

DEFLECTION AND PRE-ARREST DIVERSION: Supporting Rural Communities



October 2021

NATIONAL
COUNCIL
*for Mental
Wellbeing*

TABLE OF CONTENTS

Acknowledgments	1
Project Team.....	1
Background	2
The Overdose Crisis in Rural America	2
Deflection and Pre-arrest Diversion in Rural Communities	3
Mapping Community Assets and Needs.....	3
Transportation	4
Treatment and Support Services.....	4
Telehealth.....	5
Financing and Sustainability.....	5
Examples from the Field	6
Waynesville, North Carolina LEAD.....	6
The Yellow Line Project, Blue Earth County, Minnesota.....	7
Summary	10
Resources	10
References	11

ACKNOWLEDGMENTS

The National Council for Mental Wellbeing developed this resource with generous support from the Centers for Disease Control and Prevention (CDC). The project team would like to thank all of the key informants who devoted their time, expertise and resources to inform this document.

Project Team

Shannon Mace, JD, MPH

Senior Advisor
National Council for Mental Wellbeing

KC Wu, MPH

Project Manager
National Council for Mental Wellbeing

Margaret Jaco Manecke, MSSW, PMP

Director
National Council for Mental Wellbeing

This publication was supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$250,000 with 100% funded by CDC/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, CDC/HHS or the U.S. Government.



BACKGROUND

The overarching aims of **deflection and pre-arrest diversion (DPAD) programs** are to reduce criminal justice system involvement and to better assist people who use drugs (PWUD) and people with substance use disorders (SUDs) by linking them to evidence-based treatment and services. An increasing number of communities across the country have adopted DPAD programs to improve participant, public safety and community outcomes; however, DPAD programs vary based on local needs, opportunities and resources.

Rural communities face unique challenges establishing programs like DPAD due to inaccessibility of treatment, transportation, stable internet and limited funding and resources. Strong cross-sector partnerships are critical to ensure resources and services are available to participants when they need them. This brief provides information on establishing successful DPAD programs in rural areas.

THE OVERDOSE CRISIS IN RURAL AMERICA

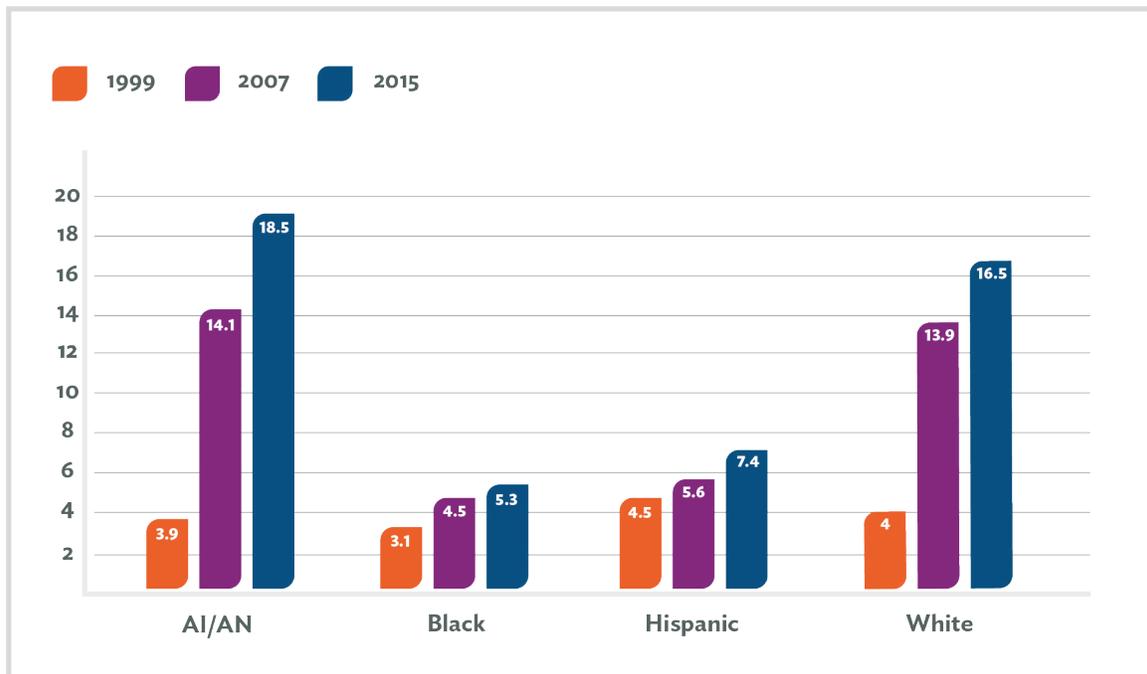
Rural communities have been disproportionately impacted by the overdose crisis with overdose deaths increasing by 325% from 1999 to 2015.¹ Prescription opioid use and overdose are particularly prevalent in states with large rural populations, which reflects higher opioid prescribing rates in rural counties compared to urban counties.^{2,3} Rural communities face myriad challenges in addressing opioid overdose and opioid use disorder (OUD), including the accessibility and availability of medications for OUD (MOUD); availability of funding and resources, including technology and internet; expansive geographic area and availability of transportation; and stigma and shame associated with SUDs and treatment.^{4,5,6}

