Assessing the Impact of Local COAP Programs on Illicit Substance Use and Misuse

Maryland Comprehensive Opioid Abuse Programs (COAP) Multi-Site Evaluation

EVALUATION REPORT

September 2025

MARYLAND CRIME RESEARCH AND INNOVATION CENTER

CESAR
CENTER FOR SUBSTANCE USE, ADDICTION & HEALTH RESEARCH

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About the Researchers

This evaluation of Maryland's Comprehensive Opioid Abuse Programs (COAP) was prepared by collaborative efforts between two research centers at the University of Maryland, College Park - the Center for Substance Use, Addiction and Health Research (CESAR) and the Maryland Crime Research and Innovation Center (MCRIC) - via a contract with the Governor's Office of Crime Prevention and Policy (GOCPP). MCRIC and CESAR share a distinctive ability to produce practical, timely, user-friendly reports and other products to ensure that research findings are accessible and applicable to current needs and concerns.

MCRIC engages in research to inform local, state, and national crime reduction strategy and policy through data-driven scholarship by conducting rigorous interdisciplinary fundamental and applied research, developing and evaluating innovative criminal justice strategies aimed at reducing crime in the State, leveraging cross-agency networks to foster data integration, and actively engaging in translational science through broad and varied dissemination of research. MCRIC aims to help make Maryland communities safer by addressing today's grand challenges, such as gun violence, social and racial disparities in the criminal legal system, and the intersection of behavioral health and public safety.

CESAR serves as an interdisciplinary research center to advise local, state, and federal agencies on changing drug and crime trends, prepare strategic plans for responding to these trends, implement programs to reduce harm and support long term recovery, and evaluate the programs implemented to address the impact of substance use and support people with substance use disorders. The evidence-based and data-driven research, practical products, and innovative technologies developed by CESAR staff have successfully informed policy makers, practitioners, and the public about substance abuse—its nature and extent, prevention and treatment, and its relation to other problems.

Both CESAR and MCRIC leverage the broad range of expertise at the University of Maryland to engage in innovative research and interdisciplinary projects to enhance community safety and inform data-driven decision making. Both collaborate with a variety of partners including communities and community-based organizations, police and practitioners, state and local lawmakers, academic peers, and industry, to promote data sharing, exchange of knowledge and best practices, and to develop new approaches. The combined strength of these research centers provided the State with a unique opportunity to plan and conduct a comprehensive evaluation of seven COAP programs while providing program staff with regular input and a clear voice in interpreting results and identifying key findings and recommendations.

About the Project

This evaluation provides an overview of the status of seven opioid-intervention programs in Maryland, who received funding from the GOCPP FY22 COAP Grant. This report summarizes key quantitative and qualitative indicators, evaluates program implementation and outcomes (when able), and provides recommendations to support future efforts by GOCPP and COAP programs. GOCPP funded this project under subaward number COAP-2022-0008.

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List of Abbreviations

AACDOH: Anne Arundel County's Department of Health

AAPOWER: Anne Arundel County's Peers Offering Wellness Education and Resources

BJA: Bureau of Justice Assistance

CARA: Comprehensive Addiction and Recovery Act

CBA: Cost-Benefit Analysis

CDC: Centers for Disease Control and Prevention

CESAR: Center for Substance Use, Addiction & Health Research

CIT: Crisis Intervention Team

COAP: Comprehensive Opioid Abuse Program

COSSUP: Comprehensive Opioid, Stimulant, and Substance Use Program

DART: Division of Addiction Research and Treatment

ED: Emergency Department

ER: Emergency Room

FY19: Fiscal Year 2019

FY22: Fiscal Year 2022

GOCPP: Governor's Office of Crime Prevention & Policy

LBHA: Local Behavioral Health Authority

LEAD: Let Everyone Advance with Dignity (formerly Law Enforcement Assisted Diversion)

LE: Law Enforcement

LEO: Law Enforcement Officer

MAT: Medication Assisted Treatment

MCRIC: Maryland Crime Research & Innovation Center

MDH: Maryland Department of Health

MOPD: Maryland Office of the Public Defender

MOU: Memorandum of Understanding

MOUD: Medication of Opioid Use Disorder

MSAC: Maryland Statistical Analysis Center

NCHS: National Center for Health Statistics

NIDA: National Institute on Drug Abuse

NIH: National Institute of Health

NIJ: National Institute of Justice

OD: Overdose

OMH/CSA: Office of Mental Health/Core Service Agency

ODMAP: Overdose Mapping and Application Program

OD SOS: Overdose Survivors Outreach Services

OPT: Open to Treatment

PAARI: Police Assisted Addiction and Recovery Initiative

QRT: Quick Response Team

SUD or SUDs: Substance Use Disorder(s)

Executive Summary

At its peak in 2023, nearly 113,000 individuals lost their life due to a drug-involved overdose, largely attributable to opioids. Though declining, the rate of fatal and non-fatal overdoses continues to be an ongoing challenge for public health and community safety. Federal and state efforts have addressed the opioid epidemic through the expansion of grant funds for program development and improvements aimed at preventing and reducing opioid use and overdose. These funds have spurred myriad responses to address the challenges associated with substance misuse. The Comprehensive Opioid Stimulant and Substance Use Program (COSSUP; formerly Comprehensive Opioid Abuse Program (COAP)) is one of these initiatives and aims to provide support to increase treatment and recovery services in the criminal justice system, strengthen data collection and sharing, maximize resources and diversion program funding across systems, and prevent illicit substance use and misuse.

Since 2019, Maryland has awarded funding to 12 of its 24 jurisdictions to support efforts to address the opioid crisis. This evaluation provides an overview of the status of seven of the nine programs that received funding in fiscal year 2022 (FY22): three newly funded in FY22 (Allegany County, Anne Arundel County, and Calvert County) and four continuing programs (Carroll County, Maryland Office of the Public Defender (MOPD), Harford County, and St. Mary's County). This report summarizes key quantitative and qualitative indicators, evaluates program implementation and outcomes (when able), and provides future recommendations for GOCPP and COAP programs.

Overview of COAP Program Characteristics

COAP programs vary in terms of the main focus and the type of referral utilized to align with the unique characteristics and needs of each jurisdiction. Two are Law Enforcement Assisted Diversion (LEAD) programs that depend on law enforcement officer (LEO) referrals (Carroll County and Harford County), two are associated with court actors/actions (MOPD and St. Mary's County), one is a detention-center focused program (Allegany County), one takes a health-centered approach (Anne Arundel County), and lastly, one heavily relies on peer specialists to help people (Calvert County). Though programs vary in their approach, they share similar goals including:

- Reduce opioid overdose deaths in designated project implementation areas.
- Reduce recidivism of LEAD participants (compared to representative proxy group).
- Reduce calls for service for drug-related activity in the pilot area.
- Reduce criminal justice costs incurred by LEAD participants (compared to control group).
- Increase LEAD participants' access to permanent housing (compared to baseline).
- Increase LEAD participants' average income.
- Improve community perceptions of police.
- Improve police understanding and response to issues related to addiction and mental health.

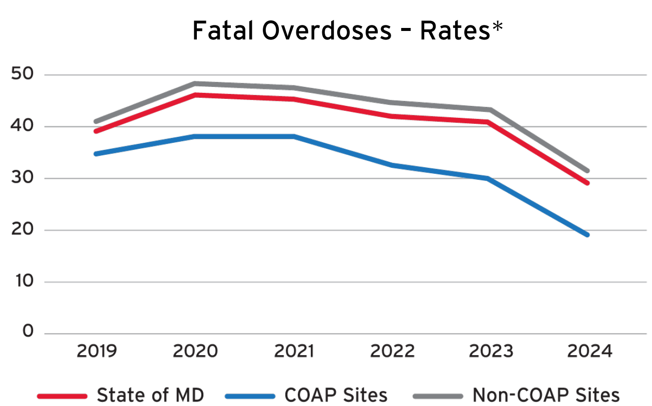
Across all programs, referrals totaled more than 1,500 people since the start of FY22 program funding. The vast majority of referrals were received through arrest diversion (84%) and social contacts outside of the criminal legal system (16%). Among those referred, 78% of eligible participants chose to enroll in a program.

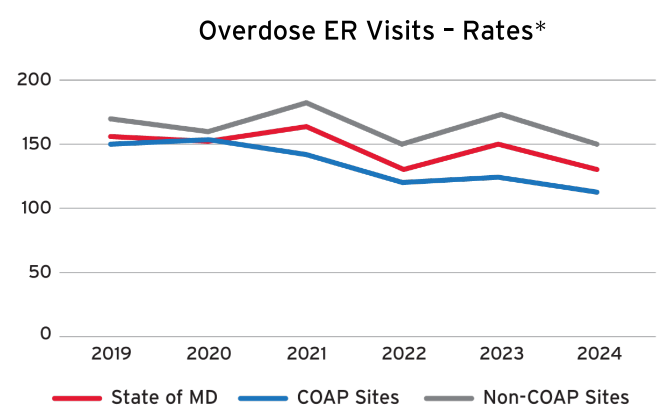
On average, participants served in Maryland are White (65.8%), male (62.5%), and have a mean age of 39 years.

Each program reported connecting individuals to treatment services. Across programs, receipt of Medication Assisted Treatment (MAT), enrollment in ongoing behavioral health care, and connection with medical insurance were the most commonly utilized services. In addition, over 50 individuals were connected to permanent housing and 45 were connected with employment, training, or education programs. Importantly, there is significant variation in data entry across programs related to referrals to treatment services, Emergency Room (ER) visits, hospitalizations, and victimization, with some capturing this only at intake and others as program participants engaged with the program to which they were referred, which limits the ability to draw broad statements about the success of COAP programs in linking individuals to services or continued challenges faced by program participants.

Longitudinal Trends in Overdose Outcomes in Maryland

Examining year-to-year trends in fatal overdoses and overdose ER visits suggests that jurisdictions receiving COAP funding experienced swifter declines in each of these outcomes in recent years. While Maryland experienced a 27.3% statewide reduction in overdose death rates from 2019 to 2024, rates fell more than 46% in counties receiving COAP funding. Furthermore, the gap between overdose death rates between COAP and non-COAP-funded counties has continually widened, with non-funded counties reporting rates nearly 70% higher than COAP-funded counties. Notably, these are descriptive observations and do not implicate a causal relationship. The counties implementing COAP programs may also be implementing other initiatives or programs designed to reduce overdoses and overdose deaths which may also impact the overdose rates in these jurisdictions. A critical next step is to assess programs more closely to better understand implementation, outcomes, and impact.





**Note: Rates are per 100,000 residents*

Key Insights

The urgency of responding to the opioid crisis and substance use and misuse is palpable in Maryland. This is a complex problem that touches each jurisdiction in Maryland, yet the way it impacts each jurisdiction and the resources they have to address it varies. This variation requires innovative solutions.

Many of the LEAD programs evaluated operate as a collaboration of multiple local programs managed across both public safety and public health agencies. Specific activities mentioned by the staff ranged from case management to community outreach and training to providing services to meet the individual needs of program participants. All of the programs provide case management/care coordination, provide services and referrals to participants, engage in community outreach and hold meetings with participating agencies. They also either utilize harm reduction approaches directly or work with harm reduction programs. At least six of the programs provide peer support.

Consistent with harm reduction principles, Maryland's COAP programs approach individuals with an understanding that recovery is a long-term process. Staff frequently define successes as unique to each participant and with the clear vision of helping them reach personal goals and overcome barriers. Programs are constituted with allowances for, and the expectation of, lapses back into substance use along the recovery journey. This forgiveness means that individuals are not barred from program access and services if they experience a relapse, but instead these are recognized as opportunities for learning (e.g., understanding triggers, identifying new coping strategies). This kind of flexibility also reduces stigma among affected populations, increasing the likelihood that they will seek out help again.

Recruitment, retention, and buy-in are commonly experienced challenges across programs. Program buy-in issues can come from key contacts for recruiting individuals to the program and diverting them from criminal legal system contact. Challenges due to program buy-in have forced some programs to alter their strategy during rollout stages, delaying the implementation.

Hesitancy toward the program also arises from individuals who could be served by programs. This is clearly seen when looking at the decline in the number of individuals referred for services across programs compared with the number of individuals enrolled in programs or receiving treatment. Program staff shared the importance of developing an education campaign to support outreach efforts before making formal recruitment efforts to allow for trust building among particularly vulnerable and hard-to-reach populations.

Responding to Evaluation Insights

Overall, there is evidence to suggest that Maryland is taking positive steps to address the opioid epidemic and substance misuse. That said, through this evaluation, we find evidence of opportunities for improvement. We draw on the data insights and interviews with program staff, as well as innovative practices taking place across the nation, to identify a variety of strategies for the LEAD programs and GOCPP to increase program awareness, improve program reporting and inform future evaluations, support program implementation, and improve service delivery to patients.

1. **Increase Awareness of LEAD Programs**. While program staff feel that there is a shared vision among participating agencies, perceptions of the level of awareness of COAP/LEAD programs varied within and across programs and individual awareness is often linked to one's specific touchpoint or role in the program. Increasing awareness can encourage buy-in and utilization, enhance coordination efforts, and ease communication across people and agencies.
    - <u>Offer more regular opportunities for staff training</u>. Several programs offer education opportunities through targeted training for (new) staff, conferences for agents of the court, and management plans with routine program meetings. Increases in staff training should include both within and across agency opportunities.

- Encourage coordination across partners. Programs encourage coordination by attending staff meetings, making presentations at roll call, and meeting regularly with staff and collaborating agencies to educate them about LEAD and encourage them to make referrals. Increasing cross-agency communication can increase program collaboration and utilization.
- Continue to address stigma so that more people can recognize the value of the program. Programs can work to address stigma by offering trainings for staff at collaborating agencies, and engaging in outreach efforts to local businesses through merchant associations and other venues. Sharing success stories and discussing challenges faced by program participants can help people understand the impact of LEAD programs.
- Encourage programs to utilize resources available through GOCPP. The Centers of Excellence at GOCPP provide training and technical assistance, as well as resources to programs engaged in direct services. GOCPP should share these opportunities more broadly and routinely with programs. When programs meet with GOCPP project officers, they should share resources that may be particularly useful for the program's efforts.

2. **Improve Program Reporting and Inform Future Evaluations.** A requirement of the receipt of funding is the collection and reporting of key data points. These data provide an opportunity to track program progress, evaluate program implementation and outcomes, and draw inferences about COAP funding across the State. However, several challenges related to a shared understanding of data inputs, data entry within quarters and over multiple quarters, and gaps in key information points limit the use of the data in its current form. Recommendations aim to enhance data accuracy and standardization to draw program insights and inform future evaluation efforts.
    - Provide technical training to programs for grant reporting. Offer technical training on data entry, reporting guidance, and variable definitions to improve data accuracy and consistency. Clarifying data definitions in the reporting manual and allowing flexibility for program differences would further enhance reporting quality.
    - Revise reporting metrics for participant needs and service referrals. Revise the reporting system to better capture key program and participant details, broaden predefined referral categories to reflect the full range of referral reasons, and to capture accurate and detailed information about each participant.
    - Revise reporting metrics for outcome-related data. Form a diverse workgroup (e.g., program staff, data personnel, individuals with lived experience, and funders) to inform the revision of reporting metrics to better capture participant progress and lapses, ensuring standardized yet flexible data collection that reflects both shared outcomes and program-specific features.
    - Conduct satisfaction surveys and interviews with program participants. Implement a participant satisfaction survey and interview program participants as part of the program evaluation to systematically capture feedback on the quality, accessibility, and relevance of services provided. This data can offer valuable insights into what participants find helpful, identify gaps in service delivery and other challenges encountered, and highlight opportunities for improvement.
3. **Support Program Implementation.** Program evaluations are critical for understanding the effectiveness of criminal justice interventions and should follow five interconnected stages: needs assessment, theory evaluation, implementation analysis, outcome evaluation, and cost-benefit analysis. However, evaluations often skip the implementation stage, overlooking challenges like recruitment and partner buy-in that can impact success.

- Provide support for program start up to ensure adequate infrastructure to support planned program needs. Programs often face early implementation challenges due to limited buy-in from key partners which can delay rollout and require structural adjustments. Requiring MOUs between collaborating agencies at proposal submission or within the first quarter of funding may help to streamline planning and support timely implementation.
- Build in funding support to allow for implementation analysis. Allocate funding to support implementation analyses for all new and expanding programs, as this stage is essential to understanding real-world delivery, improving program effectiveness, and informing policy decisions.
- Support gender and culturally informed programs. Although opioid misuse affects diverse populations, most COAP programs in Maryland primarily serve white, male participants. Investing in tailored, equitable approaches to better support diverse populations and improve recovery outcomes would align with emerging evidence on the importance of gender-responsive and culturally competent programming.
- Provide continued support to programs to maintain staff. Staffing is a key challenge for most programs and includes delays in the hiring process, nuanced certification processes, and limited workforce capacity. While trainings and routine meetings may help build awareness and encourage agencies to make referrals, it is also important to invest in efforts to attract and maintain experienced and dedicated staff.

4. **Improve Service Delivery to Patients.** A key goal of the LEAD programs is to accept referrals and work with participants to develop case plans and connect participants to the services they need. All of the programs evaluated have engaged with participants and regularly conduct community outreach and trainings, but they also expressed the need to do more. They stressed the need to expand opportunities for referrals and the reach of their programs while emphasizing the individual nature of recovery journeys. Improving the provision of services to participants can involve working within the program and also working with local community organizations and even across jurisdictional boundaries.

    - Provide more intensive case management and peer support to participants. This includes emphasizing the importance and value of hiring peer recovery specialists as program staff.
    - Engage across jurisdictional boundaries. Build connections between counties so that the needs of the participants can be addressed wherever they are located and case management can continue to be provided.
    - Engage with the community. All of the programs conduct community outreach activities including presentations at local meetings and events such as county fairs and citizens' academies; conferences with judges and states' attorneys; meetings of local groups such as On Our Own, Lions' clubs, and merchants' associations; and special events such as law enforcement appreciation day. However, many expressed an interest in working to expand the reach of their programs and developing methods to encourage social contact referrals and self-referrals.
    - Understand that participants have unique journeys and may need to cycle through multiple times. Recovery journeys vary from one participant to another and can include both successes and challenges. This means that indicators of success and level of engagement will be unique to each participant. So, it is important to engage with each participant as a unique individual and continue to provide ideas and links to services throughout the recovery process.

Scope of the Opioid Crisis

Opioid related overdoses peaked earlier in the 2020s prompting the launch and expansion of law enforcement diversion programs such as the seven programs included in this evaluation. Although decreases have been detected both nationally and in Maryland in 2024 (Figure 1), the number of people experiencing overdoses continues to be high and presents ongoing challenges for public health and community safety.

Opioids Are…

a category of addictive drugs including both prescription medications, such as oxycodone, and illegal drugs, such as heroin. The classification of opioids depends on their origins. There are three types: natural, semi-synthetic, and synthetic. Natural opioids (e.g. morphine), called opiates, are created from the opium poppy plant seed pods. Semi-synthetic opioids, such as heroin, are natural opioids that have been chemically processed in laboratories. Synthetic opioids, such as fentanyl, have no natural ingredients and are entirely manmade.

