VERA INSTITUTE OF JUSTICE

SUBSTANCE USE AND MENTAL HEALTH PROGRAM

First Do No Harm: Advancing Public Health in Policing Practices

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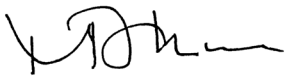
FROM THE PRESIDENT

First Do No Harm addresses the disconnect between law enforcement and public health systems, which has resulted in an ineffective default response of *arrest, incarcerate, and repeat* for some of our society's most vulnerable members—people living in poverty, using drugs, or living with mental illness.

The now well-documented and contemporaneous failures of the war on drugs and the movement to deinstitutionalize people with serious mental illness and intellectual disabilities illuminate the need for a cohesive response among system actors to society's ills. As you read this report, it will be clear to you that the money and resources spent rooting out and arresting people suffering from illness and addiction are far better reserved for finding alternatives that connect them to treatment and care. Otherwise, the burden is placed on law enforcement officers to provide a means of relief or otherwise send sick and impoverished people to overcrowded cells and through the wringer of the criminal justice system.

Recent national health care reform and bipartisan calls for criminal justice reform present an opportunity to course correct. Our public services must better align themselves to address the health disparities that arise from poverty and the lack of proper treatment and care. In the case of Gloucester, Massachusetts—which had seen an uptick in heroin-related deaths—the police chief has offered the city's precincts as sanctuary to people with drug addictions where they can be directly connected to treatment without fear of arrest or incarceration. Gloucester is surely a model for jurisdictions large and small elsewhere struggling with overburdened courts and jails and stubbornly high rates of recidivism.

With this report, we encourage law enforcement policymakers and practitioners to embrace the first principle of medicine—*primum non nocere* (first do no harm). In collaboration with public health counterparts, police can enhance both public safety and community health by helping to ensure that the people they encounter who need care are connected to it, not arrested for it.



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Foreword

Millions of medically vulnerable and socially marginalized people cycle through the criminal justice system each year because of serious structural problems entrenched in American society. The absence of a coherent and effective social safety net means that individuals lack access to health care, mental health care, social services, and housing options in their communities. In cities and communities across the nation, police act as reluctant social workers without the benefit of training and treatment providers of last resort for people with chronic, unmet health and social service needs. They must assume these roles because of laws and policies that have criminalized quality-of-life offenses and minor drug-related behaviors, with the greatest burden falling upon the poor and communities of color.

Unfortunately, the cultural divide and lack of cooperation among law enforcement, public health agencies, and harm reduction advocates amplify and sustain these problems.

As a former police chief and currently a chief deputy sheriff with more than 32 years' experience in law enforcement and the former executive director of one of New York City's first syringe-exchange programs and current executive director of the Harm Reduction Coalition for more than 20 years, we recognize the need for joint leadership, a shared vision, and mutual trust among police and community health systems. It is imperative for improving how local governments address vexing health and social problems such as drug use, mental illness, sex work, and poverty. We must work together in strengthening our partnerships so that we may improve and sustain the health and safety of our communities.

Jim Pugel
Chief Deputy Sheriff
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Introduction

Many of the issues that both public health and law enforcement agencies address in the communities they serve are rooted in health inequities, violence, trauma, racism, and poverty. As a result of the shortcomings of underresourced public health and social service systems and a longstanding lack of cooperation between law enforcement and community health agencies, millions of medically vulnerable and socially marginalized people are caught up in the criminal justice system each year. Minor offenses—such as drug possession, prostitution, public intoxication, loitering, and trespassing—frequently become grounds for arrest, incarceration, and criminal records.

The failed promises of the deinstitutionalization movement—in which the primary locus of psychiatric treatment shifted from long-term care in state hospitals to community-based settings without adequate public funding—have led to a chronic shortage of outpatient mental health services, income assistance, and housing and employment support that many people with chronic psychiatric disabilities need to live successfully in their communities.[1] As a result—and against the backdrop of the largest expansion of the criminal justice system in U.S. history—police officers have found themselves routinely serving as de-facto street-corner psychiatrists and frontline mental health workers whenever a family cannot manage a loved one who is suffering an acute episode of mental illness or a person with untreated psychiatric needs behaves erratically or menacingly in public.[2] Police also frequently encounter people who are homeless or marginally housed during patrol and may be involved in what are commonly called quality-of-life crimes—e.g., loitering, panhandling, and public intoxication. For instance, in Los Angeles County in 2013, homeless people accounted for 14 percent of all arrests, and the police spent more than three-quarters of the $100 million that the county allocated to combat homelessness that year.[3]

Against the backdrop of the largest expansion of the criminal justice system in U.S. history, police officers have found themselves routinely serving as de-facto street-corner psychiatrists and frontline mental health workers.

Concurrently, punitive sentencing laws, such as mandatory minimums, and policing practices, such as sting operations and drug sweeps, that arose under the auspices of the drug war have proven ineffective in reducing the prevalence of drug use or curbing the sale or manufacture of illegal drugs.[4] Instead, these tactics have generated large numbers of arrests and incarcerations for mostly minor drug-related crimes, backlogging courts, overcrowding correctional facilities, and taxing public resources. A 2005 survey, conducted by the National Association of Chiefs of Police showed that 82 percent of police chiefs and sheriffs said that the national war on drugs has been unsuccessful in reducing drug use.[5] A 2014 poll found that two-thirds of Americans believe that government should focus on providing people who use heroin and cocaine with access to treatment rather than prosecuting them.[6] In 2013, police in the United States made more than 11.3 million arrests, of which the greatest num-

ber were for drug-related crimes. Of all drug-related arrests, 83 percent were for possession of a controlled substance.[7] Moreover, aggressive drug war policing tactics are waged disproportionately against racial and ethnic minorities residing in urban environments. Black and Latino people residing in urban, low-income neighborhoods are far more likely to be stopped, searched, arrested, and jailed for drug offenses than white people, despite comparable prevalence of drug use and sales.[8]

The fear of arrest and exposure to incarceration can promote poor health practices that lead to the spread of infectious disease within a community.

