

EXAMINING THE IMPACTS OF ARREST DEFLECTION STRATEGIES ON JAIL REDUCTION EFFORTS

Pima County, AZ



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This report was created with support from the John D. and Catherine T. MacArthur Foundation as part of the Safety and Justice Challenge, which seeks to reduce over-incarceration by changing the way America thinks about and uses jails. Core to the Challenge is a competition designed to support efforts to improve local criminal justice systems across the country that are working to safely reduce over-reliance on jails, with a particular focus on addressing disproportionate impact on low-income individuals and communities of color.

www.SafetyandJusticeChallenge.org.

ABOUT JSP

JUSTICE SYSTEM PARTNERS

JSP is a non-profit, multidisciplinary team committed to assisting criminal and juvenile legal systems and community partners with transforming their systems. We help our partners reimagine their work by combining rigorous research, technical assistance, and knowledge of evidence-informed strategies. We infuse creativity, innovation, and passion into our work, taking an integrated approach to system transformation to help our partners operationalize meaningful change.

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WHY STUDY POLICE-LED DEFLECTIONS

US jails have recently earned the moniker “the new asylums” for the rising number of individuals with psychiatric needs and substance use disorders confined within them. Some calculations estimate that nearly 20 percent of individuals confined in jails have a severe mental health diagnosis (SMHD) and nearly 65 percent have a substance use disorder (SUD). Research shows individuals with SMHD and SUD receive lower quality of services while in custody, are vulnerable to longer-and more frequent jail stays and are more expensive to house in custody. Reducing jail populations requires jurisdictions critically examine the practices bringing these populations through the criminal legal system’s front door.

In response, many jurisdictions have implemented citation-and-release programs which help to reduce jail populations, but still entangle the individual with the legal system when linkage to community-based services is often more appropriate. Jurisdictions also implement diversion programs which offer case dismissals pending completion of a court-appointed treatment program. However, these programs leverage the threat of punishment to elicit compliance. Both strategies reduce the collateral consequences of jail booking and arrest in various ways, but do not eliminate them. For individuals who experience these options, they *still* technically enter the legal system’s front door.

Therefore, truly reducing jail populations while eliminating the collateral consequences of the legal system requires jurisdictions to think **bolder**. It requires opportunities to reduce reliance on citation or arrest, especially for populations with SMHD, *while also* providing individuals the help and referrals they need to be well.

Police-led deflection accomplishes both goals.

Deflection allows police discretion to replace arrest with outreach to community-based service providers. Importantly, deflection eliminates criminal legal system involvement, allowing those who need intervention to avoid the additional weight and collateral consequences of the legal system.

Understanding how these programs work in practice and how police make decisions about who to triage out of the legal system is key to improving and expanding these programs, reducing jail populations, and ensuring individuals get the help they need.

EXECUTIVE SUMMARY

PIMA COUNTY,
ARIZONA

Reducing jail populations and the collateral consequences of the legal system requires jurisdictions to critically examine the practices bringing these populations through the criminal legal system's front door. It requires implementing opportunities to reduce reliance on citation or arrest/booking, especially for populations with SMHD and SUD, *while also* providing individuals the help and referrals they need to be well.

Police-led deflection accomplishes both goals.

Deflection allows police discretion to replace arrest with outreach to community-based service providers. Importantly, deflection eliminates involvement in the legal system, allowing those who need more relevant interventions to avoid the additional weight and collateral consequences of arrest. Importantly, continued deflection for the same individual to resources is a positive outcome because it ensures the individual is consistently receiving treatment services instead of jail time. Further, consistent deflection to these services reflects the process of recovery which suggests individuals require many opportunities to initiate and engage fully in treatment. Understanding how these programs work in practice and how police make decisions about who to triage out of the legal system is key to improving and expanding these programs, reducing jail populations, and helping individuals get the help they need.

The goal of this research is to understand how deflection of individuals with SMHD/SUD operates in Pima County, AZ. In 2011, the county opened the Crisis Response Center (CRC), providing police access to emergency psychiatric and substance use services. Specifically, the CRC offers case management, individual and group therapies, peer supports, and medication education and management. The CRC is open 24/7 allowing officers a true alternative to jail as the primary mechanism for treatment and support for these populations any time of day. As such this work focuses on the CRC and its impact on reducing the jail population via police-led deflection. There are two primary research questions driving this work:

- (1) how does deflection to the CRC predict continued access to the CRC and exit from the criminal legal system, impacting jail reduction efforts, and
- (2) how do police make decisions about who and when to deflect individuals to community services broadly and to the CRC, specifically?

DATA OVERVIEW

We use administrative admission data from the Crisis Response Center (CRC) from February 2018 through February 2020 to understand the various experiences of individuals deflected to the CRC.

KEY QUANTITATIVE FINDINGS

- 》》》 Police in Pima County deflected 6,545 unique individuals over 11,018 deflections.
- 》》》 All individuals deflected to the CRC had a DSM Axis-I diagnoses, or a severe mental health diagnoses and 46% also had a co-occurring substance use disorder, aligning with previous research about the prevalence of these co-occurring diagnoses for individuals with police contact.
- 》》》 During their first visit to the CRC, 58.8% of individuals, on average, stay just under a half day (9.84 hours).
- 》》》 When individuals who first receive a voluntary deflection (compared to a legal commitment to the CRC) come back for a second time, they stay for much longer the second time and are more likely to continue coming back via deflection. This might speak to their treatment readiness, the process of recovery, and suggests getting these individuals to- and through CRC's front door at least twice is important.
- 》》》 For Black individuals with SMHD, individuals with OUD/SMHD, and individuals with SUD/SMHD, if they were voluntarily deflected to the CRC a second time, they stayed longer on the second trip and continued to subsequently come back and stay longer during those trips. For these specific subgroups, ensuring they are deflected a second time is important for how much programming dosage they continue to receive within and across visits.

DATA OVERVIEW

We use data from semi-structured interviews with 16 patrol officers from the Tucson Police Department (TPD). These officers work in both specialty units and in traditional patrol functions. JSP conducted interviews via Zoom and, on average, they lasted 56 minutes. Officers were majority men, had at least five years experience with TPD, and primarily worked the day shift (0700 – 1700).

KEY QUALITATIVE FINDINGS

Officers note the core of taking a behavioral health approach via deflection strategies is the ability to consistently deflect individuals regardless of their previous experiences with deflections.

Officers from specialty teams highlight the flexibility of their time as a central feature of their work because they are not responsible to the 911-dispatch queue. This allows them the flexibility and freedom to spend additional time building rapport with people in crisis and in need of services.

Officers describe five factors they consider when making a deflection decision: (1) underlying offense or situation; (2) the presence of drugs; (3) if there is a victim or complainant; (4) if any offenses include domestic violence; and (5) cooperation and willingness to engage in treatment. Officers state an individual's willingness to engage in treatment is the most salient factor they consider when the situation is deflection-eligible.

Officers describe the tension between an individual not wishing to visit the CRC and the negative impacts of an arrest, and express concern about how best to navigate these situations.

Officers describe four factors they consider when deciding *where* to deflect the individual: (1) the location of the provider compared to their current location; (2) the time the provider typically takes for an intake (and ultimately the time it will take to return in the field); (3) the rules and eligibility requirements of the provider; and (4) their relationships with the provider. Officers explain their personal relationships with providers matter the most to effectively broker the resource and successfully secure a warm hand-off/transport to the provider.

Staff passionately discuss the importance of deflection for their community members, *and* describe the emotional challenges of working with these individuals.

KEY STUDY TAKE AWAYS

Officers report an individual's willingness to initiate treatment is the most critical factor when deciding to deflect. However, when an individual does not wish to initiate treatment, officers recognize the alternative response is to arrest – even when they recognize jail is not helpful. This tension demands a critical examination about the need for *any* response to deflection-eligible offenses when individuals do not wish to initiate treatment.

When individuals who first received a voluntary deflection to the CRC come back, they stay longer each time (programming dosage). This might speak to the process of recovery and the importance of getting individuals to- and through the CRC's front door twice is important. Securing these subsequent visits requires officers subscribe to deflection as the *primary* response in the field.

Deflection first, arrest rare as both policy and principle connects vulnerable individuals to the services they need while *eliminating* the collateral consequences of the legal system. It also lessens opportunities for implicit bias, determinations of worthiness, and non-clinical judgements about readiness for change to impact the decision to deflect.

**PIMA COUNTY & THE CRISIS
RESPONSE CENTER (CRC)**

PIMA COUNTY & SERVICES



Located in the south-central region of the state and the northern range of the Sonoran Desert, Pima County includes mountain ranges, cactus forests, river valleys, and several desert washes. It is one of the oldest continuously inhabited areas of the United States and is situated on the traditional lands of the Akimel O’otham and Tohono O’odham people. It is designated as the Tucson, AZ Metropolitan Statistical Area where the majority of the one-million residents live. According to the latest census information, Pima County is 76% white, 3.7% Black, 3.9% American Indian/Alaskan Native, 2.8% Asian, .2% Native Hawaiian and Other Pacific Islander, and 5.7% bi/multi-racial. Across these races, over one third of residents, 37.8%, identify as Hispanic or Latino. Given the traditional lands on which Pima County is situated and concerns about census exclusion and underreporting for Native Americans living on reservations, these numbers should be taken with caution.

Over the last 10 years, Pima County has had a front row seat to several sentinel events, including an accelerating opioid epidemic resulting in annual record-breaking overdoses and a mass casualty event resulting in the deaths of six residents and injuries to 13 residents including US Representative Gabrielle Giffords at the hands of a man with signs of deteriorating mental health.