Opioid use and overdose have been widely documented in rural areas like the Appalachian region, where the overdose fatality rate was 72% higher than in non-Appalachian counties.⁷ The opioid prescription rate has also been significantly higher there than in the rest of the country for several decades.⁸ Many factors contribute to the higher rates of prescription opioid misuse in the Appalachian region, such as workplace injury and chronic pain leading to higher prescribing rates; loose federal and state regulations on pharmaceutical companies marketing pain medications to physicians; high rates of poverty, stress and trauma coupled with underlying health conditions; and many more.^{9,10,11} Limited availability of SUD treatment providers, high rates of under- and uninsured individuals and limited educational and economic opportunities further contribute to increased rates of overdose.¹²

Rural areas are also racially and ethnically diverse and experience substance use-related disparities, including disproportionate impacts related to law enforcement and negative health outcomes among Black, Indigenous and communities of color.^{13,14,15} While White people have the highest overall rate of opioid-related overdose deaths across the U.S., the rate of overdose deaths among Black people has increased significantly over the past several decades and exceeds that of White people in several geographic jurisdictions.^{16,17} In nonmetropolitan communities, overdose rates are higher among American Indians and Alaskan Natives (AI/AN) (19.8 per 100,000 people) compared to White people (19.2 per 100,000) and AI/AN have seen the greatest increase in overdose deaths (519%) between 1999 to 2015, compared to a 343% increase in White individuals (Figure 1).¹⁸ Across all races and ethnicities, people living in rural areas have seen a greater increase in overdose deaths compared to their urban counterparts.



Figure 1. Age-adjusted Rate per 100,000 People for Drug Overdose Deaths in Nonmetropolitan Areas by Race/Ethnicity, United States, 1999-2015



Adapted from: Mack et al., 2017, *Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas – United States*. *MMWR*, 66(19), 1-12.

Economic disparities are associated with increased rates of opioid use and overdose as well. Between 2003 and 2014, the prevalence of self-reported past-month opioid use increased by 16.5% among individuals in rural areas with an annual household income of less than \$20,000, while the prevalence decreased by 12.2% among those with an annual household income greater than \$75,000.¹⁹ Across the U.S., as county unemployment rates increase by one percentage point, the opioid mortality rate increases by 3.6 percentage points,²⁰ leading to a disproportionate impact on rural counties where unemployment rates have been higher than urban counties for several decades.²¹

DEFLECTION AND PRE-ARREST DIVERSION IN RURAL COMMUNITIES

In rural areas where public health resources can be limited, public safety agencies may have more stable funding and resources compared to other agencies and, therefore, may have greater capacity to reach people in need of support through partnerships with community-based organizations. A DPAD program can be a multi-faceted tool for addressing the overdose crisis in rural areas by pooling resources from various stakeholders to best support people with OUD in the community and break the cycles of arrest and incarceration. Considerations for establishing DPAD programs in rural areas can differ from those of urban communities due to various factors, including the availability of resources and services, geographic spread and internet connectivity, among

others. Leveraging partners and stakeholders is key to the success of connecting people to appropriate treatment and services through DPAD programs.

There are several planning and implementation considerations organizations should apply when establishing DPAD programs in rural communities. These key considerations are discussed here and resources and tools to support planning efforts are in [Additional Tools and Resources](#). Additional considerations related to establishing partnerships and a planning team, identifying stakeholders, achieving buy-in and developing a shared language are discussed in [An Overview of Deflection and Pre-arrest Diversion to Prevent Opioid Overdose](#).

MAPPING COMMUNITY ASSETS AND NEEDS

A needs assessment can help identify which partners and stakeholders can be leveraged. With a baseline understanding of existing community resources, the planning team can further determine which assets and opportunities exist and their capacity to provide services to participants, as well as which services are missing. A needs

assessment can also identify the needs of the community by gathering input from people with OUD and their families, public safety officers, hospitals, SUD treatment providers, community-based organizations and others. After matching available resources to the community's needs, identify what additional concerns remain and determine strategies to address them. Findings from community asset mapping exercises can also help to inform the development of community resource guides, such as the [Mohave Substance Abuse Treatment Education and Prevention Partnership \(MSTEPP\) Community Resource Guide](#).

