Law Enforcement and First Responder Diversion
Pathways to Diversion Case Studies Series

Self-Referral Pathway

Law enforcement officers and other first responders, such as emergency medical technicians, firefighters, and paramedics, are on the front lines of the illicit substance abuse epidemic, frequently responding to drug overdoses and calls for services involving individuals with substance use and co-occurring disorders. In response, a variety of law enforcement-led diversion and fire/emergency medical services (EMS)-led responses[1] have emerged across the country. In partnership with substance use disorder (SUD) treatment providers, peers, and recovery personnel, these multidisciplinary programs are helping to reduce overdoses by connecting individuals to community-based treatment. Law enforcement and first-responder diversion program models represent a pivotal opportunity to redirect individuals with SUDs, mental health disorders (MHDs), and co-occurring disorders away from jails or emergency departments and toward community-based treatment for substance use, mental health services, recovery support, housing, and social services.

Five Pathways for Law Enforcement and First-Responder Diversion to Treatment, Recovery, Housing, and Services

There are five frameworks or **pathways**[2] of first-responder diversion, each aimed at addressing specific public safety challenges faced by police departments and first responders in their communities. These five approaches are referred to as "pathways," because in contrast to other criminal justice interventions by which individuals are mandated to attend treatment, first responders offer pathways to community-based treatment and resources through proactive outreach and support to individuals in need. The spectrum of the "Five Pathways to Community" offers an alternative to traditional enforcement methods

Five Pathways

‹ **Self-Referral**

‹ **Active Outreach**

‹ **Naloxone Plus**

‹ **Officer/First-Responder Prevention**

‹ **Officer Intervention**

for individuals coping with SUDs, MHDs, or co-occurring disorders that often result in contact with police or other first responders.

Each pathway is associated with specific elements that work in different ways. Communities providing first-responder diversion often begin with a single pathway and then add pathways as their programs evolve. The pathway(s) implemented should be informed by a problem-solution orientation, based on the specific problems to be addressed (e.g., substance use, mental health challenges, housing instability) and how resources can be aligned to meet the needs of the target population to be served (e.g., treatment, recovery, stakeholder support). Further, diversion programs should be developed to fit the unique needs of each community: what works in one jurisdiction may not work in another. An important step in deciding which diversion pathway is the best fit is to become familiar with all of the pathways, which aspect of diversion each is meant to address, and how each pathway functions. Finally, each pathway requires different levels of investment to plan, implement, and operationalize the effort effectively. In summary, it is necessary to identify which elements of a pathway could be adapted and applied to the particular needs of a jurisdiction.

The five pathways to treatment through first-responder diversion are described in the box to the right. This brief will focus on the Self-Referral Pathway.

The sites highlighted in this case study include:
- Anne Arundel County, Maryland: Safe Stations
- Dixon, Illinois: Safe Passage
- Hudson Valley, New York: Hope Not Handcuffs
- Manchester, New Hampshire: Manchester Safe Station Program
- Walker County, Alabama: Mercy Project

Pathway	Target Population
Self-Referral: An individual voluntarily initiates contact with a first-responder agency (law enforcement, fire department, or EMS) for a treatment referral. If contact is initiated with a law enforcement agency, the individual makes that contact without fear of arrest.	Individuals with SUDs
Active Outreach: A first responder intentionally identifies or seeks out individuals with SUDs to refer them to, or engage them in, treatment; outreach is often done by a team consisting of a clinician and/or peer with lived experience.	Individuals with SUDs
Naloxone Plus: A first responder and program partner (often a clinician or peer with lived experience) conducts outreach specifically to individuals who have experienced an overdose recently to engage them in and provide linkages to treatment.	Individuals with opioid use disorder
Officer/First-Responder Prevention: During routine activities such as patrol or response to a service call, a first responder conducts engagement and provides treatment referrals. [NOTE: If a law enforcement officer is the first responder, no charges are filed or arrests made.]	Persons in crisis, or with noncrisis mental health disorders and SUDs, or in situations involving homelessness or prostitution
Officer Intervention: (applicable only for law enforcement) During routine activities such as patrol or response to a service call, a law enforcement officer engages an individual and provides treatment referrals or issues noncriminal citations for that individual to report to a program. Charges are held in abeyance until treatment and/or a social service plan is successfully completed.	Persons in crisis, or with noncrisis mental health disorders and SUDs, or in situations involving homelessness or prostitution

The Self-Referral Pathway

In many communities, a self-referral program is often a starting point toward the implementation of other first-responder diversion pathways. Programs based on the Self-Referral Pathway are often the least challenging to organize and implement and can involve fewer resources, time, and funding to initiate. These characteristics are important because many of these programs were developed by communities responding in real time to the "third wave" of the opioid crisis that began ravaging the country in the 2010s. While all diversion programs must eventually incorporate community collaboration, treatment capacity,[3] and funding to be sustainable, the leaders in law enforcement agencies, fire departments, and EMS who started the first self-referral programs did not have that option. They started their programs quickly to save lives with little support other than from their city or county officials, officers, and community volunteers.

Origins: All self-referral programs can trace their roots to the Gloucester Angel Program. In May 2015, Chief Leonard Campanello of the Gloucester, Massachusetts, Police Department posted the following message on the department's Facebook page: "Any addict [sic] who walks into the police station with the remainder of their drug equipment (needles, etc.) or drugs and asks for help will NOT be charged. Instead, we will walk them through the system toward detox and recovery. We will assign them an 'angel' who will be their guide through the process. Not in hours or days, but on the spot."[4]

This surprising announcement from a former narcotics detective marked a fundamental paradigm shift in attitudes and actual practice by law enforcement leaders toward addiction, treating it as a chronic disease of the brain rather than a drug crime. Many law enforcement officers had already come to the conclusion that SUD is not something that can be solved by involvement in the justice system—made clear by the oft-heard phrase, "we can't arrest our way out of this"—but prior to Gloucester's Angel Program, an alternative had not yet been operationalized.

Further, leaders in several first-responder agencies saw that individuals in their communities who were motivated to seek treatment often faced barriers because of the lack of available treatment or their ability to pay. The need for innovative programs to address the opioid epidemic and the feasibility of Gloucester's innovative approach resulted in a flood of calls to the Gloucester Police Department from agencies in opioid hot spots around the nation. To field all the requests for information, Chief Campanello helped found the Police Assisted Addiction and Recovery Initiative (PAARI), a nonprofit organization that provides support and resources to help law enforcement agencies nationwide create self-referral and active outreach programs.[5]

The philosophy of the Self-Referral Pathway is that addiction is a treatable and chronic disease of the brain,[6] not a moral failing, and that to stop the drug-seeking behaviors that accompany addiction, the disease itself must be treated. Understanding addiction as a disease helps to reduce the stigma around addiction, which, in turn, reduces the shame attached to seeking assistance. While the primary goal of self-referral programs is to enable access to treatment for individuals with SUDs, these programs also show promise in enhancing police-community relations and addressing SUDs as a leading cause of certain types of persistent criminal offense.

Self-referral programs, which are currently operated in a variety of first-responder agencies, including police departments, sheriffs' offices, state police barracks, and fire stations (known as "safe stations"), have the potential to offer immediate access to SUD treatment and reduce the magnitude of obstacles associated with treatment entry. Police and fire stations are located prominently in every community and are staffed around the clock. An additional benefit is that the contact and conversations that occur between first responders and individuals seeking assistance help to further break down stigma, promoting better police-community relations and a greater understanding

of addiction. Further, using community volunteers in self-referral programs can result in strong relationships between volunteers and officers in the departments with which they work and a better understanding of addiction among community members. Finally, volunteers can act as ambassadors for the program, helping to spread information to members of the community.

