PUBLIC SAFETY-LED LINKAGE TO CARE PROGRAMS IN 23 STATES:

The 2018 Overdose Response Strategy Cornerstone Project

Contents

This report examines 5 types of public safety-led linkage to care programs: pre-arrest diversion, drug courts, linkage to care upon release from incarceration, law enforcement-led post-overdose outreach, and safe stations. The information can be used to guide program planning, implementation, and evaluation, with the ultimate goal of scaling-up effective linkage to care efforts. It should be shared widely with public health and public safety partners, particularly those directly involved in programs that serve people with opioid use disorder (OUD).

Section I provides an executive summary or overview of the project. Sections II-VI describe, synthesize the literature on, and compile information gathered on each program type. These sections conclude with a 1-page "cheat sheet" with quick tips for designing, implementing, and evaluating that linkage to care program. The report concludes in Section VII with overall recommendations for public safety-led linkage to care programs.

The ordering of Sections II-VI is deliberate. It is a way to conceptualize the lifecycle of interventions for individuals with OUD, with pre-arrest diversion representing an earlier intervention and safe stations, a later intervention.

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I

Executive Summary

The Overdose Response Strategy's Cornerstone Projects

The Overdose Response Strategy (ORS) is a public health-public safety collaboration between the Centers for Disease Control and Prevention (CDC) and 11 High Intensity Drug Trafficking Areas (HIDTA)*. The partnership aims to reduce overdoses through the development and sharing of information across agencies and assisting communities with the implementation of evidence-based strategies.

Each year, the ORS undertakes a Cornerstone Project to answer a common question and address shared informational needs regarding the overdose crisis. In 2016, we reported on the presence and status of fentanyl analogs, and in 2017, on law enforcement knowledge, understanding, and experience implementing 911 Good Samaritan Laws.

The 2018 Cornerstone Project explores public safety-led linkage to care programs. While linkage to care generally refers to any effort to link people with opioid use disorder (OUD) or who show signs of problematic opioid use to relevant care or services, in this project, we focus exclusively on public safety programs that:

1. Link to evidence-based care, namely medication-assisted treatment (MAT), and other services specific to opioid use.
2. Use a "warm hand off" approach where program staff assist individuals in navigating systems of care, and in some cases, offer support during treatment and recovery. In essence, their role is more than the provision of information or referrals—it is compassionate and non-coercive accompaniment to an appropriate care provider.

Project Rationale

Substance use disorders are common among criminal justice-involved populations.[1] Individuals in the criminal justice system are at higher risk of overdose compared to the general population.[2, 3]

In response to the current opioid overdose epidemic, public safety agencies are using everyday encounters with people who use drugs as opportunities to provide linkage to care. Linkage to care advances public health and public safety goals because the use of MAT leads to reductions in overdose risk and criminal activity.[4, 5]

While linkage to care by public safety professionals is becoming more common, we know little about it, such as how linkage to care programs actually operate, whether they produce their desired outcomes, and if they have other unanticipated consequences, positive or negative.

Did you know?

Almost 2/3 of incarcerated individuals report issues with substance use.[1]

Overdose is the leading cause of death among formerly incarcerated individuals.[3]

Project Aims

This Cornerstone was thus designed to understand the range of practices that define public safety efforts that link individuals with care. Such an understanding is a necessary first step if we are to identify promising strategies for implementing and evaluating these programs.

Specifically, we aimed to:

- Describe existing public safety programs linking people with OUD to evidence-based care within ORS states.
- Explore patterns and variations in program implementation.
- Catalog programming strategies and set the stage for better program evaluation.

*The 11 HIDTAs are Appalachia, Atlanta-Carolinas, Chicago, Indiana, Liberty Mid-Atlantic, Michigan, New England, New York/New Jersey, North Central, Ohio, and Washington/Baltimore. North Florida HIDTA also contributed data to this Cornerstone Project.

This report summarizes our main findings and recommendations. While the report is largely descriptive, in an effort to capture the breadth of data collected, we also incorporate more evaluative, instructive observations. Our intention is to help new and existing programs interpret the findings and adopt those strategies that, to the best of our knowledge, are most likely to work.

Types of Linkage to Care Programs Examined

As mentioned, the linkage to care programs included in this project (1) link individuals to MAT and other support services specific to OUD and (2) use a "warm hand off" approach.

In addition, we consider 5 different linkage to care program types because of the traction they have gained across ORS states. They include:

1. Pre-arrest diversion
2. Drug courts
3. Linkage to care upon release from incarceration
4. Law enforcement-led post-overdose outreach
5. Safe stations

Project Methods

This project was implemented from August to October 2018 across 23 states in the ORS (see **Appendix 1**). In each state, ORS staff sought to:

1. Identify and enroll 1 program from each category into the project.
2. Survey program staff to document the program's definitions and rates of success, services offered and pathways to care, operations (e.g., staff, training, funding, and regulatory environment), monitoring and evaluation strategies, and perspectives on best practices.
3. If possible, conduct observations of program implementation to identify additional procedures, innovations, challenges, and staff perspectives, referred to as program observations.

Project Limitations

- Data were collected from a convenience sample of programs identified by ORS staff. Programs were excluded if they did not fit within 1 of the established program categories, did not link individuals to evidence-based care, and did not use "warm hand-offs." Data, therefore, may not be representative of all linkage to care programs in all places.
- The timing of project implementation limited the response, as linkage to care program staff are often unavailable during summer months.
- Program personnel were the main source of data presented here. Best practices and challenges cannot be fully assessed until the perspectives of program participants are also considered.
- Many of the practices described in this report require formal evaluation to assess their effect on intended outcomes. This report does not provide evidence that these strategies work, beyond anecdotal reporting.

Acknowledgements

The authors wish to thank the PHAs and DIOs within the ORS for identifying eligible programs, administering surveys, and conducting program observations. We also thank the CDC ORS team and collaborators for conducting literature reviews and providing feedback on early drafts of this report. Finally, we are grateful for the insights of all those within the broader ORS community who carefully reviewed and commented on the complete report.

SECTION

II

Pre-Arrest Diversion

What is Pre-Arrest Diversion?

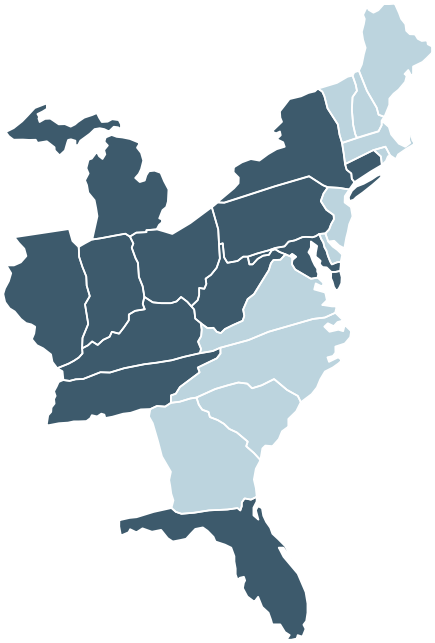
Law enforcement officers often say "we cannot arrest our way out" of the opioid overdose epidemic.[6] They encounter individuals with opioid use disorder (OUD) on a regular basis, oftentimes in the context of low-level offenses. They know from experience that making arrests in such situations may not always serve an individual's fundamental health needs.

In fact, few jails or correctional facilities offer universal MAT to individuals who request it, and those that do, typically do not offer all modalities.[7] Further, forced abstinence during incarceration increases the risk of overdose upon release,[8] and even discourages the future use of MAT in some cases.[9, 10] Therefore, one response has been to divert some arrestees away from incarceration at the outset.

In lieu of arresting low-level offenders who have OUD, some law enforcement agencies adopt pre-arrest strategies that divert them to treatment. This interrupts traditional criminal justice pathways in the service of public health and overdose prevention.[7] Diversion may also prevent individuals from acquiring a formal arrest record that later obstructs employment, social and civil rights, and even recovery.