These enforcement practices detrimentally affect important social determinants of health by obstructing social and economic mobility among residents of disadvantaged communities, as arrest and criminal records can hamper educational and employment prospects for a lifetime.[9] Moreover, the fear of arrest and exposure to incarceration can promote poor health practices that lead to the spread of infectious disease within a community and the increased risk of fatal overdose among people who inject drugs.

Through the adoption of harm reduction and health promotion practices—and in light of reforms in both the criminal justice system and national health care—community health providers and law enforcement agencies have new opportunities to work together to promote access to health services for marginalized populations and ameliorate the harms associated with needless cycles of arrest and incarceration.

In contrast to abstinence-based interventions, harm reduction is a set of practical strategies that aims to minimize the negative impacts of drug use and other high-risk behaviors, even when people are not ready or able to give up these behaviors. Harm reduction principles were initially developed to reduce the spread of HIV, particularly in communities with many injection drug users. Health promotion, as defined by the World Health Organization (WHO), is "the process of enabling people to increase control over, and to improve, their health." Successful health promotion initiatives aim to empower individuals in accessing healthcare, improve community capacity and collective efficacy, and act as social and environmental interventions."[10]

This report focuses on how police can integrate harm reduction and health promotion into their work, and the ways in which police and community health providers can partner to strengthen and expand diversion programs, keeping people who are more in need of health and social services than punishment out of the justice system. While policing practices have a large impact on the health of communities in general, they disparately affect particularly marginalized groups, including people engaged in sex work or injection drug use, homeless individuals, and people with chronic psychiatric disabilities. This report describes interagency strategies to reduce unnecessary arrests and incarceration and promote the health of people within these groups.

Background

Because of deficiencies in community mental health systems, police are routinely called to respond to situations where a person is experiencing a psychiatric crisis.[11] Studies estimate that seven to 10 percent of all police interactions involve people with a mental illness, and officers working in larger police departments report an average of six monthly encounters involving a person in a state of psychiatric distress.[12] Police themselves are emotionally affected by these growing interactions and often report inadequate training, deficient resources, frustration in accessing services, and conflicted feelings about their role as de-facto mental health workers.[13]

Without the resources police officers need, such as specialized training and alternative diversion options, these mental health emergencies can quickly escalate into violence and result in serious physical injury or death to individuals involved, including bystanders or police officers themselves. Though police agencies are not required to collect data or report on injuries or fatalities occurring during psychiatric emergencies, the Maine Attorney General's Office reported that, from 2000 to 2012, 42 percent of people shot by police had a mental health diagnosis.[14] Anecdotal reports from across the country suggest an equivalent national figure.[15] According to an analysis by the *Washington Post*, 124 people with mental illness have been shot and killed by police in the United States during the first six months of 2015.[16] Many of these tragedies have prompted civil lawsuits and federal investigations into the hiring practices, training, and culture of local police departments.[17]

In non-emergency situations, police officers report being more likely to arrest someone who displays signs of mental illness for petty offenses if they believe that jail is the only option to provide the person with access to food, a place to sleep, and basic health services. This is known as "mercy booking" and, despite good intentions, it is a driver of unnecessary jail incarceration among medically vulnerable communities.[18] Police also regularly transport people displaying signs of psychosis or disorientation to emergency rooms, even if they may not require urgent intervention and would be better served by an outpatient consultation. These tactics are symptomatic of the lack of options or training available to police officers.[19]

Moreover, law enforcement can undermine the positive effects of existing public health interventions that deliver vital services to people engaged in drug use or sex work and promote the health of communities overall. For example, in several U.S. cities, law enforcement and prosecutors use a person's possession of condoms as evidence to file prostitution charges. This practice makes many sex workers reluctant to carry condoms, thus increasing their risk of HIV and other sexually transmitted infections as well as unwanted pregnancies.[20] Drug laws and policies direct police officers to search and arrest people suspected of possessing or using small amounts of drugs and paraphernalia or partaking in minor drug transactions. While such measures are often meant

to reduce and eliminate these behaviors, research has shown that the fear of criminalization serves only to drive many people engaged in drug use or sex work further underground, decreasing their access to treatment and health care services, and increasing their risk of acquiring or transmitting infectious diseases in their social networks and communities.[21]

Injection drug users (IDUs) are one of the groups at greatest risk of contracting HIV, Hepatitis B and C, and other communicable diseases.[22] The Centers for Disease Control (CDC) estimate that about one-third of AIDS-related deaths can be attributed to injection drug use. Recent surveys indicate that about one-third of active, young IDUs (ages 18 to 30) and approximately 70 to 90 percent of older and former IDUs have the Hepatitis C virus (HCV).[23] Harm reduction services, such as syringe exchange programs (SEPs, also known as needle exchange programs), are highly effective in educating people about available treatment and behaviors that prevent infectious disease, providing access and referrals to services, and reducing other negative consequences associated with chronic drug use.[24] SEPs also connect people to drug counseling, evidence-based addiction treatment—including opiate substitution treatments (OST) such as methadone and buprenorphine—and other social services that effectively treat addiction and link individuals to employment and housing assistance.

