Sequential Intercept Model – Mapping Opioid Use Disorder Strategies

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Session Tasks

- Opioid Framework
- Sequential Intercept Model
- County Discussions
- Moving Forward
Jails and Mental Disorders

- General Population: 4% Serious Mental Illness
- Jail Inmates: 17% Serious Mental Illness, 72% Co-Occurring Disorders


Jails and Substance Use Disorders

- Drug Testing of Arrestees: 80% positive
- Jail Inmates: 63% Substance Use Disorders, 22% Co-Occurring Disorders, Only 41% Received Drug Treatment While Incarcerated

(Bronson, Zimm, & Berzola, 2017; T. Wilson, D. Draine, S. Hadley, M. Meaux, & E. Evans, 2011)
Complex Needs

Persons with OUD, SMI, SUD in general, have complex needs, even more for justice-involved (homelessness, stigma, isolation, substance use, poor physical health)

Overdose... (CDC)
Indiana Drug Poisoning Deaths and Syringe Programs

Focus on populations / Window of Opportunity

• **Opioid Use Disorder**
  - Impact across class, race, and demographic characteristics.
  - Special Populations: young adults – mid 30’s, veterans, residents of rural and tribal areas, recently released inmates, homeless, pregnant women, and people completing drug treatment/detox programs.

• **Majority of opioid overdoses are accidental**
  - Result from taking inappropriate doses of opioids, or
  - Mixing opioid drugs with other substances.
  - Window of opportunity to respond: 45-90 minutes to turn fatal
Collaboration and Data Sharing

How can PHI go to law enforcement?  
How can PHI go to the jail from treatment providers?  
How can judges address information sharing?  
How can PHI go to the jail from treatment providers?  
How can providers share information with each other?

Covered Entities vs. Business Associates

Business Associates
- Law Enforcement  
- Fire Department  
- Court Services  
- District Court  
- Corrections  
- Human Services- Outreach & Housing

Covered Entities
- Mental health  
- Treatment providers  
- Developmental Supports  
- Public Health  
- Human Services- Area Agency on Aging
Developing an Opioid Response Framework

- Collective Impact: You don’t have to do it all --- leadership, diverse stakeholders, maximize and leverage resources, Share Information, ATC - talk to each other!
- Local and Statewide - Call centers, Resources, Training, Services, Media/Campaigns
- Work across all Intercepts of the system:
  - Prevention – Diversion with Treatment – Enforcement
- Data: population, location, type, crime, trends, combined and separate
- Use Peers and Natural Supports; Supports with marathon availability
- Access and Responsive Treatment – No Wrong Door / As available as the drugs are
  - MAT – OTP, OBOT, On Demand; Readiness to Change → Harm Reduction
- Policy: address barriers, limit access to legal and illegal substance/interdict, streamline processes and improve access to care
- Fund and Resources

Materials and Process

- Powerpoint is part of the conference materials
- On the table: SIM Guide
  - County Work Sheet for Planning / Priority
- Your Job – Tracking the strategies on the Guide or Work Sheet. You will have time to discuss later...
  - It is in place,
  - It could be maximized,
  - It is needed,
  - It is not the right time or fit for your community at this time
Strategic approach to protect public safety and, improve public health

Intercept 0
Time of Crisis – Need Stabilization

Focus
- Be Proactive /No Wrong Door
- Embrace harm reduction
- Collective Impact: Align and leverage cross discipline resources
- Policy / Laws
- Education and Training
- First Responders/ Security
- Sites: Parks/ Library / Business
- Workforce Wellness
- Create an “ATC Net”
  - Crisis Stabilization
  - Follow-up

- Alternatives:
  - Assess for Release Risk
  - Screening Tools
  - Options /Collateral Impact
  - Pre-trial Sup
  - Fast Track/ Divert
  - Recovery PEERS
  - Bond 2nd Look
  - Pub Defender /Social Worker
  - Data: Charge, CH, Pre-trial/Bond Status, FTA, Timeline

Stabilize and Treat:
- Programming
- Share custody list
- Program – M/H
- Treatment Units
- Enroll Benefits
- Recovery Peers
- MAT / Med Consistency
- Maintenance
- Withdrawal Mgmt
- Induct / Treat
- Psyco/Soc Educate
- Pregnant Female
- Court Diversion –
  - Drug Court /Tx Ct
  - Pre/Post Plea
  - Civil Courts / ACT
  - Workforce Wellness
  - Data: #/% Cases, MAT Courts, Peers, Outcomes

Transitions:
- Assess Needs
- Transition / ATC
- Recovery Support / Peer
- Treatment
- Naloxone/Med
- Programming: Cog, Employment Life Skills
- Enroll / Activate Benefits/Ins
- Community Partners / VA
- Data: Programming, Supports, Recidivism