How the pathway works: Most self-referral programs, whether located within law enforcement agencies or fire/EMS departments, operate in the same way. A community member walks into a designated department and informs the officer or fire fighter that he or she is there to seek help. Most departments follow certain procedures at that point, which may include filling out intake forms, doing initial assessments, and determining eligibility for services. Eligibility requirements vary by jurisdiction, but most prohibit participation if the individual has a medical condition that requires hospitalization, a history of violent crime or sex offenses, or outstanding warrants. In some jurisdictions, collaborations with other justice system stakeholders create mechanisms for clearing or postponing the enforcement of a warrant until treatment has been completed. At this point, if the community member has any drugs or drug paraphernalia that are clearly reserved for his or her own personal use (rather than for selling, dealing, or commercial gain) or weapons, the individual turns them over to police or fire department personnel.

Depending on the procedures of each program, officers, firefighters, or emergency medical staff members may be responsible for everything from intake to assessments to treatment placement and transportation; or these tasks might be performed by someone else involved in the program. Examples include a volunteer, the program coordinator, or a clinician assigned to the program. While there are several programs that train and use community members as volunteers, others have one coordinator who conducts the bulk of the intake, treatment placement, and follow-up with individuals. There are also some self-referral initiatives that collaborate with community

behavioral health agencies, where staff members are called to work with clients at the station and then follow up with them throughout the course of their long-term recovery. Volunteers may be trained to perform a variety of functions, from completing an initial assessment to identifying treatment placement, providing transportation, and/or providing support to individuals through their treatment and recovery. Finally, some sites also use recovery specialists who have lived experience with SUDs to provide support to self-referral clients.

An underlying goal of self-deferral diversion is to make an uncomfortable situation as easy as possible for an individual seeking treatment assistance, while simultaneously making the individual feel comfortable and welcome. Some programs provide special supplies to give to program participants, including water, snacks, and blankets, or clothing and pre-packaged provisions to take with them to treatment. Other programs make sure a volunteer or officer is available to sit with participants while they wait for treatment placement or transportation.

Clients are placed in treatment as quickly as possible with the goal of only a few hours' wait. In communities with substantial treatment capacity, volunteers or program coordinators may be able to assess the needs of a client, find a facility that meets their specific needs, and transport them to the facility within an hour. However, especially in small or rural communities, clients may have to travel hundreds of miles from home or wait a significant amount of time—even with help from the program—to be placed in treatment. In these cases, it is essential that recovery specialists or volunteers continue to engage with clients awaiting treatment placement.

While most self-referral programs were created to respond to increases in opioid overdose fatalities, it soon became clear that many people who overdosed had used multiple substances (referred to as polysubstance use). Most programs, while still focusing on responding to the challenges associated with opioids, encourage community

members who suffer from addictions to other substances, including alcohol, to use their services to seek treatment. To that end, self-referral initiatives require marketing to promote the program to and within the community. Unlike other pathways that are initiated by someone other than the person who uses drugs, self-referral programs must use a variety of means to promote their services, including government websites, traditional media, social media, and word-of-mouth facilitated by the recovery community and community volunteers. Programs should also make a concerted effort to distribute program materials in areas and places where drug use is common.

The Ten Critical Elements of Self-Referral Initiatives

The following ten critical elements should be considered when creating or enhancing self-referral programs that are effective in connecting individuals who have SUDs to treatment.

1. Develop collaborative relationships with key stakeholders

Two core elements have been identified as essential to the implementation of first-responder diversion initiatives: program leadership and collaboration.[7] Every program needs a tireless and passionate champion who can lead the charge to implement the program and who recognizes the high level of collaboration necessary for successful implementation. Leaders usually emerge organically and in most, but not all communities, they have been rooted in law enforcement.

- Leaders of self-referral initiatives must recruit and work with treatment providers, hospitals, public health organizations, and service providers to develop memoranda of understanding, data sharing agreements, and other organizational arrangements to establish a process whereby law enforcement officials and other first responders are able to issue referrals to individuals seeking treatment.[8]

- Self-referral programs, like other first-responder diversion initiatives, also require collaboration with other justice system stakeholders, including district attorneys, judges, defenders, and community corrections agencies, to create processes that can reduce barriers to treatment and services, such as active warrants or technical violations of probation or parole.

- Finally, leaders could consider recruiting volunteers to assist with intake and client transportation. Depending on the program, volunteers may also be needed to help staff the program or conduct other program-related tasks.

2. Create policies and procedures for officers, dispatchers, firefighters, EMTs, and volunteers

Programs should create polices so that when an individual walks into a designated agency, the program is implemented consistently across each department and to prevent discrimination based on race, color, religion, sex (including sexual orientation, gender identity, and pregnancy), national origin, disability, or age.[9]

A program guide with step-by-step procedures should be available in the space designated for meeting with an individual seeking help. Those procedures should include instructions for ensuring that the interaction is free of stigmatizing language or judgement so the participant will feel as comfortable and welcome as possible.

There should be clear policies in place to ensure that meetings are conducted in accordance with federal (e.g., HIPAA), state, and local agency regulations regarding privacy of information. Procedures must outline proper data sharing and data protection protocols.

Further, as needed, policies regarding eligibility for the program should be in place, as well as procedures for working with other justice system agents to ensure participation for people with active warrants or who are under the supervision of probation or parole officers.

3. Hire or appoint a dedicated program coordinator

Programs started or led by first responders should consider working with or hiring a program coordinator to serve as liaison between first-responder agencies and treatment providers, recruit volunteers, coordinate training of officers and volunteers, and manage the program's data collection and evaluation efforts.[10]

A coordinator can streamline communication, provide a program with consistency and stability, troubleshoot stakeholders' concerns, work to identify resources, facilitate meetings, and develop information sharing systems. First-responder diversion programs consist of politically independent actors, so it is important that the program coordinator be primarily loyal to the program itself and independent from all political and operational stakeholders.[11]

4. Have personnel available who can conduct an initial screening to identify appropriate treatment and services

While ideally, treatment is tailored to an individual's specific needs based on an assessment by a clinical professional, programs may not always have a clinician available to provide this service in real time. Instead, first responders, nonclinical staff members of mobile crisis outreach teams, trained volunteers, and program coordinators can be empowered to routinely perform initial screenings to determine the best treatment plan from available options. Further, addressing service needs such as housing, employment, and insurance is often necessary to ensure stability during treatment and recovery.

All communities, regardless of their treatment capacities, should have one or more treatment partners who can assess participants using a validated screening tool that allows for connection to individualized treatment and services as soon as possible.[12] If treatment or services are not immediately available, volunteers or peer support counselors should engage participants until they can enter treatment.

When an individual completes treatment, recovery coaches or peer support counselors are encouraged to continue engagement activities, including facilitation of recovery support, by providing information about community resources, offering emotional support, and helping individuals to focus on their recovery.

5. Train first responders about addiction, trauma, and recovery

For a diversion program to succeed, personnel from first-responder agencies (including dispatchers) must understand and support the program. Understanding the following elements can provide officers with insight into and empathy for vulnerable populations and can help reduce the stigma attached to individuals with substance use and other behavioral health disorders.

- Training on the neuroscience of addiction to ensure that officers understand the chemical changes that occur in the brain and how these changes are manifested in individuals' behavior.[13]

- Training on adverse childhood experiences (ACEs) and trauma, especially the impact of early trauma on developmental and course-of-life outcomes.[14]

- Understanding that relapse is quite often part of the recovery process, which may result in an officer diverting an individual multiple times, although this does not reflect a failure by either the individual or the first responder.[15]

Command staff members should attend as many of the trainings as possible to convey the importance of their commitment to the program. Programs should offer renewed training as more research becomes available or to refresh prior education efforts.

