



Prescription Drug Monitoring Program Training and Technical Assistance Center

Innovative Programs for Criminal Justice-Involved Individuals With Opioid Use Disorder: Sequential Intercept Model

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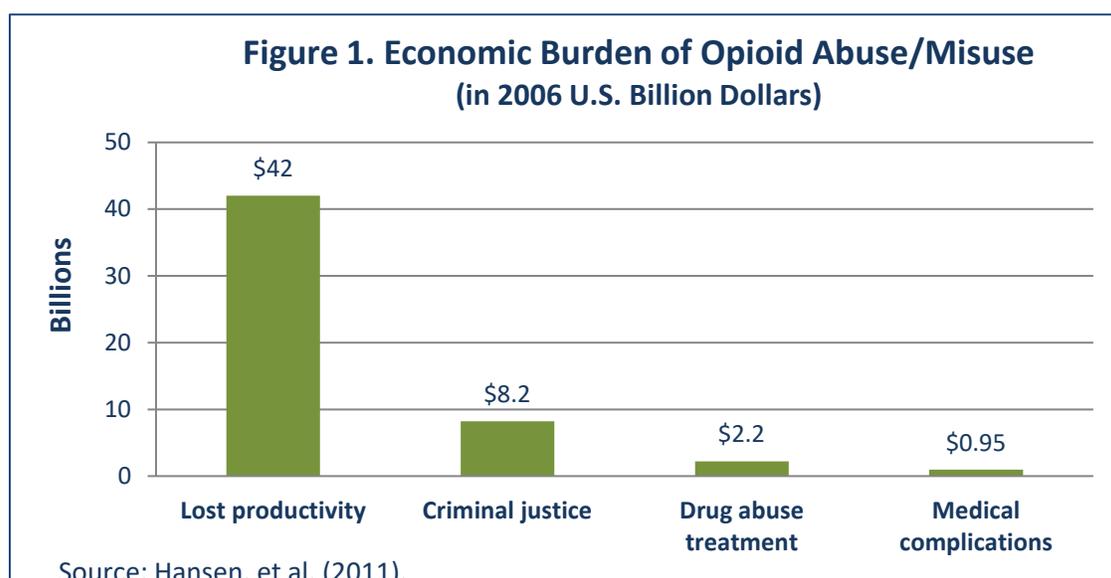
**Innovative Programs for Criminal Justice-Involved Individuals With Opioid Use Disorder:
Sequential Intercept Model**

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I. Introduction

For over a decade, prescription and nonprescription opioid drug abuse¹ have contributed to alarming rates of fatal and nonfatal overdoses. In 2014, the latest available data to date, the nation had the highest number of people who died from a drug overdose in any recorded year.² The cost to society in terms of torn families and communities is immeasurable. However, one study estimated the economic burden of nonmedical prescription opioid drug use in the United States to be \$53.4 billion. Of that amount, \$8.2 billion was attributed to costs from the criminal justice system.³



There is a well-documented link between illicit drug use and crime.^{4,5,6} According to the U.S. Department of Justice (DOJ), about 70 percent of state and 64 percent of federal prisoners

¹ Abuse and misuse are used interchangeably in this report, referring to the use of prescription drugs in a manner not directed or intended by the prescribing health-care practitioner.

² Centers for Disease Control and Prevention. Injury Prevention & Control. Understanding the Epidemic: <http://www.cdc.gov/drugoverdose/epidemic/index.html>. Accessed on November 2, 2016.

³ R. N. Hansen, G. Oster, J. Edelsberg, G. E. Woody, & S. D. Sullivan, "Economic Costs of Nonmedical Use of Prescription Opioids," *Clinical Journal of Pain* 27 (March–April 2011): 194–202.

⁴ Saadatmand, Y., Toma, M., & Choquette, J. (2012). The war on drugs and crime rates. *Journal of Business & Economics Research (Online)*, 10(5), 285.

⁵ Grogger, J., & Willis, M. (2000). The emergence of crack cocaine and the rise in urban crime rates. *Review of Economics and Statistics*, 82(4), 519–529.

⁶ Gordon, M. S., Kinlock, T. W., Couvillion, K. A., Wilson, M. E., Schwartz, R. P., & O'Grady, K. E. (2013). Gender differences among prisoners with pre-incarceration heroin dependence participating in a randomized clinical trial of buprenorphine treatment. *Journal of Offender Rehabilitation*, 52(5), 376–391.

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used drugs regularly prior to incarceration.⁷ Substance abuse is related to many types of crime ranging from unlawful possession and illegal distribution to violent offenses. For example, offender drug use is involved in more than half of all violent crimes, in 60–80 percent of child abuse and neglect cases, and in 75 percent of drug dealing and manufacturing cases.^{8,9} Yet, the vast majority of traditional criminal justice policies and the sentences imposed on individuals with a substance use disorder have done little to slow the drug abuse problem across the United States. In addition, few receive treatment for their substance use disorders, although it is well-established that treatment is effective in reducing relapse and recidivism, thereby netting huge savings to society.^{10,11,12,13,14,15,16}

Studies consistently show that up to 15 percent of those incarcerated have an opioid use disorder.^{17,18} Treatment pathways for opiate/opioid¹⁹ addiction are distinct from other substances, particularly because the medications available to assist in the withdrawal and physical dependence are often addictive themselves. Therefore, traditional criminal justice programs for individuals with an opioid use disorder may not be able to meet their need for a more specialized treatment

⁷ Mumola, C., & Karberg, J. C. *Drug Use and Dependence, State and Federal Prisoners, 2004*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2007. Available at www.bjs.gov/content/pub/pdf/dudsfp04.pdf (PDF, 441KB). Accessed on December 9, 2016.

⁸ National Institute on Drug Abuse. Legislative Testimony to Congress available at www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2006/02/examination-drug-treatment-programs-needed-to-ensure-success. Accessed on December 9, 2016.

⁹ The National Center on Addiction and Substance Abuse at Columbia University. (2010). *Behind Bars II: Substance Abuse and America's Prison Population*.

¹⁰ Anglin, M. D., et al. Offender diversion into substance use disorder treatment: The economic impact of California's Proposition 36. *American Journal of Public Health* 103(6):1096–1102, 2013.

¹¹ Chandler, R. K., Fletcher, B. W., & Volkow, N. D. Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *JAMA* 301(2):183–190, 2009.

¹² Friedmann, P. D., Rhodes, A. G., & Taxman, F. S., for the Step'n Out Research Group of CJ-DATS. Collaborative behavioral management: Integration and intensification of parole and outpatient addiction treatment services in the Step'n Out study. *J Exp Criminol* 5(3):227–243, 2009.

¹³ Greenfield, S. F., Brooks, A. J., Gordon, S. M., Green, C. A., Kropp, F., McHugh, R. K., Lincoln, M., Hien, D., & Miele, G. M. Substance abuse treatment entry, retention, and outcome in women: A review of the literature. *Drug Alcohol Depend* 86:1–21, 2007.