In conjunction with the needs assessment, data collection and analysis can help identify trends related to substance use (e.g., prevalence of OUD and overdose, frequency of substance use-related arrests and frequency of overdose-related emergency department visits), as well as assess the capacity of community partners that DPAD programs can link to. While collecting new data may be too time-consuming when establishing and implementing a DPAD program, many community partners may be able to share relevant data they are already collecting. These data can inform the specific issues impacting a community and what strategies can be implemented to address them. For example, if there is a large proportion of people with OUD who report experiencing homelessness, a priority might be exploring ways to increase access to recovery housing or affordable housing. Other types of data that may be important to collect and analyze among rural populations include economic prosperity, employment-associated injury and internet accessibility. These data can show what types of non-clinical services are needed to best support DPAD participants.

An integrated data system allows for more seamless data sharing and communication across various agencies. Sharing data between law enforcement, health care, criminal justice and other partners can improve coordination of care for participants, as well as help identify gaps in services and opportunities to enhance service provision. Integrated data systems can also be more cost-effective than running several separate systems. Having a dedicated data analyst embedded in the DPAD program can further enhance data analysis and sharing mechanisms. The [Public Health and Safety Team \(PHAST\) Toolkit](#) provides guidance on best practices for sharing data and leveraging resources in cross-agency partnerships such as DPAD programs.

In addition to an integrated data system, stakeholders should communicate regularly with one another. Monthly meetings can be an avenue for sharing new resources and information, as well as an opportunity to bring up any concerns or needs that may have arisen for the group to brainstorm solutions. Regular meetings can also help to keep stakeholders engaged in the work and bring in additional support as needed.

Transportation

Public transportation may not be available, accessible or reliable in rural communities, making it difficult for participants to access necessary services. Additionally, not all communities have a 24-hour crisis center to temporarily house participants. A number of stakeholders can be engaged to provide transportation and address transportation gaps, including public safety, first responders and crisis teams, community organizations and

Community Assessment

The Rural Community Toolbox's [Community Assessment Tool](#) provides county-level data on drug overdose deaths stratified by socioeconomic demographics, availability of mental health and substance use treatment facilities and other variables.

strategy for transporting participants to services rather than relying solely on law enforcement. For more information on peer support workers, see [Deflection and Pre-arrest Diversion: Integrating Peer Support Services](#).

Treatment and Support Services

The availability of health care services, including SUD treatment, can be limited in rural areas. It is important to assess the capacity of providers and clinics to better understand the resources available to DPAD participants. Understanding the treatment and services needs among people with SUDs, compared to the availability of treatment and services, is important for developing referral agreements and networks to meet participants' needs. Understanding the gap between needs and available resources can also inform ways to bridge that gap, whether through identifying additional funding streams, training existing health care providers or developing new care mechanisms, such as telehealth.

If treatment providers are not available, or a participant is not ready to begin treatment, participants should be offered diversion to community health and harm reduction organizations. This is where they can access primary care, harm reduction and other basic needs, which can help improve health outcomes and increase safe using behaviors. Some community organizations may be able to provide participants with transportation assistance to other services as needed. Health departments and social service agencies can also connect participants to additional services to improve quality of life, such as employment or housing.

Certified Community Behavioral Health Clinics (CCBHCs) are another resource for accessing SUD services and coordinating with systems of care, including social services, education and criminal justice.²² CCBHCs have expanded access to SUD treatment services, including MOUD, and approximately 46% of patients receive same-day access to services.²³ Currently, more than 300 CCBHCs operate across 40 states. Many CCBHCs have partnered with public safety agencies and first responders to develop collaborations that support linking individuals at risk of overdose to treatment and services. To find a CCBHC in your community, explore the [CCBHC Locator](#). Additional treatment providers can be identified using [FindTreatment.gov](#).

Telehealth

Limited availability and accessibility of SUD treatment providers, harm reduction services and other supports in rural communities can be a challenge to developing a DPAD program with strong links to care. Providing participants access to telehealth and virtual supports during DPAD interactions can help reduce barriers to care. Telehealth enables participants to connect with providers outside their immediate region. In some cases, participants engaged in DPAD outside of business hours may not need to wait until the next day for an appointment and may be linked to a telehealth provider in a shorter time. Telehealth laws and policies vary by state and some telehealth rules have been temporarily changed due to the COVID-19 pandemic. To identify telehealth laws and reimbursement policies in your state, see the [Center for Connected Health Policy \(CCHP\)](#). Other virtual supports available to DPAD participants may include harm reduction organizations providing mail-based supply distribution or virtual recovery groups.