Traditionally, law enforcement agencies and local criminal legal systems have responded to illegal behaviors instigated by severe mental health diagnoses and substance use disorders with arrest and jail bookings. However, after these events and growing public concern by Pima County residents, Tucson Police Department (TPD), the county’s largest municipal police department with 850 sworn officers and 400 civilian personnel, critically examined their role in the unnecessary entry of individuals with severe needs into jails where they are unlikely to receive mental health care.

In a 2020 interview with *The Philadelphia Citizen*, TPD Chief Magnus reflects on TPD’s historic arrest-only practices for these residents,

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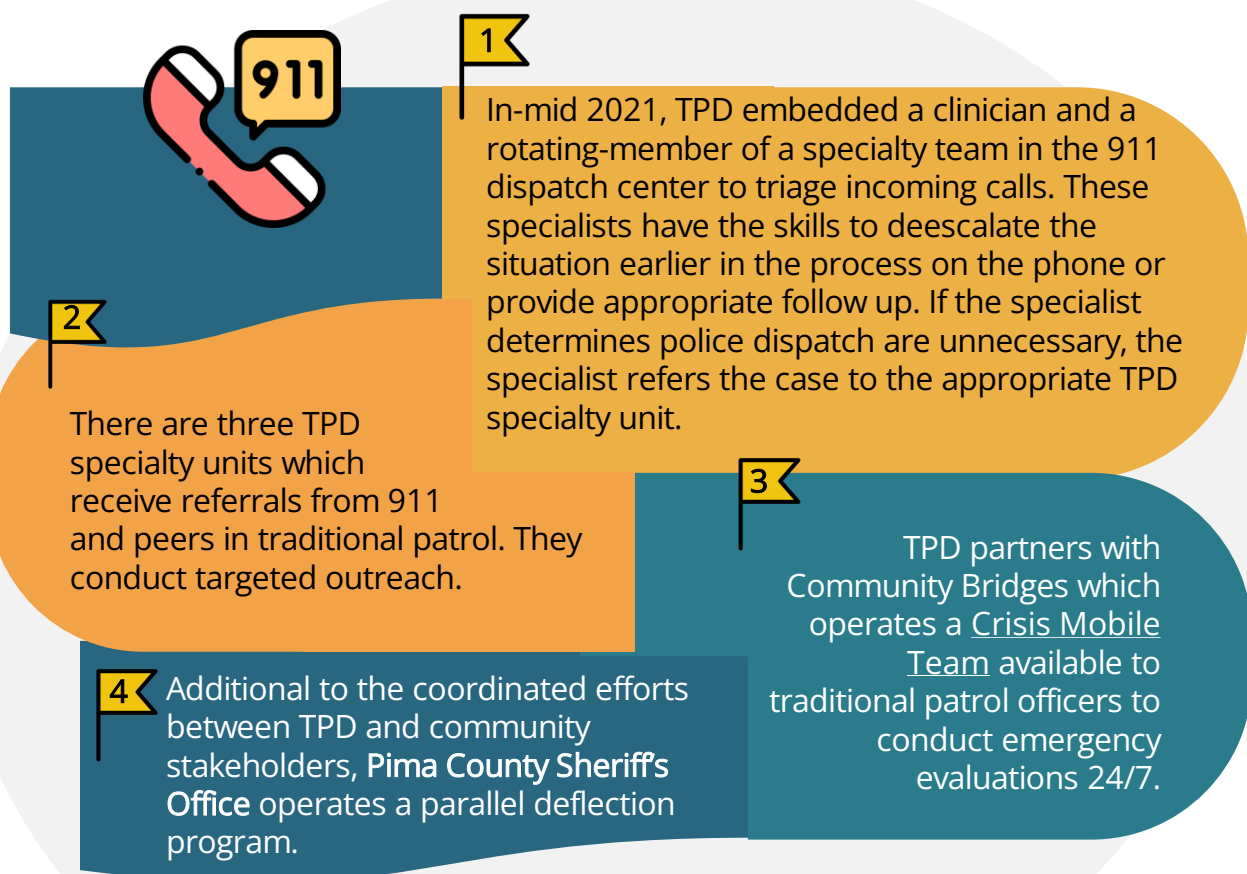
We’re really trying to develop the resources and do some cultural change around the idea that arresting people or chasing them down is a measure of success and should be celebrated. We’ve moved away from that.

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THE LARGER TPD SUPPORT SERVICES ECOSYSTEM

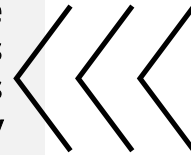
In 2011, TPD began an evolution of changing how they do business particularly to reduce the jail population. The goal of these changes included improving access to behavioral health services as early and as often as possible instead of relying on arrest and jail as the primary treatment provider. As such, TPD recast police professionals as resource brokers who prioritize treatment and intervention as the outcome of compassionate interactions over arrest and incarceration.

Reshaping the role of the police included implementing several strategies throughout their agency to work in a coordinated effort to deflect individuals from the legal system and connect individuals with the resources they need as early as possible. The figure below details some of those supports additional to the deflection strategy.



THE CRISIS RESPONSE CENTER (CRC)

The CRC was built with Pima County Bond funds as an alternative to jail, emergency rooms, and hospitals in 2011. It is part of the Banner-University of Arizona Medical Center South Campus and is managed by Connections Health Solutions. The facility also houses the crisis line and is connected via a breezeway to an emergency department, inpatient psychiatric hospital, and mental health court. Services are funded by the Regional Behavioral Health Authority via a combination of Medicaid and other state and federal funds.



The CRC operates by a “no wrong door” policy backed by a “figure out how to say yes instead of looking for reasons to say no” approach¹. They accept drops offs by any law enforcement agency in the county. Of the ten law enforcement agencies, two are primarily responsible for 85% of all drop offs to the CRC:



Tucson Police Department (TPD)



Pima County Sheriff’s Office (PCSO)

The remaining eight agencies represent town, tribal, and collegiate police including:



Marana PD, Oro Valley PD, Sahuarita PD, South Tucson PD, University of Arizona PD, Pima County Community College PD, Tohono O’odham PD, and Pasqua Yaqui PD.

The CRC maintains its own law enforcement entrance to help make the deflection to the CRC as easy as possible for police. Once they arrive, the CRC intake worker meets the officer and the individual at a secure entrance for a warm handoff. At this point, if an individual does not have a legal commitment to the CRC, they can choose to leave and not initiate treatment with the CRC. In these cases, officers do not arrest.

Importantly, as a matter of local practice, once the officer makes the decision to deflect an individual anywhere, including the CRC, they do not arrest regardless if the individual initiates treatment.

¹From personal correspondence with the director of the CRC on October 21, 2020.

CRC ELIGIBILITY

The CRC has no exclusions for behavioral acuity, level of agitation/violence, intoxication, or need for medical detox. If a patient is medically unstable upon arrival, CRC staff performs an assessment and provides emergency care while transfer to the Emergency Department is arranged. Once medically stable, the individual is transferred back to the CRC. This flexibility of acceptance ensures that police, under almost all circumstances, have an alternative to arrest.

CRC PROGRAMMATIC COMPONENTS

If an individual chooses to initiate treatment or the officer transports an individual with a legal commitment, then the intake worker begins the psychosocial assessment which includes the Columbia Suicide Severity Rating Scale. Individuals admitted to the 23-hour observation unit receive a nursing assessment and psychiatric evaluation by a Behavioral Health Medical Provider (e.g., psychiatrist, nurse practitioner, physician assistant). Typically, the nursing assessment occurs upon admission to the 23-hour observation unit and the psychiatric evaluation occurs as soon as possible. For adults, the median “door-to-doctor” time is 90-120 minutes. For youth arriving in the evening to the CRC, the psychiatric evaluation typically occurs the next morning. There is also a short-term inpatient unit which has a length of stay of two to five days.

Following all assessments, individuals receive a menu of services, including:

- Medication education and management
- Limited case management (ID, clothing etc.)
- Benefits counseling (SNAP/WIC)
- Individual substance use therapy and Buprenorphine inductions (if appropriate)
- Pet Therapy
- Group substance use therapy
- Individual, group, and family therapy
- Individual peer support therapy
- Limited family therapy and education, and
- Discharge Planning and coordination of care with family and other supports, including treatment providers.

**RESEARCH QUESTIONS,
DATA & APPROACH**

The bottom of the page features a decorative graphic consisting of overlapping geometric shapes. A large, solid orange shape is on the left, and a lighter, semi-transparent yellow shape overlaps it from the right, extending towards the top right corner.

RESEARCH QUESTIONS

This study focuses on the Crisis Response Center and its impact on reducing the jail population via police-led deflections. Two primary research questions drive this work:

- (1) how does deflection to the CRC predict continued access to the CRC and exit from the criminal legal system, impacting jail reduction efforts, and
- (2) how do police make decisions about who and when to deflect individuals to community services broadly and to the CRC, specifically?



DATA & APPROACH

To answer the first question, we worked with the CRC to identify all individuals who were deflected to the CRC *for the first time by police* between July 2018 and February 2020 (N=6,545). These police deflections included either voluntary referral or an involuntary commitment. Individuals who receive a police referral via an involuntary commitment are typically transported to the CRC by TPD's specialty Mental Health Support Team (MHST). This team's role is to serve Orders for Evaluation resulting from an Application for Involuntary Evaluation, or locally called "petitions for evaluation." However, the administrative data does not parse out the origin of the involuntary commitment. We maintained these involuntary commitments within the data, knowing some are from the court and not a "true deflection" because they still suggest an incident occurred triggering a court and, thus police response.

