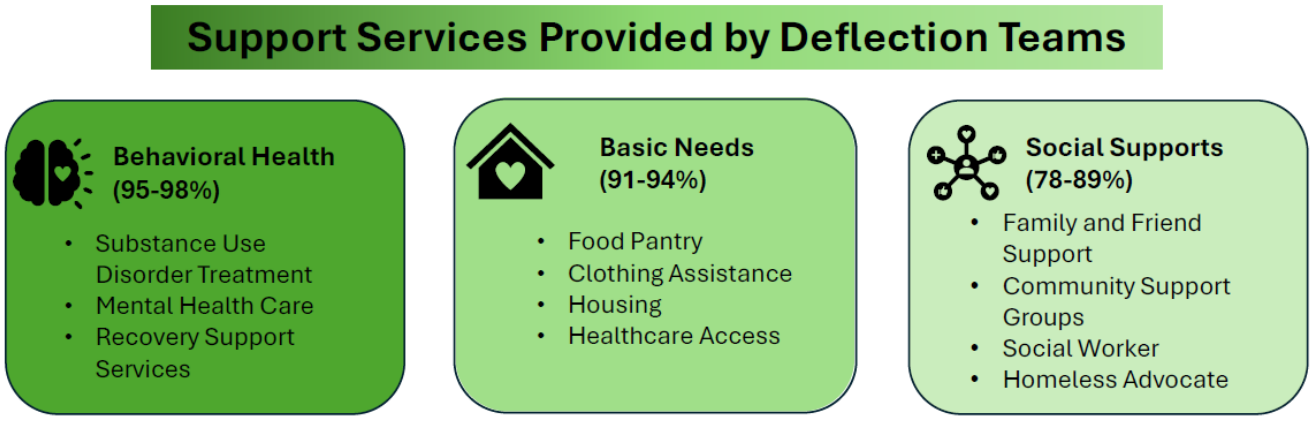
Note. This figure shows service settings where Ohio deflection teams provide outreach. "Temporary Housing" includes shelters, encampments, and hotels/motels. "Other" includes treatment agencies, nursing homes, police departments, and schools.

Support Services

The settings where teams operate are only part of the picture; equally important is the range of services they offer or link individuals to once engaged. Teams were asked to report on the support services they provide access to, including community support, healthcare, targeted outreach, basic needs resources, and other assistance. Options were informed by support service selections that can be entered by teams using Cordata Healthcare Innovations Community Navigation Platform. Notably, "providing access" includes facilitating linkages and referrals to these services.

As shown in **Figure 16**, a substantial number of teams provide access to a broad range of support services designed to treat the whole individual, address basic needs that are often barriers to recovery, and foster an environment and community supportive of recovery.

Figure 16. Support Services Provided by Ohio Deflection Teams



Note. This figure illustrates three categories of support services provided by deflection teams, ranked by the percentage of teams offering each service from most common to least common.

In addition to these support services, deflection teams reported offering or providing access to many other basic needs resources. It is important to note that this list may not be exhaustive. Teams shared these services as additional information beyond the standardized lists provided for review. As such, the data reflects what teams chose to report and may not capture all additional services offered by all teams.

Other resources included:

- Personal Hygiene
- Transportation
- Employment
- Utility Bill/Debt Assistance
- Insurance Access
- Criminal/Legal Support
- Identification Documents
- Immigration
- Petcare
- Telephone Access
- Education

Harm Reduction

Using the Substance Abuse and Mental Health Services Administration's (SAMHSA) *Harm Reduction Framework's* supported services and supplies list as a guide (2023) teams were asked to report on harm reduction services and supplies they offer or provide access to. "Providing access" encompasses facilitating linkages and referrals to these services. Overdose reversal supplies, including naloxone, were the most commonly provided (97%), along with overdose education (92%) and naloxone distribution mechanisms (86%). Teams also frequently provided or facilitated access to sharps disposal, substance test kits, HIV and hepatitis prevention education, vaccines, and safer sex supplies. Services like sterile

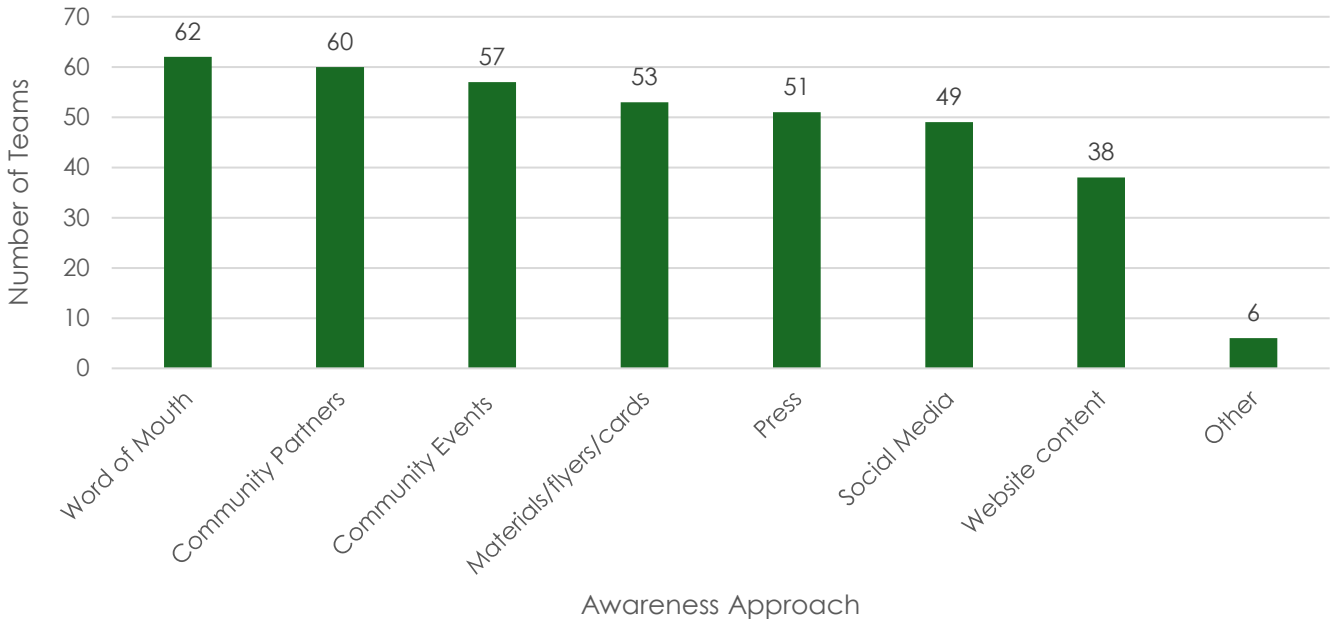
injection supplies, wound care, and nicotine cessation therapies were moderately common, and fewer teams offered sterile water, home testing kits for viral hepatitis/HIV, or safe smoking kits.