Public safety or peer support workers can provide eligible DPAD participants with tablets or mobile phones for on-the-spot connection to treatment providers, who can assess patients and even initiate buprenorphine via telehealth under the recently relaxed regulations due to the COVID-19 pandemic.²⁴ A treatment linkage specialist can also help connect participants to necessary services, which can remove some of the burden from officers who may not be familiar with all the available resources. Telehealth should also be available at community organizations or other agencies where participants may be diverted.

To offer telehealth services to DPAD participants, technology and internet need to be available. DPAD programs can connect participants to telehealth via tablets, mobile apps or phone-based telehealth. For participants who do not have reliable access to technology to continue engaging in telehealth, it is critical to refer them to community organizations where they can access devices and internet. When feasible, provide participants with their own mobile device or tablet.

While telehealth is often promoted as a solution to health care accessibility challenges in rural communities, reliable broadband concerns remain a barrier. Increasing access to internet in the community can increase engagement with telehealth, especially for participants who may not have reliable internet in their homes. In addition to public safety officers or peer support workers carrying mobile tablets for DPAD

“Prior to becoming a CCBHC, one of our clients who received psychiatric care at Swope Health Services would drive a 250-mile round trip for Suboxone treatment for his opioid addiction. During this time, he was struggling to maintain a job and attend other treatment services. Now that we are a CCBHC, he can get his MAT [medication-assisted treatment] service at Swope, much closer to home.”

**- Swope Health Services,
Missouri**

participants, private telehealth rooms can be instituted at easy-to-access locations in the community with secure internet access, such as community health organizations, social services agencies and public libraries. Another strategy is to invest in phone-based telehealth, rather than services that rely solely on internet.

FINANCING AND SUSTAINABILITY

In rural communities where funding may be limited, it is important to identify multiple funding streams to ensure services can be provided without issue. Additionally, leveraging community partnerships to distribute spending across organizations involved in DPAD and identifying cost-effective strategies for connecting participants to treatment and services are useful strategies to support program sustainability.

Sustaining DPAD programs can be challenging when rural communities face various competing concerns. Collecting and sharing data with DPAD partners, stakeholders, funders and policymakers can help ensure that programs continue to be funded. Evaluation metrics should cover a wide range of outcomes and impacts that are meaningful to the various stakeholders, such as overdose rates, criminal justice involvement and cost-savings, among others. Including testimonials from individuals who have been diverted and public safety partners implementing DPAD programs further demonstrate the positive impact of DPAD programs.

EXAMPLES FROM THE FIELD

There are a growing number of DPAD programs being established in rural communities. Descriptions of two programs follow.

WAYNESVILLE, N.C., LEAD

Waynesville, N.C., is a small town of less than 10,000 residents, where a decade ago, 25% of deaths in the county could be attributed to opioid-related overdose.²⁵ In 2016, former Waynesville Police Chief Bill Hollingsed saw that incarceration was not stopping the cycle of substance use in his community. To identify alternative ways to address the issue, Chief Hollingsed visited Seattle to gain a better understanding of the original Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) program. Two years later, Waynesville launched its LEAD program, the first in the country located in a rural community.²⁶ Similar to other LEAD programs, rather than arresting individuals on low-level drug charges, officers redirect eligible participants to a case manager who connects them to treatment and other services.²⁷ Social referral, when participants initiate engagement in services, is another avenue to enroll in LEAD that does not require police interaction. In rural communities, social referrals are an important strategy to reach more people in the community and provide them the opportunity to access treatment and other services.

Waynesville LEAD partners with Meridian Behavioral Health Services and Appalachian Community Services (ACS) to provide mental health and addictions care to participants and staffs a case manager through the North Carolina Harm Reduction Coalition (NCHRC), a statewide nonprofit organization that also supports the multiple LEAD sites in the state.²⁸ When a referral is made, the case manager conducts an intake assessment to identify the participant's immediate and long-term needs, ranging from health care to housing to employment support. For people in crisis requiring immediate care, ACS operates a 24/7 Behavioral Health Urgent Care to provide clinical intervention, medication and other supports as needed.

As a rural community, Waynesville experiences challenges related to a lack of beds in treatment centers, affordable housing and public transportation, impacting participants' ability to access the services they are diverted to. From the outset of the program, developing community relationships and partnerships has been integral to ensuring access to resources and continuity of care. The case manager has also collected data and documented processes and impacts over the course of the program to make the case for continued funding and support when grant funding runs out.²⁹

IMPACTS

Within the first six months of the program, seven participants were enrolled through both officer and social referral.³⁰ Additionally, officers reported fewer interactions with repeat offenders and faster access to long-term care for those in need of treatment.