6. Engage the larger community

Buy-in from the larger community, including residents, local businesses, and other stakeholders, can provide program support while expanding the services network. This is important for all first-responder diversion programs, but for self-referral initiatives that rely on volunteers to help facilitate their work, community participation is crucial. Some programs located in communities ravaged by the effects of opioids have had no shortage of volunteers, who say that their partnerships with law enforcement agencies helped to reduce the stigma of addiction, not only for those battling SUDs, but for their family members too.[16]

- Use public outreach (traditional media, social media, etc.) to inform the community about the program and encourage participation in public meetings and volunteer training sessions. Listen to and engage in dialogue. Explain why the program was developed, its goals, and how it will benefit the community. Offer to serve as a resource as questions arise.

- If an organization in your community offers training on how to administer naloxone, partner with it. Use those sessions to discuss the program and provide informational material along with the naloxone.

- Engaging community members from neighborhoods impacted by, or involved with, the justice system, as well as individuals in recovery, can produce an awareness of diverse perspectives that can enhance and sustain diversion efforts, help spread the word about the program to more people who might benefit from it, and create opportunities for authentic community-police relationships.

- If the program uses community volunteers, they should be trained about the science of addiction and on the policies and procedures of the program.

7. Collect data and evaluate the program

Research and data collection are vital for validating and improving any first-responder diversion effort. If possible, diversion programs should collaborate with a university or independent researcher during program planning to determine critical metrics, establish how data will be collected, and plan process and outcome evaluations. Collecting programmatic data and evaluating first-responder diversion programs can help stakeholders track implementation of the program to ensure equity among communities; demonstrate the success of the program to policymakers, the media, and the community; apply for additional funding to sustain the program; and add to the knowledge base about first-responder diversion.

8. Hold regular partner meetings

Throughout the life of the program, the program coordinator should hold regular meetings of all partners to discuss challenges, process issues, or individual situations that arise; review new data from analysis or research partners; and share success stories. This process keeps lines of communication open and enhances trust among partners.

9. Create a feedback loop

It is important for first responders to hear from or about individuals who have benefited from their diversion efforts. If an officer, fire fighter, or EMT hears news from or about an individual in treatment who is doing well, it reinforces the benefits of the program. Hearing that an individual is experiencing positive outcomes because of the collaborative work done through the program can be a more powerful incentive than the results of a program evaluation.

10. Conduct ongoing messaging through the media

Develop messaging for social media and local media at all stages of program planning to highlight successes and celebrate milestones. Invite media representatives to training sessions for officers and volunteers, and offer interviews with program officials from each key stakeholder organization. Positive media coverage can broaden awareness of the program and help cultivate community support (including recruitment of volunteers), which can lead to program expansion and sustainability.

Case Study #1:
Anne Arundel County, Maryland
Anne Arundel County Safe Stations

About Anne Arundel County

Anne Arundel County (population 584,909[17]) is located in central Maryland. This large county borders Baltimore to the north and the Chesapeake Bay to the east and hosts Maryland's capital city of Annapolis.

In 2015, rates of fatal drug overdoses began to increase rapidly, driven primarily by opioid misuse. From 2012 to

2017, the total number of unintentional nonopioid drug overdose deaths rose from 83 to 214, an increase of 258 percent. In the same period, the rate of opioid-related overdose deaths increased by 291 percent, from 68 in 2012 to 198 in 2017.[18] From 2015 to 2016, there was a 68 percent increase in the total number of calls for service in which Narcan, the drug used to reverse overdoses, was administered. The impact of the increase in service calls on the Anne Arundel County Fire Department included decreased unit availability, increased response times, and higher costs because of growing demands for services.

To combat the prevalence of drug and alcohol-related overdose deaths, the Anne Arundel County Police Department (AAPD) launched several programs, including a hospital-based substance use disorder (SUD) diversion program and a jail-based SUD diversion program. In 2016, then AAPD Chief Tim Altomare tasked one of the department's two-person Crisis Intervention Teams (CIT) to begin contacting all overdose survivors, including those at the hospital, to offer them immediate access to treatment services. The team contacted more than 800 people within the first year; however, police officers found most individuals were not receptive to treatment when they felt it was being forced on them.

During a 24-hour period on March 6–7, 2017, Anne Arundel County had 16 overdoses, three of them fatal, and fire station personnel began to run out of Narcan. Chief Altomare then reached out to Chief Scott Baker of the Annapolis City Police Department and Jennifer Corbin, Crisis Response Director for Anne Arundel County, to discuss other options for assisting individuals suffering from SUD. Director Corbin told Chief Altomare about the Angel Program, a self-referral program started by the Gloucester, Massachusetts, Police Department. In addition, Fire Chief Allan Graves had begun to study the Safe Station Program in Manchester, New Hampshire, where individuals use fire stations to access treatment. Conversations among these leaders resulted in the creation of Anne Arundel County Safe Stations on April 20, 2017.

Partner Collaboration

Anne Arundel Safe Stations began with a meeting of stakeholders from Anne Arundel County and Annapolis City, where Director Corbin, Chief Altomare, Chief Baker, and Chief Graves pitched the idea of opening up the police

and fire stations in the county and Annapolis City, enabling people to walk in during any hour of the day for assessment by the Crisis Response (CR) staff. Other stakeholders included Anne Arundel County State's Attorney Wes Adams and Dr. Jon Wendell, the Medical Director for both the police and fire departments. This meeting sparked collaboration essential to the development of the program. For example, participation by the State's Attorney's Office helped to break down legal barriers. When the program was first launched, an individual was ineligible to enter a treatment program if he or she had a pending warrant for failure to appear or a court date within 30 days of trying to access treatment. Through policies created with the State's Attorney's Office soon after the program started, Anne Arundel County Crisis Response staff can work with the Office of the Public Defender and the State's Attorney's Office to defer court proceedings until after an individual completes treatment.

Because of the indifferent response to the previous CIT outreach program, Director Corbin did not envision many people taking advantage of the program; therefore, her team was initially unprepared for the program's popularity. Although program administrators performed minimal marketing, Safe Stations had its first walk-in client fifteen minutes after the press conference announcing the opening of the program. Its popularity is one of Anne Arundel Safe Stations' most significant assets--and one of its greatest challenges. Despite a lack of promotion, the program has received media attention, and word of mouth spread quickly through Anne Arundel's vibrant recovery community. In 2019, Safe Stations had an average of 123 new clients per month, and despite the COVID-19 pandemic, in 2020 the program sustained this rate, averaging 124 new clients per month.[19]

> "If you let [people with SUD] come when they're ready, you get more people than you anticipate, and the success rate skyrockets."
>
> —Crisis Response Director Jennifer Corbin

The program launched with the support, commitment, and expertise of all stakeholder organizations, despite its minimal funding. In 2017, the program received a $287,000 grant to bolster the Safe Stations project's Crisis Response Team. Since 2017, the state's Community Health Resource

Commission has provided two $250,000 payments to help support the program.[20] Owing to the program's success, the Anne Arundel county executive pledged to cover fully the program's cost in the county's 2021 budget.[21]

In addition, the state of Maryland received a FY 2019 COSSAP grant, "Regrounding Our Response: A Coordinated Public Safety and Public Health Approach to the Opioid Epidemic," to establish six new law enforcement-assisted diversion (LEAD)[22] sites (including Annapolis City in Anne Arundel County) to reduce recidivism in LEAD participants, cut down calls for service for drug-related activity in the target areas, reduce criminal justice costs, and improve police understanding of and response to issues related to addiction and mental health disorders.

