

NORTH CAROLINA LAW ENFORCEMENT ASSISTED DIVERSION (LEAD): CONSIDERATIONS FOR OPTIMIZING ELIGIBILITY AND REFERRAL

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I

INTRODUCTION

In 2011, a diverse group of stakeholders in Seattle, Washington, developed an alternative to repeated arrests and incarceration of people whose low-level unlawful conduct stemmed from unmet behavioral health needs, launching a new model called Law Enforcement Assisted Diversion (LEAD). Centered at the intersection of public health, public safety, and racial justice, LEAD was the nation's first pre-arrest, pre-booking strategy to address the high rates of recidivism for people who use illicit drugs.¹ The LEAD program diverts people away from incarceration and into community-based care at the time of potential arrest. Instead of prosecution and incarceration, LEAD intends to provide long-term, client-directed, street-based intensive case management based on harm reduction principles.

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1. *What is LEAD?*, LEAD NAT'L SUPPORT BUREAU, <https://www.leadbureau.org/about-lead> [<https://perma.cc/7UQ4-VGUX>].

The LEAD model centers around a set of core principles that are considered essential to program success and were codified in 2020.² Programs should focus on systemic change. Programs should reduce the use of the criminal legal system to address illicit drug use and increase the provision of services to improve health and public safety. Harm reduction principles comprise the foundation of LEAD values and practices, aiming to reduce the harms associated with drug use and involvement in the criminal legal system by providing participants with resources and support services without expectation of stopping drug use or engaging in treatment. Finally, a primary objective of LEAD is for program partners to work collectively and with a shared vision to reduce racial inequities, both to reduce overrepresentation of people of color in the criminal legal system and to improve their access to a range of human services.

The LEAD model was first designed with law enforcement officers as the primary point of referral.³ The model described two LEAD referral pathways: arrest diversion and social contact referrals. Arrest diversions occur when an officer makes a referral for an individual who is actively engaging in low-level unlawful conduct at the time of their encounter, and the referral is made in lieu of arrest. Alternately, officers can offer a social contact referral to individuals they encounter whom they believe to be at risk of criminal justice involvement driven by unmet behavioral health needs and often chronic poverty, but at a time when there is no probable cause for arrest.

If the individual is eligible and interested, there is then a direct connection, or a warm hand-off, made by the officer to a LEAD case manager, who ideally responds to the location where the referral is taking place. Next, the LEAD case manager and participant complete an initial intake assessment that identifies the participant's immediate needs and priorities. From that point, case managers work as intensively as needed with participants to identify and connect them to appropriate and locally available resources and support services, including food, essential medical services, harm reduction resources such as syringe exchange and naloxone, short- or long-term housing, application for public benefits, and behavioral health services. In this client-driven, harm reduction model, LEAD imposes no behavioral mandates on participants, except for requiring an initial intake and a release of information to enable communication among providers.

Rigorous evaluations of the flagship LEAD program in Seattle have demonstrated promising findings for LEAD's effectiveness in decreasing

2. See generally PUB. DEFENDER ASS'N, <http://www.defender.org/> [<https://perma.cc/JG2B-AMLW>].

3. *Id.* See also LEAD NAT'L SUPPORT BUREAU, <https://www.leadbureau.org/> [<https://perma.cc/D2UN-ARES>]. The LEAD model design has evolved over time, most recently with referral-making expanding beyond police, allowing program staff and community members to make referrals with no police involvement. North Carolina jurisdictions participating in this study implemented their programs when the original iteration of LEAD was still the guiding model.

recidivism,⁴ increasing quality of life,⁵ and increasing access to services, which was a driving force for the implementation of LEAD programs across the country, including in North Carolina. A longitudinal study of the Seattle program found that the odds for recidivism in the six months after program entry were 60% lower for LEAD participants compared to a propensity-matched control group, and that benefit was sustained in longer-term outcomes models.⁶ Within-group analyses of LEAD participants in the flagship program also demonstrated significant reductions in homelessness and unemployment after entry in the program compared to before program involvement, as well as a significant increase in participants receiving income or benefits after referral.⁷ Subsequent studies of the effectiveness of LEAD have found similar positive outcomes as the Seattle program, including in studies of LEAD in San Francisco,⁸ Santa Fe,⁹ and Honolulu.¹⁰

While LEAD has been demonstrated to achieve positive outcomes for program participants, various iterations of LEAD across the country have encountered challenges in scaling up the number of participants that the program could serve, often due to barriers related to referrals. Common referral challenges have included: (1) logistically complicated referral processes for police officers,¹¹ (2) lack of knowledge among officers about the goals of LEAD and the details of the referral process,¹² (3) overly-restrictive eligibility requirements,¹³

4. Susan E. Collins, Heather S. Lonczak & Seema L. Clifasefi, *Seattle's Law Enforcement Assisted Diversion (LEAD): Program Effects on Recidivism Outcomes*, 64 EVALUATION & PROGRAM PLAN. 49, 54 (2017).

5. Seema L. Clifasefi, Heather S. Lonczak & Susan E. Collins, *Seattle's Law Enforcement Assisted Diversion (LEAD) Program: Within-Subjects Changes on Housing, Employment, and Income/Benefits Outcomes and Associations with Recidivism*, 63 CRIME & DELINQ. 429, 439–442 (2017).

6. Collins, Lonczak & Clifasefi, *supra* note 4, at 52.

7. Clifasefi, Lonczak & Collins, *supra* note 5, at 13.

8. AILI MALM, DINA PERRONE & ERICA MAGAÑA, CAL. STATE UNIV. LONG BEACH, LAW ENFORCEMENT ASSISTED DIVERSION (LEAD) EXTERNAL EVALUATION: REPORT TO THE CALIFORNIA STATE LEGISLATURE 117–19 (2020), <https://www.bscc.ca.gov/wp-content/uploads/CSULB-LEAD-REPORT-TO-LEGISLATURE-1-15-2020.pdf> [<https://perma.cc/2X3W-RQ9Z>].

9. N.M. SENTENCING COMM'N, SANTA FE LAW ENFORCEMENT ASSISTED DIVERSION (LEAD): AN ANALYSIS OF THE PILOT PHASE OUTCOMES 5–7 (2018), <https://nmssc.unm.edu/reports/2018/the-santa-fe-law-enforcement-assisted-diversion.pdf> [<https://perma.cc/V5B2-YCXP>].

10. SOPHIE GRALAPP, MARK WILLINGHAM, ANNA PRUITT & JOHN P. BARILE, UNIV. OF HAW. AT MANOA, LAW ENFORCEMENT ASSISTED DIVERSION HONOLULU 1-YEAR PROGRAM EVALUATION REPORT 28 (2019), <https://static1.squarespace.com/static/5db76f1aadbeba4fb77280f1/t/5dc1a85cf5bb2452deea30af/1572972666163/LEAD+HNL+1+Yr+Program+Eval.pdf> [<https://perma.cc/E7SF-PQXC>].

11. Paul J. Joudrey et al., *Law Enforcement Assisted Diversion: Qualitative Evaluation of Barriers and Facilitators of Program Implementation*, 129 J. SUBSTANCE ABUSE TREATMENT, Oct. 2021, at 1–2.

12. Erica Jovanna Magaña, Dina Perrone & Aili Malm, *A Process Evaluation of San Francisco's Law Enforcement Assisted Diversion Program*, 33 CRIM. JUST. POL'Y REV. 148, 165 (2022).

13. Evan Anderson et al., *Experiences with the Philadelphia Police Assisted Diversion Program: A Qualitative Study*, 100 INT'L J. ON DRUG POL'Y, Feb. 2022, at 5.

and (4) lack of buy-in among officers to the values and principles underlying the LEAD model.¹⁴

Examining the factors that influence officer buy-in for LEAD and other diversion programs has been the focus of several studies, given how commonly it has been reported as a barrier. Female officers¹⁵ and officers with more years of experience¹⁶ were both positively associated with interest and support of LEAD. Officers were found to be less willing to make referrals to the program¹⁷ when they viewed policing as confined to law enforcement or law and order,¹⁸ or held more pessimistic views of drug rehabilitation and drug use. Lack of sufficient training on program policies and procedures, harm reduction,¹⁹ and substance use disorder²⁰ among officers has also been identified as a barrier to buy-in, as well as successful and appropriate referrals—even among officers with strong buy-in.