Prevent: HR and Tx and Recovery
- Collective Impact / Data*
- Education / Media /Training
- Stigma Reduction
- Policy / Laws: Access - PDPM
- Crisis Services / Call Lines
- Public Health / Harm Reduction / Infectious Disease
- MAT: Access/ Availability
  - Type, Integrated Care, W/Withdraw
  - Special Populations/
  - Sites
  - Funding/Benefits
- Recovery Supports
- First/ Other Responder:
  - Naloxone
  - Workforce Wellness
- Data: Location: drug use, Tx, Public
  - Space; Public Health: HIV, Hep C,
  - Drug/Needle Disposal,
  - Demographic, OD/Naloxone #

- Calls for Service
  - Divert to What?
  - Traditional and non-traditional response
  - Training
  - Co-response
  - Crisis Services
  - Defect/Divert
  - Naloxone
  - Overdose Intervention
  - Interdict / Enforce Task Force
  - Workforce Wellness
  - Data: Use, Drug Type,
  - Offenses, Distribution, OD

Supervise, Support and Treat
- Validated RNR
- Assessment
- Trained Staff
- Supervise / Connect
- MAT/Recovery / PEER
- Graduated/Leverage
  - Sanctions, Incentives/ Tech. Violations
- -Productive Time – Neg.Peer/ Leisure
- -Transitions: Housing
  - Jobs/ Transportation
  - Build Supports (ROI)– Employers & Natural
- -Enrollment Benefits
- Workforce Wellness
- Data: TV, Relapse,
  - Success, Recidivism

Prevent:
- HR and Tx and Recovery
- Collective Impact / Data*
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  - Drug/Needle Disposal,
  - Demographic, OD/Naloxone #
Collective Impact: It will take us all...

Do we aim to **effect significant change** (i.e., 10% or more) on a community-wide metric?

Do we believe that a **long-term investment** (i.e., three to five-plus years) by stakeholders is necessary to achieve success?

Do we believe that **cross-sector engagement** is essential for community-wide change?

Are we **committed to using measurable data** to set the agenda and improve over time?

Are we **committed to having community members** as partners and producers of impact?

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**Collective Impact**

**Among**
- Professionals
- People with Lived Experiences
- Business / Insurance
- Government
- Family Members/Advocates

**From**
- Policy
- Integrated Care
- MAT Treatment
- Schools
- Criminal Justice

**Supports**
- Social Services
- Entitlements
- Public Health
- Housing
- Community
- Veterans Services
Data Use and Response:

- Data Rich ------ Analysis Poor
- Inconsistent definitions and data integrity
- Cross-issue / entity data
- Cost analysis
- Response – Address and Remove Barriers
- Integrated Data and Information Sharing and Training
### Data: Intercepts 0 - 5

- Population Demographics – Age, Gender, Race/Ethnicity, other
- Access to Medications – Primary Care, Veterinarian, Dentist, Medicine Cabinet
- Drug Type, Length/pattern of use
- Overdose and repeat overdose / Naloxone Revive
- Location of use – Public (parks, library), Business, Home, Vehicle
- Screened, Assessed; Co-Occurring; Poly Substance
- MAT: Eligible; Inducted (type); Compliant; Location (medication, treatment groups, programs etc.);
  - Continuing in treatment, Length; Relapse
- Urine drug screens/results with probation and parole
- Charges – Drug, property
  - Distribution patterns
  - Divert
- Status in criminal Justice System, system time frames
- Supports and Relapse
- Time it takes to complete paperwork and induct to MAT

### Training:

**Individual-System-Community**

- Opioid and Opiate Pharmacology
- Poly-substance dangers /
- Synthetic drugs
- Compulsion and Perseverance
- Infectious Disease
- Alternative Pain Management
- Care Continuum
- Naloxone – First Responder/Other
Clinical studies document greater efficacy and more rapid pain relief with ibuprofen liquid caps when compared to tablets

- Lower doses of faster onset ibuprofen can be as effective as higher doses of standard formulations
- Reduced need for rescue medication
- Rapid onset

<table>
<thead>
<tr>
<th>Postoperative Dental Pain</th>
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<tr>
<td>Formulation</td>
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<tr>
<td>Standard</td>
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<tr>
<td>Fast-acting</td>
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<tr>
<td>Standard</td>
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<td>Fast-acting</td>
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Adapted from Moore et al., PAIN 155:14, 2014
CDC and SAMHSA Resources - Indiana

Opioid Treatment Programs in Indiana

> Currently 13
> 5 more planned in 2018

#KnowTheOFacts
Public Information and Access

- Online power point: Information to understand opioid use disorders and how to address them

- Address Stigma
  - Language Matters
  - First-person reference

Harm Reduction: Meeting People Where They Are

**Laws that Support Harm Reduction**

- Syringe Exchange and Drug Paraphernalia Law Exemption — Local jurisdiction approve for SE sites; exempt participants, staff, volunteers from drug paraphernalia laws
- 9-1-1 Good Samaritan Law — Criminal prosecution immunity if seeking help for self or others.
- Third Party Naloxone — Allows a person to administer an opiate antagonist to another person.
- Naloxone Standing Orders — Provides for access to naloxone with out specific Rx.
- Needle-Stick Prevention — Immunity if notify law enforcement of possession of controlled substance residue or needle.