What We Already Know about Pre-Arrest Diversion

- Few studies examine the effectiveness of pre-arrest diversion programs.[11-16] Only 2 focus exclusively on outcomes specific to individuals with substance use disorders.[11, 12]
- In 1 survey, officers with favorable attitudes toward pre-arrest diversion were more likely to employ it.[17]
- Diversion can occur pre-booking or post-booking.[11]
- Participation in pre-arrest diversion:
  - Can improve the use of mental health services, including counseling, medication, and hospitalization.[11]
  - Can decrease the likelihood of being re-arrested, committing a felony, and reporting recent drug use. [11, 12, 16]
- Individuals with greater behavioral health needs and criminal histories may require additional supports to complete a pre-arrest diversion program.[13, 14]



Programs We Examined

To be included in this study, pre-arrest diversion programs had to meet the following criteria:

- Use encounters with individuals committing a crime to initiate a process of linking the individual to services.
- Make participation in the diversion program voluntary.
- Protect diversion participants from further criminal liability for the initial crime.
- Refrain from using information obtained during the diversion process for investigative purposes.

We identified pre-arrest diversion programs in 15 states. Below, we summarize findings from 13 programs surveyed (highlighted on the map), including 6 where program observations were conducted.

Did you know?

Drug law violations account for the highest number of arrests. 85% of drug law violations are for possession.[6]

Program Basics

Goals

Most pre-arrest diversion programs are unified by a common goal: to improve the lives of individuals with OUD by pursuing alternatives to arrest. Their stated goals vary, however. They include short- and long-term objectives, such as:

- Linking individuals to treatment and other support services (short-term).
- Avoiding a formal arrest or criminal record for low-level offenses (short-term).
- Reducing fatal and non-fatal overdoses (long-term).
- Reducing stigma (long-term).

Some programs also design interventions with police officers and the community in mind. They hope to give police officers more tools for engaging individuals with OUD, make public resources (e.g., hospitals and prisons) more cost effective, and improve public safety through a reduction in minor crimes.

Funding

Pre-arrest diversion is possible at any funding level. In the case of 1 program, which has no operating budget, any eligible individual can walk into a designated police department, where a trained officer transports them to a partnering hospital for medical stabilization and linkage to care. This illustrates how a program can use the "systems already in place."

> "You don't need a gargantuan amount of resources to operate such programs… A large staff isn't necessary. All that's needed is to utilize the systems already in place."
>
> ***—Pre-arrest diversion program coordinator***

3 programs are primarily volunteer run. All other programs have at least 1 salaried position.

With several million dollars, programs can do a lot more. An operating budget of $3.1 million has allowed 1 program to hire 31 personnel and carry out all steps of linkage to care, from intake to treatment, case management, and discharge planning, within a single designated facility.

Table 1.1. shows the actual costs of common budget items reported by programs.

Table 1.1. Actual pre-arrest diversion program costs

BUDGET ITEM	COST
Program coordinator	$45,000-70,000
Media development	$6,500
Cab vouchers	$1,000

Regardless of their funding status, nearly all programs surveyed offer diversion 24/7. Even programs with set operating hours try to accommodate participants after-hours. This is important because it lowers potential barriers to program enrollment. Challenges can arise, however, if programs do not have established relationships with care providers or emergency departments that can take patients at any hour.

Staffing and Staff Preparation

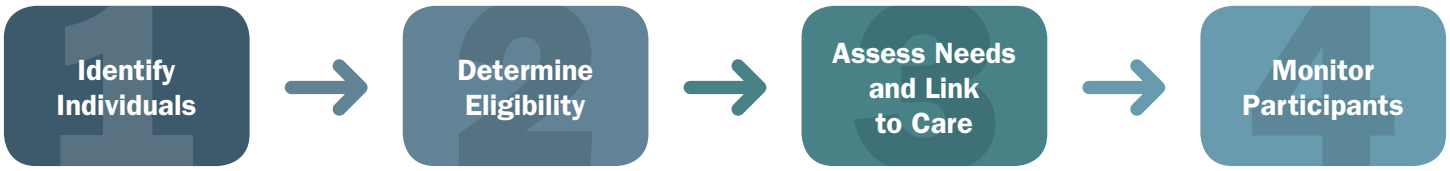
Staffing varies depending on what programs offer and how they are organized. The list below shows all the possible positions found within programs:

- **Patrol officer** serves as the initial point of contact, does initial intake and eligibility screening, and provides transportation.
- **Program coordinator** implements program, oversees spending, and completes forms.
- **Program director** supervises staff and operations.
- **Evaluator or researcher** measures a program's success.
- **Clinician** performs needs assessments to determine the best course of treatment.
- **Case manager** helps individuals connect with services.
- **Peer support specialist or navigator** provides coaching and moral support.
- **Police detective or police department prosecutor** reviews cases and determines eligibility.
- **Discharge planner** assists with discharge plans for programs that offer residential treatment.
- **Cook** prepares meals for programs that offer residential treatment.

In addition to learning how to carry out relevant procedures and protocols, program personnel may be trained in harm reduction, stigma reduction, crisis intervention, compassion, and the lived experience of drug dependency.

Steps of Linkage to Care

Most pre-arrest diversion programs have established a linkage to care continuum, shown below. We discuss each step in turn.



1. Identify individuals

Pre-arrest diversion programs are designed to serve individuals who:

- Have OUD
- Have committed low-level, non-violent offenses related to substance use
- Have experienced a crisis related to substance use or mental health

Potential participants are identified using different referral strategies shown in Table 1.2.

Table 1.2. Routes to Pre-Arrest Diversion Programs

REFERRAL STRATEGY	EXAMPLE	THIS PROCESS WORKS BEST WHEN…
1 **Self-referral**	**A.** Individual calls or comes into police station	Individuals are not charged for possession of drugs or drug paraphernalia at the time of their request for care. Such charges can deter participation, hinder or delay access to treatment and recovery, or result in a criminal record.
	B. Individual approaches officer on the street	
2 **"Stop" referral**	**A.** Officer intercepts individual committing diversion-eligible offense	The referrals are voluntary, and if the individuals accept, they are not issued citations for the offense. Such citations can hinder or delay access to treatment and recovery or result in a criminal or arrest record.
	B. Officer issues citation in lieu of arrest for diversion-eligible offense	
3 **"Social" referral**	Officer or other concerned individual refers individual to program	Officers make referrals based on established criteria for OUD as opposed to personal biases or prejudices. This will maximize the program's reach.
4 **911 referral**	Designated team is dispatched to an individual in need	The team arrives in a timely manner to ensure that all eligible individuals are offered diversion as opposed to immediate arrest.
5 **Police or court records**	Law enforcement officers review records for diversion-eligible offenses and contact individuals	It is paired with any of the other referral types. Relying on police or court records is the least direct and immediate route to diversion and does not prevent individuals from acquiring a criminal record.

2. Determine Eligibility

As shown in Table 1.2, some programs recruit or enroll self-referrals. Others offer admission only to those who commit, or are intercepted while committing, diversion-eligible offenses. Programs differ in terms of what offenses they deem eligible, but most agree to accept individuals whose offenses are:

1. Non-violent and low-level
2. Associated with drug use, poverty, homelessness or mental health

Examples include public intoxication, trespassing, and possession of 1 gram or less of a controlled substance.

Diversion-eligible offenses are not the only requirements for inclusion, however. Enrollment in many programs is governed by additional criteria related to other legal and non-legal concerns, such as an individual's past involvement in the justice system, residency, citizenship status, and overall health. Table 2.1 provides a comprehensive list of all eligibility criteria that programs use to qualify or disqualify participation.

