COAP Comprehensive Opioid Abuse Program
Collaborative Training and Technical Assistance

NEWSLETTER

SECOND EDITION 2018

TELLING BJA'S COAP STORY

Each September, we celebrate National Recovery Month, a time to share stories as personal testaments and signposts of optimism for those in recovery. Stories often inspire and can powerfully convey information, tell tales of success (and lessons learned), and build community. They come in many forms when linked to the country's opioid epidemic. For example, the overwhelming overdose statistics are a stark foreword to the tens of thousands of people whose lives tragically ended too soon, their families' lives forever altered. But the Bureau of Justice Assistance's (BJA) Comprehensive Opioid Abuse Program (COAP) is offering this narrative, providing innovations and solutions to the crisis, including:

- Supporting communities tackling this national priority in cities such as Mecklenburg County, North Carolina, and Hamilton County, Ohio.
- Supporting innovative programs such as Fresh Start in Logan, West Virginia, which includes an education and life-skill component through agricultural and artisan mentorships.
- Leveraging the powerful peer support chapters and recovery community organizations that jail-based and pre-criminal intervention programs can provide.
- Implementing data and information sharing such as prescription drug monitoring programs.

A tenet of COAP is connecting the field with vital resources and assistance for the greater good: evidence-based strategies, best practices, and opportunities for building a shared-purpose community benefit more than grantees. Knowing that every corner of America is impacted, BJA wishes to highlight COAP as it matures and evolves through this newsletter, a webinar series, the soon-to-be-released COAP Resource Center, and the open-to-all training, *From Crisis to Collaboration: Innovations to Address the National Opioid Epidemic*. More information about this conference will be available soon.

If you are willing to share your experiences—recorded on-site at the upcoming national event or virtually—we will sincerely appreciate adding your voice to the story of how BJA's COAP is transforming lives. We look forward to hearing from you at COAP@iir.com, where your input and inquiries about future editions of this newsletter are also welcomed.

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INAUGURAL COAP NATIONAL TRAINING

WASHINGTON, DC

MORE DETAILS COMING SOON

Protocols for Jail Opioid Detoxification

The opioid epidemic has thrust jails into a new role—they now serve as the largest detoxification providers in many communities. The number of defendants entering jails who are in need of detoxification from addictive drugs is staggering. For example, the Ohio Jail Advisory Board, a state board that sets jail standards, conducted a survey of 40 jails across the state in 2015 and found that more than 24,000 individuals admitted to jails received detoxification services.[1] In 2017, the Middlesex County, Massachusetts, jail reported that 40 percent of all new jail intakes needed to be detoxified, 73 percent for opioid addiction.

Withdrawal symptoms may begin within four to six hours of the last opioid use and may last for weeks, even months. Early symptoms include cravings for opioids, loss of appetite, anxiety, sleepiness, headache, fast breathing, tears, sweating, large pupils, runny nose, and irritability. Later symptoms include stomach cramps, broken sleep, hot/cold flashes, increased blood pressure and pulse, low fever, muscle/bone pain, muscle spasms, larger pupils, nausea and vomiting, and sensitivity to touch.

Opiate withdrawal is rarely dangerous except in medically debilitated individuals and pregnant women. Pregnant women taking opiates should be treated with methadone or maintained on methadone, since detoxification increases the risk of miscarriage and premature labor. Symptoms of withdrawal from short-acting opiates such as heroin can develop a few hours after the last use, peak within 36–72 hours, and subside over 5–10 days. Longer-acting opiates such as methadone produce a more protracted withdrawal syndrome, beginning in 24–48 hours, peaking in 72 hours, and subsiding over 1–3 weeks.

Both the Federal Bureau of Prisons (BOP) and the National Commission on Correctional Health Care (NCCHC) have protocols for detoxification behind the walls. Both protocols begin with identifying those entering jail who are in withdrawal.[2]

The Clinical Opiate Withdrawal Scale (COWS), an 11-item scale, can be used to rate common signs and symptoms of withdrawal and monitor these symptoms over time. There are other scales for withdrawal from alcohol and other drugs. The scores can help determine the stage or severity of withdrawal and assess the level of physical dependence. The NCCHC advises using the screening for determining level of risk. Individuals at low risk require no medical attention; medium-risk individuals require immediate medical attention not involving complicating medical conditions; and high-risk individuals require both immediate medical attention and intensive monitoring because of other medical conditions.[3]

According to the BOP, immediate medical attention is required for the following symptoms:[4]

- Changes in mental status
- Abdominal pain
- Increasing anxiety
- Upper and lower gastrointestinal bleeding
- Hallucinations
- Changes in responsiveness of pupils
- Temperatures greater than 100.4°F (These patients should be considered potentially infectious)
- Heightened deep tendon reflexes and ankle clonus, a reflex beating of the foot when pressed rostrally, indicating profound central nervous system irritability and the potential for seizures
- Significant increases and/or decreases in blood pressure and heart rate
- Insomnia

Regardless of risk, all individuals going through withdrawal should receive ample hydration. The belief that the amount of suffering a person who abuses opioids endures correlates with his or her level of motivation to recover is unfounded.[5] Medications combined with psychological support are the standard for medical practice and improve recovery outcomes. To get the best results from detoxification, the individual should be immediately connected with medication and counseling.