The LEAD model calls on a diverse set of stakeholders—law enforcement agencies, harm reduction organizations, case management organizations, treatment and social service agencies, and district attorney’s offices—to collaborate in addressing the harms associated with drug use and the criminalization of people who use drugs. The collaboration should be guided by a Policy Coordinating Group, as defined and recommended by the fidelity framework for the LEAD model,²¹ composed of members of all community groups that have a stake in LEAD and the populations it serves. Participating members should span the intersection of public safety and public health, including law enforcement leaders, public health officials, representatives from district attorneys’ and public defenders’ offices, harm reduction and racial justice advocates, and individuals from the groups that LEAD aims to serve. When LEAD is implemented successfully and with fidelity to the model, the program functions as an effective collective impact initiative.²² It can have reverberating benefits throughout communities if all stakeholders achieve consensus about program objectives, genuinely understand and embrace the principles and

14. *Id.*

15. Lonnie Schaible, Lauren Gant & Stephanie Ames, *The Impact of Police Attitudes Towards Offenders on Law-Enforcement Assisted Diversion Decisions*, 24 POLICE Q. 205, 218 (2021).

16. Saba Rouhania et al., *Police Attitudes towards Pre-Booking Diversion in Baltimore, Maryland*, 65 INT’L J. ON DRUG POL’Y 78, 81 (2019).

17. Joudrey et al, *supra* note 11, at 4; Schaible, Gant & Ames, *supra* note 15, at 210.

18. Robert E. Worden & Sarah J. McLean, *Discretion and Diversion in Albany’s Lead Program*, 29 CRIM. JUST. POL’Y REV. 584, 600 (2018).

19. Magaña, Perrone & Malm, *supra* note 12, at 163.

20. Joudrey et al., *supra* note 11, at 4.

21. EMILY KNAPHUS-SORAN & REBECCA BROWN, LEAD PROOF OF CONCEPT PROJECT, LEAD FIDELITY FRAMEWORK 9 (2022), https://7e51d59806dc4a2e85a0ef4c1e6b02eb.usrfiles.com/ugd/7e51d5_f81080cfc6a54ac0b0cfc8387656c617.pdf [<https://perma.cc/457C-B7NS>].

22. John Kania & Mark Kramer, *Collective Impact*, 9 STAN. SOC. INNOVATION REV. 36, 36–41 (2011).

practices of harm reduction, and collectively commit to actionable ways in which racial inequities can be identified and reduced through LEAD programming.

Dozens of communities around the United States have adopted and adapted LEAD, but prior to the development of a fidelity framework and other technical assistance resources, it was difficult to implement the model with fidelity. The founding organization²³ has since developed a set of foundational materials that define the LEAD model, explain its core principles and methods, illustrate the LEAD theory of change, detail associated core metrics, and present the elements of fidelity essential to LEAD. Yet individual communities have ultimately needed to attend to their unique socio-political and -environmental contexts when implementing LEAD, often adapting program features to align with local political priorities, community acceptability, resource availability, and law enforcement culture. Such adaptations may influence the extent to which the programs can achieve objectives as intended—reducing long-standing racial inequities in our criminal legal systems, identifying and addressing barriers to referral and enrollment into the program, and optimizing buy-in among law enforcement leaders and front-line officers.

North Carolina was a pioneer in the Southeastern United States in adopting alternatives to traditional law enforcement response to illicit drug use. It was also the first state in the South to implement LEAD widely. Jurisdictions in North Carolina with LEAD programs have distinctly different social, political, and geographic landscapes than earlier program adopters in large metropolitan areas. Understanding how LEAD operates in this Southeastern context provides insight into what LEAD looks like in different environments and social climates, and which features of those social contexts influence successful programming, including equitable referrals to and enrollments into the program.

Part II of this article describes the history of LEAD programs in North Carolina, including a unique partnership between law enforcement leaders around the state and a community-based harm reduction coalition. Part III describes our study's mixed-methods data collection and both quantitative and qualitative analyses. Part IV describes process outcome results of the study, starting with descriptive statistics related to program referrals and enrollment, followed by a detailed presentation of various program dimensions, factors, and experiences that influence the same. Part V synthesizes the study findings and discusses important policy, program, and practice implications. Part VI presents conclusions drawn from study findings.

23. See PUB. DEFENDER ASS'N, *supra* note 2.

II

HISTORY OF LEAD IN NORTH CAROLINA

A. Implementing LEAD in North Carolina

North Carolina Harm Reduction Coalition (NCHRC) is a grassroots organization that works closely with law enforcement and other community stakeholders to deliver harm reduction resources to people who use drugs, improve public health, and contribute to drug policy and justice reform throughout the state. Its partnership with law enforcement leaders around North Carolina is unique and progressive—an unlikely collaboration between two community groups that typically have very different perspectives about how to manage illicit drug use in the community.

NCHRC was instrumental in implementing LEAD in North Carolina. Since 2013, NCHRC has provided naloxone overdose response training to more than one-third of North Carolina law enforcement departments. As a result of those efforts, North Carolina became the first Southeastern state to equip police officers with naloxone in 2015. The same year, Fayetteville Police Department and NCHRC established a post-overdose response team, and Fayetteville Police Department began coordinating with NCHRC outreach specialists to help connect people who use drugs to treatment and support services. The partnership paved the way for the implementation of the first LEAD program in North Carolina and the Southeast in Fayetteville in November 2016. Thereafter, NCHRC supported LEAD implementation in several other locations across the state, including in Wilmington, Waynesville, Mooresville, Statesville, Catawba County, and Burke County. NCHRC staff assisted in selecting four of those LEAD programs for this study, named in this article Sites A-D. Sites were selected to represent a diversity of geographic locations across the state and length of program duration. In each of the four sites, LEAD program partners included NCHRC, the local district attorney's office, local police department(s), one or more behavioral health services agencies, and the Local Management Entity/Managed Care Organization (LME/MCO) responsible for managing and disbursing the State's Medicaid and indigent-care funds for behavioral health services in the LME/MCO's geographic catchment area.

B. The Goals and Vision for LEAD Programs in North Carolina

In each of the four study sites, program partners implemented the LEAD model in an effort to change their traditional response to pervasive illicit drug use in the community and move toward a harm reduction approach. There was a shared acknowledgment among participating agencies that the traditional approach of arresting and incarcerating individuals who use drugs and engage in low-level, nonviolent unlawful conduct is not only limited in its effectiveness, but also has a negative impact on public safety and individual and community well-being. While the overarching problem and solution were envisioned similarly, each of the four sites had unique circumstances in their communities that

motivated their implementation of LEAD. For example, two of the sites implemented their programs explicitly to address disproportionately high rates of opioid use and overdose death, one of which ultimately added an informal policy of officers making LEAD referrals at all overdose reversal incidents, while the other two started with a broader vision of responding to excessive criminalization of drug use. While a core principle of the LEAD model is to reduce racial disparities in the arrest, prosecution, and incarceration of people who use drugs, the North Carolina sites we studied did not have formally stated goals to address those disparities at the time they implemented their programs.

C. North Carolina LEAD Program Design

The target population for all North Carolina LEAD programs were individuals who use drugs and who would otherwise be charged with low-level criminal offenses or be at risk for future arrest. All four sites had formal exclusion criteria, including: (1) histories of trafficking, delivering, or intending to deliver drugs, (2) certain violent crime convictions in the past ten years, (3) promoting sex work or exploiting minors, (4) appearing to be a poor fit for the program—for example, violent, posing a risk to self or others, or not appearing to be amenable to services—and (5) being under the age of eighteen. At the time of implementation, each site’s program also excluded individuals on probation.

Over time, it became evident that excluding individuals on probation categorically disqualified many people who could benefit from LEAD, and each site informally adapted their policies to allow some people on unsupervised probation to participate with decisions made on a case-by-case basis. As part of efforts to address the opioid epidemic, Site B limited eligibility to people who used opioids at the time they implemented the program. Later, Site B opened eligibility to all illicit drugs to be more inclusive.

Participants entered North Carolina LEAD programs via arrest diversion referrals or social referrals (Figure 1), as defined previously. In both cases, and in accordance with the original LEAD model, referral decisions were made at the sole discretion of police officers. For three of the four sites, members of the community or LEAD staff could also initiate LEAD social referrals but had to do so in collaboration with a police officer. In cases of community-initiated referrals, the individual’s eligibility was determined by law enforcement, who would then connect interested individuals to the LEAD case manager.