Table 1.3. Eligibility requirements reported by pre-arrest diversion programs

REQUIREMENT	EXAMPLES
Eligible offense	• Non-violent and low-level offense • Offense associated with drug use, poverty, homelessness or mental health
Other qualifying criteria	• No past convictions for domestic violence, sexual assault, prostitution, or illegal firearm possession • No active warrants • No parole • No more than 3 drug-related convictions • No non-OUD treatment needs • No assisted living • No threatening behavior • Proof of identity, residency or citizenship • Willingness to be searched

Surprisingly, no programs base eligibility decisions on clinical criteria specific to substance use, such as overdose risk or possible OUD. This is curious because legal and clinical criteria are recommended for use by other law enforcement-led linkage to care programs, namely drug courts (see III. Drug Courts). Further research is needed to fully understand the rationale behind this omission and whether it is ultimately useful for other programs to adopt.

Programs thinking about establishing new criteria or revising existing criteria may want to know:

1. Some programs that identify individuals by self-referral, "social" referral, and even "stop" referral do not require additional screening to determine eligibility. If individuals have outstanding warrants or other charges, grounds for disqualification in other programs, they may still be invited to participate, and if they accept, the warrants and charges may be suspended until completion of the program. Programs are also known to help resolve any outstanding warrants that would otherwise serve as a barrier to participation.
2. Among programs surveyed in this study, those with eligibility criteria do not show better outcomes than those without.
3. Pre-arrest diversion may disqualify individuals without proof of identity, residency, or citizenship because such factors could later bar them from entering treatment. If possible, programs may consider helping individuals meet these treatment enrollment requirements rather than excluding their participation outright.
4. Because crime and having an OUD are linked, disqualifying individuals with past convictions may be a missed opportunity, depending on the conviction.
5. There is no evidence to suggest that individuals with past convictions for domestic violence, sexual assault, prostitution, or illegal firearm possession have poorer treatment outcomes than individuals without these convictions, which raises questions about the utility of such exclusion criteria. Nevertheless, each program should evaluate eligibility criteria in light of relevant laws in the state where the program is implemented to ensure no conflict exists.

3. Assess Needs and Link to Care

After referral, and if necessary, eligibility screening, individuals undergo a social and medical needs assessment and are linked to relevant services and other community resources. One program reports using ASAM criteria (www.asam.org/resources/the-asam-criteria/about) to assess needs.

The services and resources made available to individuals are wide-ranging. Treatment options include:

1. Detoxification
2. Substance abuse counseling
3. Intensive outpatient treatment
4. Residential treatment
5. All 3 forms of MAT

Other services and supports provided to facilitate treatment and recovery include:

1. 24-hour observation centers and other pre-treatment facilities
2. Housing support
3. Vocational support
4. Educational resources
5. Primary and specialty medical care
6. Access to benefit programs
7. Transportation to appointments and support groups
8. Meals
9. Access to ID card
10. Resources for personal care (e.g., clothes, haircut, shower, etc.)

4. Monitor Participants

Programs monitor individuals by making home visits or visits to treatment centers, conducting urine drug screens, or confirming compliance through communication with case managers and peer recovery coaches.

If individuals relapse or re-offend while engaged in pre-arrest diversion, some programs terminate participation, returning the individuals to the justice system to face the original and any subsequent charges. Other programs offer individuals a second or third chance to complete program requirements. The latter approach is most closely aligned with the principles of harm reduction and the standards of care for drug dependency.

Tracking Success

Because most programs are still in the early stages of implementation and evaluation, few have measured their outcomes. Among those that have, we have some preliminary data on linkage to MAT and recidivism, shown below.

Table 1.4. Early outcome data for pre-arrest diversion programs

STATE	% OF INDIVIDUALS LINKED TO MAT	% OF INDIVIDUALS RE-ARRESTED
A	80	X
B	X	5
C	100	X
D	X	Less than 1
E	20-30	2

X denotes unknown or unavailable information.

Other programs report efforts to measure additional variables, such as:

- Number of patients who complete treatment
- Number of ED visits
- Number of linkages to stable housing services
- Number of linkages to harm reduction services
- Size of prison population
- Number of fatal and non-fatal overdoses

Quick Tips for Pre-Arrest Diversion Programs

This guide seeks to assist anyone involved in the design, implementation, and evaluation of pre-arrest diversion programs aimed at linking people with opioid use disorder (OUD) to evidence-based care.

Design Tips

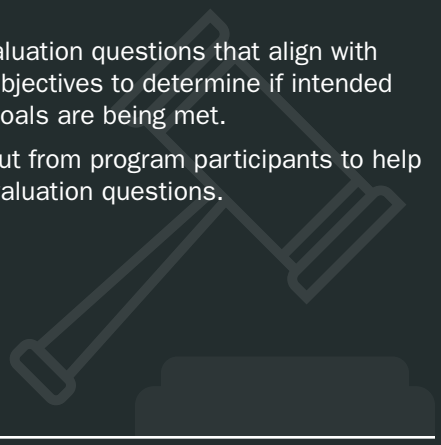
1. Treatment capacity
   - Identify all available community-based treatment options in your area, including the provision of all 3 medications commonly used to treat OUD, and highlight any gaps in care.
   - Build a network of social service agencies that provide treatment and recovery support services.
2. Local partnerships
   - Identify community partners who have a stake in your program, including law enforcement and other public safety professionals, drug treatment and social service providers, emergency department personnel, case managers, recovery coaches, and housing specialists, among others suited to your local context.
   - Host regular meetings to foster communication, trust, and network building.
3. Training
   - Provide all program personnel training in harm reduction, principles of addiction and recovery, motivational interviewing, and compassionate and non-judgmental care.
4. Goal-setting
   - Select goals with input from key stakeholders.
   - Choose goals that are explicit and measurable, such as reducing overdose deaths, reducing arrests for low-level offenses, and increasing treatment enrollment.

Implementation Tips

1. Low-threshold services
   - Allow individuals to enroll in pre-arrest diversion at any time.
   - If possible, minimize the use of legal eligibility requirements, such as no past convictions, and consider using none at all.
   - Use re-arrests or program noncompliance as opportunities to relink individuals with care and fortify treatment and recovery supports rather than return them to the justice system.
2. Treatment and recovery supports
   - Help individuals enroll in health insurance.
   - Link patients with as many social supports as needed or requested (e.g., housing, transportation, job training, educational support, meals, etc.).
   - Pair patients with recovery coaches who can provide emotional and logistical support.
   - Make counseling available to participants, but not a requirement for medication.
   - When treatment appointments are not immediately available, connect participants with pre-treatment facilities.
3. Legal considerations
   - Divert individuals pre-arrest, not pre-booking, to prevent them from acquiring an arrest record.

Evaluation Tips

- Develop an evaluation plan before the program begins.
- Select evaluation questions that align with program objectives to determine if intended program goals are being met.
- Solicit input from program participants to help answer evaluation questions.



SECTION

III

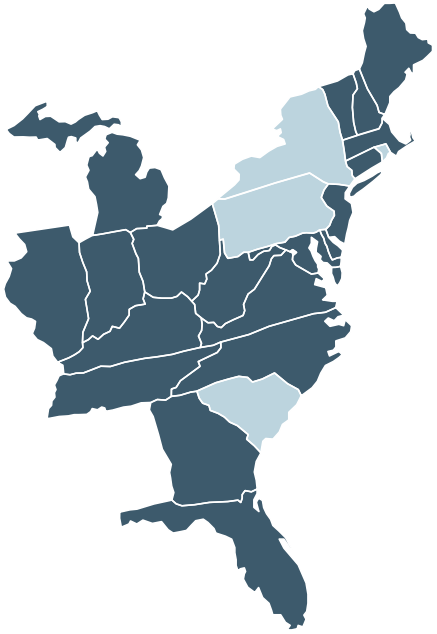
Drug Courts

What are Drug Courts?