The fear of arrest among drug users also increases the risk of overdose—the leading cause of injury-related death in the United States.[25] A recent study using New York City mortality data from 1990 to 1999 found accidental drug overdose was significantly higher in police precincts with higher misdemeanor arrest rates. The study's authors suggest that, because most overdoses are witnessed by other drug users, the fear of arrest and prosecution often makes them delay or refrain from calling 911 for emergency intervention. Fear also incentivizes people to use drugs in more secluded, less visible settings that may not be witnessed at all or harder for emergency services to access. Without a timely response from emergency medical services, otherwise preventable deaths will occur.[26]

A large body of medical and social science research demonstrates that OST programs successfully reduce heroin use, fatal overdoses, HIV transmission, criminal activity, and financial burdens among drug users.[27] However, SEPs and OST programs are often located in neighborhoods with a high police presence and often become targets for investigations and arrests despite their legality. Because many police agencies have misconceptions about how harm reduction programs operate and what value these programs have in promoting public safety, police officers may be directed to confiscate syringes or arrest program participants, directly interfering with the benefits these programs provide to community health.[28] Moreover, non-white users of SEPs are more likely to be stopped by police in a program's vicinity and more likely to stop using such programs as a result.[29] Thus, the effectiveness of and equal access to harm reduction programs is significantly dependent upon police cooperation.[30]

EACH OF US HAS A ROLE TO PLAY

In an interview with the Department of Justice's Community Oriented Policing Services (COPS) office, Michael Botticelli, the director of the Office for National Drug Control Policy (ONDCP) said, "If we're going to have a comprehensive response looking at things like prevention and treatment, we need law enforcement, law enforcement needs public health, and each of us ha[s] a role to play." Botticelli defined the current national drug control strategy as prioritizing diversion for those who come into the criminal justice system largely as the result of their own addiction. "I often hear from local law enforcement who understand that we can't arrest our way out of the problem, and they want those kinds of partnerships. They want alternatives."[a]

[a] U.S. Department of Justice, Community Oriented Policing Services (COPS), *The Beat* Podcasts, "Public Health/Public Safety Collaborations," January 2015. Transcript available at perma.cc/9NEC-PG2A.

Police and public health providers as partners

There are policies and programmatic reforms that can be implemented without legislative action to help better align the mission, culture, and practices of law enforcement, public health agencies, and harm reduction organizations. Indeed, a growing number of police departments are joining forces with advocacy organizations and public health and community treatment providers to pioneer promising collaborative reforms that reduce unnecessary arrests and promote access to health and social services.

In recent decades, health promotion and harm reduction strategies have become cornerstones of public health efforts worldwide, with partnerships among police, health experts, and community groups in pursuit of practices proven to treat mental illness, prevent the spread of HIV infection among marginalized groups, and reduce mortality by drug overdose.[31] In Frankfurt, Germany, in the 1980s and 1990s, police took a leading role in partnering with addiction and health care service providers, resulting in a decline in drug-related deaths and criminality.[32] Their model, known as "The Frankfurt Way"—which from its inception emphasized interagency cooperation, drug-specific police teams, proactive social work, and prevention with intervention—has since spread to other cities across Europe. Moreover, case studies from Burma, Ghana, India, Kenya, and Kyrgyzstan show that public health-centered law enforcement can address serious crime such as armed robbery and theft, by building community trust and increasing reporting and witness testimony, while protecting human rights. For example, in Kenya, more than 600 police officers were trained alongside sex workers and health experts, a training to help police understand the lived experiences of people who engage in sex work or drug use and about the effectiveness and availability of health services for these groups. In Kyrgyzstan, the police academy provided training for more than 800 officers on harm reduction, sex work, and HIV prevention.[33] Such trainings have fostered better relationships between drug users, sex workers, and police officers and helped reform policing practices to prioritize health promotion and harm reduction.

As of 2014, nearly 10,000 police officials from more than 35 nations have signed a statement of support for the incorporation of harm reduction principles in police work to control HIV among vulnerable communities. This document was created by the Law Enforcement and HIV Network (LEAHN), an international organization that aims to build sustainable global and local partnerships between law enforcement and public health agencies to work more effectively with vulnerable groups.[34]

Successful programs are built on partnerships that establish trust with affected communities and ensure that an appropriate range of services are

available to address their diverse clinical and social service needs. Without principles and values public health and law enforcement agencies agree upon, partnerships alone are not enough, and can falter or become counterproductive. For example, in 2005, officials in Marseille, France, created a mental health outreach team and a new central police station to address the growing rate of mental illness among homeless people. In evaluations of the pilot, outreach workers were often described as more coercive than police, due to the fear among homeless patients that they would be hospitalized involuntarily. In this particular program, the addition of coercive treatment to the possibility of arrest and jail did not create trust or improve community relations.[35]

Recommendations: Advancing health promotion and harm reduction in policing

Including people and their advocacy organizations is a way to empower marginalized groups, build trust, and promote the dignity of all people involved.

In partnership with public health agencies, treatment providers, and community advocates, police departments are increasingly developing new policies and programs that provide officers with the opportunity to connect people to behavioral health care, housing, and other social services as an alternative to arrest and detention.[36] The success that some police departments have had with such collaborations prove not only the plausibility of incorporating harm reduction and health promotion principles into policing practices but also provide instructive examples of how to do so.

The following recommendations outline some intermediary steps that health, justice, and community stakeholders can take to further align their policies, cultures, and practices with health promotion and harm reduction principles and work together to better respond to the interrelated issues of drug use, mental illness, sex work, and poverty.