Figure 1. LEAD referral and enrollment process

For individuals who met eligibility criteria, the only requirements for participation were to complete an intake assessment within fourteen days of referral and sign a release of information and consent to share information among the project partners and treatment providers. If an individual referred to LEAD via an arrest diversion did not complete the enrollment process, the referring police officer and the district attorney’s office could opt to reinstate the diverted charges.

Once an individual was enrolled in LEAD, they remained in the program for as long as they chose, with no imposed end date for participation. Consistent with harm reduction approaches, LEAD participants were not required to abstain from using drugs. After the intake assessment, LEAD participants met with LEAD staff as often as was desired and feasible, and staff provided a variety of supports and connections to services.

D. Socio-Demographics of North Carolina LEAD Sites

The sites had relatively high levels of poverty as compared to the United States average, including low levels of home ownership, housing stability—except Site A—labor force participation, and health insurance coverage among their respective community members (Table 1).²⁴ Two of the sites had a larger proportion of community members who reported their race as Black alone compared to national averages, with almost half of the population (42%) reporting Black alone for Site C. In contrast, the two sites—Sites A and D—with fewer Black community members than the national average were both largely rural communities.

24. *United States Census Bureau QuickFacts*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts> [<https://perma.cc/M7YV-JUTK>] (accessed Jan. 2022); *Voter Registration Statistics*, N.C. STATE BD. OF ELECTIONS, <https://vt.ncsbe.gov/RegStat/Results/?date=01%2F15%2F2022> [<https://perma.cc/LMZ9-ZZ5F>] (accessed Jan. 2022); John Gramlich, *What the 2020 Electorate Looks Like by Party, Race and Ethnicity, Age, Education and Religion*, PEW RSCH. CTR. (Oct. 26, 2020), <https://www.pewresearch.org/fact-tank/2020/10/26/what-the-2020-electorate-looks-like-by-party-race-and-ethnicity-age-education-and-religion> [<https://perma.cc/58MS-HX8R>].

Table 1. LEAD site socio-demographics

	Site A	Site B	Site C	Site D	United States
Percent Black alone	9%	18%	42%	2%	13%
Owner-occupied housing unit rate 2016-2020	71%	45%	44%	56%	64%
Living in same house 1 year ago, percent of persons age 1+ year, 2016-2020	88%	78%	75%	85%	86%
Bachelor's degree or higher, percent of persons age 25+, 2016-2020	23%	42%	27%	28%	32%
Persons without health insurance, under age 65, percent	15%	12%	11%	13%	10%
In Civilian Labor Force, total, percent (population 16 years and over)	62%	61%	52%	53%	63%
% registered voters as Republican	44%	31%	23%	35%	29%
Persons in poverty, percent	12%	22%	19%	18%	11%

The jurisdictions also varied in the severity of their communities' drug epidemics.²⁵ The two sites located in more urban counties reported significantly higher drug overdose death rates (40 and 44 per 100,000 residents, respectively) than the North Carolina average (28 per 100,000 residents), whereas overdose death rates in the two more rural sites' counties were relatively low and below the state average (22 and 23 per 100,000 residents, respectively).²⁶ Substance use treatment rates were reportedly high in all four sites compared to the State average (375 per 100,000 residents), most notably in Site B, which has been described as a "recovery town" (709 per 100,000 residents), and where buprenorphine prescriptions were also especially high.²⁷

25. *Opioid and Substance Use Action Plan Data Dashboard*, N.C. DEP'T OF HEALTH & HUM. SERVS., <https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard> [<https://perma.cc/ZGE5-DAFB>] (accessed Jan. 2022).

26. *United States Census Bureau QuickFacts*, *supra* note 24.

27. *Opioid and Substance Use Action Plan Data Dashboard*, *supra* note 25.

III

INTRODUCTION RESEARCH METHODS AND DATA SOURCES

Our research team, in consultation with NCHRC, conducted a four-site, mixed-methods study of LEAD programs in North Carolina. We examined program processes, including program implementation and operations, and participant outcomes. Study sites were selected to represent the diversity of different drug-affected communities in North Carolina. We conducted semi-structured interviews with program stakeholders, focus groups with law enforcement officers, and semi-structured surveys with program participants. We also generated a series of descriptive statistics using administrative records, such as behavioral health service utilization, case management, and criminal justice involvement to illustrate various features of program practices and processes (Table 2).

Table 2. Data sources and descriptions

Quantitative data		
Data	Data source	Timeframe of observation
Arrest charges for LEAD participants	Statewide criminal justice database (CJLEADS)	One year pre-LEAD participant's referral date until December 21, 2020
Incident reports for LEAD referrals	Local police department record management systems	LEAD participant's referral date
All drug charges eligible for diversion in LEAD program's geographic area	Local police department record management systems	Program duration (different for each site)
LEAD program documentation (officer referral forms, intake assessments, case notes)	Case management agency's LEAD files	Program duration (different for each site)
Qualitative data		
Data	Timeframe of data collection	N of participants
Semi-structured interviews with LEAD stakeholders	October 2019–February 2021	Twenty-seven
Focus groups with law enforcement officers	December 2019–March 2021	Four focus groups with nineteen total participants
Semi-structured interviews with LEAD participants	December 2019–February 2021	Twenty-two

A. Quantitative Data

For the process evaluation, quantitative data were collected from three sources, including (1) Criminal Justice Law Enforcement Automated Data Services (CJLEADS), the statewide criminal justice database, (2) local police department record management systems, and (3) program partner agency LEAD files and reports from staff, which we call LEAD program documentation. From these data we generated a series of descriptive statistics for various features of referral and enrollment, as well as jurisdiction-wide drug arrests. This article presents quantitative data relevant to the process evaluation, and future publications will describe the outcome evaluation findings.

1. Criminal Justice Data

For each study site, de-identified data were collected for all individuals who had been charged with LEAD-eligible drug offenses in that jurisdiction, starting from the time the programs were implemented. Available data associated with the criminal charges included demographic information, date, time, location, and description of the charge. We used these data to identify how LEAD participants compared demographically to the larger populations of people in their communities who were arrested for LEAD-eligible drug charges. As criminal history was not available in the jurisdiction-wide data, however, it is unknown whether these individuals would have been eligible for LEAD based on their criminal history and probation status. These data were also limited to drug charges eligible for diversion, rather than other types of low-level offenses that were LEAD-eligible. As such, it is likely that some individuals who used drugs and could have been eligible for LEAD were omitted from the dataset because their drug use was not observable in these data.

2. LEAD Program Documentation

LEAD program partner agencies provided relevant program records that documented participants' experiences in LEAD. With some variability in availability across sites, such documentation included (1) incident reports outlining the circumstances of the interaction in which a police officer referred an individual to LEAD, (2) referral forms completed by a police officer at the time of the LEAD referral for individuals who accepted the referral, (3) intake assessments and other forms included in the enrollment process for LEAD participants, and (4) case notes documenting LEAD participant updates throughout the course of their engagement with the program. All documents were de-identified by LEAD partner agencies prior to data delivery. All forms included quantitative data. Some reports also contained qualitative data with lengthy narratives, responses to open-ended questions, and hand-written notes by LEAD staff members.

B. Qualitative Data

1. Program Partner Interviews

We conducted semi-structured interviews (N=27) with stakeholders between October 2019 and February 2021. Interviewees included LEAD case managers, LEAD outreach workers, LME/MCO representatives, LEAD law enforcement coordinators, district attorney representatives, clinical supervisors, and NCHRC staff. All stakeholders who expressed interest in participating were interviewed. Thirteen interviews were conducted in-person; fourteen interviews were conducted using Zoom conferencing services after the emergence of COVID-19. All interviewees were offered thirty dollars for their time, but compensation was declined in some cases due to organizational policies.

The interviews explored wide-ranging circumstances related to LEAD implementation across stakeholder groups. Specifically, stakeholders were asked about their perceptions of the referral process, the quality of collaboration across agencies, the extent to which their programs were guided by specific core values and objectives, facilitators and barriers to the effective implementation of LEAD, and challenges and successes of the LEAD program.