A majority of incarcerated individuals (63% in prisons and 58% in jails) meet the criteria for drug dependency.[1] Many return to substance use and are at an increased risk of overdose after release.[2, 3, 19] Drug treatment courts, or drug courts, can divert individuals with non-violent drug and other low-level offenses from jails and prisons and toward evidence-based treatment.[20]

What We Already Know about Drug Courts

- Drug courts can reduce the costs associated with incarceration.[21]
- Participants with a history of non-compliance or violent offenses require additional supports to fully benefit from drug courts.[22]
- A variety of implementation strategies exist for drug courts.[22]
- Drug court participation is associated with decreased drug use and crime, improved family functionality, and increased use of services.[23, 24]
- 1 review found that drug courts can be effective in reducing recidivism among participants.[22] It found that the following characteristics make drug courts more effective in reaching this goal:
  - Pre-adjudication drug courts rather than post-adjudication
  - Continuing supervision after graduation
  - Staff who attend national conferences and weekly team meetings
  - Requiring restitution and education; not requiring fines, community service, or employment
  - Keeping participants in substance abuse treatment for longer periods of time; not requiring Alcoholics Anonymous/Narcotics Anonymous participation
  - Including participants with an initial positive drug test and those who previously failed the program
  - Utilizing multiple treatment providers and internal providers
- Many drug court evaluation studies have mixed findings and methodological flaws.[25]
- Despite the known efficacy of MAT (all three medications) for treating OUD, in 2010 only 56% of drug courts offered it to its participants.[20]



Did you know?

Less than half of all drug courts offer methadone or buprenorphine.[20]

Programs We Examined

To be included, programs had to:

- Integrate social services and professional drug treatment with judicial processes.
- Provide access to a continuum of treatment and recovery services that include MAT.
- Provide remediation (e.g., dismiss charges, reduce sentences) for participants who graduate.
- Obtain input from medical professionals and/or employ validated assessment tools.

We identified drug courts in 20 states. Below, we summarize findings from 19 programs surveyed (highlighted on the map), including 12 where program observations were conducted.

Program Basics

Goals

All drug courts list criminal justice-related goals. These include reducing crime in the community, reducing recidivism among participants, and reducing the size of the prison population. Whereas some programs only indicate criminal justice-related goals, most aim to treat substance use disorders or provide linkage to care as well. Other goals include improving efficiencies in use of resources and facilitating re-entry into the community for those involved in the criminal justice system.

Drug courts often define success as the proportion of participants that graduate from the program. Graduation requirements vary across programs; examples include:

- Drug free for 1 year
- 12-15 month period after treatment program completion with less than 3 sanctions
- In "stable sobriety," leader within program, employed, and housed independently
- 6 months sobriety after treatment, employed, progress toward high school diploma, and payment of all program fees

Evaluation is needed to identify graduation requirements associated with an increased likelihood of reaching program goals.

Scope, Funding, and Staffing

Programs use the majority of their budgets for:

- Staff (e.g., administrators/coordinators, clerks, case managers, clinicians)
- Treatment services (e.g., counseling, treatment beds at residential treatment)
- Supplies and services (e.g., drug tests, staff training, transportation)

The majority of drug courts are securely funded. Program budgets range from $82K, the lowest reported funding level, to $1.7M, the highest. Table 2.1. compares the operations of programs at these funding levels.

4 programs use volunteers, often serving as peer recovery specialists, whereas the rest rely on paid staff members.

The vast majority of people served by drug courts are male and white. Depending on the burden of the local overdose epidemic, drug courts may be failing to reach all impacted populations.

Most drug courts operate a few days per week.

Table 2.1. Drug courts at the lowest and highest funding levels

WHAT PROGRAMS DO WITH:	$82,252	$1,743,000
Serve	39 people	294 people
Hire	1 salaried staff member	11 salaried staff members (coordinators, case managers, clinical staff, counselors)
Use volunteers	No	No
Provide training for judges	Yes	Yes
Provide support staff for judges	No	Yes
Link individuals to	Drug treatment (naltrexone only)	Various drug treatment modalities, case management, mental health treatment, group counseling, and employment support

Staff Preparation and Support

Judges:

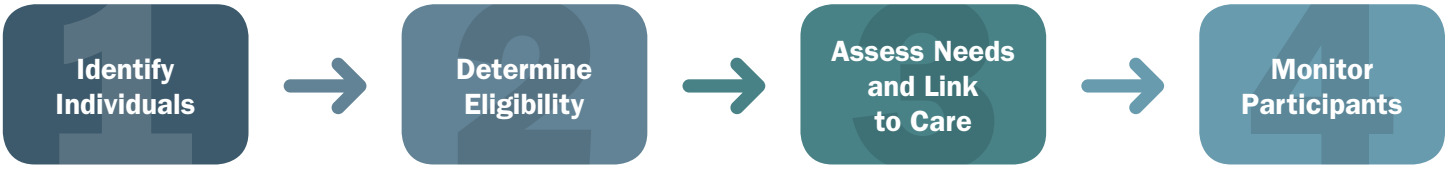
- Initially, drug court judges receive training from the National Drug Court Institute. Annual follow-up training is provided by the National Association of Drug Court Professionals or through annual meetings with state-based drug court associations.
- Some programs reported additional training measures for judges covering topics like problem solving, drug trends, and best practices in working with people with substance use disorders.
- Training is not mandated for judges serving on drug courts, as several programs indicated that judges do not receive drug court-specific training.
- Many judges receive additional support through a drug court coordinator or clerk who manages daily operations and paperwork. In 1 case, this coordinator operates at the state level. In another, the coordinator is tasked with distributing research and resources on drug courts to the staff.

Social workers, clinicians, and peer navigators:

- Training for social workers or clinicians involved in the program comes from their own professional licensing organization, but is not specific to working in a drug court.
- For some, professional training includes training on addiction and recovery.
- 1 program sends clinical staff to annual drug court conferences for professional development.

Steps of Linkage to Care

Most drug courts have established a linkage to care continuum, shown below. We discuss each step in turn.



1. Identify Individuals

Drug courts aim to serve individuals with OUD following an arrest, especially if the arrest is associated with substance use. In areas where pre-arrest diversion is also available, drug courts may be intended as a safety net for individuals for whom pre-arrest diversion has not been effective.

Individuals can ask to participate. They can also be referred by a judge, district attorney, personal attorney, probation officer, law enforcement officer, defense counsel, or family member.

2. Determine Eligibility

All drug courts surveyed in this study restrict enrollment to individuals who meet pre-established eligibility requirements. Similar to some pre-arrest diversion programs, drug court programs consider the type and severity of the current offense, in addition to other legal and non-legal factors. Unlike pre-arrest diversion, however, they extend non-legal requirements to include clinical concerns specific to OUD. The below table shows the full scope of eligibility requirements used by drug courts. Criteria specific to OUD appear in bold.

Table 2.2. Eligibility requirements reported by drug court programs

REQUIREMENT:	EXAMPLES
Eligible offense	• Non-violent and low-level offense • Non-sex offense • Drug-related offense or felony
Other qualifying criteria	• Guilty plea • Sentence of at least 4 months • No objection by victim • No past convictions for violent crimes, sexual assault, drug dealing, or gang involvement • No active warrants • Not currently an informant • No parole • No past felonies • No acute physical or mental illness • City or country residency • **History of substance use** • **Diagnosis of OUD** • **Diagnosis of mental health disorder** • **Recognition of OUD** • **Interest in treatment** • **High criminological risk/high clinical need**

Survey respondents indicated that, in practice, some programs override eligibility rules and admit individuals on a case-by-case basis, paying more attention, for example, to an individual's interest in the program or motivation for treatment than past criminal involvement. In fact, excluding individuals with past criminal involvement may be eliminating individuals with the most serious addictions. Programs that adopt more flexible screening practices should ensure that eligibility decisions are ultimately dictated by a patient's needs.

1 program reported a team decision-making approach, where drug court staff make eligibility decisions in collaboration with local treatment providers and recovery support specialists. Such an approach is recommended as long as non-clinical staff defer to treatment providers and other clinical personnel for decisions about clinical diagnoses, needs, and suitability for treatment.[26]

3. Assess Needs and Link to Care

Once individuals are deemed eligible, they undergo a more comprehensive needs assessment by drug court staff, usually a case manager. Then a case manager, clinical coordinator, or recovery coach identifies and makes linkages to relevant services and care.