REACH OUT TO ADVOCACY GROUPS AND THEIR CONSTITUENTS

The sustainability, success, and impact of any program that targets the health and social service needs of people engaged in drug use or sex work and people with mental illnesses will be greatly enhanced by including these people and their advocacy organizations in the planning process of new initiatives. Most important, it is a way to empower marginalized groups, build trust, and promote the dignity of all people involved.

Although a growing body of research suggests that police officers are receptive to learning about the benefits of harm reduction services and are willing to incorporate certain aspects into their own practices, most harm reduction agencies do not provide trainings to police officers.[37] Indeed, most SEPs in the United States are not involved with police training and have not invested in building relationships or partnerships with police leadership.[38]

THE PRINCIPLES OF HARM REDUCTION

Harm reduction refers to a range of widely accepted public health policies, practices, and programs that seek to reduce morbidity and mortality associated with drug use and sexual activity, while respecting the autonomy, rights, and dignity of people who use drugs or engage in sex work. Such efforts include promoting condom use and the creation of needle-exchange programs and methadone clinics, which have been shown to greatly reduce mortality by drug overdose and the spread of infectious diseases such as HIV.[a]

While harm reduction policies and programs for people who use drugs can take many different forms, there is general agreement among public health experts that the ultimate goal is to "meet drug users where they're at," in order to promote safer and managed drug use, even if total abstinence is beyond their reach. The Harm Reduction Coalition, a "national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use" has developed the following eight principles to help government and community agencies craft effective harm reduction policies and programs.[b]

Similar principles can help shape the policies and practices that law enforcement agencies craft to support and enhance the health of the communities they protect.

- Accepts, for better and/or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies that meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

[a] Rachel Thomas, Sanjay Patil, Roxanne Sacier, and Anna-Louise Crago, *To Protect and Serve: How police, sex workers, and people who use drugs are joining forces to improve health and human rights* (New York, NY: Open Society Foundations, 2014), perma.cc/8YMN-53WJ.

[b] Harm Reduction Coalition, "Principles of Harm Reduction," perma.cc/4223-FL8V.

There are a number of local and national advocacy groups that have successfully worked with police to implement harm reduction policies. For instance, the Harm Reduction Coalition (HRC) has worked with police around New York State through partnerships with the Division of Criminal Justice Services and the state Department of Health. New York City has adopted their training manual, which details best practices on drug treatment, syringe access laws, and Good Samaritan laws, and emphasizes common goals to help

people receive health services not guaranteed by arrest. In the first year, more than 5,000 officers outside of New York City had been trained and 436 uses of naloxone were reported.[39] (See "The Principles of Harm Reduction," page 11, for more information.)

Several other agencies in New York also provide harm reduction and health promotion resources to police leadership. Voice of Community Activists & Leaders (VOCAL-NY)—a group led by people who are active and former drug users—has published information on how Medicaid funding can be used for harm reduction programs and how the penal code can be reconciled with public health law. They currently have campaigns centered on syringe access, preventing low-level marijuana arrests, preventing overdoses, and improving methadone programs.[40] Staff from the Washington Heights CORNER Project (WHCP), a harm reduction organization, regularly present to community boards, business development organizations, and law enforcement agencies—including police executive management, precinct commanders, training officers, task forces, and police recruits—on the benefits of their program.[41] The organization provides access to clean syringes through street-based outreach and delivers health services, education, and health promotion services that curb risks associated with drug use, including HIV, viral hepatitis, and overdose.

THE GLOUCESTER ANGEL PROGRAM: ABATING THE FEAR OF ARREST

In May 2015, the Gloucester Police Department in Massachusetts announced that a person seeking treatment for substance use can walk through the doors of any precinct house without fear of arrest and be voluntarily directed to treatment on the spot. After an increase in opiate overdoses across the state—with a population of 30,000, Gloucester sees 30 overdoses in a given year—Police Chief Leonard Campanello sought alternatives to arrest and incarceration, acknowledging that police shouldn't have to be involved in the issue, but that "lives are literally at stake."[a]

As part of this new program, the department partnered with the Addison Gilbert Hospital and a dozen other treatment centers to expedite the intake process. The department also pairs people seeking treatment with an on-call volunteer, referred to as an "angel," who joins them after they are taken to the hospital by an officer.[b] The volunteer then stays with the person to provide comfort and companionship while they wait to be seen.

The Gloucester Police Department has also been working with their local pharmacies to provide naloxone—a drug that is used for counteracting the effects of an overdose—at little to no cost to people seeking treatment. For those without insurance, the department will pay for the antidote using money they've seized from drug dealers.

The program also promises to not use a person's possession of drugs or drug equipment as cause for arrest if they are seeking treatment; how-

In addition, the National Alliance on Mental Illness (NAMI) is an advocacy and support group for people living with mental illness and their families and friends with extensive experience working with law enforcement. They have led campaigns on attaining parity in mental health coverage in national health reform and work on the reduction of arrest and incarceration for people living with mental illness. NAMI affiliates across the country work with local police departments on jail diversion and reentry programs and the use of Crisis Intervention Teams (CIT). Police agencies can contact their local NAMI affiliate to explore potential partnerships.[42]

MINIMIZE ARRESTS AROUND HARM REDUCTION CLINICS

In the United States, there are currently 228 known syringe exchange programs (SEPs) located in 35 states, Washington DC, Puerto Rico, and Indian Nations.[43] As part of their effort to combat the heroin epidemics in their states, legislators in Kentucky and Indiana also recently passed new laws allowing needle exchanges.[44] However, policing practices across the country still target SEP participants, despite the demonstrated benefits these programs provide.