Protocols for Jail Opioid Detoxification (continued)

The BOP recommends that, whenever possible, the jail "should substitute a long-acting medication for short-acting drugs of addiction. A safe withdrawal plan entails, when feasible, substituting a long-acting, cross-tolerant substance and gradually tapering that substance (not more rapidly than 10–20% per day—depending on the substance and the setting available for detoxification). Every effort should be made to ameliorate the inmate's signs and symptoms of alcohol or drug withdrawal. Adequate doses of medication should be used, with frequent reassessment. Inmates experiencing withdrawal should also be kept as physically active as medically permissible."[6]

Complicating the detoxification process, many individuals withdrawing from opioids have co-occurring conditions. The BOP advises: "Initiation of withdrawal should be individualized. Substance abuse often leads to significant medical sequelae including liver disease, chronic infections, trauma, cognitive impairment, psychiatric disorders, nutritional deficiencies, and cardiac disease. Detoxification and withdrawal are stressors and may exacerbate or precipitate medical or psychological decompensation. In some cases, medical stabilization may be preferred to resolve the immediate crisis prior to initiating withdrawal."

At the same time, jails must guard against the diversion of medication. The BOP protocol includes the following: "Administration of all controlled medications should be directly observed in a pill line. In addition, consider direct observation of ancillary medications (e.g., clonidine). Inmates should be counseled on the dangers of supplementing their detoxification regimens with over-the-counter medications, prescription medications diverted from other inmates, or illicit drugs and alcohol."

Many medications can be used to help ease withdrawal symptoms. For example, some of the prescription medications used off-label on a short-term basis for opioid withdrawal include the following:

- Clonidine—normally used for blood pressure
- Baclofen—derivative of gamma-aminobutyric acid (GABA) and a muscle relaxant
- Lofexidine—alpha 2-adrenergic receptor agonist, used for high blood pressure
- Methocarbamal—normally used as a muscle relaxant[7]

Standards, Guidelines, and Information on Withdrawal Severity Screening

The National Sheriffs' Association provided the following correctional detoxification resources:

- Wesson, D. R. and Ling, W. The Clinical Opiate Withdrawal Scale (COWS). *Journal of Psychoactive Drugs*, 35(2), 253–9 (2003).
- Detoxification of Chemically Dependent Inmates. Federal Bureau of Prisons clinical practice guidelines, February 2014. www.bop.gov/resources/pdfs/detoxification.pdf
- TCU Drug Screen V Opioid Supplemental. Texas Christian University, September 2017. https://ibr.tcu.edu/forms/tcu-drug-screen/
- Managing Opiate Withdrawal: The WOWS Method. CorrectCare, Summer 2016. www.ncchc.org/filebin/CorrectCare/30-3-WOWS.pdf

It is important to note that detoxification is not treatment. After being detoxified, individuals should be enrolled in counseling and support programs. Planning should begin for their eventual reentry, continued care, and support in the community, including appropriate induction of medication-assisted treatment, as needed and appropriate.

1. Dissell, R. ,"Ohio Jails Accept Role as State's Busiest Opioid Detox Centers," *Cleveland Plain Dealer*, October 1, 2017.
2. Galanter, M. and Kleber, H., Textbook of Substance Abuse and Treatment (4th ed.) American Psychiatric Association. (2013). Opioid Withdrawal. In Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.
3. Fiscella, K., Guide to Developing and Revising Alcohol and Opioid Detoxification Protocols, (September, 2015) retrieved from National Commission on Correctional Health Care website, http://www.ncchc.org/filebin/Resources/Detoxification-Protocols-2015.pdf.
4. Federal Bureau of Prisons, Detoxification of Chemically Dependent Inmates: Federal Bureau of Prisons Clinical Practice Guidelines (February 2014), retrieved from https://www.bop.gov/resources/pdfs/detoxification.pdf, p. 3.
5. Miller, W. and Rollnick, S., Motivational Interviewing: Helping People Change, Guilford Press, New York (2013).
6. Federal Bureau of Prisons, Detoxification of Chemically Dependent Inmates: Federal Bureau Of Prisons Clinical Practice Guidelines (February 2014), retrieved from https://www.bop.gov/resources/pdfs/detoxification.pdf, p. 2.
7. Federal Bureau of Prisons, Detoxification of Chemically Dependent Inmates: Federal Bureau Of Prisons Clinical Practice Guidelines (February 2014), retrieved from https://www.bop.gov/resources/pdfs/detoxification.pdf.

Did You Miss It?

Using Web-Based Motivational Assessment Strategies: MAPIT

"**Using Web-Based Motivational Assessment Strategies: MAPIT**" was held on May 17, 2018, as part of the COAP Webinar Series. Although drug and alcohol treatment is a common mandate in the U.S. criminal justice system, many clients do not initiate treatment. To address this gap, MAPIT is a web-based motivational intervention that links a client's risk and needs factors to case plans that the client can develop. Listen to the webinar to explore the clinical features of MAPIT, research findings from a randomized controlled trial, and a cost-effectiveness study.