Of note, while harm reduction vending machines were not included on the original list, 8% of teams reported connecting individuals to these machines within their communities. It should be noted that this figure may not fully represent the prevalence of vending machines, as not all teams were directly asked about them. Teams also reported that reviewing this list prompted adjustments to their harm reduction services and supplies, informing their efforts to ensure more comprehensive offerings.

Community Outreach

Increasing the visibility of deflection teams and building community trust emerged as key themes throughout the inventory. As seen in **Figure 17**, teams employ a variety of strategies to engage their communities and promote their work. These findings highlight the efforts teams invest in raising awareness about the work that they do. To maximize the impact of these efforts, teams may benefit from guidance on evaluating outreach effectiveness to ensure the most efficient use of their resources.

Figure 17. Community Awareness Approaches Used by Ohio Deflection Teams (N=64)



Note. This figure illustrates the approaches used by Ohio deflection teams to raise awareness of their programs and services. "Other" includes recognition through special events, acknowledgments, and similar activities.

Community Innovation in Practice

Substance use trends in Ohio are constantly evolving, and the needs of communities continue to shift in response. Throughout the inventory process, teams shared a range of innovative and responsive strategies developed to meet the complexities of these changes. These practices reflect not only creativity, but also a deep understanding of the social, emotional, and health-related factors that shape substance use and recovery at the local level.

Innovative practices identified include:

- Peer-led alumni networks that emerged organically from outreach efforts and now provide sober, pro-social activities and ongoing peer-to-peer support.
- Child-focused response protocols, including the creation of "kid kits" containing comfort items (e.g., teddy bears) and age-appropriate books to help children cope when present during a deflection encounter.
- Assessments on site, made possible either through the presence of a clinician on the team or via telehealth access using tablets or computers.
- Cross-training for first responders, such as one team supporting their staff in completing Chemical Dependency Counselor Assistant (CDCA) training to improve understanding and engagement with individuals experiencing substance use.
- Dispatch to scene, with a few teams responding at the time of the emergency call, either by serving as first responders themselves or by carrying radios to receive dispatches.
- A pre-hospital buprenorphine induction pilot, in which paramedics initiate treatment in the field and then facilitate warm handoffs to longer-term care.
- Utilization of community paramedicine models to respond to chronic needs, including mental health, substance use, and physical health concerns, while reducing repeat calls for emergency services and improving overall health outcomes.

Infrastructure and Organizational Supports

Structural Components

During the inventory, we sought to understand the foundational and structural aspects of deflection teams' operations, illustrated in **Figure 18**. Most teams reported having Memorandums of Understanding (MOUs) or Business Associate Agreements (BAAs) with community partners. These agreements outline roles, responsibilities, and terms of collaboration, providing a clear framework for coordination.

Some teams also had mechanisms to document their processes, such as process guides, position descriptions, or meeting agendas and minutes. This type of documentation is critical for promoting continuity and sustainability, particularly when personnel changes occur, or roles evolve.

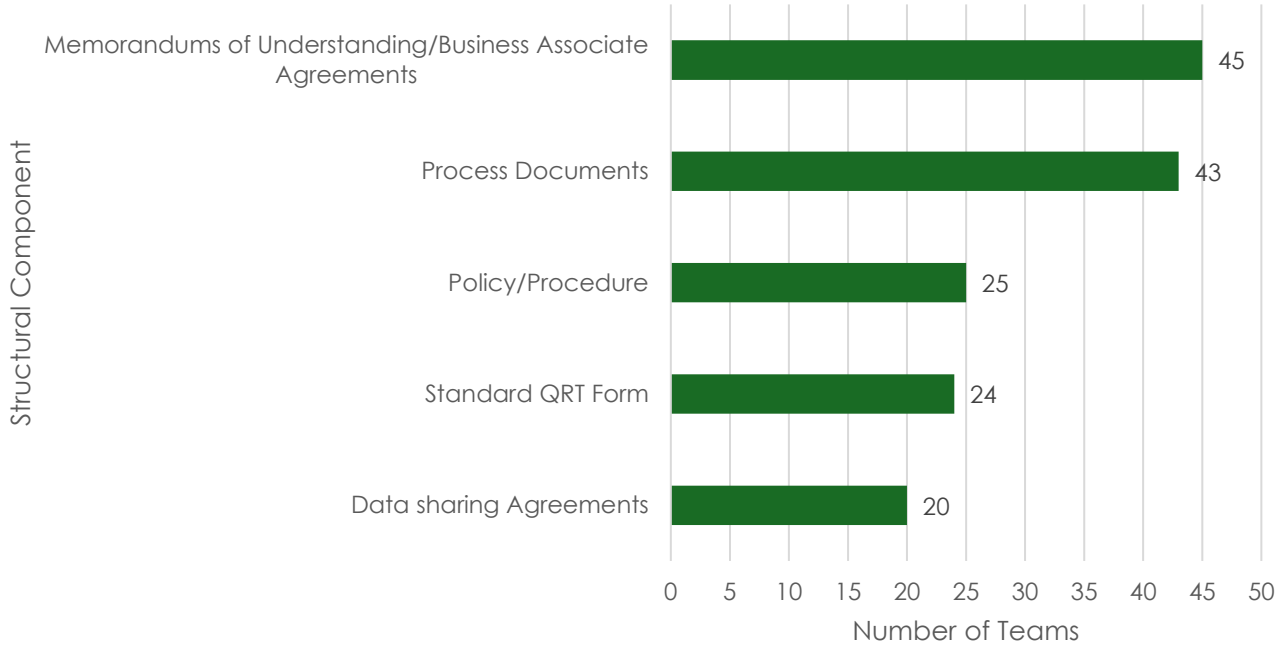
Fewer teams had formal policies guiding their work. Where policies existed, they primarily focused on response protocols, naloxone distribution, and transportation. Since formal policies support consistency, compliance, training, and operational efficiency, this presents an opportunity to further assist teams in strengthening this foundational component.