The OUD treatment options made available to individuals include:

1. Substance abuse counseling
2. Intensive outpatient treatment
3. Residential treatment
4. All types of MAT
5. Support groups
6. Recovery coaching

Other services and supports provided to facilitate treatment and recovery include:

1. Housing support (e.g., 1-3 months of paid housing for individuals exiting residential treatment)
2. Vocational support (including letters of recommendation)
3. Educational resources (e.g., GED support, life skills classes)
4. Individual and family counseling
5. Primary and specialty medical care
6. Access to health insurance
7. Transportation to appointments and support groups

> "Ancillary services are critically important. …Building out housing networks, employment opportunities, [and] education … must be a part of the drug court intervention process."
>
> ***—Drug court coordinator***

4. Monitor Participants

Drug courts primarily monitor participants for treatment and probation compliance, which they measure using drug screens, curfew checks, home visits, and court appearances. Some programs also use GPS to monitor an individual's adherence to their schedule. Programs find that some screening measures can be overly burdensome and counter-productive to treatment and recovery. As a survey respondent explained, it can be difficult for individuals to make weekly court appearances if they are also working and challenged to secure transportation.

Individuals who show compliance receive certificates of appreciation and honor roll awards. Noncompliance is met with sanctions, such as community service requirements, increased probation supervision, and brief periods of incarceration. The use of sanctions, as opposed to outright expulsion, is important. In the words of a drug court coordinator: "Relapse is part of recovery, and people [who] slip up… shouldn't be kicked out for this."

Some programs nonetheless terminate individuals who show noncompliance, at which time their cases are processed as usual and their sentences may be heavier.

Quick Tips for Drug Courts

This guide seeks to assist anyone involved in the design, implementation, and evaluation of drug courts aimed at linking people with opioid use disorder (OUD) to evidence-based care.

Design Tips

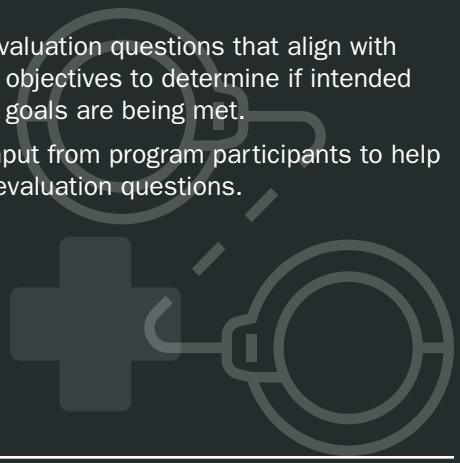
1. Treatment capacity
   - Identify all available community-based treatment options in your area, including the provision of all 3 medications commonly used to treat OUD, and highlight any gaps in care.
   - Build a network of social service agencies that provide treatment and recovery support services.
2. Local partnerships
   - Identify community partners who have a stake in your program, including law enforcement and other public safety professionals, drug treatment and social service providers, emergency department personnel, case managers, recovery coaches, and housing specialists, among others suited to your local context.
   - Host regular meetings to foster communication, trust, and network building between partners.
3. Training
   - Provide all program personnel training in harm reduction, principles of addiction and recovery, motivational interviewing, and compassionate and non-judgmental care.
4. Goal-setting
   - Select goals with input from key stakeholders.
   - Choose goals that are explicit and measurable, such as reducing overdose deaths, increasing treatment enrollment, reducing recidivism among participants, and reducing the size of the prison population.

Implementation Tips

1. Low-threshold services
   - If possible, minimize the use of legal eligibility requirements, such as no past convictions, and consider using none at all.
   - Eligibility decisions are best made by teams that include drug court personnel, local treatment providers, and recovery support specialists.
   - Use re-arrests or program noncompliance as opportunities to relink individuals with care and fortify treatment and recovery supports rather than return them to the justice system.
2. Treatment and recovery supports
   - Help individuals enroll in health insurance.
   - Link participants with as many social supports as needed or requested (e.g., housing, transportation, job training, educational support, meals, etc.).
   - Pair participants with recovery coaches who can provide emotional and logistical support.
   - Make counseling available to participants, but not a requirement for medication.
   - Provide overdose prevention education and naloxone to reduce fatal overdose risk.

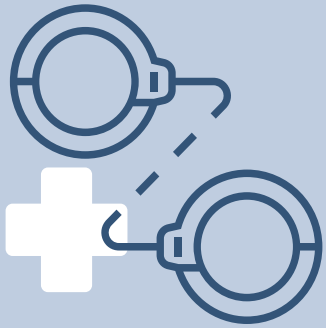
Evaluation Tips

- Develop an evaluation plan before the program begins.
- Select evaluation questions that align with program objectives to determine if intended program goals are being met.
- Solicit input from program participants to help answer evaluation questions.



SECTION

IV



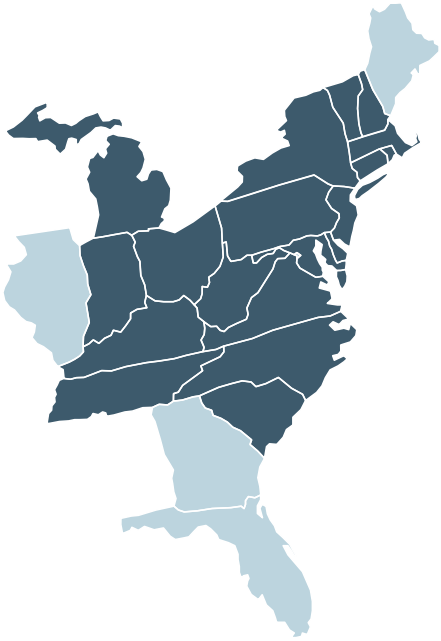
Linkage to Care upon Release from Incarceration

What is Linkage to Care upon Release from Incarceration?

Formerly incarcerated individuals are at high risk of overdose, particularly in the weeks immediately following release.[2, 3] To combat this, linkage to care programs engage individuals in community-based care upon release, thus reducing their risk of overdose. Wider implementation of this program is needed. In 2009, only 45% of state prison systems provided referrals upon release and even fewer provided linkage to care.[7]

What We Already Know about Linkage to Care upon Release from Incarceration

- Little evidence for these linkage programs is available. A large body of evidence shows that treatment during incarceration reduces drug use, criminal behavior, and overdose risk.[28]
- More than half of those linked to care post-release initiate community-based care.[29, 30]
- For people with opioid use disorder (OUD), receipt of treatment while incarcerated (before release) reduces recidivism and improves treatment continuation after release at higher rates than linkage post-release.[29, 31]
- Forced withdrawal, or lack of treatment, during any incarceration period reduces the likelihood of treatment engagement upon release.[9, 31]
- Lack of insurance and financial hardship are barriers to initiating care for those linked post-release.[32]



Programs We Examined

To be included, programs had to:

- Screen incarcerated individuals prior to release to assess care needs.
- Offer treatment plans that provide a level of care appropriate for the individual.
- Provide a “warm hand-off” to community-based service providers upon release.

We identified programs that provide linkage to care upon release in 21 states. Below, we summarize findings from 18 programs surveyed (highlighted on the map), including 9 where program observations were conducted.

Overall, 2 types of programs emerged:

1. Continuing programs: linkage to care post-release is a continuation of treatment received during incarceration
2. Initiating programs: linkage to care post-release is an initiation of treatment services

Program Basics

Goals

Programs that link individuals with care upon release have criminal justice and treatment/recovery-oriented goals. A survey respondent indicated that their program's goal is "that participants do not return to jail or prison, that they do not overdose, that they are employed and living independently." Table 3.1. summarizes the goals across all programs.