¹⁴ Kinlock, T. W., Gordon, M. S., Schwartz, R. P., Fitzgerald, T. T., & O'Grady, K. E. A randomized clinical trial of methadone maintenance for prisoners: Results at 12 months post-release. *J Subst Abuse Treat* 37(3):277–285, 2009.

¹⁵ Lee, J. D., Friedmann, P. D., Kinlock, T. W., Nunes, E. V., Boney, T. Y., Hoskinson Jr, R. A., & Gordon, M. (2016). Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. *New England Journal of Medicine*, 374(13), 1232–1242.

¹⁶ Rich, J. D., McKenzie, M., Larney, S., Wong, J. B., Tran, L., Clarke, J., & Zaller, N. (2015). Methadone continuation versus forced withdrawal on incarceration in a combined U.S. prison and jail: A randomized, open-label trial. *The Lancet*, 386(9991), 350–359.

¹⁷ Gordon et al., 2013.

¹⁸ Mitchell, S. G., Kelly, S. M., Brown, B. S., Reisinger, H. S., Peterson, J. A., Ruhf, A., & Schwartz, R. P. (2009). Incarceration and opioid withdrawal: The experiences of methadone patients and out-of-treatment heroin users. *Journal of Psychoactive Drugs*, 41(2), 145–152.

¹⁹ Opioids are referred to a general category of (semi-) synthetic opiates, including heroin. Opiates, such as morphine, are derived from the opium poppy plant. While these are chemically distinct and have different clinical implications, this report focuses on both opiates and opioids.

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approach. The most effective treatment models for criminal justice-involved individuals with an opioid use disorder have integrated the criminal justice and drug treatment systems, creating a multidisciplinary approach to provide systematic planning for treatment that includes screening for potential drug use, treatment placements, drug testing and monitoring, and ongoing supervision as well as use of sanctions and rewards.²⁰

The purpose of this report is to provide examples of efficacious community-level interventions that apply a multidisciplinary approach to assist individuals with opiate/opioid abuse issues involved in the criminal justice system. The overall goal is to enable other communities to replicate similar interventions in their efforts to address opioid abuse-related overdose and crime.

II. Conceptual Framework

The Sequential Intercept Model is a conceptual framework, originally developed by Munetz and Griffin (2006) in conjunction with the GAINS Center for Behavioral Health and Justice Transformation, to assist communities addressing issues on the criminalization of individuals with mental health disorders.²¹ The model is based on three foundational principles. First, individuals with behavioral health disorders should not be arrested or incarcerated at a higher rate than those without disorders. Second, such individuals should not be arrested or incarcerated if their crimes are a result of their symptomatic disorders or lack of access to appropriate treatment. Third, the costs associated with the criminal justice system vary by its multiple entry points. For example, the farther along an individual moves through the system, the harder it is to leave the system and therefore costlier to the individual as well as to society. There are potentially five intercept points at which coordinated interventions may prevent individuals from moving farther into the criminal justice system:

1. Law enforcement and emergency services as alternatives to arrest and criminal charges
2. Initial detention and initial hearings
3. Jail, courts, forensic evaluations, and forensic commitments
4. Reentry from jails, state prisons, and forensic hospitalization
5. Community corrections and community support (see diagram A)²²

The Sequential Intercept Model offers communities a framework to develop systematic strategies to assist individuals with opioid use disorder avoid unnecessary criminal justice involvement and instead receive treatment and other services as appropriate.

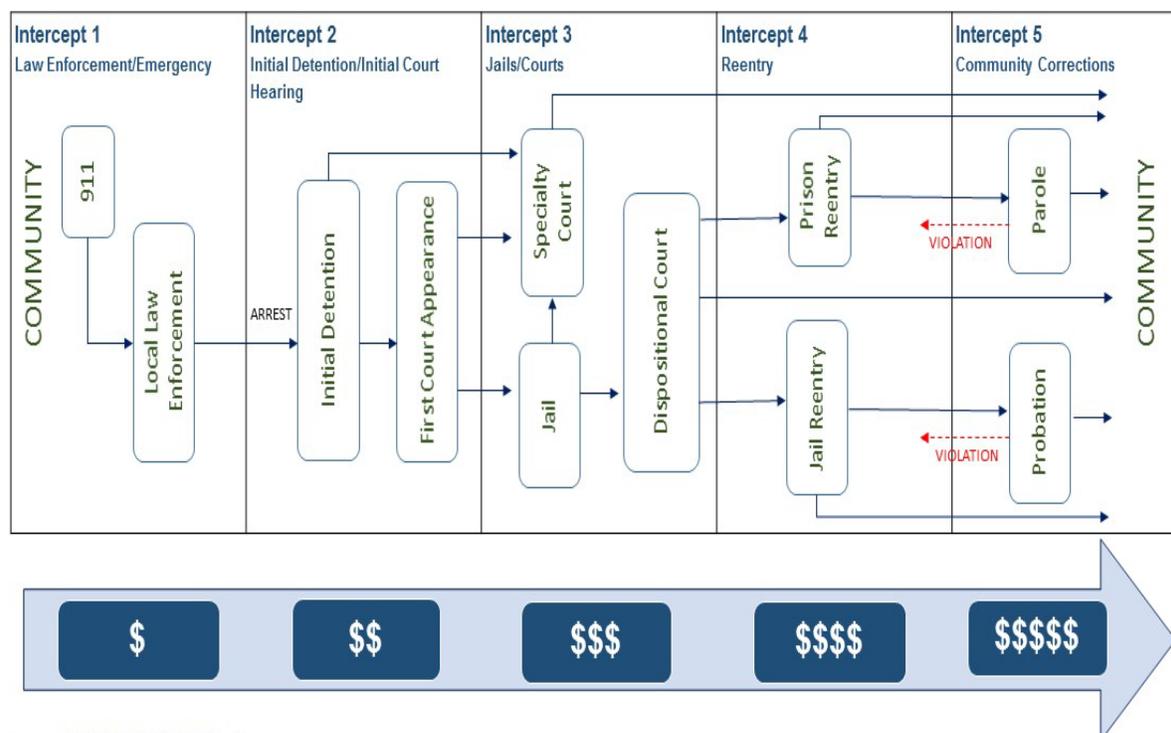
²⁰ National Institute on Drug Abuse. Principles of Drug Abuse Treatment for Criminal Justice Populations, A Research-Based Guide; <https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles>. Accessed on November 2, 2016.

²¹ Substance Abuse and Mental Health Services Administration. GAINS Center for Behavioral Health and Justice Transformation. *Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model*. Available at www.nmlegis.gov/handouts/CJRS%20042314%20Item%203%20Sequential%20Intercept%20Model.pdf.

²² Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57(4), 544–549.