- Manage Infectious Disease
  - HIV, Hep C
- Drug Take Back
- Signage and Brochures
Support for MAT

- Access to MAT
  - Hours, Location,
  - Hub and Spoke - OTB and OBOT
  - Treatment on demand
  - Crisis Lines and Care
- Availability
  - Community Integrated Care
  - Jail
  - Medical Home
- Special Populations:
  - Pregnant Women, Young Adults,
  - Returning, Homeless
- Funding – Private, Grants
  - Medicaid, Medicare?

Indiana: New Resources:
- Growing OTP to 27 in 2018; Access within ONE hour drive; Adding treatment centers and inpatient residential services
- Medicaid pay for methadone tx
- CMS 1115 Waiver obtained to increase MAT and short-term residential coverage and peer support
- DOC – Screening, Naloxone; Diversion – Allen County; Involuntary Commitment piloted in Wayne and Tippecanoe Counties – repeat OD

Other Supports:
- Mobile Crisis Funding; Peer Recovery Coaches in ED; Open-beds platform via 211
- Grants; FSSA – Office of Social Determinants, System of Care
- Workforce Recovery Initiative
- PEW Charitable Trust – Treatment System Recommendations
- Fresh Start Recovery / Community Health Network – Pregnant Women
- Website – Know the Opioid Facts

Medication-Assisted Treatment (MAT)

Medication is used in combination with counseling and behavioral therapies

Medication:
- Reduce the cravings and other symptoms associated with withdrawal
- Block the rewarding sensation that comes with using a substance
- Induce negative feelings when a substance is taken.

Medication for Opioid Use Disorders:
- Methadone
- Buprenorphine
- Extended-release injectable naltrexone
  - Reduces the risk of relapse
  - Helps control cravings.
  - Particularly for people exiting a controlled setting where abstinence has been enforced
MAT Resources

- TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction – 2004
- TIP 43: Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs – 2008
- Methadone Treatment for Pregnant Women – 2009
- Advisory: An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People with Opioid Dependence – 2012
- SAMHSA Opioid Overdose Prevention Toolkit – 2014

Treatment Responsivity:

- Individual and group counseling
- Inpatient and residential treatment
- Intensive outpatient treatment
- Partial hospital programs
- Case or care management
- Medication Assisted Treatment
- Recovery support services
  - 12-Step fellowship
  - “sober” housing, places
  - WRAP
- Peer supports
Services are often provided by peers, or others in recovery

- **Transportation** to and from treatment and recovery-oriented activities
- **Employment** or educational supports
- **Peer-to-peer services**, mentoring, coaching
- **Parent / Family Education**
- **Spiritual and faith-based support**
- Specialized living situations
- **Self-help and support groups**
- Outreach and engagement
- **Staff**: drop in centers, clubhouses, respite/crisis services, or warm-lines, living room
- Peer-run listening lines
- Education about strategies to promote wellness and recovery

Peer support has been shown to:

- Improve quality of life,
- Improve engagement and satisfaction with services and supports,
- Improve whole health, including chronic conditions like diabetes,
- Decrease hospitalizations and inpatient days, and
- Reduce the overall cost of services
- Peer support empowers people to make the best decisions for them and to strive towards their goals in their communities. (MHA, website)
WRAP –
Individuals know themselves best

Wellness Recovery Action Plans – 5 components
1. Daily Maintenance Plan
2. Triggers
3. Early Warning Signs
4. When Things are Breaking Down
5. Crisis Plan and Post Crisis

- Hope
- Personal Responsibility
- Education
- Self Advocacy
- Support

Stable Housing is Treatment

Building a strong continuum of housing resources...

- Emergency Shelter
- Transitional Housing
- Permanent Supportive Housing
- affordable Housing
- Home Ownership
- Rapid Re-housing

Getting Started with Evidence-Based Practices

Permanent Supportive Housing
First and Other Responder, Treatment Provider and Workforce Wellness

Responders:
- Fire – EMS – Park Ranger – Security
- Public Space and Business
- Treatment Provider
  - Naloxone Administration

Support:
- HR and Risk Management
- Training / Expectations
- Trauma and Exposure
- Support and Resources

Intercept 1
Law Enforcement – Decision to Contact and Action

- Divert to What?
- Criminal Justice vs Deflect
- Guardians and Warriors
- Clinical Co-Response
- Training and Resources
- Leverage System
- Drug/Interdiction Task Force
- Workforce Wellness
- Pass Forward Information
- Laws: tools and tangle
9-1-1: Asking Specific Behavioral Health “??”

