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Testimony by Jac Charlier, TASC Center for Health & Justice Executive Director Submitted October 20, 2020, to the Senate Criminal Law Committee and Special Committee on Public Safety

Thank you for the opportunity to provide testimony today. My name is Jac Charlier, and I am the executive director of TASC's Center for Health and Justice. I am also co-founder and executive director of the **Police, Treatment, and Community Collaborative (PTACC),** a national alliance of practitioners in law enforcement, behavioral health, community, advocacy, research, and public policy whose mission is to widen community behavioral health and social service options available through police diversion, as well as its forms that include fire departments and emergency medical services (EMS) in what are commonly called co-responder programs.

Founded in 1976, **TASC** is a statewide, non-profit agency designated by the State to conduct substance use disorder assessments, referral to treatment and other recovery support services, and specialized case management for individuals involved in or at risk for involvement in the criminal justice system. We collaborate with law enforcement, courts, jails, prisons, probation, and parole to help break the cycle of substance use disorder, arrest, conviction, and incarceration. **TASC's Center for Health and Justice** is our consulting and technical assistance arm that offers solutions for improving community health, reducing system involvement, and efficient use of public dollars to partners across the globe.

The subject matter of today's hearing, *Alternatives to Police Response and Co-Responder Models,* is part of a larger field of practice already underway across the U.S. and in Illinois sometimes referred to as "deflection." **I'm here today to speak with expertise from our national work on what has come to be known as "deflection," in its various forms,** including first-responder (i.e., police, EMS, or fire department alone), co-responder (i.e., a first responder and behavioral health responder), and community responder models (i.e., when no police are involved), and to **discuss its expansion throughout Illinois as a key feature of a public health strategy to address the behavioral healthcare needs in our communities, one with potential to advance racial equity** in preventing unnecessary justice-system involvement and ensuring enhanced, rapid, and easy access to treatment. Ideally, what we should want to see in Illinois is an array of deflection programs in place, including all three of these designs, as each one addresses different types of problems or challenges our residents and communities want to solve.

What Is Deflection?

I'd like to start with a brief discussion of what we mean by "deflection." Broadly speaking, deflection is any collaborative intervention connecting first responders (police, sheriffs, fire departments, emergency medical services) and public health systems to create community-based pathways to treatment for people who have a substance use disorder (SUD), mental illness (MI), or both, and who often have other service needs, *without their entry into the justice system, and critically important, without fear of arrest.* Some deflection is police-led, EMS-led, or fire department-led, and this is called "first responder" deflection. Some deflection adopts a "co-responder" model, and this involves police, fire, or EMS with a behavioral health partner. Deflection that has behavioral health teamed with others and excludes the involvement of police, fire, or EMS is referred to as "community responder" deflection.

Recognizing the persistent prevalence of untreated behavioral health conditions among people in our communities[1] and among individuals involved in the justice system,[2] the harmful effects of criminal records and incarceration on the health and well-being of individuals and families,[3] and scientific advances in understanding of substance use disorder as a treatable biopsychosocial condition, many jurisdictions have engaged in efforts to better identify substance use treatment needs, and to make connections to appropriate treatment and overdose prevention. Given the sheer number of contacts law enforcement officers have with community members, many of which involve behavioral health in some

way, deflection holds great promise to help achieve these goals, with special potential to do so at the very front door of the justice system, where racial disproportionality begins.

In the simplest terms, as a criminal justice diversion tactic, deflection provides law enforcement a third option—to connect people with community-based services that address their underlying issues. Traditionally, police have only had two choices—to arrest or to not arrest. Deflection programs provide a different approach by leveraging the encounter to make it instead an opportunity to connect people to needed treatment, housing, and services via case management. Deflection is distinct from criminal justice diversion programs, which generally involve prosecutors, courts, probation, and/or parole offering post-arrest alternative programming and services to individuals in lieu of conviction, traditional sentencing, or violations of supervision conditions.

Deflection "pathways," discussed later in more detail, facilitate connections to treatment, recovery support, housing, and social services via case management. Deflection programs utilizing police as the referral source are typically one-tenth law enforcement and nine-tenths public health and community. Critical to note is that while police are co-equal partners with treatment and community in the deflection process, that's it. The police do not have oversight for nor do they supervise the people who have been deflected. Deflection is not diversion.

The approaches involved in deflection aren't new. Crisis intervention teams (CIT), mobile crisis, co-responders, and community responder programs that coordinate responses among first responders and community behavioral health professional teams in various combinations (e.g., social workers, recovery peer specialists, substance use or mental health treatment professionals, community outreach workers), have been in place for decades. These are all forms of the larger field of deflection that have now caught the attention of the wider public and policymakers, likely due to the proliferation of programs over the past decade in response to the current opioid epidemic, and now catalyzed by recent, intensifying interest in the role law enforcement plays when officers encounter individuals with behavioral healthcare needs.