How the Anne Arundel Safe Stations Program Works

Under the Safe Stations program, all firehouses and police stations in Anne Arundel County, the City of Annapolis, and both state police barracks are designated as Safe Stations and are open 24/7. An individual who wants to use the program need only walk into any fire department or police department to request assistance in disposing of any drugs or drug paraphernalia without fear of arrest. While fire personnel do a quick medical assessment to make sure there are no emergency medical issues present, other fire staff members use the county's community warm line to alert CR that there is a Safe Stations client. CR clinicians begin working on the client's assessment on the way to the fire station, while fire personnel keep the individual company and comfortable. When CR clinicians arrive, they complete their assessment and work with the client to determine the best immediate resources or destination for him or her.

Most of the time, the CR clinician transports the client to the treatment or detox facility the client agreed to, but if the clinician is called to another emergency, a CIT officer from the AAPD is called. According to Lieutenant Steven Thomas, Crisis Intervention Team, Anne Arundel County Police, having a police officer drive a client to treatment in the front seat of his or her cruiser while listening to the client's story is powerful. Based on his experience, this process creates a bond and is the embodiment of community policing.

After CR clinicians assist the client with treatment placement, care coordinators, who also work for Anne Arundel County Crisis Response, step in to assess the individual's longer-term needs and assist him or her in obtaining resources such as food stamps, government identification cards, transportation to and from treatment appointments, and general social support. Care coordinators work with the client for whatever period is deemed appropriate.

System Impact

The benefits of the Safe Stations program are demonstrated by reductions in both overdose and crime rates in Anne Arundel County since 2017. In 2019, the county saw its first decreases in total fatal overdoses and opioid overdoses in more than five years. From 2018 to 2019, the total number of overdose deaths dropped from 241 to 208, and the number of fatal opioid overdose incidents dropped from 218 to 183.[23] In the year preceding the launch of Anne Arundel Safe Stations, there were 1,824 burglaries and 3,000 thefts from motor vehicles. Both of these crimes are heavily associated with SUD. In 2019, the number of burglaries fell to 961, and the number of thefts from motor vehicles fell to 2,051.[24]

The Safe Stations program has successfully connected 81 percent of prospective clients with treatment services, and 58 percent of those individuals completed treatment.[25] Many past participants now recommend the program to their friends and families. The popularity of the program has had a snowball effect, nearly stretching it to capacity. Program practitioners go out of their way to avoid the public spotlight, preferring to focus on quality of treatment provided over quantity.

The Anne Arundel Safe Stations program is just one of many routes of SUD and mental health diversion in Anne Arundel County. The county had a culture that valued crisis intervention and support for mental health and SUD that predated the Safe Stations program, and the program benefited from and further contributes to this culture. In light of this, when repeat clients use the Safe Stations program, now stretched to capacity, to access CR, clinicians tell them: "The fire station is just there to give you and other people who need us a safe place to start. We know you now; just call the warm line and we will meet you at home or in the community."

Lessons Learned

◄ Outreach after an overdose is important, but if the program allows people to come when they are ready, there is even more participation in treatment, and the success rate can rise dramatically.

◄ CR clinicians and care coordinators must have passion for this work. Like police and fire services personnel, their offices are open 24 hours a day, 7 days a week, and their importance in supporting Safe Stations clients cannot be overestimated.

◄ A thoughtful rollout and stakeholder buy-in are necessary components for starting a program of this nature.

◄ The ability to show firefighters that the program works in reducing overdoses and demonstrate crime prevention benefits to police has increased stakeholder buy-in.

◄ Much of this program is driven by word of mouth; when word gets out that people are treated well, success breeds success. Program officials observed some clients driving by several fire stations just to get to one where they or a friend/family member had been treated especially well.

Case Study #2:
Dixon, Illinois
Safe Passage

About Dixon

Dixon (population 15,197[26]), a town in rural northern Illinois, is the county seat of Lee County. The city features numerous art venues and two historic parks, and its largest industries are government and health care.

In the years leading up to the Safe Passage program's development, Illinois experienced steadily increasing rates of substance use and overdose. From 2013 to 2015, the total number of overdose deaths rose from 1,579 to 1,836, and the number of opioid-related overdose deaths increased from 1,072 to 1,382.[27] In addition, the number of nonfatal opioid overdoses increased from 5,796 to 7,429.[28] In February 2015, Lee County experienced an unprecedented spike in fatal heroin overdoses, leading to the deaths of three people in only ten days.

How Safe Passage Began

In response to these deaths, the Lee County Health Department convened a meeting of key stakeholders to discuss how they could advance the "Four Pillar Approach," which focuses on prevention, education, treatment, and enforcement to combat substance use disorder (SUD) in Lee County. The group, later called Prevention, Recovery, Intervention, Substance Abuse, and Mental Health (PRISM) of Lee County, included representatives from the Lee County State's Attorney's Office, Katherine Shaw Bethea (KSB) Hospital, Sinnissippi Centers, and local faith-based organizations, as well as Lee County Sheriff John Simonton, former Dixon Police Chief Danny Langloss, and Alison White from Safe Harbor, a group primarily composed of individuals in recovery from SUD.

During a PRISM of Lee County meeting, White presented the idea for the Safe Passage Initiative, modeled on the Angel Program in Gloucester, Massachusetts.[29] After a subsequent call with Gloucester Chief Campanello, who created the Angel Program, Sheriff Simonton and Chief Langloss agreed to develop a local self-referral initiative. On September 1, 2015, Safe Passage officially launched, offering people struggling with SUD the opportunity to walk into the Lee County Sheriff's Office or any local police department to be connected to treatment and recovery resources. The program's mission is "police giving hope through the tools for recovery." Within two months of its launch, 25 people had entered the program, and by March 1, 2016, programming had expanded to include Whiteside County.[30] Following the first full year of Safe Passage, Dixon Police saw a 39 percent decrease in drug arrests.[31]

Program Development

Lee County has only one drug treatment center. In the months preceding the program's launch, Chief Langloss visited neighboring communities to garner support from

additional treatment providers. Through his efforts, vital partnerships were developed with treatment providers; some providers agreed to provide scholarships and bed space specifically for Safe Passage participants. As of August 2020, Safe Passage had partnered with 12 facilities.

In the earliest iteration of the program, the responsibility of screening prospective participants fell to law enforcement officers—Chief Langloss, Detective Jeff Ragan, and Detective Sergeant (and current Dixon Police Chief) Steve Howell—while PRISM of Lee County member Sinnissippi Centers, a community-based behavioral health center, assisted with care coordination after participants engaged in treatment. Eventually, other law enforcement officers began assisting with the screening process.

In 2017, Safe Passage hired individuals in part-time positions to expand the program's capacity to check on and provide support to individuals who had left treatment. In early 2019, responsibility for performing the screening and follow-up support shifted to Alison White, who originally proposed the Safe Passage program and then joined the program as the full-time coordinator. Until this point, bed space availability had determined where individuals were placed for treatment. However, White began utilizing the American Society of Addiction Medicine (ASAM) model of SUD-assessment, which allowed for more appropriate and personalized treatment placement.[32]

Safe Passage has utilized various means to market the program to the residents of Lee and Whiteside counties. Practitioners created flyers, promoted the program through social media, and even produced a television commercial. The program also benefited from informal marketing as word of mouth spread throughout both counties' tight-knit communities. As more law enforcement officers participate in project activities, they increasingly recommend the program to individuals they encounter in the field.