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Diagram A. Sequential Intercept Model



Source: SAMHSA GAINS Center

III. Selected Community Interventions at Each Sequential Intercept Point

Intercept Point 1: Law Enforcement/Emergency Services

First responders to an opioid drug overdose crisis are usually law enforcement officers or emergency service providers. Many communities are exploring ways to divert individuals involved with the abuse or misuse of opioids from being arrested or charged. Such initiatives include implementing Good Samaritan Laws²³ and enabling first responders to use naloxone, an opioid antagonist designed to reverse the effects of an opioid overdose. Some communities have created opportunities for interventions at the pre-arrest intercept point to systematically link law enforcement and emergency services with other human service sectors, including mobile crisis teams and community treatment providers. Generally, these interventions are designed for individuals who have not committed a violent or other high-level offense.

²³ Law Atlas Policy Surveillance Dataset, Good Samaritan Overdose Prevention Laws; created by NPO staff, available at lawatlas.org/query?dataset=good-samaritan-overdose-laws. Accessed on November 10, 2016.

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Based on work conducted by the SAMHSA funded GAINS Center, the key characteristics of a successful pre-arrest diversion program are:

1. Trained call dispatchers who report identified opioid overdose cases to designated, trained responders.
2. Trainings for law enforcement officers on how to respond appropriately when opioid abuse is a factor.
3. Documentation of police contacts related to opioid overdoses.
4. Providing police-friendly drop-off at a local hospital, crisis unit, or triage center.
5. Ensuring linkages among law enforcement, mobile crisis teams, case managers, and key community service providers.
6. Providing follow-up services to individuals hospitalized and post-hospitalization.
7. Monitoring or evaluating services through regular stakeholders' meetings to ensure a continuous quality improvement process.²⁴

Below are some pre-arrest diversion programs with these elements that may serve as exemplars for other communities interested in establishing a similar program.

Model Program A. The ***Law Enforcement Assisted Diversion (LEAD)*** initiative is a pre-arrest diversion program, grounded on a harm-reduction approach, for eligible “low-level offenders” who may be redirected from prosecution or jail to a community-based substance abuse treatment program and other social services. The first LEAD pilot program was initiated in Seattle, Washington, in 2011 with the goal of reducing recidivism rates and criminal justice costs by means of coordinating services across the multiple public health and safety systems. In 2014, the city of Santa Fe, New Mexico, implemented a LEAD program in response to a heroin use epidemic using the same model. Stakeholders include police officers, district attorneys, mental health and drug treatment providers, housing advocates, other local service agencies, and the business community. Individuals involved in “low-level criminal offenses” including drug possession and sales are assigned to a case manager and connected to a comprehensive network of services. The multidisciplinary approach applied to the LEAD program enables program participants to make positive changes in a variety of areas (e.g., employment, housing, personal relationships) rather than focus on a goal of abstinence expected of traditional diversion programs.

“For the first time in my life—as long as I’ve been involved in this dope game, which is a long time—I’ve seen local government reach out and offer a hand to us.” Another participant noted, “I think it’s one of the best programs as far as being in the criminal justice system. . . You’ve got welfare offices, DSHS. . . but [LEAD] is dealing with you. Saving your life pretty much. That’s what I’m saying, you see. It’s saving your life.” (Clifasefi, 2016)

—Program Participant

²⁴ SAMHSA GAINS Center.

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A systematic evaluation of Santa Fe’s LEAD program is currently under way. However, in late 2015, the attorney general reported that the city had experienced the lowest rate of property crime since the program was implemented in early 2014.²⁵ Other studies based on the evaluation of Seattle’s LEAD program have also found positive results. For example, one study found that program participants were 60 percent less likely than nonparticipants to be rearrested within the first 6 months of the study and that 58 percent were less likely to be rearrested during the full study period. Program participants had also spent 39 fewer days in jail compared with non-program participants.^{26,27} Program participants perceive the LEAD program as a novel, holistic approach to receiving services.

For more information on Santa Fe’s LEAD program, please contact Shelly Moeller, LEAD project manager, at santafelead@gmail.com.

For more information about LEAD in general, please visit [LEAD Bureau](#).

Model Program B. The *Pre-Criminal Intervention Program (PCIP)* is led by the Nevada Board of Pharmacy to provide case management to individuals identified through the state’s prescription drug monitoring program (PDMP) who may be engaged in doctor- and pharmacy-shopping activity. The program staff consists of one intervention officer—a permanent, half-time employee of the Nevada Board of Pharmacy, who is supervised by the PDMP administrator. Potential participants in the program are contacted by the intervention officer and informed that their recent prescription history indicates possible violation of Nevada’s laws against doctor shopping, but that they can avoid criminal justice involvement by agreeing to work with the officer towards addressing potential issues related to their opioid dependence. Those willing to participate sign an agreement stating that they will use only one prescriber and one or two pharmacies for controlled substances. They also become eligible to receive case management from the intervention officer, for example, help in finding substance abuse treatment, affordable and coordinated medical care, job and housing assistance, and other services as necessary. Participants’ PDMP data are reviewed regularly during the course of the agreement to help ensure appropriate use of controlled substances.

Data suggest that the PCIP has been successful in helping clients avoid arrest and achieve greater stability. Of 80 participants who received interventions in the program between 2008 and 2011, 71 (89 percent) were able to remain in compliance with the intervention agreement, and, as

²⁵ District Attorney Pacheco Testimony to the United States House of Representatives, Committee on the Judiciary Subcommittee on Crime, Terrorism, Homeland Security, and Investigations. Law Enforcement Assisted Diversion – Santa Fe. July 28, 2015.

²⁶ Rand, J. LEAD Cost Benefit Analysis, Santa Fe Community Foundation. June 24, 2013.

²⁷ University of Washington–Harborview Medical Center. LEAD Program Evaluation: Recidivism Report. March 27, 2015.

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of 2016, 60 (75 percent) were still compliant, thus had avoided arrest.²⁸ The average number of prescribers seen by participants fell from 12 in the year prior to intervention to 4.5 in the year following, while prescriptions fell from an average of 64 to 36. The case management services and individual consultations provided by the intervention officer were instrumental in achieving these outcomes. Although the PCIP was suspended from 2011 to 2015 because of lack of funding, it was restarted in June 2016, with 33 prospective participants under consideration and two participants thus far in compliance with signed intervention agreements.

For more information on Nevada’s PCIP, please contact
Jenine Davis, PCIP officer, at jmdavis@pharmacy.nv.gov.

Model Program C. The *Arlington Opiate Outreach Initiative* (AOOI) in Massachusetts is a community-based strategy, co-facilitated by the police department, to create a pathway for individuals “known” to be addicted to heroin by law enforcement and other first responders based on their unique position and duties in the community. The identities of potential program participants come from three primary sources:

1. Response to 9-1-1 calls for overdoses
2. Information gathering during criminal investigations into suspected drug distribution
3. Community police officers engaged within their respective areas of responsibility

Another mechanism for program participation is directly from case investigations involving an arrest for illicit drug distribution. Upon approval from the chief of police, the case investigator may provide a list of the drug distributor’s customers to the AOOI coordinator, a trained mental health clinician, who, in turn, attempts to meet with the individual at risk for opioid overdose for treatment options and to avoid criminal prosecution. Individuals who refuse to participate are referred to law enforcement for consideration for criminal complaints for their role in the drug distribution operation and/or for unlawful possession of drugs. The AOOI also includes a component aimed to conduct outreach, support, and educate community members dealing with opioid addiction issues. These educational training initiatives offer a wide range of services and resources, including trainings on the proper use of naloxone.

