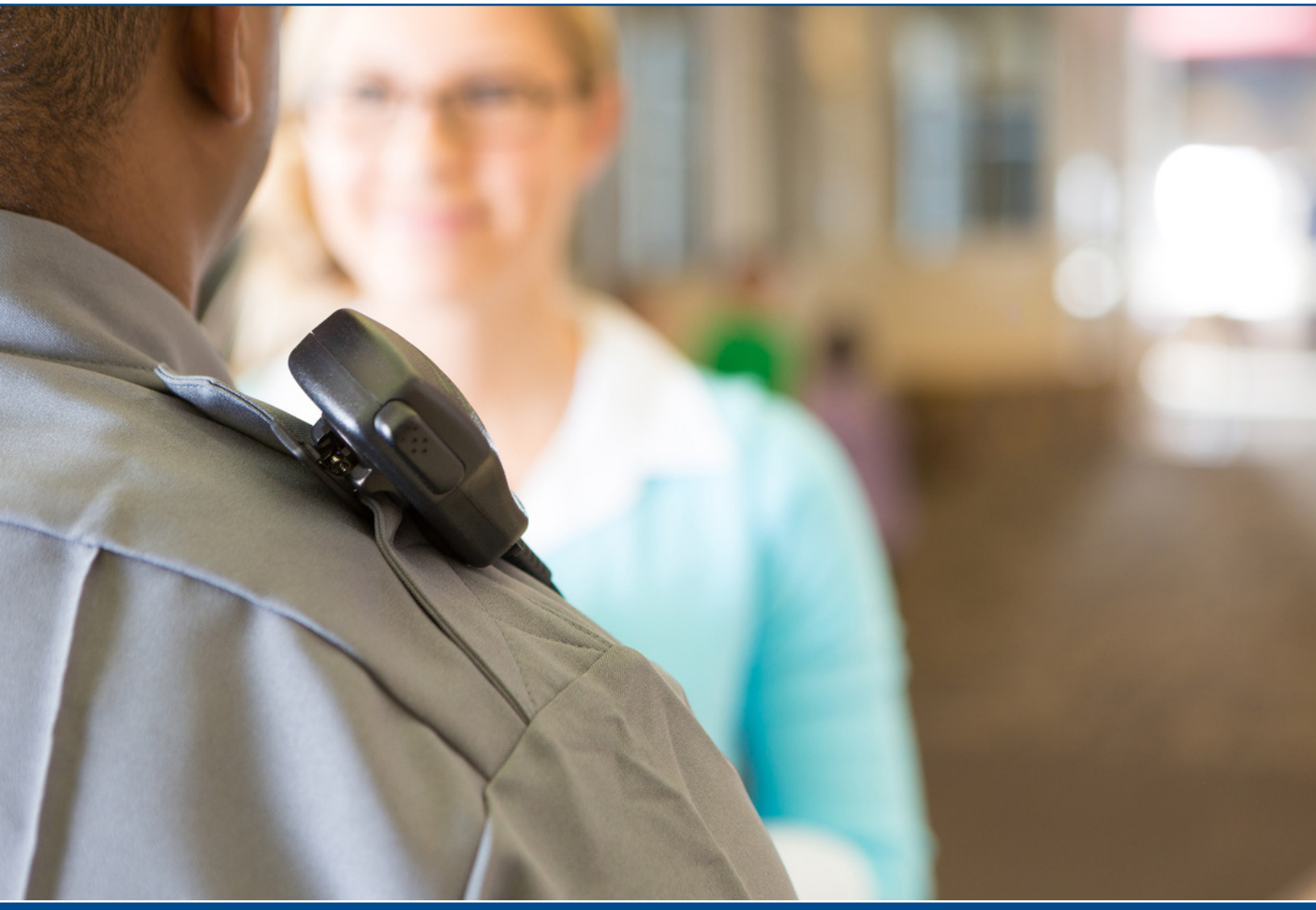
State of Illinois
Bruce Rauner, Governor
John Maki
Illinois Criminal Justice Information Authority

POLICE-LED REFERRALS TO TREATMENT FOR SUBSTANCE USE DISORDERS IN RURAL ILLINOIS: AN EXAMINATION OF THE SAFE PASSAGE INITIATIVE



ICJIA

Police-Led Referrals to Treatment for Substance Use Disorders in Rural Illinois: An Examination of the Safe Passage Initiative

Jessica Reichert, Senior Research Analyst
Lily Gleicher, Research Analyst
Lynne Mock, Research Analyst
Sharyn Adams, Research Analyst
Kimberly Lopez, Research Intern

Center for Justice Research and Evaluation
Illinois Criminal Justice Information Authority

This project was supported by Award No. 13-DJ-BX-0012 awarded by the U.S. Department of Justice Bureau of Justice Assistance The opinions, findings, and conclusions or recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice or the Illinois Criminal Justice Information Authority.

Suggested citation: Reichert, J., Gleicher, L., Mock, L., Adams, S., & Lopez, K. (2017). *Police-led referrals to treatment for substance use disorders in rural Illinois: An examination of the Safe Passage Initiative*. Chicago, IL: Illinois Criminal Justice Information Authority, Center for Justice Research and Evaluation.

Illinois Criminal Justice Information Authority
300 West Adams, Suite 200
Chicago, Illinois 60606
Phone: 312.793.8550
Fax: 312.793.8422
www.icjia.state.il.us

Table of Contents

Key Findings

Illinois Criminal Justice Information Authority (ICJIA) researchers conducted a process evaluation of Safe Passage Initiative, an initiative in which individuals get help from police in accessing substance use disorder treatment without fear of arrest. Researchers sought to understand how the initiative was developed and operated, as well as gain perspectives of those involved in the initiative—stakeholders, police officers, treatment providers, and clients. Researchers used a multi-method approach by gathering information from administrative intake data, a law enforcement staff survey, interviews with treatment provider and clients, and a focus group with stakeholders.

In Safe Passage, a person voluntarily enters the police department for help and a police officer on duty conducts an intake process to collect basic information, including the individuals' substance use and criminal histories. Officers reserve the right to refuse those with extensive violent criminal backgrounds. In addition, in cases where the individual has an outstanding arrest warrant for contempt non-payment or failure to appear on minor criminal offenses, an officer will contact the state's attorney to negotiate quashing the warrant or postponing a court date until after treatment participation.

Once eligibility is determined, a police officer contacts a treatment provider with whom Safe Passage services have been pre-arranged. The provider conducts a phone interview with the client to determine appropriate level of care. Trained volunteers, recruited through community agencies, drive program participants to treatment facilities often located an hour away or more. After the client enters treatment, minimal contact is made by the police department or program volunteer. Follow-up by the client with Safe Passage is voluntary.

Safe Passage has operated in the two rural, northwestern Illinois counties of Lee and Whiteside since 2015. Spearheaded by the Dixon police chief, the initiative was developed in response to the region's opioid crisis, but helps anyone with a substance use disorder. Program developers engaged the community and used media to increase awareness. A majority of interviewed treatment providers and some surveyed police officers indicated enhanced awareness would be beneficial to recruit clients into the program.

Intake forms obtained from the program showed 83 individuals entered Safe Passage and received detoxification and/or treatment services in its first year, from August 2015 to August 2016. Of them, 12 entered Safe Passage more than once. A majority of clients were single, unemployed, high school graduates; 54 percent were male; and the clients' average age was 33 years. Forty-two percent indicated they suffered from a mental health disorder (n=36). All clients misused opioids. All reported using an opioid on the day of intake: 88 percent used heroin, and of them, 69 percent use it intravenously. Clients reported using opioids for an average of almost five years. Fifty-eight percent of Safe Passage clients reported receiving prior treatment and 55 percent reported previously trying to but failing to access treatment. Most clients—83 percent—had no health insurance at intake. Records indicated 86 percent had a criminal history.

Feedback from stakeholders, police officers, treatment providers, and clients was positive. Eighty-six percent of the 79 police officers surveyed were supportive of Safe Passage and 75

percent told someone with a substance use disorder about the initiative while on duty. Most officers surveyed reported receiving some training on Safe Passage (90 percent), but treatment providers indicated that officers could use more training, particularly on levels of care of substance use treatment. The six treatment providers who were interviewed offered unanimous support of Safe Passage and indicated they had good working relationships with police involved in Safe Passage. The five clients that were interviewed also expressed support for the program and appreciation for assistance.

Implications for Policy and Practice

The following are policy and practice recommendations for Safe Passage and similar initiatives based on data collected and analyzed for this evaluation.

Engage a service coordinator. Stakeholders and treatment providers suggested employing a full-time case manager with a clinical background to conduct assessments of clients for placement in the proper level of care and offer aftercare services in order to improve outcomes.

Enhance police officer training. Although 90 percent of officers surveyed reported receiving some training on Safe Passage, more education, or refresher training, on substance use disorders would be beneficial. According to some treatment providers, some police officers presumed all with substance use disorders need detox and inpatient care. In fact, that course of treatment may not be beneficial for all clients, and there are assessments available to determine the appropriate level of treatment. Police officers initiate the call to the treatment provider on behalf of the client and may tend to call only providers offering detox and residential services. In addition to clients, police encounter individuals and families in the community in need of assistance for substance use disorders, so such training can further help people in need (Branson, 2016).

Ensure the public is aware assistance is available to clients with any substance use disorder, not just an opioid use disorder. Although spurred by the opioid crisis, Safe Passage is equipped to, and has helped, individuals with many substance use disorders, not just opioid use disorders. The initiative was designed to accept anyone with a substance use disorder and the public needs to know that assistance is not limited to opioid users.

Enhance community awareness. Although Safe Passage administrators spread the word via local media, the police department website, and social media, expanding awareness could potentially help more people assess treatment. Treatment providers and some police officers agreed; they recommended enhancing community awareness to increase impact. A Safe Passage website could offer information or allow individuals to email questions. This may be a first, anonymous step that does not require an individual to walk into a police station to seek help, which may be scary or intimidating for some.

Ensure continuation of treatment/aftercare. Continuing care for individuals is an important aspect of recovery and clients should be offered recovery support. Safe Passage reported having minimal contact with clients after intake and few treatment providers offered aftercare services. Funding of recovery support coaches offering case management to clients also would be beneficial to support clients' long-term recovery.

Safe Passage is just one component of a larger continuum of services needed to reduce drug overdoses and promote client safety, recovery, and well-being. Client access to all components is necessary for individual components to fully succeed. Communities considering Safe Passage or similar programs should assess the extent to which treatment and aftercare programs are available.