TASC's Center for Health and Justice's national and international technical assistance leadership, networks, and initiatives provide unique perspective and opportunity to study and inform the developing field in all its forms. In 2014, we coined the term "deflection" to organize emerging programs and models, and to differentiate it from other types of diversion. In 2017, we co-founded PTACC to build a collaborative platform that would support, advance, and give voice to its development.

In its first year, PTACC developed a typology to understand and convey the breadth and diversity of program design in the emerging field, with five key community "pathways" to treatment, each addressing the unique needs and challenges of local jurisdictions and utilizing available resources. These five pathways represent approaches rather than any specific, branded programs. Some programs utilize one pathway, and others adopt multiple pathways within one program.

- *Self-referral:* An individual voluntarily initiates contact with a first responder (law enforcement, fire services, or EMS professional) seeking access to treatment—without fear of arrest—and receives a referral to a treatment provider. Can be done by fire and emergency medical services without law enforcement. (The *Safe Passage* program pioneered in Lee County and the *A Way Out* program in Mundelein are self-referral programs.)

- *Active outreach:* A law enforcement officer or other first responder identifies or seeks out an individual in need of substance use or mental health treatment (can include housing and other services), and a referral is made to a provider who engages them in treatment (and ideally case management services are also provided). Can be done by fire and emergency medical services without law enforcement.

- *Naloxone plus:* A law enforcement officer or other first responder engages an individual in treatment as part of an overdose response, preferably at the point of overdose or as close to the point of overdose as possible, such as at the emergency department. Can be done by fire and emergency medical services without law enforcement.

- *Officer prevention:* A law enforcement officer, alone or as a member of a co-responder team, initiates treatment engagement (which can also be directly to a case manager first), but no criminal charges exist or are present, and hence no criminal charges can be filed. Officer prevention occurs as part of police patrol duties including "on-view," citizen "flag down," or in response to a call for service. Can be done in a co-responder approach.

- *Officer intervention:* A law enforcement officer, alone or as a member of a co-responder team, initiates treatment engagement (which can also be directly to a case manager first), and either charges are filed and held in abeyance or a citation with treatment requirement is issued. Note: This is not the same as citation in lieu of arrest, as it involves some type of mandated treatment assessment or participation. Law enforcement required, also can be done in a co-responder approach. Officer intervention occurs as part of police patrol duties including "on-view," citizen "flag down," or in response to a call for service.

The federal government began investing in the field of deflection in 2017, supporting its development through national technical assistance and site-based grants, later adding mentor sites and expanding technical assistance to non-grantee sites. The National Institute of Justice has provided research and evaluation support. The Office of National Drug Control Policy included deflection in its 2019 and 2020 *National Drug Control Strategies,* and the Substance Abuse and Mental Health Services Administration and Centers for Disease Control and Prevention have distributed site-based grants. With anecdotal evidence of some 500 deflection programs operating across the country, the Bureau of Justice Assistance is currently undertaking the first national survey of deflection sites, a project our Center is leading. Now, with funding and support from local jurisdictions and the federal government, we are also supporting the development and implementation of deflection projects across the country and here in Illinois.

As is often the case with emerging models and approaches, research must simultaneously catch up with practice and sprint ahead to inform it. To date, the limited research on the emerging field of deflection has focused on describing program participants or offering qualitative data to inform an understanding of police, participant, and community perspectives. Individual program evaluations have provided information about officer and participant perspectives, and have also provided early insight into their successes with respect to subsequent criminal justice system involvement, treatment access, housing, and employment outcomes. An upcoming issue of the *Journal for Advancing Justice* will be dedicated to documenting existing literature on the field, with an introduction I co-authored with Jessica Reichert, acting research director at the Illinois Criminal Justice Information Authority (ICJIA).

Deflection in Illinois

Illinois is a legislative leader among states when it comes to deflection. State lawmakers recognized and endorsed it in 2018, when the first comprehensive deflection legislation in the nation passed our General Assembly with broad, bi-partisan support under the leadership of Senators Bush and Bivins and Representatives Evans and Demmer. TASC and law enforcement officials from Mundelein and Dixon who had pioneered deflection programs in their communities partnered to initiate SB 3023, the Community–Law Enforcement Partnership for Deflection and Substance Use Disorder Treatment Act.