If you were unable to join the COAP MAPIT webinar, the recording is available at **https://iir.adobeconnect.com/psd9l1zclhp5/**.

The Power of Data and Collaboration: The Ohio Pre-Criminal Intervention Program (PCIP)

As part of the COAP Webinar Series, **"The Power of Data and Collaboration: The Ohio Pre-Criminal Intervention Program (PCIP),"** was held on March 28, 2018. As part of Ohio's strategy to reduce prescription drug misuse and abuse, hear how the Ohio Board of Pharmacy plans to use data from the Ohio Automated Rx Reporting System (OARRS) to identify those who may be engaged in patterns of behavior indicative of substance misuse or abuse and who may be in violation of Ohio's doctor-shopping law. Specially trained Board of Pharmacy agents, along with local treatment professionals and law enforcement, will engage the identified individuals to connect them to appropriate drug treatment resources or other support services. In addition, the Supreme Court of Ohio plans to assist health-care providers in better clinical decision making for patients participating in drug court programs. The overall goal of the project is to utilize OARRS to support cross-system collaboration and data sharing among prescribers, law enforcement, and treatment professionals to reduce opioid abuse and misuse by implementing a PCIP.

If you were unable to join the COAP PCIP webinar, the recording is available at **https://iir.adobeconnect.com/pw0f6at6lzll/**.

Webinars

Saving a Life Twice—The Naloxone Plus Solution to Reducing Overdoses and Connecting to Treatment

"Saving a Life Twice—The Naloxone Plus Solution to Reducing Overdoses and Connecting to Treatment," part of the COAP Webinar Series, was held on March 21, 2018. As communities across the country struggle with the opioid crisis, our nation's first responders, law enforcement officers, and public and behavioral health personnel are having to quickly learn how best to respond—*and respond together*—to save lives. Post-overdose strategies require much more than simply administering naloxone. Now, a solution is at hand: With the "Naloxone Plus" pathway, public health and public safety workers can offer assistance beyond the immediate overdose (OD) incident, connecting people to treatment and, hopefully, preventing additional ODs. This strategy—and webinar—are geared toward all projects, sites, and jurisdictions responding to overdoses at the intersection of the public health and public safety systems. While the framework was built as a public health response, it can be adapted for a variety of populations and systems, such as the public safety community (including fire and emergency medical services workers) and hospitals (for post-release tracking).

If you were unable to join the COAP Naloxone Plus webinar, the recording is available at **https://iir.adobeconnect.com/pfii3vajvmaj/**.

New Resources for Behavioral Health and Justice Professionals to Help Individuals With Substance Use Disorders Build Recovery Capital: Digital Health Technologies

The webinar "**New Resources for Behavioral Health and Justice Professionals to Help Individuals With Substance Use Disorders Build Recovery Capital: Digital Health Technologies**" was held on June 28, 2018. For many individuals with a substance use disorder, finding a source of support is essential to the recovery process. There are many pathways to recovery that can help people enter and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and lead meaningful lives in their communities. However, traditional treatment and recovery models are unable to meet the needs of many individuals requiring services, especially in rural areas of the country. This has led to the development of innovative approaches that take advantage of the pervasive use of computers, mobile phones, and other forms of technology to reach individuals who are at the highest risk of needing (but unable to attain) services. Technology offers one more avenue by which treatment and recovery support services can be provided, thereby increasing participation and decreasing the likelihood of relapse.

If you were unable to join the COAP Digital Health Technologies webinar, the recording is available at https://iir.adobeconnect.com/p4n6jxcw9sxg/.

Jail and Prison Naloxone Distribution Programs

Not only are more and more law enforcement agencies and other first responders now equipped with naloxone to help them save the lives of persons overdosing from opioids, but they are also distributing naloxone to those at risk, their family members, and associates. Some law enforcement agencies, for example, provide naloxone to homes where a household member has survived an overdose to guard against future overdoses.

One of the highest-risk populations for drug overdose deaths is people being released from prisons and jails. This is no small number—annually more than 10 million pass thorough jails awaiting trial, and more than a million are released from prison or jail sentences. Studies have found that a large proportion of incarcerated individuals have abused drugs, and a high proportion of them are addicted to opioids. Incarcerated opioid abusers lose tolerance, even if the enforced abstinence provided by jail is only a few days. The period immediately following release is a high-risk time period for many opioid abusers. Research also has found that among individuals released to the community, the risk of dying of an overdose within two weeks of release from prison is more than 120 times that found in the general population.[1]

Jails and prisons from Rhode Island to California have established naloxone distribution programs that are proving to significantly reduce drug overdose deaths among high-risk recently released individuals. These jail and prison programs have two main components. First, they instruct individuals, as well as any family members who willingly visit them before their release, on overdose risks and the use of naloxone. Then, when these individuals are on their way out the door, the programs provide them with naloxone kits to take with them.