Source: NIDA, NIH. 11/22/2024. Opioids. Retrieved from https://nida.nih.gov/research-topics/opioids on 9/10/25

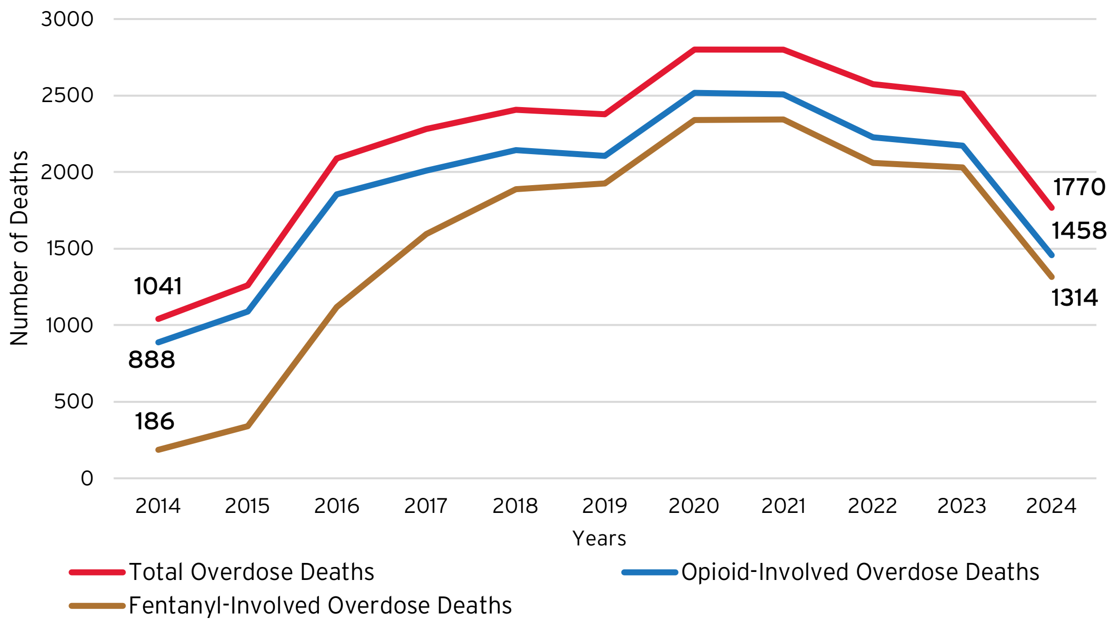
Overview of National Trends

Predicted drug-involved overdose deaths nationwide first topped 100,000 deaths in a twelve month period in spring 2021 and peaked at more than 110,000 deaths in summer 2023 (CDC, 2025). This increase is largely attributable to opioids, particularly synthetic opioids such as fentanyl (NIH NIDA, 2024). After peaking at 112,966 predicted drug overdose deaths for the 12-month period ending August 2023, however, the trend began to change. Since then, the number of predicted overdose deaths decreased to 76,516 in April 2025.

Overview of Maryland Trends

Similar trends are also apparent in Maryland where Maryland Department of Health (MDH) data show fatal overdose deaths peaked at 2,800 in 2021, remained above 2,500 in 2022 and 2023, and then decreased 30% to 1,770 in 2024 (see Figure 1). Opioids, particularly fentanyl, were the most frequently detected drugs in these deaths. Fentanyl involved deaths increased sharply from 186 in 2014 to a peak of 2,344 in 2021 and remained above 2,000 in 2022 and 2023 before decreasing 35% to 1,314 in 2024. Fentanyl accounted for approximately 80% of the overdose deaths reported in 2022 (2,060 of 2,576) and 2023 (2,032 of 2,511) and 74% in 2024 (1,314 or 1,770) (MD OD Dashboard, 2025). The only drug to show an increase in overdose deaths in 2024 was heroin which decreased steadily from more than 1,200 in 2016 to 121 in 2023 and then increased to 169 in 2024. There have been 1,338 overdose deaths in the first 8 months of 2025 including 958 related to fentanyl, 1,074 related to any opioid, and 689 related to cocaine.

Figure 1: Total Maryland Drug Overdose Deaths by Drug and Year, 2014-2024



Note: As noted by MDH, intoxication death may involve more than one substance. Opioid-related deaths are defined as "the result of recent ingestion or exposure to an opioid substance, including prescription and/or illicit opioids." (MD OD Dashboard, 2025)

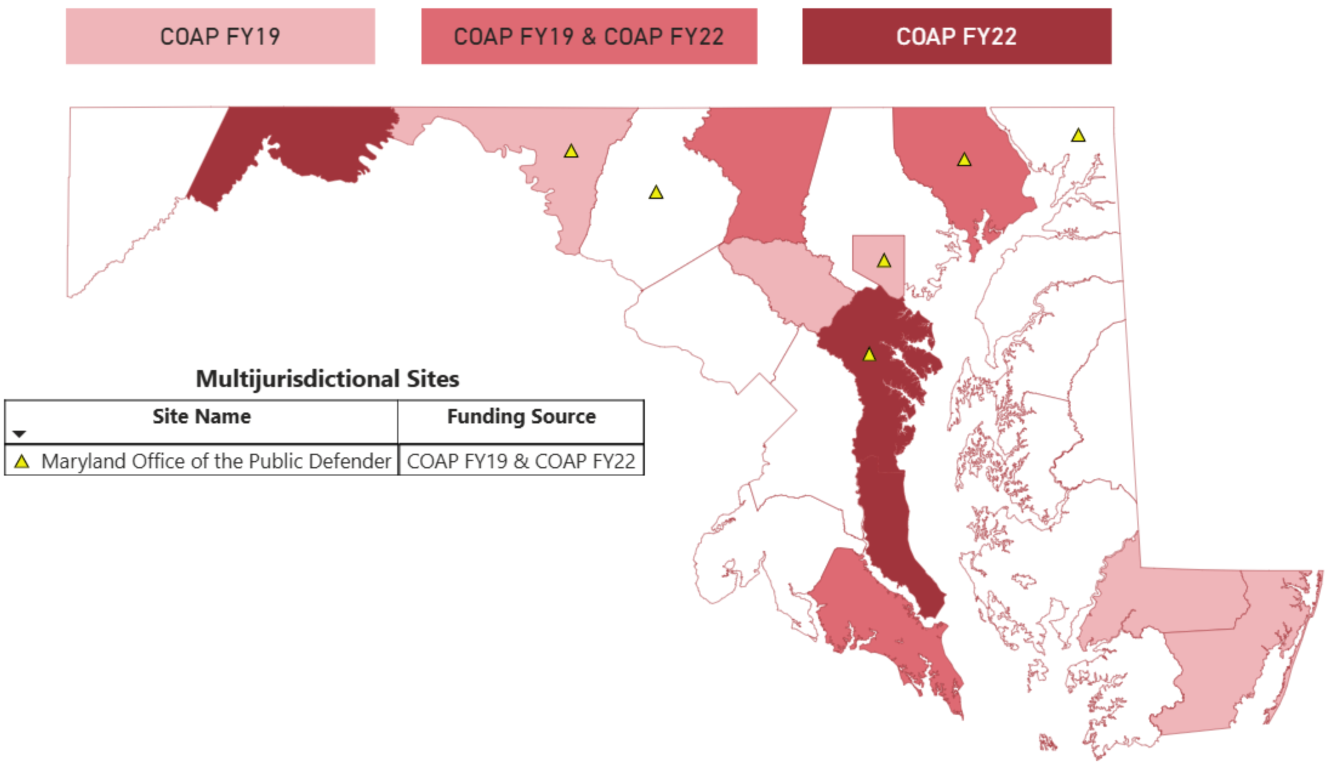
Source: Graphic adapted from data on the MD OD Dashboard. Data accessed 10/10/25.

From 2014-2021, overdose deaths among non-Hispanic Black Marylanders more than tripled from 298 to 1,198. Overdose deaths among non-Hispanic White Marylanders, in contrast, reached more than 1,500 in 2017 and again in 2020 before decreasing steadily. The number of overdose deaths involving non-Hispanic Blacks surpassed the number involving non-Hispanic Whites for the first time in 2023. Non-Hispanic Blacks made up about a third (31%) of Maryland's population in 2022, but nearly half (45-46%) of fatal overdoses in 2023 and 2024 (MD OD Dashboard, 2025). In 2024, however, the number of overdose deaths involving non-Hispanic White, non-Hispanic Black, and Hispanic populations all showed decreases.

Scope of Work

In 2019, the Governor's Office of Crime Prevention, Youth, and Victim Services (now the Maryland Governor's Office of Crime Prevention and Policy (GOCPP)) began providing grant funding to programs that address the impacts of substance use/misuse, especially those providing services to individuals who experience persistent adversity and inequality. A total of nine communities – six with new programs and three with expanded programs – received fiscal year 2019 (FY19) funding. Subsequently, in 2022, GOCPP awarded COAP grant funding to an additional 9 programs to implement or expand police-led diversion, court-associated, and detention-based referral programs (see Figure 2).

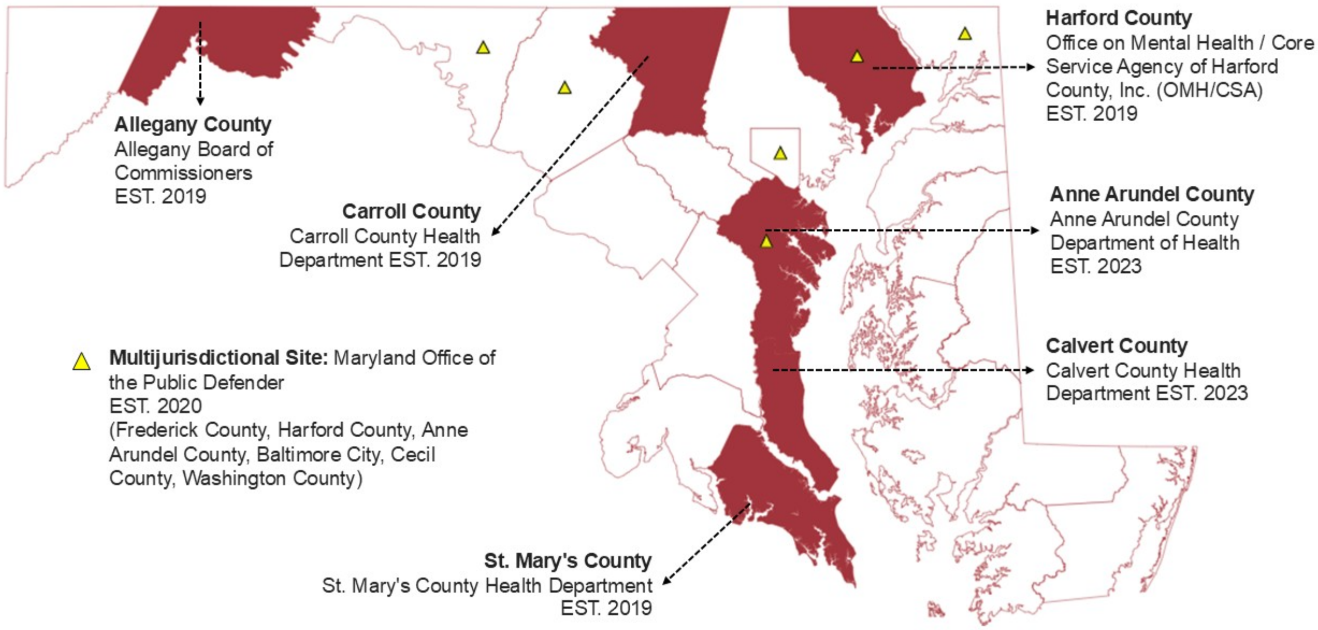
Figure 2. Map of FY19 and FY22 funding cycle for each program.



This evaluation focuses on the seven programs shown in the map in Figure 3. Three were newly funded in FY22 (Allegany County, Anne Arundel County, and Calvert County)[1] and four are continuing programs (Carroll County, Maryland Office of the Public Defender (MOPD), Harford County, and St. Mary's County).

[1] Allegany County is a newly funded COAP grant program but began implementing substance use disorder (SUD) treatment program efforts back in 2019 with the implementation of the Division of Addiction Research & Treatment (DART) initiative. LEAD-based initiatives began in 2021 with official COAP funding from GOCPP being granted in the FY22 funding cycle, which started in October 2023.

Figure 3. Detailed Map of FY22 COAP-funded program locations.



Goals of this Evaluation

Our evaluation was motivated by six overarching goals:

- Goal 1: Analyze how agencies utilized COAP funding to identify individuals in need of substance abuse treatment services.
- Goal 2: Evaluate the effectiveness of the COAP-funded programs in connecting individuals to treatment services.
- Goal 3: Identify the efforts taken to reduce overdose deaths.
- Goal 4: Examine the effectiveness of the COAP programs based on the recidivism rate of individuals connected to services.
- Goal 5: Determine if current programmatic reports are effective measures of the program and provide recommendations on how the Office can more effectively measure the COAP program.
- Goal 6: Incorporate a quality control component that will provide strength-based feedback and programmatic support (including database development as needed) to COAP funding recipients.

Methodology

The primary aims of the evaluation included understanding the current landscape of LEAD programs in Maryland, assessing the accomplishments and challenges of each program, and identifying a structure to expand and support future evaluation activities and increase the evaluation readiness of LEAD programs. The research team used a multipronged methodological approach including quantitative analyses of program and participant data, qualitative interviews with program staff and insights from quarterly reports, and a series of group meetings with program staff to assess COAP programmatic characteristics for each funded program, understand patterns of client contact, and assess outcomes.

The project was conducted in three phases:

Phase 1: Scoping Review and Landscape Analysis

The project began with a review of research related to LEAD programs and evaluations of law enforcement diversion programs that focused on substance use reduction efforts to understand the national scope of work related to LEAD, COAP, and legal system assisted diversion. A landscape analysis of COAP-funded programs in Maryland focused on generating insights into local level dynamics and characteristics.

Phase 2: Data Analysis

Utilizing data from a variety of entry points (e.g., client, staff, program / jurisdictional, state and national), provides a holistic view of programmatic efforts and overdose trends across the seven funded programs.

- **Quantitative Data**. The research team worked with the Maryland Statistical Analysis Center (MSAC) and GOCPP's Criminal Justice department to curate data derived from quarterly reports submitted by each program which were shared using an encrypted data transfer system to ensure secure delivery. The research team worked with each program to understand data entry and add additional data points where needed to best understand recruitment, retention, client needs, service delivery, and outcomes. These data cover a period from October 1, 2023[2] through July 31, 2025, and include the following information points:
    - Individual-level data pertaining to each client including LEAD referrals, intake information, case management recommendations, service referrals and enrollment, program progress, and outcomes (i.e., arrest, overdose, discharge).[3]
    - Performance measures including jurisdictional, aggregated data that reports on arrests and probation violations, referrals, program communication and discharges, ER admittance, overdoses, connections to different public health services and benefits, and victimizations.[4]
    - State and national level data to track longitudinal trends in overdose and ER visits to contextualize efforts taking place at the jurisdiction level.
- **Qualitative Interviews.** The research team conducted 22 interviews including 2-4 staff members of each of the seven programs being evaluated. The goal of the interviews was to collect insights on the impact of the programs on the participants and on the collaboration of local organizations. Questions were designed to collect participant perceptions in six areas: scope of the program and services provided, level of awareness/understanding of COAP/LEAD among participating organizations and the public and local collaborations, program specific activities, program successes, program needs/challenges, and future hopes and plans. The staff members interviewed were adults aged 18 or older. To ensure that they had adequate knowledge of the program and the collaborating organizations, they were active members of the program staff for at least 4-8 weeks. Participating staff included law enforcement officers, case managers, program administrators, public health representatives, and peer specialists. The 50-60-minute interviews were conducted via Zoom and were recorded for future review and transcription. No personally identifying information was collected and participation was voluntary.

[2] Carroll County FY22 grant cycle started February 1, 2024.
[3] For a complete guide of data definitions and reporting instructions, please visit: Law Enforcement Assisted Diversion Initiatives - Governor's Office of Crime Prevention and Policy.
[4] See Appendix B for the guide on Performance Measures.

Phase 3: Assessment of Findings and Development of Recommendations

Phase 3 involved assessing information gleaned from program data, performance measures, interviews, program and advisory board meetings collectively to identify patterns such as commonly experienced challenges, issues, and opportunities, and changes in opioid overdose and ER trends. These insights inform a series of recommendations.

Scoping Review and Local Context

Overview of Comprehensive Opioid Abuse Programs (COAP)

COAP uses a multidisciplinary approach to assist substance use disorder (SUD) to reduce overdose deaths and harm, reduce recidivism, increase access to substance abuse treatment, and build sustainable healthy living practices through the collaboration of public safety, public health, and medical sectors. In recent years, the program has evolved into the Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) to broaden the inclusion of stimulants and substances other than opioids to the purpose of these programs. Though the aim is similar – divert individuals in crisis away from the criminal legal system to treatment services - the mechanisms used by programs to divert individuals vary to include those led by law enforcement (LE), courts (i.e., drug courts), and social services (i.e., family-based agencies). Law Enforcement Assisted Diversion (LEAD) programs collaborate directly with law enforcement agencies and utilize law enforcement officers (LEOs) in identifying potential arrestees, or providing referrals upon request/officer discretion, to refer them to treatment facilities/clinics, with some even suspending criminal charges as motivation to engage in this opportunity. Similar to the expansion of the COAP name change, LEAD has taken on a different acronym – Let Everyone Advance with Dignity – to reduce the stigma of the program and provide more grace to participants while on a harm reduction, progress-focused journey. The overarching common theme surrounding these types of programs is utilizing multiple offices and services to provide collaborative care.

Federal and state efforts have addressed the opioid epidemic through the expansion of grant funds for program development and improvement aimed at preventing and reducing opioid use and overdose. The Comprehensive Addiction and Recovery Act (CARA) is a strategic effort to enhance grant-funded substance addiction programs by increasing the comprehensive nature and coordinated efforts of treatment and recovery services (CARA, Public Law 114-198). This 2016 legislative action awards $181 million annually and was essential in the establishment of the COSSUP, formerly COAP, which provides financial and technical assistance, from the Bureau of Justice Assistance (BJA), to different units of government and Indian tribal governments for the purposes of identifying the status of substance use/abuse in that region along with developing and implementing comprehensive efforts to address myriad problems associated with substance use.[5] For instance, these programs support efforts to increase treatment and recovery services in the criminal justice system, strengthen data collection and sharing, maximize resources and diversion program funding across systems, and prevent illicit substance use and misuse.

[5] Information on these programs and BJA involvement in reducing substance use/misuse can be found here: Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) | Overview | Bureau of Justice Assistance

Pre/Post-Arrest Diversion Initiatives

Because they are frequently the first responders on the scene, law enforcement officers play a particularly critical role in opioid overdose incidents.[6] They are often in a position to offer immediate intervention to save lives, for example, by administering naloxone. They also are a key conduit by which individuals can access substance use interventions with the potential for long-term treatment and recovery through things like pre-arrest diversion initiatives. In short, while increasing access to and use of naloxone likely helped to slightly decrease the number of fatal overdoses in Maryland, combining acute responses with ongoing access to SUD treatment and recovery services is necessary to curb the opioid crisis, address poly substance use, and change the perceptions providers and first responders can have of people with SUDs (e.g. stigma).[7]

Recognizing the critical link that law enforcement officers can provide has resulted in the growth of LEO initiatives to connect people with treatment such as the Police Assisted Addiction and Recovery Initiative (PAARI) and LEAD programs. A common feature of these programs is the partnership between public safety and public health professionals who work together to identify individuals and link them with appropriate services to meet their needs.