Similarly, few teams reported using a standardized QRT form or similar tool to collect initial information on individuals served. Developing and implementing a standardized form could enhance consistency in information gathering and support future evaluation efforts.

Finally, while the vast majority of teams reported engaging in data sharing, less than one-third had formal data-sharing agreements. Some teams indicated that data-sharing provisions were embedded within their MOUs or BAAs and may not be separately documented. However, it remains unclear whether the low percentage reflects incorporation into other agreements, the sharing of only aggregate data, or other

factors. This finding highlights an opportunity for further exploration into strengthening data-sharing practices.

Figure 18. Structural Components Employed by Ohio Deflection Teams (N=64)



Note. This figure shows the number of Ohio deflection teams employing various structural components and documents.

Training

While there is no defined curriculum or standardized training series for deflection teams, most teams report participating in some form of training, with the frequency commonly described as on an as-needed basis. In an open-ended question about training, teams had the opportunity to list their practices, illustrated in **Figure 19**. Please note, this data may not be exhaustive as each team was not specifically asked about every option reflected here.

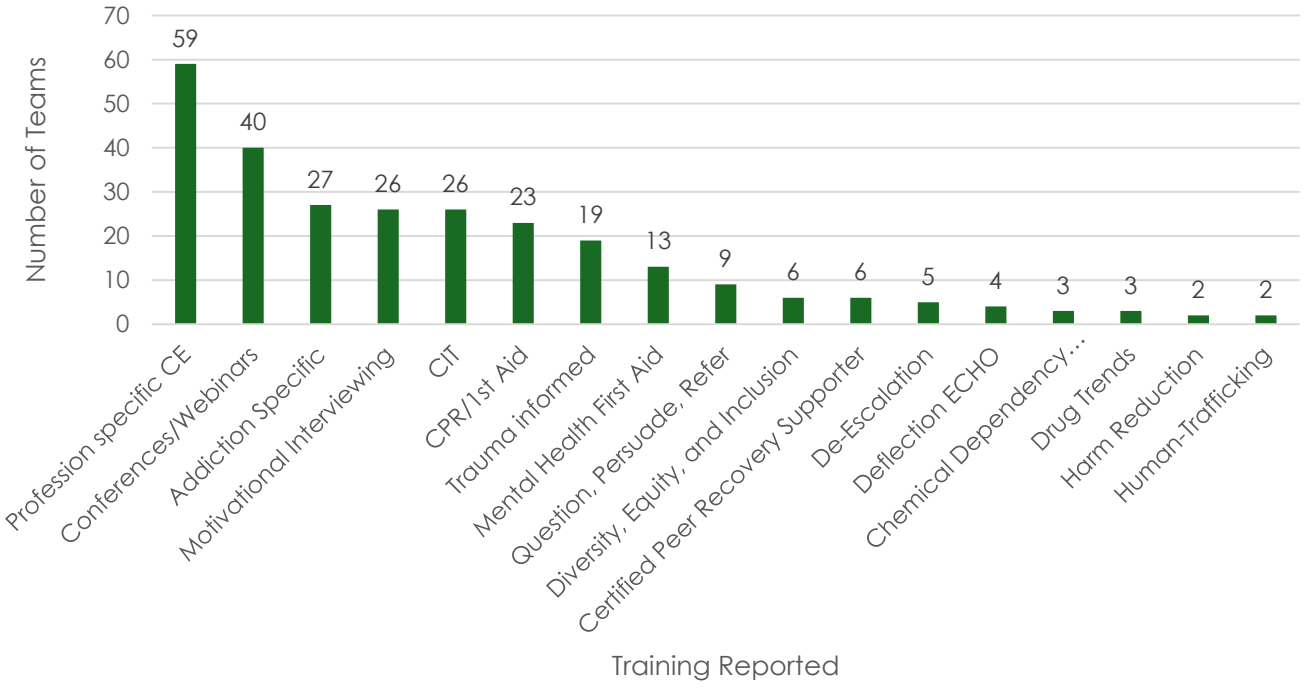
Most teams reported that they include profession-specific continuing education as part of their training. This encompasses continuing education for first responders, clinicians, PH staff, and PRS, each tailored to their specific roles and requirements. Additionally, many teams cited attending conferences and webinars on deflection-related topics as a regular training activity, often citing the Ohio Quick Response Team, Deflection and Outreach Summit held annually by the Ohio Deflection Association.

Less than half of teams mentioned substance use disorder-specific training, with certain specialized topics, such as harm reduction and drug trends, being cited less frequently. Some teams also trained in Crisis Intervention Team (CIT) Training, Motivational Interviewing (MI), and Trauma-Informed Care.

These findings may highlight the importance some teams place on providing trauma-informed services, crisis response, and employing strategies consistent with stages of change. Conferences, webinars, and profession-specific continuing education opportunities emerge as common avenues for training and

present valuable opportunities to incorporate specialized deflection content. Moreover, there is ample opportunity to enhance expertise in areas such as substance use, trauma-informed care, and motivational interviewing, which could further improve the effectiveness and success of engagement with individuals experiencing substance use disorders.

Figure 19. Specialized Training Cited by Ohio Deflection Teams (N=64)



Note. This figure shows training topics cited by Ohio deflection teams. Teams could indicate training in more than one topic area.