- Does this call involve anyone with mental health issues?  
  - If No, proceed with call-slip processing.
- If Yes, the following questions are to be asked and the responses added to the call-slip:
  - Does the individual appear to pose a danger to him or herself or others?
  - Does the person possess or have access to weapons?
  - Are you aware of the person’s mental health or substance abuse history

Track and analyze data…

Divert TO WHAT?

- Training:
  - Crisis Intervention Teams (CIT)/Training
  - Mental Health First Aid Training
  - SUD Pharmacology / Overdose
  - Naloxone / Overdose Signs
  - Synthetic Opioids
- Co-Clinical Response Models
  - Mental health / Substance Use Disorder / professionals / Peers working along side police department
- Co-Responder / Mobile Mental Health Crisis Teams (LAPD, Houston, Denver, Boulder, Knoxville, Pima County, etc)
- Peer Recovery Support
- Deflect /Diversion Options (LE): LEAD/PAARI
- Coordinated Overdose Response*
  - Information / Observation Sharing
- Crisis Support – Drop off Centers/ Hospital /Detox – Sobering, Social Model
- Off Site Support
  - Telephone / Video Conference Support to on scene officers (Hawaii, Fort Worth, Tx / Lincoln, NE; Springfield, MO)
- First and Other Responders
  - Specialized EMS/Fire Response
  - Training/Co-response (Atlanta, GA; Wake Co, NC, Denver, Co)
- Park Rangers / Other Security
- Work Force Support
  - Policy/Laws Education: Good Samaritan, Needles, Etc
- Data tracking, analysis and sharing
Coordinated Overdose Response

- Team Approach
  - Police
  - Hospital / Drop in Center
  - Clinician
  - Recovery Peer
- Trigger: Overdose
  - Responder
  - Hospital
- Proactive outreach, education and wellness

Plymouth County Outreach

- OD Follow Up Outreach Visit
- Drop In Centers
- Awareness & Wellness

Law Enforcement Action

- Law enforcement observations are key to understand what is happening
  - Data tracking is robust
  - Information is no good if not passed forward
- Deflection happens when alternatives are available - smooth
- Interdict and Enforcement
  - Laws can be tools or entangle law enforcement hands
    - Indiana –(18) HEA1359 Penalties for manufacture or distribution for drugs resulting in overdose
Challenges in Crisis Stabilization Services

- Challenges:
  - Culture: call the police; “law enforcement social workers”
  - Divert to What?
    - Services limited to normal business hours
    - Agencies often reach capacity limits
  - Gaps in appropriate crisis care services—“Churn and Constrict = Align and Sort”
  - Safety – Fentanyl and Carfentanil

- Better utilization of existing resources:
  - Call centers, crisis and walk-in centers / referral and follow-up
  - Underutilization of services (such as detox)
  - Clinical and Peer Response

Diversion Equation in Intercepts 0/1

What First Responders Do Differently

What Treatment Providers Do Differently

System Change

They work together differently
Intercept 2
Initial Detention/Initial Court Hearings

Focus
• Assess/identify Risk and Needs
• Detain or Release
  • Pre-trial release
  • Bond / Bail
• Stabilize and Public Safety
• Diversion: Treatment? Fast Track?
• Accountability and Treatment
• “Give’em a nudge” –
  • Court Reminder Cards/Text/Call
• Divert to Civil Actions

NACo Analysis of Jail Populations

- 87% Percent of jails owned by counties
- 67% Percent of confined jail population that is pretrial
- 40% Percent of jails that use a risk assessment
- 60% Percent of jail population assessed “low risk” among jails that use risk assessments
Identification and Referral for Diversion

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<tr>
<th>Systems</th>
<th>Strategies</th>
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<tr>
<td>Law enforcement</td>
<td>Law enforcement observations</td>
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<tr>
<td>Pretrial services</td>
<td>Validated risk-based screening/assessment</td>
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<tr>
<td></td>
<td><strong>Monitoring Options... GPS, SCRAM, Drug Test</strong></td>
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<tr>
<td>Booking officers</td>
<td>Inmate identification and classification</td>
</tr>
<tr>
<td>Jail medical staff</td>
<td>Medical/BH current/Future Treatment Needs</td>
</tr>
<tr>
<td>Prosecutors</td>
<td><strong>Charging and initial diversion options</strong></td>
</tr>
<tr>
<td>Public defenders</td>
<td>Identify potential options / <strong>Social Worker</strong></td>
</tr>
<tr>
<td>Judges</td>
<td>Weighing risk and options/ <strong>Diversion</strong></td>
</tr>
</tbody>
</table>

Goal: balancing public safety, personal rights, and appropriate use of jail

Substance Use Screenings, Assessments, and Interventions

- SAMHSA’s Screening & Assessment of Co-Occurring Disorders in the Justice System (2016)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - SAMHSA’s Systems-Level Implementation of SBIRT (2013)
Recommended Substance Use Screens

- **Texas Christian University Drug Screen-V (TCU-DS) and Opioid Supplement**
  - Past 12-month use based on DSM-V criteria; 17 items
  - Consider combining with the AUDIT for alcohol use

- **Simple Screening Instrument for Substance Abuse (SSI-SA)**
  - Past 6-month alcohol and drug use; 16 items
  - Considering combining with the AUDIT for alcohol use

- **Alcohol, Smoking, and Substance Involvement Screening Test (ASSI-ST)**
  - Screens for lifetime use, current use, severity of use, and risk of IV use. Available from the World Health Organization and NIDA.