Since LEAD programs were first developed and implemented in 2011, several studies have evaluated the effectiveness of these programs across jurisdictions. Outcome and process evaluations have been conducted in Seattle (WA), Antioch (CA), New Haven (CT), San Francisco (CA), Honolulu (HI), and Los Angeles (CA), among others. These evaluations have examined a variety of criminal justice outcomes, including arrests, probation violations, convictions, days spent in jail, and legal costs. A variety of other social outcomes have also been assessed, including housing, employment, income/benefits, use of emergency shelters, hospital admissions, emergency department (ED) visits, and self-reported substance use. Results suggest that participation in LEAD programs is associated with reductions in arrests,[8] probation violations and convictions,[9] and felony charges.[10] Additionally, LEAD participants have been shown to have fewer average yearly jail bookings, spend fewer days in jail per year, and experience significant pre-to-post reductions in legal costs.[11]

In terms of non-criminal justice outcomes, LEAD programs have been shown to significantly improve participants' housing, employment, and income/benefits.[12] Achieving housing and employment was subsequently associated with 17% and 33% fewer arrests during the study's follow-up period. Finally, LEAD program participants indicated decreased use of emergency shelters and increased use of transitional shelters, as well as

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[6] Lurigio, A. J., Andrus, J., & Scott, C. K. (2018). The opioid epidemic and the role of law enforcement officers in saving lives. Victims & Offenders, 13(8), 1055-1076.
[7] Doleac, J. L., & Mukherjee, A. (2018). The moral hazard of lifesaving innovations: naloxone access, opioid abuse, and crime.
[8] Bastomski, Sara; Cramer, Lindsey; Reimal, Emily (2019). Evaluation of the Contra Costa County Law Enforcement Assisted Diversion Plus Program. Urban Institute; Collins, Susan E.; Lonczak, Heather S.; Clifasefi, Seema L. (2017). Seattle's Law Enforcement Assisted Diversion (LEAD): Program effects on recidivism outcomes. Evaluation and Program Planning, 64:49-56; Malm, Aili; Perrone, Dina; Magana, Erica (2020). Law Enforcement Assisted Diversion (LEAD) External Evaluation Report to the California State Legislature. Long Beach: California State University Long Beach; Perrone, Dina; Malm, Aili; Magana, Erica (2022). Harm Reduction Policing: An Evaluation of Law Enforcement Assisted Diversion (LEAD) in San Francisco. Police Quarterly, 25(1):7-32.
[9] Bastomski, Sara; Cramer, Lindsey; Reimal, Emily (2019). Evaluation of the Contra Costa County Law Enforcement Assisted Diversion Plus Program. Urban Institute.
[10] Collins, Susan E.; Lonczak, Heather S.; Clifasefi, Seema L. (2017). Seattle's Law Enforcement Assisted Diversion (LEAD): Program effects on recidivism outcomes. Evaluation and Program Planning, 64:49-56; Malm, Aili; Perrone, Dina; Magana, Erica (2020). Law Enforcement Assisted Diversion (LEAD) External Evaluation Report to the California State Legislature. Long Beach: California State University Long Beach.
[11] ibid
[12] Clifasefi, Seema L.; Lonczak, Heather S.; Collins, Susan E. (2017). Seattle's Law Enforcement Assisted Diversion (LEAD) Program: Within-Subjects Changes on Housing, Employment, and Income/Benefits Outcomes and Associations With Recidivism. Crime & Delinquency, 63(4):429-445.

decreased reports of client hospital admissions, ER visits, and methamphetamine use.[13] While the evidence for LEAD programs appears promising, some sites have not been as successful and process evaluations reveal several barriers to effectiveness.[14] These include procedural complexity of arrest diversion, concerns about reduced penalties for substance use among officers, stigma surrounding SUDs, and officer buy-in.

Taken together, though there is evidence to suggest that these programs produce favorable outcomes both for criminal justice indicators (e.g., recidivism) and well-being (e.g., housing, employment, income), empirical evaluations are limited in number and often derived from individual geographic locales.[15] In Maryland, LEAD programs have yet to undergo rigorous evaluation to assess the number and characteristics of clients served (e.g., number of diverted individuals), what the treatment process looks like (e.g., services/treatment referrals, case management), and outcomes for those served (e.g., re-engagement with public safety services, program completion, treatment received).

Summary

The lack of rigorous and non-isolated evaluation of these programs is not unique to Maryland. Reflecting on law enforcement responses to the opioid epidemic, the National Institute of Justice (NIJ) reports that "Many programs have been implemented across the country in response to the opioid crisis, yet rigorous evaluations are difficult or impossible to carry out because of a lack of planning for research and evaluation. This limits the ability of stakeholders to gauge a program's success and limits the potential for creating knowledge that can inform future programs."[16] Expansion of knowledge on the programs would not only build support for programs, but also positively change implementation of the program to reach a greater population. For instance, there is evidence that potential program participants are frustrated because they feel that they would benefit from the program, but do not fit eligibility criteria.[17] Additionally, programs tend to be soft-funded, meaning that funding is not guaranteed and needs to be constantly chased. The need to constantly search for financial program support can affect program implementation, geographic coverage, and populations served. These concerns are echoed in scholarly research that finds that while participants offered praise for programs, there are frequent limitations due to eligibility restrictions and availability of funding support for services, and differential access to programs in disadvantaged communities.[18]

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[13] Willingham, Mark; Gralapp, Sophie; Barile, John (2020). Law Enforcement Assisted Diversion Honolulu 2-Yer Program Evaluation Report. Manoa: University of Hawai'i.

[14] Bastomski, Sara; Cramer, Lindsey; Reimal, Emily (2019. Evaluation of the Contra Costa County Law Enforcement Assisted Diversion Plus Program. Urban Institute; Joudrey, Paul; Nelson, Christina; Lawson, Kelly; Morford, Kenneth; Muley; Dakibu; Watson, Cyntia; Okafor, Martha; Wang, Emily; Crusto, Cindy (2021). Law Enforcement Assested Diversion: Qualitative evaluation of barriers and facilitators of program implementation. Journal of Substance Abuse Treatment, 129 (2021) 108476; Magana, Erica; Perrone, Dina; Malm, Aili (2022). A Process Evaluation of San Francisco's Law Enforcement Assisted Diversion Program. Criminal Justice Policy Review, 33(2):148-176; Perrone, Dina; Malm, Aili; Magana, Erica (2022). Harm Reduction Policing: An Evaluation of Law Enforcement Assisted Diversion (LEAD) in San Francisco. Police Quarterly, 25(1):7-32.

[15] Collins, Susan E.; Lonczak, Heather S.; Clifasefi, Seema L. (2017). Seattle's Law Enforcement Assisted Diversion (LEAD): Program effects on recidivism outcomes. Evaluation and Program Planning, 64:49-56; Clifasefi, Seema L.; Lonczak, Heather S.; Collins, Susan E. (2017). Seattle's Law Enforcement Assisted Diversion (LEAD) Program: Within-Subjects Changes on Housing, Employment, and Income/Benefits Outcomes and Associations with Recidivism. Crime & Delinquency, 63(4):429-445.

[16] Goodison, Sean E.; Vermeer, Michael J.D.; Barnum, Jeremy D.; Woods, Dulani; and Jackson, Brian A. (9/25-26/18). Law Enforcement Efforts to Fight the Opioid Crisis: Convening Police Leaders, Multidisciplinary Partners, and Researchers to Identify Promising Practices and to Inform a Research Agenda. Priority Criminal Justice Initiative: RAND Corp, Police Executive Research Forum, RTI International, University of Denver. Accessed 5/13/24.

[17] Schiff, D. M., Drainoni, M. L., Weinstein, Z. M., Chan, L., Bair-Merritt, M., & Rosenbloom, D. (2017). A police-led addiction treatment referral program in Gloucester, MA: Implementation and participants' experiences. Journal of substance abuse treatment, 82, 41-47.

[18] Donnelly, E. A., Brown, C. L., McBride, A., Beletsky, L., & Anderson, T. L. (2023). Emerging disparities in the placement of law enforcement-based treatment referral and recovery programs. Criminal Justice Review, 48(3), 359-376; Schiff, D. M., Drainoni, M. L., Weinstein, Z. M., Chan, L., Bair-Merritt, M., & Rosenbloom, D. (2017). A police-led addiction treatment referral program in Gloucester, MA: Implementation and participants' experiences. Journal of substance abuse treatment, 82, 41-47.

Maryland COAP Programs

As shown in Table 1, COAP programs vary in terms of the main focus and the type of referral utilized. Two are LEAD programs that depend on LEO referrals (Carroll County and Harford County), two are associated with court actors/actions (MOPD and St. Mary's County), one is a detention-center focused program (Allegany County), one takes a health-centered approach (Anne Arundel County), and lastly, one heavily relies on peer specialists to help people (Calvert County). Three types of referrals are utilized (arrest diversion, social contact referral, self-referral) with some programs having one primary type and others using multiple types.

- **Arrest Diversion:** This referral type provides LEOs the authority to refer individuals into LEAD instead of arrest for diversion-eligible offenses.[19]
- **Social Contact Referral:** Eligible individuals can be referred into LEAD without waiting for the moment of potential arrest (i.e., LEOs or community provider's knowledge of at-risk, family, friends).
- **Self-Referral:** Individuals who are seeking help themselves, can "refer themselves" via asking community providers or LEOs in the community for help.[20]

Though programs vary in their approach, they all received the same goals from the State as part of their grant award including:

- Reduce opioid overdose deaths in designated project implementation areas.
- Reduce recidivism of LEAD participants (compared to representative proxy group).
- Reduce calls for service for drug-related activity in the pilot area.
- Reduce criminal justice costs incurred by LEAD participants (compared to control group).
- Increase LEAD participants' access to permanent housing (compared to baseline).
- Increase LEAD participants' average income.
- Improve community perceptions of police.
- Improve police understanding and response to issues related to addiction and mental health.

[19] This is, on average, what is meant by "Arrest Diversion", but for more COAP-focused, rather than LEAD-managed, programs. This type of referral can be through a different process by which detention center or court actors refer people while in custody after an arrest and/or reviewing their case (i.e., MOPD has attorneys refer potential participants after they have been arrested and charged). This differs from the traditional approach because it is not referring to LEOs stopping and referring people on the street.
[20] This is a newer type of referral that is acknowledged in Anne Arundel County, Calvert County, and St. Mary's County.

Table 1: FY2022 COAP Subrecipients Participating in Evaluation

Implementing Agency	Award Dates	New/ Continuing	Referral Dates	Jurisdiction(s) Served	Approach/ Focus	Type of Referral(s)	Program Objectives
Allegany County Board of Commissioners	10/1/23-09/30/25	New	October 2023 - July 2025	Allegany	Detention Center-Based; MAT	• Pre/Post Arrest Diversion	1. Offer MAT, reentry services, and alternative sentencing options to address SUDs and opioid dependency 2. Reduce recidivism and enhance public safety via harm reduction and reentry planning 3. Connect individuals with supportive services while navigating the complexities of rural community resources
Anne Arundel County Department of Health	10/1/23-09/30/26	New	January 2024 - June 2024	Anne Arundel	Health-Centered	• Pre/Post Arrest Diversion • Social Contact Referral	1. Add weekend hours for medication for opioid use disorder prescribers 2. Increase access to wound care and naloxone via vending machines 3. Provide support to those recently released from Anne Arundel County Detention facilities 4. Provide hope for recovery and improve attitudes of those needing treatment
Calvert County Health Department	10/1/23-09/30/26	New	May 2024 - March 2025	Calvert	Social Contacts	• Prearrest Diversion • Social Contact Referral	1. Improve collaboration between agencies to increase data sharing to improve data-driven approaches to criminal justice issues 2. Reduce non-crisis, behavioral health related contact with law enforcement 3. Spread knowledge and resources of substance use and treatment to reduce stigma among community members and providers
Carroll County Health Department	2/1/24-09/30/26	Continuing	March 2024 - May 2025	Carroll	Law Enforcement	• Prearrest Diversion • Social Contact Referral	1. Train more LEOs and service providers on the program and in naloxone administration 2. Identify participants who experience more chronic forms of SUDs and connect them with the right services 3. Provide secondary care for overdose survivors

Maryland Office of the Public Defender	10/1/23-09/30/26	Continuing	January 2024 - March 2025	Anne Arundel, Baltimore City, Cecil, Fredrick, Harford, and Washington	Court	• Arrest Diversion	1. Connect individuals at risk of overdose to recovery and supporting services 2. Curate comprehensive management plans to reduce overdose risk and recidivism risk among those held in detention centers
Office of Mental Health/Core Service Agency of Harford County, Inc. (OMH/CSA)	10/1/23-09/30/26	Continuing	January 2024 - March 2025[21]	Harford	Law Enforcement	• Pre/Post arrest diversion • Social Contact Referrals	1. Reduce recidivism, drug overdoses, and harm for people who use substances 2. Address substance-use-related health matters with behavioral health care rather than processing individuals through the criminal justice system 3. Expand jurisdictional range of program implementation and care support
St. Mary's County Health Department	10/1/23-09/30/26	Continuing	March 2025 - July 2025	St. Mary's	Court / Mental Health Docket	• Pre/Post arrest Diversion • Court actors/ actions • Social Referrals	1. Reduce recidivism, calls for service, and overdose risk 2. Improve perception of police and community relationships 3. Increase participant income and improve quality of life

NOTE: For the continuing programs (receipt of both FY19 and FY22 support), the referral dates associated with FY22 were based on referrals reported in Referral-Individual-Level Data. Variation in program referral start date is due to carry over funds from FY19 and to lagged program start dates due to staffing and participant recruitment.

[21] There was one referral from 2022 in the data.

General Overview of Maryland COAP Program Characteristics

Across all programs, referrals were given to more than 1,500 people since the start of FY22 program funding (see Table 2).[22, 23] The vast majority of referrals were received through arrest diversion (84%) and social contacts outside of the criminal legal system (16%). Among those referred, 78% of eligible participants chose to enroll in the program. The time between referral and program enrollment was an average of 12 days; however, enrollment time varied considerably. Whereas several programs were able to enroll participants on the same day or within a week of the initial referral, others took up to 22 days to enroll to properly review the case according to their policies and on-board participants with the program. On average, participants served in Maryland are White (65.8%), male (62.5%), and have a mean age of 39 years. However, there is great variation in who the programs serve across jurisdictions in terms of race and gender. In general, the mean age was relatively similar across all programs.

The rate of service enrollment (35%) aligns with service referral (34%), but these rates are only about half of the percentage of people who actually initiated the case management process (65%). This reflects the difficulty program staff report with maintaining contact with the participants. People go through an intake process and are assessed for needs after being referred to LEAD but lose contact and disengage prior to receiving referrals and enrolling in the services.

Table 2. Outcome of Participants by COAP Site

	Range	Total / Average
Total Referrals	1 - 916	1575
Total Persons Referred	7 - 872	1506
LEAD Participants	4 - 872	1337
% Participated	5.8 - 100%	78%
Mean Days from Referral to Enrollment	0 - 22	12
Referral (Arrest Diversion)	1 - 916	1326
Referral (Social Referral)	6 - 151	249
Demographics		
Male	46.4% - 70.5%	62.5%
Female	29.5% - 46.4%	35.9%
White	15.9% - 86.4%	65.8%
Mean Age	37 - 41	39

[22] Some of the discrepancy between number of referrals and those enrolled / participated can be attributed to the fact that some people referred were previously enrolled in a program in that county, or another, that made them ineligible for receiving additional services from these COAP programs. Moreover, some programs were unable to share data for every quarter, meaning some data and accompanying dates for referrals are missing.
[23] For all programs, except Carroll County, the FY22 program start date was October 2023. Carroll County's start date for this funding cycle was February 2024.

Services Received		
Harm Reduction Principles	46.7% - 100%	85%
Case Management Plan	20% - 100%	65%
Referred to Services	5.8% - 79.1%	34%
Enrolled in Services	5.8% - 70%	35%

As described by all programs in their proposal for funding and during various conversations with program staff (e.g., interviews, stakeholder meetings), each program aimed to follow harm reduction principles.[24] The variation in services received across programs (46.7-100%) is likely due to reporting differences across programs rather than receipt of harm reduction services. When it comes to case management, service referral, and service enrollment, participants are funneled from one stage to the next, and at times, that meant that retention decreased between the steps. Case management numbers tend to be, on average, higher than referrals and enrollment. According to meetings with stakeholders, this happened because case management would be initiated at intake to identify services and referrals needed. So, participants, especially, those in more vulnerable situations, would disappear and not follow-up with the plan that case managers created for them. On average, a third of individuals encountered by programs are referred to and enrolled in services. However, as is described in the individual program profiles below, there is wide variation across programs in proportion of individuals referred to services and then enrolled in services.

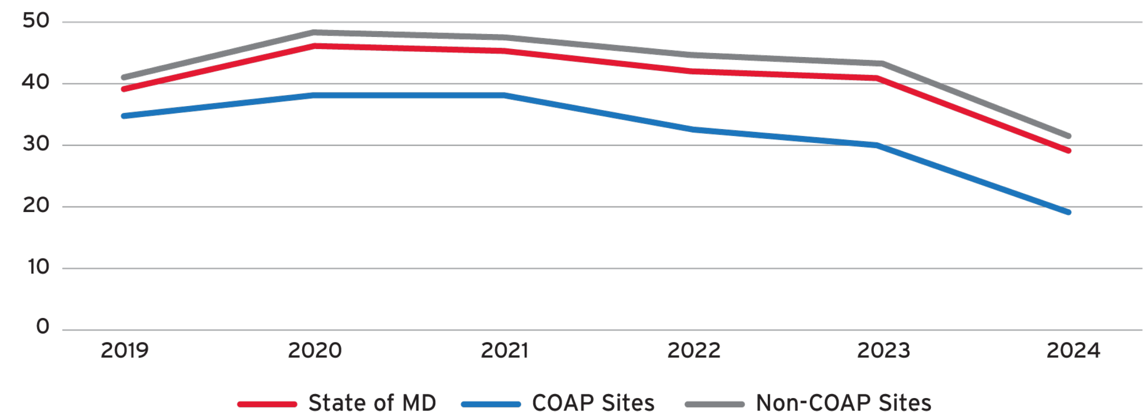
Longitudinal Trends in Overdose Outcomes in Maryland

To assess changes potentially associated with the COAP in Maryland, we examined year-over-year trends in fatal overdoses and overdose ER visits by comparing COAP-funded vs. non-funded counties to state-level rates. It is important to note that these trends are descriptive in nature, and do not control for any additional factors, therefore it is not possible to attribute these changes in outcomes to the programs alone. Additionally, as represented below, COAP sites could include FY19, FY22, or both funding cycle programs.

As shown in Figure 4, from 2019 to 2024, fatal overdose death rates declined across the State of Maryland, with notable differences between counties that received COAP funding and those that did not. The overall rate of overdose deaths in Maryland decreased from 39.4 to 28.6 in 2024, representing a 27.3% reduction statewide. The highest rate occurred in 2020 (46.2), followed by a consistent year-over-year decline. Counties receiving COAP funding experienced the most substantial improvement. Overdose death rates dropped from 34.6 in 2019 to 18.6 in 2024, a 46.3% decrease. These counties consistently reported lower fatality rates than both the State average and non-funded counties throughout the six-year period. Counties that did not receive COAP funding started with higher overdose death rates and experienced a smaller decline (22.8% reduction from 2019 to 2024). Rates in non-funded counties remained above both the State average and COAP-funded counties for the entire reporting period. In fact, the gap between COAP and non-COAP counties has continually widened, with non-funded counties reporting rates nearly 70% higher than COAP-funded counties (31.3 vs. 18.6).