Gather more information at intake. Safe Passage intake forms were designed to collect basic information on the type of opioid used, the date of last opioid use, the date of first substance use, and the first substance used. Safe Passage should modify the intake form to include more detailed questions on substance use to have data that reflects their clients. The initiative can know who is seeking help and for what drug(s) which over time, may show trends in drug use and availability in the community.

Measure initiative outcomes. Safe Passage officers and volunteers had minimal or no contact with clients after they entered treatment. Safe Passage should implement a more formalized follow-up process rather than relying on informal conversations or calls with clients. An aftercare/recovery specialist could assist with follow-up. In addition, the program should undergo a formal outcome evaluation to document long-term impact on client recovery and well-being.

In conclusion, Safe Passage represents a new model for police to help those suffering from substance use disorders which is of great interest to other jurisdictions across the country. While more research is needed, this initiative shows promise in connecting clients to treatment with the support of stakeholders, treatment providers, and police officers.

Section 1: Introduction

Police administrators across the country are recognizing a need to connect individuals in their communities with treatment and other services to better address the large social and economic burden of substance use disorders (SUD). As gatekeepers of the criminal justice system, police personnel play a vital role in preventing and intervening in the cycle of offending and advancement through the criminal justice system. Police frequently encounter substance-using individuals and their families in the community and often have repeated contact with individuals suffering from SUD.

In an emerging police program model, police departments serve as a point of contact for individuals who can walk in and request access to SUD treatment without fear of arrest. The Gloucester Police Department in Massachusetts was the first to implement this model with its ANGEL program in 2015. The model has since been adopted by more than 153 police departments in 28 states (Schiff, Drainoni, Bair-Merritt, Weinstein, & Rosenbloom, 2016). These initiatives vary somewhat from jurisdiction to jurisdiction, but all feature the option for individuals living in the community to voluntarily enter the police station and ask for placement into substance use disorder treatment (Reichert, in press).

Police departments have pre-arranged agreements with treatment providers to provide rapid entry into substance use disorder treatment. A designated police officer contacts a treatment provider who conducts a phone screening to determine eligibility. Program administrators develop their own eligibility criteria; some exclude those with outstanding arrest warrants or violent arrest histories. Transport to a treatment facility is provided.

These strategies have the potential to:

- Reduce crime.
- Reduce substance use.
- Avoid or limit movement of citizens into the criminal justice system.
- Improve police-community relations.
- Restore and save lives.
- Save taxpayer money. (Charlier, 2017)

Illinois Criminal Justice Information Authority (ICJIA) researchers conducted a process evaluation of the second program of this kind, Safe Passage, initiated in rural northwestern Illinois—in Lee and Whiteside counties—in fall 2015 based on the ANGEL program model. Major research questions of the evaluation included:

- How was the initiative developed and how does it operate?
- Who were the clients and what were their experiences with Safe Passage?
- What were client arrest outcomes?
- To what extent are police officers and treatment providers supportive of Safe Passage?

Researchers used a multi-method approach, which included examining administrative intake data and client criminal history records, and conducting a police staff survey, interviews with former clients, interviews with treatment providers, and a focus group with stakeholders. This report shares findings on this emerging police model.

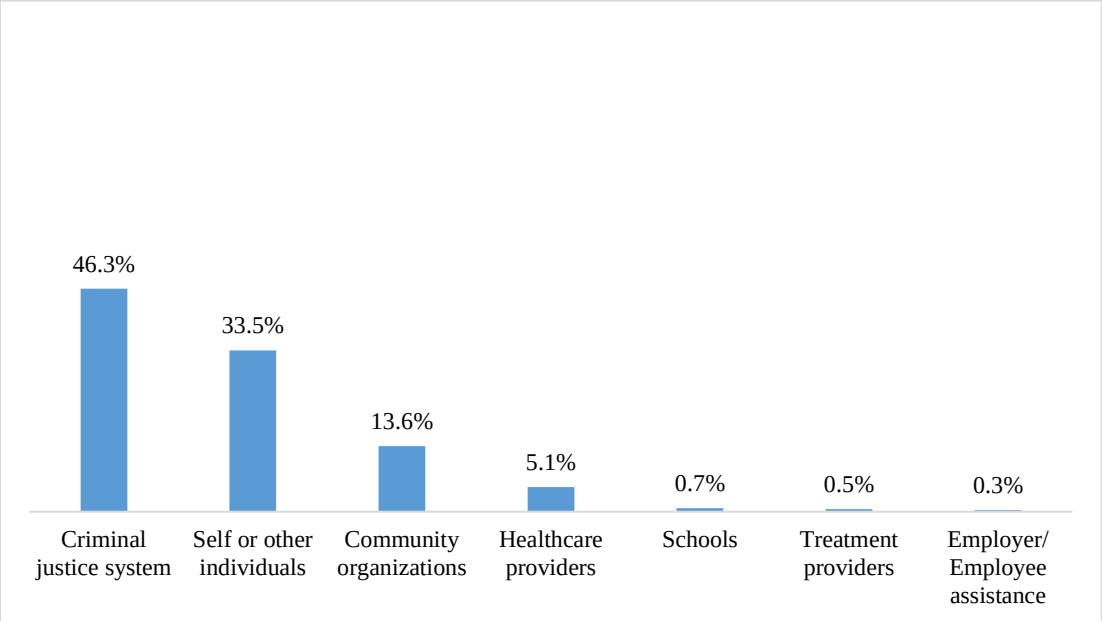
Section 2: Literature Review

The United States is facing an opioid crisis—about 90 Americans die each day from overdose, one every 15 minutes (Rudd, Seth, & Scholl, 2016). Annually, drug overdose deaths kill more people than car accidents and gun violence. About 10 percent of the 20 million Americans and 11 percent of the 1.1 million in U.S. jails and prisons with a substance use disorder receive the treatment they need (Gleicher, 2017). The Centers for Disease Control and Prevention estimates the economic burden from prescription drug misuse at over $78 billion per year of which criminal justice is a large portion. Many addicted to opioids or other drugs commit crimes to obtain drugs as a part of their substance use disorder. Police are frustrated with making multiple arrests of these individuals and jails and prisons should be the last resort as a treatment mechanism (Chandler, Fletcher, & Volkow, 2010). Law enforcement program models such as the one implemented in Safe Passage offer treatment without fear of arrest in an attempt to lessen the drug-related criminal justice "revolving door" while helping individuals overcome barriers to treatment.

Linkages to Treatment

According to the Substance Abuse and Mental Health Association (SAMHSA), individuals gain admission to treatment in a variety of ways (*Figure 1*). The majority of young adults who access publically funded substance abuse treatment are referred by criminal justice agencies. This can include civil commitment, court-ordered treatment, or diversion to treatment, as either an addition or alternative to disciplinary consequences for substance abuse offenders (Urbanoski & Wild, 2012).

Figure 1
Daily Admissions to Publicly-Funded Substance Use Treatment by Referral Source



Data source: SAMHSA, Behavioral health Statistics and Quality, Treatment Episode Data (TEDS), 2011.
Note: Young adults age 18 to 25, on average day.

Obstacles to Treatment

Individuals with substance use disorders face a range of obstacles and barriers that may prevent them from entering or gaining access to treatment, including personal and family issues, lack of insurance/Medicaid, and lack of understanding of treatment services. Individuals who are hesitant to enter treatment cite reasons such as not wanting their spouse to become aware of their disorder and being unable to afford leaving their family for treatment. Fear of treatment and negative prior treatment experiences also were cited as barriers to treatment (Appel, Ellison, Jansky, & Oldak, 2004).

Accessing treatment also involves navigating logistical obstacles. The requirement of possessing a personal ID is one such obstacle. Those with SUD often experience difficulty in obtaining proper identification. Another obstacle is the need to have proof of healthcare coverage through private insurance or Medicaid prior to receiving treatment. Finally, treatment facilities may lack sufficient capacity to provide treatment for everyone who seeks it. When an individual has to wait for a significant period of time to enter treatment, they are likely to not enter at all (Appel, et al., 2004).

Recognizing that increased police contact and arrests for those with SUD will not improve individual and community outcomes and that SUD is both a criminal justice and public health problem, police have implemented pre-arrest diversion initiatives (also referred to as deflection initiatives) (Charlier, 2015). Through these initiatives, police serve as a point of contact for those seeking treatment in their communities, offering immediate access, and reducing the magnitude of obstacles associated with treatment entry.

Section 3: Current Study

This evaluation of Safe Passage focused on Year 1 of the initiative and applied mixed methods to answer the following research questions:

- How was the initiative developed and how does it operate?
- Who were the clients and what were their experiences with Safe Passage?
- What were client arrest outcomes?
- To what extent are police officers and treatment providers supportive of Safe Passage?

All data collection components of the evaluation were approved by the ICJIA's Institutional Review Board.

Data Collection

Administrative data: Client intake forms. The Safe Passage Initiative client intake forms are completed by a police officer or sheriff during an in-person interview with the potential participant. The initiative's coordinator, the Dixon Police Chief, sent ICJIA researchers 83 scanned paper intake forms spanning from August 2015 to August 2016. The forms collected age, gender, education level, marital status, employment status, and if any prior criminal history. Data on race and ethnicity were not collected on these forms. Throughout this report, the authors refer to those participating in Safe Passage as "clients" to differentiate them from focus group, interview, or survey "participants."

Administrative data: Criminal History Record Information. For research purposes, ICJIA has access to the state's Criminal History Record Information (CHRI) System maintained by the Illinois State Police (ISP). Arresting agencies, state's attorneys' offices, circuit courts, and state and county correctional institutions are statutorily mandated to submit information for the purpose of creating an individual's cumulative history of such events. Criminal history record information of Safe Passage clients was electronically extracted from CHRI to obtain any prior arrest histories and records of arrests submitted post Safe Passage enrollment.

To search for potential criminal history records, Safe Passage clients were matched based on the first three letters of the last name, first three letters of the first name, and the date of birth, a conventional method for conducting name-based searches. A SQL query into the system returned unique state identification numbers of possible matches that researchers then manually examined to confirm accuracy. Safe Passage clients were matched to an arrest record and after confirmation of accuracy, the records were extracted, reviewed, and analyzed by an ICJIA researcher, excluding minor traffic violations and offenses that were less than a Class B misdemeanor, which is not statutorily mandated for reporting. Offense types and classes were coded into major categories based on statutory definitions. The CHRI data used in this report were extracted for analysis on May 24, 2017.