How Safe Passage Works

To enter the Safe Passage program, an individual can walk into any participating law enforcement agency in Lee or Whiteside counties and ask for help seeking treatment for drug addiction. The individual can hand over any drugs or drug paraphernalia without fear of arrest. On-duty personnel promptly notify White that they have an individual interested in the program and in need of assessment. All law enforcement officers involved in Safe Passage are

trained on the intake process, so if White is occupied with other activities, the on-duty officer can begin walking the prospective participant through the intake form before her arrival.

Once White arrives, she either fills out or completes the intake paperwork or conducts an assessment of the individual; then she calls treatment facilities based on the individual's specific needs and circumstances. Once an available treatment facility is identified, staff members from that facility perform a phone assessment with the participant to determine eligibility. Participants are typically enrolled in treatment within 24-48 hours of entering the law enforcement agency. Often, because of estranged relationships with friends and family, participants do not have access to the resources of a social network, such as assistance getting transportation to treatment. In this case, either White or law enforcement officers will assist with transportation to a treatment facility, which may be located more than an hour away in some cases. However, because the program provides hope to individuals who have been accepted for treatment, some friends and family members have become more willing than before to provide transportation to treatment facilities.

Anyone can seek entry into Safe Passage. Participants are deemed ineligible to participate only if they have active warrants or have been found guilty of sex crimes, since most treatment facilities do not allow convicted sex offenders into their programs. However, the Lee County State's Attorney's Office often works with an individual on his or her warrant or reschedules a court date to enable that individual to enter treatment. Treatment facilities have the discretion to accept or deny entry to any individual with a history of violence, based on the circumstances.

In addition to performing the initial assessments, White provides follow-up support to participants and stays in touch with them for as long as they like. The level of contact depends entirely on a participant's needs and is not limited to individuals who have maintained their sobriety. If participants relapses, as is common among individuals suffering from SUD, they are neither cut off nor abandoned. White will continue to support them, providing them with harm-reduction resources and techniques. Participants can go through the program multiple times if necessary; when a participant is ready White will work with the individual to get him or her back into treatment.

System Impact

Although it took time, Safe Passage has helped law enforcement to build relationships with the recovery community and individuals with SUD. When law enforcement officers participate in the intake process and provide transportation to participants, it increases the officers' knowledge of SUD, expands their empathy and understanding around addiction issues, and reduces stigma. Because of the ongoing relationship building, individuals with SUD now understand that they can reach out to law enforcement without fear and be linked to treatment two to four weeks faster than they could on their own, rather than the 24–48 hours it takes through the program.

> "Safe Passage has resulted in many law enforcement officers in Dixon becoming more educated on addiction. They have more understanding, knowledge, and empathy than some treatment providers I've seen. They are extremely skilled at recognizing, understanding, and acknowledging addiction for what it is."
>
> —Alison White, Safe Passage Coordinator

Safe Passage is one of the few programs able to provide access to SUD treatment for residents of Lee and Whiteside counties. The program has become a staple of both counties' SUD-treatment infrastructure, and nearly 100 people enter the program annually.

Early on, Chief Langloss visited neighboring jurisdictions to discuss the importance of programs such as Safe Passages in reducing the number of overdoses and helping people with SUD. These efforts gained attention and buy-in for diversion programs, but there was an unforeseen consequence. Other law enforcement agencies began to launch similar programs, leading to a significant increase in demand for bed space, with only marginal increases in the supply. Treatment facilities that had once been reliable locations for Safe Passage began prioritizing bed space for individuals from their own communities. Consequently, while it may have only taken a couple of hours to get a participant placed in treatment when Safe Passage started, it may now take one to two days to find a placement. Because Lee and Whitehead counties are in rural parts of Illinois, treatment capacity continues to be among the significant challenges the Safe Passage program faces.

In August 2018, SB3023, the Community Law Enforcement for Deflection and Substance Abuse Treatment Act, was signed into law by Illinois Governor Bruce Rauner, due in large part to the leadership of former Chief Langloss, now the City Manager of Dixon. Others whose leadership contributed to passage of the law include Chief Eric Guenther of the Mundelein (Illinois), Police Department (now the Village Administrator), and a team of policy and subject-matter experts. This law, the first of its kind, authorizes programs such as the Safe Passage Initiative, creates five pathways for police deflection, provides funding for deflection programs, and creates immunity for law enforcement officials engaging in these programs. The bill also strongly encourages community partnerships to combat the opioid epidemic.[33]

Recognition of Safe Passage is not limited to Illinois; it has also received national attention. In June 2019, Addiction Policy Forum (APF), a national nonprofit organization whose mission is to eliminate addiction as a major health problem, recognized Safe Passage as one of eight leading innovative programs addressing substance use disorder in Illinois.[34] APF also credited Safe Passage as a national model for SUD diversion.

Lessons Learned

‹ As the Safe Passage program developed, practitioners moved away from placing individuals in treatment based on available bed space and began placing them based on specific needs reported in clinical assessments. According to Safe Passage Program Coordinator Alison White, "Being selective with treatment placement has led to better outcomes for individuals."

‹ Currently, all calls to Safe Passage, no matter the time of day, go to White in her role as program coordinator. These include calls from family members, officers, and dispatch. Eventually, she hopes the program will have the capacity to host a crisis call line staffed by additional individuals.

‹ Being in a rural community presents many problems: there is no residential treatment facility; only a handful

of 12-step program meetings are available each week; there is no support for family members of people either in treatment, post-treatment, or still battling addiction; and there is a lack of access to psychiatric care. In addition, after individuals leave residential treatment, there are no respite programs to support them in their recovery. Many rural areas share similar limitations across available services.

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Case Study #3:
Hudson Valley, New York
Hope Not Handcuffs–Hudson Valley

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About the Hudson Valley

The Hudson Valley encompasses ten counties in upstate New York, including Columbia, Rensselaer, Dutchess, Putnam, Westchester, Rockland, Orange, Ulster, Greene, and Albany. The region, which is bisected by the Hudson River, encompasses residential and farming areas and is known for its history and natural beauty.

In the early 2000s, New York began to see a surge in fatal overdose incidents. From 2005 to 2018, the rate of fatal overdose involving any substance increased from 944 to 3,697.[35] Overdose incidents involving opioids drove this trend and accounted for roughly 500 deaths in 2005 and 2,991 deaths in 2018.[36]

According to Sergeant Guy Farina, law enforcement liaison to Hope Not Handcuffs–Hudson Valley, the emergence of the opioid epidemic became apparent in the Hudson Valley as early as 2005, when opioids overtook crack cocaine as the drug of choice in the area. In 2018, Dutchess, Ulster, Sullivan, and Orange counties ranked in the top five counties for fatal overdose incidents per 100,000 residents in New York.[37] Similar to other counties in the Hudson Valley, Dutchess, Ulster, Sullivan, and Orange counties also experienced increased emergency department (ED) admissions due to opioid use. From 2010 to 2013, the number of ED-related admissions increased by 27 percent in

Dutchess County (555 to 707), 56 percent in Ulster County (355 to 554), 89 percent in Sullivan County (100 to 189), and 115 percent in Orange County (442 to 951).[38]

In 2016, to combat the increasing number of opioid overdoses, Annette Kahrs, president of the Tri-County Community Partnership, decided to hold a training for the community on how to administer naloxone—a drug that rapidly reverses the effects of an opioid overdose. Armed with 100 naloxone kits, she was shocked to see more than 100 people sign up for what would become the first of several naloxone training sessions, each one full to capacity.