[24] Harm reduction principles follow a "set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and belief for, the rights of people who use drugs." (National Harm Reduction Coalition)

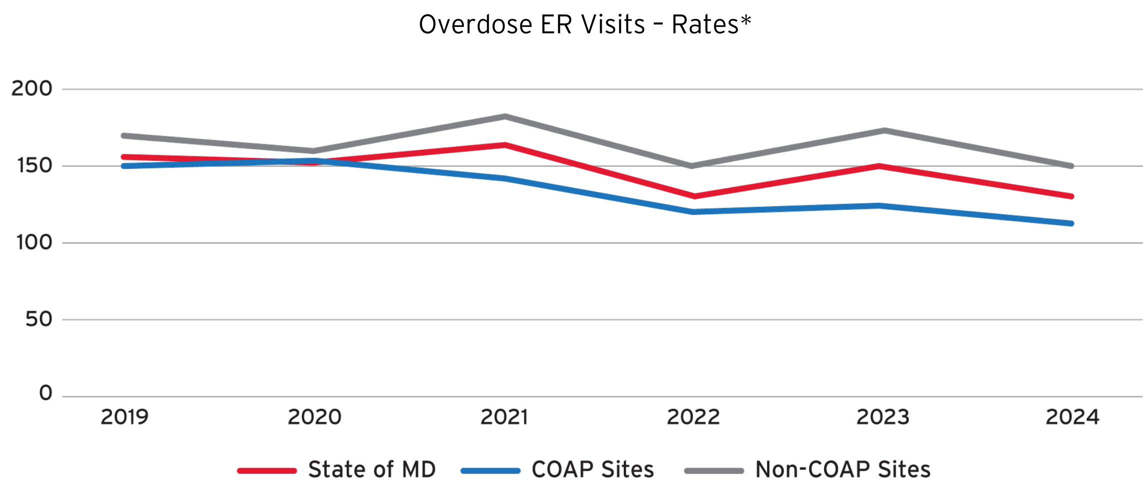
Figure 4. Maryland Fatal Overdose Rates* by COAP Funding



**Note: Rates are per 100,000 residents*

Similar trends emerged for overdose-related ER visits from 2019 to 2024 (see Figure 5). While fluctuations occurred statewide, counties receiving COAP funding showed more sustained improvements compared to non-funded counties. For instance, the overdose-related ER visit rate in Maryland declined from 155.7 in 2019 to 128.6 in 2024, representing a 17.5% reduction statewide. COAP-funded counties consistently reported lower ER visit rates than the non-funded counties. Rates decreased from 149.7 in 2019 to 111.8 in 2024, representing a 25.3% decline. Notably, COAP-funded counties experienced the lowest rates overall in 2021 onward. Counties without COAP funding exhibited higher and more variable ER visit rates. From 169.1 in 2019, the rate increased to a peak of 182.7 in 2021, then declined to 148.2 in 2024, resulting in a 12.4% reduction over the full period. Despite this decline, non-funded counties continued to report substantially higher rates than both COAP-funded counties and the State average.

Figure 5. Maryland Overdose ER Visits by COAP Funding



**Note: Rates are per 100,000 residents*

To note, we also examined trends within the funded COAP jurisdictions to understand the localized impact of LEAD interventions within broader public health contexts (reported in the Program Profiles section). *We caution again that these are descriptive trends and do not implicate a causal effect of specific programs.*

Overall, the observed trends suggest that many COAP-funded jurisdictions experienced substantively larger reductions in fatal overdoses when compared to both the State and national patterns, indicating a potentially meaningful association between LEAD program implementation and improved outcomes in terms of fatal overdose prevalence. These data were obtained from the Maryland Department of Health’s (MDH) Overdose Dashboard and the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS).

Across these graphs, year-over-year trends in fatal overdoses varied in magnitude and direction, yet several counties with LEAD program implementation experienced notable declines during key years. In many cases, these counties saw reductions in fatal overdoses that were more substantial than those observed at the State or national levels. While the timing and consistency of these reductions differed by jurisdiction, the years in which decreases occurred often aligned with or exceeded statewide or national trends. These observations suggest that local dynamics, including potential programmatic efforts, may be contributing to improved outcomes in some jurisdictions. However, these trends should be interpreted with caution, as the available data do not allow for definitive conclusions about causality. Continued monitoring and evaluation are needed to better understand the patterns and potential associations between local strategies and changes in fatal overdose trends over time.

Program Profiles

Anne Arundel County

Anne Arundel County's Department of Health (AACDOH) manages the Opioid Prevention Team (OPT), which is a LEAD initiative but also includes a variety of services and resources available for community members struggling from opioid/substance use. Additionally, Anne Arundel has separately established programs, like a Mobile Crisis Intervention Training (CIT) Team, not managed by the AACDOH. These programs work in tandem to address the opioid and substance use issues, including the deployment of a mobile van providing an array of immediate health care services (aka Wellmobile), vending machines, reentry services, peer support, and anti-stigma campaigns.

Anne Arundel's program features a Harm Reduction Advisory Council, which brings together stakeholders to guide the initiative's priorities and strategies. Established in 2019, the Wellmobile provides treatment for wounds as well as low barrier buprenorphine, harm reduction supplies (i.e., naloxone and syringes), HIV testing, vaccines, and helps to link individuals to recovery resources and peer support. Beyond Wellmobile, the County has implemented harm reduction vending machines, which provide essential supplies, including naloxone, hygiene kits, and educational resources, to empower individuals to take control of their health. This approach reduces stigma and barriers to accessing care, particularly for those hesitant to seek help from traditional health care settings.

The program collaborates with hospitals, community organizations, and peer networks to ensure a seamless continuum of care, with peer networks being a large part of the program's efforts. Partnerships between detention centers and medical vendors allow peers to identify recently released individuals who are in need of assistance obtaining and maintaining medication assisted treatment (MAT). The Anne Arundel County's Peers Offering Wellness Education and Resources (AAPOWER) also provide services to reduce drug use risks and increase health. Peer support specialists utilize the Overdose Mapping and Application Program (ODMAP) along with police, emergency medical services, and hospital data to identify where people who are suffering from a possible overdose are. They can provide financial and medical insurance coverage assistance. Part of this continuum of care is provided through the Overdose Survivors Outreach Services, or 'OD SOS', line which offers peer support for individuals experiencing substance use crises, operating from 8 a.m. to 12:30 a.m. daily. The program's use of Uber Health further addresses transportation barriers, enabling participants to access care and services without delay.

Complementing these wound care and peer efforts is a robust media campaign aimed at raising awareness of available resources and encouraging community engagement. Anti-stigma campaigns include messaging around acknowledging one's struggles and providing hope for recovery (i.e., "Denial is Deadly", "Save a Life", "BUPE=HOPE"). These messages are spread around the county via commonly visited places and places that can provide help, like fire stations, libraries, police stations, along with billboards, public transportation, social media, etc.

Anne Arundel County: Program Characteristics, Referrals, and Services

The Anne Arundel County program is health-focused with mobile services and teams implemented to help those who they come across in the county suffering from SUD. The program served roughly equal proportions of men and women; the proportion of women served in Anne Arundel is higher than the average for FY22 COAP-funded programs. The large proportion of non-white individuals served is also a unique feature of this program. The average age of those served is 38. The decrease from total referrals (n=69) to enrolled participants (n=4) indicates that the service utilized the most is the traveling Wellmobile that provides on-the-go services for people who are wounded or need a type of treatment via medication (see Table 3). All of these people are referred to the program, but most just want immediate help with very few engaged with longer-term assistance. Therefore, while all individuals who engaged with the program received harm reduction services, few are referred to and enroll in continued services.

Table 3. Characteristics of Anne Arundel Program, Referrals, and Services

	Anne Arundel	Total/Average across All Programs
Total Referrals	69	1575
Total Persons Referred	69	1506
LEAD Participants	4	1228
% Participated	5.8%	78%
Mean Days from Referral to Enrollment	-	12
Referral (Arrest Diversion)	-	1325
Referral (Social Referral)	69	250
Demographics		
Male	46.4%	62.5%
Female	46.4%	35.9%
White	15.9%	65.8%
Mean Age	38	39
Service Received		
Harm Reduction Principles	100%	85%
Case Management Plan	-	65%
Referred to Services	5.8%	34%
Enrolled in Services	5.8%	35%

Note: The values in this table reflect a condensed period of time, from January to June 2024, which is why values reported in Tables 3 and 4 differ.

Anne Arundel County: Performance Measures

Overall, Anne Arundel County's COAP program reported low service utilization and outcomes across nearly all performance measure domains, with the exception of program discharges, enrollment in ongoing behavioral health care, receipt of MAT, and social referrals to the program. While there were 40 individuals discharged from the program in the first quarter of 2024, these numbers dropped to three or fewer over the remaining quarters. Table 4 also shows that the number of individuals enrolled in ongoing behavioral health care and receiving MAT reached peak numbers in the second quarter of 2024, after which these numbers trailed off slightly, but were still greater than initial levels. Finally, it appears that the number of individuals receiving social referrals to the program has somewhat steadily increased over time, with the largest increase and greatest number of referrals observed in the first quarter of 2025, suggesting that the program's reach has expanded since its implementation.

Table 4. Anne Arundel County

Performance Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Total
Number of individuals admitted to the ER[25]	0	0	1	0	0	0	1
Number of individuals arrested for a new crime	0	0	0	0	0	0	0
Number of individuals arrested for a violation of supervision	0	0	0	0	0	0	0
Number of individuals connected to permanent housing	0	0	0	0	0	0	0
Number of individuals connected with employment, training or education	0	0	0	0	0	0	0
Number of individuals connected with medical insurance	0	0	0	0	0	1	1
Number of individuals connected with primary care physician	0	1	0	0	0	0	1
Number of individuals discharged from program	0	40	2	0	2	3	47
Number of individuals diverted from arrest or criminal summons into the program	0	0	0	0	0	0	0
Number of individuals enrolled in ongoing behavioral health care	0	1	8	5	4	4	22
Number of individuals identified as victims of crime	0	0	0	0	0	0	0
Number of individuals receiving MAT	0	1	12	1	2	4	20
Number of individuals receiving social referrals to the program	0	53	16	20	24	102	215
Number of individuals screened for and eligible who are receiving benefits	0	0	0	0	0	0	0
Number of individuals who experienced an overdose	0	0	0	0	0	0	0

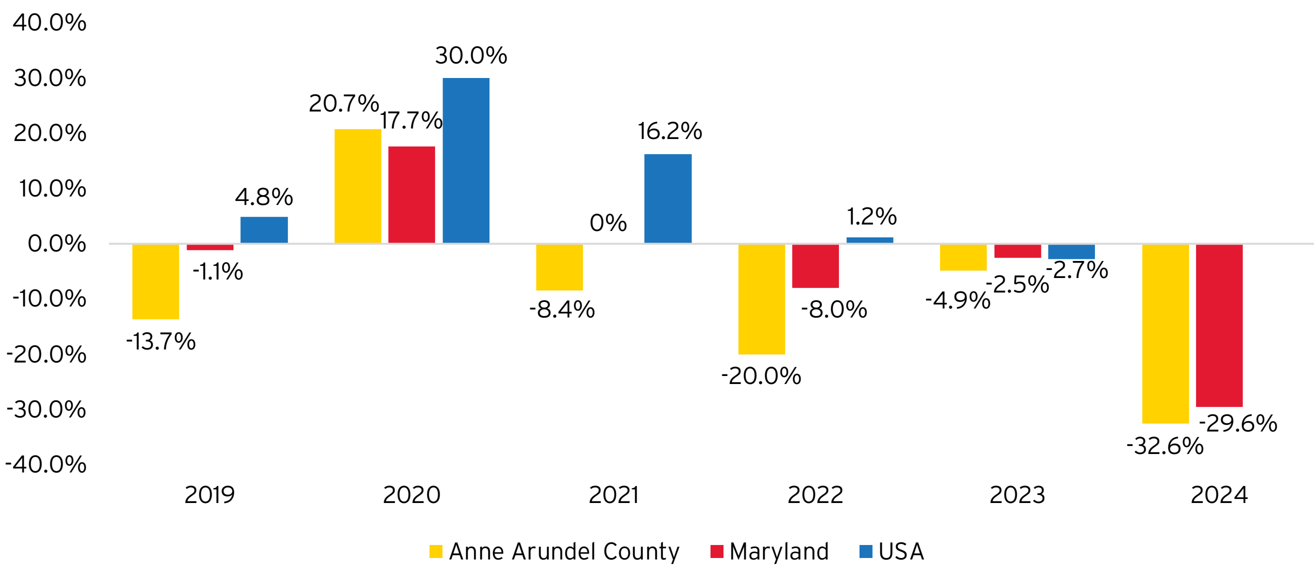
Anne Arundel County: Year-to-Year Percent Change in Fatal Overdoses

While Anne Arundel County has witnessed some promising yet modest decreases in overdoses over the last decade, recent data highlights both progress and the persistent need for robust intervention. Anne Arundel County's fatal overdose trends from 2019 to 2024 generally aligned with broader state and national patterns, though the county often saw more pronounced changes (see Figure 6). In 2019, Anne Arundel experienced a 13.7% decrease, contrasting with the relatively stable figures in Maryland (-1.1%), and the US (4.8%). In 2020, fatal overdoses rose sharply by 20.7%, which was in line with state (17.7%) and national (30%) increases during the height of the COVID-19 pandemic. The county then saw an 8.4% decrease in 2021, while Maryland remained flat (0%) and national deaths continued to rise from the previous year (16.2%). In 2022, Anne Arundel reported a 20% decrease, which was more substantial than Maryland's 8% decline and in direct contrast to the US, which still saw a slight increase (1.2%). A more modest decline followed in 2023 (-4.9%) that remained consistent with both Maryland (-2.5%) and the US (-2.7%). By 2024, Anne Arundel recorded a significant 32.6% reduction, slightly exceeding Maryland's 29.6% decline (national data unavailable). Overall, Anne Arundel County mirrored state and national trends generally, but often experienced larger year-over-year shifts, suggesting that the county has outpaced both Maryland and the US in reducing fatal overdoses since 2021.

[25] ER visits is a complex indicator with reporting variation across programs whereby some programs reported an ER visit as an intake variable while others appear to have been tracking this data for each participant throughout their time in the program. Trends should be interpreted cautiously.

Despite these encouraging figures, the community has experienced concerning spikes in recent years, underscoring the ongoing public health challenge. Even with hurdles like financial stability and community stigma, the program's commitment to meeting individuals where they are—both literally and figuratively—has positioned it as a model for harm reduction strategies in Maryland.

Figure 6. Annual Change in Fatal Overdoses



Allegany County Board of Commissioners

The Allegany County LEAD program is managed by the Allegany County Sheriff's Office and the State Attorney's Office. Designed to help those being currently held at a detention center and re-entering the community following incarceration, this program offers SUD treatment for those incarcerated as well as providing resources and connections to treatment services following release. There are three different entry pathways into this program, which include via the detention center, pretrial supervision, or the State Attorney's Office diversion program. Currently administered by the Allegany County Sheriff's Office and the State Attorney's Office, the program targets individuals incarcerated or under pretrial supervision, offering comprehensive SUD treatment. At the detention center, a partnership with the Allegany County Health Department and the University of Maryland enables telemedicine evaluations for MAT eligibility. Those arrested for low-level, nonviolent offenses linked to SUDs are provided opportunities for diversion, education, and treatment, with successful completion leading to record expungement. Successful completion of these programs results in record expungement, providing participants with a fresh start.

A hallmark of the Allegany County LEAD program is its commitment to harm reduction and reentry planning. Participants leaving detention are equipped with Narcan kits and overdose prevention training, while peer recovery specialists provide ongoing support throughout their transition back to the community. Even those who are not enrolled in the program receive peer specialist support if desired. The program ensures connections to critical services, including housing, employment, and insurance, fostering stability and reducing the recidivism likelihood.

Allegany County: Program Characteristics, Referrals, and Services

Allegany County's program focuses on detention center populations and those preparing for reentry, providing SUD treatments (e.g., MAT services via Naloxone) within and outside the detention center. The program serves more men than women. The relatively low referral and service enrollment numbers are likely due to the nature of the program which focuses on delivery of services while detained rather than referral and receipt of services in the community. Depending on need in the county, Allegany may be a good candidate for adopting strategies that emphasize continuity of care following release.

Table 5. Characteristics of Allegany Program, Referrals, and Services

	Allegany	Total/Average across All Programs
Total Referrals	916	1575
Total Persons Referred	872	1506
LEAD Participants	872	1228
% Participated	100%	78%
Mean Days from Referral to Enrollment	-	12
Referral (Arrest Diversion)	916	1325
Referral (Social Referral)	-	250
Demographics		
Male	70.5%	62.5%
Female	29.5%	35.9%

White	86.4%	65.8%
Mean Age	-	39
Services Received		
Harm Reduction Principles	100%	85%
Case Management Plan	100%	65%
Referred to Services	11.4%	34%
Enrolled in Services	7%	35%

Allegany County: Performance Measures

Allegany County was one of the first LEAD sites to become fully operational and has consistently recorded the highest counts across nearly all performance measures, indicating a strong level of engagement and service delivery in this jurisdiction. Over time, their LEAD program has been associated with fewer overdoses among participants as the program has progressed. Table 6 shows an increasing number of individuals being diverted from arrest or criminal summons into the program from Q4 2023 to Q3 2024, though this number decreased substantially in the last quarter of 2024 and the first quarter of 2025. The number of individuals admitted to the ER has also dramatically and consistently decreased since the program's inception, with 0 reported ER admissions over the last three quarters.

Table 6. Allegany County Reported Performance Measures

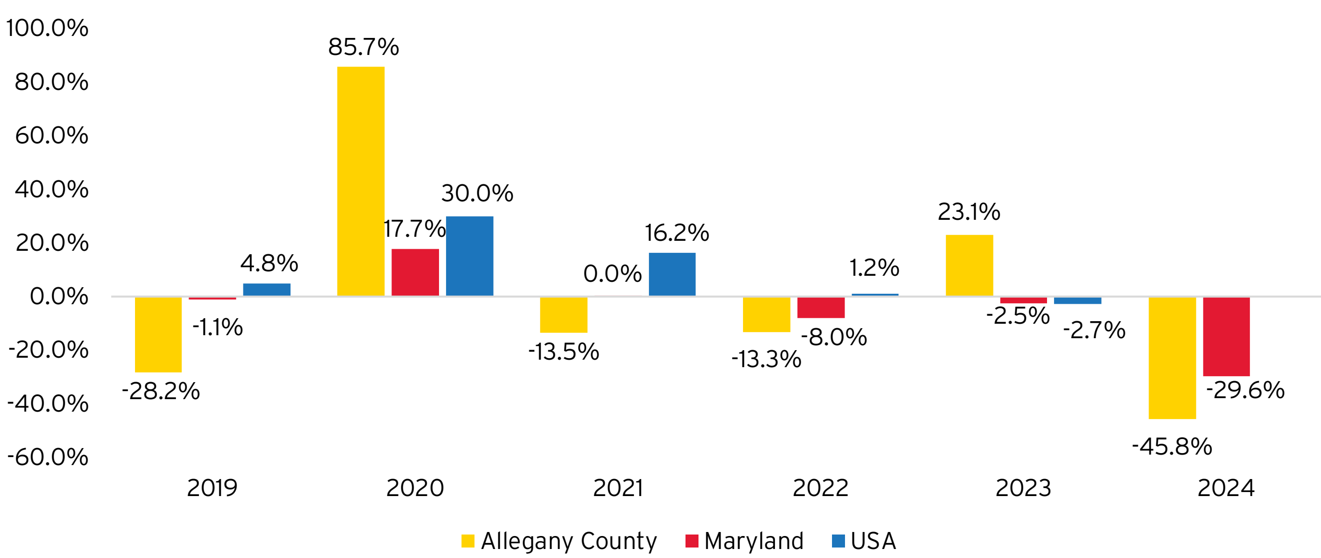
Performance Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Total
Number of individuals admitted to the ER	90	36	1	0	0	0	127
Number of individuals arrested for a new crime	2	2	2	24	9	6	45
Number of individuals arrested for a violation of supervision	13	23	0	24	5	15	80
Number of individuals connected to permanent housing	0	2	5	1	1	0	9
Number of individuals connected with employment, training or education	4	2	3	3	1	3	16
Number of individuals connected with medical insurance	81	21	171	59	124	23	479
Number of individuals connected with primary care physician	0	21	2	0	124	1	148
Number of individuals discharged from program	2	4	7	41	3	9	66
Number of individuals diverted from arrest or criminal summons into the program	49	56	59	158	14	43	379
Number of individuals enrolled in ongoing behavioral health care	22	139	76	34	149	53	473
Number of individuals identified as victims of crime	0	0	0	0	0	0	0
Number of individuals receiving MAT	92	840	68	142	94	88	1324
Number of individuals receiving social referrals to the program	34	16	6	0	14	0	70
Number of individuals screened for and eligible who are receiving benefits	162	319	171	53	109	64	878
Number of individuals who experienced an overdose	26	39	1	0	0	24	90

Allegany County: Year-to-Year Percent Change in Fatal Overdoses

Allegany County has been disproportionately affected by the opioid crisis, with fentanyl accounting for 91% of fatal overdoses in 2021 and notable disparities in overdose rates relative to its population size in 2020. The presence of withdrawal symptoms in the Allegany Detention Center is witnessed daily, and approximately 60% of individuals entering custody report active substance use or recent treatment. In response, the LEAD program has played a critical role in supporting justice-involved individuals with SUDs.