“Historically, law enforcement has done little or nothing with the identity of known [heroin] users, and the users subsequently move onto other suppliers and in some instances, they become victims of overdoses. This practice by law enforcement should be seriously reconsidered.”

—Police Chief Frederick Ryan

²⁸ Data are from a presentation on the PCIP available at http://www.pdmpassist.org/pdf/PPTs/19-01A_Davis_Precriminal_Intervention.pdf. The program is also described in a case study available at http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/2_nevada_pcip_nff_1_19_11.pdf.

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The AOOI action plan, developed in July 2015, also called for the collection of data to track and monitor progress, including the number of program participants, persons enrolled in outpatient versus inpatient programs, persons trained in the delivery of naloxone, dispensed doses of Naloxone, and referrals to veterans' services.

For more information on the Arlington Opiate Outreach Initiative, please visit [AOOI](#).

Model Program D. The *Lowell Opioid Overdose Project* (LOOP) in Massachusetts is a multidisciplinary stakeholder initiative co-led by the city's police and health departments. This project was recently funded by the Bureau of Justice Assistance to accomplish the following goals:

1. Strengthen multidisciplinary collaborative efforts to address prescription drug and opiate abuse.
2. Incorporate a variety of data sources, including PMP data, to better understand drug use trends and gaps in services in Lowell.
3. Enhance capacity of law enforcement to investigate fraudulent prescriptions/over-prescribing.
4. Increase awareness of the importance of the PDMP with local dispensaries and prescribers.
5. Inform research policy and future programs for adults and children impacted by opiate addiction in Lowell and other cities struggling with similar issues.

LOOP will enable the city to streamline and enhance ongoing initiatives aimed to combat prescription and nonprescription opioid drug abuse, overdose, and other adverse events. For example, the Child Assessment and Response Evaluation (CARE) Project is a pilot program focused on providing a rapid response intervention for children who witness an overdose to help them cope with the traumatic experience, build resiliency, and ultimately decrease the odds of intergenerational substance abuse. The Community Opioid Outreach Program (CO-OP) is another ongoing project enabling three dedicated police officers to locate and conduct immediate outreach to individuals who experienced an overdose and refer them to treatment. Since it began operating in March 2016, the CO-OP team has conducted outreach to nearly half of the 137 nonfatal overdose victims the city has seen. In rare cases, CO-OP officers will utilize the Section 35 civil commitment process of petitioning a judge to involuntarily commit an individual to a state facility for up to 90

"Addiction knows no boundaries and the opioid crisis has affected individuals of different ethnicities, gender, religions, ages and socioeconomic status in every neighborhood in [Lowell]. This new funding from the Bureau of Justice [Assistance] will allow the city to expand upon the work we have been doing over the past few months and enable the city to implement some innovative strategies to combat this issue."

—Police Superintendent
William Taylor

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days.²⁹ However, the success of CO-OP has thus far been attributed to two factors: (1) the mantra of the team that even one life saved is worthwhile and (2) connecting with the community to maintain residents' trust.

LOOP will also develop a multisource data system that will supplement existing data sources such as the Massachusetts Prescription Drug Monitoring Program, emergency departments, medical examiners, and hospital admissions. This new database will consist of criminal history information and qualitative data of individuals who experienced an overdose to better understand drug use patterns, allowing the city to ensure effective interventions.

For more information about Lowell's initiatives, please contact Maryann Ballotta,
Public Safety Research and Planning Director, at MBallotta@lowellma.gov.

Intercept Point 2: Initial Detention and Initial Hearings

For some individuals with opioid use disorders, the first opportunity to receive appropriate treatment may be after an arrest. Interventions at this stage are designed to divert individuals into treatment services as opposed to being prosecuted or incarcerated and are generally considered appropriate for individuals who have not committed violent or other serious offenses. Individuals who are screened and deemed eligible for these programs are offered treatment and other recovery support services including housing and health care.

Key characteristics of a successful program at this second intercept point have been observed to take the following action steps: (1) utilize validated screening instruments in a process to identify eligible individuals in jail or court; (2) assist individuals in navigating the process of pretrial diversion and release; and (3) link participants with comprehensive care coordination, access to medication, and other human services, as appropriate.³⁰

Model Program A. The *Rapid Intervention Community Court (RICC)* program, originated in September 2010 as the Rapid Arraignment Intervention Model (RAIM), is currently operated under the authority of Chittenden County of Vermont's State Attorney. Its mission is to "provide services that address the root cause of the criminal behavior of individuals that are charged with a criminal offense."³¹ For this pre-charge diversion program, individuals undergo a screening process for eligibility into the RICC designed for persons arrested or cited for nonviolent offenses that appear to be associated with a substance use addiction or mental illness. Those who

²⁹ Feathers, T. (2016, September 16). "Community Opioid Outreach Program Members of Lowell team help save lives, one at a time." *Lowell Sun Online*. Retrieved from www.lowellsun.com/latestnews/cj_30369511/community-opioid-outreach-program-members-lowell-team-help.

³⁰ SAMHSA GAINS Center.

³¹ Bellas, M. L. (2014). Chittenden County Rapid Intervention Community Court Process Evaluation Final Report (page 13 of 64). Available at www.crgvt.org/news/report-chittenden-county-rapid-intervention-community-court-process-evaluation.

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successfully complete the program, consisting of a 90-day treatment plan of counseling, drug treatment, and life skills training, are not charged; those who fail to complete the program are rearraigned in district court. Overall, the RICC aims to reduce recidivism and costs to society, lower barriers to substance abuse treatment and other human services, and make restitutions to any victims involved.

According to a report from the Vermont Center for Justice Research (VCJR), a study on the initial program (RAIM) estimated a savings of more than \$4 million in state expenditures for every 500 participants diverted from the traditional court system. A comprehensive cost-saving analysis of the current RICC program has yet to be conducted. However, one preliminary analysis that did not take into account recidivism rates and external costs to RICC, such as social service agencies, found that the program was at least as cost-effective as the traditional court system. The program also showed positive results in reducing recidivism. Among those who completed the program (n=756 of 1,027 participants), only 7.4 percent were found to have been convicted of a new crime after leaving the program. Among those who did not complete the program (n=152), 25 percent had recidivated. Although the study did not control for the time out of the program in its analysis of recidivism rates, meaning that the participants had varying lengths of time in which they may reoffend, the findings suggest that the program is efficacious in reducing recidivism.³²

"It doesn't make sense to spend more money on the Department of Corrections on locking people up in the state of Vermont than we do on higher education." (Thurston, 2014)

—State Attorney T. J. Donovan

For more information about Chittenden County's Rapid Intervention
Community Court, please visit [RICC](#).