The Act authorized local, collaborative, law enforcement–led programs that refer people to treatment rather than arrest, codifying all five deflection pathways identified by PTACC to divert people away from arrest and into services. It also provided a funding mechanism for implementation and expansion, and

included performance measurement provisions. This legislation was utilized by the National Alliance for Model State Drug Laws (NAMSDL) to develop guidance for states seeking to introduce similar legislation.

We know anecdotally that deflection programs are being developed and implemented across Illinois, though we aren't aware of any current, accurate inventory of them. In 2017, ICJIA researchers identified 11 deflection programs operating in the State (Braidwood, Elgin, Lake Co, Lee & Whiteside counties, Lemont, Livingston County, Lockport, McHenry County, Mokena, Naperville, and Rolling Meadows), with more in development since then. Chicago has implemented and is working to expand its Westside Narcotics Diversion and Treatment program. Initial data from our BJA-funded national survey shows 62 sites in Illinois reporting deflection programs operating in their areas, some offering multiple pathways to treatment. As noted in the 2020 *State of Illinois Opioid Action Plan Implementation Report,* ICJIA has conducted three evaluations of deflection programs, with results demonstrating support by participating law enforcement officers and recommendations for future implementation efforts that provide enhanced officer training on SUD, community engagement to increase awareness of programs, and attention to local treatment capacity issues.

Through ICJIA, in alignment with the Act, the State has funded deflection grants to an additional six local jurisdictions seeking to develop or expand their deflection initiatives. SAMHSA and CDC have recently funded initiatives to grow deflection in Cook Co., with our Center responsible for implementing the technical assistance and training needed to create awareness of deflection and its value in communities, and to build understanding of how to develop and implement deflection programming likely to meet local needs using local resources. These initiatives also incorporate our deflection specialists on the ground to perform outreach to police and provide case management services in support health and recovery.

<u>Recommendations</u>
Even with the solid foundation laid by SB 3023, the grant program that supports it, and the innovative initiatives being implemented in communities across the State, we know that deflection still holds untapped potential Illinois. We must seize this moment to scale up deflection—including in the co-responder and community responder approaches—to make real change, and to make it well.

With recognition that communities across the state are doing this work, we support Illinois' efforts to expand deflection in all its forms, and to do so in a way that will advance racial justice. To that end, we offer the following recommendations:

1) **Build awareness among law enforcement, other first responders, decision-makers, and communities to create demand for local deflection programs, and support their successful implementation in a manner consistent with emerging best practices, with a special focus on expansion in communities of color and rural areas.** Deflection programs in Illinois have tended to concentrate in suburban communities. Building on the frameworks and pathways authorized in SB 3023, and informed by emerging best practices, we recommend promoting broad awareness across the State of the full range of deflection pathways as a means of addressing local law enforcement diversion and community treatment needs, as well as continued elevation of the discussion in urban settings to make deflection more accessible to low-income communities and communities of color.

   With regard to achieving this recommendation and aligning with emerging best practices, we offer the following guidance:

   – <u>*Equity*</u>: Because deflection is still an emerging field, and because the evidence base for what works is still forming, there is still much to be learned from the many programs operating about what works and how well it works. This includes the efficacy of specific program goals related to equity. While most programs are not primarily designed to ensure equity, they certainly can be

developed with an equity lens, grounded by goals and metrics reflecting that, and including features able to address it. Programs aiming to include this approach should be clear about it, across partners and in all aspects of development, implementation, and evaluation.

- *Informed design:* While it is an attractive, instinctual, and relatively easy way to implement a new program, we strongly recommend against simply copying another municipality's program. Instead, program development must start with a problem-solution orientation. Each community is unique and has its own set of problems, challenges, capacities, and resources. It is only after assessing these variables, and after developing an understanding of the array of available approaches, that a local program can be created. Copying another program without such an assessment may result in solutions to problems that don't exist or reliance on resources that aren't available. These will likely not be successful programs.

- *Responder design:* There are a variety of ways to design the responder feature of a deflection program; that is, whether a program will utilize law enforcement, EMS, or a fire department as the responder, use a co-responder or community responder approach, or as is most likely, jurisdictions will have all three types of deflection to address a variety of problems. For any particular program, this design should reflect the combination likeliest to address identified, specific problems facing a community. In other words, context matters. Starting program development with a specific approach in mind—say, social worker plus EMS, or police plus treatment, or mental health provider plus peer worker—puts the cart before the horse. Again, community problems and resources must first be identified, and then partners can build a sustainable program designed to address them. Note that some deflection designs will require work to change 9-1-1 and other dispatch processes and systems. Achieving this requires no small amount of dedicated effort, given its foundational nature as a mechanism for dispatching and directing teams, especially in community responder deflection models.