Between 2019 and 2024, Allegany County exhibited variable trends in fatal overdoses, with several years showing substantially different patterns compared to both statewide and national trends (see Figure 7). In 2019, while the U.S. experienced slight increases in overdose deaths (4.8%), Allegany County saw a dramatic 28.2% decrease, suggesting early progress at the local level. However, in 2020, fatal overdoses in Allegany County surged by 85.7% from the previous year, far outpacing the increases seen statewide (17.7%) and nationally (30%), potentially reflecting heightened vulnerability during the onset of the COVID-19 pandemic. In 2021, Allegany County saw a 13.5% decrease, despite continued growth at the State (0%) and national levels (16.2%). This divergence continued in 2022, with Allegany County reporting another 13.3% decline, while Maryland decreased by only 8% and the US rose slightly (1.2%). In 2023, however, Allegany County experienced a 23.1% increase, contrary to modest declines observed in Maryland (-2.5%) and the US (-2.7%). Finally, in 2024, Allegany County recorded its most significant reduction of 45.8%, surpassing the 29.6% statewide decline (national data for 2024 were not available). Taken together, these trends suggest that Allegany County's fatal overdose patterns have not only diverged from broader State and national trajectories at key points but may also reflect the localized impact of LEAD interventions, particularly in years marked by steep declines. Despite these achievements, the program continues to face challenges, including financial constraints, transportation barriers, and stigma.

Figure 7. Annual Change in Fatal Overdoses



Calvert County

Calvert County's LEAD program is managed by Calvert County Department of Health and led by the County's Local Behavioral Health Authority (LBHA) with partnerships between the Calvert County Sheriff's Office, Calvert County's State's Attorney's office, and behavioral health service providers. Calvert County is a somewhat rural county with limited access to surrounding counties, limited access to physician and psychiatrist care, and a disproportionately large veteran population, indicating that access to behavioral health care is restricted in this region.

At the start of program implementation, the LEAD program heavily utilized LEO's interactions with community members to identify those who are involved in criminal activity due to unmet behavioral health needs but encountered challenges focusing on this approach including low recruitment success among LEO referrals and strict eligibility limitations. In response, the program shifted to focus on non-arrest referrals, such as social referrals from local providers, family referrals, and some self-referrals. The diversion aspect of this program that involves dropping charges has yet to reach its potential. The pool of crimes eligible for diversion is limited and behaviors engaged in by the target population are often not eligible for diversion. Moreover, though qualifying offenses for diversion have been identified and formal requests for charge dismissals were submitted, each of these requests was declined by the State's Attorney's Office. This suggests an area for focus to aid communication in program goals, agency concerns, and how to work collaboratively to achieve those goals while balancing public safety priorities.

Calvert County's focus on harm reduction is evident in its comprehensive and flexible approach to participant support. The operational model is supported by peer recovery specialists and case management staff. Participants are considered to have completed the program when the team and participant mutually agree that stated goals have been met. However, in the absence of formal discharge, most clients are marked as "inactive" if they have not engaged within a 90-day window, unless relocation or other permanent circumstances apply. This approach allows for reengagement at any time to build long-term trust with vulnerable populations, minimize stigma, promote a client-centered recovery path, and ensure that individuals who lose contact remain eligible for services with no punitive discharge policies. The program has already reported early engagement success, with at least one participant consistently meeting treatment milestones.

Implemented later in 2024, following a full year of policy development and planning, the available program data is minimal, but reflects a deliberate and collaborative approach to aligning local resources with state objectives for harm reduction and recovery support. Despite its promising foundation, the program faces significant structural and community challenges, such as homelessness, lack of transportation, and stigma negatively impacting community buy-in, and State Attorney's collaboration surrounding addiction continues to present obstacles to full community buy-in.

Calvert County: Program Characteristics, Referrals, and Services

Calvert County's program shift from LEO-focused work to social contacts has produced more referrals since the new program started implementation. We refrain from providing demographic data given the number of referrals and enrolled participants for this program, as it could be identifying information. The average age of those served is 41, similar to the average age across programs. The decrease from total referrals (n=7) to enrolled participants (n=4) to engaged ("Enrolled in Services") participants (28.6% of those initially referred) indicates that the program lost track of people between the referral and enrollment processes (see Table 7).

This is evidenced by about a quarter of the initial referrals following up to receive case management and confirmed via Stakeholder Committee meetings and individual program meetings.

Table 7. Characteristics of Calvert Program and Participants

	Calvert	Total/Average across All Programs
Total Referrals	7	1575
Total Persons Referred	7	1506
LEAD Participants	4	1228
% Participated	57.1%	78%
Mean Days from Referral to Enrollment	22	12
Referral (Arrest Diversion)	0	1325
Referral (Social Referral)	7	250
Demographics		
Male	-	62.5%
Female	-	35.9%
White	-	65.8%
Mean Age	41	39
Services Received		
Harm Reduction Principles	57.1%	85%
Case Management Plan	28.6%	65%
Referred to Services	28.6%	34%
Enrolled in Services	28.6%	35%

Calvert County: Performance Measures

Calvert County's LEAD program was not implemented until July 31, 2024, and therefore Table 8 reflects that data collection did not begin until Q3 2024. Overall, this jurisdiction has reported relatively low levels of service utilization and outcome measurements since implementation. Due to this later implementation and low reporting numbers, we are unable to draw meaningful conclusions regarding program trends across quarters.

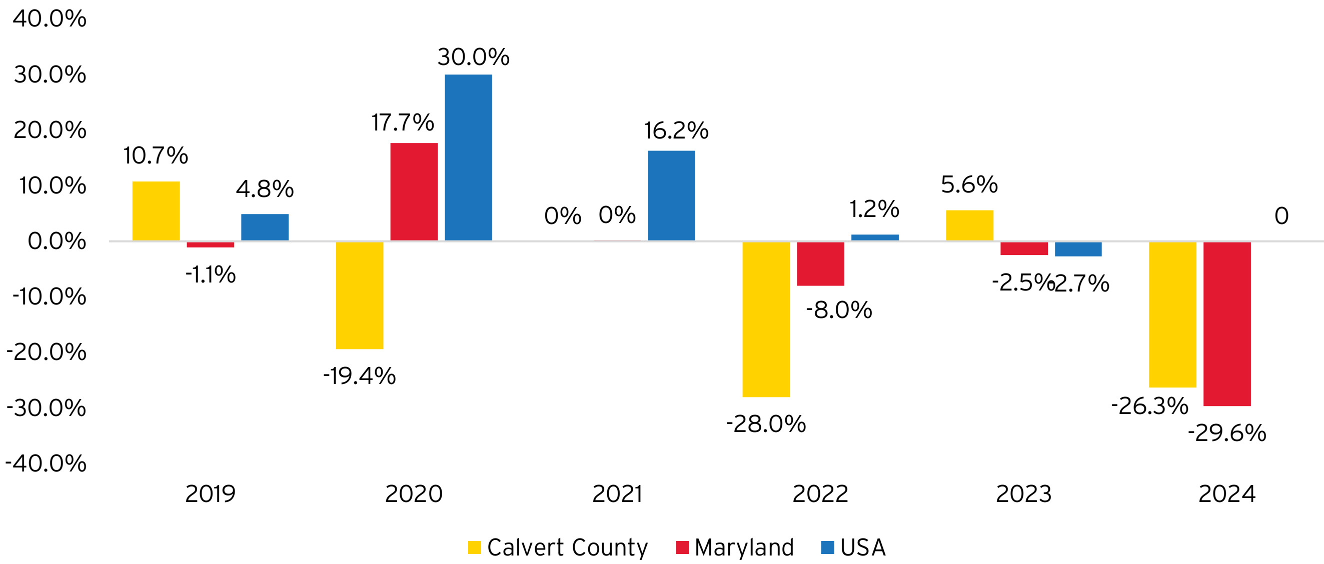
Table 8. Calvert County Reported Performance Measures

Performance Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Total
Number of individuals admitted to the ER	-	-	-	2	1	0	3
Number of individuals arrested for a new crime	-	-	-	0	3	0	3
Number of individuals arrested for a violation of supervision	-	-	-	0	0	0	0
Number of individuals connected to permanent housing	-	-	-	1	0	0	1
Number of individuals connected with employment, training or education	-	-	-	1	1	0	2
Number of individuals connected with medical insurance	-	-	-	2	0	0	2
Number of individuals connected with primary care physician	-	-	-	1	0	0	1
Number of individuals discharged from program	-	-	-	0	0	1	1
Number of individuals diverted from arrest or criminal summons into the program	-	-	-	1	0	0	1
Number of individuals enrolled in ongoing behavioral health care	-	-	-	2	2	0	4
Number of individuals identified as victims of crime	-	-	-	0	0	0	0
Number of individuals receiving MAT	-	-	-	0	0	0	0
Number of individuals receiving social referrals to the program	-	-	-	4	2	2	8
Number of individuals screened for and eligible who are receiving benefits	-	-	-	1	2	0	3
Number of individuals who experienced an overdose	-	-	-	0	0	0	0

Calvert County: Year-to-Year Percent Change in Fatal Overdoses

Calvert County's fatal overdose trends from 2019 to 2024 revealed several notable divergences from state and national patterns (see Figure 8). In 2019, the county experienced a 10.7% increase in fatal overdoses, in contrast to Maryland's 1.1% decrease and the 4.8% increase at the national level. The following year, however, Calvert experienced a 19.4% decline, moving in the opposite direction of the significant increases observed statewide (17.7%) and nationally (30%) during the pandemic. In 2021, Calvert County and Maryland's fatal overdoses remained stable (0% change), while the numbers continued to rise nationally (16.2%). The most significant drop came in 2022, with a 28% decrease in the county, which far surpassed Maryland's 8% reduction and the national increase of 1.2%. In 2023, Calvert saw a 5.6% increase, in contrast to continually declining trends statewide (-2.5%) and nationally (-2.7%). Finally, in 2024, Calvert recorded a 26.3% decrease, comparable to Maryland's 29.6% drop (national data were not available). Overall, Calvert County's year-to-year changes were more sporadic, but in the years when reductions did occur (2020, 2022, 2024), they were substantial and often exceeded the magnitude of declines observed at the State and national levels.

Figure 8. Annual Change in Fatal Overdoses



Harford County

The Harford County LEAD program, administered by the Office of Mental Health/Core Service Agency of Harford County, inc. (OMH/CSA) in partnership with the Bel Air Police Department and Kleins Family Center, has been operational since 2024,[26] offering a well-established and impactful framework for addressing SUDs and mental health crises. The program has recently extended collaboration efforts with the Aberdeen and Havre de Grace jurisdictions.

The program places a strong emphasis on proactive engagement and the initiative features a dual-track referral system consisting of stop referrals (post-arrest diversion) and social contact referrals (prevention-oriented support). This structure allows the program to serve both justice-involved individuals and those at risk of future involvement in the criminal legal system. Stop referral participants are considered to have successfully completed the program when they meet requirements such as counseling or other behavioral interventions. Social contact participants, however, follow a more flexible path—disengaging and re-engaging as needed—which aligns with the program's harm reduction philosophy and long-term recovery goals. These referral types offer a crucial access point for individuals facing homelessness, mental illness, or substance use who may not yet be in crisis. The Operational Work Group coordinates to curate individual care plans and utilizes a law enforcement liaison and case managers to ensure linkages to community resources are being made. Importantly, arrests during engagement are not viewed as automatic failures; instead, new law enforcement contacts may result in renewed enrollment and services, reflecting the county's nuanced understanding of client trajectories and needs.

Beyond the engagement with and referral from LEOs, individuals may seek care on their own. The walk-in clinic is a cornerstone of the program, providing immediate access to behavioral health and mental health services. Plans for countywide expansion, facilitated by partnerships with Bel Air, Havre De Grace and Aberdeen police departments, highlight the program's scalability and adaptability. By integrating case managers into its framework, the program fosters trust, reduces stigma, and promotes long-term stability for participants.

The program's flexible approach, which allows participants to return to services even after extended absences, demonstrates its commitment to meeting individuals where they are and addressing systemic barriers. Despite these achievements, challenges remain, which include inconsistent participant engagement among transient individuals and stigma around addiction continues to hinder community acceptance.

Harford County: Program Characteristics, Referrals, and Services

The Harford County program is a law enforcement led program with a designated LEO meeting people where they are to provide a referral and education on the program. The program identified and referred a higher percentage of men than women; similarly to the average for FY22 COAP-funded programs. The large proportion of White individuals targeted is also a unique feature of this program. The differences between case management, service referral, and service enrollment stem from the fact that many participants were hard to track down for case management after referral and some were provided with referrals without going through the formal process of case management (see Table 9). Following referral, there is a decrease in enrollment because of this lack of stable access to participants and a lack of trust to engage in the program.

[26] Harford County's program had early versions of the program that date back to 2017 and have evolved since then to what it is as of 2023.

Table 9. Characteristics of Harford Program, Referrals, and Services

	Harford	Total/Average across All Programs
Total Referrals	235	1575
Total Persons Referred	210	1506
LEAD Participants	109	1228
% Participated	52.3%	78%
Mean Days from Referral to Enrollment	-	12
Referral (Arrest Diversion)	84	1325
Referral (Social Referral)	151	250
Demographics		
Male	63.4%	62.5%
Female	36.2%	35.9%
White	81%	65.8%
Mean Age	-	39
Services Received		
Harm Reduction Principles	100%	85%
Case Management Plan	44.3%	65%
Referred to Services	79.1%	34%
Enrolled in Services	31.9%	35%

Harford County: Performance Measures

Compared to the other sites, Harford County’s program has had relatively moderate service utilization and reported outcomes. As of quarter 1 in 2025, 82 individuals were diverted from arrest or criminal summons into the program and 163 individuals received social referrals to the program (see Table 10). Additionally, the number of social referrals appears to be generally increasing as the program continues. This site has also consistently reported zero overdoses for the past three quarters, experienced declining numbers of arrests for new crimes, and has observed increases in the number of participants enrolled in ongoing behavioral health care, connected with medical insurance, and connected to permanent housing.

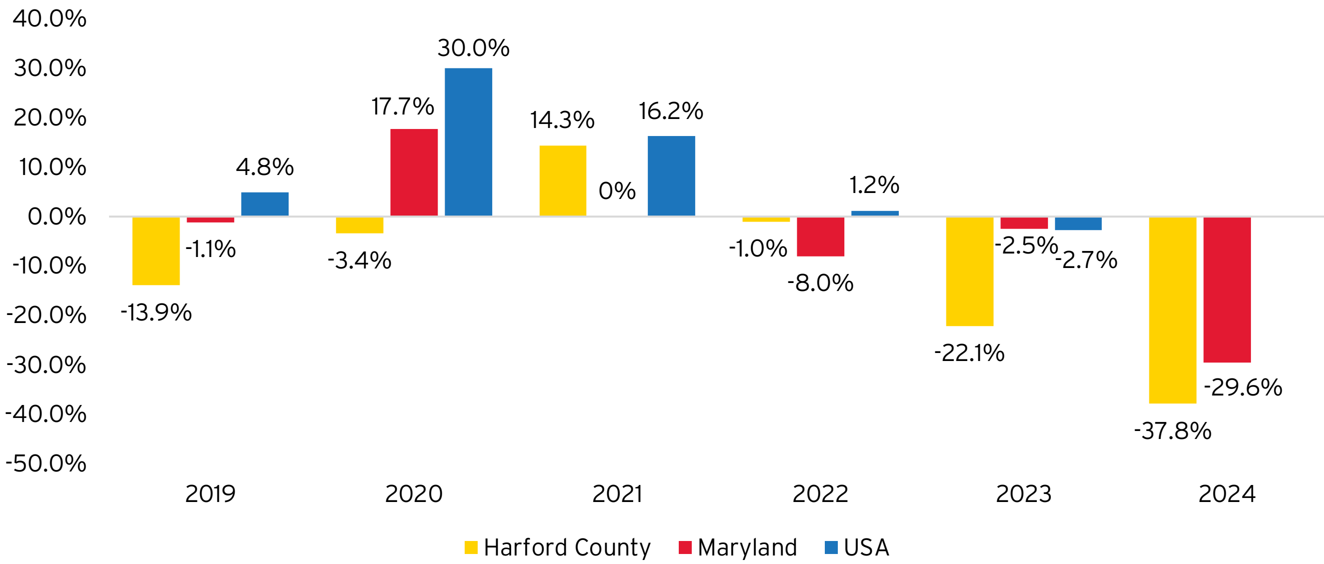
Table 10. Harford County Reported Performance Measures

Performance Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Total
Number of individuals admitted to the ER	1	1	6	7	7	4	26
Number of individuals arrested for a new crime	3	1	1	1	0	0	6
Number of individuals arrested for a violation of supervision	0	1	0	0	0	0	1
Number of individuals connected to permanent housing	5	2	0	8	12	3	30
Number of individuals connected with employment, training or education	1	0	0	0	1	2	4
Number of individuals connected with medical insurance	3	0	0	0	7	1	11
Number of individuals connected with primary care physician	0	1	0	1	1	0	3
Number of individuals discharged from program	0	0	0	4	13	6	23
Number of individuals diverted from arrest or criminal summons into the program	5	7	16	27	16	11	82
Number of individuals enrolled in ongoing behavioral health care	1	3	2	13	15	14	48
Number of individuals identified as victims of crime	0	0	0	0	0	0	0
Number of individuals receiving MAT	0	0	0	1	2	2	5
Number of individuals receiving social referrals to the program	16	17	24	25	43	38	163
Number of individuals screened for and eligible who are receiving benefits	2	3	4	26	51	2	88
Number of individuals who experienced an overdose	1	2	2	0	0	0	5

Harford County: Year-to-Year Percent Change in Fatal Overdoses

With the exception of 2021, Harford County's fatal overdose trends from 2019 to 2024 generally showed consistent reductions, often outpacing both the State and national patterns (see Figure 9). In 2019, the county experienced a 13.9% decrease, compared to a modest 1.1% decline in Maryland and a 4.8% increase nationally. In 2020, while fatal overdoses rose sharply across Maryland (17.7%) and the US (30%), Harford County reported a 3.4% decrease. In 2022, the county's 1% decline was modest but still compared favorably to the national 1.2% increase, though it was smaller than Maryland's overall 8% drop. Harford saw a more substantial decrease (22.1%) in 2023, far exceeding statewide (-2.5%) and national (-2.7%) declines. This downward trend continued in 2024 with a 37.8% reduction, again outperforming the 29.6% statewide decrease (national data unavailable for 2024). Overall, Harford County demonstrated a pattern of meaningful progress in reducing fatal overdoses in most years, with reductions that were frequently greater than those seen at the State and national levels.

Figure 9. Annual Change in Fatal Overdoses



Carroll County LEAD Initiative

The Carroll County LEAD initiative serves as the pilot site for Maryland's use of COSSUP-supported efforts to address opioid use, reduce harm from substance use, and limit unnecessary involvement in the criminal justice system. Launched officially in August 2020, following an intensive planning and policymaking phase funded by GOCPP, the initiative reflects a long-standing commitment to systems change. While originally funded through a COAP subgrant, Carroll County has received multiple funding extensions, including the most recent COAP award in February 2024, which supports operations through September 2026.