Research shows that this type of targeting reduces program attendance, impedes the expansion of effective SEPs, and increases the length of time

ever, this amnesty does not extend to a person with an outstanding arrest warrant or an extensive history of drug offenses, such as trafficking.[c]

Since the program's launch, Campanello has met with the staff of the federal Office of National Drug Control Policy, including Director Michael Botticelli, and members of Congress to discuss what has also come to be known as "The Gloucester Program."[d] Massachusetts State Senate Minority Leader Bruce Tarr has proposed an allocation of state funds to further develop the program and implement it in two other municipalities. Other states have since expressed interest in establishing a similar program.

In the wake of the positive response from local constituents and national leaders, Campanello said in a statement on the Gloucester Police Department website, "….[D]rug addiction is a disease and police departments can take a more active role in reducing the demand for drugs, not just the supply. My only hope is that this conversation continues and that we can create real change in our community and elsewhere."[e]

[a] Massachusetts recorded 1,000 overdose deaths in 2014, a 33 percent increase from 2012. Luke O'Neil, "This New England Town Is Trying to Help Opioid Users Instead of Arresting Them," VICE, May 6, 2015, perma.cc/BZV8-FFM6; Deborah Becker, "Gloucester, Mass., Police Program Provides Treatment for Drug Users," National Public Radio, June 4, 2015.
[b] Gloucester Police Department, "For Addicts and Their Friends, Families, and Caregivers," 2015, perma.cc/5TQW-MGA4; Sean Horgan, "'Angel' program takes in first patient," *Gloucester Times*, June 2, 2015, perma.cc/4NYS-KPAW.
[c] Becker, 2015.
[d] Gloucester Police Department, "Gloucester Police Chief Leonard Campanello Returns from Washington with Pledges of Support from Federal and State Government for New Drug Policies," May 18, 2015, perma.cc/S84D-CCC5
[e] Ibid.

that contaminated needles are circulated on the street.[45] Furthermore, making drug arrests in areas surrounding SEPs deters safe injection practices because intravenous drug users, who are concerned about being charged with possession of drugs or paraphernalia, are less likely to seek or carry sterile syringes and engage in hygienic injection practices.[46] These issues can increase the risk of community members contracting blood-borne diseases, with police officers also at risk of infection, as they can be stuck with contaminated needles during searches.[47]

To ensure that vulnerable people are not driven underground and away from the harm reduction services that benefit them and prevent the spread of infectious diseases, police can work with SEPs and local harm reduction advocates to build trust and develop collaborative policies that take a public health-oriented approach to addiction. For example, several harm reduction programs in New York City—like BOOM!Health and Washington Heights CORNER Project—and programs in California, like the LA Community Health Project, have been able to thrive because of law enforcement policies against targeting the people who use them.[48] (See "Resources for Public Health-Informed Policing," page 22, for New York State Chiefs of Police's toolkit on syringe access programs.)

Similar partnerships internationally have thrived as the result of interventions aimed at changing the negative public perception of injection drug users (IDUs) and a variety of legislative and policy changes in management, training, and street level tactics. For instance, Australian health, law enforcement, and government managers focused on shifts in organizational culture and priorities to better integrate harm reduction and law enforcement policies; in the United Kingdom, police managers adopted policies that encouraged the identification of treatment for people who use drugs along the criminal justice continuum, from diagnosis at arrest to treatment in prison.[49]

CREATE OVERDOSE PREVENTION PROGRAMS

The U.S. Department of Health and Human Services (HHS) has a three-pronged initiative aimed at reducing prescription opioid- and heroin-related overdose, death, and dependence. This initiative includes assisting health professionals in making informed decisions around prescribing opioids such as methadone and buprenorphine, expanding the use of Medication-Assisted Treatment (MAT) for opioid-use disorders, and supporting the distribution of naloxone.[50]

Leaders in government have also engaged police departments in developing comprehensive opioid overdose prevention initiatives. For example, on July 31, 2014, then-U.S. Attorney General Eric Holder announced a plan for federal law enforcement to also begin carrying naloxone, which is commonly referred to as Narcan or Evzio, among other pharmaceutical trade names. It is considered a highly effective, safe, and inexpensive harm reduction intervention that can be administered intravenously, intramuscularly, or through a nasal spray to quickly resuscitate an individual experiencing respiratory failure from an opioid overdose.[51]

Holder also urged local law enforcement authorities to routinely carry naloxone. Since 2001, hundreds of local police departments in more than 23 states have used the antidote to prevent more than 1,000 deaths.[52] In Quincy, Massachusetts, for instance, 357 overdoses were reversed with naloxone as of January 2015.[53] In southern New Jersey, local hospitals have established programs with county prosecutors to supply police officers with free naloxone doses. Engaging local hospitals in establishing police-based naloxone programs is an important strategy for ensuring that police agencies have a sufficient supply of the antidote and are adequately trained in its administration.

As of July 2015, 29 states and the District of Columbia have enacted laws that shield any person from civil and criminal liability who administers naloxone

AN INTRAVENOUS DRUG USE-FUELED HIV EPIDEMIC: ONE STATE'S REPONSE

In May 2015, Indiana Governor Mike Pence issued an executive order declaring a public health emergency in response to the largest HIV epidemic in the state's history, mostly attributed to injection drug use. The order included authorization through May 2016 for a targeted needle exchange program in Scott County, where the epidemic is concentrated. State legislation was quickly passed that allows county officials to petition the state health commissioner to legally distribute clean needles to IV drug users. The program, which includes mobile units and one storefront location, is the first of its kind in Indiana.[a]

Notably, while Indiana's program has gained support from law enforcement and other public officials, the *New England Journal of Medicine* (NEJM) points out that the program is not paired with sufficient investments in the state's public health infrastructure, so it is not equipped for long-term sustainability.[b] Such sustainability is needed to abate deeper-seeded problems underlying the state's HIV outbreak, including insufficient reimbursements for opiate substitution treatment (OST) programs, inadequate Medicaid coverage for at-risk communities, and a lack of resources for HIV and HCV testing. In many instances, local police officers are still arresting people who are not registered with the program for possessing needles, on the belief that a criminal sanction will encourage participation. However, research suggests that such fear exacerbates mistrust of SEP's services and deters people from using the vital health services they provide.[c] Echoing calls from public health experts, NEJM also suggests permanently removing the ban on using federal dollars to support SEPs, which will make it easier for states and local governments to respond to the national heroin and prescription drug epidemics.