Intercept Point 3: Jail and Courts

Individuals who have been adjudicated (found guilty of an offense) may be screened for post-conviction interventions within the correctional institution. Specialized "problem-solving" courts (e.g., drug courts) are one method to offer eligible individuals a way to focus on long-term recovery by enabling the judiciary, prosecution, defense, probation, law enforcement, mental health and substance abuse treatment providers, and other social services to coordinate their efforts. Research indicates that drug courts are effective in reducing recidivism among their

³² Bellas, M. L. (2014). Chittenden County Rapid Intervention Community Court Process Evaluation Final Report (pages 22, 29).

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participants compared with those who receive traditional sentences.^{33,34,35,36} In addition, it has been estimated that for every \$1 spent on a drug court, \$3.36 is saved in avoided criminal justice costs alone. When taking into account other factors such as reduced victimization and health-care service utilization, the cost savings can be up to \$27 for every \$1 invested.³⁷

Effective interventions designed at this intercept point generally have the following characteristics:

1. A reliable process to screen for and identify eligible incarcerated individuals using a validated screening instrument
2. Ensuring pathways into diversion programs in specialty and nonspecialty courts
3. Linkages to comprehensive services including care coordination, access to medication, and other human services
4. A process for continuous communication and feedback to nonspecialty courts and service providers on a program participant's progress, using clear policies and procedures
5. Jail-based services consistent with community and public health standards³⁸

Model Program A. The *Brown County Heroin Treatment Court* in Wisconsin was initiated in the spring of 2015 with funding from the state's treatment alternative and diversion grant program³⁹ to "improve the overall quality of life in our community by providing a court-supervised program for heroin/opiate dependent users that will enhance public safety, reduce crime, hold offenders accountable, reduce costs to our community..."⁴⁰ The program provides individualized treatment plans for eligible individuals, many of whom do not have support networks or community structure beyond what is available through the court's treatment team,

³³ Mitchell, O., Wilson, D. B., Eggers, A., & MacKenzie, D. L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice*, 40(1), 60–71.

³⁴ Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review*, 8(1), 6–42.

³⁵ Rossman, S. B., Rempel, M., Roman, J. K., Zweig, J. M., Lindquist, C. H., Green, M., & Farole, D. J. (2011). *The Multi-Site Adult Drug Court Evaluation: The impact of drug courts, volume 4*. Washington, DC: Urban Institute Justice Policy Center. Retrieved from www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf.

³⁶ U.S. Government Accountability Office. (2011). *Adult drug courts: Studies show courts reduce recidivism, but DOJ could enhance future performance measure revision efforts (GAO-12-53)*. Washington, DC. Retrieved from <http://www.gao.gov/assets/590/586793.pdf>.

³⁷ Marlow, D. B., J.D., Ph.D. (2010). Research update on adult drug courts. National Association of Drug Court Professionals. Retrieved from www.nadcp.org/sites/default/files/nadcp/Research%20Update%20on%20Adult%20Drug%20Courts%20-%20NADCP.pdf.

³⁸ SAMHSA GAINS Center.

³⁹ Wisconsin Legislature passed 2005 Wis. Act 25 ([Wis. Stat. § 165.955](#)) authorizing "grants to counties to enable them to establish and operate programs, including suspended and deferred prosecution programs and programs based on principles of restorative justice, that provide alternatives to prosecution and incarceration for criminal offenders who abuse alcohol or other drugs."

⁴⁰ Brown County Heroin/Opiate Court, General Information. (2017). Retrieved from www.co.brown.wi.us/departments/?department=716426d4c36b&subdepartment=b2376a72d3a6.

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consisting of a judge, an assistant district attorney, two assistant public defenders, a representative of law enforcement, a probation agent, and a social worker. As with other drug courts, a main component to the Brown County Heroin Treatment Court is the judge's regular and active participation in not only delivering strict sanctions but also rewarding each participant's milestone. There are three key factors that drive this heroine treatment court. First is the recognition that the treatment of heroin addiction involves distinct treatment paths from other drugs that include medications to reduce the withdrawal symptoms. Second, all members of the treatment court team are trained about heroin addiction and dependence. Finally, there is a need for a medical practitioner's involvement in the short-and long-term treatment plans and potentially long-term medication coverage for the program participants. The long-term outcomes of the Brown County's heroin court have yet to be determined; however, key stakeholders have observed an immediate positive impact among the court participants' paths to recovery as well as the court system.⁴¹

"When they're in this court, we're having success at keeping people off heroin. That has surprised me. I had really expected that week after week after week, I'd be dealing with people who go back to heroin and that's not the experience we're having."

—Judge Tom Walsh

For more information on Brown County's program,
please visit [Heroin Treatment Court](#).

Model Program B. The *Addiction Treatment Program (ATP)* is a legislatively established strategy⁴² that expanded as a multipronged, county-level approach to address opioid abuse throughout Ohio since 2014. The ATP requires the state's Department of Mental Health and Addiction Services to work with the Supreme Court of Ohio, other state agencies, and certified drug courts to develop a program to provide addiction treatment to nonviolent adult offenders. ATP participants must be enrolled in a drug court, have an opioid and/or alcohol addiction, and be eligible for medication-assisted treatment (MAT), which entails having a diagnosis of opiate dependence or alcohol dependence, and, upon medical evaluation, be offered the option of utilizing an antagonist (Vivitrol) or partial agonist (Suboxone) in their treatment plans. MAT-eligible participants may opt to not use the medication. One key component of ATP has been to ensure that participants who are enrolled in Medicaid receive Medicaid-covered MAT, as well as additional services and benefits (e.g., transportation). ATP also established a funding mechanism to enable services for co-occurring mental health issues, specialized case management/probation services, recovery support services, child care, and housing to participants.

⁴¹ Walsh, T. J. (2016). In the Crosshairs: Heroin's Impact on Wisconsin's Criminal Justice System. *Wisconsin Lawyer*, 89(1). Retrieved from www.wisbar.org/newspublications/wisconsinlawyer/pages/article.aspx?Volume=89&Issue=1&ArticleID=24551.

⁴² House Bill 59, Section 327.120, signed by the governor in July 2013, appropriated \$5 million to addiction treatment pilot programs for drug courts; for the current 2016/2017 state budget, Section 331.90 appropriated \$11 million.

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According to an evaluation study of the pilot ATPs conducted during June 2014–2015, past-month drug use among program participants decreased 69 percent and crimes committed decreased 86 percent. At the same time, employment increased 114 percent, while stable housing increased by 29 percent. Among participants, 60 percent had jobs and 91 percent had stable housing upon completion of the program, compared with 27 percent and 70 percent, respectively, before enrolling in the program. Although individuals who received MAT did not have different recidivism rate compared with those who did not receive MAT, they had a statistically significant positive change in overall health between the intake and six-month follow-ups. The study’s focus group participants stated that MAT has an impact on the mental clarity of participants as well as their physical state.⁴³ Another evaluation study is under way for the current ATP to assess the impact of MAT on drug court participants on substance use, criminal justice involvement and recidivism, service utilization and treatment retention, and program completion. In addition, the evaluation will identify lessons learned on barriers and facilitators to MAT program implementation and sustainability in certified drug courts.