THE YELLOW LINE PROJECT, BLUE EARTH COUNTY, MINN.

In Blue Earth County, Minn., alcohol and methamphetamine use disorders have been a significant health issue, and opioid use disorder is a growing threat. In 2015, the Department of Human Services (DHS) and the county sheriff's office began discussing strategies to address substance use and increase access to treatment among justice-involved individuals. A working group assessed substance use trends in the rural county and identified human services to integrate into the criminal justice system. As a result, the Yellow Line Project (YLP) was established to better engage with and support justice-involved individuals with mental health and/or substance use concerns. The three goals of YLP are:

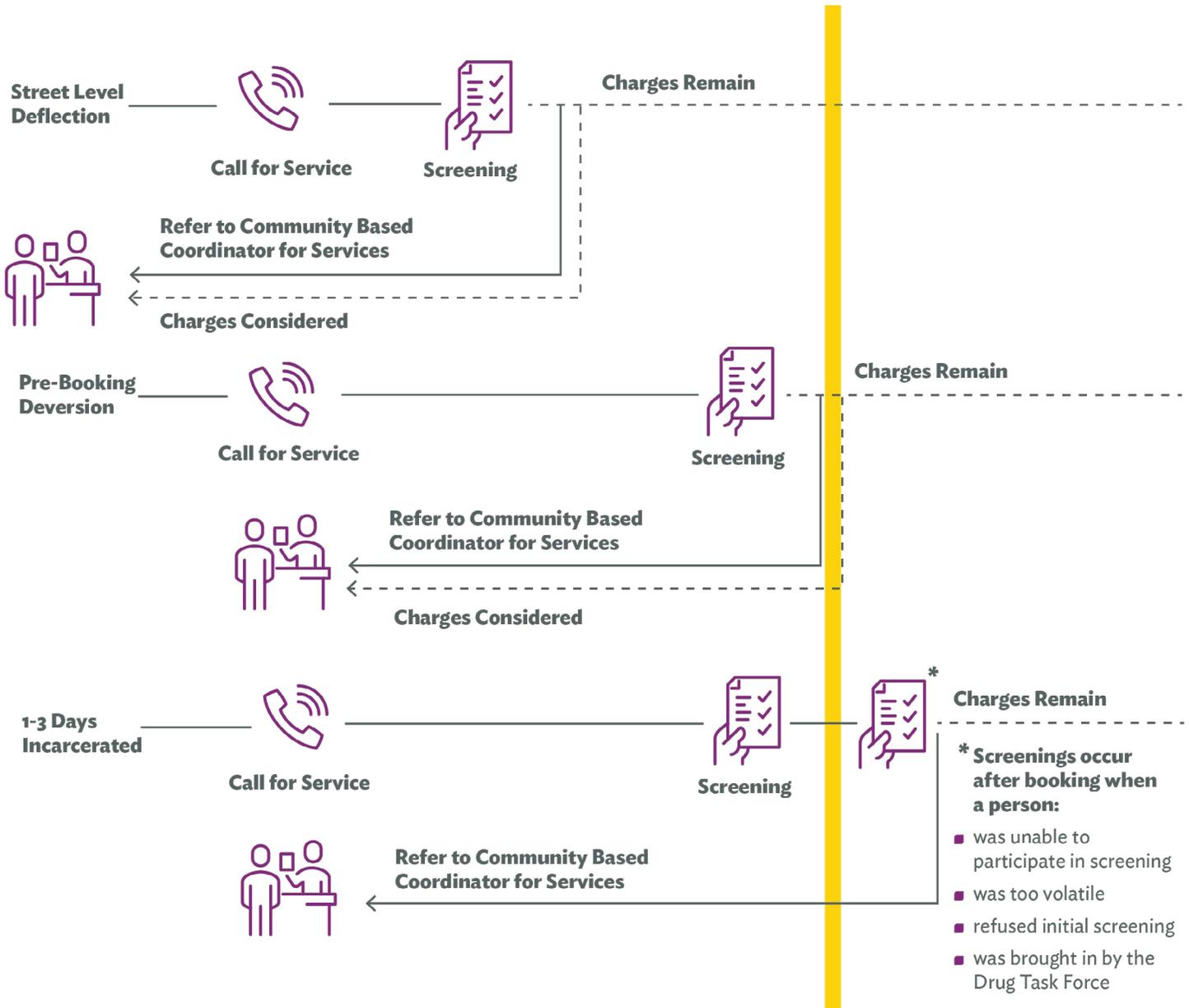
- Improve access to services.
- Increase engagement for timely linkage to services.
- Reduce jail-bed days for participants with mental health challenges or SUDs.³¹