2. Law Enforcement Focus Groups

Focus groups with law enforcement officers were conducted with each of the four study sites between December 2019 and March 2021. Three of the four focus groups were composed of law enforcement officers who had made at least one referral to LEAD, and the fourth group was composed of officers who had never made referrals to LEAD. Focus groups were facilitated by a study team member and attended by a second team member who took notes on the flow of discussion and non-verbal communications. The first two focus groups were conducted at the police departments prior to COVID-19, and the remaining two groups were conducted virtually. Officers in the in-person focus groups were provided a meal but were not compensated monetarily. No compensation was provided for the virtual focus groups.

The focus group protocol centered around several topics, including LEAD training for officers; perceived level of buy-in for LEAD among officers and police leadership; factors that influence referral decision-making processes and strategies; officers' role after referral; and perceived challenges and successes of the LEAD program.

3. LEAD Participant Interviews

Interviews with LEAD participants (N=22) were conducted between December 2019 and February 2021. Interviews were conducted in person by study staff, typically in LEAD case managers' offices, but shifted to being conducted virtually in March 2020 at the start of the COVID-19 pandemic. All interviewed participants were compensated thirty dollars for their time.

The participant interview protocol took a comprehensive approach to understanding participants' program experiences and life changes since enrolling

in LEAD and included both open-ended and fixed-response questions. Participants were asked about the referral process, their involvement in and satisfaction with the LEAD program and staff, suggestions for program improvement, and the perceived effect of various services on their drug use and life circumstances.

4. Data Analysis

Interview and focus group recordings were transcribed and de-identified, and then analyzed using a coding scheme specific to each respondent type.

To develop the coding system for each set of interviews, two members of the study team read study transcripts and wrote detailed memos, reflecting on content and identifying key themes. A codebook documenting all identified themes was developed with both deductive, theory-driven analysis, and inductive analysis, where themes emerged directly from the narratives and discussions. Codes were refined until all relevant themes were captured.

Discrepancies were identified and coders identified and clarified disagreements on the application of the codes. Finally, the interviews were divided among the coders and independently coded. All coding was recorded using Nvivo qualitative analysis software. The coded transcripts were reviewed for consistency and any remaining discrepancies were resolved using an iterative process to achieve consensus.

After coding, we identified broad patterns and themes within and across codes, following the general framework for thematic analysis. For the present analysis, we focused codes relevant to the implementation and processes of the sites' programs. All coded segments were annotated and clustered into broader conceptual themes. Conceptual themes were refined until all subcategories were adequately captured and represented.

IV

STUDY RESULTS

A. The Number and Types of Referrals and Enrollments

Across the sites, there were 242 referrals made during the study observation period, which was each of the programs' respective start dates through September 2020. Of those, 121 people—50% of referrals—went on to enroll in the program. With ninety-one referrals and fifty-four enrollments since its program's inception, Site A had markedly more average monthly referrals and enrollments than the other sites. Site D, which started at the same time as Site A—mid-2018—had the fewest average referrals and enrollments. Both of these sites were based in mostly rural counties. The average number of monthly referrals and enrollments differed by site and ranged from approximately one to three referrals per month and from less than one to two enrollments per month.

The majority of referrals (70%) were social referrals. Although arrest diversions only made up 30% of referrals, they comprised 45% of enrollments. Of those referred by an arrest diversion, 79% (53 of 67 people) enrolled compared to only 41% (64 of 157 people) of people given a social referral. Among the diversion referrals (n=67), the majority (81%) of the charges were drug related, including drug possession and paraphernalia charges and one driving while intoxicated (DWI) charge.

Table 3 describes details about 132 referrals made by the three police departments with the highest referral rate, which accounted for 55% of all referrals.²⁸ Of those referrals, most (59%) were made during business hours for LEAD staff, between 9 am and 5 pm. Most individuals who were referred between 9 am and 5 pm (67%)—when warm hand-offs were most easily made—went on to enroll, compared to only 33% of people who were referred outside of those hours. This pattern was especially notable in Site C, where 72% of the people who went on to enroll had been referred during business hours, while 70% of those who did not enroll were referred outside business hours when a case manager was not available for a warm hand-off.

Table 3. Circumstances of officer contact during LEAD referrals

Characteristic	Enrolled, N = 70	Not Enrolled, N = 62	Total, N = 132
Reason for police contact			
Officer responded to medical or behavioral health-related incident	19 (31%)	33 (58%)	52 (44%)
Officer responded to reported crime or accident	19 (31%)	14 (25%)	33 (28%)
Patrol	13 (21%)	6 (11%)	19 (16%)
Person came to officer	10 (16%)	4 (7.0%)	14 (12%)
Traffic stop	1 (1.6%)	0 (0%)	1 (0.8%)
Unknown	8	5	13
Referral made between 9am and 5pm	47 (67%)	31 (50%)	78 (59%)
Transported by EMS	7 (11%)	9 (16%)	16 (13%)

28. The circumstances of LEAD referral data were only available for three of the largest law enforcement agencies involved with the LEAD programs across the four sites, with one site not represented at all in the data. Thus, the data in this table include information for 55% of all the referrals that were made across all LEAD programs.

Unknown	6	7	13
Transported by law enforcement	24 (38%)	8 (15%)	32 (27%)
Unknown	6	7	13

44% of the 132 referrals were made when a police officer responded to a medical or a behavioral-health related incident. However, the majority (58%) of those individuals did not go on to enroll in LEAD. For the two sites with the most enrollments, the reason for police contact was fairly equally distributed across the five reported referral circumstances, with only 31% and 27%, respectively, being referred following a medical or behavioral-health related incident. In contrast, Site B, which had relatively fewer enrollments compared to the number of referrals made, 64% of referrals were made in response to a medical or behavioral-health related incident. This finding is likely influenced by the expectation of officers making referrals at all overdose reversal incidents at this particular site. Across the sites, 31% of individuals who enrolled in LEAD came into contact with the referring officer when the officer was responding to a reported crime. In these instances, the referred individual could have been a suspect or merely present at the crime scene—for example, if drugs were found on one person but not the other, or if the police were responding to a domestic violence call.

B. Demographics of Individuals Referred and Enrolled to LEAD

Referrals and enrollments varied substantially by socio-demographic characteristics (Figures 2–4). Across the sites, women within the sites' jurisdictions accounted for an average of 33% of LEAD-eligible drug charges but received 52% of referrals and represented 60% of program enrollments. Conversely, men accounted for 67% of LEAD-eligible drug arrests across jurisdictions but received just 48% of program referrals. Men were also less likely to enroll than women, comprising just 40% of program enrollments. Referrals and enrollment also varied markedly by race (Figure 3). Across jurisdictions, an average of 30% of community populations was comprised of Black individuals, yet they accounted for 44% of LEAD-eligible drug arrests. Where Black people were over-represented in drug arrests, they accounted for just 14% of program referrals and enrollments. White women were most likely to be referred and enroll in the program, representing 51% of enrollments; where Black men were least likely, representing just 7% of enrollments (Figure 4).

Figure 2. Referrals and enrollment by sex, comparisons by community census, jurisdiction-wide demographics, and LEAD-eligible drug arrest

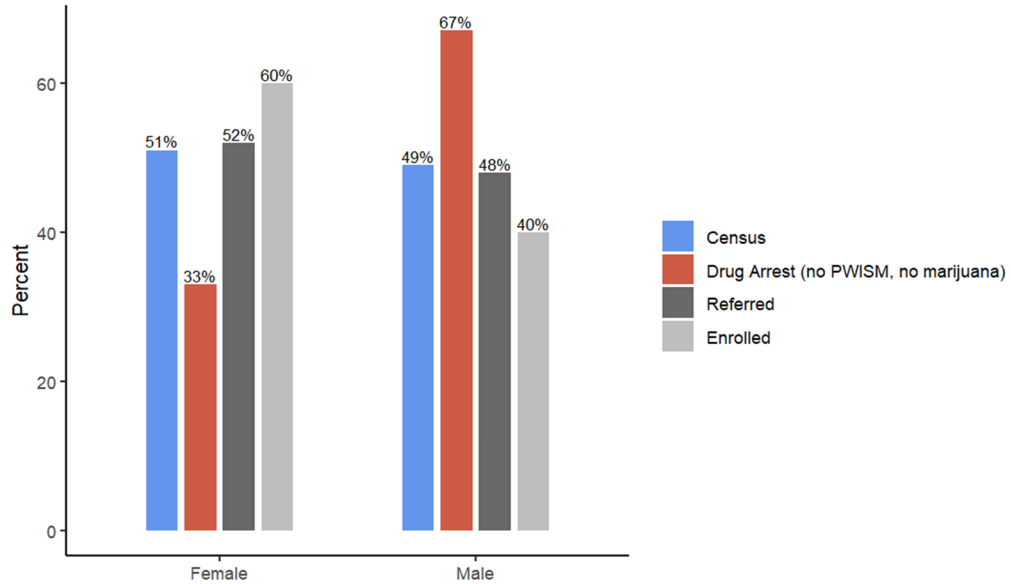


Figure 3. Referrals and enrollment by race, comparisons by community census, jurisdiction-wide demographics, and LEAD-eligible drug arrests