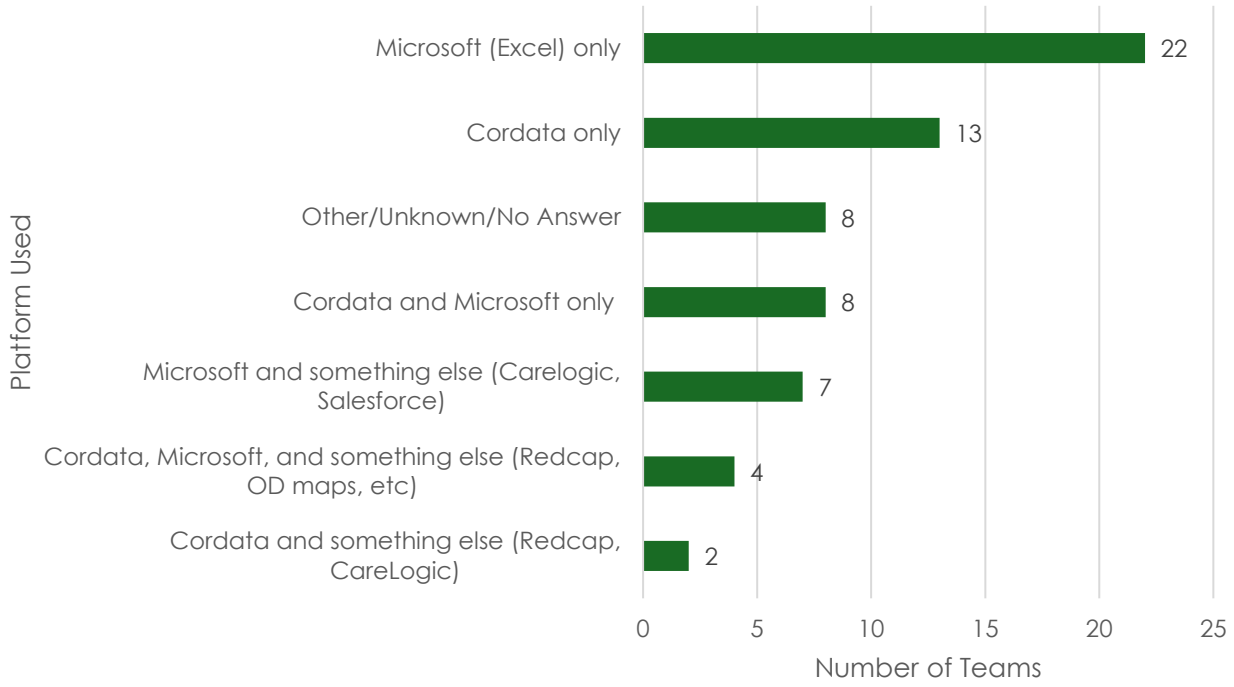
Data Practices and Definitions

Data Collection

All teams that completed the inventory reported that they collected data on the work that they did. However, data collection processes and data points measured varied among teams, illustrated in **Figure 20**. Microsoft platforms were the most common tool used to input and track data across teams with Excel being the favorite. Cordata followed as the second most commonly used platform. Other tools included electronic health records, REDCap, and Google based platforms. The variation in data collection methods, metrics, and systems presents a challenge for compiling state level data to evaluate outcomes and begin to identify best practices.

Notably, over a third of teams used multiple platforms for data collection, raising questions about the efficiency and effectiveness of the systems or processes in use. This highlights a potential opportunity to enhance existing systems to better meet team needs, particularly by reducing or eliminating the need for duplicate data entry.

Figure 20. Platforms Used by Ohio Deflection Teams (N=64)



Note. This figure shows data platforms used by Ohio deflection teams.

Data Sharing

Most teams (94%) reported sharing data. Teams share data with a variety of stakeholders, including government agencies, grant funders, community partners, research institutions, and the public. Common recipients are health departments, Mental Health and Recovery Boards (MHRBs), addiction task forces, treatment providers, and universities under research agreements. Data is shared in aggregate or de-identified formats to protect privacy, with secure systems used for sensitive information. Detailed case data is shared under strict conditions, such as Releases of Information (ROIs), particularly with treatment providers and project teams. Data-sharing practices are often driven by grantor reporting requirements and tailored to specific audiences to inform policies, enhance programs, and support community collaboration.

Definitions

Connecting individuals to treatment or services is a key outcome frequently requested by funders, stakeholders, and supporters. However, this measurement is inherently complex. As a relatively young field, deflection is still developing its own standardized language, which is further complicated by the multidisciplinary nature of deflection teams. Professionals from various backgrounds bring their own terminology, leading to inconsistencies in how concepts like "connection to services or treatment" are defined and understood. Recognizing this ambiguity, the inventory interviews specifically asked teams what the phrase “connect someone to services/treatment” meant to a team to gain clarity on their practices.

The concept of connection varies significantly among teams. For some, it involves providing informational resources, making phone calls, or scheduling appointments. Others define connection as a verified action, such as the individual attending their first treatment session or completing an intake. Practices range from offering guidance and transportation to facilitating on-site assessments or warm hand-offs, where individuals are physically escorted to service providers. Some teams distinguish between "referrals," which involve sharing information or arranging appointments, and "connections," which denote confirmed engagement in services while others use the words interchangeably.

Collecting data on treatment connections presents challenges, particularly in verifying outcomes and tracking long-term success. While many teams rely on self-reported data or provider feedback, systemic barriers such as privacy laws and gaps in local service availability complicate the process. Establishing clearer definitions and standardized data collection practices would enhance the ability of teams to measure their impact, improve coordination, and allocate resources more effectively, ultimately strengthening outcomes for the individuals and communities they serve.

Goals, Outcomes, Methods of Success

Common Team Goals

During the inventory interviews, teams were asked about goals. The majority (92%) reported having goals, either formally or informally, which clustered around several key areas: reducing overdoses, facilitating linkage to care, improving response and outreach, fostering community collaboration, training and capacity building, and ensuring long term sustainability.