The popularity of the naloxone training sessions demonstrated to Kahrs the community's willingness to assist individuals suffering from substance use disorder (SUD). To build on this support, Kahrs considered replicating a program she was aware of in her home state of Michigan, Hope Not Handcuffs (HNH), which she wanted to bring to the Hudson Valley. HNH was developed by the Michigan-based nonprofit Families Against Narcotics (FAN) and modeled on the Angel Program in Gloucester, Massachusetts. Through HNH, participating police departments encourage individuals with SUD to come to the police station, where they can surrender drugs and drug paraphernalia without fear of arrest and a volunteer angel will connect them to treatment.

Kahrs approached FAN in the summer of 2018 and proposed developing an HNH program in the Hudson Valley—the first expansion of the program outside Michigan. Through a collaboration of the Police Assisted Addiction and Recovery Initiative (PAARI), the Tri-County Community Partnership, FAN, and the Town of Wallkill Police Department, Hope Not Handcuffs–Hudson Valley (HNH-HV) launched in November 2018 and began to grow almost immediately. By August 2020, law enforcement agencies in five counties (Orange, Dutchess, Putnam, Rockland, and Westchester) had adopted the HNH-HV program.

How Hope Not Handcuffs Evolved

The HNH-HV Initiative spread to 20 Hudson Valley police departments within nine months of its launch. In January 2019, Sergeant Guy Farina, a drug recognition expert from the Montgomery Police Department (MPD), attended the first HNH-HV angel training. Subsequently, MPD became the second department to adopt HNH-HV, and Sergeant

Farina joined the project in a volunteer capacity as a law enforcement liaison.

Initially, when a local police department expressed interest in adopting HNH-HV, Kahrs would send the department a PowerPoint presentation explaining to line officers the program's goals and how it works. However, few officers expressed real interest in the program. To help overcome this obstacle, Kahrs began personally conducting the training sessions, highlighting the program's value by presenting case studies about people helped by the program.

Sergeant Farina assisted by adding additional material to the training about the role addiction plays as an underlying condition in crimes such as larceny, burglary, and impaired driving, and how connecting individuals who have SUD to treatment can lead directly to a reduction in the number of these crimes.

> "Traditional policing strategies as related to drug crimes have become counterproductive in that, when dealing with those suffering from a SUD, the arrest/prosecution could be more harmful than helpful. It addresses the effect but not the cause. This type of non-traditional policing strategy is designed to attack the root cause of drug-related crime, thereby preventing crime."
>
> —Sergeant Guy Farina, Town of Montgomery Police Department and Law Enforcement Liaison, Hope Not Handcuffs–Hudson Valley.

HNH-HV relies equally on law enforcement and volunteer angels. Qualifications for becoming an angel include, but are not limited to, attending the mandatory training class, submitting to a background check, and making a commitment to be on call for at least one six-hour shift per month. During the 2 1/2-hour training sessions, volunteers are presented with information about the program, the neuroscience of addiction, the role of stigma in addiction,

and community policing. By August 2020, the program had trained more than 500 angels.

> "You don't have to be certified in anything or be a trained clinician to provide compassion."
>
> —Annette Kahrs, Program Director, Hope Not Handcuffs–Hudson Valley

How Hope Not Handcuffs Works

Every police department participating in HNH-HV has a manual with step-by-step instructions on what personnel should do when someone comes to them seeking help through the program. When an individual suffering from SUD enters the department, he or she talks to a dispatcher to begin the process. The dispatcher notifies a supervising officer and then calls the angel coordinator overseeing the county. The supervisor checks for any warrants that might exclude the individual from eligibility, including warrants for domestic violence or other violent crimes.

Other circumstances that could render an individual ineligible are medical conditions that require hospitalization or being considered a danger to others. HNH-HV uses an app called SignUpGenius to schedule angels for shifts. The county coordinator checks SignUpGenius to see who is on call and dispatches an angel to meet with the participant.

Once at the police department, an individual who has illicit drugs or drug paraphernalia can turn them in to police without fear of arrest. This policy allowed for one instance in which an individual turned in almost a kilo of heroin. It usually takes between 20 and 30 minutes for an angel volunteer to arrive at the department. Until then, law enforcement staff members spend time talking with and listening to the participant and do what they can to make the individual feel at ease.

Each participating police department has a blue bin stocked with supplies for participants, including granola bars, water, and toiletries, and emergency clothing such as sweatpants, socks, and gloves. The container also contains letters of encouragement from people in long-term recovery. These items are meant to keep program participants comfortable and help them feel supported as they prepare for treatment. Once at the police station, an angel walks a participant through HNH-HV intake paperwork before calling

appropriate treatment facilities, taking into consideration the participant's individual needs and health insurance status. If the participant has insurance, the angel locates a treatment center within his or her coverage plan; for people on Medicaid or without insurance, the angel works with the local Office of Substance Abuse Services to determine placement. When an angel contacts a facility and self-identifies as calling from HNH-HV, the facility knows who the angel is and that the angel is currently with someone who needs immediate access to treatment. Treatment placement typically takes about two hours.

Program Challenges

HNH-HV has grown quickly, and law enforcement leaders continue to contact Kahrs to join the program. But it faces challenges. First, while HNH-HV enjoys a great deal of support from communities, it suffers from a lack of funding. The program, which has a four-person volunteer administrative staff, would benefit from paid positions to support oversight of each county's angel coordinators and hundreds of angel volunteers, as well as the numerous training sessions they offer, both for new angels and for police officers whose departments have just joined the program. Having a paid staff member would also help with data collection and program evaluation.

There also has been pressure to transfer programming to county behavioral health departments and have peer recovery coaches do the angels' work. Individuals would still have access to treatment, but eliminating the role of community volunteers could have broad implications. Many HNH-HV angels have or have had family members with SUD. Becoming an angel has empowered many of them by giving them tools to help others with SUD. Every volunteer is an ambassador of the program who gets the word out by leaving HNH-HV literature in places where someone who needs help might find it and by supporting HNH-HV in other ways, such as promoting the program at community events. Designating community members to do this work has other benefits: training community members about addiction and having them work with individuals who have SUD reduces the stigma around addiction. Also, when community members work in partnership with police officers, trust and relationship building are promoted.

"I hear impactful stories from our angels, program participants, and police officers regarding the program. They find it very rewarding to know they made a direct impact on someone in need. Complete strangers and the police working together to offer compassion and support; they don't forget that. It's actually a powerful thing to witness."

—Annette Kahrs, Program Director, Hope Not Handcuffs – Hudson Valley

System Impact

HNH-HV benefits from and contributes to the strong ties between local communities and their police departments. The community is motivated to participate in HNH-HV because the opioid epidemic has affected so many families. HNH-HV has brought communities together to work on a common goal. HNH-HV also has enabled communities to work with police departments to do what Sergeant Farina calls "advocacy policing"—taking a community problem and empowering the community to partner with the police to address it. The community takes ownership of the program and is enthusiastic about its partnership with the police department.

The program also helps to create relationships between officers and people with SUD. During the intake process at the police department, a volunteer angel takes the lead in working with an HNH-HV participant. But before the angel arrives, and when he or she is on the phone with treatment providers, officers interact with the HNH-HV participant, listen to his or her story, and offer support. Participants are not used to having such interaction with police officers, and the conversations that happen during these instances help officers get to know an HNH-HV participant—not just as someone with SUD but as a person. These interactions help to break down stigma around addiction and build trust with law enforcement.

HNH-HV has built such a positive reputation among member law enforcement agencies that the program sometimes receives calls about individuals who have been arrested but who would benefit from linkage to treatment.

Sergeant Farina and Kahrs created a new training curriculum for police departments, including information and case studies on all five pathways of diversion. Several member agencies practice most of the pathways.