Initially, YLP was solely a pre-booking diversion program, where individuals would be screened by a practitioner at the jail for mental health challenges or SUD; they have since expanded to include street-level deflection activities conducted by a Mobile Crisis Team, which can respond to crisis calls with or without an officer present and conduct screenings for short-term jail stays. Currently, the Mobile Crisis Team provides 24/7 access to screenings and hands off to the Community Based Coordinator (CBC), based in DHS, to work with the participant to develop an individualized treatment plan with short-term actionable goals, called "My Yellow Line Plan."^{32, 33} The CBC also provides referrals to services, links to community resources and guidance on navigating social service systems. All individuals screened are provided information and referral services and resources, regardless of whether they are referred to the YLP or CBC, to ensure that people in need of services can access them.

An important component of the YLP is the focus on linking participants to services, regardless of whether or not they are charged. Additionally, the program has moved away from holding charges in abeyance to completion of the participant's individualized plan as it has not had a significant impact on participants' completion of their plan.



PATHWAYS OF THE YELLOWLINE PROJECT



Yellow Line Project. (n.d.). Pathways. <https://www.yellowlineproject.com/pathways>

IMPACTS

Since YLP's inception, Blue Earth County has seen improvements in cost-savings, access to and engagement in treatment and other services and criminal justice outcomes.³⁴ From 2016 (just before YLP went into effect) to 2019, county costs decreased by almost 20% for detoxification services, the first downward trend in over 15 years, and decreased by 86% for state hospital costs. The cost-savings were reinvested into the YLP.

In 2019, 290 individuals were referred to YLP; of these, 119 developed a "My Yellow Line Plan," and 76 participants completed their plan, representing a 64% success rate. From 2018 to 2019, among participants who successfully completed their plan, almost all had no newly identified contact with law enforcement after three months, around 80% had no new contact after six months and at least 60% had no new contact after 12 months.³⁵ The most common types of information and referral materials provided included substance use providers, mobile crisis and crisis center services, mental health and substance use services and housing/shelter services. The majority of participants in YLP were engaged through pre-booking diversion efforts, while half as many were engaged through street-level deflection activities.

SUSTAINABILITY

The success of the YLP has led to significant buy-in from state and local policymakers, as well as attracted the interest of neighboring counties in Minnesota. After the initial grant from DHS ended, the YLP has relied on reinvestment of cost-savings to continue funding the program. The Minnesota legislature recently approved adding care coordination services provided by the CBC as a Medicaid billable service, which, if approved by the Centers for Medicare and Medicaid Services (CMS), would further support sustainability of the role and the program.

To support other counties interested in implementing the program, the YLP created the **Operational Toolkit**, which includes screening forms, workflows, consent forms and other tools that demonstrate how the YLP works and can be adapted for use by other counties. The YLP also identified **five critical implementation steps** necessary to successfully establish the program.



SUMMARY

Because rural areas have been significantly impacted by the overdose crisis, it is critically important that PWUD and people with SUDs, including OUD, are linked to evidence-based treatment and services through as many pathways as possible. In rural communities, DPAD programs offer an opportunity to strategically identify and align existing resources across agencies and organizations to better address the needs of people with SUDs. In areas where SUD treatment services or other supports are limited, regional partnerships and the use of telehealth may provide viable mechanisms to link people to care. A growing number of DPAD programs are being established in rural areas capitalizing on the existing resources and strengths of communities and introducing novel and innovative ways to meet people's needs through non-punitive measures.

RESOURCES

- ❑ **Tailoring Crisis Response and Pre-arrest Diversion Models for Rural Communities.** Developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides recommended strategies for rural communities to better support DPAD and crisis programs.
- ❑ **Community Assessment Tool.** Created by the Rural Community Toolbox, provides valuable county-level information on a range of indicators, including mental health and SUD treatment facilities and socio-demographic data.
- ❑ **Engaging People with Lived Experience Toolkit.** Developed by Community Commons, offers step-by-step guidance to successfully engage people with lived experience into program planning and implementation efforts.
- ❑ **FindTreatment.gov.** Offers state-based searchable databases for SUD treatment providers, including buprenorphine providers and opioid treatment programs.
- ❑ **CCBHC Locator.** Developed by the National Council for Mental Wellbeing, offers a searchable state database for locating CCBHCs.
- ❑ **Center for Connected Health Policy.** Offers current information on telehealth laws and reimbursement policies for all 50 states.