Rhode Island has implemented a naloxone program in both its jail and its prison systems. Both types of facilities are operated by the state Department of Corrections (DOC). The DOC has developed a five-minute DVD education program on the nasal naloxone spray. Any Inmate who completes the education program is given a naloxone kit at discharge. The discharge officer, the last official to see an individual leaving prison or jail, retrieves a naloxone kit from the DOC health department upon request and gives it to the exiting individual. The individual must sign for the kit and certify that he or she watched the DVD. Last May, the DOC expanded the program to families. Signs are now posted in visiting rooms inviting family members visiting inmates to remain an extra five minutes to see the DVD; afterwards, they are given a naloxone kit.

Similarly, inmates leaving the San Francisco jail receive naloxone kits. The effort is part of a larger, communitywide overdose prevention campaign sponsored by the San Francisco Department of Public Health and a community overdose prevention organization. New York's Department of Health, in collaboration with the state's Department of Corrections, has established a naloxone distribution program in the state's prisons. Since 2017, the naloxone distribution program has operated in all 54 state correctional facilities, which estimate that more than 6,000 kits have been distributed. Other jail naloxone programs can be found in Durham County, North Carolina; Bernalillo County, New Mexico; Stark County, Ohio; and elsewhere across the country.

The biggest challenge implementing a naloxone program is finding the resources to pay for the naloxone. The Rhode Island program dispenses kits to about 100 exiting inmates a month, about half of those released each month. Funding for this program is provided by grants. The same is generally true for the other prison and jail naloxone programs. The funding for naloxone is provided by state or county public health agencies, often originating from federal grants from the Bureau of Justice Assistance or the Substance Abuse and Mental Health Services Administration.

1. Binswanger, I. A., Blatchford, P. J., Mueller, S. R., Stern, M .F., "Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009," Annals of Internal Medicine, 2013;159(9), 592–600.

Peer Support—Defining and Exploring Its Reemergence and Roles Across the Intercepts

Peer support for addiction recovery is not new, nor is peer support for rehabilitation or reentry. Individuals with lived experience in addiction recovery and criminal justice involvement have been helping others break the cycle and find a new way of life in recovery for a long time. Their guidance, suggestions, and resources for healing from the past; for creating—or recreating—a meaningful life; and for being of service to family, friends, and the community have helped many persons have successful lives in recovery.

Author and researcher William White has noted that peers comprised 70 percent of the addiction services workforce in the 1960s and that over the last four decades, that changed dramatically with the medicalization of addiction services and the influence of insurance and managed care. According to White, with the professionalization of addiction treatment, peers make up only 30 percent of the workforce; the reemergence of peer recovery support services is an effort to again place lived experience at the core of recovery support.

Examples of peer support projects at different intercepts

Intercept 0: Community Services

In the AnchorED program (Rhode Island), peer workers visit overdose survivors in the hospital. They also do street outreach, hand out Narcan, and educate individuals and families about opioid abuse and misuse. Learn more about AnchorEd in a Cover 2 podcast and a report by NPR.

Intercept 1: Law Enforcement

A number of law enforcement diversion models have been created to assist opioid drug abusers in seeking recovery, help distribute naloxone to prevent and treat overdoses, and connect individuals with treatment programs. There is a variety of recognized pathways to diversion, including self-referral, active outreach, naloxone plus, officer prevention, and officer intervention. Examples of diversion programs that reflect these different pathways include Police Assisted Addiction and Recovery Initiative (PAARI), Quick Response Teams (QRT), Drug Abuse Response Teams (DART), Stop, Triage, Engage, Educate and Rehabilitate (STEER), and Law Enforcement Assisted Diversion (LEAD). One example is

Definitions

Peer

Identifies a single person with a particular lived experience that positions the person as a distinct other. As a label, "peer" has been used to distinguish one group of people from another, often based on differing levels of power, compensation, perceived knowledge, or even social value.

When combining their experiential expertise with technical knowledge and specialty training and certifications, peers—that is, people in recovery—are the movers and shakers at the forefront of establishing quality addiction treatment and recovery supports.

Peer recovery support services (PRSS)

PRSS refers to recovery support services provided by persons in personal/family recovery who may possess additional characteristics (e.g., age, gender, ethnicity, sexual orientation, military service, past incarceration) that enhance the process of mutual identification with the recovery support relationship.

Peer support includes guidance through inquiry to allow for person-centered goal planning and resource sharings. It promotes self-directed healing from the past; creating, or recreating, a meaningful life; and being of service to family, friends, and community. The help is often freely given. People in recovery are drawn to work in the field, often out of a sincere desire to "pass it on," to use their experience to benefit others.

Peer practice

This term refers to the application and implementation of a set of defined principles, structures, and methods when providing a peer service or program.

In some communities, peers are employed by a law enforcement agency or a partner government agency. In others, government institutions have partnered with treatment providers or community-based organizations that offer peer supports.

Peer Support—Defining and Exploring Its Reemergence and Roles Across the Intercepts (continued)

Operation HOPE, a partnership between the Scarborough Police Department and the Portland Recovery Community Center.