Table 3.1. Linkage to care upon release from incarceration goals

CRIMINAL JUSTICE GOALS	TREATMENT/ RECOVERY-ORIENTED GOALS
• Reduce recidivism • Prevent re-incarceration • Reduce jail or prison time	• Increase linkage to care • Reduce problem drug use • Prevent overdose and death • Provide treatment for co-morbid conditions • Promote reintegration with community

Funding, Scope, and Staffing

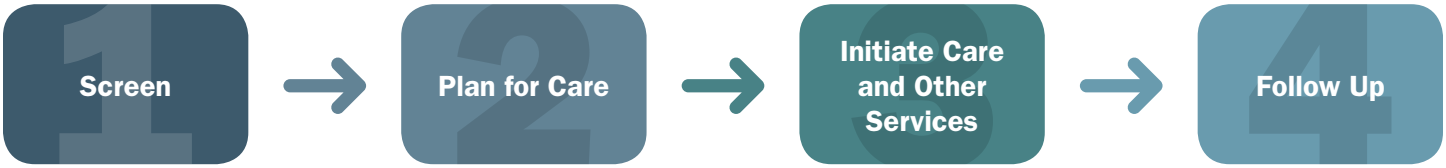
These programs operate with yearly budgets as small as $135,000 and as large as $3.5 million, with an average value of $1.4 million and median value of $1 million. The below table showcases the 2 programs whose operating budgets are at the lowest and highest ends of the funding spectrum. This allows us to see what these levels of funding afford in terms of program operations.

Table 3.2. Linkage to care upon release from incarceration at the lowest and highest funding levels

WHAT PROGRAMS DO WITH:	$135,000	$3.5 MILLION
Serve	15 people	1,288 people
Hire	5 salaried staff members	8 salaried personnel
Provide training for personnel	Yes	Yes
Provide peer support services*	Yes	Yes
Link to MAT**	Yes	Yes

Steps of Linkage to Care

Most linkage to care upon release from incarceration programs have established a linkage to care continuum, shown below. We discuss each step in turn.



1. Screen

Linkage to care upon release from incarceration serves individuals with OUD. In the absence of national standards for identifying these individuals in the criminal justice system, programs create their own screening protocols. These protocols vary widely across states.

Table 3.3. highlights four key components of screening protocols to show the range of practices involved; those practices shown in bold have the strongest evidence-base.[36]

*Peer support specialists, also known as peer recovery specialists, draw on personal experiences with seeking and attaining recovery to help others do the same. While common in behavioral health interventions, they are newer to programs in the criminal justice system. Of the linkage to care upon release from incarceration programs surveyed here, 50% provide some type of peer support service to individuals pre- and post-release, including coaching and moral support, transportation to treatment, and assistance with housing and employment.

Data on the effectiveness of peer support for individuals with OUD is generally favorable.[33] Although peer support for incarcerated populations is an emerging practice, it is particularly promising for individuals receiving MAT.[34]

**Individuals have the best chance of establishing recovery when MAT clinics offer a variety of medication options and tailor treatments to individual needs and preferences.[35]

Table 3.3. Variations in screening practices

KEY COMPONENTS OF A SCREENING PROTOCOL	VARIATIONS IN PRACTICE
1 Screening eligibility	**Everyone**
	Referrals from corrections officers, judges, or lawyers
	Self-referrals or self-reports
	Non-violent offenders
	Offenders with no federal offenses
2 Timing of screening	**At booking or shortly thereafter**
	Weeks or months prior to release
3 Screening assessments & tools	**Diagnostic and Statistical Manual of Mental Disorders (DSM-V) Criteria for Substance Use Disorders**
	SAMHSA's Screening, Brief Intervention, and Referral to Treatment (SBIRT)
	Texas Christian University Drug Screen V (TCUDS V)
	Instruments based on Risk-Need-Responsivity model
	National Institute on Drug Abuse Quick Screen
	Columbia-Suicide Severity Rating Scale
	Urine tests for the presence of drugs
	Other risk, health, and mental health assessments
4 Screening administration	**Mental health or addiction specialists**
	Corrections staff members

Programs looking to create or enhance a screening protocol, may want to know:

1. Universal screening, or screening everyone for OUD, reduces the risk of excluding individuals whose substance use is less recognizable or who fear they would be punished for reporting drug use.[36]

2. Early screening paired with regular re-screening best captures an individual's needs and interest in treatment. [36]

3. Screening that aims to identify not only OUD but also high criminal risk and co-occurring disorders is ideal because it helps programs better understand an individual's complex, intersecting needs and tailor treatment plans accordingly. Individuals with OUD and other social and health needs merit special attention and resource allocation.[36]

4. Screening and assessment tools are most helpful when administered by individuals with advanced training in the fields of mental health and OUD and good knowledge of available treatment modalities.

5. Evidence shows that coerced or compulsory initiation of treatment is less effective than voluntary initiation.[37] Thus, while universal screening is recommended, actual participation in linkage to care should remain voluntary. Treatment initiation should not be bartered for more favorable court proceedings or sentence mediation.

2. Plan for Care

Planning for the initiation or continuation of treatment in the community usually begins when a release date is set. Here, an individualized treatment plan is developed. When release dates are unexpected and linkage cannot be initiated, connection with a community-based peer navigator and the provision of naloxone become critically important.

Approaches to linkage fall into 2 categories that we call active and passive to describe the role assigned to the individual in the process. The differences between active and passive approaches are summarized below.

ACTIVE	PASSIVE

• Begins pre-release.*
• Involves direct communication between individual patients and community care providers.
• Includes individual patients in the development of their own plans.*
• **Examples:**
  ○ A treatment provider visits correctional facility to meet with patients and discuss treatment plans
  ○ A patient visits community-based treatment center to prepare for post-release care initiation
	• Begins at or post-release.
	• Involves indirect communication between individual patients and community care providers; criminal justice officers speak on patients' behalf.
	• Does not include individual patients in the development of their own plans.
	• **Examples:**
	  ○ A re-entry specialist assesses needs pre-release and shares information with a parole officer who provides linkage after the individual is released.
	  ○ A corrections-based counselor calls or meets with community-based care provider to make appointment and share client information.

*Pre-release planning and including the individual in the planning are best practices. These strategies ensure that individuals have a plan and are engaged with providers before release.[31]

3. Initiate Care and Other Services

To help individuals initiate care, many programs assist with transportation. They may provide bus tokens or delegate peer navigators as escorts. Escorted visits and the provision of transportation are evidence-based practices.[38]

Several programs link to naltrexone-only MAT. This contradicts evidence-based practice. MAT works best when all 3 FDA-approved MATs are available.[35]

The variety of treatment options available largely depends on partnerships: more and stronger partnerships means that more comprehensive services and supports are available to individuals. Such service integration is yet another evidence-based linkage to care practice.[39]

In addition to MAT, additional services to which individuals are linked are listed below, in order of how frequently programs mentioned linking to them (from most to least):

- Behavioral health services (e.g., individual and group counseling, motivational enhancement therapy, cognitive-behavioral therapy)
- Transportation
- Wraparound services (e.g., supportive housing, employment assistance, EBT cards for food, education and vocational training, legal services)
- Medical care (physical and mental health)
- Overdose prevention and naloxone training

In addition to the wraparound services described above, additional attempts to support individuals in initiating and continuing treatment include:

- Ensuring insurance enrollment prior to release
- Educating families on treatment to garner their support
- Discussing potential barriers to treatment retention and how to mitigate them
- Making follow-up appointments
- Maintaining weekly contact with recovery coaches

4. Follow Up

Many programs cite treatment compliance as a condition of early release and parole. Therefore, the criminal justice system (i.e., case manager or parole officer) conducts the follow-up, often through drug screens. Drug screens may not be an appropriate indicator, however, because recovery should be promoted over abstinence.[40]

In 2 programs, peers conduct follow-up and support retention. Additional programs should consider this strategy, as peer support is associated with adherence to and retention in care.[41]

HIPAA and other confidentiality policies pose challenges to following-up on an individual when treatment providers, law enforcement, and public health are involved. Some programs invoked these confidentiality policies as a rationale for not monitoring individuals. Other programs described procedures for obtaining consent from individuals and organizations to share information (e.g., a release of information), demonstrating that follow-up is possible.