- **Risk and Needs Triage (RANT) Tools**
  - Developed by Treatment Research Institute (TRI); Good for treatment courts
  - RANT Streamline risk/needs assessment; 15 min or less to administer
    - 19 Items; Sorts into 4 risk/needs quadrants

Identification and Referral of Veterans

**Veterans Reentry Search Service (VRSS)**

VA's web-based system to allow prison, jail, and court staff to quickly and accurately identify Veterans among their inmates populations

**Veteran Justice Outreach (VJO) Program**

https://vrss.va.gov/
Accountability, Public Safety and Collateral Consequences of Justice System Involvement

Collateral Consequences
- Employment
- Housing
- Voting rights
- Driver’s license
- Student loans
- Relationships
- State Benefits: TANF/ SNAP
- Federal Entitlements: SSI/SSDI

Identification and Screening
- Court-based Clinician
- Recovery-based Engagement
- Proportional Response

Focus
- Facility Programming: Increase stabilization
  - Share list of who is in jail
  - Assess needs / Hx Care
  - Programming/address presenting issues in custody / Continuity services to community
  - Peer Supports
  - Sort Population – Serve Med-High
  - Initiate Benefit Enrollment – Medicaid/ SOAR
  - Treatment Housing Units
- Medication Consistency
- MAT protocols
  - Maintain
  - Induct
  - W/D Management
  - Stabilize / Craving
  - Naloxone – Exit
- Funding / Medical Continuity
- Courts:
  - Drug Court
  - Civil Court
  - Assisted Outpatient Treatment (AOT)
• In-jail services
  • Notice of who is in jail
  • Assessment of in-custody needs; Ask:
    • Substance Use Disorder / Opioid
    • Mental Health / Trauma / TBI / Suicide
    • Veteran
    • Benefits – SSI/ SSDI
  • Sort the population to provide services to med-high risk and needs populations
  • Medication Consistency: Access to medications, mental health services, and substance use services
  • MAT – all levels; minimum of withdrawal management, Naloxone release, Women
  • Communication with community-based providers/ Programming

• Divert to Treatment and Special Populations Courts
  • Drug/DUI courts, mental health courts
  • Civil Court - AOT

Managing Complex Issues and Individuals in a Jail Setting

- Treatment Housing Units
  • High Acuity Treatment
  • Mental Health Stabilization
  • Substance Use Disorder
  • Infirmary
- Medication Continuity
- MAT Protocols
- Transition Services (ATC)
  • Programming
  • Reentry planning
  • Peers / Recovery

- Challenges
  • Space / Movement
  • Cost
  • Staff
- Limited Formulary
  • Leaving $ on the table / Partners
  • Inconsistent Formulary
- Limited MAT Scope
  • Policy’s that don’t support MAT
  • Medication Cost
  • Surrounding jails wont maintain MAT
- Programming Limitations
  • Population are not sorted to deliver services to high needs individuals
  • Prohibit peers
MAT in Jails and Prisons

**FDA-Approved Medications for Substance Abuse Treatment and Tobacco Cessation**

<table>
<thead>
<tr>
<th>Medications for Alcohol Dependence</th>
<th>Naltrexone (ReVia®, Vivitrol®, Depade®)</th>
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<tbody>
<tr>
<td></td>
<td>Disulfiram (Antabuse®)</td>
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<tr>
<td></td>
<td>Acamprosate Calcium (Campral®)</td>
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<tr>
<td>Medications for Opioid Dependence</td>
<td>Methadone</td>
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<tr>
<td></td>
<td>Buprenorphine (Suboxone®, Subutex®, and Zubsov®)</td>
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<td></td>
<td>Naltrexone (ReVia®, Vivitrol®, Depade®)</td>
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<tr>
<td>Medications for Smoking Cessation</td>
<td>Varenicline (Chantix®)</td>
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<td>Bupropion (Zyban® and Wellbutrin®)</td>
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<td>Nicotine Replacement Therapy (NRT)</td>
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</tbody>
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SAMHSA and HRSA Integrated Solutions as resources
http://www.samhsa.gov/medication-assisted-treatment