“For persons involved in the felony system, the best opportunity to achieve a full recovery from addiction may be provided by a certified drug recovery court program. The combination of intensive treatment and strict accountability to the court provides a winning combination for those who are willing to do the hard work of recovery.”

—Judge Scott Barrett
Hardin County Common Pleas

For more information, please contact Julie Spohn, Behavioral Health/Criminal Justice Program coordinator, at julie.spohn@mha.ohio.gov.

Model Program C. Family Dependence Treatment Courts (FDTC) in Ohio are specialized court dockets that focus on parents with a substance use or mental health disorder whose children have been removed from their care or are at risk of removal. Participants of this specialized court work closely with the court judge, treatment service providers, and child welfare to support their active engagement and retention in treatment. As with other drug courts, treatment plans are developed to provide parents with opportunities to achieve sobriety and mental health, maintain a safe and nurturing home, and retain custody of their children. Therefore, judicial oversight is vital to the program’s success.

⁴³ Baughman Sladky, M. C., Singer, M. I., Tuschman, P., & Gearhart, M. (2015). Ohio MHAS Addiction Treatment Pilot Program Final Report. Retrieved from mha.ohio.gov/Portals/0/assets/Initiatives/ATPP/2015-ATP-Begun-Center-Final-Report.pdf.

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In Lucas County, an FDTC was initiated in March 2000 and received certification by the Specialized Docket Section of the Ohio Supreme Court in August 2014. In 2015, 69 percent of all referrals to the Lucas County program were related to heroin and other opioid abuse.⁴⁴

While the treatment plans are similar to those offered in other drug courts (i.e., drug screenings, counseling, and other recovery support services), the program leverages the motivation of parents to maintain or regain custody of their children to assist them along their path to recovery, which may include MAT and the availability of naloxone or Narcan. In addition, the Lucas County court team increased its training in evidence-based MAT and utilizes a multidisciplinary approach with other service agencies, including child protective services, to meet the needs of parents and their children's long-term welfare.

"Our community has been significantly impacted by heroin and opiate addiction. Many parents struggle with addiction. The Family Dependency Treatment Court will provide the extra support and accountability to parents as they work to achieve and maintain sobriety. The program is designed to benefit the parents, the child and ultimately, our community."

- Judge James A. Shriver

For more information on Lucas County's FDTC, please contact Kristen Blake, Family Drug Court coordinator, at kblake@co.lucas.oh.us.

Model Program D. Veteran Treatment Courts (VTCs) exist in recognition that criminal justice-involved veterans benefit greatly from the unique aspects of military and veteran culture while addressing underlying issues that challenge conventional legal approaches as well as barriers to accessing benefits and programs specific to veterans. National figures estimate that 9.3 percent of incarcerated persons are veterans and that 83 percent of those veterans are eligible for at least some civil benefits.⁴⁵ The first VTC was initiated in Buffalo, New York, by Judge Robert Russell in 2008.⁴⁶ Similar to other drug courts, VTCs require regular court appearances (i.e., weekly or biweekly), as well as mandatory attendance at treatment sessions and frequent and random testing for substance use. VTC judges also play a strong leadership role in an interdisciplinary team with better understanding of the issues pertinent to veterans (e.g., post-traumatic stress disorder, major depression, traumatic brain injury, military sexual trauma) and knowledge of the special veterans' benefit programs designed by various agencies (Veterans Health Administration, Veterans Benefit Administration, State Department of Veterans Affairs, Veterans Service Organizations, and

⁴⁴ Lucas County Juvenile Court, Ohio. (2015). Annual Report. Retrieved from co.lucas.oh.us/DocumentCenter/View/59574.

⁴⁵ Representing Washington Veterans, Northwest Justice Project. Veterans in the Criminal Justice System. Retrieved from www.repwavets.org/justice-involved-veterans.html.

⁴⁶ Russell, R. T. (2009). Veterans treatment court: A proactive approach. *New Eng. J. on Crim. & Civ. Confinement*, 35, 357.

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volunteer Veteran Mentors) that are often difficult for criminal justice-involved veterans to access without assistance.⁴⁷

As a result, too many veterans succumb to repeated criminal involvement because too few veterans can access counsel that would address underlying issues through the full range of available civil legal and nonlegal benefits. For example, homelessness has been a major focus of multiple federal and state agencies since 2010, and, as a result, the number has declined by 47 percent nationwide in recent years. However, according to Veterans Affairs Secretary McDonald, it became evident that substance abuse is the number one risk factor behind veterans who are homeless.

“. . . all too often, that substance abuse begins with opioids prescribed by DoD or VA doctors for service-related conditions. Veterans are also more likely to suffer from post-traumatic stress disorder, traumatic brain injury and mental illness, which can lead to substance abuse, homelessness, criminality and even suicide.”

—VA Secretary Robert McDonald

VTCs report positive results: Two-thirds of participants complete their treatment regimens, 88 percent see a reduction in arrests, and 30 percent see an increase in stable housing in the year after. Despite these encouraging results, there is wide variation across VTCs throughout the country. Some issues include how a veteran is defined for benefits; how sentences may be diverted, deferred, or reduced; and the various structures and philosophies employed by the courts.

One example of a model program is the King County Regional Veterans Court (RVC) in Washington, where officials estimate that 8 to 13 percent of state prisoners are veterans.⁴⁸ The overall goals of RVC are to:

1. Address the underlying issues that have resulted in a veteran’s involvement in the criminal justice system.
2. Provide a courtroom environment that fosters support and respect of the veteran and the victim (if any) and is conducive to a positive outcome.
3. Strive to increase public safety through a multidisciplinary approach that includes the veteran and incorporates individualized treatment plans, close monitoring, and creative approaches.⁴⁹

Veterans may be referred to the RVC in two situations: (1) if the veteran is being charged with a felony, only the city prosecutor must make the referral prior to final disposition; and (2) if being charged with a misdemeanor, anyone including the defense attorney may make the referral. The RVC applies evidence-based practices that include regular interaction with court and probation staff, random drug monitoring and testing, and treatment and support services (i.e.,

⁴⁷ Justice for Vets. What is a Veteran’s Treatment Court. Retrieved from www.justiceforvets.org/what-is-a-veterans-treatment-court.

⁴⁸ Representing Washington Veterans. Veterans Treatment Courts in Washington. Retrieved from www.repwavets.org/veterans-treatment-courts-in-washington.html.

⁴⁹ King County District Court. (2015, March 9). Regional Veterans Court. Retrieved from www.kingcounty.gov/courts/district-court/regional-veterans-court.aspx.

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benefits and entitlements for veterans). In addition, MAT, ranging from methadone and suboxone to Vivitrol/naltrexone, is offered as part of the treatment options for participants.

For more information about the King County Veterans Court, please contact the regional manager at mentalhealthcourt@kingcounty.gov.