[a] The Associated Press, "Indiana: County to Try Needle Exchange," *New York Times,* May 21, 2015.
[b] Steffanie A. Strathdee and Chris Beyrer, "Threading the Needle—How to Stop the HIV Outbreak in Rural Indiana," *New England Journal of Medicine*, June 24, 2015.
[c] Jake Harper, "Indiana's HIV Outbreak Leads To Reversal On Needle Exchanges," NPR, June 2, 2015.

to save a life.[54] These laws are designed to limit liability and encourage police, first responders, and others who witness an overdose to administer naloxone in an emergency.[55]

Police officers have a particularly important role in reducing overdoses, because they are frequently the first to arrive on the scene in response to a 911 call. Police also routinely interact with people at high risk for overdose during their street patrols. By partnering with each other, police agencies and harm reduction programs can work together to prevent deaths from opiate overdose.

DEVELOP COLLABORATIVE DIVERSION PROGRAMS

A growing number of police departments are partnering with local health departments and behavioral health service providers in their communities to develop pre-arrest and pre-booking diversion programs.[56] Providing law enforcement with alternatives to making an arrest or booking a person into jail can have a range of benefits. It can mitigate many of the negative consequences that follow arrest, prosecution, and incarceration, including deteriorating mental health, imposition of court fees, disruption of employment or education, and damage to family relationships.

By partnering with each other, police agencies and harm reduction programs can work together to prevent deaths due to opiate overdose.

Establishing community drop-off centers that provide a variety of clinical, medical, and social services are an integral component of launching a successful jail diversion program. Community drop-off centers typically have no-refusal policies and can offer a range of services, including 24-hour respite care, crisis beds for short-term stays, case management, detox services, health education, and referrals to ongoing treatment, housing, and other social services if necessary.[57] Los Angeles, Seattle, and multiple localities across Virginia, for example, have instituted drop-off centers as a way to increase jail diversion and enable officers to connect people with appropriate clinical assessments, services, and referrals, which can also reduce the time that officers spend escorting patients to hospital emergency rooms.[58] New York City is currently establishing two such centers as part of the Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan.[59]

San Antonio: Smart Justice

Recognizing law enforcement's role as mental health workers, San Antonio, in Bexar County, Texas, developed a multi-pronged, public health-oriented policing model they call "smart justice." The Bexar County police, county jail, mental health department, criminal courts, hospitals, and homeless programs pooled their resources to develop a 40-hour crisis intervention training (CIT) curriculum to include in police training, establish six-person mental health squads who answer emergency calls where mental illness might be an issue, and create two drop-off centers—both a short-term crisis center and a restoration center, which is a separate facility that houses a 16-bed psychiatric unit, a medical clinic, and a "sobering room." These two centers give law enforcement

USING MEDICAID FUNDS TO EXPAND JAIL DIVERSION PROGRAMS

Expanding the capacity to deliver addiction, psychiatric care, and social services in the community is imperative for building effective diversion programs. Doing so requires maximizing the number of people enrolled in health insurance to cover costs associated with delivering health and social services in settings such as drop-off centers, harm reduction service centers, and other community health organizations.

The federal Patient Protection and Affordable Care Act (ACA) provides one of the largest expansions of mental health and substance use disorder (SUD) coverage in U.S. history. It is estimated to extend health insurance to 27 million people who previously lacked coverage and provides a wider range of reimbursable behavioral health services to 62 million citizens.[a] Especially in states opting to expand Medicaid, the ACA offers a historic opportunity to jurisdictions to bolster the capacity of their behavioral health systems to serve people who were previously ineligible for Medicaid or subsidies for health insurance, including childless adults up to 138 percent of the federal poverty level.

Improved health insurance coverage also opens previously unavailable funding streams to support the expansion and sustainability of jail diversion programs. To capitalize on these newly available funds, leaders in public health and law enforcement can work with state Medicaid agencies to develop strategies for increasing enrollment and coverage rates among justice-involved populations, build relationships with service providers in the community that serve these individuals, and test new ways to deliver and pay for health care services by using funding mechanisms such as Medicaid waivers, Medicaid Administrative Claiming (MAC), and Targeted Case Management (TCM). Together, state and local agencies may be able to use these federal funding sources to cover costs related to jail diversion, such as making referrals, transporting a patient to care, and conducting outreach for Medicaid beneficiaries. While eligibility varies by state, public safety agencies are often able to receive MAC and TCM payments.

[a] Kirsten Beronio, Rosa Po, Laura Skopec, and Sherry Glied, "Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans," (Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2014), perma.cc/3C8Q-NF93.
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options other than arrest and booking into jail when dealing with people with mental illness or drug use disorders who are in crisis.