Focus group. The focus group had one session on November 1, 2016, and one session on December 6, 2016. Both sessions were held in a Dixon Police Department meeting room. One

ICJIA researcher was the moderator and one served as note taker. Both sessions were audio recorded. Participants were stakeholders of the Safe Passage Initiative; there were nine participants at the first session and seven at the second session. Stakeholders included representatives from the police department, sheriff's department, probation and court services, state's attorney's office, health department, local community groups, mental health and substance abuse providers, faith-based community, hospital, city council, National Alliance on Mental Illness, and volunteers. Throughout this report, these individuals are referred to as "stakeholders" or "focus group participants."

All focus group participants signed a consent form for their participation and consented to be audio-recorded. Questions focused on collaboration, support, impact, goals, success, challenges, and limitations. The objective was to gather opinions and perspectives on the Safe Passage Initiative to gain a better understanding of the characteristics and operations of the initiative. Researchers transcribed the audio recordings and analyzed and summarized the qualitative data by themes.

Client interviews. ICJIA researchers requested that a representative of the Safe Passage Initiative help recruit former clients for interviews. Safe Passage designated a volunteer who performs informal client follow-ups to contact clients and read a script asking for permission to share their contact information with the researchers. With permission, their contact information was provided to ICJIA researchers. Ultimately, Safe Passage provided researchers with the names and phone numbers of eight former Safe Passage participants. Researchers contacted them and were able to schedule five interviews which took place in person (n=3) or by phone (n=2). Out those interviewed, two were female and three were male. All were White adults and their ages ranged from 28 to 47 years old (mode was age 28).. All interview participants signed a consent form for their participation and consented to be audio-recorded. Questions focused on demographics, criminal justice involvement, substance use, prior treatment episodes, Safe Passage, and treatment experience. Researchers transcribed audio recordings and the transcriptions were summarized in this report.

Treatment provider interviews. Safe Passage provided researchers with contact information for its eight treatment providers. All were contacted and researchers conducted phone interviews with six providers. Treatment providers were located in northern and central Illinois and in Florida. Those in the sample had worked at their agencies for an average of 10 years and in the substance use disorder field for an average of 16 years. Four were licensed in their field as clinical professional counselor, certified counselor, a certified alcohol and drug abuse counselor, or a registered nurse. Their titles varied: executive director, president and chief executive officer, chief operations officer, regional nurse manager, and director of outreach. All interview participants signed a consent form for their participation and consented to be audio-recorded. Questions focused on their agencies and their work with and views of Safe Passage. Researchers transcribed audio recordings which were analyzed based on themes that emerged from the interview responses.

Police survey. Researchers provided an online survey with consent form to the Dixon Police Chief to share with police and sheriff department officers and staff involved in the Safe Passage Initiative. The sample size was 79 law enforcement staff or officers from the Dixon Police

Department, Lee County Sheriff's Office, Sterling Police Department, Rock Falls Police Department, and Whiteside County Sheriff's Office. Sixty-two percent of respondents were either a police officer or deputy, 20 percent were sergeants, and other respondents held titles including lieutenant, captain, command staff, chief, and sheriff. Respondents reported an average of 14 years of service in law enforcement and 75 percent had more than 20 years of experience. Survey questions focused on their views on and experiences with the initiative. The survey data were collected using an on-line platform. Researchers examined descriptive statistics on the survey data.

Study Limitations

All studies have limitations and this study is no exception. First, police diversion model programs are still relatively new. Little is known about their operations or efficacy and researchers had little from which to draw meaning or comparisons. Second, as a rural program, Safe Passage yielded a relatively small sample size. Researchers could not adequately draw inferences on the characteristics of typical clients within the small sample. Third, self-reported intake information collected from the focus groups, survey, and interviews was subject to each individual's recall, possibility of omission, and/or honesty.

Safe Passage Description

ICJIA researchers created a logic model for the Safe Passage Initiative *(Figure 2)*. The short-term goals are to increase the number of individuals in the community accessing treatment and to engage individuals in treatment services. The long-term goal is to increase the duration of desistance and misuse of illicit substances. Desistance, rather than abstinence, is a realistic goal, as 90 percent of those with substance use disorders relapse. A tertiary benefit, but not a goal of the initiative, is that it has the potential to improve police-community relations.

Initiative Development

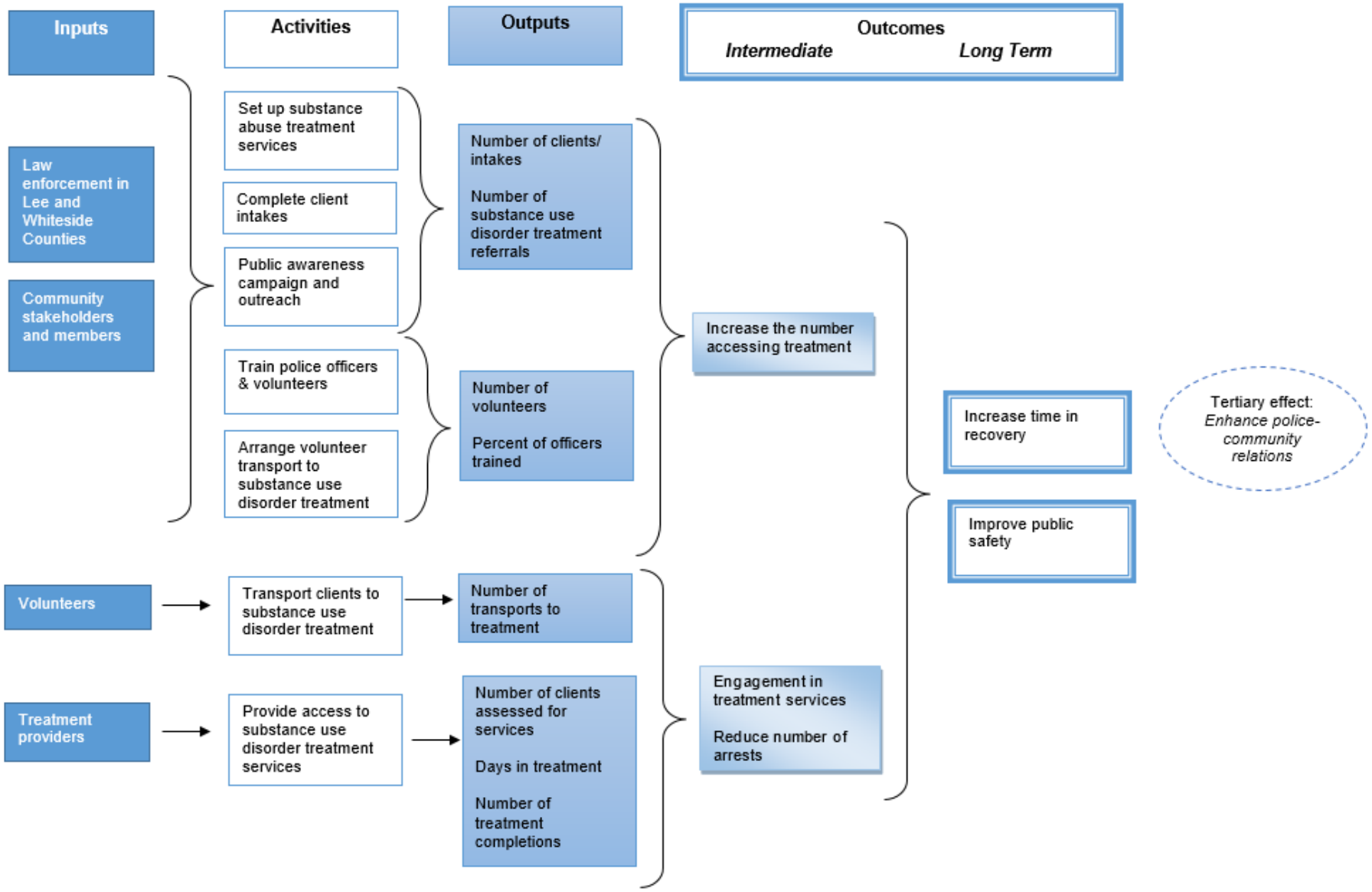
The Safe Passage Initiative was started after the city of Dixon experienced three heroin overdose deaths in three days in February 2015. A community member shared information about Gloucester's ANGEL Program with the Dixon Police Chief and the Safe Passage initiative serving Lee County was started in August 2015 after four months of planning and development. It later expanded to include neighboring Whiteside County and Whiteside County treatment providers. Although a part of Safe Passage, Whiteside County does its own intake process, has its own volunteers, and contacts the treatment centers.

To initially set up the initiative, the Dixon Police Department and Lee County Sheriff's Department completed the following.

- Identified treatment providers willing to work their clients.
- Trained officers on the program and substance abuse.
- Screened and trained volunteers to provide transportation for clients to treatment providers.
- Created intake forms to obtain basic information on clients.
- Developed policies and procedures including eligibility rules.
- Communicated and collaborated with community organizations and community members.

The Dixon Police Chief spent more than three months contacting treatment providers to engage and enroll agency directors in partnering to form the initiative. Stakeholders said treatment partners were more than willing to work with law enforcement agencies. Police officers received program training from the chief and training on addiction from a person with personal experience.

Figure 2
Safe Passage Logic Model



Program Operations

Clients can make an initial contact with Safe Passage through the substance abuse hotline, the program Facebook page, local emergency department, or talking to an officer involved with Safe Passage. Most clients present to the police department; however, several were transported directly from the emergency room to treatment after being medically cleared by a physician. However, all must present themselves in person at the police or sheriff's department in order to access treatment. Clients can go to the Dixon Police Department, Lee County Sheriff's Department (located in Dixon), Rock Falls Police Department, Sterling Police Department, or the Whiteside County Sheriff's Department (located in Morrison).

After an individual enters the station, an officer on duty will greet them and complete an intake form. Prior to transport to a treatment facility, clients must consent to a search of their person and personal belongings to ensure the safety of all involved pat them down to ensure a safe interaction. During intake, clients are able to turn over drugs or drug paraphernalia, although few do. The officer escorts the client to a community room or conference room at the station to complete an intake form. The officer then reviews the individual's criminal history record to determine eligibility for Safe Passage. Individuals with a violent history are ineligible. Officers will contact the state's attorney to negotiate quashing outstanding arrest warrants. As of November 2016 (when focus groups were conducted), all warrants on potential clients had been recalled and vacated by the state's attorney. When the client is on probation or parole, the initiative notifies their probation or parole officer.