Importantly, partner agencies in Carroll County view LEAD not simply as a program, but as a philosophical shift—a long-term, systems-based initiative focused on improving coordination and access for individuals with chronic behavioral health conditions. The initiative is managed by the Carroll County Health Department and involves a highly coordinated collaboration among the Westminster Police Department, Sykesville Police Department, countywide Sheriff's Office, State's Attorney's Office, Office of the Public Defender, Division of Parole and Probation, and a range of treatment providers.

The LEAD team includes a clinical case manager and peer recovery specialist who provide trauma-informed, person-centered services. Health Department staff deliver both case management and peer support, targeting individuals who often fall through the cracks due to the chronic nature of their mental health or SUDs. Participants are not discharged in the traditional sense; rather, they are classified as either "engaged" or "disengaged," with disengagement occurring due to factors like relocation, treatment completion, or sustained loss of contact. This open-door approach aligns with the county's long-term goal of reducing barriers and supporting individuals through repeated touchpoints. The Operational Work Group meets biweekly to review cases and referrals, with the majority of participants referred through social contact pathways rather than arrest diversion, and vote on whether to allow a referred participant to enroll. This voting process was introduced later in the program implementation to reduce the number of participants who were being inappropriately referred to the program. As such, the workgroup has a chance to discuss whether this is the right program given the referred individual's needs, case, and possible engagement with other county resources.

One of Carroll County's key strengths is its responsiveness to local needs. The Quick Response Team (QRT) plays a crucial role in engaging individuals following non-fatal overdoses who refuse hospital transport. Team members provide outreach, naloxone training, and harm reduction resources. The QRT is complemented by countywide efforts to distribute naloxone and deliver education on overdose prevention, which has contributed to a reduction in calls for service. These services have been instrumental in filling service gaps and reaching individuals outside the traditional system of care.

Despite the initiative's strengths, funding limitations and the structure of short-term grants pose ongoing challenges. While LEAD is designed to be a long-term intervention, grant cycles often impose shorter program timelines and require adjustments with each renewal. The initiative also faces philosophical barriers from some stakeholders who view diversion as contradictory to traditional models of crime control. This tension underscores the need for continued engagement and education among law enforcement personnel and justice system partners.

Carroll County: Program Characteristics, Referrals, and Services

The Carroll County program is led by an Operational Work Group at the Health Department that focuses on connecting participants to the right services and treatment, even if they are not the services and treatment offered through LEAD. The program referred a slightly higher percentage of men than women; aligning with the average for FY22 COAP-funded programs. The proportion of White participants is higher than that found across the programs. The average age of those served is 39. This program has a higher service enrollment percentage than case management and service referral rates, which could be in reference to service utilization without formal processing (see Table 11). While this program receives referrals from LEOs and social contacts, the Operational Work Group votes to allow the referred individual to join LEAD. Beyond the eligibility criteria, the group tries to identify if the referred individual was enrolled in services somewhere else and they need to be reconnected to those services, and if there are services outside of the program that they can refer the person to. During a Stakeholder Committee meeting, a member explained that the County is rich in resources, so LEAD acts as a safety net for those who have slipped through all of the other cracks in the County.

Table 11. Characteristics of Carroll Program, Referrals, and Services

	Carroll	Total/Average across All Programs
Total Referrals	10	1575
Total Persons Referred	10	1506
LEAD Participants	10	1228
% Participated	100%	78%
Mean Days from Referral to Enrollment	20	12
Referral (Arrest Diversion)	2	1325
Referral (Social Referral)	8	250
Demographics		
Male	60%	62.5%
Female	40%	35.9%
White	80%	65.8%
Mean Age	39	39
Services Received		
Harm Reduction Principles	90%	85%
Case Management Plan	20%	65%
Referred to Services	10%	34%
Enrolled in Services	70%	35%

Carroll County: Performance Measures

Carroll County's program has also had relatively low service utilization and reported outcome measures. However, there are a few quarterly trends worth noting (see Table 12). First, since the third quarter of 2024, the number of individuals admitted to the ER has continuously decreased, with zero reported ER admissions in the first quarter of 2025. Second, this site also reported that in the first quarter of 2025, no participants had been arrested for a new crime or a violation of supervision, nor were any participants victims of crime. Third and finally, peak numbers of participants enrolled in ongoing behavioral health care screened/eligible for benefits were reached in the first quarter of 2025, which could suggest that the program's reach is expanding.

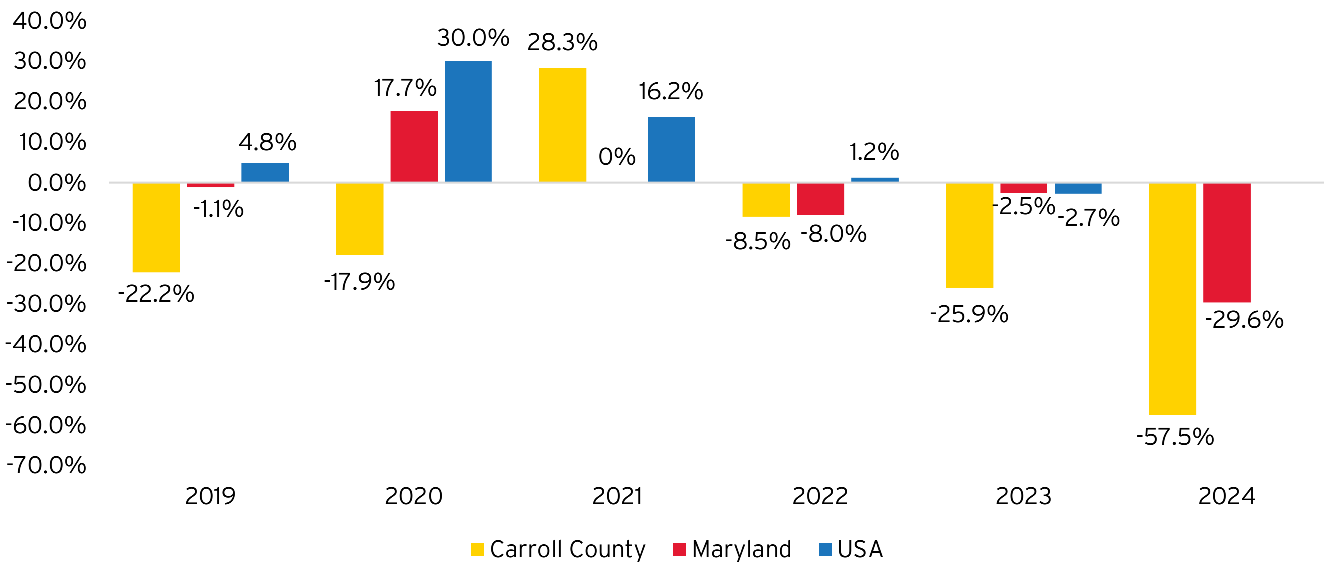
Table 12. Carroll County Reported Performance Measures

Performance Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Total
Number of individuals admitted to the ER	-	2	5	2	1	0	10
Number of individuals arrested for a new crime	-	2	0	3	2	0	7
Number of individuals arrested for a violation of supervision	-	1	1	1	2	0	5
Number of individuals connected to permanent housing	-	2	0	0	0	0	2
Number of individuals connected with employment, training or education	-	0	3	2	1	0	6
Number of individuals connected with medical insurance	-	0	0	0	1	0	1
Number of individuals connected with primary care physician	-	0	1	0	0	0	1
Number of individuals discharged from program	-	0	2	0	0	2	4
Number of individuals diverted from arrest or criminal summons into the program	-	0	0	1	0	0	1
Number of individuals enrolled in ongoing behavioral health care	-	2	2	2	1	9	16
Number of individuals identified as victims of crime	-	0	1	0	1	0	2
Number of individuals receiving MAT	-	0	0	1	0	0	1
Number of individuals receiving social referrals to the program	-	2	3	1	1	1	8
Number of individuals screened for and eligible who are receiving benefits	-	0	3	2	1	9	15
Number of individuals who experienced an overdose	-	0	1	1	0	1	3

Carroll County: Year-to-Year Percent Change in Fatal Overdoses

Carroll County experienced some of the most dramatic year-to-year fluctuations in fatal overdoses from 2019 to 2024, often differing substantially from State and national patterns (see Figure 10). In 2019, the County reported a 22.2% decrease, compared to much smaller changes in Maryland (-1.1%) and an increase nationwide (4.8%). In 2020, while both Maryland and the US experienced sharp increases (17.7% and 30%, respectively), Carroll County again moved in the opposite direction, with a 17.9% decrease. This trend reversed in 2021 when fatal overdoses rose by 28.3% in Carroll County, before returning to a trend downward. In 2022, the County recorded an 8.5% decline, closely aligning with the State (-8%), but diverging from the slight national increase (1.2%). A more substantial decrease followed in 2023 (-25.9%), exceeding both Maryland (-2.5%) and national (-2.7%) declines. Most notably, in 2024, the county saw a dramatic 57.5% reduction, nearly double the Statewide decrease of 29.6% (national data for 2024 were unavailable). Overall, Carroll County's fatal overdose trends were variable, but included several years with significant reductions that greatly outpaced broader state and national trends, particularly in 2023 and 2024.

Figure 10. Annual Change in Fatal Overdoses



Maryland Office of the Public Defender

The MOPD program provides a critical safety net for justice-involved individuals who may not fit into traditional diversion pathways. Since its inception in 2020, the program has effectively connected clients with community resources and peer support services, addressing SUDs and other behavioral health needs through a unique and client-centered approach.

The program operates through a highly collaborative model that integrates public defenders, peer recovery specialists, and community providers. Referrals are initiated by public defenders for eligible clients post-detention. Once connected, clients receive comprehensive case management, including links to housing, treatment, and recovery services. Peer recovery specialists serve as trusted mentors, helping clients navigate recovery while also acting as "fact witnesses" during legal proceedings. This approach fosters trust and provides crucial context for defense teams, leading to more effective advocacy and better client outcomes. By bridging the gap between public defense and behavioral health services, the program ensures clients receive holistic support tailored to their needs.

The program defines completion as the conclusion of a client's legal case. Successful completions are marked by consistent engagement, including compliance with court-ordered service plans and participation in treatment or social support as needed. Conversely, disengagement or rearrest prior to case resolution is considered non-completion. While program engagement typically concludes when legal proceedings end, the impact often extends well beyond this point, as clients are equipped with tools and resources for long-term recovery and stability. Overdose events among clients are monitored qualitatively, with current data occasionally distinguishing between fatal and non-fatal occurrences. Expanding reporting capabilities in this area could enhance evaluation of participant outcomes over time.

One of the program's standout features is its use of peer recovery specialists, who have significantly improved client engagement and trust. These specialists not only support clients through the legal process but also connect them to critical resources that address underlying behavioral health issues. The program's success, however, has been constrained by resource limitations, which have restricted its ability to scale and meet growing demand. Addressing these gaps will be essential for maximizing its impact.

MOPD: Program Characteristics, Referrals, and Services

The MOPD COAP program is managed through court actors and people with lived experiences, aka peer specialists. The program served a higher percentage of men than women; similar to the demographic breakdown of the average for FY22 COAP-funded programs. The large proportion of White individuals served is also comparable to the average across the programs. The average age of those served is 38. Case management was provided to all referred persons because they were referred and processed for needs while being detained, so there were no challenges with finding people after referrals. The decrease in service referral and enrollment could be due to people being incarcerated and not wanting, or being able, to enroll in services (see Table 13). This program enrolled participants across jurisdictions, meaning that there was overlap in service availability in some counties.

Table 13. Characteristics of MOPD Program, Referrals, and Services

	MOPD	Total/Average across All Programs
Total Referrals	323	1575
Total Persons Referred	323	1506
LEAD Participants	323	1228
% Participated	100%	78%
Mean Days from Referral to Enrollment	0	12
Referral (Arrest Diversion)	323	1325
Referral (Social Referral)	-	250
Demographics		
Male	67.8%	62.5%
Female	30%	35.9%
White	57.9%	65.8%
Mean Age	38	39
Services Received		
Harm Reduction Principles	100%	85%
Case Management Plan	100%	65%
Referred to Services	68.7%	34%
Enrolled in Services	66.9%	35%

MOPD: Performance Measures

MOPD's site reported that zero individuals were diverted from arrest or criminal summons into the program, whereas 293 individuals received social referrals (see Table 14). Eight program participants were arrested for a new crime and 19 were arrested for a violation of supervision. Only one participant experienced an overdose, and none were reported to be victims of crime. In terms of positive program outcomes, six participants have been connected to permanent housing, 15 were connected with employment, training, or education, 17 were connected with medical insurance or a primary care physician, 109 were enrolled in ongoing behavioral health care, and 51 received MAT.

Table 14. Maryland Office of the Public Defender (MOPD) Reported Performance Measures

Performance Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Total
Number of individuals admitted to the ER	0	1	0	2	2	1	6
Number of individuals arrested for a new crime	0	2	0	3	3	0	8
Number of individuals arrested for a violation of supervision	0	3	0	5	4	7	19
Number of individuals connected to permanent housing	0	0	0	3	3	0	6
Number of individuals connected with employment, training or education	0	0	0	3	5	7	15
Number of individuals connected with medical insurance	0	0	0	2	7	2	11
Number of individuals connected with primary care physician	0	0	0	3	1	2	6
Number of individuals discharged from program	0	25	0	74	31	81	211
Number of individuals diverted from arrest or criminal summons into the program	0	0	0	0	0	0	0
Number of individuals enrolled in ongoing behavioral health care	0	5	0	39	30	35	109
Number of individuals identified as victims of crime	0	0	0	0	0	0	0
Number of individuals receiving MAT	0	4	0	15	21	11	51
Number of individuals receiving social referrals to the program	0	20	0	94	80	99	293
Number of individuals screened for and eligible who are receiving benefits	0	0	0	0	46	3	49
Number of individuals who experienced an overdose	0	1	0	0	0	0	1

Given that the MOPD program operates across multiple counties and overlaps with other program jurisdictions, we do not present annual trends in fatal overdose rates for this program.

St. Mary's County

The St. Mary's County LEAD program is a collaborative initiative aimed at reducing justice involvement and addressing the needs of individuals with substance use and behavioral health challenges. Administered by the St. Mary's County Department of Health, this program originally proposed to leverage partnerships with the local Sheriff's Department and the State's Attorney's Office but have had to make adjustments as buy-in with these agencies was not successful. The program now works with detention centers, the district court, and the Public Defender's Office. With a focus on harm reduction and early intervention, the program represents a critical effort to support individuals during and after their interaction with the criminal justice system.

The newly established framework of comprehensive provision includes establishing peer connections in the detention center and building relationships with the district court judge and Public Defender's Office. St. Mary's County's approach to addressing recidivism and promoting legal compliance includes working closely with the local detention center to provide social referrals and peer connections upon release. Case managers identify individuals with a history of legal system involvement and connect them with resources such as appointment reminders, crisis walk-ins, and referrals to behavioral health programs. This proactive engagement aims to reduce the likelihood of re-offense by ensuring individuals have access to the support they need to stabilize their lives. This program has also been able to establish a Mental Health docket at the district court once a month to address the complex behavioral health needs of charged populations. The Public Defender's Office has started to cooperate with the St. Mary's Department of Health via pre-screening practices to detect need for intervention early in an individual's case.

Despite initial implementation and buy-in challenges, the program has begun to make an impact, particularly in fostering coordination between courts and case management services. Judges and public defenders are actively referring individuals to LEAD, enabling the department to assess participants and connect them with the most appropriate programs.

St. Mary's County: Program Characteristics, Referrals, and Services

St. Mary's County's program took a few years to establish supportive collaborations and pivoted from their original approach of LEO assistance to working with judges and a mental health court docket. The program served roughly equal proportions of men and women; the proportion of women served in Anne Arundel is higher than the average for FY22 COAP-funded programs. They served a larger percentage of White individuals compared to the average across the programs. The average age of those served is 37. The decrease from total referrals (n=15) to only a third of them being enrolled in services follows a similar pattern that we saw amongst the other programs. From initial contact, or referral, to case management, and service enrollment, people are witnessed to be dropping from the sample (see Table 15).

Table 15. Characteristics of St. Mary's Program, Referrals, and Services

	St. Mary's	Total/Average across All Programs
Total Referrals	15	1575
Total Persons Referred	15	1506
LEAD Participants	15	1228
% Participated	100%	78%
Mean Days from Referral to Enrollment	7	12
Referral (Arrest Diversion)	-	1325
Referral (Social Referral)	15	250
Demographics		
Male	66.7%	62.5%
Female	33.3%	35.9%
White	73.3%	65.8%
Mean Age	37	39
Services Received		
Harm Reduction Principles	46.7%	85%
Case Management Plan	100%	65%
Referred to Services	33.3%	34%
Enrolled in Services	33.3%	35%

NOTE: The values reported in Table 15 include Quarter 2 of 2025, which is why they differ from those reported in Table 16.

St. Mary's County: Performance Measures

Overall, this jurisdiction has reported low levels of service utilization and reported zeros for nearly all performance measures across quarters (see Table 16). Since the program's implementation, three participants have been connected to permanent housing, two have been connected with employment, training, or education, four have been connected with medical insurance or a primary care physician, two have been enrolled in ongoing behavioral health care, and one individual has received MAT. According to these quarterly reports, only three individuals have received social referrals to the program and only two have been screened and found eligible for receiving benefits.

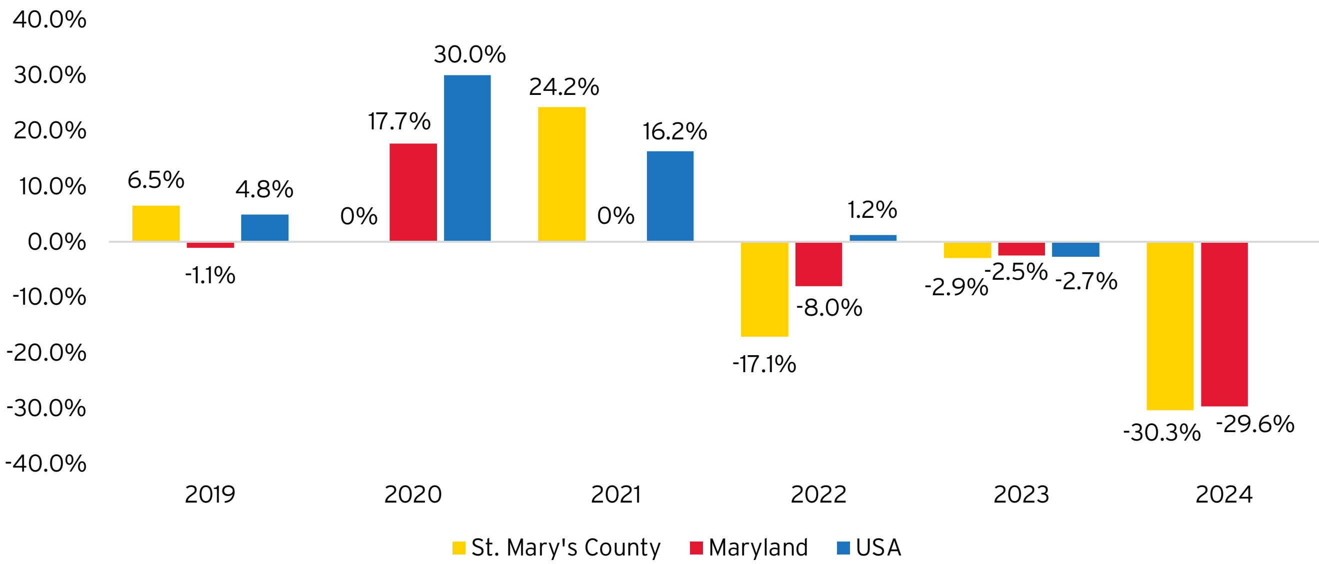
Table 16. St. Mary's County Reported Performance Measures

Performance Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Total
Number of individuals admitted to the ER	0	0	0	0	0	0	0
Number of individuals arrested for a new crime	0	0	0	0	0	0	0
Number of individuals arrested for a violation of supervision	0	0	0	0	0	0	0
Number of individuals connected to permanent housing	0	0	0	0	0	3	3
Number of individuals connected with employment, training or education	1	1	0	0	0	0	2
Number of individuals connected with medical insurance	0	0	0	0	0	3	3
Number of individuals connected with primary care physician	0	0	0	0	0	1	1
Number of individuals discharged from program	0	0	0	0	0	0	0
Number of individuals diverted from arrest or criminal summons into the program	0	0	0	0	0	0	0
Number of individuals enrolled in ongoing behavioral health care	0	0	0	0	0	2	2
Number of individuals identified as victims of crime	0	0	0	0	0	0	0
Number of individuals receiving MAT	0	0	0	0	0	1	1
Number of individuals receiving social referrals to the program	0	0	0	0	0	3	3
Number of individuals screened for and eligible who are receiving benefits	0	0	0	0	0	2	2
Number of individuals who experienced an overdose	0	0	0	0	0	0	0

St. Mary's County: Year-to-Year Percent Change in Fatal Overdoses

St. Mary's County experienced several years of meaningful reductions in fatal overdoses between 2019 and 2024, often exceeding or aligning with broader state and national trends (see Figure 11). St. Mary's County did not experience reductions until 2022, in which the county saw a 17.1% decrease, more than double the 8% reduction at the State level and in contrast to the national 1.2% increase. A modest decline followed in 2023, with a 2.9% decrease that was consistent with Maryland (-2.5%) and national (-2.7%) trends. In 2024, St. Mary's County recorded its largest drop in the period (-30.3%), which closely mirrored Maryland's 29.6% decrease (national data were not available for 2024). These periods of decline suggest that, while overall trends in the county were variable, the reductions that did occur were substantial and often exceeded or matched those observed at the State and national levels.