As a result of its Smart Justice diversion program, Bexar County has diverted more than 17,000 people from jails and emergency rooms since 2003; the county's jails are currently under capacity; and San Antonio estimates that diversion has saved the city $50 million over the past five years.[60] A cost analysis

of the jail diversion program showed that just the pre-booking programming, including CIT training and drop-off centers, save both the criminal justice system and community treatment system more than $1.2 million during the six months immediately following diversion and was associated with improved access to treatment.[61] By providing better resources for case management and medical triage, the program has also helped reduce the amount of time that police spend escorting people to emergency rooms, which is often not medically necessary, freeing time and resources necessary to respond to serious crimes.[62]

Law Enforcement Assisted Diversion (LEAD)

The arrest and incarceration of people who possessed small amounts of opiates and drug paraphernalia did not meaningfully improve the overall health and safety of the community and cost Santa Fe nearly $1.5 million a year.

Launched in 2011, Seattle's LEAD program is the first pre-booking diversion program of its kind for people arrested on drug and prostitution charges in the United States. It was developed collaboratively by community members, the King County Prosecuting Attorney's Office, Seattle City Attorney, Seattle Police Department, Seattle Mayor's Office, State Department of Corrections, Public Defender Association, and the ACLU of Washington. It allows police officers to redirect people to community-based services, including housing and treatment, instead of booking them into jail.

The LEAD program demonstrates how law enforcement agencies can successfully adopt an approach that advances public safety through harm reduction and health promotion.[63] The program is built on the commitment to a "harm reduction framework for all service provision" and incorporates principles of individual and community wellness, rather than abstinence and sobriety, into its goals and evaluation.[64] It was also designed to reduce policing of low-level drug offenses, which is a major driver of racial disparities in the criminal justice system through the disproportionate arrest and incarceration of people of color from low-income neighborhoods. This health-centered policing model is reinforced through harm reduction training that every Seattle police officer is required to undergo.[65] A recent evaluation found that participants in Seattle's LEAD program had a 58 percent lower chance of being rearrested than a control group, while the program is dramatically improving relationships between police, public health, and advocacy organizations.[66]

Other jurisdictions have taken notice of Seattle's early success and have taken steps to create similar programs. Leaders in Santa Fe, New Mexico's police department and city council recognized that the arrest and incarceration of people who possessed small amounts of opiates and drug paraphernalia did not meaningfully improve the overall health and safety of the community and cost the city nearly $1.5 million each year. The implementation of Santa Fe's LEAD program is projected to cut these expenditures in half by reducing money spent on arrests, court appearances, and incarcerations.[67] In June 2015, alongside the Drug Policy Alliance and the Center for Law and Justice, city leaders in Albany, New York announced a partnership among law enforcement, prosecutors, public defense and human service agencies, community advocates, business leaders, and public health agencies to establish the first LEAD program on the East Coast.[68] The acclaim for LEAD is sparking the interest of

city leaders in Baltimore, Oakland, San Francisco, New Orleans, New York City, and Atlanta, who are looking for better ways to address issues related to drug use in their communities.[69]

Crisis Intervention Teams

In the past 20 years, a growing number of police departments train police officers to serve on CITs to respond to psychiatric emergencies in the community. According to the National CIT Center at the University of Memphis, there are currently 2,619 local CIT programs in the United States.[70]

While the components of programs vary, the CIT model is founded on strong partnerships among police, mental health providers, and individuals and families affected by mental illness with the aim of preventing violence, avoiding unnecessary arrests, and improving access to mental health services. CITs also rely on local hospitals and community mental health centers adopting no-refusal policies that permit police officers to confidently transport a person experiencing a psychiatric emergency to the emergency room or other community-based services, in lieu of arrest, without worrying about the person being turned away.

In CIT training, experienced public health and law enforcement officials educate police officers on the range of psychiatric illnesses they are likely to encounter in the community; how to respond to people experiencing a psychotic or emotional crisis; the range of resources in the community available to people with mental health needs other than general and psychiatric emergency rooms; and the legal standards governing involuntary psychiatric evaluation and hospitalization. In some jurisdictions, specially trained police officers work with mental health professionals from community mental health services to respond jointly to psychiatric emergencies in the field.

Research shows that CITs are an effective tool for diverting people with mental illness from jail. Police who receive CIT training are more likely to transport a person to a treatment facility or refer them to services in the community, and less likely to make an arrest than officers without training.[71] For example, a study comparing police-led diversion programs—in Birmingham, Alabama, and Memphis and Knoxville, Tennessee—found that in responding to mental health calls, police resolved more than a third of calls on the scene, made referrals to mental health specialists 13 percent of the time, and immediately transported people to a treatment facility—such as a psychiatric emergency room, a general hospital emergency room, a detoxification unit, or another psychiatric facility—in 46 percent of cases. Among all three jurisdictions, between 2 and 13 percent of mental health-related calls resulted in arrest.[72] Adopting CITs also improves occupational health outcomes of police officers, by improving their ability to safely de-escalate situations involving a person experiencing a mental health emergency without resorting to the unnecessary use of force. Several police agencies report reducing their deployment of aggressive tactical units, such as SWAT teams, following the adoption of CITs.[73]

ALIGN PUBLIC HEALTH METRICS AND INCENTIVES

Partnerships with public health and advocacy groups are essential for successfully infusing harm reduction and health promotion into police work and inducing positive multi-system outcomes that speak to the effectiveness of interagency collaborations. Measurable outcomes include the number of police referrals to community health and social services, community perception and satisfaction with police encounters, and lives saved through overdose prevention.

Ultimately, arrests averted, rather than arrests made, should serve as a core metric that governments track and value following police encounters with marginalized populations.