After the intake form is complete, the police officer contacts one of nine treatment providers—located throughout the state and one in Florida—by phone to determine service availability and program appropriateness for the client. All treatment providers have agreed to offer quick access to services for Safe Passage clients. New clients participate in the initial call to answer questions that help determine the appropriate level of care. Once accepted into treatment, the officer contacts a volunteer who will transport the client by car to the treatment facility. Volunteers are reimbursed for travel expenses.

Volunteers with histories of violent or sex crimes are ineligible, those with prior drug offense histories and in recovery for at least a year may participate in transporting clients. Volunteers receive four hours of training by a therapist and are issued a Safe Passage ID badge. The volunteer protocol guide instructs them to be supportive, good listeners, but not to dig in to clients' pasts or drug use. As of November 2016 (when focus groups were conducted), Safe Passage had 20 volunteers.

Eight of the nine treatment providers are in Illinois (one in Florida) and most are a one- to two-hour drive from Dixon (*Map 1*). All clients obtained detoxification services and/or treatment. The initiative did not keep records on utilization of treatment providers.

Map 1
Illinois Safe Passage Treatment Providers

Of the six treatment providers interviewed:

- Three offered detoxification services.
- Two offered outpatient care.
- Four offered intensive outpatient services.
- Two offered partial hospitalization – a service through which clients spend most of their day in treatment, but are not require to stay overnight.
- Three offered inpatient/residential services.

Two treatment providers reported offering medication-assisted treatment (MAT) for opioid use disorder. MAT uses medication in conjunction with behavioral therapy. Medications, such as methadone or buprenorphine, can reduce cravings and symptoms associated with withdrawal from a substance by occupying receptors in the brain associated with using that drug. Another

drug, naltrexone (brand name Vivitrol®), blocks the pleasurable feeling of the drug. One treatment provider used naltrexone and one provided Suboxone (buprenorphine with naloxone).

A hotline was available to help clients find recovery support group meetings (e.g., AA, NA) or some other area of aftercare. A Safe Passage volunteer made attempts to follow up with clients by phone to discuss aftercare plans while they were still in treatment. Many clients could not be reached and were not provided traditional case management.

Challenges and Needs

Clients often languished on wait lists for treatment post-detox. This is problematic because individuals are at increased risk for overdose post-detox because their drug tolerance has been lowered. Treatment providers that relied on state-funded residential treatment facilities for services reported the wait lists were particular lengthy.

Training needs were identified for officers on substance use disorders and levels of care in treatment. Training for officers was provided by a person with lived experience (in recovery); however, a certified addiction specialist should provide training. Addiction specialists hold board certifications in addiction medicine and have the education and expertise to train on the complex topic of addiction (American Society of Addiction Medicine, n.d.).

According to treatment providers, when the Dixon Police Department has a potential Safe Passage client, the chief or one of his colleagues calls a treatment provider to ask if they have a "bed" available. In fact, that course of treatment may not be beneficial for all clients and there are assessments available to determine the appropriate level of treatment. Instead, officers should call the treatment provider indicating that the level of care needs to be determined for the client.

Stakeholders reported needing more volunteers, and particularly male volunteers, in order to match the volunteers' genders with those of their clients during the transport to services. Safe Passage Stakeholders also expressed the need for job placement and housing services, as there were no available "sober homes" or halfway homes in the area. Finally, the Safe Passage Initiative stakeholders expressed a desire for a full-time case manager and recovery coaches for aftercare support.

Safe Passage Clients

Demographics

A total sample of 83 people completed the Safe Passage Initiative intake process from August 18, 2015, through August 11, 2016; 12 of the 83 clients had re-entered the program after a previous intake. Based on intake form data, a majority of clients were single, unemployed men with a high school education. The average age was 33 years old with a median age of 31 (*Table 1*).

Table 1
Safe Passage Client Characteristics (N=83)

Demographics	Frequency	Percent
Gender		
Male	48	58%
Female	31	37%
Missing	4	5%
Total	83	100%
Education Level		
Some high school	21	25%
High school or GED	35	42%
Some college	22	27%
College graduate	3	4%
Missing	2	3%
Total	83	100%
Marital Status		
Single, never married	45	54%
Married	15	18%
Committed relationship	14	17%
Divorced	6	7%
Separated	3	4%
Total	83	100%
Employment Status		
Unemployed	55	66%
Part-time	11	13%
Full-time	13	16%
Missing	4	5%
Total	83	100%
Any Prior Criminal History		
Yes	71	85%
No	12	15%
Total	83	100%

Source: Safe Passage client intake forms

Substance use history. Safe Passage clients reported beginning drug use at an average age of 17, with a median age of 15 years old; and more than half of the clients reported cannabis as the drug first used. Eighty-one percent of clients reported using more than one substance when first using drugs. When asked to name the type of substance they used first, 70 percent reported cannabis, 10 percent reported opiate pain medication, 10 percent reported heroin, and 8 percent reported cocaine.

Safe Passage clients first used an opioid at an average age of 21 years old, with a median age of 19 years old. The majority of Safe Passage clients reported last using heroin prior to their intake (70 percent) and 16 percent reported prescription drug use prior to intake. Four percent used both heroin and a prescription opiate prior to intake. The majority of participants indicated drug use on the day before or the day of intake.

Most used heroin (n=73) and, of those, 69 percent used it intravenously (n=57). The 33 Safe Passage clients who reported how long they had been using heroin said had used for an average of 58 months (just under five years), with a median of 36 months (three years). Sixty percent of all clients reported heroin or other opioid use at least once a day; one client reported using an amphetamine twice daily and heavy daily alcohol use. A majority of the clients were smokers (67 percent, n=56).

Two Safe Passage clients turned over drugs (heroin, blood pressure medication) and three turned in paraphernalia (needles, spoons, syringes, lighter, scale, and cooker) upon entering the program.

Substance use disorder treatment history. Fifty-eight percent of Safe Passage clients reported receiving treatment (excluding detoxification) prior to Safe Passage enrollment (n=48). In addition, 52 clients reported undergoing detoxification at least once prior to program enrollment.(minimum once, maximum 10 times) Fifty-five percent of clients indicated they had previously tried but failed to get treatment for substance use (n=46) (*Table 2*).

Table 2
Safe Passage Clients Previous Substance Use Treatment and Support Services (n=75)

Type of Service	% Received
Recovery support after previous treatment	76%
Self-help program	52%
Recovery group participation	12%
Mental health treatment	10%
Detoxification only	8%

Source: Safe Passage client intake forms

Physical and Behavioral Health

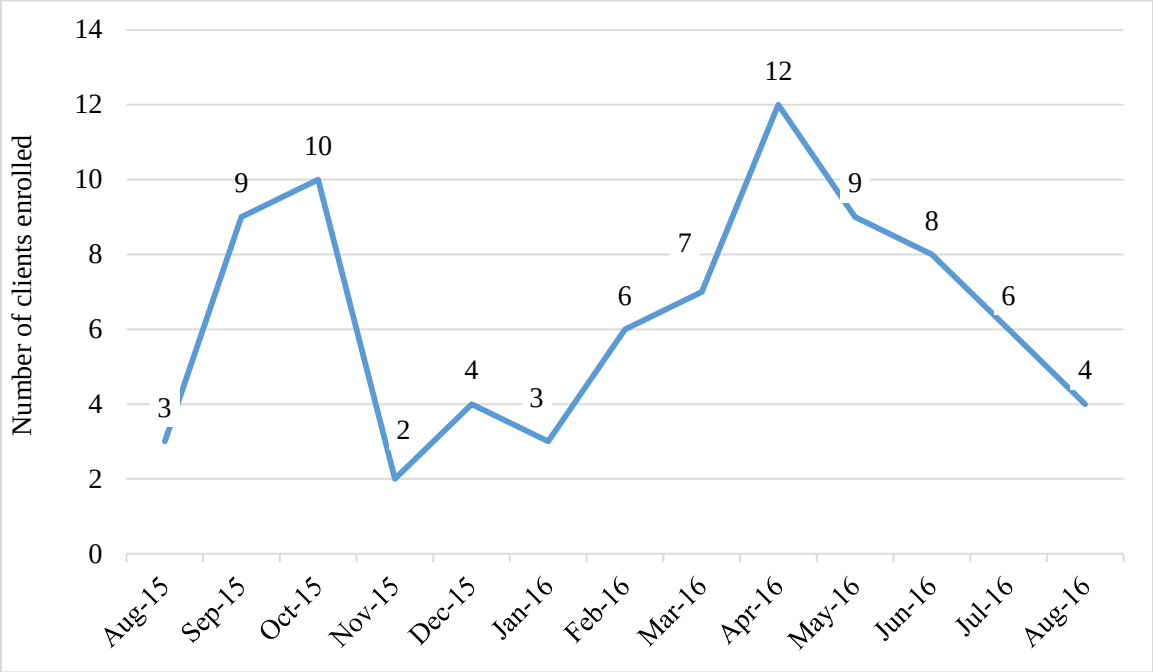
Most clients received Medicaid -funded treatment. The treatment providers used state Department of Human Services, Division of Alcohol and Substance Abuse (DASA) funds to cover treatment and the Whiteside County health department helped individuals enroll in Medicaid. One treatment partner provided free treatment at its Florida locations.

Intake forms showed in addition to substance use disorders, 40 percent reported having medical issues (60 percent, n=54), a few reported their specific issue such as high blood pressure (n=5), Hepatitis C (n=2), asthma (n=4), or non-specific heart issues (n=4) or other cardiovascular issues. Thirty-nine percent reported having an identified doctor or medical facility location that they use (n=32).

Forty-two percent indicated having a mental health disorder (n=36). Three individuals reported a diagnosis of bipolar disorder, and three reported a diagnosis of attention deficit hyperactivity disorder (ADHD). In addition, two reported a diagnosis on the autism spectrum. Most frequently, individuals reported taking the following medications: opiate narcotic medications (n=5); selective serotonin reuptake inhibitor (SSRI), an antidepressant and anti-anxiety medication (n=5); anti-epileptic medications for seizures and bipolar disorder (n=5); and high blood pressure medication (n=4). Other reported medications included benzodiazepines (psychoactive drugs), amphetamines (used for ADHD), GABA analogues (used for seizures and anxiety), anti-psychotics, and antihistamine and asthma medications.