Additional DPAD resources and tools are also available in the following:

- ❑ **An Overview of Deflection and Pre-arrest Diversion to Prevent Opioid Overdose**
- ❑ **Deflection and Pre-arrest Diversion: Applying a Harm Reduction Approach**
- ❑ **Deflection and Pre-arrest Diversion: Integrating Peer Support Services Experts'**
- ❑ **Roundtable Findings**
- ❑ **Deflection and Pre-arrest Diversion Programs: Sample Job Descriptions**
- ❑ **Additional Tools and Resources**

REFERENCES

- ¹ Mack, K. A., Jones, C. M., & Ballesteros, M. F. (2017). Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas – United States. *Morbidity and Mortality Weekly Report (MMWR)*, 66(19), 1–12. https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm?s_cid=ss6619a1_w
- ² Keyes, K. M., Cerdá, M., Brady, J. E., Havens, J. R., & Galea, S. (2014). Understanding the Rural—Urban Differences in Nonmedical Prescription Opioid Use and Abuse in the United States. *American Journal of Public Health*, 104(2), e52–e59. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935688/>
- ³ García, M. C., Heilig, C. M., Lee, S. H., Faul, M., Guy, G., Iademarco, M. F., Hempstead, K., Raymond, D., & Gray, J. (2019). Opioid Prescribing Rates in Nonmetropolitan and Metropolitan Counties Among Primary Care Providers Using an Electronic Health Record System – United States, 2014–2017. *MMWR*, 68(2), 25–30. <https://www.cdc.gov/mmwr/volumes/68/wr/mm6802a1.htm?rel=o>
- ⁴ Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). Tailoring Crisis Response and Pre-arrest Diversion Models for Rural Communities. HHS Publication No. PEP19–CRISIS–RURAL. <https://store.samhsa.gov/product/Tailoring-Crisis-Response-and-Pre-Arrest-Diversion-Models-for-Rural-Communities/PEP19-CRISIS-RURAL>
- ⁵ The Pew Charitable Trusts. (2019). Opioid Use Disorder: Challenges and Opportunities in Rural Communities. https://www.pewtrusts.org/-/media/assets/2019/02/opioiduseruralcommunities_final.pdf
- ⁶ Thomas, N., van de Ven, K., & Mulrooney, K. J. D. (in press). The impact of rurality on opioid-related harms: A systematic review of qualitative research. *International Journal of Drug Policy*. <https://www.sciencedirect.com/science/article/abs/pii/S0955395919303147>
- ⁷ National Association of Counties (NACo) and Appalachian Regional Commission (ARC). (2019). Opioids in Appalachia: The Role of Counties in Reversing a Regional Epidemic. <https://www.naco.org/sites/default/files/documents/Opioids-Full.pdf>
- ⁸ NACo and ARC. (2019). Opioids in Appalachia: The Role of Counties in Reversing a Regional Epidemic. <https://www.naco.org/sites/default/files/documents/Opioids-Full.pdf>
- ⁹ NACo and ARC. (2019). Opioids in Appalachia: The Role of Counties in Reversing a Regional Epidemic. <https://www.naco.org/sites/default/files/documents/Opioids-Full.pdf>
- ¹⁰ Dasgupta, N., Beletsky, L., & Ciccarone, D. (2018). Opioid Crisis: No Easy Fix to Its Social and Economic Determinants. *American Journal of Public Health*, 108(2), 182–186. <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.304187>
- ¹¹ Moody, L., Satterwhite, E., & Bickel, W. K. (2017). Substance Use in Rural Central Appalachia: Current Status and Treatment Considerations. *Rural Mental Health*, 41(2), 123–135. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5648074/>
- ¹² Moody, L., Satterwhite, E., & Bickel, W. K. (2017). Substance Use in Rural Central Appalachia: Current Status and Treatment Considerations. *Rural Mental Health*, 41(2), 123–135. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5648074/>
- ¹³ Rural Health Information Hub (RHInhub). (2020). RHInhub Maps on Rural Demographics. <https://www.ruralhealthinfo.org/rural-maps/demographics>
- ¹⁴ Lippold, K. & Ali, B. (2020). Racial/ethnic differences in opioid-involved overdose deaths across metropolitan and non-metropolitan areas in the United States, 1999 – 2017. *Drug and Alcohol Dependence*, 212, 108059. <https://doi.org/10.1016/j.drugalcdep.2020.108059>