Intercept 3: Jails/Courts

Specialty courts across the country provide a range of services to their participants, including peer supports. The National Drug Court Initiative fact sheet *Building Recovery Oriented Systems of Care for Drug Court Participants* noted that peer support workers are important for connecting offenders to recovery-supportive resources. And initial findings of a Temple University study on peers in drug treatment court settings presented at the 2018 National Association of Drug Court Professionals (NADCP) conference indicate that peers do positively affect outcomes.

Intercept 4: Reentry

Peer support can make a huge difference for newly released inmates with behavioral health conditions, helping them to overcome lack of support, lack of employment, and lack of access to services. In this Hogg Foundation podcast, two peer supporters talk about their work in support of successful reentry.

Sequential Intercept Model

The Sequential Intercept Model is a useful tool to plan peer supports across a recovery-oriented continuum. The graphic (on the right) gives examples of supports at each intercept.

Sequential Intercept Model

Action for System-Level Change Related to Integrat

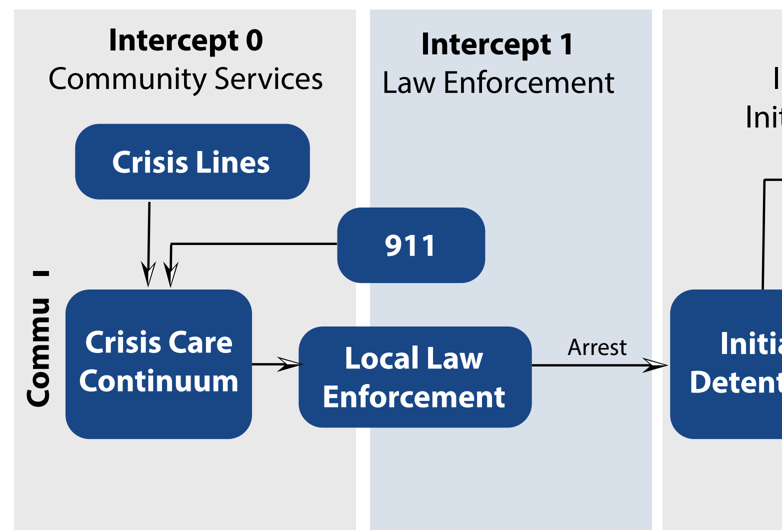
Engage persons with lived experience in all phases of planning, implementation, and program operation.

Encourage support and collaboration with recovery community organizations and community-based providers of recovery support services, including recovery housing.

Ensure positive linkages among law enforcement and community-based peer recovery supports.

Take legislative action into jail diversion prog health disorders.

Improve access to pee Medicaid funding.



Potential Peer Services at Each Intercept

Use peer navigators to assist with service linkages and follow-up for individuals who survive overdose; operate warm lines.

Integrate peers as part of mobile crisis outreach/crisis invervention teams, working in crisis stabilization units and respites, or on Assertive Community Treatment (ACT) teams.

Connect individuals to comprehensive peer supports, including harm reduction and recovery planning, peer recovery coaching, support group facilitations, and telephone recovery supports.

Integrate peer supports into pre-arrest deflection or diversion programs that engage individuals based on risk factors and needs.

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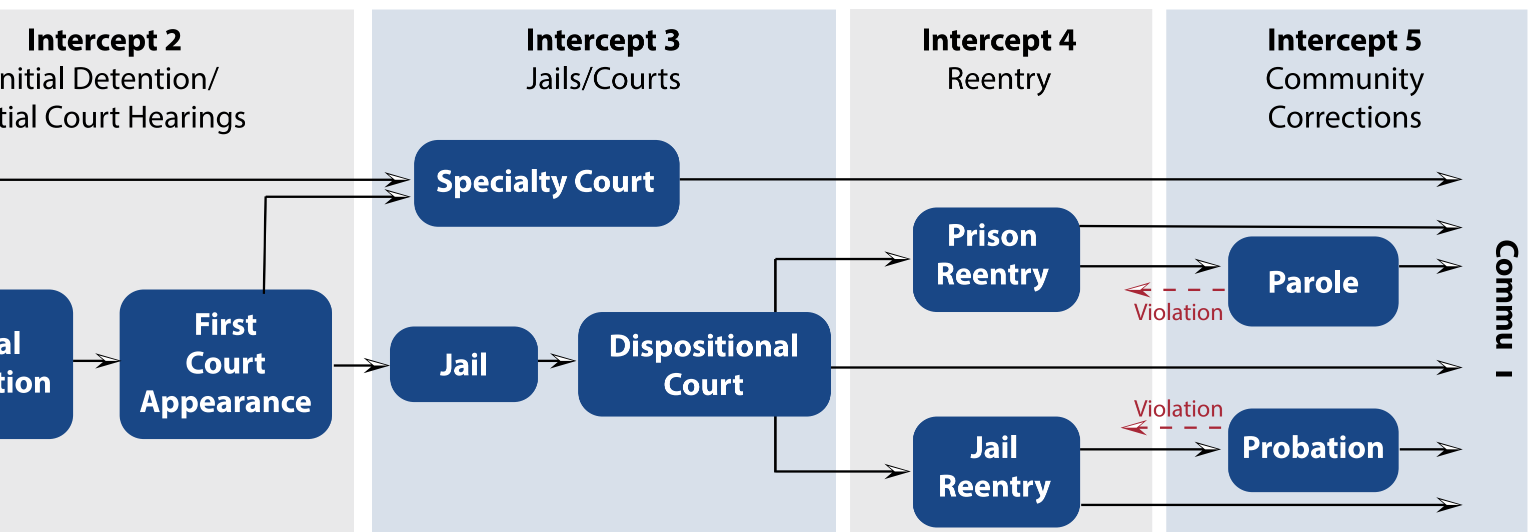
Make recovery housing for offenders with behavioral health disorders a priority.