Enrollment and referral to Safe Passage. On average, Safe Passage enrolled six clients per month. The month and year with the greatest number of enrollees was April 2016, and the lowest enrollment period was November 2015 (*Figure 3*). The Initiative began enrolling clients in August 2015. Researchers and police are unsure of the reason for spike in April 2016, but cited the possibility of increased program awareness, word of mouth, or other factors. Similar initiatives may expect variation in client intakes each month.

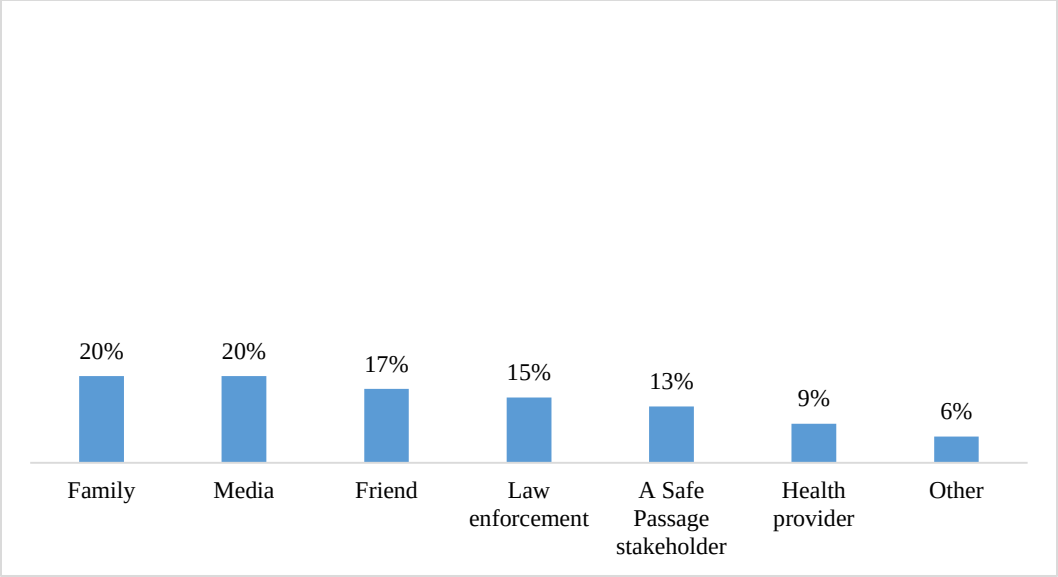
Figure 3
Monthly enrollment in Safe Passage Initiative August 2015-2016 (n=83)



Source: Safe Passage client intake forms
Note: Nine individuals were enrolled in Safe Passage more than once; however, second enrollments are not included in this analysis.

Referrals to Safe Passage. The client intake forms showed clients learned about the initiative in a variety of ways—many from a friend, but also from family members, law enforcement professionals, media, such as news, Facebook) and medical and social service providers (*Figure 4*).

Figure 4
Ways Clients Learned about Safe Passage (n=81)

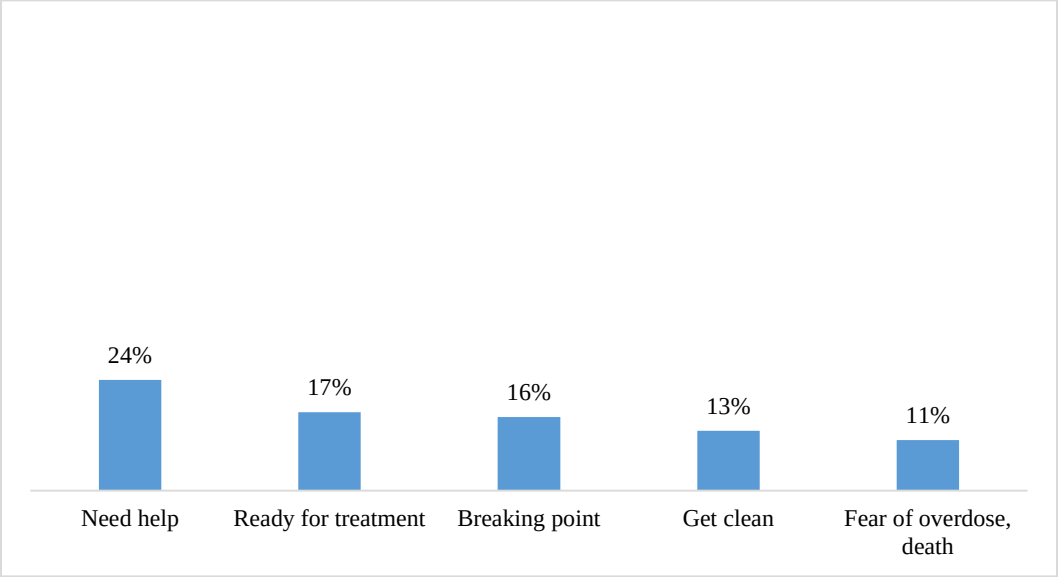


Source: Safe Passage client intake forms

Other referral methods. According to the stakeholders in the focus group, other referral methods were jail and drug court. The jail can identify a person in need of treatment through Safe Passage following release. A focus group participant shared a story about a man with a delivery of heroin charge, but he was clearly suffering from a heroin use disorder. After being in completing his time served in jail, Safe Passage arranged for his treatment upon release. At the time of the focus groups, he was in recovery and reported he was helping others and that he had saved three people's lives by reversing overdose with naloxone. In addition, the partnerships through Safe Passage have helped place drug court clients more quickly through Safe Passage instead of waiting 60 days in jail.

Safe Passage clients indicated the following reasons for engaging in Safe Passage on their intake forms (*Figure 5*). The main reason was to "get help."

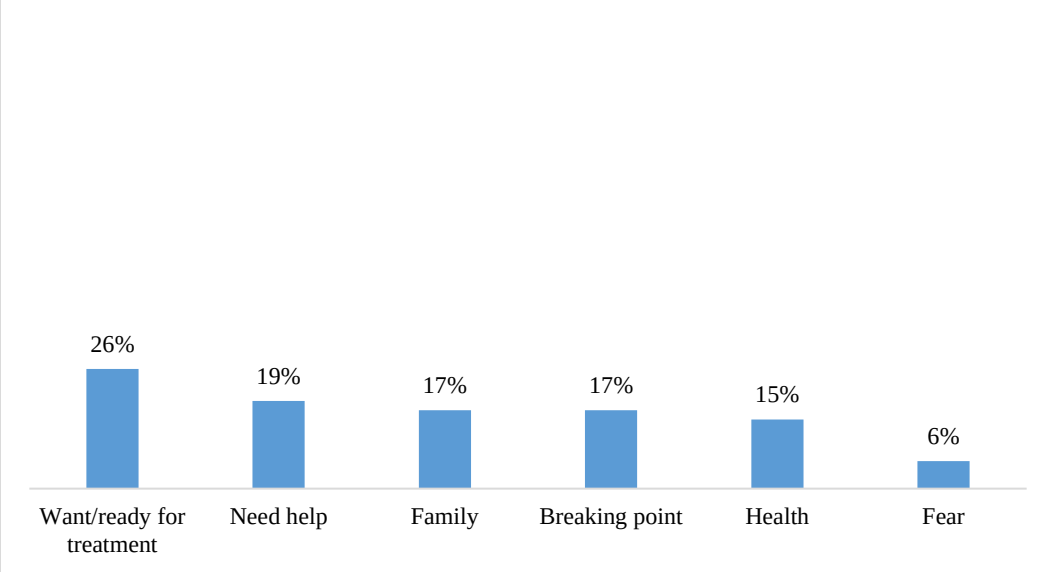
Figure 5
Reasons for Engaging in Safe Passage (n=83)



Data source: Safe Passage client intake forms

Motivations for treatment. Based on intake form information, the main reasons participants wrote they were ready for treatment were needing help obtaining treatment, reaching rock bottom/could not live the lifestyle anymore, and wanting to improve their health. Other reasons included pregnancy or being a parent, wanting to get clean for family, and fearing overdose or death (*Figure 6*).

Figure 6
Reasons Ready for Treatment through Safe Passage (n=78)



Source: ICJIA Safe Passage Intake Form database

According to the stakeholders in the focus group, clients have a high "level of readiness" because they have to ask for help at the police department. Two of the five clients interviewed went to Safe Passage to get help immediately. One client stated that he approached Safe Passage for two reasons—a friend got help through Safe Passage and he wanted treatment to fulfill obligations for visitation with his child. Although Safe Passage is a pre-arrest initiative, one interviewee explained that he was offered Safe Passage after his arrest as an alternative to jail.

Three treatment providers said client motivation levels vary by case. Two agencies mentioned Safe Passage clients seem very motivated in order to take the initiative to ask for treatment at the police department.

Criminal History

Self-reported criminal justice history. Police officers conducted warrant checks on potential clients upon intake. They were able to complete warrant checks on 89 percent of the clients, three of whom had warrants. Fifty-three percent of clients responded that they had been arrested for drugs, twice on average. Most officers noted no reasonable concerns that the potential client would harm the volunteer guide (94 percent).

Of the five clients interviewed, only one reported no prior crime involvement. Three had been charged with possession and three were charged for dealing. One individual reported being on probation for possessing illegal "pills," which resulted in the hospitalization of two friends.

Administrative Data: Arrests Prior To Intake

ISP's Criminal History Record Information System revealed criminal histories of 71 of 83 Safe Passage clients, suggesting that 12 clients had no previous criminal justice record.

***Lifetime arrest history*.** Of the clients with previous criminal justice involvement:

- 48% had at least one previous arrest for a violent/person crime.
- 73% had at least one previous arrest for a property crime.
- 61% had at least one previous arrest for a drug crime.
- 28% had at least one previous arrest for a DUI.

The records of 68 clients showed at least one previous misdemeanor arrest and 59 client records showed at least one previous felony arrest (*Table 3*).