The CRC's "no wrong door" policy and dedicated physical entrance for local law enforcement makes it as easy as possible for police to triage individuals out of the legal system revolving door and *into* a treatment revolving door via the CRC. To note, continuous deflection of the same person to the CRC is a positive outcome for the individual. Importantly, it ensures they continue to receive access to treatment services instead of jail, and reflects the process of recovery which suggests individuals may require several attempts at initiating treatment before committing and engaging with a program. As a result, our key outcome of interest is subsequent deflections to the CRC.

We conducted a series of descriptive statistics (described in findings) to understand the broad demographics of the individuals in our data set. We then conducted a time series analysis to understand individuals' experiences with deflection over time, and how that might differ when considering the intersection of race and diagnoses.

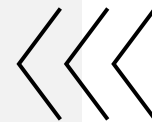


DATA & APPROACH

To answer the second question, we worked with the lead Sergeant of the Mental Health Support Team (MHST) to recruit officers from both patrol and TPD's specialty units – those primarily tasked with a wide range of behavioral health responsibilities, including deflection. Following targeted email recruitment, 22 officers indicated interest in the study, and we conducted semi-structured interviews with 16 officers. Each interview lasted, on average, 56 minutes and all participants consented to recording.

The interviews consisted of four focal areas:

- (1) deflection decision-making and experiences;
- (2) how officers decide where to deflect individuals;
- (3) perceptions of ease of use with community providers and resources used during deflection process, and;
- (4) perceptions of the role and responsibility of police to broker community resources during crisis.



Following the interview, we uploaded all transcribed interviews into a qualitative analysis software and used a semi-grounded theory approach. This means, we used each of the four focal areas to guide our initial coding scheme, but then allowed themes to emerge within these areas. We present the most representative quotes with pseudonyms when describing emergent themes.

We chose to use pseudonyms for two main reasons. First, it allows us to protect the confidentiality of our participants. Second, the use of pseudonyms, instead of role titles (e.g. patrol officer 1), serves to remind readers these voices are from active frontline staff and are representative of real experiences working with- and caring for these vulnerable populations in the community.

THE USE OF PSEUDONYMS REMINDS READERS THESE VOICES ARE FROM ACTIVE PATROL STAFF AND REPRESENTATIVE OF REAL EXPERIENCES WORKING WITH- AND CARING FOR THESE VULNERABLE POPULATIONS IN THE COMMUNITY.

QUANTITATIVE FINDINGS

The background features a white upper section and a lower section composed of overlapping geometric shapes. A dark orange shape is at the bottom left, a lighter orange shape is at the bottom right, and a yellow shape overlaps the top of the dark orange one.

STUDY DEMOGRAPHICS



11,018
DEFLECTIONS

HOW OFTEN DID PEOPLE
EXPERIENCE DEFLECTIONS TO THE
CRC BETWEEN JULY 2018 - MARCH
2020?

Police across Pima County made 11,018 deflections for 6,545 individuals to the CRC between July 2018 and March 2020. Based upon qualitative findings (described in the subsequent sections), officers use other community-based services additional to the CRC and, thus, this number might underrepresent the true total of unique deflections experienced by the CRC group and the wider community. Community members received deflection to the CRC via two primary statuses: voluntary status and involuntary status. Voluntary status includes individuals who willingly accepted an officer's offer for transport to the CRC following a police contact. Involuntary status reflects cases where there is a petition for evaluation ordered by the court or emergency evaluation typically initiated through the partnership between TPD and Community Bridges' Crisis Mobile Team.

Across first referrals, 67% included an involuntary transfer by police. However, over one-third (37%) of deflections included a voluntary transfer. This included 4,076 unique individuals who received treatment services instead of a jail booking.

WHO IS DEFLECTED TO THE CRC?

Two-thirds (68%) of individuals deflected were white, 8% were Black, 4% were Native American, 3% were Latinx, 2% were bi-racial, less than 1% were Asian, and 12.5% identified as another race. Although this demographic roughly reflects Pima County's larger demographic profile, there are significantly fewer deflections for Latinx

people than represented in the county (37.8%). This might reflect the CRC's practice of capturing "Latinx" as a race instead of an ethnicity. Specifically, this number looks higher if we reported ethnicity demographics instead of race. Continued work is critically necessary to understand if this underrepresentation is a function of how Latinx is captured, if this is a cultural reflection of how the Latinx community navigates crisis, and/or a result of potentially disparate deflections by police.

4,076 <<<

UNIQUE INDIVIDUALS
AGREED TO
VOLUNTARY REFERRAL

& RECEIVED
TREATMENT
SERVICES INSTEAD OF
A JAIL BOOKING.

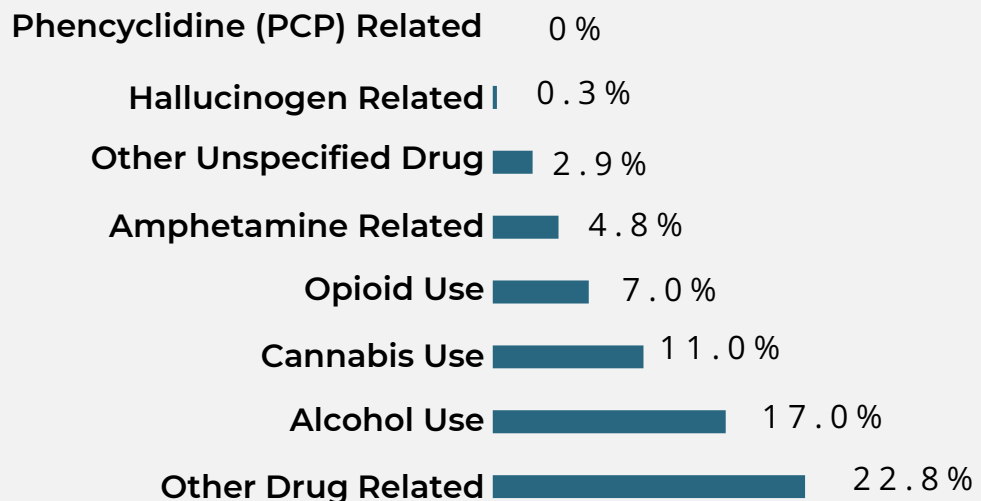
Individuals deflected to the CRC varied widely in age, from 5 to 89 years old. The representation by youth in this data is likely a result of the CRC as a primary resource for juvenile observation. Youth (individuals 17 and under) represent 18.5% of deflected individuals. However, on average, individuals were 33.8 years old. When coming into the CRC for the first time, over three-fourths of individuals (77%) reported living in their own apartment or home, 18% reported experiencing homelessness, 4% reported living in foster or group homes, and 1% reported living with family, in assisted living, in shelters, or in hotels/motels.

All 6,545 individuals deflected to the CRC had at least one primary Axis-I diagnosis. These diagnoses include: disruptive, impulse-control and conduct disorders, personality disorders, trauma- and stressor related disorders, anxiety disorders, bipolar and related disorders, depressive disorders, schizophrenia spectrum and other psychotic disorders, intellectual and emotional disabilities, and substance-related and addictive disorders.

Importantly, nearly half of individuals (46%) were diagnosed with a co-occurring substance use disorder, aligning with previous research about the common nexus between these two conditions.

PRIMARY SUBSTANCE USE DIAGNOSIS

% OF INDIVIDUALS WITH SUBSTANCE AS PRIMARY DRUG FOR SUD



NOTE: ALL INDIVIDUALS REPRESENTED HERE HAVE AN AXIS-1 DIAGNOSES, OR A SEVERE MENTAL HEALTH DIAGNOSES

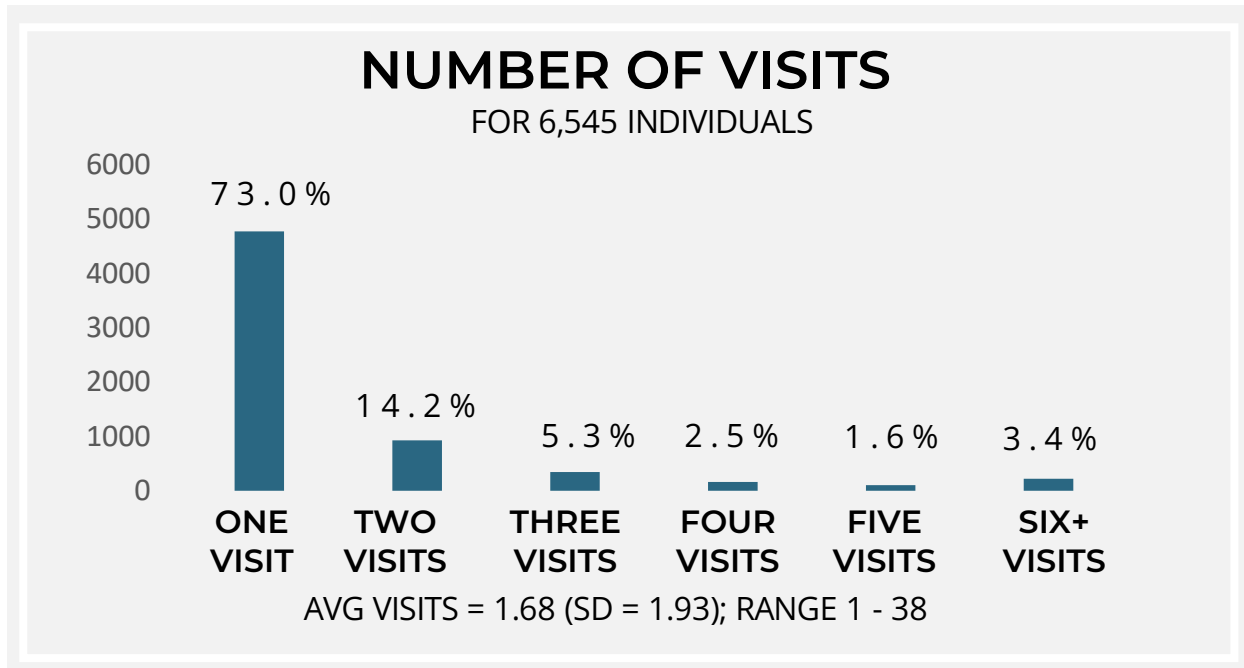
The data here states alcohol use disorder is the most significant substance related disorder among individuals who are deflected. However, alcohol use disorder did not significantly predict subsequent deflections to the CRC.