Tracking Success

The text box to the right shows examples of indicators used by 1 linkage to care upon release from incarceration program. Not only are these indicators clear and measurable, they are all relevant to at least 1 of the outcome objectives, which include reducing opioid use and criminal behavior. Further, they are backed by scientific literature. For example, because we know that delays in treatment initiation are associated with poorer treatment outcomes,[42] a measure of how long it takes to engage individuals with community treatment providers post-release has strong technical merit (see Indicator 2).

PROGRAM SPOTLIGHT: Examples of quality indicators

1. % of individuals engaged in treatment at the time of release
2. Time to engagement with community treatment providers post-release
3. % of individuals with psychiatric co-morbidity receiving medication at the time of release
4. % of individuals in stable housing at the time of release
5. % of individuals with employment at the time of release
6. % of individuals with new arrest within six months of release
7. % of individuals with new incarceration within six months of release

Methods for collecting evaluation data include contracting evaluation teams, conducting surveys among participants, reviewing electronic medical records, and integrating client records across multiple stakeholders. Some programs utilize data generated from within the criminal justice system through the monitoring of participants on parole. This follow-up was time limited (usually 6 months to 1 year).

Quick Tips for Linkage to Care upon Release from Incarceration Programs

This guide seeks to assist anyone involved in the design, implementation, and evaluation of programs that provide linkage to care upon release from incarceration aimed at linking people with opioid use disorder (OUD) to evidence-based care.

Design Tips

1. Treatment capacity
   - Identify all available community-based treatment options in your area, including the provision of all 3 medications commonly used to treat OUD, and highlight any gaps in care.
   - Build a network of social service agencies that provide treatment and recovery support services.
2. Local partnerships
   - Identify community partners who have a stake in your program, including parole officers, judges, and other public safety professionals, drug treatment providers, case managers, recovery coaches, and social service providers including housing specialists, among others suited to your local context.
   - Host meetings to foster communication and relationship-building between partners; coordinating partnerships at the county-level may work best.
3. Training
   - Provide all program personnel training in harm reduction, principles of addiction and recovery, motivational interviewing, and compassionate and non-judgmental care.
   - Sensitize clinical staff to working in criminal justice settings.
4. Goal-setting
   - Select goals with input from with key stakeholders.
   - Choose goals that are explicit and measurable, such as reducing overdoses, increasing enrollment in treatment, reducing time to treatment initiation following release, and reducing recidivism among formerly incarcerated individuals.

Implementation Tips

1. Screening and linkage
   - Implement universal screening; conduct screening soon after booking and routinely thereafter.
   - Involve participant and healthcare provider in decisions about linkage and treatment.
   - Arrange for transportation to community-based treatment.
   - Ensure active participation of parole officers in linkage process.
2. Treatment and recovery supports
   - Help individuals enroll in health insurance.
   - Link participants with as many social supports as needed or requested (e.g., housing, transportation, job training, educational support, meals, etc.).
   - Pair participants with recovery coaches who can provide emotional and logistical support.
   - Make counseling available to participants, but not a requirement for medication.
   - When treatment is not immediately available, connect participants with pre-treatment facilities.
   - Provide overdose prevention education and naloxone to reduce fatal overdose risk.

Evaluation Tips

- Develop an evaluation plan before the program begins.
- Select evaluation questions that align with program objectives to determine if intended program goals are being met.
- Solicit input from program participants on program approaches (e.g., screening timing, screening tools, personnel involved in linkage) and their impact on intended outcomes.

SECTION

V

Law Enforcement-Led Post-Overdose Outreach

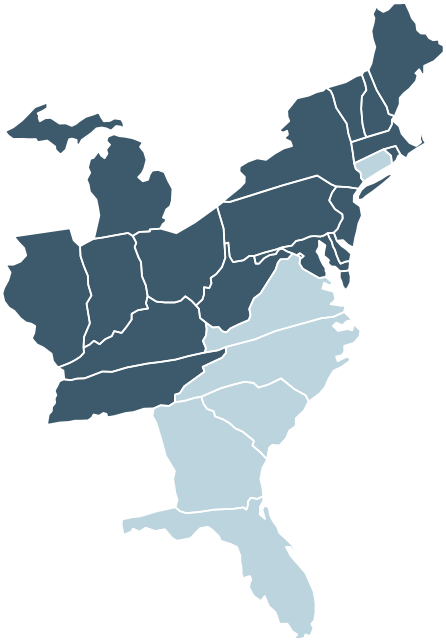
What is Law Enforcement-Led Post-Overdose Outreach?

Previous non-fatal overdose is a strong predictor of future fatal overdose. Thus, the period following a non-fatal overdose may present a key opportunity for intervention.[43] Some emergency departments capitalize on this knowledge, using their encounters with overdose survivors as opportunities to provide overdose prevention education, naloxone, and referrals to treatment.[44, 45]

More recently, law enforcement and other public safety professionals have replicated this model to engage overdose survivors in the privacy of their homes in the days and weeks following the overdose event. These efforts are driven by the theory that individuals affected by overdose may be more amenable to intervention outside of an institutional setting.

What We Already Know

- There are no scientifically rigorous studies that measure the outcomes of law enforcement-led post-overdose outreach efforts.
- Among the 23 known post-overdose outreach programs in Massachusetts in 2017, nearly all (90%) aim to reduce overdoses by providing overdose prevention education and linkages to drug treatment.[46]
- Outreach efforts differ across programs. Some teams are multidisciplinary, whereas others involve clinicians or police officers only. Some extend to sites beyond the home.[46]
- The following indicators are used to evaluate programs: number of successful outreach contacts (60% of programs), activities during visits (30%), number of referrals (30%), and number of linkages with providers (25%).[46]



Programs We Examined

To be included, programs had to:

- Conduct person-based outreach (i.e., to a person's home).
- Target individuals who experienced a confirmed or suspected overdose.
- Refrain from using information collected through outreach for investigative purposes.

A total of 19 states with post-overdose outreach programs were identified. Surveys were completed for 17 of them (highlighted on the map), and observations, for 8.

Program Basics

Goals

All post-overdose outreach programs share the explicit aim to link overdose survivors with relevant services and resources. For some programs, these services and resources are treatment-specific, whereas for others, they comprise anything that supports a person's recovery or general health and well-being.

Some programs also extend their vision to include community-level goals, for example:

- To improve public safety.
- To reduce costs associated with drug-related emergency room visits, arrest, and incarceration.
- To reduce drug-related stigma.
- To change lay perceptions of law enforcement, recasting it as a community service as much as a policing mechanism.

Funding and Scope

Some programs are relatively well-funded and well-staffed. Others make do on shoestring budgets and few, if any, salaried personnel.

- The program with the highest reported level of funding received $1.3 million over a 3-year period. This program has reached 300 overdose survivors, 30% of whom have agreed to enter treatment.
- At the other end of the spectrum, programs have small operating budgets, unreliable funding sources, and a primarily volunteer staff. They reported reaching far fewer individuals.

Staffing

Police officers, peer recovery specialists, and clinicians conduct most outreach visits. Visits assume 1 of the following forms, each of which has advantages and disadvantages.