Table 3
Safe Passage Client Criminal History

Offense Type Priors	Min.	Max.	Mean	Median	Mode
Property Crime	1	10	3.5	3.0	1.0
Violent Crime	1	11	2.6	2.0	1.0
Drug Crime	1	10	2.26	2.0	1.0
DUI	1	4	1.42	1.0	1.0
Misdemeanor	1	19	4.87	4.0	2.0
Felony	1	12	3.14	2.0	1.0

Data source: ICJIA analysis of CHRI data

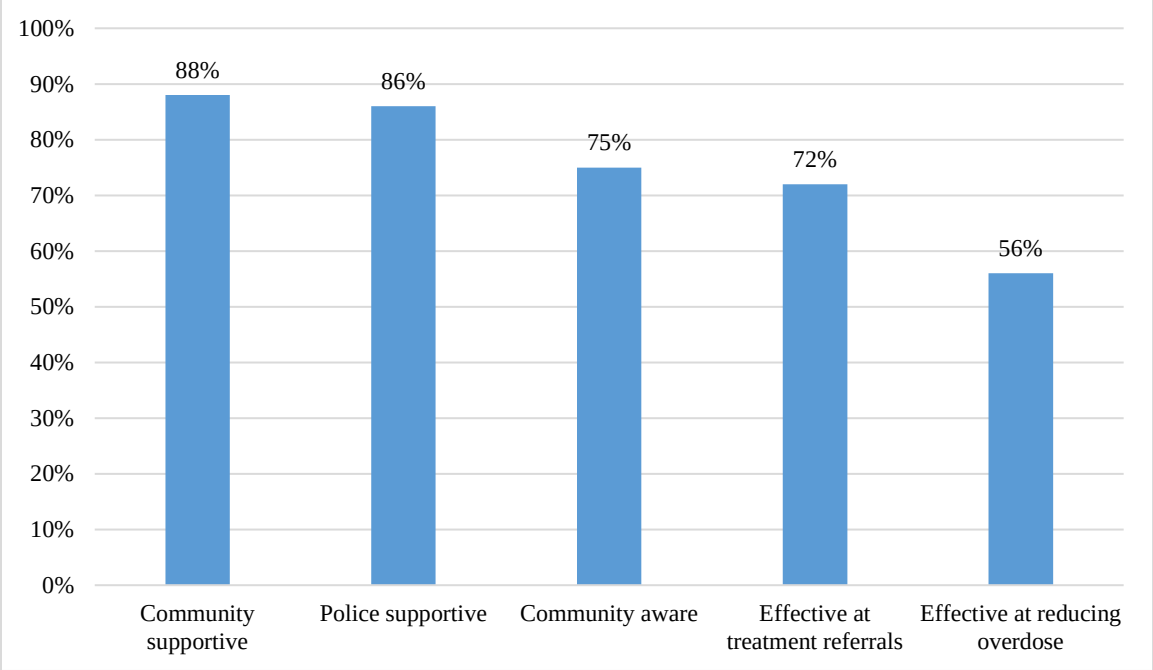
Safe Passage Feedback

Police Officer Feedback

In the survey of officers and staff in the police and sheriff departments involved in Safe Passage (n=79), 72 percent indicated there was either a *very big need* or an *extremely big need* for the Safe Passage initiative. Nearly all said the initiative should be expanded to other jurisdictions/counties (90 percent).

Support, awareness, and effectiveness of Safe Passage. A majority of law enforcement reported moderate or extreme program support, awareness, and effectiveness (*Figure 7).*

Figure 7
Law Enforcement Reporting Moderate or Extreme
Support, Awareness, and Effectiveness of Safe Passage (n=79)



Data source: ICJIA survey of police staff
Note: Respondents could indicate multiple responses

Safe Passage stakeholders in focus groups said police were "sick and tired of dealing with the same people multiple times every week" and that "Safe Passage offers officers a tool to really help people." Another stakeholder said,

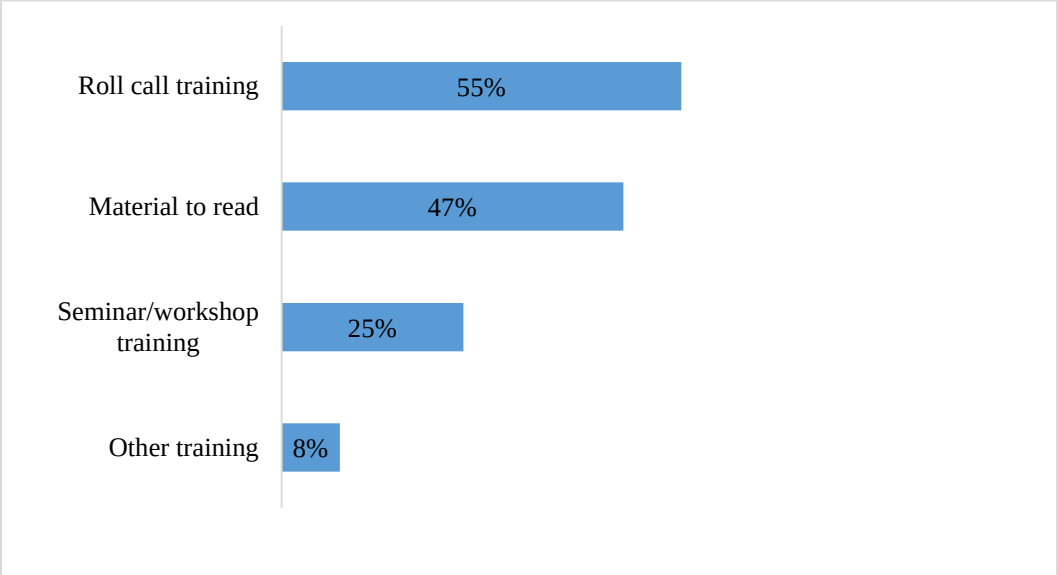
> Frequent flyers come in all the time for not only drug-related crimes but associated crimes and it wasn't stopping and the population was growing. We weren't helping people, and the cost was enormous as compared to if you take a couple of these people to treatment and try to get them off that addiction. And some of these other crimes, along with the drug crimes, start slowing down around our area.

The stakeholders explained that police officers are the ones meeting people face to face and showing this change in policing philosophy. Finally, one focus group participant believed that in part, Safe Passage had reduced the jail population, which lead to "huge cost savings."

***Police training*.** Nearly all survey respondents indicated that they received some type of training on the initiative (90 percent). Officers reported receiving roll call training (55 percent), written materials (47 percent), and seminar/workshop training (25 percent) (*Figure 8*). Additional trainings received included training by a person in recovery and policy review.

Safe Passage stakeholders reported an impactful moment during one at the training in which officers were asked to raise their hands if they had family members impacted by substance use disorder. A lot of hands went up and some had even lost friends or family to addiction. "That was powerful," said one officer.

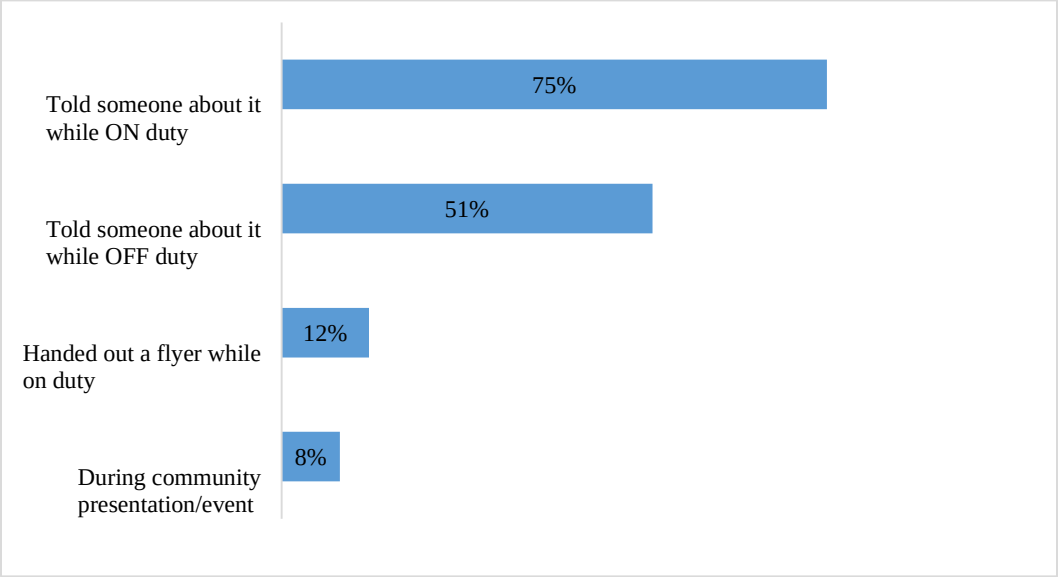
Figure 8
Police Training on Safe Passage (n=79)



Data source: ICJIA survey of police staff
Note: Respondents could indicate multiple responses

Ninety-one percent of survey respondents reported that they share information in some way with the community about the initiative. Respondents were asked how they shared information with the community on the Safe Passage Initiative (*Figure 9*).

Figure 9
Police Sharing Information about Safe Passage (n=79)



Data source: ICJIA survey of police staff
Note: Respondents could indicate multiple responses

When encountering a person suffering from a substance use disorder that is in possession of drugs, 20 percent responded they *often* or *always* make a referral to the Safe Passage initiative or treatment rather than make an arrest. Twenty-seven percent of respondents said they *rarely* or *never* make a referral. Statistically, no difference in responses were seen on referrals based on an officer's title or years employed in law enforcement.

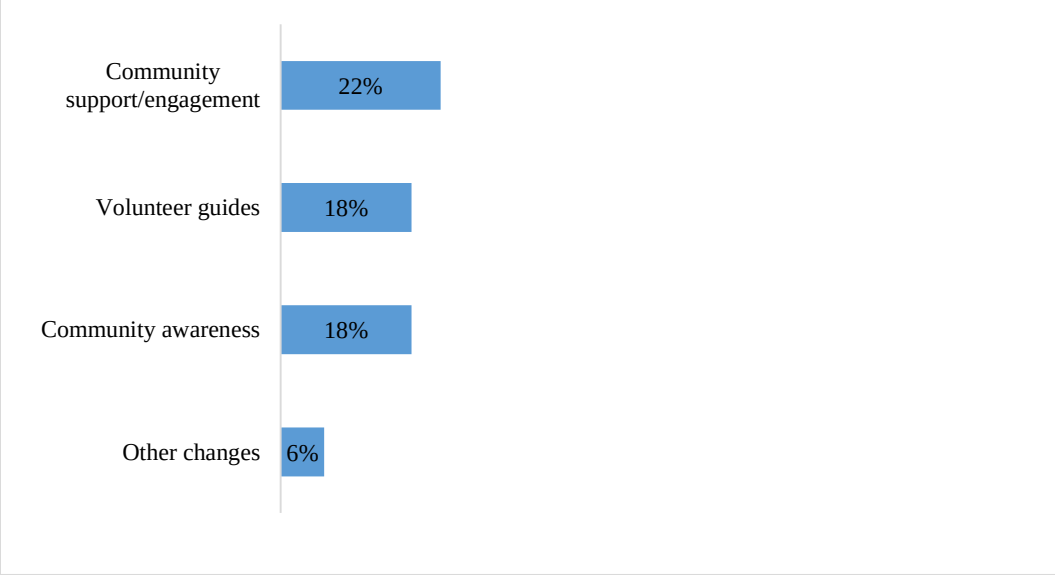
Police community relations. Initiatives like Safe Passage that involve the community has the potential to promote positive police-community relations (Mazerolle, Bennett, Davis, Sergeant, & Manning, 2013). One focus group participant said nothing can help and affect more families than treatment for substance use disorders and mental illness. One participant said he viewed Safe Passage as a major crime prevention strategy founded in community policing. Another focus group participant said some officers have seen the benefits and there was a "trickle-down effect" to other officers. One participant said, "A large majority of our deputies are very comfortable with this now and know it's the right direction to go."