Interestingly, individuals with opioid use disorder account for only 7% of individuals deflected. Although we did not hypothesize a percent of representation, news and other reports we collected about the site indicate an accelerating opioid epidemic. However, it is possible those with opioid use disorders are deflected to community providers with a focus on substances and opioids, instead of crisis.

RESULTS

HOW OFTEN WERE THE SAME PEOPLE DEFLECTED TO THE CRC? AND, HOW LONG DID THEY STAY?

Across the 6,545 individuals deflected to the CRC, 4,778 or 73% were deflected only once, either via voluntary or involuntary status, but individuals ranged between this singular visit and 38 visits.



SIGNIFICANTLY LIKELY TO COME BACK AT LEAST ONCE
INDIVIDUALS

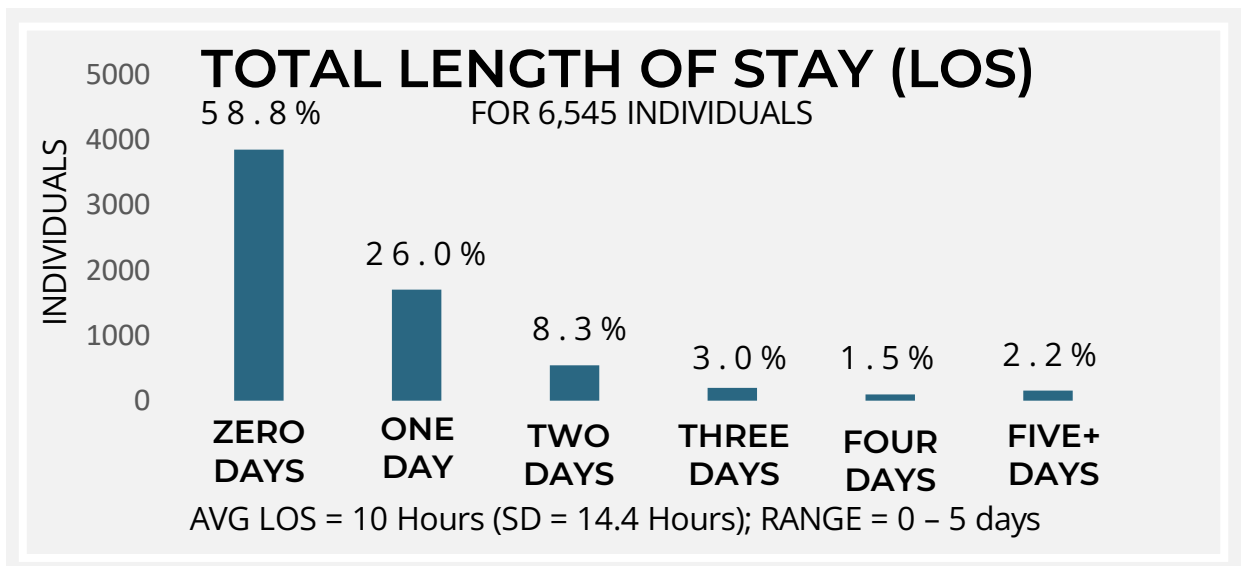
BLACK INDIVIDUALS* LIVING IN OTHERS' SPACES* INDIVIDUALS WITH SUD* INDIVIDUALS WITH OUD*

* & severe mental health diagnoses

Black individuals with SMHD were significantly more likely to come back at least once compared to all other racial groups, even though they only represent 8% of the data ($\chi^2(2) = 40.471, p < .001; \phi = .024, p < .01$). This effect was very weak and should be interpreted with caution, but this may be a function of disproportionate police contact Black individuals experience in the community. Nonetheless, their continued return to the CRC means they are moving through a revolving door of treatment instead of the legal system’s revolving door. Individuals with opioid use disorder (OUD) were also significantly more likely to come back to the CRC via deflection compared to individuals without OUD ($\chi^2(2) = 22.203, p < .001; \phi = .212, p < .01$). A TPD specialty team designated to do substance use related outreach and follow-up with non-fatal overdose cases might explain, in part, continued police contacts and deflections. Lastly, individuals living in other’s spaces compared to those living alone (e.g., family, group/foster homes, assisted/living) were significantly more likely to have at least two visits ($\chi^2(2) = 93.286, p < .001; \phi = .431, p < .01$). This effect was very strong and might indicate the ability of others to intervene and call police for assistance during crisis.

During their first visit to the CRC, 58.8% of individuals, on average, stay just under a half day or ten hours. For adults, the time from “door-to-doctor” is 90 to 120 minutes. This half day might reflect individuals receiving an assessment, then discussing with the Behavioral Health Medical Provider the need for their continued stay within the unit and discharging from the unit same day. Unfortunately, our data does not include time stamps to understand if same-day discharge occurred after the 90-to-120-minute range. Future research should consider why individuals leave “early,” and if there is an hour-mark tipping point that encourages continued stay. Individuals under 18 typically have longer lengths of stay because the CRC must obtain consent from a guardian for treatment.

The length of stay ranged from zero to five days. Five days reflects the full length of stay for short-term inpatient care before an individual is automatically discharged, and 104 individuals stayed the allowable five days.



WHAT ARE THE EXPERIENCES OF INDIVIDUALS WITH AT LEAST ONE DEFLECTION TO THE CRC?

EXPERIENCE 1: 45.8% (N=3,000)

INVOLUNTARY >>> CRC >>> NO SUBSEQUENT

EXPERIENCE 2: 27.2% (N=1,778)

VOLUNTARY >>> CRC >>> NO SUBSEQUENT

EXPERIENCE 3: 16.8% (N = 1,102)

INVOLUNTARY >>> CRC >>> SUBSEQUENT CRC

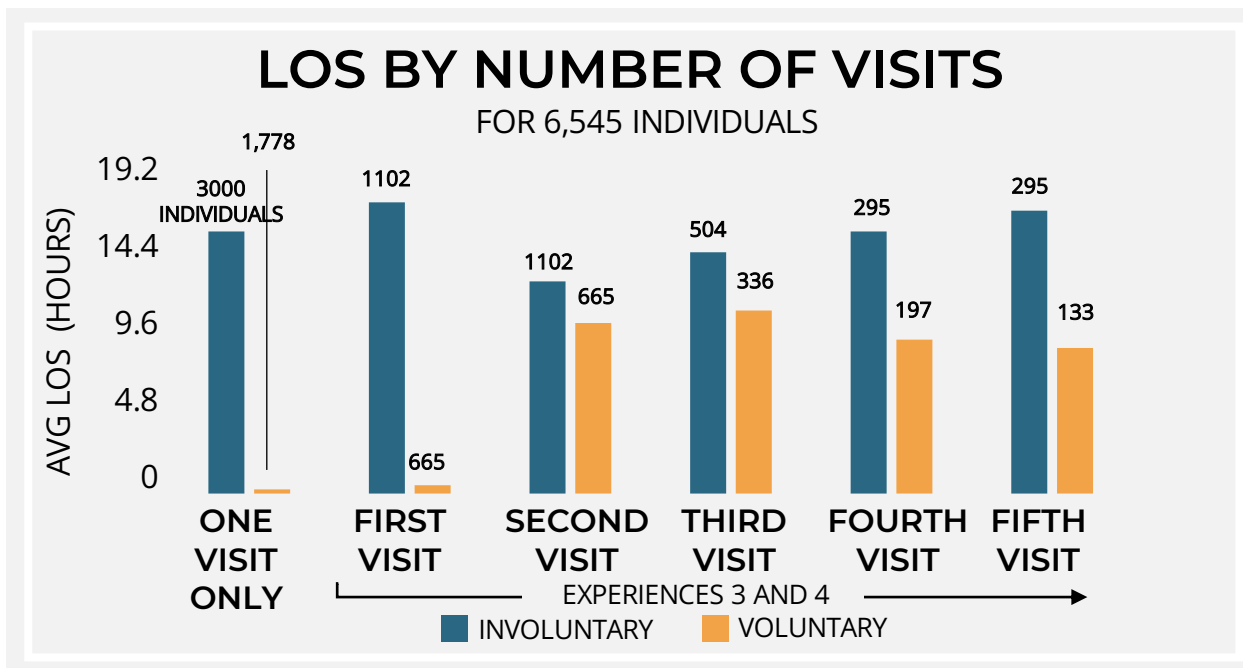
EXPERIENCE 4: 10.2% (N=665):

VOLUNTARY >>> CRC >>> SUBSEQUENT CRC

Across the individuals deflected to the CRC, there were four distinct experiences reflecting how the individual was initially referred to the CRC and whether they subsequently returned to the CRC. The first experience included individuals who were involuntarily referred to the CRC for their first visit and did not return (45.8% of individuals' experiences). The second experience includes individuals deflected by police in the field to the CRC but did not return (27.2% of individuals' experiences). Combined, 73% of individuals did not experience a subsequent visit to the CRC via police. How optimistic we can be about these findings is unclear – one visit may be enough to connect these individuals with the resources they need, particularly for individuals who experienced an involuntary referral. However, as we describe later, police consider an individual's wishes to initiate treatment as a primary factor when deflecting. Therefore, "one-timers" may be ready for treatment at the point of the deflection opportunity.