Denver Sheriff Department Levels of Intervention for Opioid Use Disorder

1. Participate in the collective impact, coordination, and communication
2. Continued dosing if already on MAT protocols and in central registry
3. Detention based, short-term Methadone induction - 4 day process
   - Reduced sentence with compliance
   - Release directly to treatment provider; release with peer support
4. Jail based MAT Induction:
   - Buprenorphine Based on withdrawal status and LOS
   - Pregnant woman inducted with Methadone or Buprenorphine.
   - Ability and support to access ongoing medical support
   - Length of stay is longer in jail allows for supporting observation, stabilization, cognitive skill training
   - Supports cognitive treatment to support MAT
5. Naltrexone (Vivitrol—shot, extended release), or, if not able to be inducted, use Buprenorphine to manage withdrawal.
6. Naloxone (Narcan) at release – especially for those not on MAT to prevent overdose
Using Criminal Charges as Leverage for Involvement in Treatment  (Griffin, Steadman, & Petrila, 2002)

- **Diversionary ---**
  - Example: Prosecutor holds charges in abeyance based on agreement to enter treatment under supervision of mental health court; Plea is entered but adjudication is withheld

- **Post-Plea Based ---**
  - Example: Guilty plea is accepted; Sentence is deferred

- **Probation Based -**
  - Example: Conviction with treatment as a term of probation plus suspended jail sentence

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**Drug Courts Embracing MAT**

- Drug Courts support MAT as part of treatment
- Forensic Peer Support/Navigators
- Expedited access to treatment
- Access to jail based services*
  - Induction = reduce sentence
- Solid release coordination
- Policy – when is enough, enough…

* Illustrated content related to MAT access in drug courts.
**Intercept 4**
Transition and Reentry

**Focus**
- Assess Reentry Needs by Time
- Transition - Continuity of Services
  - Jail – community - Warm hand-off – ATC, Appointments
  - Service Information
  - Programming: Cog Skill, Employment, Life Skills
  - Community support visible and available in jail
  - Benefit Enrollment / Activate
  - Recovery Peers and Supports
- Medication Continuity
- Medication at release / Naloxone

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**Reentry is a Matter of Life and Death**

- Study of 30,000 prisoners released in Washington State (2007)
  - 443 died during follow-up period of 1.9 years
    - Death rate 3.5 times higher than general population
  - Death rate for inmates with SMI 13 times higher in the 14 days following release
  - Primary causes of death
    - Drug overdose (71% of deaths)
    - Other: heart disease, homicide, and suicide
- Post-release death by suicide nearly times higher than jail deaths

*Source: BJS Statistics, August 2015, NCJ 248756*
Naloxone given to releasing inmates: especially those who are not engaged in MAT

Inmates released from incarceration are 129 times more likely to die of drug overdose than the general population in the first 2 weeks
3.5x more likely to die of any cause


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Transition Facility- to- Community

**Re-entry Framework**
- Reentry begins as soon as a person enters a facility
- Sort the population by risk and need. Focus on persons medium- high risk
- Assess: a) Validated risk/needs screening tool, b) Reentry “check list”
- Recovery and stability: first 24 hours, week, 3 months and 9 months
  - Recovery Peers and Supports
- Basic: Benefit/Insurance Enrollment, Release Medication /Naloxone, Provider List, Employment Resources

**Re-entry Models**
- Refer out
  - Institution staff provide inmates referrals to community-based services
- Reach in
  - Providers conduct intakes and arrange service plans
- Transitional reentry
  - Shared responsibility. Services delivered in facility and community
The APIC Model of Transition Planning

<table>
<thead>
<tr>
<th>Assess</th>
<th>Plan</th>
<th>Identify</th>
<th>Coordinate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess the inmate’s clinical, social needs, &amp; public safety risks</td>
<td>Plan for the treatment &amp; services required to address the inmate’s needs</td>
<td>Identify required community &amp; correctional programs responsible for post-release services</td>
<td>Coordinate the transition plan to ensure implementation &amp; avoid gaps in care with community-based services</td>
</tr>
</tbody>
</table>

GAINS Re-Entry Checklist

- Based on APIC model
- Assist jails in re-entry planning
- Quadruplicate form
- Inmates’ potential needs
- Steps taken

Re-Entry Checklist Domains

- Mental health services
- Psychotropic/MAT medications
- Housing
- Substance abuse services
- Health care
- Health care benefits
- Income support/benefits
- Food/clothing
- Transportation
- Other (often used for child care needs of women)

Jail and Prison Transition Challenges....