Initiative alignment with police work. Law enforcement officers who participated in the focus groups emphasized that drug traffickers and suppliers were still being investigated and arrested and that they are still addressing many other crimes associated with substance use, including selling drugs, property crime, theft, rape, and other forms of violence. One participant said, "Some police departments will say [connecting individuals to treatment] is not the police officer's job; it's to arrest people. [They believe] that it is a 'soft on crime' approach. However, after the model is presented, people change their attitudes, and come on board."

Another participant explained, “It definitely isn’t a light-on-crime approach, just a different approach. I think as law enforcement our job is to create safer communities, and sending people to prison and putting them in a cycle of recidivism when they have mental illness or addiction doesn’t make a safer community.”

Recommendations. Nearly half of law enforcement officials who responded indicated that they would recommend changes to the initiative (47 percent). The changes included enhanced community support/engagement (22 percent) and improved community awareness (18 percent). Additional recommendations included better community outreach and education on the initiative, sending clients directly into treatment from detox, and recruiting additional volunteers (*Figure 10*).

Figure 10
Recommendations to Change Areas of Safe Passage (n=79)



Data source: ICJIA survey of police staff
Note: Respondents could indicate multiple responses

Treatment Provider Feedback

During the interviews with treatment providers, one shared that it was “amazing” that the police department was being proactive in helping their communities. One said being a part of Safe Passage was something they “could not pass up.” Two interviewees said that participating in Safe Passage is the right thing to do because it is important to give back to the community and help those wanting help. One agency representative stated that they agreed to participate in Safe Passage to save lives by getting people into treatment, keeping them out of the criminal justice system, and breaking the cycle of criminal justice involvement. One treatment provider stated that their agency’s primary goal was to care for those in need and the secondary goal was to “run a business and fill up beds.” As one treatment provider stated in the interview, “I think it’s a

great program. I think in theory and in practice it's helping a lot of people…As Safe Passage continues to grow and develop in the Dixon area."

This sentiment was supported by the Safe Passage stakeholders in the focus groups. They shared that treatment providers want to help people get directly into treatment, encourage law enforcement to view addiction as a disease, and increase access to funding for treatment.

During interviews, all of the treatment providers acknowledged that Safe Passage is a great at building relationships between treatment providers, police, and the community. In particular, each treatment provider noted the availability and responsiveness of the Dixon Police Chief and his colleagues regarding Safe Passage and potential clients. Each treatment provider saw Safe Passage as a great initiative, with hopes for expansion.

Two treatment providers discussed the difficulty that individuals face in trying to navigate the treatment process on their own. Three providers interviewed said that Safe Passage was able to help clients navigate through the system and assist them in finding the correct level of care.

Relationship with law enforcement. Providers interviewed said the Dixon Police Chief was the point of contact for all of the agencies. Two said they also have a contact with other police officers, but that the police chief was their main contact. All reported that the chief was always available when they needed him and that he seemed very knowledgeable about substance use disorders.

Treatment providers indicated that police officers involved in Safe Passage seemed to have a decent understanding of substance use disorders compared to other police officers they encountered. However, most treatment providers acknowledged that further education for police would be important, particularly as it relates to asking for services. For example, they said, some police officers call requesting an open bed for detox even when clients don't require detoxification services. Providers noted police may be confused or lack awareness on assessments used to determine appropriate levels of care.

Community Response

During the focus groups, stakeholders shared that the community was very supportive of Safe Passage; the response had been completely positive and there was a lot of pride in the community about the initiative. Stakeholders further said that family members had a lot of gratitude. One participant stated, "I've never encountered anyone, not one single person that ever said…'why are you doing that' or 'what a crazy program.'"

Collaboration. Focus group participants agreed that collaboration was key to Safe Passage's success. Stakeholders reported engaging Safe Harbor, a small community group that formed after several overdose deaths. This group is comprised of people in recovery or family members of people with substance use disorder. In addition, PRISM (Prevention, Recovery, and Information on Substance Abuse and Mental Health) of Lee County has been involved with Safe Passage from inception. PRISM works to implement prevention and treatment and to improve behavioral health in the community. As one stakeholder mentioned, "[It is] a huge benefit, for this

community, to have these people as part of a stakeholder program of the entire PRISM organization. Bringing in the community, community members, was a great idea. I don't think many other counties can say that they have [such community collaboration]." Both Safe Harbor and PRISM were involved in the planning of Safe Passage and attend Safe Passage meetings.

Cultural change. Safe Passage stakeholders said in the focus groups that many community stakeholders collaborated to start the initiative. Community partnership helped reduce the stigma of addiction not only for those battling substance use disorder, but for their family members. One participant called it a "culture change" that was "fast, enormous, and just unbelievable." They explained before they partnered for Safe Passage, "people were just dying" and "nobody was talking about it."

Community awareness. Stakeholders and officers reported that clients learned of Safe Passage by word of mouth, high school presentations, community forums, flyers, local newspapers, on the radio, and via social media, including the Safe Passage Facebook page. One stakeholder said, "There's been a lot of great coverage in the press of all these efforts." One stakeholder stated, "From the community perspective, I think that [Safe Passage] changes perceptions of law enforcement tremendously…people that didn't trust law enforcement before now do."

Client Feedback

All five interviewed clients went through intake at the Dixon Police Department. Three stated that the process was simple and straightforward. Two struggled during the intake process – one because he or she did not fully trust law enforcement and the other because of the physical effects of withdrawal. The interviewees all stated that they felt nervous, scared, and hesitant at first to approach the police for help.

All clients interviewed had positive things to say about Safe Passage. One client said, "If it wasn't for them, I'd probably be dead and overdosed." Another client said about Safe Passage, "Amazing; I'm grateful. I would not be sitting here right now if it was not available in my area." Another client reported the police were "very supportive," that they were made to feel comfortable, and they believed the officers truly cared.

All five interviewees would support statewide expansion of the initiative. Two stated that Safe Passage should be more heavily promoted. One individual said every person with an alcohol and substance abuse problem should know about the initiative, so that if they wanted to quit, they would know how to access help. All five clients said they have recommended or would recommend Safe Passage to others.

Section 4: Implications for Policy and Practice

Safe Passage represents a new model and role for police as they set out to help those suffering from substance use disorders. It appears Safe Passage had a champion in the local police chief who was integral in making the program a part of the police culture. In addition, Safe Passage engaged a broad array of community stakeholders in the development and operation of the initiative. This evaluation found much support for the initiative from clients, community stakeholders, law enforcement personnel, and treatment providers. The program meets needs of those with SUDs in rural areas where treatment is often otherwise inaccessible. While more research is needed, this initiative shows promise.

As police deflection initiatives expand, treatment capacity will need to be considered. Every treatment provider acknowledged the scarcity of treatment resources across the state as the biggest barrier to treatment. In addition, a majority of Safe Passage clients paid for treatment with Medicaid. At this time the federal government is still deciding the fate of, and extent of, federal Medicaid coverage for substance use treatment disorders. Reductions in coverage could hinder the police department's ability to place individuals into treatment. Finally, treatment provider services vary in quality and not all are evidence-based. Research is needed on treatment quality to ensure clients receive the best treatment available.

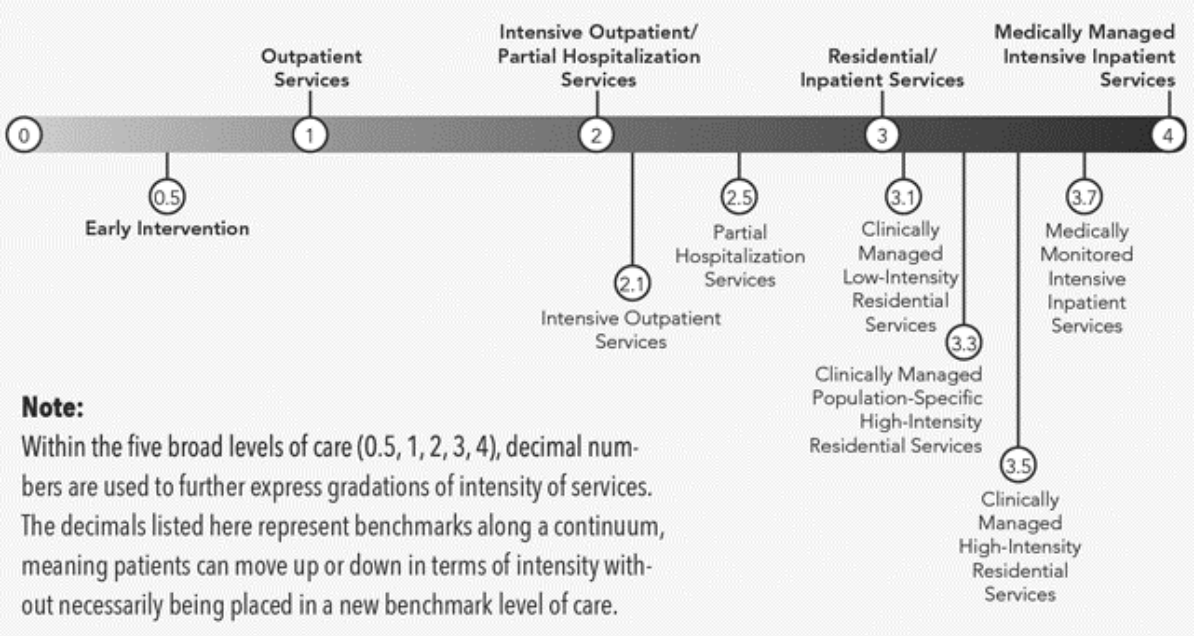
Implications for Initiative Operations

Engage a service coordinator. Stakeholders noted the need for case management services that begin with client needs assessment. Two treatment providers said trained clinicians assess clients to determine the proper level of care, but three did not specify who completes these assessments. One treatment provider said that an uncertified police officer makes the assessment. A well-trained civilian coordinator also can follow up with clients, rather than rely on volunteers whose follow-up is sporadic and who are less qualified for assisting during and after treatment. Volunteers may have experience within the substance use disorder field but should not be the ones to assess the appropriate level of care and follow up with clients.