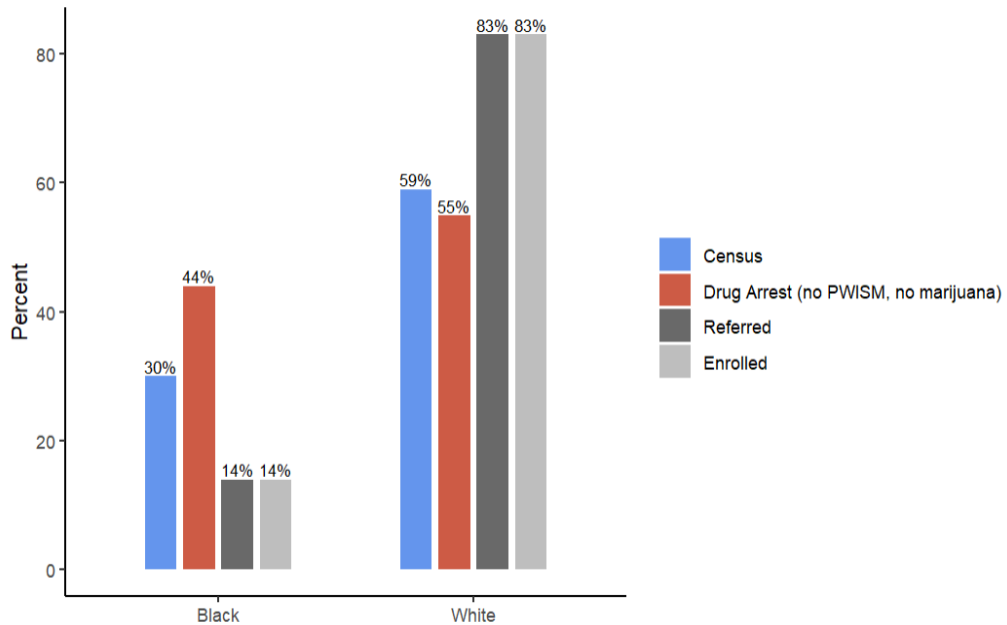
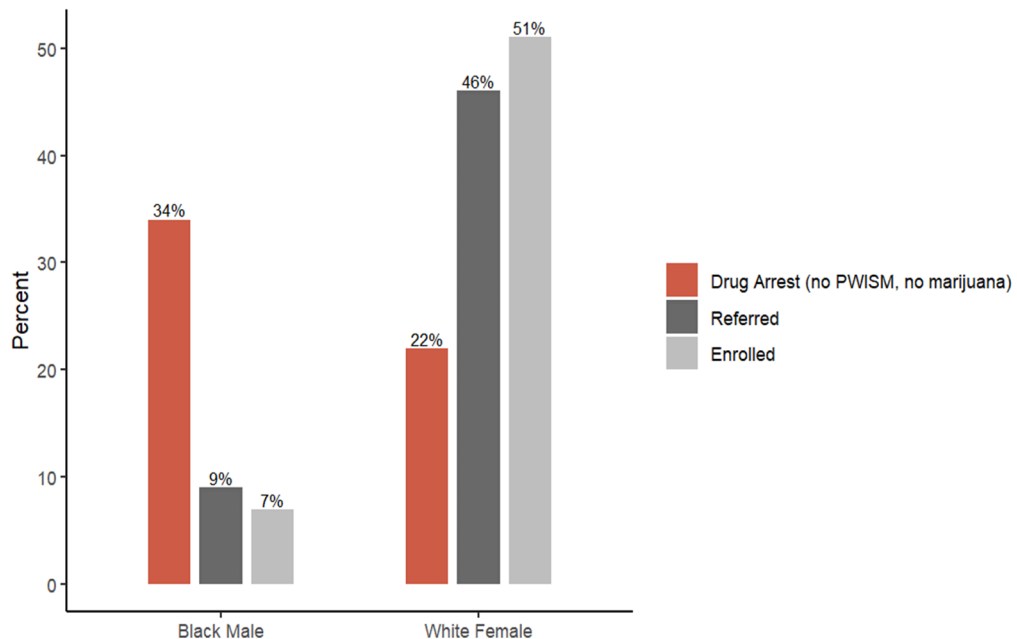


Figure 4. Referrals and enrollment by race and sex, comparisons by jurisdiction-wide LEAD-eligible drug arrest



C. Factors Influencing Successful Referrals and Program Enrollments

Diverse factors influenced the referral pathway, and ultimately, access to program services. These important influences included attitudes about LEAD, harm reduction, and treatment expectations among program partners and participants; agency culture and how it aligned with LEAD values; circumstances surrounding the referral event and experience that affected both referrals and their conversion to enrollment; and program policies and procedures that directly affected how and for whom referrals were made.

1. Participant Attitudes

a. Distrust of law enforcement. Respondents from each of the stakeholder groups—LEAD participants, program partners, and law enforcement officers—reported that people who lacked trust in law enforcement were less likely to accept a referral or feel comfortable during the referral process. They indicated that many people who use drugs have histories of negative interactions with, or had been harmed by, law enforcement, and that they brought those experiences to interactions with police officers, including at the time of the LEAD referral. One participant described the profound influence of their past experiences with police on their experience during the referral interaction:

I didn't have a good rep with the officers. I didn't like them. I don't really feel like they . . . helped that much. It was . . . odd having an officer actually be like, "Hey, this

could benefit you and we don't want you to be arrested, we want to help you, get you some help." And that was just very weird, I was like, "What?" That blew my mind. I just couldn't – I was very confused by that. The whole situation really confused me and I think that was one of the reasons why I really didn't understand what was going on whenever [the LEAD staff] came out to the house. I didn't know who [they were] or what [they] stood for or anything like that, because I was so used to, "Hey, you're going to jail," . . . I'd never heard of anything like that before. I was so used to [it] being "You're such a f***-up" . . . So, it was different. It was really different.²⁹

A common sentiment expressed by LEAD participants was feeling "weird" or "uncomfortable" joining a program that was offered by a law enforcement officer, and only later understood that police actually played a small role in the program. One participant explained their interaction with police at the time of their referral, "It was kind of weird at first because you know most addicts and drug users, we don't want nothing to do with the police and we don't want our friends seeing us talking to the police. So, I don't know, it was kind of weird at first." Another participant described a similar experience:

It was a little weird at first. I was definitely apprehensive about it. I definitely had thoughts of like being monitored by the police or being tracked by the police. After my first interaction with [the LEAD staff], I felt a lot better about it. I didn't have that paranoia, I guess, of the police on my back.

Officers and other program partners at each study site also identified distrust of the police by potential LEAD participants as a major obstacle to making successful referrals. They describe various tactics they used to overcome the unbalanced power dynamic between the officer and potential participant, including being very clear about the officer's role in the program ending after the referral interaction or by changing their typical tone, as one officer put it "to just talk to them adult to adult." Some officers shared that the distrust was insurmountable, especially in sensitive cases or circumstances, such as immediately after an overdose reversal, and suggested that law enforcement should not be involved in the LEAD referral process at all during overdose responses.