- Medication: Continuity, off formulary, no prescriptions upon release
- Programming: Limited access, lack continuity between facility and community
- Population is not sorted, meaning high-risk individuals are not served
- Insufficient connection to community-based services; Service providers who can meet needs
- Release: time, lack of notice, transportation; services are not immediate or two short in duration
- Lack of Medicaid/SSI enrollment
- Hold and transfers to other non-MAT jails
Intercept 5
Community Corrections/Community Supports

Focus
• Staff training: MI, Peer, Cog, OUD, Mental Health, Trauma
• Validate Risk /Needs Assessment – Address RNR / ASAM
• Foster natural supports / peers
• Develop cross discipline relationships
• Re-weave the net
• Build provider capacity
• Maximize resources
• Honor culture
• Create new transition
• Workforce Wellness

Parole

Probation

COMMUNITY

Violation

6.9 Million Under Correctional Supervision

Parole 12%
Prison 22%
Jail 11%
Probation 55%
Amplify Best Practices in Probation and Parole with a Focus on Opioid Use Disorder

• Staff Training: MI, CST, Trauma, Mental Health, ASAM/SUD/OUD, Mat
• Build effective partnerships with treatment providers, business and system
• Graduated Sanctions and Incentives - Reduce Technical Violations
• Community-based supervision if possible
• Recovery Supports with peers and natural supports, services
• Support treatment / MAT
• Validated RNR Assessment Tool
• Case Plan = WRAP Plan?
• Specialized caseloads with low ratio
• Focus on criminogenic risks and needs
  • Housing, Employment
  • Productive Time: Leisure Time and Pro-Social Supports
RNR Model: Risk - Need - Responsivity

Major Risk Factors for Recidivism: Central Eight

**Big Four**
- History of antisocial behavior
- Antisocial personality pattern
- Antisocial cognition
- Antisocial associates

**Moderate Four**
Can Be Protective Factors
- Family circumstances
- School/Work
- Leisure/Recreation
- Substance Abuse

Coordinating with Community Resources:
ASAM Criteria- Moving away from the cookie cutter approach

**Note:**
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.
<table>
<thead>
<tr>
<th>Criminogenic Risks</th>
<th>Needs</th>
<th>Potential Approaches/Enhance Responsivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial Behaviors</td>
<td>Reduce antisocial acts</td>
<td>Education, frequent contact with case manager/peer, strong communication between provider and probation/parole</td>
</tr>
<tr>
<td>Antisocial Personality Patterns</td>
<td>Decrease impulsivity, irritability, irresponsibility, help coping, problem-solving</td>
<td>Stress management exercises, problem-solving exercises, trauma informed care (TIC)</td>
</tr>
<tr>
<td>Antisocial Cognitions</td>
<td>Decrease antisocial cognitions, risk thinking</td>
<td>Referral to EBPs such as MRT, Thinking for a Change, etc.</td>
</tr>
<tr>
<td>Antisocial Peers</td>
<td>Decrease association with other criminals, enhance pro-social contacts</td>
<td>Peer supports, activities that allow for pro-social associations (e.g. volunteering, community service), fostering hope and positive connections</td>
</tr>
<tr>
<td>Family/marital relationships</td>
<td>Improve relationships with family and significant others when possible</td>
<td>Treat symptoms of mental illness, Help examine broken ties and how to rebuild, TIC, factor in criminal issues (e.g., DV)</td>
</tr>
<tr>
<td>Employment/Education</td>
<td>Assist in enhancing employment/academic skills and achieving goals</td>
<td>Identify housing, treat mental illness, Vocational skills linkages, employment supports, rewards for positive achievement</td>
</tr>
<tr>
<td>Leisure and recreation</td>
<td>Increase time in prosocial activities</td>
<td>Identify schedules, activities, community service</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Decrease substance use, enhance motivation for change</td>
<td>Active treatment (not just detox), monitoring as needed, plan for relapses, treat co-occurring mental illness</td>
</tr>
</tbody>
</table>

CRIMINOGENIC RISKS, NEEDS AND SAMPLE TREATMENT PLANNING
(adapted from www.missionmodel.org)

Probation Resources
Your Turn

- On your table is a copy of the SIM OUD areas of work, and worksheets
- At your table, prioritize resources and gaps
Indiana Opioid Summit: Sequential Intercept Map (SIM), County Work Sheet

County: ____________________________

Below are three tables that follow the SIM presentation. As the presentation unfolds think about the status of each strategy in your County. In this exercise, we will identify your current opioid strategies, and gaps you may want to consider implementing based on your tables discussion. Some of the strategies may be specific to an agency who becomes the natural champion for their implementation…all contributing to the collective impact that needs to occur. The full SIM includes 6 intercepts, however, here you will see intercepts combined as: 0-1, 2-3, and 4-5.