Enhance police officer training. Treatment providers reported a need for enhanced police training on substance use disorders and levels of care. Training should be offered by a certified addiction specialist. Police frequently encounter people struggling with substance use disorders and related issues. Police often interact with these individuals in a life-saving capacity in cases of overdose as well as in repeated contact for illegal activity (Branson, 2016). Periodic training can help address police capacity to engage or help individuals who are under the influence, connect individuals to treatment, and ultimately help to reduce the stigma associated with substance use disorders and increase access to appropriate treatment (Branson, 2016). Additionally, education regarding the psychological and physiological nature of substance use disorders can help police understand their role in intervening to be more effective in helping reduce recidivism and increase public safety (Branson, 2016). Rutgers Center of Alcohol Studies developed the Certificate for Advanced Police Training on Addiction Interventions (CAPTAIN) Program, offering free training and train-the-trainer services for police in New Jersey, New York, and Pennsylvania (Rutgers Center for Alcohol Studies, n.d.).

According to some treatment providers, there were police officers who asked specifically for detox for Safe Passage clients; however, it is incorrect to assume that all with substance use disorders need detox and inpatient care. In fact, that course of treatment may not be beneficial for all clients and there are assessments available to determine the appropriate level of treatment. The American Society of Addiction Medicine (ASAM) developed a system and criteria to determine the appropriate level of care (*Figure 11*). Three treatment providers interviewed for this study mentioned using ASAM criteria. One specified that a trained clinician performs a biopsychosocial assessment to ultimately find the proper level of care, which again, may not include detox. In fact, for opioid use disorders there are medications that can be prescribed during treatment that do not require detox. Instead, officers should call the treatment provider indicating that the level of care needs to be determined for the client.

Figure 11
Continuum of Care for Substance Use Disorders



Source: American Society of Addiction Medicine (ASAM)

Ensure the public is aware that Safe Passage serves individuals with any substance use disorder. Although opioid deaths in the small city of Dixon was the catalyst for Safe Passage, the initiative is equipped to help individuals suffering from any type of substance use disorder. In fact, two of the five clients interviewed received treatment for marijuana and alcohol use disorders through Safe Passage. Further, the intake forms used for Safe Passage only ask for information on opioids used, thereby the initiative does not have a complete understanding of its clients substance used and/or misuse.

Enhance community awareness. The majority of interviewed treatment providers and some surveyed police officers stated that there was a lack of awareness about this initiative. Fifteen percent of clients stated on their Safe Passage intake form that they learned of the initiative

through the media. Local media reported information on Safe Passage, but expanding community awareness could help spread the word to more people seeking help. Similar initiatives in the United States have websites to help promote their programs.[1] While it may be intimidating for an individual to walk into a police station to seek help, a website could offer an alternate, anonymous way to ask questions and potentially get help.

Implications Regarding Treatment

Ensure continuation of treatment/aftercare. Continued care for individuals is vital to recovery. Clients who don't receive treatment immediately following detox, are at greater risk relapse, overdose, and death due to a lowered drug tolerance. Some Safe Passage treatment providers offer aftercare programs to connect their clients to other agencies for continued care. Recovery support coaches would be beneficial to clients' long-term recovery.

Safe Passage is just one component of a larger continuum of services needed to reduce drug overdoses and promote client safety, recovery, and well-being. Communities considering a program like Safe Passage should assess the extent to which all components, including treatment and aftercare, exist.

Implications for Future Research

Gather more information at intake. Safe Passage intake forms collect limited opioid-specific information, including type of opioid used, the date of last opioid use, the date of first substance use, and the first substance used. This inherently limits individuals' answers and may result in inaccurate identification of primary substance(s) of use and other major drug problems in the Dixon area.

Safe Passage should modify the intake form to include more detailed questions on substance use in order to get a better understanding of major drug problems and potential polysubstance use. The initiative will know who is seeking help and for what drug(s) which over time, may show trends in drug use and availability in the community.

Measure initiative outcomes. To better measure outcomes, Safe Passage should implement a more formalized follow-up process rather than having informal conversations or calls with clients. Outcomes of Safe Passage clients compared to a control group also should be measured. Relevant outcomes include, but are not limited to, substance use disorder and treatment outcomes, substance use desistance, changes in attitudes and behaviors (pre- and post-tests), employment outcomes, physical and mental health outcomes, and criminal justice outcomes. ICJIA researchers are conducting a Safe Passage outcome evaluation that will examine many of those areas.

[1] See Michigan's Help Not Handcuffs website at www.familiesagainstnarcotics.org/helpnothandcuffs

References

American Society of Addiction Medicine. (n.d.) *What is an addiction specialist*? Retrieved from https://www.asam.org/resources/public-resources/what-is-an-addiction-specialist

Appel, P. W., Ellison, A. A., Jansky, H. K., & Oldak, R. (2004). Barriers to enrollment in drug abuse treatment and suggestions for reducing them: Opinions of drug injecting street outreach clients and other system Stakeholders. *The American Journal of Drug and Alcohol Abuse*, *30*(1), 129–153. doi:10.1081/ada-120029870

Branson, K. (December 2016). Training police to deal with addiction. *Rutgers Today.* Retrieved from http://news.rutgers.edu/news/training-police-deal-addiction/20161204

Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/

Centers for Disease Control and Prevention. (2012). CDC grand rounds: Prescription drug overdoses – a U.S. epidemic. *Morbidity and Mortality Weekly Report*, 61, 10-13.

Chandler, R. K., Fletcher, B. W., & Volkow, N. D. (2010). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association, 301*(2), 183-190.

Charlier, J. (2015). Want to reduce drugs in your community? You might want to deflect instead of arrest. *The Police Chief,* 30-31

Charlier, J. (2017, January 27). *A public health approach to better public safety*. [Powerpoint presentation].

Gleicher, L. (2017). *Reducing Substance use and related offending: Evidence-Informed practices in the criminal justice system*. Chicago, IL: Illinois Criminal Justice Information Authority, Center for Justice Research and Evaluation.

Guilfoil, J. (2015). *P.A.A.R.I. - police assisted addiction and recovery initiative*. Retrieved from http://jgpr.net/2015/06/16/introducing-the-police-assisted-addiction-and-recovery-initiative-non-profit-organization-to-help-gloucester-and-other-police-departments-battle-heroin-addiction/

Mazerolle, L., Bennett, S., Davis, J., Sargeant, E., & Manning, M. (2013). Procedural justice and police legitimacy: A systematic review of the research evidence. *Policing: An International Journal of Police Strategies & Management*, *36*(3), 245–274. doi:10.1108/pijpsm.2013.18136caa.004

Mental and substance use disorders. (2015). Retrieved from

http://www.samhsa.gov/disorders/substance-use

Police-Assisted Addiction and Recovery Initiative. (2016). *About us.* Newton, MA. Retrieved from http://paariusa.org/

Police Executive Research Forum. (2016). Building successful partnerships between law enforcement and public health agencies to address opioid use. *COPS Office Emerging Issues Forums*. Washington, DC: Office of Community Oriented Policing Services.

Reichert, J. (in press). *Fighting the opioid crisis through substance use disorder treatment: A study of a police program model in Illinois*. Chicago, IL: Illinois Criminal Justice Information Authority, Center for Justice Research and Evaluation.

Reichert, J., & Gleicher, L. (2017). *Rethinking law enforcement's role on drugs: Community drug intervention and diversion efforts*. Chicago, IL: Illinois Criminal Justice Information Authority, Center for Justice Research and Evaluation.

Rudd, R. A., Seth, P., David, F., & Scholl, L. (2016). Increases in drug and opioid-involved overdose deaths—United States, 2010–2015. *Morbidity and Mortality Weekly Report*,65

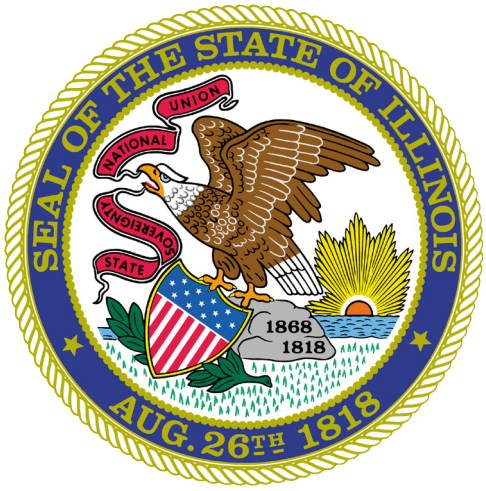
Rutgers Center of Alcohol Studies. (October 2016). *Rutgers announces free trainings for police about heroin, substance abuse and community policing.* Camden, NJ. Author. Retrieved from http://greenagel.com/rutgers-announces-free-trainings-for-police-on-heroin-substance-abuse-and-community-policing/

Schiff, D. M., Drainoni, M. L., Bair-Merritt, M., Weinstein, Z., & Rosenbloom, D. (2016). A police-led addiction treatment referral program in Massachusetts. *New England Journal of Medicine*, 375(25), 2502-2503.

Substance abuse/use. (2014). Retrieved from https://www.aids.gov/hiv-aidsbasics/prevention/reduce-your-risk/substance-abuse-use/

Center for Substance Abuse Treatment. (1999). *Enhancing motivation for change in substance abuse treatment. Treatment improvement protocol (TIP) series, No. 35*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2014). *The CBHSQ Report: A Day in the Life of Young Adults: Substance Use Facts.* Rockville, MD



Illinois Criminal Justice Information Authority
300 W. Adams Street, Suite 200
Chicago, Illinois 60606
Phone: 312.793.8550
Fax: 312.793.8422
TDD: 312.793.4170
www.icjia.state.il.us