The third experience involves individuals who were initially involuntarily referred to the CRC and had subsequent visits that were either voluntary or involuntary (16.8% of individuals' experiences). Finally, the fourth experience involved individuals who were initially voluntarily referred to the CRC and had subsequent visits that were either voluntarily or involuntarily (10.2% of individuals' experiences). Combined, 27% of individuals had multiple visits to the CRC and represent a subset of individuals that are experiencing the treatment revolving door. However, this data does not include arrests as part of understanding an individual's full experience with both the legal system and treatment revolving door. It is possible between deflections to the CRC (or other providers) an individual is arrested. Unfortunately, the data presented here cannot tease this out, but future research should consider how individuals simultaneously experience both revolving doors.

Involvement with the revolving door of treatment is positive because it eliminates the jail experience while providing an individual with increased opportunities for treatment initiation and engagement. Importantly, treatment research suggests individuals may need several opportunities for access to treatment before agreeing to initiate treatment. Further, this research suggests once initiated, individuals may need several more opportunities to remain engaged. To be clear, this does not suggest individuals have failed treatment when they do initiate or do not remain engaged. There are several reasons an individual may choose to leave any program early such as finances/insurance, need to return to work/family life, and culturally irrelevant experiences with the treatment itself.

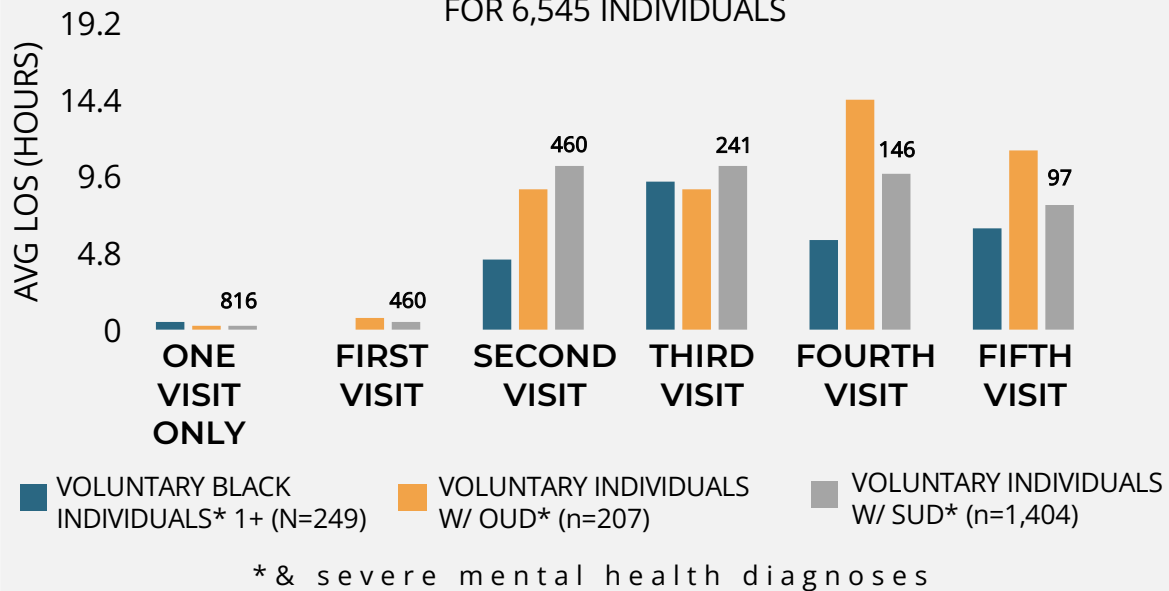


For individuals initially referred to the CRC involuntarily and only had one visit, they stay substantially longer than those individuals who came to the CRC by a voluntary police deflection. This is also true for individuals who are involuntarily referred to the CRC and come back multiple times. In other words, those who are likely actively in crisis and require an involuntary transfer are getting more treatment in a singular visits and over time. Simply, those with an involuntary transport benefit the most by simply showing up.

Within individuals who are initially deflected by voluntary transport and do not return, 2,414 are discharged on the same day. However, when individuals who first receive a voluntary transport then receive a subsequent deflection back to the CRC, they stay for much longer each new time. This suggests getting these individuals to-and through CRC's front door is important for how they continue to engage with the provider.

LOS BY NUMBER OF VISITS BY VOLUNTARY

FOR 6,545 INDIVIDUALS



We continued to dig deeper into voluntary deflections to understand who has access to the CRC when it ultimately up to police. By understanding the demographic profile of individuals who return to the CRC, we can understand who has access to the revolving door of treatment, but importantly who does not. Therefore, we looked at the intersection of race, disability and co-occurring substance use disorder. For Black individuals with SMHD, individuals with OUD/SMHD, and individuals with SUD/SMHD, if they were voluntarily deflected to the CRC a second time, they continued to come back and stay longer each time.

Continuous deflections for this subgroup might reflect both individuals' wishes to initiate treatment *and* the types of people police more often have contact. As such, if police have more contact with these sub-groups, then these groups are equally vulnerable for increased jail bookings if officers do not offer deflection. This suggests securing this second visit requires that officers subscribe to deflection as the *primary* response in the field.

WE MUST CHALLENGE OURSELVES TO CONSIDER DEFLECTION AS THE PRIMARY RESPONSE BY POLICE IN THE FIELD.

QUALITATIVE FINDINGS

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INTERVIEW RECRUITMENT & SAMPLE



We met with executive command staff at TPD to introduce the goals of the project, intention of the interviews, and how we plan to use the data. Once command staff agreed staff could participate, they connected us with the supervising Sergeant of one of the specialty teams. We provided the Sergeant a pre-authored email with an embedded Survey Monkey link for research participation. This strategy allowed a local representative to introduce the project to staff, while maintaining the confidentiality of participants. As officers signed up for the interview via the link, the lead researcher on the project then reached out to coordinate a meeting time and sent a calendar invitation with an embedded private-Zoom link for the interview. We agreed to conduct interviews when they were most convenient for officers to attend while working around police shift work.

Following the interview, the lead researcher sent a follow-up thank you email acknowledging the officer for sharing their time. This email also included the Survey Monkey study registration link to allow officers to forward the email to other staff, if they felt inclined. In this way, our approach to recruitment took both a convenience sample approach via the Sergeant's initial email list and a snowball sampling strategy.

In total, 22 officers expressed interest in the research, and we conducted semi-structured interviews with 16 officers. Although patrol officers were included in the recruitment strategy, 87.5% of the officers represented one of three specialty units:

MENTAL HEALTH SUPPORT TEAM (MHST)
SUBSTANCE USE RESOURCE TEAM (SURT)
HOMELESS OUTREACH TEAM (HOT)

On average, police participants had at least five years experience with TPD, primarily worked the day shift (0700 – 1700), and 75% of participants were men. We present the most representative quotes with pseudonyms when describing emergent themes.

ITERATING ON THE FLY

Prior to conducting the interviews, we had nearly no knowledge of the differences of the specialty teams, their primary functions, and how their roles relate to deflection practices more broadly. Initially, we intended to simply talk with officers about deflection decisions. However, we quickly realized their unique roles within TPD contextualized *why* they valued and prioritized deflection day-to-day and why they had so many experiences with deflection. As such, we decided to amend the semi-structure interview protocol and added three additional focal areas about:

- (1) the unit and its function;
- (2) training and preparedness for the unit, and;
- (3) how the unit primarily receives referrals.

We present these additional focal areas first to help contextualize the responses to the remaining focal areas from the original interview protocol.

RESULTS

WHAT IS THE CENTRAL FUNCTION OF THE TEAM AND HOW DOES THE TEAM APPROACH THEIR WORK?

TPD prioritizes compassionate interactions between police and the community. To this end, the responsibilities, structures, and practices informing each of the specialty units are designed to provide officers the training, knowledge, and experience necessary to de-emphasize arrest/citation and, instead, emphasize more appropriate alternatives. While each of the units differ in their central behavioral health focus, their combined work helps tackle root-causes of crime and proactively connect people with services prior to a behavioral health crisis.

THE MENTAL HEALTH SUPPORT TEAM (MHST)

MHST is outfitted with a sergeant, two detectives, and five officers. The team is primarily tasked with locating individuals serving petitions for evaluation. As a separate unit, officers are not beholden to the 911-dispatch queue. As a result, they can execute the petition for evaluation without worry of needing to leave the interaction for an in-coming call-for-service. This flexibility allows officers the time they need to serve the petition, prepare the individual to leave their homes/belongings, and de-escalate any resistance to the petition.

Although they have the power to force an individual into their car for a transport, their unit policy is to rely on non-violent communication to convince a person to the transport. Then, they transport the individual to the provider as described in

the petition; this is usually a local hospital or the CRC. In this way, the structure of the unit deemphasizes traditional police performance metrics of “clearing cases” and emphasizes compassionate interactions between police and the community members they serve.

THE SUBSTANCE USE RESOURCE TEAM (SURT)

SURT is outfitted with a sergeant and six officers. The team primarily conducts active outreach in the community, along with two peer support specialists (PSS) from CODAC, a community provider. Together, they form a cooperative co-response model, working together to engage individuals suffering from substance use disorder (SUD). These co-responders travel to tunnels, desert washes, and other known areas for drug use. At the point of contact, the CODAC-PSS, who has lived experience with the criminal legal system and SUD, talks with residents about initiating treatment and provides information about CODAC and other services. If an individual agrees to initiate treatment, the officer will transport the individual to the community provider.