Theme	Goals
Preventing Overdose Deaths	✓ Expanding naloxone distribution ✓ Increasing leave behind naloxone by first responders ✓ Engaging in proactive outreach ✓ Combatting stigma around naloxone through community education
Connection to Treatment and Recovery Supports	✓ Adding or expanding peer support within teams ✓ Partnering with Medication for Opioid Use Disorder providers to improve quick access to this gold standard of care ✓ Expanding provision of harm reduction supplies and services
Improve Response and Outreach	✓ Maintaining a response window of 24-72 hours ✓ Increasing outreach attempts when unsuccessful at engagement ✓ Building trust in communities most affected by substance use ✓ Implementing specific intervals (30/60/90-day contacts)
Foster Community Collaboration	✓ Building strong partnerships with first responders, hospitals, and the criminal justice system to streamline referrals for service ✓ Supporting families and fostering relationships with community partners offering family services ✓ Hosting outreach events to raise community awareness about addiction, reducing stigma, and available resources
Training	✓ Increasing training for key areas including motivational interviewing and emerging drug trends
Strategic Planning to Ensure Sustainability	✓ Expanding services to underserved and neighboring communities ✓ Securing funding to support longevity of efforts ✓ Continuous evaluation and improvement to enhance effectiveness of program over time

Defining Success

When asked how they defined outcomes and successes, deflection teams offered a diverse range of perspectives, some citing specific outcome measures and others reflecting their experience with the work. A primary measure of success for many teams was simply making a connection, with numerous teams emphasizing the significance of just having someone answer the door. This underscores the challenges of engaging individuals following a substance use crisis and the level of mistrust sometimes felt by those impacted. Additionally, linking individuals to treatment, services, or harm reduction resources was frequently cited as success.

Many teams highlighted the importance of meeting individuals where they are in their stage of change, tailoring care to each person's unique needs and goals. This approach reflects a commitment to person centered care. Positive harm reduction impacts were also seen as critical markers of success, including increased naloxone distribution, decreased overdoses, and reductions in repeat overdoses, emergency calls, and other system interactions. A number of teams identified community-level outcomes as

important measures of success, pointing to strengthened partnerships, reduced stigma, increased first responder engagement, and higher referral rates as indicators of positive progress. Ultimately, many teams shared a common goal: to see individuals improve their emotional and physical health, achieve long-term recovery, and lead more stable and productive lives.

Discussion and Lessons Learned

The findings offered by this inventory provide a detailed snapshot of substance use deflection efforts across Ohio. While the phrase "If you have seen one QRT, you have seen one QRT" held true in the variation of approaches observed, common threads emerged illustrating both strengths of the field and areas for future growth.

Key findings include

- **Diversity in Implementation:** Deflection teams vary widely in structure, leadership, funding, response models, and community engagement. This flexibility allows teams to meet local needs but also creates challenges in developing shared practices and building a unified evidence base.
- **Sustainability Concerns:** Most teams rely on short-term grants and have limited capacity to secure long-term resources. Many lack internal infrastructure, such as policies and processes, needed to maintain operations through leadership or staffing changes.
- **Varied Data Collection and Evaluation Capacity:** While all teams collect data, their capacity to analyze and apply it varies widely. Inconsistent definitions (e.g., "connection to treatment") and limited infrastructure for evaluation present challenges. Additionally, many teams are supporting improvements in health and well-being that go beyond traditional metrics, such as providing access to basic needs, harm reduction supplies, housing, or healthcare. These outcomes are meaningful but are often not captured in current data systems.
- **Gaps in Foundational Training:** All teams reported participating in training, demonstrating their commitment to effectiveness; however, training content, frequency, and format vary widely. Without a shared mechanism for ongoing education, teams may face skill gaps as needs evolve.
- **Relationships Are Central to Deflection Success:** Relationships with public safety partners, service providers, and individuals served are fundamental to engagement and program effectiveness. Champions with social and political capital also play a critical role in gaining and sustaining community buy-in.
- **Innovation Remains Central to Deflection:** Teams across the state continue to adapt creatively to emerging needs. Innovations include peer-led alumni networks, child-focused outreach protocols, telehealth assessments, prehospital buprenorphine induction, and integration with community paramedicine models.

Deflection in Ohio has grown well beyond its original focus on opioid overdose response. Teams have evolved by adapting to emerging community needs. They are addressing substance use regardless of the substance involved, supporting mental health, assisting families, and responding to social determinants of health. Their approaches are diverse and shaped by geography, local partnerships, community support, and available funding. This diversity is a core strength, enabling teams to remain responsive to their communities' unique contexts and to keep up with constantly shifting substance use trends. It fosters innovation and tailored solutions. However, this variation also presents challenges in evaluating impact and in identifying and scaling best practices across communities.

Geography plays a significant role in shaping deflection team structure. In rural communities, teams are more often led by BH or PH agencies, while urban areas more frequently see fire/EMS, municipal government, or HC based organizations leading teams. This may reflect the limited emergency and clinical infrastructure in many rural areas, where fire departments are often volunteer-based, and hospitals are small or geographically dispersed.

One of the clearest themes to emerge is the importance of relationships. Whether with public safety agencies, treatment providers, or the individuals being served, trust and collaboration are essential to effective deflection. Many teams emphasized that building trust is often the key to engagement and sometimes as fundamental as getting someone to answer the door after a crisis. Additionally, having the right champions and collaborators within the community often makes the difference in whether teams can effectively reach those most at risk.

Despite tremendous progress, deflection teams continue to face challenges. Many operate on short-term funding cycles and lack core components of infrastructure that promote long term sustainability. Approaches to training, response, and data collection vary considerably across teams. Outcome tracking is not standardized, limiting the field's ability to understand and demonstrate long-term impact. While innovative practices are emerging, they are often locally developed and remain siloed within individual communities. In many cases, these innovations have not yet been evaluated, making it difficult to build an evidence base or scale effective grassroots strategies.

As deflection continues to mature, these findings highlight opportunities to strengthen the field through diverse and sustainable funding models, investment in foundational training, greater consistency across improved data systems, and the development of standards that support long-term sustainability and infrastructure while still honoring the unique needs of communities and the flexibility required by local teams.