- *Crisis management:* Deflection programs can exist both within crisis and a non-crisis spaces. Public expressions of serious mental illness symptomology and opioid overdoses reflect obvious crises. But the range of police and first responder encounters with community members experiencing substance use or mental health problems on a non-crisis basis is much wider.

- *Culture change and community involvement:* Deflection is about much more than setting up a new program, as many jurisdictions have learned. It is often about aligning policies, practices, funding, and most importantly, cultural change. Often law enforcement culture needs to change; sometimes treatment culture needs to as well. This does not happen easily or quickly. The community must be involved and engaged in these efforts, a process that takes time and requires community involvement early on and supported throughout.

- *Criminal justice outcomes.* Deflection programs can contribute to crime reduction, depending on how they are built. However, because it is a prevention-type approach, this type of outcome is likelier to be demonstrated over a longer period of time rather than immediately. Further, deflection programs are not appropriate for violent crime reduction and should not be considered as an intervention in that arena.

- *Low-threshold, case management, and timely treatment and service access:* Deflection programs create a low-bar, simple, rapid access point to community-based treatment, housing, and supportive services through a community case manager. After an initial encounter, ongoing case management in support of access to and continuity of care is often a critical component of deflection, a point sometimes missed in development efforts, to the detriment of participants.

2) **Consider expanding the definition of deflection in Illinois statute to include non-law enforcement first responders.** While deflection from law enforcement to community-based treatment and services is the approach focused on today, there is national momentum to expand deflection toward a broader, preventive approach. This entails deflection programs that equip non-police first responders (EMS and fire departments) to serve as the point of contact. Like law enforcement, they are well-positioned for this work, available on a 24/7/365 basis. The public act established by SB 3023 could be amended to reflect this revised definition, allowing EMS and fire departments to develop programs and seek funding in support of them.

3) **Broaden and sustain State investments and fully leverage federal grants and Medicaid dollars to support deflection program development, implementation, and service delivery.** Deflection relies on the State's substance use treatment system to provide services for program participants. It also often requires service navigation and other supports, such as transportation to treatment, which may not be billable in a Medicaid environment. Since FY19, the State has invested in grants for local development and expansion of deflection programs, and has also brought in federal funds to do the same. Outside of these limited grants, the State has authorized a federal 1115 Medicaid waiver to allow reimbursement for case management that supports criminal justice clients receiving substance use disorder treatment, and there are efforts within the Department of Human Services to determine a funding strategy to apply these funds in the service of deflection. Investments in the community-based treatment system, including case management, recovery supports, and other services are critical to the future of deflection in Illinois, and must continue. This is critical because in deflection, there is a gap between when the encounter with the person occurs and when they are able to access treatment and services. This period, known as the warm-handoff, requires a gap funding source so contact and engagement with the person deflected continues until they are engaged in treatment and services. Following that, funding for medium- and long-term case management is needed.

In summary, deflection can divert people with behavioral healthcare needs from the justice system at its front door, before people even enter it. From a racial equity standpoint, this is the main lift of deflection—reducing the number of people making their way through the system by preventing arrests that lead to jail, court cases, convictions, and prison. Indeed, deflection is the only initiative of its type that can do this for those who would otherwise become or are justice-involved. Again here, deflection must be developed with a racial equity lens as well, looking for and addressing inequities before they set in.

As TASC's President, Pam Rodriguez, noted here last week, deflection has untapped potential in Illinois. As a still-developing field, we should not be surprised that it requires a little time to take root. This is the case here, as it is across the country. But we have authorizing and guiding legislation, and we must work to put what we are learning into practice in our communities, for the mutual benefit of our residents and justice systems alike. TASC's Center for Health and Justice, along with PTACC, stand ready to offer our experience, assistance, and partnership to the State and its communities who want to know more about deflection—whether police-led, or as is the focus of today's hearing, as alternative to police-led approaches such as co-responder deflection or community responder deflection. We're glad to share what we have learned to inform policymaking, program development and implementation, and evaluation. Thank you again for the opportunity to speak today.

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Endnotes

[1] Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[2] Bronson, J. and Stroop, J. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics: NCJ 250546. Retrieved from https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf.

[3] National Research Council. (2014). *The Growth of Incarceration in the United States: Exploring Causes and Consequences.* Washington, DC: The National Academies Press. https://doi.org/10.17226/18613. *NOTE: See chapter 7 for a discussion of the consequences of incarceration on health and mental health, chapter 8 for a discussion of the consequences related to future employment and earning potential, and chapter 9 for a discussion of consequences for families and children.*