Expand access to peer support services to sustain recovery, across the range of emotional, information, instrumental, and affiliational supports, to include peer recovery coaching, recovery housing, and recovery community centers.

Ensure access to evidence-based peer support services in jails and prisons to help with transition to community support.

Ensure that all systems and services are culturally competent, gender specific, trauma-informed, and supportive of many pathways to recovery.



...r supporters to help individuals ...what has happened and prepare ...is coming next, for explaining ...st, detention, and arraignment ...es; helping to ensure that the ...al feels safe and respected; and ...he individual hope that they can ...from mental illness and ...ce abuse and cope with criminal ...ystem involvement.

Offer comprehensive peer supports, including recovery planning, peer recovery coaching, peer support groups, and other recovery supports as part of the services available through specialty courts and diversion programs.

Offer peer support groups within jail, and connect individuals with range of recovery supports.

Assertively connect individuals with community-based peer recovery supports as a part of planning for reentry. Offer recovery planning, recovery management, and system navigation including connection to recovery housing, and connection with a recovery community.

Incorporate peer services at day reporting centers (DRC) and residential reentry centers.

Co-locate recovery community centers with DRCs.

Ensure all individuals under community supervision have access to a peer recovery coach and other supports that help with a life in recovery, balancing the responsibilities of meeting the provisions and conditions of their probation or parole with other daily-living needs, including housing, employment, and benefits.

Source: GAINS Center/ PRA Inc.

Pre-Criminal Intervention Programs

State prescription drug monitoring programs (PDMPs) continue to enhance their analytic capabilities to identify potential doctor or pharmacy shopping. The Nevada and Ohio PDMPs have instituted pre-criminal intervention programs through a BJA Harold Rogers PDMP grant. Both initiatives leverage state laws and utilize PDMP data to serve three essential functions: (1) identify individuals in need of intervention; (2) induce enrollment in the program; and (3) monitor program participants' purchases of prescription drugs, a key indicator of behavior change and treatment compliance.

The Nevada PDMP, operating within the Board of Pharmacy, implemented its initiative in 2004. Once a potential candidate for the program is identified, he or she is contacted by an intervention officer. The officer informs the individual that his or her recent prescription history indicates possible violation of Nevada's laws but that the participant can avoid potential arrest by agreeing to work with the officer towards addressing potential issues related to his or her opioid abuse or misuse. The program leverages the law and affidavits from medical providers to persuade individuals to restrict their controlled prescription drugs to a single prescriber and one or two pharmacies. An individual willing to participate also becomes eligible to receive additional support from the intervention officer; for example, help in finding substance abuse treatment, affordable and coordinated medical care, job and housing assistance, and/or other services as necessary. Compliance with treatment is monitored by reviewing the participant's PDMP data during the course of the agreement to help ensure the appropriate use of controlled substances.

Data from 2008 to 2011 found that of the 80 participants who agreed to the program conditions, 89 percent were able to comply with their intervention agreements while receiving case management support from their intervention officers. Follow-up on the same participants approximately five years later, when the program was suspended due to lack of funds, found that 75 percent remained compliant with their intervention agreements and thus avoided arrest. The program was reinstated in June 2016 with limited resources, focusing primarily on the northern parts of Nevada. Since then, two participants have entered the program and have stayed in compliance for more than a year.

The Ohio Automated Rx Reporting System (OARRS), also operated by the Board of Pharmacy, became the second PDMP to initiate a pre-criminal intervention program. Through the BJA COAP grant, OARRS is conducting a pilot program in Franklin County. A local intervention agent and a local law enforcement officer contact any individual identified by the OARRS data as exhibiting questionable doctor or pharmacy activity to offer the individual substance abuse treatment in lieu of a potential arrest. If the person agrees to participate, he or she is immediately referred for services. The "warm hand-off" approach is made possible through established agreements with the local prosecutor and treatment providers to ensure immediate access to care. If the person does not agree to participate, he or she may be charged for a criminal offense by the local prosecutor. Although the program has been operating for only a couple of months, three participants have successfully entered treatment for their opioid abuse.