Some program partners and officers also expressed the opinion that Black individuals, compared to those of other races, were less likely to accept LEAD due to a greater distrust of law enforcement. One law enforcement leader reported:

We do have some, a few black males [in LEAD], I believe. But . . . everybody knows, obviously black males are most suspicious of the police, historically . . . the mistrust of police and that scenario would happen with black males a lot. Because unfortunately we know that they're disproportionately incarcerated.

b. Participants' perspectives on the referral experience. Participants varied in how much autonomy they perceived having in the decision to join the LEAD program, often depending on officers' communications. Most participants reported feeling fully autonomous in their decision to join LEAD. Among the participants who completed study surveys or interviews (N=22), one who

29. All anecdotal quotes were derived from study interviews and focus groups.

received a social referral after overdosing reported, “I do distinctly remember him saying you don’t have to do it. Basically, he said that if you choose not to do the program . . . it doesn’t mean [you]’ll be charged.”

Conversely, some participants reported feeling there was no good alternative to joining LEAD in arrest diversion circumstances, which is in accordance with our finding that people who had arrest diversions were more likely to accept the referral and enroll in the program—presumably, to avoid arrest and jail—than people with social referrals. One program participant reported, “I asked them what [LEAD] was and they explained it and I said, ‘What’s the other option?’ They said, ‘Jail.’ I was like, ‘Well, sign me up. Let’s try it.’”

Participants varied in their impressions of the role of police in the referral process. Almost half of interviewed participants perceived the interaction with police as having been positive (n = 9). The participant said, “He treated me like a human being. That was really actually very powerful”

Notably, only two participants perceived the interaction with the officer during the referral entirely negatively, one reporting, “[The referring officer] was actually very rude . . . I was surprised that he even referred me to the program in the first place because of the way he was acting”

While most participants expressed some apprehension about the interaction with police during the referral, many eventually appreciated the referral, and every participant reported improved perceptions of police resulting from their involvement in LEAD. Reported improvements included participants feeling officers genuinely cared about them, particularly when participants and officers connected in a meaningful way or when participants felt that officers saw them in a more positive light. Some participants reported an improved sense of self resulting from referral by police. Improvements were also ascribed to a sense of hope, dignity, and potential conveyed by officers. It is important to note that there was likely some degree of selection bias that affected study findings from program participant interviews, given everyone in that sample had enrolled in the program and engaged with the LEAD staff. These individuals may have been more likely to think favorably about their referral experience than people who did not follow-up with the enrollment process.

2. Law Enforcement Attitudes

a. Time and effort involved in referral process. During focus groups, officers who had made at least one LEAD referral reported that referrals required the same amount of time or less than making an arrest or coordinating with another outside agency—that is, the Department of Social Services—to respond. They also described the referral process as simple and straightforward. Many officers described using a simple flow chart provided by the program to make a referral, which they found helpful and easy to use. They described the expediency of the referral process as a practical reason, beyond their mission-driven commitment to the program, and called it a positive feature of the program. Officers noted

that raising awareness regarding the efficiency of making referrals could help increase officer buy-in to the program.

Although officers across the focus groups indicated that the actual event during which an individual accepts LEAD may take the same amount of time or less than it takes to make an arrest, they also raised that in some cases it could take multiple conversations over many interactions with the same person to move them towards accepting LEAD. Some officers discussed that they considered building rapport during the referral event or during previous interactions as part of the referral process and sometimes that took additional effort beyond their typical role as law enforcement officers. One officer explained the incremental nature of working toward acceptance of a referral for people they knew and believed could benefit from the program:

And so, people like [Officer A] . . . probably come into contact with them, ten, eleven, twelve, fifteen times before they're able to make a successful referral. But those ten, eleven, twelve, fifteen times might incorporate 150 to 200 minutes of contact . . . So, the point is . . . it can be[a] first [encounter], you've never had any kind of relationship with them, and you're able to establish rapport for a fifteen-minute field interview or an encounter. It could be that you've worked on building a rapport for several months, or it could be that you've had a rapport with that person for three or four years.

b. Buy-in among law enforcement. Program partners and law enforcement officers both reported a lack of sufficient buy-in to LEAD principles within the LEAD-affiliated police departments, which they believed contributed to low rates of referrals. In some cases, stakeholders shared that only a handful of officers made referrals while the rest of the patrol force made none, and in some instances even spoke negatively of the program. Other stakeholders noted a lack of buy-in among law enforcement leadership who were not sufficiently championing the program within their department ranks. Whether low buy-in was reported among leadership or frontline officers, two shared attitudinal causes were cited: (1) officer perception that LEAD referrals were outside the scope of law enforcement's role, and (2) officer beliefs that LEAD and other harm reduction efforts were not valuable.

The vast majority of stakeholders, including those in law enforcement, agreed that some officers did not want to make referrals because they did not consider diversion or referrals a part of their law enforcement role. Program partners in law enforcement suggested that such officers felt they "entered this profession because they believe in law and order" or were more invested in "enforcing laws" than in "dealing with people's personal problems." Officers who took part in the focus group reported that LEAD was regarded by some officers who do not make referrals as soft on crime and thus remained unpopular among officers who entered the field to "catch criminals," or who were expected to do so by a supervisor. One officer expressed:

So, for a fairly significant portion of [law enforcement officers], LEAD has always been an option. But I think a big part of it is that attitude, which I try not to outwardly have with [other] officers, but I have internally, which is, we're cops, we're not service providers. We didn't create this person's problem. We didn't write the laws. The laws

were written. They said, “If somebody does this, it’s illegal.” Somebody needs to take care of that. That’s the cops. That’s what I am.

By contrast, several officers and program partners indicated that LEAD-engaged officers viewed their role in society as extending beyond strictly law enforcement. Some reported that newer officers were more amenable to LEAD because its principles and practices aligned well with what they perceived to be their role given recent changes in the scope of policing, and especially the increasing presence of law enforcement during behavioral health crises.

Several law enforcement officers explained that they had been biased against people who use drugs before they received education and training about harm reduction. They went on to say that it was not until they acquired a better understanding of addiction as a medical condition that they appreciated the value of harm reduction approaches like LEAD. Some stakeholders, including those in law enforcement, also stated that some officers did not utilize LEAD because they did not believe the program could be successful, stemming from a lack of understanding of addiction, substance use, and harm reduction. One officer in a LEAD leadership role shared:

[My chief] took me from being basically the S.W.A.T. Team Commander . . . fighting the war on drugs to giving me two projects back to back, Naloxone and LEAD, where . . . I had to understand Harm Reduction. So, I went from why are we even giving people Naloxone? And why aren’t we arresting, we can’t just let people off. To now, understanding – you aren’t just educated on the program, you have to be educated on Harm Reduction in a way where you understand the nature of substance use disorder and relapse and recovery and, you know, appreciating the different stages . . . that people are in.

The most common suggestions by law enforcement for increasing buy-in were to bolster and hold more frequent officer trainings, and to use personal stories and statistics from their own LEAD programs to illustrate successes to other officers. One officer reported:

Some people buy in when they see it work. And I’ll be honest . . . I didn’t buy in immediately. But I saw it work. So, the best evidence is actually seeing it for yourself So, people that have been here longer and fall into that philosophy about, “We’re just gonna arrest away the problem. We’re not here to coddle people and do stuff like that,” they see evidence of people turning lives around because of this program.

c. Lack of Awareness and Exposure to LEAD. Program partners and officers reported that some of the police force simply lacked awareness of LEAD which, like low officer buy-in, led to the program’s under-utilization. Officers may have lacked awareness because they had not received training in LEAD or had forgotten about it as time passed. Some officers reported that they did not receive regular reminders or discussion and promotion of the program within their departments. As a result, they, or their peers, tended to forget to make referrals, even though they had been trained in LEAD. Stakeholders also reported that turnover of the LEAD law enforcement representative, police chief, or other high-ranking champions of the program contributed to lower awareness of LEAD because program promotion received lower priority after leadership change.

3. Perceptions of Readiness to Change

Many participants, program partners, and law enforcement officers referenced an individual's readiness to make changes to their substance use, and that readiness influenced whether they accepted the LEAD referral. Stakeholders reported that people seemed most ready to change when they were at "rock bottom" or the "end of their rope." One participant described accepting LEAD during a time of desperation and the importance of the program being available to them during what could be fleeting moments of readiness to receive help:

[T]hat window of opportunity when you're desperate like I was, it's a small window. Like, somebody from harm reduction drove down, this is how God works, just happened to be in [jurisdiction] doing a syringe exchange the day I was willing to go get some help, and was able to bring me back to [other North Carolina jurisdiction] and drop me off at the doors of detox. And then, I started my journey there.