SURT officers are also assigned non-fatal opioid overdose cases for follow-up. When SURT conducts follow-up on these cases, they provide the person Naloxone, along with providing resource and treatment options. In 2020, SURT provided over 500 Naloxone kits into the community.

Combined, this co-responder model combines the unique experience of peer support specialists with law enforcement personnel to provide referrals, intervention, and/or placement in treatment facilities for individuals needing medication for opioid use disorder (MOUD).

THE HOMELESS OUTREACH TEAM (HOT)

HOT is the most recently formed of the specialty units and is outfitted with a sergeant and two officers. They approach their work with the understanding that homelessness is often a symptom of SUD and SMHD and not a crime. The team partners with a housing navigator from a local community provider to conduct targeted outreach to individuals or targeted outreach to larger encampments to connect individuals with the housing voucher program. This outreach includes the VI-SPDAT assessment which determines a person’s level of vulnerability and need. Higher scores on the assessment can place someone higher on the voucher list and expedites their housing placement. HOT also works to locate individuals when they are selected for the housing voucher.

At times, large encampments must be moved from private areas or as the result of community complaints. In these cases, the team follows the county protocols to work with waste management to clean the area and work with encampment residents to find- and transport them to an appropriate relocation area. During these moves, officers will also conduct a VI-SPDAT assessment.

HOW DO THE TEAMS RECEIVE REFERRALS AND WORK?

By the nature of their units' charge and daily responsibilities, MHST, SURT, and HOT principally lead the agency in deflections in lieu of arrest. There are four primary pathways in which these teams engage with citizens; although, **not all interactions and pathways for deflection involve probable cause for arrest.**



CALL FOR SERVICE

First, a specialty unit officer might engage with a citizen in more traditional scenarios including dispatched by 911, called as back-up to a call-for-service, or through an officer-initiated stop. These engagements are the most likely to have probable cause for arrest and present more opportunities for deflection in lieu of arrest.



SELF REFERRAL

Police also engage with citizens through self referrals, where an individual comes to the police station seeking help or through a social referral when a person contacts the specialty unit directly seeking help for a person. The HOT specifically advertises the team's referral email on the local news for citizens to report encampments directly to them instead of using emergency services to report the issue. These pathways present less opportunities for deflection in lieu of arrest as the individuals in need are typically not involved in criminal behavior but are opportunities TPD can connect residents with resources and treatment.



SOCIAL REFERRAL



ACTIVE OUTREACH

Lastly, each of the units conducts their own outreach to connect residents with services. In these interactions, particularly for SURT and HOT, there are opportunities to deflect in lieu of arrest.

WHAT TRAINING IS RECEIVED, HOW PREPARED DO OFFICERS FEEL TO DO THIS WORK, AND WHAT HELPS THEM DO THIS WORK?

RECRUITMENT

As a designated specialty team, placement on the unit requires an administrative screening process. This process requires a prospective officer to submit a memorandum of interest to the unit's leadership detailing their law enforcement experience and interest in the unit. Based upon these submissions, leadership selects individuals to participate in an oral board where they are asked more specific follow up questions about their interest in the unit and how they would approach the work. From these conversations, leadership selects the top candidates for placement on the unit. Often there are limited positions and those selected are placed on a waiting list.

Many officers working in these units report they feel the behavioral health approach comes naturally to them or makes intuitive sense. This recruitment and application process then potentially funnels like-minded officers into the units who are uniquely prepared to take on the work.

TRAINING & PREPAREDNESS


Police must make several critical decisions about people throughout a single shift. Often, officers make decisions with limited information presented on scene and bounded by few trainings discussing behavioral health. For those who ultimately work on TPD's specialty teams, their trainings are far more exhaustive than their traditional patrol peers. The trainings offered aim to reduce the stigma associated with mental health, substance use disorder, and homelessness; increase awareness of presentation of symptomology in the field, and; build understanding that access to treatment is a legitimate approach to public safety.

Some officers come into the unit as members of other teams: Hostage Negotiation Team or Special Weapons and Tactics (SWAT). Officers with dual membership discuss the transferability of these teams' skills to the behavioral health work of their specialty team.

For most officers they receive additional trainings once working in the unit. These additional trainings include:

- Mental Health First Aid (MHFA),
- De-escalation Training,
- Active Listening Training,
- Motivational Interviewing,
- Adverse Childhood Experiences (ACEs) training, and
- Trauma-Informed care Training.

For some officers, trainings helped them understand the context for these behaviors and helped build empathy for the citizens they serve. Officers also discuss how these training helped them understand the nexus of mental health and substance use, symptomatic behaviors that can present in the field, and how best to create compassionate interactions with individuals in crisis. Officer Dez describes the training most impactful to him,




One thing that helped me wrap my head around substance use was the ACEs training. It helped me understand how to deal with some of these people and say, "You're not okay and you're not thinking straight, but I understand how you got here." You have to think to yourself, what did this person go through in their childhood? What made them get to the point they're at now? What kind of trauma did they live through for them to make these choices? So, that helped me a lot to understand them.



SKILLS & APPROACH


When asked about the types of skills necessary to do this work well, participants described only soft skills, including the most discussed skill of *patience*. Many officers noted these skills are the same skills needed working patrol, but the contexts and situations mean they lean on these skills more often than their patrol peers, as noted by officer Henry,



Having patience helps in patrol, but you just have to have a uniquely higher bandwidth for patience in this setting.




Additional to patience, officers describe the need for *communication skills*, *active listening skills*, *kindheartedness*, *understanding*, and the *ability to connect with people* or *relate*. Throughout the discussions about skills, many officers began highlighting the priority of compassionate interactions as described by officer Hodge,



The people we come across don't think we get it. You don't want to say the wrong thing and then they get agitated. Really, it's about being compassionate and understanding. Your job is to let them believe that you totally understand where they're coming from. You don't demean them because they're homeless or they're in the situation that they're in. You have to show compassion, talk and show them that you care - just relate.



The ability to show compassion and relate to individuals was a central theme when discussing successful officers and the unit's approach to the work. Many emphasized not using stigmatizing language, softening their demeanor in the interaction, and showing empathy. In this way, the trainings offered to build these skills are evidenced in how much officers prioritize these skills, as described by Officer Renolds,




Oh, you need compassion. If you don't have compassion for people, I really would see this work being tough because a lot of these people have been through an insane amount of trauma. They didn't decide one day to wake up and do drugs and be homeless. It's about having compassion for people and real empathy.



HOW DO OFFICERS MAKE DECISIONS IN THE FIELD TO DEFLECT? WHAT FACTORS DO THEY CONSIDER IN THESE DECISIONS?

OFFERING DEFLECTION

All officers note the opportunity for deflection is only contingent upon the offense and is not constrained by previous offerings for deflection. Officer Grove offers important insight about the need to offer on-going deflection opportunities,



It doesn't matter if I've offered it to him before, I can offer it again. That's important because we've learned it takes something like upwards of 14 tries before someone agrees *and* commits to getting clean. I know I'll see him again next week, and I'll offer it again.



In the spirit of TPD's behavioral health approach, the unit officers and the policy acknowledge the recurring nature of the issues they are trying to reduce. In fact, many of the SURT officers specifically describe many experiences deflecting the same people and even note they expect to offer many opportunities of deflection to the same people. Officer Mead details this expectation,



It's a cycle because if they're using drugs, they either got addicted because of a legitimate prescription or self-medicating for some underlying issues. So, continuing to arrest them every time I see them and put them in the criminal justice system isn't solving the problem. It's only making it hard for them, especially if they also have mental health issues. It is really hard navigating the mental health system while you're also navigating the criminal justice system. And, if you're homeless on top of that. For them, their biggest concern is where am I going to lay my head or how am I going to get something to eat. Or, maybe it's how am I going to get enough drugs to keep from being sick. They aren't concerned about court dates. They're just concerned about living in the moment. So, I'd rather just continue to bring them to the places that can help them fix those underlying problems.



DECISION MAKING

While officers note the importance of offering deflection in lieu of arrest and their inclination to offer it, they detail many factors that weigh into this decision.



Officers describe first considering the underlying incident or situation that brought the person to the attention of police. One officer notes that he considers heavily if someone has called on their behalf not to report an offense but because the referrer believes the person needs help.



Officers across the units describe their outreach work often brings them into situations where drug paraphernalia or substances are present. They note they are more than likely to offer deflection in these situations, but the cooperation of the person directly informs if they offer deflection in lieu of arrest.



In cases of trespassing or "unwanted persons," they are most likely to ask the person to leave the situation. However, if a person repeatedly returns to the location some officers comment that arrest is the primary course of action particularly if a property owner or manager is interested in pressing charges.



Officers note that deflection is not available for domestic violence offenses, but comment that they do consider if there is a victim or if someone was hurt when deciding.



The most important factor considered by officers is the person's willingness to agree to treatment.

Officer Walzdorf explains how he engages with residents and the compassionate interaction he will have with them to understand their willingness to go to treatment. However, when an individual is unwilling, he will resort to arrest. In this way, he understands the situation does *not* need arrest, but may do it anyway.



If someone has drug paraphernalia or possession, I always just have a conversation with them to find out what's going on. I ask how long they've been using, if they've tried to get clean before, and if they're interested in trying again. If they showed interest in it then, offer it. If they show no interest in it, then sometimes an arrest is the choice because if they aren't interested in it, then I'm going to take them to a center and leave them there, and they won't go in. But, for me, I like to build that dialogue to get an understanding of what they want.



HOW DO OFFICERS MAKE DECISIONS ABOUT THE PROGRAMS TO USE, AND UNDER WHAT CONDITIONS DO THEY CHOOSE THE CRC?

NEGOTIATING INITIATION

Once the officer makes the decision to deflect, they work with the individual to determine the most appropriate community provider for them.