A key component of Ohio's program is sustainability. Therefore, the intervention agent will train local law enforcement officers so that the program can be implemented through the local law enforcement agency.

The goal of these intervention programs is to help program participants comply with the law and regain stability in their lives. While a comprehensive evaluation is necessary to determine the effectiveness of pre-criminal intervention models, preliminary findings indicate that the programs in both Nevada and Ohio are helping connect individuals in need of treatment services.

MECKLENBURG OPIOID SYSTEMIC RESPONSE PLAN—MECKLENBURG COUNTY, NORTH CAROLINA

Mecklenburg County Criminal Justice Services (CJS) has launched the Mecklenburg Opioid Systemic Response Plan, a comprehensive cross-system response to the opioid epidemic's impact on the Charlotte–Mecklenburg County region. The county's Substance Use Disorder (SUD) Task Force, a multidisciplinary stakeholder group initiated in 2013, provides oversight of the grant activities. The initial grant activities focused on developing a strategic plan to address the opioid epidemic, informed by research conducted by the University of North Carolina at Charlotte (UNCC) and CJS's Research & Planning Division. Research activities included gathering and analyzing opioid-related data (e.g., from EMS, 9-1-1 calls, emergency departments); gathering information on underserved populations; conducting an environmental assessment of the pathways to treatment services for offenders; and Sequential Intercept Model mapping. This information will be used by CJS and the SUD Task Force to develop targeted programming for the jail and community reentry population.

Comprehensive Opioid Abuse Program-supported project services include improved screening and identification of opioid abusers in jails and enhanced opioid tracks within the jail-based substance abuse treatment and drug court programs. To ensure and enhance continuity of care for individuals reentering the community, the project includes a full-time peer support specialist to initiate work with clients prior to release and up to six months post-release. The project also will implement targeted medication-assisted treatment (MAT) for two groups: (1) incarcerated individuals prior to release and during their transition to community-based treatment; and (2) individuals participating in the drug treatment court whose inability to access/afford MAT limits their recovery and progress in court. UNCC and CJS's Research & Planning Division are conducting process and outcome evaluations of the intervention services to support program implementation, identify obstacles to program participation, and identify the impact of project services, including key project features associated with recidivism.

NORTH CAROLINA

HAMILTON COUNTY, OHIO—QUICK RESPONSE TEAM

The Hamilton County Heroin Coalition (HCHC)—a partnership of public health officials, law enforcement, first responders, hospitals, elected officials, treatment providers, and faith-based organizations—is implementing a Quick Response Team (QRT). The QRT is composed of law enforcement, peer support staff members, and addiction treatment staff members who provide outreach and follow-up to educate overdose survivors and engage them in treatment services.

While QRT intervention has been implemented in jurisdictions across the United States, there is no single, homogeneous model for QRT services. One of the goals of the HCHC project is to provide the field with concrete, empirically informed guidelines for implementing QRTs. To this end, HCHC and its research partner, the University of Cincinnati, Institute of Crime Science (ICS), worked with local law enforcement and addictions services practitioners during the project planning phase to identify the critical components of QRT and develop a protocol for how information is recorded and tracked for each component. This will allow ICS to identify the effectiveness of the QRT elements and inform future implementation of the QRT model.

The HCHC QRT model consists of four core activities:

1. Tracking and locating the overdose victim.
2. Making initial face-to-face contact with the QRT team to build rapport, assess the individual's level of treatment motivation, and make treatment referrals.
3. Conducting follow-up phone calls by treatment team members to promote treatment engagement.
4. Linking individuals to treatment and support services.

QRT will also use social network analysis, conducted by ICS, to identify "hot" places, people, or times for substance-related offenses to focus QRT outreach efforts on individuals at risk of overdose.

OHIO

Fresh Start Program—Logan, West Virginia

The Southwestern Regional Day Report Center (SRDRC), the community correction diversion and alternative sentencing provider, serves as a one-stop shop for substance abuse treatment, case management, drug screening, community service opportunities, and direct supervision for the four-county region of Boone, Lincoln, Logan, and Mingo in West Virginia. SRDRC has implemented the Fresh Start Program, designed to improve access to treatment and support services; promote skill development through educational and vocational services; reduce the risk of recidivism; and improve the quality of life among individuals affected by opioid abuse and misuse.

The Fresh Start Program is a three-phase, opioid-specific treatment program that combines intensive outpatient treatment, case management services, and unique education and life-skill opportunities through agricultural and artisan community-based mentorships. Referrals to Fresh Start come through SRDRC and local courts. In the first phase of the program, clients receive intensive individual and group therapy provided by SRDRC. In the second phase, clients receive intensive case management, enroll in life and employment skills programming, and receive mentoring services. Southern West Virginia Community and Technology College (SWVCTC) will provide college credit for direct agriculture work at the Fresh Start Community Garden (to be developed by the program). Clients may use these credits towards certificate or degree programs. Refresh Appalachia will provide agriculture-related classes and skill-building opportunities, which also may be applied as education credits. The final phase of the program will focus on helping clients apply the skills they acquire and give back to the community. Fresh Start also partners with the Logan County Health Department at a satellite health center to provide services to at-risk opioid abusers or misusers. Marshall University and the Marshall University Research Corporation serve as research partners, collecting information on recidivism, relapse, level of service, and quality of life from face-to-face client interviews.