Officers shared that a common reason people declined the LEAD referral was that they were "not ready" and "don't want the help." One officer explained why people may have been closed to the idea of engaging with the program:

Sometimes, it's their attitude. Some of them are receptive to [a LEAD referral]. Some of them are not. I've tried – there's one girl I've tried [to refer] twice and she's just . . . "[N]o, don't wanna do it right now. Nope. I like smoking meth" . . . [I]t's just their attitude towards it.

The only expectation of the LEAD program is that participants be ready to engage with LEAD staff as much as they wish, to address any life challenges that the participant feels are most important. However, some officers, program staff, and participants reported perceiving "readiness" in the narrower sense of readiness—to reduce or stop their drug use or seek treatment. For instance, some officers reported how they described the LEAD program during a referral and told potential participants that if they continued to use drugs, there would be serious negative consequences that LEAD could help prevent. One officer described a typical conversation they would have with people they wanted to refer to the program:

[I] say, hey I get it I realize you've been arrested thirty times in your life and you don't like law enforcement, I'm okay with that, I don't need you to like me; but . . . right now you're drowning whether you can admit it or not – and again because of my background, [family who struggled with addiction], and at the end of the day nobody looks in the mirror and likes what they see when they're a heroin addict. I promise you there are mornings that you wake up and you don't wake up going "I'm glad to be a heroin addict today," nobody does that. And so, I get that you don't like me, but I also get that you dislike where you're at in your life a lot more than you dislike me.

Framing LEAD as a tool that helps LEAD participants change their current behaviors and lifestyle could be compelling to some potential LEAD participants who were ready to change; for others, such a message could have led them to believe the program expected them to engage in treatment or otherwise achieve sobriety.

Several LEAD participants expressed that the priority of readiness to stop using drugs among program partners and officers was the catalyst for their decision to enroll in the program. Participants commonly described their

willingness to accept a referral in terms of being “ready to stop getting high” or “to get better.” Relatedly, some LEAD participants stated that they had previously declined LEAD because they had not been ready to accept help. One program participant expressed:

It’s a great program. But I would tell any other person the same thing what I just told you that, if it’s something that’s offered to you, it’s great. Take it if you’re committed to changing, but if you just think you’re just gonna run through it, it’s not for you. If you’re not committed to fully change, then it’s not gonna work.

4. Law Enforcement Agency Culture

a. Supportive policing culture. Program partners and officers at one of the participating police departments that made the most LEAD referrals across the sites reported that garnering buy-in to make LEAD referrals among frontline officers had been extremely successful. They all attributed strong buy-in among frontline officers to the uniquely heavy emphasis on community policing within their department’s culture. According to them, the emphasis on community policing created a more compassionate police force that was oriented toward supporting and getting to know people in the community and being more aware of the forces that drive people to engage in unlawful conduct. Officers described these pillars of community policing as aligning well with the LEAD model principles and credited them with helping achieve significant buy-in within their department.³⁰

One officer expressed strong commitment to their department’s community policing approach:

[Y]ou’ll hear us refer to that a lot – the community policing aspect . . . I think the reason our program has been so successful, too, in a short period of time is . . . the type of people that we have here . . . [O]ur officers are truly . . . trying to make a difference in people’s lives . . . there really is a humanistic side to us. We really are very passionate about that.

5. Circumstances Affecting the Referral Event and Experience

a. Community-initiated referrals. In three of the North Carolina LEAD programs, community-initiated referrals were a type of social referral that was initiated by someone outside of law enforcement such as a program partner, a family or community member, another LEAD participant, or the referred individual themselves. After the person was identified, a law enforcement officer would determine eligibility in regard to criminal history and then meet with the individual to complete the referral process. Although it was not written in program policy and procedures, there was wide agreement across program partners that allowing community-initiated referrals was beneficial. Allowing community-initiated referrals increases the number of referrals and improves accessibility of the program to potentially eligible individuals, socio-demographic

30. Community policing was not specifically mentioned by stakeholders at any of the other sites, though each had community policing-oriented programs and practices in place, which may also have facilitated the adoption of LEAD in their jurisdictions.

groups, or neighborhoods that the officers might not be reaching. For example, program partners at one site agreed that community-initiated referrals reduced barriers to including more Black individuals and people who use crack and other non-opioid illicit substances. At the one site that did not accept community referrals, many of the program partners and officers expressed that they would like their program to include that referral-making expansion.

b. Unintended negative effects of referrals made at scene of overdose reversals. A large proportion of people were referred to LEAD by an officer who was responding to a medical or behavioral health-related incident (Table 3). Those incidents were most commonly an opioid overdose and subsequent naloxone reversal. Program partners acknowledged that an overdose could present an important opportunity for a LEAD referral because it is a moment when the individual is likely experiencing heightened fear about the risks of their drug use and may be more open to accepting LEAD. However, they also emphasized that the success of a post-overdose referral depended on its timing and the surrounding circumstances. Referrals immediately following an overdose reversal rather than in the following days were reportedly challenging, if not counterproductive, as the individual who experienced the overdose could be disoriented and suffering from withdrawal symptoms. Therefore, they may feel vulnerable and especially opposed to interacting with law enforcement at that time. This concern was most commonly raised by officers at Site B, where they believed they were required to make a LEAD referral on-site during all overdose responses. This common practice, though not a written policy, prevented these officers from using their discretion to not make the referral in the immediate aftermath of an overdose in instances when they thought the timing or circumstances were not appropriate. The officers at Site B noted that other first responders who were present at the encounter would have been better suited to make the LEAD referral. One officer reflected:

Maybe the best step is not to involve officers. Maybe the best step is just to involve the other first responders who are there on the scene who are not feared by these people who are overdosing . . . [T]here is not going to be a mutual agreed upon relationship between us and these victims if we want to tell them [about LEAD] at the time of the overdose. It's always going to be a hostile interaction, especially once they're waking up from these overdoses.

c. Confusion around referral and post-referral protocols. Some officers, program partners, and LEAD participants reported sometimes being confused about the procedure to be followed after someone accepted a referral. These stakeholders noted a lack of clarity regarding how officers should transfer referral forms or make warm hand-offs to program staff, while LEAD participants expressed confusion about what to do after having been referred. Program partners and officers observed that some of this confusion and breakdown in communication could explain why some officers did not make referrals and why some referred individuals failed to complete the enrollment process. Different reasons for the confusion were noted. For example, program partners at one site reported having issues with referrals when both the case

manager and the facility-based crisis center were unavailable. Program partners at another site reported confusion about who they should send referral forms to due to frequent turn-over in LEAD staff. Across sites, some program partners reported a lack of clarity about how to proceed after a referral when the case manager was not on duty and officers had to rely on a third-party provider that was also subject to limited capacity. Officers did not always know about the changes with these providers. Even when reference documents were provided to officers—for example, a visor card of patrol cars that indicated after-hours referral protocols—the process would not always proceed as intended. Program data were consistent with these observations. 41% of referrals occurred outside of 9 am to 5 pm, when LEAD staff members were least likely to be working and a warm hand-off was sometimes impossible. Further, more people who enrolled were referred between 9 am to 5 pm (67%) than those who did not enroll (50%) (Table 3).

d. Importance of warm hand-offs. The value of consistently conducting warm hand-offs from officer to program staff during the referral event was exemplified by Site A, for which this practice was the norm and the expectation. The implementation team made an intentional decision to have LEAD staff—either the program’s case manager or mobile crisis, if after hours—travel to the scene of the referral to meet the officer and the person they referred. A primary objective in that practice was to avoid participants perceiving the case manager to be employed by and based in the police department; it also avoided the individual being transported in a police vehicle. Both of those circumstances could increase the likelihood of referrals converting to enrollments by increasing participants’ comfort-level. That process was largely reported to be successful, though one program partner noted that confusion persisted among some participants who continued to mischaracterize case managers as law enforcement staff. It was also reported that windows of interest to engage with the program could be narrow, with some individuals having felt ready for support at the time of the referral encounter but not later, when LEAD staff followed up if a warm hand-off was not possible.

6. Program policies and procedures

a. Eligibility criteria that are too exclusive. Across all sites, a subset of officers, program partners, and LEAD participants reported that program eligibility requirements were too limiting. They reported that their current criteria prevented the referral of some individuals who would otherwise be appropriate for LEAD. That may be one factor contributing to the relatively low number of average monthly referrals to LEAD. Despite each of the programs having informally adjusted their policies to be more inclusive, for example by allowing people on unsupervised probation to participate in LEAD, some officers expressed that current eligibility requirements continued to categorically exclude many people based on their probation status or disqualifying prior criminal convictions, both of which were often by-products of their substance use.