Officers discuss that the decision to offer deflection in lieu of arrest happens rather quickly in the interaction. If the primary concern presents as a mental health issue, officers say they will likely offer and transport the person to the CRC. If the primary concern presents as substance use, officers note they will typically transport the individual to their partner agency CODAC or another community provider, Community Bridges. However, officers express that some people are hesitant to agree to deflection because of their experiences with these providers. Officer James describes how he navigates this situation,



We do have some choices. Sometimes, they've expressed some concerns about certain places based upon an individual experience. It's important we develop rapport and some trust to help them share these experiences with us so we can consider other options.



Officers comment that people often show hesitancy to accept the treatment option – even when they know it is in lieu of arrest – for a litany of reasons. Officers note that there is concern about previous experiences with victimization at the provider, leaving their property or animals particularly if they are homeless, the inability to smoke cigarettes or impending withdrawal symptoms, shame from previous experiences of treatment engagement, and concerns about fees and insurance. Officer Molina talks about his process for navigating insurance concerns,



Once they agree, we'll call around. They can talk to the provider and ask them specifically what insurance they carry and if they will accept theirs or learn about how it works if they don't accept insurance. There are a variety of agencies, and if the person is willing to wait, we can call them all.



A handful of officers comment that the fear of not knowing what to expect or the anxiety about the rules also complicates an individual's willingness to accept the deflection and transport. Although officers do not contextualize this with examples, many of the community members they are engaging with in the field have severe mental health diagnoses, intellectual disabilities, and other concerns that may create anxiety about change or new situations. Officer Renolds details how his training helped him prepare for this concern,




We've networked with some of the providers extensively. So, we're comfortable with how they operate. And, we can talk to people and put them at ease about what to expect. We've gone through tours, spoken to staff, personally know the staff, and spoken with hundreds of people who have gone through the program. We have a good sense of what it's going to look like for them. Then, it makes it easy for us to say, "Look, here's the deal. This is a voluntary transport. We're willing to take you. You're not in trouble. This is not a criminal investigation – you're not going to be labeled in a report by police or considered a suspect. It's to get you help. Here are some of the things you can expect there.' And, I think that helps.



Many officer participants note that while not formalized in policy, agency deflection practice states that once an officer makes the decision to deflect, arrest or citation is no longer an option, regardless of the individual's treatment initiation. Therefore, even if the individual agrees to transport, arrives to the provider, and expresses the same concerns they just worked through in the field, the person can leave the provider without any legal consequence. Two officers explicitly noted that while they do not tell people they can leave after the transport without legal system involvement, some residents know from previous experience. However, both comment that that while they believe it happens that people use the transport to avoid arrest, it is not a pressing concern.

For MHST officers who primarily serve petitions for evaluation from the court, transport is not voluntary. An individual must comply with the court order. However, the unit's approach to serving the court order prioritizes negotiation over use of force. MHST officers detail many of the same concerns of other officers negotiating deflection. Officer Henry notes how he helps people navigate the mandatory court order to allay their concerns,



I tell people I'm not going to lie or play games, and I will tell them exactly what has to happen and why, and we can work through it. They could be leaving their residence for multiple days. I let them smoke cigarettes, change their clothes, feed their cat. We've dropped off kids at a friend's house, found a dog sitter, changed someone's car tires. They all have different concerns they need alleviated before they say, "Okay, let's do this." And, in our unit, we have the freedom and time to stay for hours and hours to do what needs to be done to get them where they need to go without escalating the situation.




NEGOTIATING PLACEMENT

For MHST officers who are serving petitions for evaluations, they note the provider is typically named in the petition. However, when the petition for evaluation does not name a specific provider, they rely on the CRC or two primary hospitals in the area. However, when they or their specialty unit peers have the option to determine a location on their own, they describe various considerations in this decision.

LOCATION MATTERS

One officer notes that for individuals who are homeless, they are sometimes less likely to agree to transport to a provider because it is too far away from their camp. In these situations, they try to find a provider who is close by or personally arrange to pick the individual up once they have completed their appointment and bring them back to where they shelter.

Officer Dez comments that for those in crisis, going to the closest provider or hospital is important,




If you're dealing with someone in crisis, you don't want to drive an extra 20 minutes. So, where we might go might be a matter of which provider or hospital is closest.



TIME MATTERS

Nearly all interview participants state the structure of the unit and its separation from the 911 dispatch queue allows them the time they need to work with individuals in the field. Despite feeling as though they have more time with residents in the field, they state the length of time it takes the provider to enroll the individual matters as describe by Officer Munez,




At some of these providers, it is super easy for law enforcement to bring people there. It's very quick and they have very specific protocols for us that allow for minimal time at the provider and so we can get back in the field.



RULES & ELIGIBILITY

At times, officers also described how the eligibility requirements or rules of the provider itself might play into if they connect the individual with the services. One officer comments that some of the providers, particularly those that offer housing, have strict eligibility requirements that often make individuals unwilling to go or ineligible. One officer comments that requirements related to current intoxication make individuals they meet in the field ineligible and another officer comments that the no-pet policy can get in the way of where someone will want to go. Another officer comments that many of the people they meet in the field have previous experiences with providers in the community, and, as a result, they know what will be required of them if they go. Officer Hodge explains,




Sometimes the provider won't fit for that person. Like, they've been before and they know they will have to do chores and they don't want to do chores. Or, they know there's a curfew, or they don't like the food. Or, there's just something they don't like about it. So, sometimes it's not that we can't find them a place, it's that they don't like the conditions or the rules that the provider will make them follow. So, we'll have to call around or convince them it's still the right fit.



RELATIONSHIPS MATTER THE MOST


Overwhelmingly, officers describe their personal relationships with the providers as the primary reason they rely on the service. Some describe the provider's willingness to work through eligibility requirements, to answer or return phone calls quickly, and a general responsiveness to law enforcement concerns. Officer Beard describes her relationship with a member of a community provider specifically,



There's one gentleman I work with who is phenomenal. He answers my call whenever I call him. We text, he responds. He acts. I see him just about every day and he's willing to bend over backwards to get people help even if it's not into his facility.



Although a few officers comment about their relationship with one or two specific people at a provider they prefer, others comment on how some providers are more amenable to law enforcement, generally. Officer Fowler explains why he likes the CRC so much,



They have a specific protocol for law enforcement. They are also very good about adapting and changing. If they are presented with reasonable law enforcement concerns, like, 'Hey this isn't working for us. We've run into this problem several times and it's creating legal and logistical nightmares.' But they get on it right away to make sure it's fixed and make sure we come back and use them.



As described previously in this report, the CRC is committed to making their center as easy as possible to use for police – with the slogans “no wrong door” and “figure out a way to say yes instead of looking for reasons to say no.” This is largely evidenced by the overwhelming number of deflections made to the center by police. However, Officer's Fowler commentary also reflects on this relationship and the willingness of the provider to adjust protocols/processes on their end to accommodate police. In this way, the willingness to adapt to each might be the core component to securing a treatment revolving door in a community.

HOW DOES THIS UNIQUE WORK IMPACT OFFICERS?

Throughout the interviews, officers stress the importance of finding people the help they need and their willingness to work with people multiple times and try multiple pathways and providers. At times though, officers describe how the work impacts them personally. Officer Walters describes the impact of working with the same person and how he tries to manage it,



I worked with a young female earlier today. She was mixed up with smoking fentanyl. I've taken her to CODAC twice before. Today, is the third time I found her on the streets. I tried another place in town. I told asked her, 'Do you have a place to stay? We have the detox center I can take you to.' I tried to gauge her to try something else. I know she's probably going to get sick tonight and I tried to convince her that it'll at least give her a place to sleep instead of on the street for the night and maybe she'll like it. I try and see everyone as a human being, I try not to become numb to it all because that's when they know I'm not being real or being genuine, and they can sense that. This is why we have deflection, we're trying to change things up to have a positive domino effect.



Officer Waltzdorf discusses her repeat interactions with someone, their unique needs, and the personal impacts of working with this population,



There's this woman I work with often who is in a wheelchair. I talked to her one day and was trying to get her into help and she's like, 'No, No, No, I don't want to go right now, how about tomorrow?' I say, 'Okay, I'll come back tomorrow and personally pick you up at whatever time you like.' I came back the next day and couldn't find her. I searched all over the neighborhood and nope, no sign of her anywhere. I had given her my card and she never called them. Then, later in the day I see her in an intersection panhandling. Her being in a wheelchair makes her a prime candidate for housing and I explained that to her. I tried to tell her that she won't have to climb in and out of her wheelchair in the desert with rocks and everything else. She still chose her tent. That's the hard part of all of this, seeing folks just flat out not want help.



Throughout the interviews, officers describe trying to work through the barriers of an individual's willingness to accept help. A few officers describe this conversation as more emotionally challenging when they are interacting with an individual on referral compared to those who are negotiating deflection in lieu of arrest. Officer Molina describes how he approaches these situations and its impact on him.



You have to give this job your all every day. You see your own child in a person when you're working with a young person. Or, even if they're older, you see yourself. You know, a lot of us could have down a really bad road if they would have taken the same steps as this person did. I remember that, but it's all mentally draining.



COMBINED, THESE OFFICERS DESCRIBE HOW THE WORK ITSELF CAN DESENSITIZE THEM TO SITUATIONS, FRUSTRATE THEM WHEN THEY PERCEIVE THEY CAN HELP PEOPLE IN VULNERABLE SITUATIONS, AND PRESENT AS TOUGH EMOTIONAL LABOR.