- ¹⁵ SAMHSA. (2020). The Opioid Crisis and the Black/African American Population: An Urgent Issue. Publication No. PEP20-05-02-001. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf
- ¹⁶ SAMHSA. (2020). The Opioid Crisis and the Black/African American Population: An Urgent Issue. Publication No. PEP20-05-02-001. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf
- ¹⁷ James, K. & Jordan, A. (2018). The Opioid Crisis in Black Communities. *The Journal of Law, Medicine & Ethics*, 46(2), 404-421. <https://journals.sagepub.com/doi/10.1177/1073110518782949>
- ¹⁸ Mack, K. A., Jones, C. M., & Ballesteros, M. F. (2017). Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas – United States. *Morbidity and Mortality Weekly Report (MMWR)*, 66(19), 1-12. https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm?s_cid=ss6619a1_w
- ¹⁹ Mack, K. A., Jones, C. M., & Ballesteros, M. F. (2017). Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas – United States. *Morbidity and Mortality Weekly Report (MMWR)*, 66(19), 1-12. https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm?s_cid=ss6619a1_w
- ²⁰ Hollingsworth, A., Ruhm, C. J., & Simon, K. (2017). Macroeconomic Conditions and Opioid Abuse. *Journal of Health Economics*, 56, 222-233. <https://www.sciencedirect.com/science/article/abs/pii/S0167629617303387?via%3Dihub>
- ²¹ RHIhub. (2020). Unemployment Rate in Metro and Nonmetro Counties, 2007-2019. <https://www.ruralhealthinfo.org/charts/63>
- ²² National Council for Mental Wellbeing, CCBHC Success Center. (2020). Overview. <https://www.thenationalcouncil.org/ccbhc-success-center/ccbhcta-overview/>
- ²³ National Council for Mental Wellbeing. (2019, August). Data Highlights: Certified Community Behavioral Health Clinics. <https://www.thenationalcouncil.org/wp-content/uploads/2019/09/Data-highlights-from-CCBHC-surveys-8-22-19.pdf?daf=375ateTbd56>
- ²⁴ SAMHSA. (2020, April 21). FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency. <https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf>
- ²⁵ Friend, E. (2019, February 22). Across NC, Police Make Fundamental Shift To Addressing Opioid-Related Crime. WUNC North Carolina Public Radio. <https://www.wunc.org/post/across-nc-police-make-fundamental-shift-addressing-opioid-related-crime>
- ²⁶ Perrotti, K. (2018, July 6). After long wait, LEAD program lifts off. *The Mountaineer*. https://www.themountaineer.com/news/after-long-wait-lead-program-lifts-off/article_8ae4foaa-8053-11e8-99e0-4f4f9c213927.html
- ²⁷ Friend, E. (2019, February 22). Across NC, Police Make Fundamental Shift To Addressing Opioid-Related Crime. WUNC North Carolina Public Radio. <https://www.wunc.org/post/across-nc-police-make-fundamental-shift-addressing-opioid-related-crime>
- ²⁸ Stone, J. (2018, September 12). LEADing the way: Jail diversion program aims to address opioid crisis. *Smoky Mountain News*. <https://www.smokymountainnews.com/archives/item/25512-leading-the-way-jail-diversion-program-aims-to-address-opioid-crisis>
- ²⁹ Perrotti, K. (2018, July 6). After long wait, LEAD program lifts off. *The Mountaineer*. https://www.themountaineer.com/news/after-long-wait-lead-program-lifts-off/article_8ae4foaa-8053-11e8-99e0-4f4f9c213927.html
- ³⁰ Perrotti, K. (2018, July 6). After long wait, LEAD program lifts off. *The Mountaineer*. https://www.themountaineer.com/news/after-long-wait-lead-program-lifts-off/article_8ae4foaa-8053-11e8-99e0-4f4f9c213927.html

³¹ Bureau of Justice Assistance (BJA) Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP). (n.d.). Law Enforcement and First Responder Diversion, Pathways to Diversion Case Studies Series: Officer Intervention. https://www.cossapresources.org/Content/Documents/Articles/Pathways_to_Diversion_Case_Studies_Series_Officer_Intervention.pdf

³² BJA COSSAP. (n.d.). Law Enforcement and First Responder Diversion, Pathways to Diversion Case Studies Series: Officer Intervention. https://www.cossapresources.org/Content/Documents/Articles/Pathways_to_Diversion_Case_Studies_Series_Officer_Intervention.pdf

³³ Yellow Line Project. (n.d.). Frequently Asked Questions. <https://www.yellowlineproject.com/faq>

³⁴ BJA COSSAP. (n.d.). Law Enforcement and First Responder Diversion, Pathways to Diversion Case Studies Series: Officer Intervention. https://www.cossapresources.org/Content/Documents/Articles/Pathways_to_Diversion_Case_Studies_Series_Officer_Intervention.pdf

³⁵ Yellow Line Project. (n.d.). Goals and Outcome Metrics. <https://www.yellowlineproject.com/goals-and-outcome-metrics>