HNH-HV has earned both local and national recognition and received numerous awards. In June 2019, HNH-HV was recognized at the Rockefeller Institute's Forum on Opioids in Rural Communities. Then in July 2020, Kahrs received a New York State Senate Commendation award from State Senator Jen Metzger for her work on HNH-HV.[39,40]

Lessons Learned

◄ Having a law enforcement liaison—an officer with whom to collaborate and create training—is tremendously important. In addition to serving as an advisor, the liaison gives programs credibility with law enforcement, which can aid in program expansion.

◄ Program practitioners need to show officers how diversion for people with SUD prevents crime, especially crimes primarily driven by addiction, and that linking individuals to treatment is not a "get-out-of-jail-free" card.

◄ Training people in a new agency has the greatest impact when it is done in person and when it includes stories from and about real people. Training should include dispatchers. Sometimes, individuals reach out to an agency to inquire about HNH-HV and are told that the agency does not participate in the program, when in fact it is an HNH-HV partner.

◄ Make sure that feedback from participants is relayed to officers. HNH-HV often asks treatment facilities to call HNH-HV staff members to give them a status update on new clients and if there is a message for the department a client visited or an officer to whom he or she spoke. Kahrs will make sure that message is delivered. This feedback provides follow-up information to officers as well as positive reinforcement about the benefits of the program.

About Manchester

Manchester, New Hampshire (population 113,441[41]), nicknamed the Queen City, is the largest American city north of Boston. Straddling the Merrimack River, Manchester is one of the two seats of Hillsborough County.

In the early 2010s, substance use disorder (SUD) emerged as a significant issue in Manchester. In 2014, there were about 20 to 30 overdose incidents per month across all drug types. In December of that year, the number of overdoses increased to more than 70 recorded incidents related to opiates alone. The rise in opiate-related overdoses was driven by the prevalence of fentanyl, which, in 2015, was involved in nearly two-thirds of New Hampshire's drug deaths.[42] To address this alarming statistic, the Manchester Fire Department began leaving a card with a list of treatment resources with every person for whom it successfully reversed an overdose. However, obtaining access to treatment for SUD was challenging for individuals because, while New Hampshire ranked second in the nation for opioid-related deaths relative to population in 2016, it had the second-lowest rate of spending on substance use treatment and prevention.[43] The result was that many individuals had to wait six to eight weeks for treatment.

This gap in resource capacity led many individuals who wanted to escape the cycle of addiction to overdose while waiting for treatment. One day in 2016, a desperate individual, the family member of a firefighter, was convinced to walk into the local fire station to seek help based on the card he had been given that outlined treatment resources. One of the firefighters on duty, paramedic Christopher Hickey, tried connecting with each resource on the card and discovered that there was no immediate help available. EMS Officer Hickey then took matters into his own hands and called a nearby facility, Hope for New Hampshire (NH) Recovery, and was able to connect the individual to

treatment immediately. This interaction led to the creation of the Manchester Safe Station Program, a self-referral service meant to help individuals with SUD connect to treatment resources.

How the Manchester Safe Station Program Began

After hearing about how the fire station was able to provide timely access to treatment, Manchester's mayor reached out to EMS Officer Hickey to ask him to set up an official program. Drawing from the concept of Safe Haven programs,[44] wherein individuals can drop off unwanted newborns at local fire stations, and the Gloucester (Massachusetts) Police Department's Angel Program, a law-enforcement-led self-referral program for people with SUD, Manchester Safe Station was born. On May 16, 2016, just two weeks after EMS Officer Hickey's meeting with that first individual who came through the doors of the fire station, Safe Station was operational in all ten firehouses in Manchester.

Initially, the Safe Station Program relied on cooperation among the Manchester Fire Department, Hope for NH Recovery, and Serenity Place, another behavioral health treatment agency. Through the Safe Station Program, the Manchester Fire Department provided a portal to treatment for anyone who needed it and performed preliminary medical screenings. Clients then would be referred to Hope for NH Recovery or Serenity Place, where they would be connected to insurance if they did not already have it and receive appropriate assessments by clinical staff. Serenity Place had its own inpatient and outpatient programs but put individuals in touch with other treatment centers as well.

Hope for NH Recovery was originally established as a respite program for people with SUD. Its mission was to provide support and resources to people in recovery, such as connections to recovery coaches, support meetings, and job placement, thus helping them maintain their sobriety. By stepping up to meet the needs of the Safe Station Program, Hope for NH Recovery practitioners began spending the majority of their time working with people in crisis. Serenity Place had the resources to provide detox services as well as acute treatment and other clinical services. After about six months, Hope for NH Recovery returned to its original mission as a community recovery organization, and Serenity

Place stepped up as the sole behavioral health treatment partner.

The Need to Evolve

For almost two years, Serenity Place was the only referral outlet for the Safe Station Program. During that time, nearly all of the more than 3,000 people who went through Safe Station went directly to Serenity Place, straining the agency's capacity. This experience demonstrated to the fire department command staff that one agency could not serve as the sole provider of treatment /recovery services and that several agencies offering services had to come to the table as partners. In this way, Safe Station brought together several partners to address more than just services for SUD. Partners such as Granite Pathways, the Farnum Center, Families in Transition, HOPE for NH Recovery, Makin' It Happen, and others, as well as city and state officials, began to address issues including chronic homelessness, behavioral and physical health, and family reunification.

Manchester Safe Station also entered into a formal agreement with ride-share company Lyft to provide safe and reliable transportation for clients to and from treatment or recovery-related appointments. Using Lyft's concierge service, the fire station can track a vehicle after a Lyft driver picks up a client and confirm that the client arrives safely at his or her destination.

In 2019, the Safe Station Program went through yet another change as New Hampshire launched its Doorway Initiative, a "hub and spoke" system that includes nine regional Doorway locations. Doorways act as hubs and provide walk-in SUD screening, evaluation, and care coordination. The treatment providers are the "spokes" in the system. Granite Pathways serves as the Doorway for Manchester Safe Station, an existing partner.

The evolution of Manchester Safe Station benefited from stakeholder and community buy-in. Manchester Safe Station received significant local media coverage, and word of the program also spread rapidly through the local SUD community. Dartmouth College evaluated Manchester Safe Station,[45] and the positive assessment helped to garner further support for the program.

How It Works

Anyone, including non-Manchester residents, can take advantage of the Manchester Safe Station Program 24 hours a day, seven days a week. An individual can access the program by walking into any fire station in Manchester. Once there, he or she is met with a handshake and made to feel as comfortable as possible. An individual with any drugs or drug paraphernalia is asked to relinquish it to firefighters, who have appropriate receptacles for needles, illegal substances, and weapons. On-duty firefighters perform a medical assessment to ensure that there is no need for medical attention. If a firefighter identifies medical issues, the individual is transported to a medical facility for care and can access treatment and recovery services once medically cleared. If no pressing medical problems are identified, the time of day determines where the on-duty firefighter sends the individual.

During business hours from Monday through Friday, individuals are sent to the Doorway program, which provides an SUD assessment before connecting the individual to appropriate treatment and recovery resources. After 5:00 p.m. and on weekends, individuals might be sent to Granite Recovery in Effingham, New Hampshire, or Nashua Respite, a male-only sober respite house.

> "It doesn't matter if you come to the fire station one time, ten times. . .you're going to be greeted without judgment or stigma."
>
> —EMS Officer Christopher Hickey, Manchester Fire Department

System Impact

From the program's launch in 2016 to August 2020, nearly 8,500 individuals passed through Manchester Safe Station. On average, six to seven people take advantage of the self-referral pathway daily. The community's gratitude is evident in the number of thank-you letters the station receives from past participants and their family members.