Relatedly, some officers explained they had made few or no referrals due to having little contact with people they perceived to be eligible. Some officers reported that the LEAD policy's eligibility requirements effectively limited their referrals to first-time offenders due to criminal history exclusions, which may also have contributed to disproportionate referrals and enrollments among women. The informal change of allowing people on unsupervised probation often occurred on a case-by-case basis and was not an option known to all stakeholders, including some referring officers.

b. Factors contributing to racial inequities. Some program partners and officers expressed concern that the restrictiveness of their existing eligibility requirements systematically excluded Black people and men from LEAD. They explained that Black individuals and men and, in particular, Black men, were more likely to have disqualifying criminal histories and probation status than White people and women, thereby contributing to systematic exclusion of those demographic groups. Additionally, program partners shared concerns that some officers incorrectly believed that LEAD was only for people who use opioids, possibly because that was the initial goal of their particular program. Prioritizing individuals who use opioids for LEAD could have contributed to a disproportionate number of referrals of White individuals if opioid use was more common in that demographic.

Some program partners also discussed the highly subjective nature of officers using their own discretion in making referral decisions, which they believed were informed by officers' own states of mind at the time, experiences, and biases—both racial and otherwise. One program staffer shared their related insight:

Now [eligibility requirements are fair]. Now, yeah, because it encompasses every form of substance or drug But again, it goes back into whose hand is it in? Who's running the beat that day or if they stop this car, how they feel. You know? So, there's too many variables, intangibles that you can't control and there's no way to know.

The same program staffer described inequitable referral practices that some officers employed based on both neighborhoods they intentionally avoided, having disproportionately negative associations with certain drugs, and related skewed optics of who might be an appropriate fit for the program:

[All drugs are qualified], but still – all right, officers look at like – there's a few areas in [the jurisdiction] . . . like and I tell the staff and this is like [XX] pockets around [the jurisdiction]. And officers know this and there's some pockets with just crack – just crack, crack, crack, crack, crack, crack, crack, crack, crack. You know? They don't care. . . . There ain't nobody going over there. You understand what I mean? They just don't care but you let little Susie with the blonde hair and the blue eyes overdose – yeah, we got a problem. So, yeah, that's for me very problematic . . . as I said earlier, on a social referral base, it's more crack and alcohol and African American.

V

INTRODUCTION SUMMARY AND IMPLICATIONS

Communities around the United States have been grappling with how to respond to illicit drug use for decades. Traditionally framed and addressed as a criminal concern, societal responses have been grounded in the criminal legal system, with arrest and incarceration of people who use drugs considered a morally appropriate solution. Meanwhile, U.S. communities' drug problems have persisted, and even worsened with the emergence of the widespread opioid epidemic, taxing both public health and criminal legal systems. Further, marked racial inequities that exist throughout our societal structures are embedded and perpetuated in criminalized responses to drug use. In response, some law enforcement and community stakeholders have embraced the idea that they cannot arrest their way out of the drug problem and have instead assumed a more public health-informed, collaborative approach to managing drug use.

The LEAD model offers an alternative to traditional responses to illicit drug use via multi-stakeholder commitment to diverting individuals away from the criminal legal system and instead connecting them to a range of services. The moment of referral is the gateway to program access and engagement, and many factors influence programs' ability to make successful and appropriate referrals to as many people in the community as possible who could benefit from the program.

This article presents an in-depth examination of the pathway into the LEAD program via a mixed-methods, multi-site study of four LEAD programs in North Carolina, which pioneered LEAD adoption in the Southeastern United States. We identify an array of attitudes, policies, practices, and experiences that affect programs' ability to achieve desired reach, equity, and operational functionality.

Buy-in, knowledge, and support for harm reduction in principle and practice are all essential to optimizing both how and how often LEAD referrals are made. Committed engagement among both law enforcement leadership and frontline officers who regularly encounter people who could benefit from the program is a necessity, and genuine shifts in agency culture toward collective impact and collaboration with community stakeholders are also critically important. The strategic and operational integration of community policing missions and LEAD programming appeared to maximize successful implementation and impact of LEAD and should be examined further to better understand that synergy. The challenges of achieving widespread buy-in among officers took place in the context of a national staffing crisis in law enforcement, leading to officer departures as well as high turnover, which for the North Carolina LEAD programs could have translated to LEAD-trained officers leaving and new officers not having received any training.

Our findings also demonstrated that even when programs and their partners endorsed harm reduction as fundamental to LEAD, most continued to expect participants to reduce or stop their drug use, rather than meeting them where they are and imposing no such expectation. Those expectations, whether explicit

or implicit, shaped the driving concept of readiness for the program expressed across stakeholder groups. Expectations also may have shaped law enforcement's messaging about the program, presenting LEAD as a link to treatment or an opportunity to stop drug use, rather than as access to a range of harm reduction and social services. Such messaging is in direct contrast to the principles of harm reduction and, instead, reflects prevailing societal ideas about how to address drug use, that is, that sobriety is the only real goal. That could have alienated some people at the time of referral who could have benefited from program services but who were not, and may never have been, ready to engage in treatment or move toward sobriety.

There was also evidence that allowing community-initiated referrals extended the program's reach in important ways. Allowing program staff or community members to make initial referrals to the program reached groups of people who had been traditionally overlooked and marginalized, including people of color. One site specifically implemented this policy change to improve outreach and program access for Black people. This expansion, in part, addresses the basic and pervasive challenge of distrust of police among people who use drugs, especially people of color. Successful connections to the program could be made by program and community members that might otherwise have been missed among eligible individuals who avoided interacting with police whenever possible or declined officer's referral offers.

Program policies are key drivers of program reach and equitable referrals and enrollments, often in ways that were not originally expected by the programs' partners. For example, it is likely that eligibility criteria that categorically exclude people with certain types of criminal convictions disproportionately affect people of color who could benefit from LEAD. Incremental adaptations to expand eligibility were likely helpful—for example, moving from exclusion of any probation to allowing unsupervised probation—but may not have been inclusive enough—for example, continued exclusion of people on supervised probation. Another example that operates from the other direction was requiring officers to make referrals at the scene of overdose reversals, which may have unintentionally contributed to categorical *inclusion* of some, such as White people who use opioids, while overlooking others, like people of color who may have been more likely to use other drugs. Aside from equity concerns, the overdose referral policy is an example of policy that was intended to achieve targeted outreach but that proved to be problematic and even counter-productive when people who experienced an overdose were unable to engage during the stressful and chaotic moments immediately following an overdose reversal.

Essential policy and practice features that influence referrals into the program, and ultimately, enrollment and engagement, included having a community policing model that fosters positive attitudes towards LEAD by referring officers; decentralizing police in referrals by allowing LEAD partners and community members to initiate referrals for people who might otherwise be overlooked; engaging in more targeted outreach to populations that have been

historically over-criminalized; reconsidering timing and law enforcement involvement in referrals post-overdose; building robust officer buy-in; and developing eligibility criteria that are as inclusive of underserved socio-demographic groups as possible. These features of LEAD programs could be assessed, guided, and optimized via regular meetings of Policy Coordinating Groups.

VI

CONCLUSION

LEAD is an innovative approach to managing illicit drug use in the nation's communities. LEAD is a collective impact collaboration at the intersection of the criminal legal system, public health, and community and social services. North Carolina was the first among Southeastern states to implement LEAD programs across the state. This study examined a range of program features that influence programs' ability to reach and engage people who could benefit from program services. To expand programs and reach more people who could benefit from their services, we recommend LEAD programs hold regular officer trainings, expand eligibility to increase the number of appropriate referrals and reduce racial inequities, systematically track demographic data on referrals—including for people not given referrals and people who were offered referrals but declined—to identify inequities and guide targeted outreach, clarify program description during referrals to avoid communicating treatment expectations, systematize warm-hand offs to increase the rate of enrollment after referral, and encourage and strengthen participant and community engagement. To achieve these recommendations, LEAD programs' Policy Coordinating Groups should review and revise program policies as needed to achieve maximum benefit for program participants and the community at large.