Recommendations

Building on these lessons, several strategies have emerged to strengthen deflection efforts across Ohio. The following recommendations are informed by the experiences and insights shared by teams during the inventory.

- **Pursue long-term, braided funding models.**
  Most teams currently operate on short-term grant cycles, limiting their ability to plan for sustainability or build lasting infrastructure. State leaders and advocates play a critical role in securing and sustaining these funding streams through policy development, budget prioritization, or coordinated resource alignment across systems. Additionally, teams need support in pursuing diverse and sustainable funding models. Braided funding strategies that combine local, state, and federal resources, including Medicaid reimbursement, opioid settlement funds, and local appropriations, can help establish a more stable foundation for ongoing deflection work. While these models offer flexibility, they also require alignment across agencies, administrative coordination, and dedicated capacity to manage diverse funding streams.

- **Need for Standardized and Inclusive Data Practices.**
  Deflection teams use diverse approaches shaped by local context, which leads to variability in what data is collected and how it's reported. Without shared definitions or core measures, it is

difficult to compare efforts or identify emerging best practices. Standardizing foundational metrics while expanding them to include indicators of stability, safety, and health would support more accurate evaluation. Accessible data tools, training, and evaluation partnerships can help ensure that the full scope of team impact is recognized and leveraged.

- **Support the identification and development of best practices.**
  To strengthen the field of deflection, it is important to support the ongoing identification, development, and dissemination of best practices. While embedding evaluation into team structures and providing access to evaluation resources are key strategies, they should be complemented by broader field-building efforts. These include synthesizing lessons learned across teams, piloting and refining emerging approaches, creating practical frameworks and guidance documents, and facilitating the spread of effective models. Together, these efforts ensure that lessons are not only captured but translated into actionable practices that advance the field.

- **Establish a shared training foundation.**
  A shared training foundation is essential to ensure consistent quality and effectiveness across teams. Cross-disciplinary training in motivational interviewing, harm reduction, trauma-informed care, and mental health, framed through a deflection lens, can equip all team members with the skills needed to provide responsive, person-centered support.

- **Provide infrastructure guidance while preserving local flexibility.**
  As the field evolves, teams have expressed the need for foundational guidance related to infrastructure such as policy, process, and MOUs. Establishing basic standards that define core components of deflection can provide clarity and consistency across communities. At the same time, it is essential that these standards allow opportunities for local adaptation and innovation, recognizing that community needs and resources vary widely.

- **Build cross-sector partnerships to address risk and recovery needs.**
  Deflection teams should prioritize collaboration with community-based organizations that both identify individuals at risk and support long-term recovery. Schools, primary care providers, and other frontline agencies are often well-positioned to recognize early signs of substance use and intervene before crises occur. At the same time, partnerships with providers of housing, employment, food assistance, treatment, and other wraparound services are essential for addressing the social determinants that influence substance use and relapse. Sustainable recovery is more likely when individuals not only receive treatment but also have access to stable housing, meaningful employment, and supportive community networks.

- **Recognize and scale innovation.**
  Deflection strategies are often developed locally, and teams have limited opportunities to learn from one another or share promising practices across communities. Fostering peer learning opportunities, highlighting team successes, and creating platforms for shared knowledge can help spread promising practices across the state, reduce duplication of effort, and encourage collective growth within the field.

- **Invest in leadership development and community engagement.**
  Finally, the presence of local champions and supportive leaders is critical. Strong recovery advocates, judges, and public safety officials have often played a pivotal role in helping teams gain buy-in, launch, develop traction, and thrive. Investing in leadership development, community engagement, and storytelling can help elevate the work of deflection teams and build the widespread buy-in needed for lasting support.

By embracing these recommendations, Ohio can continue to build a resilient and sustainable deflection system that responds to evolving substance use challenges while honoring the unique needs of each community.

Conclusion

Ohio continues to face a persistent and ever evolving substance use crisis. Overdose deaths remain among the highest in the nation and the impact of alcohol, cocaine, and psychostimulants continues to grow. In response, deflection has emerged as a critical strategy that allows for early intervention, access to treatment, and wraparound care while steering individuals at risk away from the criminal justice system.

While deflection efforts have gained momentum across Ohio, the field remains relatively young and demonstrates variation in approach and implementation. The findings from this deflection inventory illustrate both the progress made and challenges faced in building sustainable deflection models. Many early teams formed organically in response to local needs, often led by first responders. As the field evolves, it embraces a broader community-based approach, diversification of team leads and representation, and the adoption of multiple pathways of deflection and pre-arrest diversion.

Despite the richness of diversity found in teams, many teams operate with limited resources. They rely on local support and collaboration, grassroots efforts, and innovation. Teams continue to adapt in real time, navigating workforce strain, funding instability, shifting substance trends, and gaps in organizational capacity, underscoring the importance of building strong infrastructure that encourages sustainability.

Deflection in Ohio continues to show a commitment to cross sector collaboration, community adaptability, flexibility, and a deeply person-centered approach. Continued coordination, investment, and knowledge sharing will be essential to support this field as it matures. At the same time, developing shared standards around response protocols, policies, training, data systems, and evaluation must be balanced with respect for local adaptation and autonomy.

Ohio's first responders, peer supporters, public health professionals, and behavioral health providers have led the charge in advancing deflection with extraordinary passion, compassion, and resilience. They understand that change often begins with a single open door. As deflection efforts continue to mature, investing in both the people and the infrastructure that sustain this work is essential. By supporting those on the frontlines and strengthening the systems that enable them, Ohio can build a lasting, adaptable, and lifesaving response to the evolving substance use crisis.

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Your contributions reflect the heart, strength, creativity, and resilience of deflection programs operating in communities large and small, urban and rural, across the state. Whether newly formed or well-established, each team offered valuable perspectives that have shaped this report and advanced our collective understanding of what makes deflection effective, responsive, and sustainable.

Thank you for the important work you do every day to meet people where they are, build bridges to care, and create healthier, more connected communities. This report is a reflection of your efforts and a celebration of your impact.