Instructions:
1) At each table choose a lead and someone to take notes. You will have about 30 minutes to discuss strategies across all of the intercepts. I will give reminders of when to move to next set of Intercepts. You will not have time to go into depth, so please use your time to review all of the strategies rather than discussing a few. Review and briefly discuss the strategies, add strategies you are using locally that are not on the table. The goal is for you to identify priority areas that you can act on when you return home.
2) Determine if the strategy is already in place and maximized. If it is in-place, place and “X” in the box. If not currently in place, leave it blank.
3) If it is in place but not maximized, mark the box with an “X” and consider prioritizing it as an action state.
4) If it is not in place locally, but “needed”, mark that box.
5) If it is not in place locally, and you don’t believe it is “not the right time or fit”, mark that box.
6) In the priority box, review the items you have identified as “needed” and/or maximize and prioritize them and who would be the lead or champion.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>In place</th>
<th>Maximize</th>
<th>NEEDED</th>
<th>Not the Right Time/Fit</th>
<th>Priority; Champion? When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collective Impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education, Media Campaign and Messaging, Training, Stigma Reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harm Reduction: Syringe Exchange, Infectious Disease</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>MAT: Access/Availability – OTP, OBOT, Psycho/Soc Education. Integrated Care – Primary, Mental Health, SUD/DUO. Withdrawal Management, Treatment on Demand.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Populations: Pregnant Women, Homeless, Young Adult, Repeat Naloxone/Revived</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Funding – Insurance, Grants, Medicaid, Medicare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery Supports / Peers / Housing / WRAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
First and Other Responders – training and carry Naloxone

Calls for Service – 9-1-1 and Crisis Call lines ask about mental health and substance use disorders

Divert to What? Clinical Co-Response, Peers, Targeted training

Deflection – to treatment with support (MAT, LEAD)

Overdose Intervention – response: Police, Peer, Clinical post any overdose or use of Naloxone

Workforce Wellness

Interdict / Enforce / Task Forces

Data

Intercept 0-1 Notes:

<table>
<thead>
<tr>
<th>Intercepts 2 – 3</th>
<th>Initial Detention / Initial Court Hearings / Jails and Courts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy</td>
<td>In Place</td>
</tr>
<tr>
<td>Validated Risk based assessment tool</td>
<td></td>
</tr>
<tr>
<td>Using validated substance use screening tools to inform decisions</td>
<td></td>
</tr>
<tr>
<td>Options: Understanding of collateral impact of detention, jail and prison</td>
<td></td>
</tr>
<tr>
<td>Pre-trial supervision with monitoring as appropriate</td>
<td></td>
</tr>
<tr>
<td>Fast-Track Divert to Treatment</td>
<td></td>
</tr>
<tr>
<td>Recovery Peers</td>
<td></td>
</tr>
<tr>
<td>2nd Look for bond eligibility</td>
<td></td>
</tr>
<tr>
<td>Social Worker working with public defender to identify clients where treatment is needed</td>
<td></td>
</tr>
<tr>
<td>Jail programming: Share custody list, Programming – Medium and High risk, Treatment units, Benefit Enrollment/ODAR</td>
<td></td>
</tr>
</tbody>
</table>
Recovery Peers in facility and as part of Transition

MAT Protocols in Facility:
- Maintenance, Induct on Methadone, Buprenorphine
- Withdrawal Management on Buprenorphine
- Psycho/Social Education

Pregnant Female protocols

Drug or Treatment Court Diversion; leverage MAT treatment

Pre-Plea and Post-Plea Diversion Prosecutor / Courts - Divert to Treatment

Explore use of Civil Action and Assisted Outpatient Treatment (AOT) for repeat overdose incidents.

Workforce Wellness education and support

Funding / Insurance Coverage; Benefit Enrollment

Data

Intercept 2 – 3 Notes:

**Strategy**

**In Place** | **Maximize** | **NEEDED** | **Not the Right Time / Fit** | **Priority/Champion? When?**
---|---|---|---|---
Assess for Transition Needs before leaving the facility: First hour, 24 hrs, Week, Month, 3 months, 9 months
Recovery and Transition Support: Peer, WRAP, Treatment, MAT/Naloxone on Release, ATC
In FACILITY Programming: Cognitive Skill Training (CST), Employment training, Life Skills, etc.
Transition – facility to community – continuity; Veteran Services;
Probation/Parole Validated RNR Tool Leverage Resources; Embrace Recovery Peers
Trained Staff: MI, Trauma Informed Care, Mental Health, ASAM/SUD/DUD, Cognitive Skill
Supervise and Connect to community supports.
Recovery Supports as part of supervision: recovery peers, “WRAP” as part of case plan, MAT support, etc.
Graduated Sanctions and Incentives; Use of technical violations – Support access to treatment.
Go forward and Continue to do good work...

- Don’t Let Great Get in the Way of Good
- Manage what you can
- Collaborate When Possible /Collective Impact
- Step up – Step in
- Marathon not a Sprint
- Remove barriers / Streamline processes
- Manage “The MET” - Money, Ego and Turf

- ATC - seamless transition across the system
- Peers, Peers, Peers
- Employment, Transportation and Housing
- Data
- Using the SIM model to leverage the community brain trust
  - Strategic approach to protect public safety and improve public health
Thank You!

Regina Hueter
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"Coming together is a beginning; keeping together is progress; working together is success."
Henry Ford

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