Figure 11. Annual Change in Fatal Overdoses



Qualitative Interviews with Program Staff

As shown in Table 17, 22 staff members across seven programs were interviewed between January and July 2025. As shown in prior sections, the programs included in this evaluation varied greatly in terms of scope, length of operation, lead agency, and the key staff involved. The staff interviewed filled various roles including project coordinator/manager/supervisors, peer supervisors/recovery specialists, law enforcement representatives, case managers, reentry coordinators, buprenorphine expansion coordinators, resource coordinators, public defenders, and others. These positions were selected to collect the perspectives of a broad representation of professionals actively participating in the programs and interacting regularly with other program staff and participants referred to the programs. All interviews were conducted via Zoom by a trained interviewer and each interview lasted for approximately one hour.

Table 17: Staff Interviews Completed (n = 22), by Program January-July 2025

Implementing Agency	Jurisdiction(s) Served	Number of Interviews
Allegany County Board of Commissioners	Allegany	3
Anne Arundel County	Anne Arundel	4
Calvert County Health Department	Calvert	4
Carroll County Health Department	Carroll	2
Maryland Office of the Public Defender	Anne Arundel, Baltimore City, Cecil, Fredrick, Harford, and Washington	3
Office of Mental Health/Core Service Agency of Harford County, Inc. (OMH/CSA)	Harford	4
St. Mary's County Health Department	St. Mary's	2
Total		**22**

There was great variation in the perceptions of respondents depending on the scope and location of the programs, other programs available in the jurisdictions, and the role of the person interviewed in the program. The program coordinator/manager/supervisor was the only common role included in the interviews across the programs, and they tended to have a deeper and more complete understanding of the scope of the programs and how they operated than other staff interviewed who were often more focused on their specific areas of expertise and regular daily activities.

Due to the variation in programs and roles interviewed and the small number of interviews completed for each program, the findings are reported in aggregate for each of six main topic areas covered in the interviews: scope of the program and services provided, level of awareness/understanding of COAP/LEAD among participating organizations and the public, program specific activities, program successes, program challenges, and future hopes and plans. Findings for each of these categories were discussed with program representatives participating in Stakeholder Committee meetings. Participation in these meetings was voluntary. Representatives provided clarifications and expanded on information collected through the interviews to ensure that findings were accurately interpreted. The first stakeholder meeting served as an introductory meeting, and subsequent meetings involved discussions of qualitative and quantitative findings.

Scope of Program and Services Provided

The length of implementation of the programs evaluated ranged from approximately two years to six years. Although each of these programs is considered a LEAD program, many staff interviewed selected other types of programs as well. Other types mentioned included court diversion (3 programs), reentry (3 programs), and harm reduction (7). Each staff member interviewed was also asked to identify the agencies participating in their program. Agencies mentioned included the local health department (5), Sheriff's office (5), local police department (5), public defender's office (3), local detention center (6), social services (2), and local recovery programs (5).

Eligibility. In general, the programs evaluated reach a variety of populations with a focus on adults encountering law enforcement after a nonviolent offense. Representatives from three programs specifically mentioned including people with SUDs or who had a low-level drug offense.

When asked what would make someone ineligible to participate, the staff members interviewed mentioned violent crimes (e.g. murder, assault, carjacking), arson and adults who want to hurt themselves or others. However, the staff try to reach as broad a population as possible. They want to help people who are appropriate for treatment and open to treatment. A couple mentioned that they try to be open and not to deny anybody and others stated that even if a person is ineligible for the program they will still talk to the family or connect the person to services through another program.

Referral of Participants. As shown in Table 1 earlier in this report, referrals to the COAP/LEAD programs can occur prearrest via law enforcement or social contacts or post arrest as part of court proceedings or reentry planning. Six programs received referrals both pre and post arrest, though two have more of a focus on prearrest referrals. The physical locations of recruitment ranged from the site of the criminal act to detention centers to court proceedings. Other types of referrals mentioned included social contact referrals, self-referrals, and a program representative at a Stakeholder Committee meeting discussing these findings also mentioned that referrals could be made as part of post overdose follow ups at hospitals and homes.

Program Specific Activities

To start the interview, researchers asked about the vision and goals of the program and the specific activities or services provided. The COAP/LEAD programs share the overall goals of the national model, but they are customized to meet local needs and fill gaps in local programs and initiatives. Many operate as a collaboration of multiple local programs managed across both public safety and public health agencies. Specific activities mentioned by the staff interviewed ranged from case management to community outreach and training to providing services to meet the individual needs of program participants.

All of the programs provide case management/care coordination, provide services and referrals to participants, engage in community outreach and hold meetings with participating agencies. They also either utilize harm reduction approaches directly or work with harm reduction programs. At least six of the programs provide peer support. Three programs that work with local detention centers provide reentry support and planning.

Community outreach activities mentioned during the interviews include presentations at local meetings and events such as county fairs and citizens' academies; conferences with judges and states' attorneys; meetings of local groups such as On Our Own, Lions' clubs, and merchants' associations; and special events such as law enforcement appreciation day. In addition, staff interviewed reported meeting regularly (weekly, monthly, quarterly) with or conducting site visits with collaborating agencies including local police departments, local behavioral health administrations, hospitals, detention centers, and local providers.

Staff interviewed at all of the programs also discussed providing direct services to meet the needs of individual participants. This can include providing housing and transportation assistance, mental and physical health support, referrals for medications, and wound care. Program representatives participating in stakeholder committee meetings with evaluation staff to discuss these findings elaborated on these efforts mentioning other types of support such as financial assistance vouchers for local food store/food assistance, courtroom support/advocacy, assistance with paperwork for IDs, vouchers for transportation, hygiene kits, and insurance assistance.

Level of Awareness of COAP/LEAD

Six questions were designed to assess the level of awareness both within the program (among collaborating agencies) and in the general public, what the respondent thought could be done to increase the level of awareness, and what additional support the programs may need from GOCPP. Perceptions of the level of awareness varied among respondents both across and within programs. In general, staff interviewed feel that there is a shared vision among participating agencies. Collaborators and providers tend to be more aware of the parts of LEAD they work with and may have less awareness of the full scope of the program. Program staff tended to perceive a higher level of awareness in programs with active collaborations with multiple agencies.

Many of the staff interviewed believe that their activities have increased awareness of and utilization of their program, but some feel that awareness is still limited in some areas. For example, staff interviewed in two programs stated that word of mouth can do a lot to increase awareness and utilization in locations like detention centers and hospitals. However, staff interviewed in some programs reported that awareness and utilization of their programs in law enforcement agencies is sometimes limited and that more needed to be done to increase buy-in of specific groups such as police officers, jails, or hospitals.

Each of the programs evaluated conducted regular activities to increase collaboration and improve the level of awareness and utilization among collaborating agencies. For example, program staff in four programs reported attending role call at local law enforcement agencies, conducting service trainings and developing targeted marketing materials. More informally, LEAD senior staff reported engaging in activities such as sending reminders to staff at collaborating agencies, joining agency staff meetings, and sending emails to encourage them to make more referrals. Most programs have instituted management plans including regular program meetings which may be held quarterly, monthly, or biweekly depending on need.

Staff also regularly conduct outreach to the public by visiting local community-based organizations such as On Our Own, Lions clubs, and merchant associations, attending local meetings of business and government communities, and making social media posts. Staff also attend community events and fairs to share information and distribute flyers. Staff at one program also mentioned including training about COAP/LEAD in the local Citizen's Academy.

The staff interviewed at several programs expressed appreciation for the information and support they have received from GOCPP.

Program Successes

The interview included six questions designed to capture perceptions of success. Successes were identified at both the agency and the participant levels. On the agency level, successes cited included developing effective collaborations, building awareness of COAP/LEAD, achieving a shared vision across collaborating agencies, getting more participants referred to them, and filling necessary positions. At least one staff member interviewed at each of five programs felt that there was a shared vision either within their program or across collaborating agencies while others felt that due to their position in the program, they did not have the knowledge to assess this. One staff member interviewed highlighted the ability to work with many different types of people. Another from the same program suggested that they felt that the COAP/LEAD program helped to improve the understanding of SUDs in their county and to address related stigma (though stigma remains a concern).

Success can also be very personal for both the staff and the participants. Many staff interviewed stressed that success is unique to each participant and focused on the development of individual case plans or reentry plans for those released from jail. According to one staff member interviewed, the first success can be when the participant shows up and asks for services. Others in this program stressed the importance of linkages – making the pathway to services easier, whether or not a participant is linked to a provider, and whether or not they stay connected with the provider.

In general, staff worked to maintain contact with participants and support them to follow their case plan. Staff want to help the participants to overcome boundaries and meet personal goals to the best of their abilities. When the participants maintain contact with their case manager and meet their personal goals no matter how simple, it is considered a success by the staff. This can include entering drug treatment, getting a GED, getting a job, finding an apartment, managing a personal budget, and other things that can make a noticeable improvement in a participant’s life. One staff member interviewed indicated that their biggest success is helping a participant move away from criminal behavior and the circumstances that got them there towards a healthier and more stable lifestyle.

Program Challenges

The interview included three questions designed to capture perceptions of challenges. As with successes, challenges were often identified at both the agency and the participant levels. At the agency level, challenges encountered often revolved around improving coordination and buy-in across key agencies such as local police departments, emergency departments, and detention centers/jails. Increasing buy-in involves expanding education and outreach to introduce COAP/LEAD to local agencies and court systems to reduce the stigma around people with SUDs and MAT and to build a supportive understanding of the recovery process.

Staff interviewed from several programs also stressed staffing as an ongoing challenge. Concerns included being able to pay adequate wages, hire staff with specialized skills such as wound care and maintaining enough staff over time to respond to referrals and manage participant cases. In one program, all of the staff interviewed emphasized the need for more funds to support staff so that their program could accept more referrals.

At the participant level, a variety of challenges were identified. These challenges ranged from increasing opportunities for referrals and the need for intensive case management and peer support that would include providing after-hour services and follow-up care to meet the personal needs of individual participants such as transportation and housing. Staff interviewed also mentioned special challenges reaching non-English speakers and working with populations with mental health disorders.

Future Hopes and Plans

The staff interviewed had many hopes for the future. Most comments involved working to expand the reach of their programs and increasing methods of referral and support and services provided to participants. Staff at one of the smaller programs expressed interest in expanding collaborations to include more local agencies and hiring more staff. Staff at several programs expressed interest in expanding their program countywide, across jurisdictional boundaries and across the State to better connect program participants to services convenient to them.

Staff at several programs expressed an interest in conducting more intensive case management by providing services such as after-hours support, follow-up work with participants, offering more peer support, and adding new services such as primary care in Wellmobiles. Staff at one program emphasized an interest in developing a process to allow self-referrals. During a discussion of qualitative findings at a Stakeholder Committee meeting, a representative suggested developing self-referral cards.

Staff interviewed were also asked about additional populations that could be reached through the COAP/LEAD programs. Responses varied depending on the current scope and level of implementation. Populations mentioned included juveniles, young adults, unhoused populations, elderly on fixed incomes in senior living facilities, and non-English speakers.

Summary

All of the staff interviewed share a dedication to the LEAD mission, and staff interviewed at each of the programs felt that the staff participating in their program have a shared vision to help connect people to the services they need. However, that vision may not always be shared by the collaborating agencies. So, staff regularly participate in meetings and provide training to improve the understanding and utilization of the program.

All of the programs evaluated are currently accepting referrals and are working to reach as broad a population as possible through their program. Depending on the agency leading the program, recruitment can occur prearrest or post arrest or both. The scope of the programs and specific roles included varied greatly, but staff interviewed at each provided information about successes and challenges on both the program and the participant levels.

The programs evaluated have developed various methods for monitoring successes and challenges including collecting data on specific statistics (recidivism, reentry plans, referrals), quarterly progress reports prepared for GOCPP, goal sheets, and case management tools. Success at the program level included developing effective collaborations and increasing awareness of LEAD. Successes for participants focused on overcoming boundaries and meeting their personal goals to the best of their ability. Staffing is an ongoing challenge for the programs. Challenges for the participants included increasing opportunities for referrals and peer support and meeting basic participant needs such as housing and transportation.

As part of the review and analysis of the qualitative interviews, researchers presented and discussed key findings at evaluation stakeholder committee meetings. Additional context for interpreting the findings was provided by the program representatives present. The Stakeholder Committee included representatives from each of the programs included in the evaluation. Participation in the meetings was voluntary, and the representatives were invited to participate as available. A regular topic of discussion was challenges experienced by many programs regarding hiring and maintaining staff. Members of the stakeholder committee described how although they may have qualified and interested applicants for positions, there can be lengthy delays in hiring and training new staff. This has resulted in at least one program being unable to accept and manage participants for an extended period. Another mentioned losing a highly qualified applicant who had originally accepted a position due to the lengthy hiring delays.

Discussion

Overall, there is evidence to suggest that Maryland is taking positive steps to address the opioid epidemic and substance misuse. That said, through this evaluation we find evidence of opportunities for improvement.

How do agencies utilize COAP funding to identify individuals in need of substance abuse treatment services?

Agencies varied in their approaches to identify eligible individuals in need of treatment for SUDs and this variation reflects individual programmatic characteristics. The overall eligibility profiles of participants were similar across programs. Programs were limited to the type of offenses that were eligible for participation by the State's Attorney's Office and those offenses tended to be low-level, nonviolent offenses (i.e., trespassing, disorderly conduct, theft, etc.), with social referrals being more of a discretionary effort by LEOs or community providers. Programs did not limit eligibility based on number of previous offenses, but in general, programs did not accept people who had histories of violence / violent offenses, even if the current offense did not involve violence. For the most part, programs did not limit participation to being contingent on complete sobriety and staying out of further contact with the criminal justice system for new offenses. Given the harm reduction and progress-focus approach of the programs, the goals were to reduce substance use and continued contact with the system, but they recognized that they could not always prevent recidivism entirely.

Efforts to recruit individuals into the programs were less focused on reaching individuals directly, and instead concentrated on educating collaborative agencies, and health providers, and the broader community. There was evidence of significant recruitment effort, often more than anticipated by programs, as many shared that they would send team members into the community to attend events, visit offices, meet with community-based organizations and/or host educational workshops to inform as many people in the community as possible about the population that they were targeting and how to make referrals. For the programs that had access to a detention-based population (i.e., Allegany County and MOPD), recruitment was more direct with lawyers, case managers, and peers who could recruit eligible participants directly to enroll in the program.

How effective are COAP-funded programs in connecting individuals to treatment services?

Throughout the duration of the programs, practitioners at participating LEAD sites were asked to report on a range of performance measures to assess service delivery and outcomes. These data were collected on a quarterly basis, with counts reflecting site-level activity and implementation progress over time (see Table 18). Several data challenges limit the ability to compare trends across programs including data collection differences, varied implementation timelines, and missing data on key indicators such as the total number of individuals served by each program. Instead, we present individual program-level performance measures from data collected using quarterly programmatic reports, providing unique context across each of the LEAD sites.

In general, each program reported connecting individuals to treatment services. Trends suggest that receipt of MAT, enrollment in ongoing behavioral health care, and connection with medical insurance were the most commonly utilized services across sites. Social referrals and screenings for eligible benefits also showed high engagement, suggesting strong linkages to external support systems.

Table 18. Connection to Services among Program Participants as Reported via Quarterly Reports[27]

	Allegany (n= 872)	Anne Arundel (n=4)	Calvert (n=4)	Carroll* (n=10)	MOPD (n=323)	Harford (n=109)	St. Mary's (n=15)	Total (N=1337)
Performance Measures								
Connected to permanent housing	9	0	1	2	6	30	3	51
Connected with employment, training or education	16	0	2	6	15	4	2	45
Connected with medical insurance	479	1	2	1	11	11	3	508
Connected with primary care physician	148	1	1	1	6	3	1	161
Discharged from program	66	47	1	4	211	23	0	352
Diverted from arrest or criminal summons into the program	379	0	1	1	0	82	0	463
Enrolled in ongoing behavioral health care	473	22	4	16	109	48	2	674
Identified as victims of crime	0	0	0	2	0	0	0	2
Received MAT	1324	20	0	1	51	5	1	1402
Received social referrals to the program	70	215	8	8	293	163	3	760
Screened for and eligible who are receiving benefits	878	0	3	15	49	88	2	1035
Experienced an overdose	90	0	0	3	1	5	0	99

**Carroll County's LEAD FY22 initiative began in February 2024 as opposed to the other programs, which began their FY22 grant in October 2023.*

[27] The numbers included in Table 18 are the aggregates of these variables collected over six calendar quarters, from October 2023 to March 2025.

What efforts are being taken to reduce overdose death?

The overall goal on the Maryland LEAD initiative is "reducing opioid overdose deaths while increasing access to care and treatment through police and detention-based referrals."[28] The COAP/LEAD programs evaluated share the overall goals to divert program participants and increase access to care and treatment, but their programs were customized to meet local needs, provide linkages between local programs, and fill gaps in services. Many operate as a collaboration of multiple local programs managed across both public safety and public health agencies.

Several program staff interviewed mentioned perceived connections between their programs and addressing SUDs and overdoses. Staff interviewed at one program reported that their most important goal is reducing the number of drug overdoses, and staff at another indicated that they believe that their LEAD program plays a role in decreasing overdoses in their county. One staff member interviewed suggested that they felt that their program helped to improve the understanding of SUDs in their county and to address related stigma. Another described working to address stigma around people with SUDs and MAT to build a supportive understanding of the recovery process. Examples of specific activities initiated by the programs evaluated include providing case management/care coordination, services and referrals to participants, and training for program staff and staff at collaborating agencies, engaging in community outreach and holding meetings with participating agencies. They also either utilize harm reduction approaches directly or work with harm reduction programs.

How effective are COAP programs in reducing recidivism among individuals connected to services?