DESPITE THESE IMPACTS, OFFICERS REPEATEDLY DISCUSS THE IMPORTANCE OF THEIR WORK TO TACKLING ROOT CAUSES OF BEHAVIOR, AND A BEHAVIORAL HEALTH APPROACH AS A LEGITIMATE STRATEGY FOR PUBLIC SAFETY.

RECOMMENDATIONS

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POLICY & PRACTICE RECOMMENDATIONS

THE MORE THE MERRIER

The data show when individuals who first receive a voluntary transport then receive a subsequent deflection back to the CRC, they stay for much longer each new time. This was especially true for Black individuals with SMHD, individuals with OUD/SMHD, and individuals with SUD/SMHD. Although this might be reflective of their treatment readiness, it nonetheless suggests that ensuring they are deflected a second time is important for how much program dosage they continue to receive within and across visits. Getting these individuals to- and through CRC's front door is important for how they continue to engage with the provider.

Therefore, the more often officers can deflect the same individuals to the CRC, the more likely they are to receive *more* treatment each time. At times, officers reported getting frustrated when individuals they previously deflected did not want or were not willing to go back the second time. In some cases, individuals admitted to arresting these individuals.



Recommendation: On-going strategies and tools which acknowledge, support and heal staff frustration for familiar faces. These strategies could include education about neuroscience related to brain changes from substance misuse, the process of recovery, and barriers to treatment initiation to ensure officers are willing to continue to offer deflections each time.

UNPACKING TREATMENT INITIATION

Throughout the interviews, officers discussed the importance of a new approach to tackling the issues of mental health crisis, substance use disorder, and homelessness. Many officers spoke at length about why the traditional arrest and release exacerbates these issues and invites additional barriers for individuals. Central to this approach is empathy, patience, and a deep understanding that individuals do not arrive to these situations by choice and both previous experiences and system failures have contributed to the problem. However, when making decisions about offering deflection in lieu of arrest, officers offer that a person's willingness to accept help is heavily considered in their decision-making.

Many officers state an individual's situation is not by choice but offer that they believe individuals do have some agency to change their situation. In this way, officers' decisions to deflect and work with individuals in the field is influenced by an individual's ability to lean into their perceived agency. However, evidence about the process of recovery suggests there is more to treatment initiation than simply willingness or willpower, and there are a host of other concerns. Interestingly, officers do acknowledge treatment initiation is complicated and nuanced but mostly for those individuals with a substance use disorder and who are homeless.

However, treatment initiation is a concern for many individuals and includes considers about paying for treatment, income loss from missed work while attending treatment, and concerns about missing family obligations while in treatment. Further, wishing to engage in treatment is also contextualized *by* the intersection of disability, race, gender, and the interplay of these factors. This is a very important, but likely a new nuance for officers. Experiences *with* racism, cis-sexism, ablism and stigma while engaged in previous treatment programs might explain an individual not wishing to engage with the treatment options offered by TPD at the point of contact. Therefore, officers may overestimate how easy it is for individuals to harness their agency and agree to a treatment transport. When officer make these overestimations, it may end in frustration for some officers and a decision to arrest for others.



Recommendation: On-going training and learning sessions that continue to unpack the nuance of barriers to treatment initiation *and* experiences with treatment. This might increase officer's willingness to offer deflection in lieu of arrest and provide new ways of working with individuals about their hesitation.

DEFLECTION FIRST, ARREST RARE.

TPD's deflection program considers many criminal offenses as symptomatic of serious, underlying concerns, including mental health, substance use disorder, and homelessness. The spirit of the program recognizes that behavioral health is deeply connected to public safety and a legitimate approach to public safety is treatment not incarceration. By the admission of officers across interviews, they are apt to offer deflection for an eligible offense and do so quickly, but a person's willingness to accept help impacts their decision-making. At the same time, officers recognize that arrest and jail stays can make an individual's situation worse than doing nothing at all. TPD could consider a more aggressive approach to deflection.



Recommendation: Provide officers the language tools and talking points to educate community members about larger agency goals for the community and their role in achieving those goals.

MEASURES, DATA & ANALYSIS RECOMMENDATIONS

CURRENT MEASURES

Tucson Police Department is committed to implementing evidence-informed practices and making data-driven decisions. As part of this commitment, the department measures their work and tracks their progress often.



Importantly, they measure the number of deflections completed through a standard report writing process.



They measure the “contact category” or how officers meet individuals in the field and how often each of these categories receive deflections.



They measure the deflection count by criminal charge category, age group, race/ethnicity, sex, and division/unit



They measure the number of unique individuals who receive deflections and the number of repeat participants and their frequency of participation.



Most importantly, they conduct gap analyses to understand the number of deflection-eligible offenses compared to actual deflections and analyze the gap along all the subgroup analysis listed above.



Lastly, with the help of Southwest Institute for Research on Women (SIROW) at the University of Arizona, they measured the length of time to complete a deflection and an arrest to understand both the hours saved by the program and the overhead for sworn personnel saved by the program.

FUTURE MEASURES

TPD's informal practices and institutionalized training all prioritize contacts with residents as "compassionate interactions." Across interviews, officers describe compassionate interactions as showing empathy, understanding, and kindness.



Recommendation: TPD could consider measuring this via participant surveys collected at the point of initiation with the provider. Survey questions could ask participants specifically about the empathy and kindness shown by the officer, as well as how much the officer understood their needs and discussed their options. This data would take a large step toward unpacking the *quality* of the deflection in addition to the understanding they currently have about the quantity of deflections. Given the unit's extensive relationships with several providers, it seems reasonable providers could collect this information anonymously and provide the raw, de-identified data to TPD for analysis.


The goal of TPD's program is to interrupt the cycle of many of the underlying causes of criminal behavior through *access* to effective treatment options. However, officers recognize that one-time access to services is typically not enough for an individual to initiate treatment. And, they recognize that even a few days in treatment can be positive progress toward continuous treatment engagement.





Recommendation: TPD could consider measuring the number of treatment enrollments. Given their strong partnerships with providers, this metric would simply involve the provider sharing the number of intakes completed. Additionally, providers could share the number of days someone remained in treatment for each intake that results from police-led deflection, and how these number of days change over time. In this way, TPD is measuring their impact to access and engagement in a consistent manner with the treatment evidence suggesting multiple enrollments in programming is typically required to initiate long-term engagement and recovery.

FUTURE RESEARCH RECOMMENDATIONS

Based upon these findings there are several exciting areas for knowledge growth and understanding specifically for Pima County, the CRC, and broadly for deflection programs.

 **POLICE AGENCIES & TPD:** According to the latest census data, 37.8% identify as Hispanic or Latino; however, only 4% of individuals deflected to the CRC are Latinx/Hispanic. This might reflect CRC measuring Latinx/Hispanic as a race and not ethnicity – previous identity research suggests nuance about why this distinction matters. Although we report Hispanic/Latinx as race, when considering the ethnicity variable in our data, we find similar proportions. Our data does not include the wider population of deflections to understand if the Latinx/Hispanic community is experiencing significantly less deflections broadly or relative to the other People of Color. This is an important next step both for local law enforcement and race/ethnicity/identity research. If there are disparate outcomes for deflection of this population, local law enforcement agencies must prioritize understanding why and developing culturally sensitive and responsive strategies to reduce and eliminate these disparities.

 **DEFLECTION CENTERS & CRC:** During the initial visit to the CRC, 58.8% of individuals, on average, stay just under half a day (9.84 hours). Unfortunately, our data does not include time stamps to understand if same-day discharge occurred after the 90 to 120 minute “door-to-doctor” range which might contextualize why individuals leave the same day. Future deflection center or CRC research should measure the process down to the hour, or even less, to understand when during the treatment intake process individuals leave *and why*. This will help inform strategies about where and how best to intervene to encourage and support treatment initiation/engagement.

 **BROAD DEFLECTION:** Critical across the qualitative data was the concept of readiness or willingness to engage in treatment as a potential factor for deflection decisions themselves. Researchers should consider how this is a moderating variable for deflections. Additionally, future research should begin to dig into an individual’s willingness and concern *at the point of police contact*. This iteration must consider how the intersection of race, gender, diagnoses, and disability matter for the system barriers that impact someone’s willingness to initiate treatment at the point of contact (e.g. insurance). It must also consider how an individual’s experiences with racism, cis-sexism, and ablism *during previous* treatment matter for willingness to initiate treatment at the point of police contact.

POLICE-LED DEFLECTION in PIMA COUNTY

AN ORIGIN STORY

START

On **January 8, 2011**, Jared Loughner opened fire in a crowded grocery store parking lot, leaving six individuals dead and 13 individuals injured, including his intended target US Representative Gabrielle Giffords. An investigation into the mass casualty event revealed Loughner had signs of a severe mental health diagnoses. However, he never received a formal evaluation despite encounters with campus police where he went to community college and local law enforcement. This event changed the trajectory of the Tucson Police Department (TPD) and the impetus for a decade of police led deflection and its evolution within TPD.

2011

The Crisis Response Center (CRC) opens, providing police 24/7 access to emergency psychiatric and substance use services.

2017

Pima County launches United Medication Assisted Treatment Targeted Engagement Response, or U-MATTER, with 4 officers conducting opioid-related outreach.

2013

TPD establishes the Mental Health Support Team (MHST) to serve petitions from the court and conduct outreach prior to a behavioral health crisis; Mental Health First Aid (MHFA) training begins for TPD.

2018

TPD implements deflection for eligible offenses and the U-MATTER team expands into its own team, the Substance Use Resource Team (SURT). SURT partners with peer supports from CODAC, a community provider, and continues outreach as part the team's charge.

2020

The Homeless Outreach Team (HOT) is established, treating homelessness as a symptom, not a crime, of the intersection of SMHD and SUD. They conduct outreach and deflect when appropriate.

JSP

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