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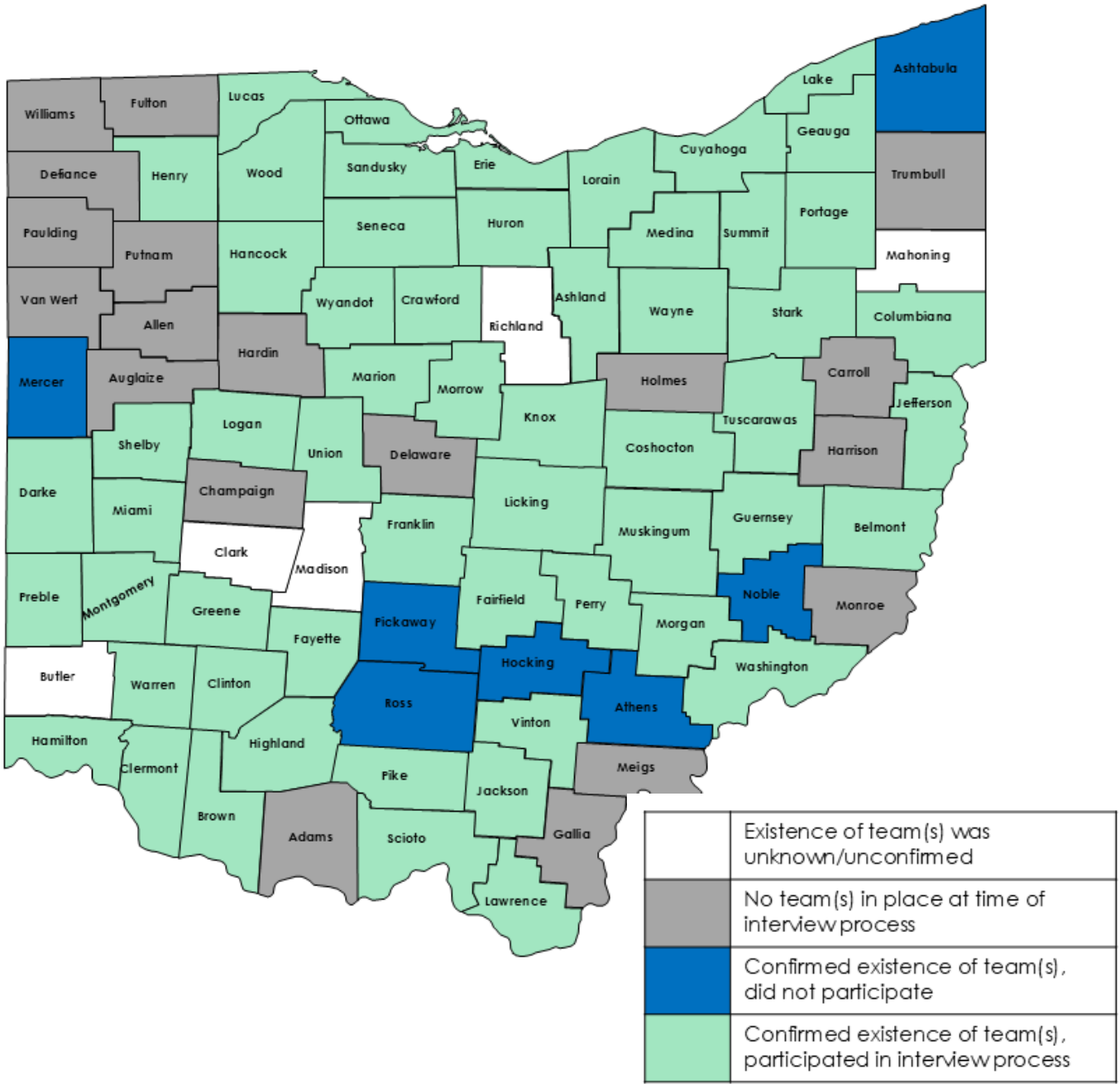
Appendix A: Map of Counties Included

Interview Responses from Ohio's Deflection Teams by County



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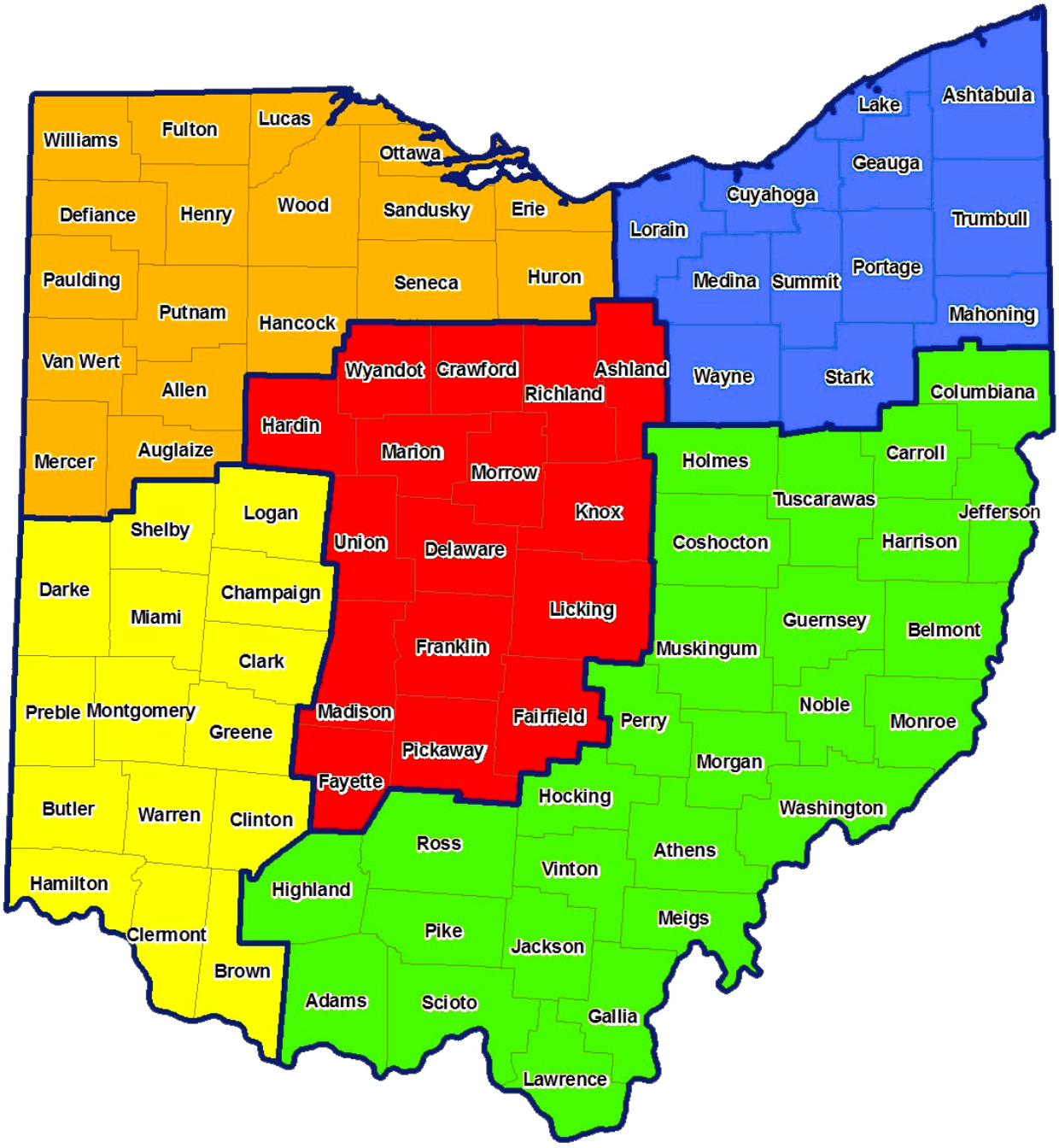
Appendix B: Ohio Deflection Association Regions Map