West Virginia

Resources

Hospital Toolkit: Resources, Tools, and Best Practices for Emergency Medicine to Address Addiction

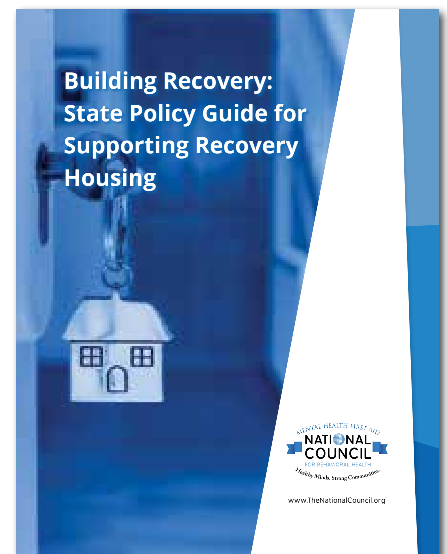
The Addiction Policy Forum launched a **hospital toolkit** to empower medical providers, patients, families, and policymakers to improve evidence-based screening, assessment, early intervention, and treatment best practices—critically important resources that can transform a trip to the emergency department into the first step toward recovery. Addiction is a progressive disease and the sooner we can intervene, the better the outcomes. The purpose of the Addiction Policy Forum's Hospital Toolkit is to empower patients, families, health care providers, and policymakers to work collaboratively to identify patients in need of help; initiate evidence-based treatments; and connect patients and families to comprehensive support services.

https://www.addictionpolicy.org/hospitaltoolkit

Building Recovery: State Policy Guide for Supporting Recovery Housing

The guide from the National Council for Behavioral Health and the National Alliance for Recovery Residences is designed to assist in the creation of certification systems for sober homes. The National Council recommends that states support efforts to adopt a common definition of recovery housing and establish a recovery housing certification program based on national standards; incentivize recovery housing operators to adhere to nationally recognized quality standards; and expand investment in and provide technical assistance for recovery housing.

https://www.thenationalcouncil.org/wp-content/uploads/2018/04/18_Recovery-Housing-Toolkit_5.3.2018.pdf.



Resources (continued)

National Public Safety Partnership

The National Public Safety Partnership (PSP) was established in June 2017 under the direction of Attorney General Jeff Sessions in response to President Trump's Executive Order on a Task Force on Crime Reduction and Public Safety, which emphasizes the role of the U.S. Department of Justice (DOJ) in combating violent crime. It states:

> "The Department of Justice shall take the lead on federal actions to support law enforcement efforts nationwide and to collaborate with state, tribal, and local jurisdictions to restore public safety to all of our communities."

PSP provides an innovative framework for DOJ to enhance its support of state, tribal, and local law enforcement officers and prosecutors in the investigation, prosecution, and deterrence of violent crime, especially crime related to gun violence, gangs, and drug trafficking. This approach serves as a platform for DOJ to directly engage with cities to identify and prioritize resources that will help local communities address their violent crime crises.

PSP serves as a DOJ-wide program that enables cities to consult with and receive coordinated training and technical assistance and an array of resources from DOJ to enhance local violence reduction strategies. PSP comprises two distinct levels of engagement: diagnostic and operations. These two complementary levels of engagement are offered based on the needs of the jurisdiction. This model enables DOJ to provide American cities of different sizes and diverse needs with data-driven, evidence-based strategies tailored to their unique local needs to address serious violent crime challenges.

https://www.nationalpublicsafetypartnership.org/

Funding Opportunities

1

Edward Byrne Memorial Justice Assistance Grant (JAG) Program FY 2018 Local Solicitation

The U.S. Department of Justice (DOJ), Office of Justice Programs (OJP), Bureau of Justice Assistance (BJA) is seeking applications for the Edward Byrne Memorial Justice Assistance Grant (JAG) Program. This program furthers the Department's mission by assisting state, local, and tribal efforts to prevent or reduce crime and violence.

Applications due: August 22, 2018

https://www.bja.gov/funding/JAGLocal18.pdf

2

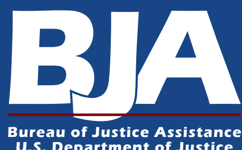
Edward Byrne Memorial Justice Assistance Grant (JAG) Program FY 2018 State Solicitation

The U.S. Department of Justice (DOJ), Office of Justice Programs (OJP), Bureau of Justice Assistance (BJA) is seeking applications for the Edward Byrne Memorial Justice Assistance Grant (JAG) Program. This program furthers the Department's mission by assisting state, local, and tribal efforts to prevent or reduce crime and violence.

Applications due: August 22, 2018

https://www.bja.gov/funding/JAGState18.pdf

Additional funding opportunities may be available on the Bureau of Justice Assistance website https://www.bja.gov/funding.aspx.



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