For more information about VTCs, please visit <http://justiceforvets.org/what-is-a-veterans-treatment-court>.

Intercept Point 4: Reentry From Jails, State Prisons, and Forensic Hospitalization

Interventions at this intercept point aim to provide a seamless continuum of treatment for individuals leaving the correctional setting and returning to their communities, a vulnerable time for potential relapse and fatal opioid overdose. Care at this intercept may include the use of medication-assisted treatment (MAT; i.e., buprenorphine, methadone, and Vivitrol), which has been found to be effective for certain individuals leaving jails or prisons and reentering their communities.⁵⁰ Vivitrol, in particular, has been more commonly used in MAT programs throughout the country's correctional facilities because of the monthly injection method, which helps to address medication compliance issues. As a sustained-release naltrexone, it blocks the euphoric effects of opioids and helps to reduce cravings. Some studies have found the naltrexone medication, along with supervision and behavioral health counseling, helps newly released individuals from incarceration to abstain from opioids.^{51,52,53} However, one recent study funded by the National Institute on Drug Abuse illustrates the complex nature of addiction and that the medication-assisted treatment is not effective as a stand-alone treatment. This study found that the cohort of individuals receiving Vivitrol, a group of primarily heroin users on probation or parole, had a relatively high relapse rate, although it was significantly lower than the comparison group receiving brief counseling and a referral to treatment programs (43 percent versus 64

⁵⁰ Sharma, A., O'Grady, K. E., Kelly, S. M., Gryczynski, J., Mitchell, S. G., & Schwartz, R. P. (2016). Pharmacotherapy for opioid dependence in jails and prisons: Research review update and future directions. *Substance abuse and rehabilitation*, 7, 27.

⁵¹ Cornish, J. W., Metzger, D., Woody, G. E., Wilson, D., McLellan, A. T., Vandergrift, B., & O'Brien, C. P. (1997). Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment*, 14(6), 529–534.

⁵² Lee, J. D., McDonald, R., Grossman, E., McNeely, J., Laska, E., Rotrosen, J., & Gourevitch, M. N. (2015). Opioid treatment at release from jail using extended-release naltrexone: A pilot proof-of-concept randomized effectiveness trial. *Addiction*, 110(6), 1008–1014.

⁵³ Comer, S. D., Sullivan, M. A., Yu, E., Rothenberg, J. L., Kleber, H. D., Kampman, K., & O'Brien, C. P. (2006). Injectable, sustained-release naltrexone for the treatment of opioid dependence: A randomized, placebo-controlled trial. *Archives of General Psychiatry*, 63(2), 210–218.

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percent, respectively).⁵⁴ Studies on the effectiveness of Vivitrol for this population are still inconclusive: The limited follow-up period of participants and the cost associated with the medication (average of \$1,000 per dosed treatment) are some primary barriers to expanding its availability. In addition, there are adverse effects from the use of Vivitrol, including fatal overdoses when interacting with an opioid, that need to be seriously considered. Clinical program directors who have offered Vivitrol as part of their MAT programs in correctional facilities have pointed out that the drug is not appropriate for everyone with an opioid use disorder. Instead, they highlight the need for MAT in conjunction with mental health counseling, support groups, and other social services to ensure individuals' long-term recovery.

Based on findings from the SAMHSA GAINS Center, program developers at this intercept point should consider the following elements to ensure success: (1) implement a transition planner or discharge coordinator for service planning and for assessing clinical, social, and public safety risks; (2) plan for treatment and services with documentation and communication with community providers and supervision agencies on various domains (e.g., access to medication, benefits, housing, and behavioral health services); (3) identify additional treatment requirements for post-release services and specialized case management teams; and (4) coordinate transition plans to avoid gaps in care.⁵⁵

Model Program A. The *Barnstable County Sheriff's Office* began the Vivitrol Program in April 2012 as part of the county's Residential Substance Abuse Treatment (RSAT) program, one of the first of its kind in the United States. This voluntary program provides eligible inmates with the Vivitrol injection, a sustained-release naltrexone, within a week prior to their release, along with Medicaid insurance registration, medical examination, and pre-release counseling. Upon reentry to their communities, program participants are connected to a community treatment center that provides continuity of care and other supportive services aside from the medication. According to Barnstable County's correctional facility, the program has provided Vivitrol treatment to about 210 participants (27 percent females). They reported that 70 percent of participants had reduced opioid cravings and that 80 percent showed up for their first post-release treatment. Finally, the program has seen a low recidivism rate (9 percent) among its participants during the past four years.⁵⁶

For more information on Barnstable's RSAT MAT program using Vivitrol, please visit
<http://www.bsheriff.net/vivitrol.html>.

⁵⁴ Lee, J. D., Friedmann, P. D., Kinlock, T. W., Nunes, E. V., Boney, T. Y., Hoskinson Jr., R. A., & Gordon, M. (2016). Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. *New England Journal of Medicine*, 374(13), 1232–1242.

⁵⁵ SAMHSA GAINS Center.

⁵⁶ Vestal, C. (2016, January 13). "Stateline: Helping Drug-Addicted Inmates Break the Cycle." The Pew Charitable Trusts. Retrieved from www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/13/helping-drug-addicted-inmates-break-the-cycle.

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Model Program B. *Wisconsin's Opioid Addiction Treatment Pilot Program* has recently been funded close to \$1.7 million by the state legislature for fiscal years 2015–2017 to expand the use of medication-assisted treatment to other correctional facilities after seeing some successful results from the Dane County Opiate Recovery Pilot Project, the first in the state to provide Vivitrol injections to individuals released from the Dane County jail. The pilot program was initiated in 2013 with long-term goals to decrease recidivism and overdose rates among individuals with a history of opioid dependence after release from incarceration. The program consisted of six monthly injections of Vivitrol for 78 of 173 eligible participants between 2013 and 2014.⁵⁷ Preliminary findings indicated that while in program, participants abstained from opioids and about 80 percent remained in treatment.⁵⁸ The Dane County pilot program has demonstrated promising results in helping to prevent relapse and potential overdose among newly released prisoners and has raised barriers to success for the expanded pilot programs.^{59,60}

For more information, please visit:
[Wisconsin's Opioid Addiction Treatment Pilot Program](#)

Model Program C. *New York State's Opioid Overdose Prevention Program* includes education and training for all state prisoners on the use of nasal spray naloxone when they are released through a partnership consisting of the Department of Corrections and Community Supervision, the Department of Health, and the Harm Reduction Coalition.⁶¹ Research indicates that prisoners are at significantly high risk of experiencing a fatal overdose within the first two weeks following their release, in part due to their lower tolerance level for the same amount of opioids used prior to their incarceration.^{62,63} Although treating a substance use disorder and its underlying causes is more complex than preventing overdoses, the program hopes to give ex-prisoners another opportunity to enter into treatment. As a short-acting opioid antagonist

⁵⁷ Wahlberg, D. (2016, July 2). "State giving prisoners medication to prevent opioid relapse." *Wisconsin State Journal*. Retrieved from http://host.madison.com/wsj/news/local/health-med-fit/state-giving-prisoners-medication-to-prevent-opioid-relapse/article_8daee960-51df-5d4c-bc38-035988e0ce73.html.