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[2] Map source: Ohio Deflection Association. https://ohiodeflectionassociation.org/ODA-County-Map.html

Appendix C: Deflection Team Inventory Interview Questions

1. What county/counties do you operate in?
2. What is the name of your team?
3. Official/Informal name?
4. Who is the leading agency for your team?
5. Do you have a person in your community that is your go-to when there are questions?
6. When did this team begin its work (month/year)?
7. Do you have local champions?
8. Do you have funding?
9. What type of funding is this? (Grant, budgeted allocation, other.)
10. What is the annual budget to fund your team and its work?
11. Who is your funding agency?
12. What activities/positions are funded?
13. What is the funding cycle or duration of your support?
14. What community partnerships are in place to support your work? (MOUs, BAAs, other)
15. Please tell us who is on your team, their profession/area of experience?
16. Are these full-time positions?
17. Are any of these unfilled FTE's?
18. What was the specified population that your team decided to serve? Has that changed with time and experience in doing field work? How so?
19. What hours & days are set to do mobile work? What hours & days are set to do anything outside of mobile?
20. How does your team receive referrals?
21. How do you present yourself?
22. When engaging with individuals do you use an issued vehicle or a personal vehicle?
23. What would you say are the primary sites for the services you provide?
24. Please tell us what methods you use to engage individuals?
25. Are there any limits to the attempts you make when contacting referrals for the first time?
26. If yes, then: What are the limits in place?
27. How often do you engage with a client once contact is made? What does that ongoing interaction entail?
28. What are the available resources/referrals offered?
29. When do support/services by your team conclude with a client?
30. Does your team have expectations around timing of response and follow-up?
31. What harm reduction supplies or services do you offer?
32. What does the phrase "connect someone to services/treatment" mean for the team?
33. Of the 6 Pathways to treatment and services, which do you offer?
34. What team model do you feel most closely aligns with your team structure?
35. Do team members engage in specialized training?
36. If yes, then: What specialized training do team members have?
37. How often do team members engage in training?

38. Do you have an established process to document and/or communicate the work being done by the team?
39. If yes, then: What has been established to record/document/communicate the processes of the team and its work?
40. Do you have policies in place regarding the specific work being done by your team?
41. If yes, then: What policies do you have regarding the specific work being done?
42. Do you use a standard QRT form to collect information on interactions with individuals?
43. Do you use a central database or other repository to collect incidents with individuals? Do you use a system to track/collect data on contacts the team makes?
44. What system do you use to collect data, (excel, online platform, paper)
45. Is this a HIPAA Compliant platform?
46. Do you share data?
47. Who do you share your data with?
48. Do you have data sharing agreements?
49. Has your team set specific goals?
50. If yes, then: What specific goals have been set for your team and its work?
51. How does the team define outcomes and successes?
52. What approach does the team take to ensure that the community is aware of services?
53. What plans are in place to sustain this work?

Appendix D: List of Acronyms

Acronym	Full Term
AGO	Attorney General's Office
BAA	Business Associate Agreement
BH	Behavioral Health
BJA	Bureau of Justice Assistance
CDCA	Chemical Dependency Counselor's Assistant
CIT	Crisis Intervention Team
COSSUP	Comprehensive Opioid, Stimulant, and Substance Use Program
DART	Drug Abuse Response Team
DJFS	Department of Job and Family Services
EMS	Emergency Medical Services
HC	Healthcare
HIPAA	Health Insurance Portability and Accountability Act
LE	Law Enforcement
MAT-PDOA	Medication Assisted Treatment- Prescription Drug and Opioid Addiction
MOU	Memorandum of Understanding
OCJS	Office of Criminal Justice Services
OhioMHAS	Ohio Department of Mental Health and Addiction Services
OSAM	Ohio Substance Abuse Monitoring Network
PH	Public Health
PORT	Post Overdose Response Team
PRS	Peer Recovery Supporter
PTACC	Police, Treatment, and Community Collaborative

QRT	Quick Response Team
REDCap	Research Electronic Data Capture
ROI	Release of Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SIM	Sequential Intercept Model
SOR/SOS	State Opioid Response/State Opioid and Stimulant Response
SUDI	Substance Use Deflection Initiative

Appendix E: List Of Figures