Data limitations did not allow us to analyze impacts of program participation on recidivism, however, there is evidence to suggest that programs are working to divert individuals in need away from the criminal legal system and into treatment. Table 19 shows that 69 participants across five programs were arrested for a new crime, and 105 participants across four programs were arrested for violations of supervision. These outcomes were primarily observed at the Allegany County program, however, the higher incidence of arrest in these counties is likely due to their programs' contact with a substantially higher number of participants overall.

Table 19. Subsequent System Contact among Program Participants as Reported via Quarterly Reports[29]

	Allegany (n=872)	Anne Arundel (n=4)	Calvert (n=4)	Carroll* (n=10)	MOPD (n=323)	Harford (n=109)	St. Mary's (n=15)	Total (N=1337)
Performance Measures								
Admitted to the ER	127	1	3	10	6	26	0	173
Arrested for a new crime	45	0	3	7	8	6	0	69
Arrested for a violation of supervision	80	0	0	5	19	1	0	105

**Carroll County's LEAD FY22 initiative began in February 2024 as opposed to the other programs, which began their FY22 grant in October 2023.*

[28] GOCPP, https://gocpp.maryland.gov/law-enforcement-assisted-diversion/, accessed 09/21/25.
[29] The numbers included in Table 19 are the aggregates of these variables collected over six calendar quarters, from October 2023 to March 2025.

Are current programmatic reports an effective measure of the program?

Across all programs, there was uncertainty regarding quarterly reporting requirements for the grant and how they aligned with program specific features. As explained in detail in earlier sections, each program was developed to meet specific needs and challenges within a jurisdiction or jurisdictions. As a result of this community-based variation in program scope and management, there is a need for more program specific data recording metrics. Even when reporting metrics are applicable to different programs, there were substantive differences in how these metrics were interpreted by the programs. As such, evaluations across programs are not equivalent.

This means that while each program submitted a quarterly report, there is great variation between programs in what and how they report data as well as variation within programs across reporting periods with some documenting progress since the start of the program in some quarters, and since the date of the last report in other quarters. This variation diminishes evaluation potential and the assessment of general trends over time and across programs.

Provide strength-based feedback and programmatic support (including database development as needed) to COAP funding recipients.

During Phase 2 of the evaluation, the research team worked to establish a Stakeholder Committee comprised of members of each program who agreed to meet routinely both individually and in group format to discuss progress, troubleshoot, review evaluation protocols, review and discuss findings, and identify future needs. These meetings are used in concert with the quantitative metrics and qualitative insights to inform programmatic support for the recommendations.

Recommendations

Combined, the insights derived from the evaluation activities were used to inform recommendations for the LEAD programs and GOCPP. The researchers and program representatives identified the following four specific recommendations to increase awareness of the LEAD programs, three recommendations to improve program reporting and inform future evaluations, four recommendations to support program implementation, and four recommendations to improve providing services to patients.

Recommendations to Increase Awareness of LEAD Programs

1. Offer more regular opportunities for staff training
2. Encourage coordination across partners
3. Continue to address stigma so that more people can recognize the value of the program
4. Encourage programs to utilize resources available through GOCPP

Program staff feel that there is a shared vision among participating agencies about supporting participants and that the LEAD programs have decreased or at least built awareness of stigma in their jurisdictions to some degree. However, stigma remains a key challenge and perceptions of the level of awareness of COAP/LEAD programs varied within and across programs, and individual awareness is often linked to one's specific touchpoint or role in the program. Increasing awareness can encourage buy-in and utilization, enhance coordination efforts, and ease communication across people and agencies.

1: Offer more regular opportunities for staff training.

Several programs offer education opportunities through targeted training for (new) staff, conferences for agents of the court, and management plans with routine program meetings. Increases in staff training should include both within and across agency opportunities.

> We recommend that GOCPP support ongoing activities conducted by LEAD programs to increase awareness of LEAD by promoting educational opportunities on topics such as stigma around substance use disorder, treatment and harm reduction.

2: Encourage coordination across partners.

Program staff encourage coordination by attending staff meetings, making presentations at roll call, and meeting regularly with staff and collaborating agencies to educate them about LEAD and encourage them to make referrals. Increasing cross-agency communication can increase program collaboration and utilization.

> We recommend that GOCPP work with funded programs to identify and share successful examples of approaches for sharing information about participants and encouraging coordination across partners.

3: Continue to address stigma so that more people can recognize the value of the program.

Programs can work to address stigma by offering trainings for staff at collaborating agencies and engaging in outreach efforts to local businesses through merchant associations and other venues. Sharing success stories and discussing challenges faced by program participants can help people understand the impact of LEAD programs and improve their understanding of SUDs.

4: Encourage programs to utilize resources available through GOCPP.

The Centers of Excellence at GOCPP provide training and technical assistance, as well as resources to programs engaged in direct services. GOCPP should share these opportunities more broadly and routinely with programs. When programs meet with GOCPP project officers, they should share resources that may be particularly useful for the program's efforts and request information about resources used by the program that could be shared with other programs.

> We recommend that GOCPP provide opportunities for and encourage LEAD staff to share information and guidance across programs and to utilize resources available through GOCPP.

Recommendations to Improve Program Reporting and Inform Future Evaluations

1. Provide technical training to programs for grant reporting
2. Revise Reporting Metrics
   2a: Revise reporting metrics for participant needs and service referrals
   2b: Revise reporting metrics for outcome-related data
3. Conduct satisfaction surveys and interviews with program participants

1: Provide technical training to programs for grant reporting

A requirement of receipt of COAP funding is the submission of quarterly reports that include progress on performance measures, challenges with implementation, and program successes. Programs frequently noted challenges with the reporting system and need for assistance and training with the current reporting measures.

The variation in understanding of the measures and completion of the data entry for these measures both across programs and across reports for individual programs means that it is not possible to track program progress over time and limits evaluation potential.

We recommend that GOCPP provide technical training to each program as part of the receipt of funding. This training should cover data entry for the Performance Measures and Participant-Level data sheets with guidance on reporting, variable definitions, and changes between quarters. Doing so will increase data accuracy and standardize information across programs. Refinement of data definitions in the grant reporting instruction manual would also provide greater clarity and increase reporting accuracy. To note, programs vary greatly in their structure and purpose and while aiming for standardized data, allowances should be made to accommodate the unique characteristics of each program.

2a: Revise reporting metrics for participant needs and service referrals

The current reporting system is inadequate to capture important features of programs and participants. For instance, programs revealed that participants frequently reported using multiple substances. Given limitations of reporting processes (e.g., dropdown menus with no option to modify categories) this degree of nuance is not captured in the data. Moreover, programs reported a greater variety of reasons for referral than what appears in the reporting mechanism[30] which led to variation in reporting across programs, with some forcing a prepopulated category and others overriding the system. Overriding also occurred when programs wished to include more details and information on the needs of the participant and the services that were provided. The dropdown menu only allowed for one option, but many programs felt it necessary to include information beyond this one category.

2b: Revise reporting metrics for outcome-related data

The analysis of individual-level data was limited when referring to the outcomes of the program (i.e., arrest, overdose, discharge) because there was a lack of data availability on these measures for most programs. While several programs did not report this data as it was too early in the implementation phase of the program, other programs that did record outcome-related information (e.g., arrest and overdose) stated that these were not disqualifying events. As such, reporting metrics need to be revised to allow for accurately capturing participants' progress, possible lapses, and continued enrollment in the program.

We recommend the convening of a workgroup, comprised of individuals with diverse perspectives including, but not limited to, program staff familiar with participant experiences, data entry and data analysis personnel, and funders, to review and revise the existing reporting protocol. Reporting metrics should be crafted to collect standardized information across all projects but also allow for program specific features to better reflect progress and processes.

3: Conduct satisfaction surveys and interviews with participants

Implement a participant satisfaction survey and interview program participants as part of the program evaluation to systematically capture feedback on the quality, accessibility, and relevance of services provided.

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[30] See GOCPP's LEAD "Data Definitions and Reporting Guide" (https://gocpp.maryland.gov/wp-content/uploads/Law-Enforcement-Assisted-Diversion_-Data-Definitions-and-Reporting-Guide-06052024.pdf)
for more information on the Dropdown menu and definitions of the measures. This menu was provided by GOCPP to programs in the excel workbook that they recorded individual-level data in. There were some variables that programs were provided guidance on answering, i.e., there were preset categories, including "Other" and "None" categories, that they would choose for each observation.

This data can offer valuable insights into what participants find helpful, identify gaps in service delivery and other challenges encountered, and highlight opportunities for improvement.

Recommendations to Support Program Implementation

1. Provide support for program start up to ensure adequate infrastructure to support planned program needs
2. Build in funding support to allow for implementation analysis
3. Support gender and culturally informed programs
4. Provide continued support to programs to maintain staff

1: Provide support for program start up to ensure adequate infrastructure to support planned program needs

Though programs can be conceptualized as multi-agency endeavors, challenges due to program buy-in from key partners may arise during early stages of program implementation or as the result of staff changes. This was evident in a lack of cooperation from some Sheriff's Offices, LEO's understanding of the program, and State Attorney's limiting criteria. These challenges required programs to adjust their structure and partnerships, impacting the rollout timeline, recruitment and staffing, and program needs.

We recommend assisting with and requiring memorandum of understanding (MOU) agreements between cooperating agencies and offices submitted at the time of proposal submission or at least within the first quarter of program funding to minimize the planning period of the grant and maximize the implementation and rollout of the program.

2: Build in funding support to allow for implementation analysis

Program evaluations are essential tools to assess the effectiveness and impact of programs and policies. In general, there are five core stages for assessing criminal justice policies and programs.[31] Each stage provides valuable information to aid in program development, implementation, and decision-making with the aim of enhancing a program's impact and value. The five stages of program evaluation should not be viewed in isolation but instead work in a sequential fashion to ensure a comprehensive approach to determining the effectiveness of interventions. The first stage involves a needs evaluation to determine if a program is needed while the second step of a theory evaluation examines why a particular program is needed. Third, an implementation/process evaluation assesses a program's implementation, protocol, and associated challenges with outcome/impact evaluation measuring whether the program is achieving its intended goals. Finally, a cost-benefit evaluation assesses whether the benefits of a program outweigh the costs associated with a program. See appendix A for detailed descriptions of each stage.

As a part of the proposal submission process, jurisdictions assess and report their specific needs as well as articulate (theoretically based) explanations for why the services proposed would address the identified problem(s). However, evaluations often miss the critical implementation stage and instead focus on an evaluation of outcomes. This gap has a potentially profound influence on our understanding of program effectiveness by missing an opportunity to address challenges that arise during the early phases of program implementation (e.g., recruitment, buy-in) that can be detrimental to the success of programs. It may be that a

[31] Mears, D. P. (2010). American criminal justice policy: An evaluation approach to increasing accountability and effectiveness. Cambridge University Press.

program has encountered challenges not because of what it is intended to do, but because it was implemented with poor fidelity to program features or experience unforeseen challenges that hinder program delivery as planned.

> We recommend including funding support to allow for implementation analyses of all new and expanding programs. Investing more in implementation stages of program development is not just beneficial, but essential for ensuring that policies, programs, and interventions are effective, scalable, and sustainable. By understanding the implementation process, its challenges, issues, and opportunities, the full complexity of real-world program delivery helps to make findings more useful, actionable, and more accurately inform policy.

3: Support gender and culturally informed programs

While opioid and substance misuse can affect anyone, the experiences, risk factors, and recovery needs vary across gender and cultural lines. Most COAP programs in Maryland serve majority male and white populations. There is a growing awareness of the importance of gender-based and culturally-competent programming for best supporting recovery.[32] The extent to which women, homeless, youth, and under-served populations may have unique needs (e.g. childcare, housing, health care) is not well understood but future evaluations should be supported to better understand and provide tailored support for these needs.

> We recommend investing in gender-based and culturally competent programming to build comprehensive, equitable, and effective responses. Recognition of the unique challenges that individuals face and meeting them where they are can help to empower them to achieve more successful recovery pathways.

4: Provide continued support to programs to maintain staff

Staffing is a key challenge for most programs and includes delays in the hiring process, nuanced certification processes, and limited workforce capacity. While trainings and routine meetings may help build awareness and encourage agencies to make referrals, it is also important to invest in efforts to attract and maintain experienced and dedicated staff.

Recommendations to Improve Providing Services to Participants

1. Provide more intensive case management and peer support to participants
2. Engage across jurisdictional boundaries/build connections between counties so that the needs of the participants can be addressed wherever they are located and case management can continue to be provided
3. Engage with the community
4. Understand that participants have unique journeys and may need to cycle through multiple times

A key goal of the LEAD programs is to accept referrals and work with participants to develop case plans and connect participants to the services they need. All of the programs evaluated have engaged with participants and regularly conduct community outreach and trainings, but they also expressed the need to do more. They

[32] The Council on Criminal Justice, Women's Justice Committee is set to release a report in October 2025 with recommendations for women with system contact.

stressed the need to expand opportunities for referrals and the reach of their programs while emphasizing the individual nature of recovery journeys.

Improving the provision of services to participants can involve working within the program to expand opportunities for referrals and to provide intensive case management and peer support to participants. It should also involve supporting the programs to reach out to their local communities and across jurisdictional boundaries to ensure that participants continue to receive needed services wherever they are located and that warm handoffs can be made from one program to another when necessary.

1: Provide more intensive case management and peer support to participants.

This includes emphasizing the importance and value of hiring peer recovery specialists as program staff. Peers can provide crucial front line experience and a unique level of understanding that can foster the participant's progress and reassure them that they are not alone.

- We recommend that GOCPP work with funded programs to enable them to expand social contact and selfreferrals connected to more intensive case management including peer support to identify each participants' uniques goals and challenges.

2: Engage across jurisdictional boundaries.

It is important to build connections between counties so that the needs of the participants can be addressed wherever they are located and case management can continue to be provided. It is necessary to ensure that the provision of support and services isn't when participants move to secure better housing or employment opportunities.

- We recommend that GOCPP provide opportunities for program staff to continue and expand their efforts to coordinate with programs in neighboring jurisdictions and ensure the ability to make a warm hand off to a new case manager and/or peer.

3: Engage with the community.

All of the programs included in this evaluation conduct community outreach activities such as presentations at local meetings and events such as county fairs and citizens' academies; conferences with judges and states' attorneys; meetings of local groups such as On Our Own, Lions' clubs, and merchants' associations; and special events such as law enforcement appreciation day. However, many expressed an interest in working to expand the reach of their programs and developing methods to encourage social contact referrals and self-referrals.

- We recommend that GOCPP support programs to continue their efforts to engage with their communities, expand awareness of LEAD and the value of the LEAD approach. GOCPP should also work with programs to address challenges in encouraging an understanding in collaborating agencies that indicators of success and the level of engagement with be unique to each participant.

4: Understand that participants have unique journeys and may need to cycle through multiple times.

Recovery journeys vary from one participant to another and can include both successes and challenges. They may have different indicators of success or levels of engagement with services and may need to cycle through multiple times; it is important to engage with each participant as a unique individual and to continue to provide ideas and resources throughout the recovery journey. This means that indicators of success and level of engagement will be unique to each participant. So it is important to engage with each participant as a unique individual and continue to provide ideas and links to services throughout the recovery process.

- We recommend that GOCCP recognize that standard indicators may not be an appropriate method to assess the impact of LEAD efforts on participants. Instead, case studies should be used to highlight individual successes and challenges encountered by participants and to lead discussions with program staff to identify additional resources that may be needed to meet participant needs.

Appendices

Appendix A. Detailed Description of Evaluation Hierarchy Steps

Figure 12. Criminal Justice Program Evaluation Process

Needs Evaluations

Needs evaluations are the first level of the evaluation hierarchy and aid in determining whether there is problem and if so, the extent and nature of a problem. This step identifies the issue and quantifies the scope of the problem to inform decision making regarding an appropriate course of action. Needs evaluations serve many purposes including identifying new problems and determining whether a problem still exists and based on that information, if a policy to address the problem should be retained.

Theory Evaluations

Whereas a needs assessment qualifies that a problem exists, a *theory evaluation* identifies why, or the causes, of the problem. These assessments provide information on why and how a particular policy would operate as a solution to the problem. The identification of services or programs offered to response to problems should be aligned with the theory (e.g., source of the issue) and impacted populations. The importance of these evaluations includes giving the policy purpose, addressing source(s) of the problem, keeping agencies accountable for their part of the solution, and illuminating unexpected consequences of policy implementation.

Implementation/Process Evaluations

The third step in the hierarchy of evaluations is an *implementation evaluation*, focusing on how a program or activity is being put into action. Here the focus is on evaluating the delivery of the program to assess if it is being implemented as planned, whether and how the target population is being appropriately identified and served, identify any challenges that may impact program delivery (e.g., resource shortages, training gaps, communication problems). This type of evaluation also examines program operations, including the evaluation of inclusion and exclusion criteria for the targeted population, the delivery of high-quality services, and properly dosed services to participants. Ongoing implementation evaluations and regular monitoring of performance measures allows for the identification of ongoing and emergent problems and solutions.

Outcome & Impact Evaluations

Outcome and impact evaluations are the fourth level of the evaluation hierarchy. The first emphasis is on observing whether there is an association between the activities and intended outcome(s). Outcomes can be both short- and long-term, focusing on immediate processes and results that may involve a longer timeframe to unfold. Similarly, outcomes may be assessed among clients currently engaged in programs or after completion of a program (distinguishing "in-program" and "after-program" outcomes).

The second emphasis establishes a causal relationship between the activity and outcomes in order to isolate the policy's impact. The main goal of an *impact evaluation* is to try to observe what would have happened to clients engaged in the program had they not participated. Because this type of scenario cannot be observed, these types of evaluations use particular research designs, like experiments or quasi-experiments, to estimate counterfactual conditions.

Cost-Efficiency Evaluation

The final step(s) of the hierarchy involves cost-*efficiency* evaluations, which are intended to assess whether activities are delivering intended results in a cost-*effective* manner. This step involves conducting a cost-benefit analysis (CBA) that compares expenses (direct and indirect costs) and outcomes, to understand how much is being spent to achieve a specific result.

Appendix B. Performance Measures

Programs funded in FY22 were required to report quarterly on these items identified as performance measures.

1. The number of individuals diverted from arrest or criminal summons into the program.
2. The number of individuals receiving social referrals to the program.
3. The number of individuals in active communication with program staff in the last 30 days.
4. The number of individuals who have not been in contact in the last 30 days.
5. The number of individuals discharged from the program.
6. The number of individuals arrested for a new crime.
7. The number of individuals arrested for a violation of supervision.
8. The number of individuals admitted to the ER.
9. The number of individuals who experienced an overdose.
10. The number of individuals connected to permanent housing.
11. The number of individuals receiving MAT.
12. The number of individuals enrolled in ongoing behavioral health care.
13. The number of individuals connected with a primary care physician.
14. The number of individuals connected with medical insurance.
15. The number of individuals connected with employment, training, or education.
16. The number of individuals screened for and eligible who are receiving benefits.
17. The number of individuals identified as victims of crime.

Appendix C. Individual-Level Data

Reporting individual-level data was not a requirement of receipt of FY22 COAP funding as it was in the prior funding cycle. Most programs were able to cull together this data for most of the funding period to support this evaluation.

1. The number of people referred to LEAD, and the circumstances for the referral.
2. The demographic breakdown of people referred to LEAD.
3. The number of people enrolled in LEAD, and the circumstances identified at intake.
4. The number of participants referred to services, based on their identified needs in the case management plan.
5. The number of participants enrolled in services.
6. The number of participants who reported an increase in their quality of life, and the magnitude of this increase after 90 days (or the typical duration of intensive engagement); and the number of participants who expressed a high level of satisfaction with their involvement in LEAD.
7. The number of participants arrested or experienced an overdose while in the program, and/or were discharged from the program.
8. Are meetings occurring regularly with key decision makers?

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