One of the primary systems-level benefits of Manchester Safe Station is that, even though the program merely acts as a point of entry for treatment in the community,

it brought various stakeholders to the table who had not worked together before. This collaboration had the effect of breaking down silos, especially between mental health and law enforcement practitioners; creating stakeholder collaboration; and encouraging people to work toward the same goals. This collaboration continues outside the purview of substance use and is credited with quickly facilitating the implementation of COVID-19 testing in Manchester.

Another benefit of the Manchester Safe Station Program is that it has helped to decrease stigma about SUD and increase understanding that addiction is a disease. The collaboration that began with Manchester Safe Station has resulted in several initiatives, including New Hampshire's Recovery Friendly Workplace Initiative, which empowers workplaces to support people recovering from SUD.

The Safe Station blueprint has been implemented around the country, including in Maryland, Ohio, Tennessee, Virginia, and Washington.[46] Owing to the simplicity of the Safe Station model, it can be adapted by almost any community, no matter the scope of its resources, and EMS Officer Hickey is willing to share documentation about the program with other communities.

Lessons Learned

- ◂ Manchester Safe Station started quickly from an acute need, but it would have helped to assess and obtain stakeholder buy-in before launching the program.

- ◂ If a locality has a need, fear should not get in the way of starting an innovative program. Sometimes you have to know your community and service availability, trust your instincts, and jump in.

- ◂ Be willing to be flexible so that if circumstances change, the program has the ability to change. The important thing is to make decisions as a collaborative and address challenges together.

Walker County, Alabama

Mercy Project

About Walker County

Walker County (population 72,674[47]), a rural county in central Alabama, is located about an hour northwest of Birmingham and is known for its outdoor recreational activities, including award-winning fishing on Lewis Smith Lake and Walker County Lake.

In 2016, *The Washington Post* published an article[48] detailing the suffering of thousands of low-income Alabamians resigned to a life that centered on the cycle of drug abuse, poverty, and recovery and calling attention to the severity of substance use disorder (SUD) in Walker County. The county had the fifth-highest per capita rate of overdoses in the United States and the highest overdose rate of any county in the state. As a result, Walker County Sheriff Nick Smith wanted to create a program to help people struggling with SUD and reduce the recidivism rate resulting from substance misuse. Drawing on similar programming in Mississippi, the Walker County Sheriff's Office launched the Mercy Project in January 2019 to provide a self-referral pathway to treatment and recovery services.

How the Mercy Project Began

Deputy T. J. Armstrong, public information officer at the Walker County Sheriff's Office and project coordinator for the Mercy Project, emerged as an early program champion and now administers every aspect of it. His reputation in the community and the trust he and Sheriff Smith built over time have been critical to developing stakeholder and community buy-in. As the project began to take form, Deputy Armstrong met with and garnered support from local churches and faith-based organizations. The local homeless coalition and the American Red Cross also joined as initial project partners. Over time, the program built partnerships with 12 treatment centers, the Northwest Alabama Mental Health Center, and local emergency departments.

These partnerships allow participants to access services regardless of their ability to pay, since many associated treatment providers defer entrance fees for program participants until they are stabilized and able to earn incomes. In cases in which payment is required, practitioners can draw from a general fund administered by the sheriff's office.

The Mercy Project does not receive any state or federal funding, nor has it been awarded any grants. The general fund is made up solely of donations from faith-based groups and congregations that believe in the work, as well as those from around the United States who have viewed media reports about the program (e.g., on CNN and other media outlets[49]).

Community members not only support the program financially but also volunteer to assist with program activities, which is indicative of the level of community and stakeholder buy-in for the project. This support has been essential to the development of the program, especially considering the lack of external funding.

How the Mercy Project Works

When someone is interested in participating in the program, the first step is filling out the application on the Mercy Project website.[50] The application can be submitted through the website, sent via email, or dropped off at the front desk of the sheriff's office. Deputy Armstrong then contacts the individual for an initial consultation, during which he assesses the individual's level of motivation and desire to begin the recovery process.

People are ineligible for program entry if they are facing drug charges or have outstanding warrants. However, the consultation allows a potential participant to turn in any drugs or drug paraphernalia without the threat of arrest, and although the individual must still enter the justice system, drug court is an option. If the person is accepted into the program, this meeting helps determine individualized treatment needs. Some participants prefer faith-based treatment facilities, while others prefer secular treatment services.

Based on the individual's needs and interests, Deputy Armstrong immediately begins making calls to treatment

providers. When a provider is identified, the participant is linked with a Mercy Project accountability partner, an individual whose role is to send specialized care packages and notes of encouragement to the participant during treatment and provide a variety of additional supports after treatment. The accountability partner may be Deputy Armstrong or a program volunteer from the faith community. Although volunteer accountability partners do not receive specialized training, each volunteer is recommended by clergy and vetted by Deputy Armstrong. Some have lived experience and know firsthand what the participant is going through, whereas others are simply willing and motivated to help.

After treatment, Deputy Armstrong and accountability partners try to help participants maintain their sobriety by assisting with needs such as job placement or marriage counseling or by advocating on their behalf in child custody cases. Services are tailored to the needs of the individual. In addition, through Sheriff Smith's "Good Morning" program, a dispatcher calls Mercy Project participants between 9:00 a.m. and 10:00 a.m. to wish them a good morning. If a call to participant goes unanswered, a deputy sheriff may be sent to check on that individual.

System Impact

Since its launch, 75 participants have accessed treatment through the Mercy Project. The project is now an established community entity, and treatment providers reach out to Deputy Armstrong when they have an individual seeking treatment but do not have space available. Provider capacity continues to be the most significant obstacle in accessing treatment; however, the Mercy Project can connect clients to available treatment providers and community supports as needed.

Treatment providers, community members, law enforcement, and other justice system stakeholders (such as the district attorney and judges), trust and support the Mercy Project. A survey conducted in July 2019 by Southeast Research found that, of 310 Walker County residents surveyed, 66 percent reported that they did not know that the county has a substance abuse/opioid treatment facility, but 19 percent knew that law enforcement could facilitate treatment because of their familiarity with the Mercy Project.[51]

"This type of program is a huge part of community policing. As a law enforcement officer, I understand that a badge doesn't just give me authority. It marks me as a public servant who is here to serve the community. This program helps to build relationships with people. Programs like this should be the face of police work; this is where we need to be."

—Deputy T. J. Armstrong, Project Coordinator, Walker County Sheriff's Office Mercy Project

The program's popularity is evident in the number of calls Deputy Armstrong receives from people hoping to participate in the program, media requests for program information, treatment facilities or local hospitals asking him to locate additional treatment beds, and prospective volunteers. He also receives calls from local law enforcement officers who have encountered an individual who might benefit from participating in the program. This local interest and support reflect how the project has been able to do so much with minimal funding.

Lessons Learned

‹ Every potential participant should be treated as an individual who warrants a personalized treatment and recovery plan.

‹ Language matters: To reduce stigma, it is essential not to label participants as "addicts" and to separate the person from the disease.

‹ Being funded solely through local donations allows the Mercy Project the freedom to function independently, free of the stipulations that can come with government funding.

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- Deputy T. J. Armstrong, Public Information Officer, Walker County Sheriff's Office; Project Coordinator, Mercy Project

Endnotes

1.   In many jurisdictions, these programs may be known as pre-arrest diversion, deflection, pre-booking diversion, co-responder programs, law enforcement/police-assisted diversion, and crisis intervention. In this case study, law enforcement and fire/EMS-led responses will be referred to as first-responder diversion or FRD.

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