⁵⁸ Fetterly, J. (2015, March 20). "County program keeps inmates off of opiates." *The Waunakee Tribune*. Retrieved from http://www.hngnews.com/waunakee_tribune/news/regional/article_9088bf46-cd73-11e4-9051-8b776dd6dd55.html.

⁵⁹ Holzmacher, R. Medical Director Wisconsin Department of Corrections. Presentation at *Evidence-Based Treatment (and Recovery) Programs for Opioid Addiction*, University of Wisconsin Population Health Institute, on April 28, 2016.

⁶⁰ Associated Press. (2016, November 14). "Prisons fight opioids with \$1,000 Vivitrol injections: Does it work?" *CBS News*. Retrieved from www.cbsnews.com/news/prisons-fight-opioids-with-1000-vivitrol-injections-does-it-work/.

⁶¹ Zucker, H., Annucci, A. J., Stancliff, S., & Catania, H. (2015). Overdose prevention for prisoners in New York: A novel program and collaboration. *Harm Reduction Journal*, 12(1), 1.

⁶² Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates. *New England Journal of Medicine*, 356(2), 157–165.

⁶³ Merrall, E. L., Kariminia, A., Binswanger, I. A., Hobbs, M. S., Farrell, M., Marsden, J., & Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction*, 105(9), 1545–1554.

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medication, naloxone temporarily reverses an opioid overdose by allowing a person to start breathing again. The medication has no effect when used for purposes other than an overdose episode. The statewide expansion of the program is based on a pilot conducted in New York City's Queensboro Correctional Facility, a minimum security correctional setting.

The pilot, which began in February 2015, trained more than 700 prisoners, and about 200 kits were distributed within seven months. It also found that teaching people how to respond to an overdose using naloxone was not only effective but also very time-efficient (trainings could take about 10 minutes).⁶⁴

"Drug overdoses are one of the greatest threats facing the health and well-being of individuals recently released from prison. Through this groundbreaking training pilot, these individuals will have the knowledge and skills necessary to not only protect themselves, but to save the lives of others when they come home."

—Dr. Howard Zucker
New York State Health Commissioner

For more information on New York State's Overdose Prevention Program, please visit [NYS DOH](#)

Intercept Point 5: Community Corrections and Community Support

As previously mentioned in Intercept Point 4, the business-as-usual model consisting of providing a substance abuse treatment center brochure or referral card to soon-to-be-released prisoners with the expectation that they will engage in treatment in the community is not effective. Even those individuals who receive probationary or parole supervision in the community may require additional behavioral health and other services to support their long-term opioid recovery process. This may be particularly relevant to recently released individuals who have received opioid treatment while incarcerated. For example, peer mentors or "navigators" who serve as resources and guides immediately after release from a correctional facility to a substance abuse and/or mental health provider have been recognized as a critical component of ensuring continuity of care by some programs.⁶⁵

While no programs are offered as exemplars for this intercept point, communities interested in developing programs may be interested to review a brief document developed by the PDMP Training and Technical Assistance Program on key questions to assess for risk of an opioid overdose. The document is available at

⁶⁴ Clear, A. (2015, February 6). "Overdose Prevention in a New York City Prison: Start of a Groundbreaking New Initiative." *The Huffington Post*. Retrieved from <http://harmreduction.org/miscellaneous/overdose-prevention-nyc-prison/>.

⁶⁵ Advocates from Human Potential. Promising Practices Guidelines for Residential Substance Abuse Treatment. Available at <http://www.rsat-tta.com/Home>.

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http://www.pdmpassist.org/pdf/PDMP_admin/assessing_overdose_risk_intake_20170217.pdf).

In addition, the GAINS Center recommends the following action steps:

1. Screen all individuals for substance use disorders and linking them to necessary services.
2. Connect individuals to employment, health, housing, and other supportive services in the community.
3. Implement a supervision strategy, adjusting as needed.
4. Ensure options for community corrections officers to reinforce positive behavior and effectively address violations or noncompliance with the conditions of release.⁶⁶

IV. Conclusion

Research indicates that for every dollar invested in substance abuse treatment, society saves \$4 in health care costs and \$7 in criminal justice costs.⁶⁷ Aside from the cost savings, mass incarceration of low-level, nonviolent drug offenders has rippling effects on families and communities. For example, an incarceration of a family member is associated with a 64 percent decrease in household assets, affecting up to 2.6 million American children who have a parent in prison or jail.⁶⁸ Yet, the general public's persistent view that opioid abuse is an act of choice or a result of one's moral failing is a major barrier to enhance policies aiming to provide efficacious treatment options to individuals who encounter the criminal justice system. Over the last decade, policymakers, along with the criminal justice system and law enforcement leaders, have made great strides to implement evidence-based practices to facilitate multiple pathways to substance abuse treatment for criminal justice-involved individuals with substance use disorders. However, more work is needed to educate the general public on the need for more innovative programs to focus on access to treatment.⁶⁹ Many state leaders are trying to get the message out.⁷⁰

"The opioid epidemic is not a moral issue, it's a disease."

—Andrea Boxill, Deputy Director
Ohio Governor's Opiate Action Team

There is substantial evidence that opioid addiction can be treated and overdoses can be prevented or reversed. Each of the programs highlighted across the Intercept Points utilizes a

⁶⁶ SAMHSA GAINS Center.

⁶⁷ Ettner, S. L., Huang, D., Evans, E., Ash, D. R., Hardy, M., Jourabchi, M., & Hser, Y. I. (2006). Benefit-cost in the California treatment outcome project: Does substance abuse treatment "pay for itself"? *Health Services Research, 41*(1), 192–213.

⁶⁸ Sykes, B.L., & Maroto, M. (2016, November 16). A Wealth of Inequalities: Mass Incarceration, Employment, and Racial Disparities in U.S. Household Wealth, 1996 to 2011. *The Russell Sage Foundation Journal of the Social Sciences, 2*(16). Retrieved from www.rsfsjournal.org/doi/full/10.7758/RSF.2016.2.6.07.

⁶⁹ McGinty, E. E., Kennedy-Hendricks, A., Baller, J., Niederdeppe, J., Gollust, S., & Barry, C. L. (2015). Criminal Activity or Treatable Health Condition? News Media Framing of Opioid Analgesic Abuse in the United States, 1998–2012. *Psychiatric Services*.

⁷⁰ Cass, A. (2017, January 5). "Kasich signs bill combating opioid abuse." *The News-Herald*. Retrieved from <http://www.news-herald.com/article/HR/20170105/NEWS/170109700>.

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multistakeholders approach to better facilitate and coordinate services across the different systems intersecting with the criminal justice system. Expansion of these types of programs can result in continued cost savings for the criminal justice system, repair community relationships with police departments across the country, help shift cultural beliefs about addiction, and ultimately curb the opioid overdose epidemic.