In an evaluation of the effectiveness of Seattle's LEAD program, key metrics included reductions in drug-related harms, drug use, and recidivism; improvements in health; psycho-social functioning; employment and family/community involvement; cost savings; impacts on the community; and racial disparities in drug law enforcement.[74] Because the program was conceived by law enforcement in collaboration with public health agencies and the community, program leaders ensured that the incentives for all participating agencies were aligned, helping to increase both public health and public safety.

In most jurisdictions, however, the effectiveness of law enforcement is measured differently. Law enforcement agencies tend to focus on the number of arrests to track their success at responding to a range of problems in communities that are intricately tied to socioeconomic, racial, and health disparities. Particularly in the context of the drug war, states and local governments use drug arrest rates and the number of drugs and assets seized as yardsticks that prove the efficacy of policing practices to ensure federal funding. Such measurements sustain policies and practices that perpetuate a cycle of arrest and incarceration for low-level crimes among medically vulnerable and economically disadvantaged communities.

Ultimately, arrests averted, rather than arrests made, should serve as a core metric that governments track and value following police encounters with marginalized populations, such as drug users, people with serious mental illness, and sex workers. In addition, health agencies and professionals should consider justice-system involvement, including arrest and incarceration in the metrics of success for their programs.

The ACA offers historic opportunities for states and local governments to greatly expand the capacity of community-based services for people with mental health and substance use disorders. The lack of adequate community-based mental health treatment, housing options, and harm reduction services across the United States underlies many of the challenges that police, courts, and jails encounter when interacting with people with complex health needs. Local leaders from community health and law enforcement agencies have an important role to play in jointly advocating for the expansion of vital health and social services in disadvantaged communities that are necessary for building successful pre-booking diversion programs.

Conclusion

Diverse jurisdictions around the world have demonstrated that police, as first responders to myriad emergencies, can be powerful and positive agents of harm reduction and health promotion in the communities they serve. Police commissioners, district attorneys, and public health system stakeholders can build upon the lessons learned from successful crisis intervention teams and pre-booking diversion programs in the United States and abroad to provide officers in the field with viable options for connecting people to the services they need, rather than ensnaring them further in the criminal justice system.

However, burdens arising from the failures of current community health and social service systems are often unfairly placed on the shoulders of law enforcement, who serve as gatekeepers to the criminal justice system. Though police officers can and should be an asset to public health work, the overreliance on the criminal justice system to respond to problems rooted in health inequities and poverty has allocated significant public resources to law enforcement agencies that may be better invested in increasing access to health care, housing, harm reduction services, and other social services.

In the wake of national health reform and calls for criminal justice reform, state and local jurisdictions seeking ways to reduce the number of people incarcerated in jails and prisons have new opportunities to expand and strengthen community-based mental health, substance use, and social service programs for people with mental illness or substance use disorders.

RESOURCES FOR PUBLIC HEALTH-INFORMED POLICING

Opioid Overdose Tool Kit – Substance Abuse and Mental Health Services Administration (SAMHSA)
This tool kit has facts, advice, and essential action items for prescribers, community members, first responders, and people recovering from overdose and their families.

For more information, visit: perma.cc/2TFF-UBC8

Practical Advice on Jail Diversion – Center for Mental Health Services (CMHS) National GAINS Center
This document provides facts and information for designing, planning, implementing, sustaining, and evaluating a jail diversion plan for interested community members.

For more information, visit: perma.cc/7TE2-UZDE

Crisis Intervention Training (CIT) Tool Kit – National Alliance on Mental Illness (NAMI)
This tool kit offers a series of documents, from learning more about CIT in general to advocating for its implementation in local communities. There is also a step-by-step guide on starting a CIT program and engaging community members to become involved.

For more information, visit: www2.nami.org/template.cfm?section=CIT2

To learn more about setting up a CIT in your jurisdiction or to find existing CIT programs in your area, visit the National CIT Center at the University of Memphis's website: www.cit.memphis.edu/citmap/

Law Enforcement Naloxone Tool Kit – Bureau of Justice Assistance
This tool kit provides information necessary for law enforcement agencies to implement overdose reversal programs, including advice and funding opportunities.

For more information, visit: www.bjatraining.org/tools/naloxone/Naloxone-Background

Police and HIV Programs – Law Enforcement and HIV Network (LEAHN)
This international network provides examples of partnerships among health and law enforcement agencies to reduce HIV in the communities they serve.

For more information, visit: www.leahn.org/police-hiv-programs

New York State Medicaid Coverage for Harm Reduction Services – Injection Drug Users Health Alliance (IDUHA)
This document details how Medicaid funding can be used for harm reduction programs and how the penal code can be reconciled with public health law.

For more information, visit: perma.cc/Z2VC-P8E2

Seeding Change: How Small Projects Can Improve Community Health and Safety – U.S. Department of Justice's Office of Community Oriented Policing Services (COPS)
This publication details key lessons learned from collaborations among law enforcement professionals, public health researchers, and representatives from funding institutions.

For more information, visit: perma.cc/ACE6-FS84

Syringe Program Sample Policy – New York State Association of Chiefs of Police
These sample policies and other resources created by law enforcement professionals educate and train New York State police about existing syringe programs and harm reduction policies.

For more information, visit: perma.cc/DX4W-UTHD

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Mass incarceration has become one of the major public health challenges of our time. The millions of people who cycle through our nation's courts, jails, and prisons every year experience far higher rates of chronic health problems, infectious diseases, substance use, and serious mental illness than the general population. Justice Reform for Healthy Communities is a year-long initiative of the Vera Institute of Justice that aims to improve the health and well-being of individuals and communities most affected by mass incarceration. Guided by a national advisory board comprising public health and criminal justice policymakers, practitioners, researchers, and advocates, the initiative advances its mission through public education, coalition building, briefings, and publications.

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