1. Multidisciplinary team visit: police officer and peer recovery specialist or clinician conduct outreach
    - **Pros:** Can facilitate rapport quickly and address an individual's complex social and health needs
    - **Cons:** Can be resource-intensive
2. Police officer visit: police officer conducts outreach
    - **Pros:** Can build trust in public safety
    - **Cons:** Can overtax jurisdictions with limited law enforcement; can lend the impression that the visit is for investigate purposes if the officer is uniformed and in a marked vehicle
3. Clinician visit: clinician conducts outreach with or without peer recovery coach
    - **Pros:** Can facilitate rapport quickly and address an individual's complex social and health needs
    - **Cons:** Can be overwhelming if the clinician is working alone; can obscure the role of law enforcement

Of these 3, multidisciplinary team visits have the strongest evidence base for linking people with OUD to appropriate care.[47]

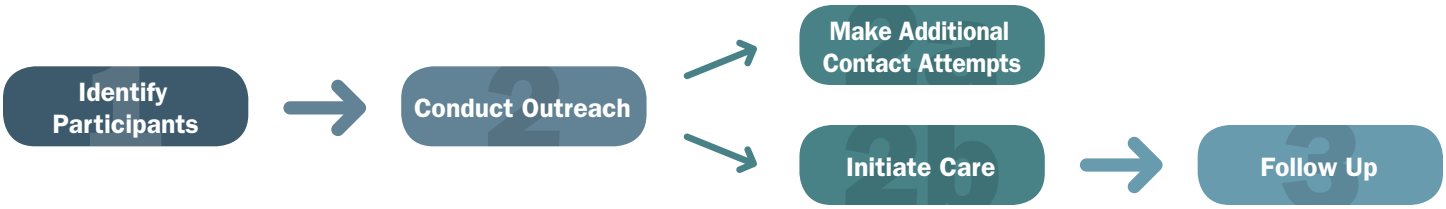
Staff Preparation

At a minimum, staff are trained in the program's goals and day-to-day operations. Some staff also receive training in 1 or more of the following:

- Addiction medicine and Stages of Change model
- Crisis intervention
- Motivational interviewing
- Grief counseling
- Available treatment options and community resources

Steps of Linkage to Care

Most post-overdose outreach programs have established a linkage to care continuum, shown below. We discuss each step in turn.



1. Identify Participants

Post-overdose outreach potentially benefits everyone. There are no eligibility criteria or screening processes. Participants do not need to travel, make appointments, or cover program costs, all of which are known barriers to care.[48]

Because most states do not have mandatory reporting requirements for nonfatal overdoses, programs identify potential participants for outreach in informal and ad-hoc ways. They typically use third party sources, listed in Table 4.1, to collect names, phone numbers, and addresses of individuals who have overdosed in the past 24-72 hours. This strategy allows programs to cast a wide net, yet it may also put some populations beyond reach.

Table 4.1. Referral sources for conducting post-overdose outreach

REFERRAL SOURCE	POPULATIONS SERVED	POPULATIONS EXCLUDED

• Public records
  ○ Public safety dispatch logs
  ○ Real-time overdose surveillance reports
• First responders, hospitals, self, family, friends, and providers
	• Anyone with a reported overdose in a given jurisdiction
	• Anyone who visits an ED for overdose treatment
	• Anyone with a concerned family, friend, or provider who knows about this program
		• Anyone whose overdose is unreported by bystanders or first responders.
		• Anyone whose overdose is inaccurately reported by bystanders or first responders.
		• Anyone who is unhoused or without a working phone number

Did you know?

In all but 3 states, nonfatal overdose is not a mandatory reportable condition.[49]

What strategies can improve post-overdose outreach?

1. Consider mandating timely reporting of nonfatal overdose.[49, 50]
2. Enforce comprehensive Good Samaritan Laws to encourage overdose reporting by bystanders.[51]
3. Supplement residence-based outreach with place-based outreach to reach unhoused and more transient populations.[52]
4. Make efforts to consent or enroll participants prior to home-based outreach. Voluntary participation is a best practice and unanticipated outreach visits may have the unintentional consequence of driving drug use-related risk underground.[53]
5. Extend post-overdose outreach services to the friends and family members of overdose survivors. If someone has witnessed the overdose of a loved one, they may be in need of grief counseling and other forms of support. Witnessing an overdose can also prompt someone to want to enter treatment.

2. Conduct Outreach

- Outreach is initiated within 72 hours of an overdose, with few exceptions. 2 programs make contact immediately after the event either at the location of the overdose or in the ED, and 1 program makes contact within a week.
- Outreach teams are defined by program partnerships. 8 programs use multidisciplinary teams consisting of police officers and either peer recovery coaches or clinicians.
  - 4 programs include all 3 types of professionals.
  - 2 programs exclude police officers from outreach activities entirely.
- In some programs, police officers conducting outreach are required to use civilian clothes and unmarked cars to avoid issues of fear and mistrust of police among drug-using communities.
- In 1 program, officers are tasked with the dual role of law enforcement (i.e., identifying drug suppliers) and outreach, which can exacerbate mistrust, fears of arrest, and avoidance of public safety and services.

2a. Make Additional Contact Attempts

Commonly, individuals are unable to be reached by phone or not home at the time of an outreach visit. In response, some programs make 2-3 follow-up attempts, and they are not likely to continue after 30 days of no contact. The most consistent outreach effort makes weekly contact attempts for 1 month, followed, at minimum, by repeat attempts at 3 and 6 months.

2b. Initiate Care

Once contact is made, treatment-oriented programs offer linkages with drug treatment and peer recovery coaches.

Recovery-oriented programs expand their scope to include the following, in addition to drug treatment:

- Primary care and mental health treatment
- Housing
- Overdose prevention education and naloxone rescue kits
- In the event of overdose deaths, grief counseling for relatives and friends

For some programs, it is not simply finding an appropriate linkage option that matters, but rather finding a place that is known to treat individuals with OUD with dignity and respect.

These programs provide “warm hand-offs” in 1 or more of the following ways, all evidence-based practices:

- Involving peer recovery specialists to provide moral support and experiential knowledge.[54]
- Scheduling intake appointments, and additionally accompanying individuals to appointments to improve initiation and retention.[55]
- Providing transportation or covering the cost of travel.[38, 56]

3. Follow Up

Post-linkage to care, many programs limit their involvement in people's lives. For 1 program, once a participant enrolls in treatment, they are "off the radar," unless they initiate future contact.

2 programs make efforts to track participants after enrollment into drug treatment through self-report, in case they need to re-intervene. 1 program makes 2 follow up communication attempts, whereas the other makes 3. These attempts occur at 1-, 2-, or 3-month intervals after treatment initiation.

Some programs offer more robust support to individuals by making peer recovery coaches available during treatment. In 1 case, peer recovery coaches also work exclusively with participants who complete treatment programs. Evidence shows that peer support facilitates linkage and retention in care.[54]

Tracking Success

Given the novelty of post-overdose outreach, few programs have been operating long enough to conduct meaningful evaluations. Those programs that track success select among the following indicators that measure linkage to care.

- Number of participants reached
- Number of referrals to treatment
- Number of treatment admissions
- Number of treatment completions
- Number of fatal and non-fatal overdoses
- Rates of infectious disease

Future evaluation could utilize records from outreach programs, participant satisfaction surveys, and formative research among potential participants to answer key evaluation questions. In addition to the listed indicators, which address linkage to care outcomes, programs could pose questions about program processes and development, such as:

- Whether the first 12-72 hours following an overdose is in fact an ideal time for intervention, and if so, for whom.
- What types of data sources (third party sources, referrals, self-referrals, etc.) lend themselves to the most successful contacts.
- Whether potential participants would prefer to be reached by phone or in person.
- Whether potential participants are amenable to unannounced home visits.

Quick Tips for Post-Overdose Outreach Programs

This guide seeks to assist anyone involved in the design, implementation, and evaluation of post-overdose outreach programs aimed at linking people with opioid use disorder (OUD) to evidence-based care.

Design Tips

1. Treatment capacity
   - Identify all available treatment options in your area, including the provision of all 3 medications commonly used to treat OUD, and highlight any gaps in care.
   - Build a network of social service agencies that provide treatment and recovery support services.
2. Local partnerships
   - Identify community partners who have a stake in your program, including drug treatment and other healthcare providers, emergency department personnel, case managers, recovery coaches, and social service providers, among others suited to your local context.
   - Host meetings to foster communication, trust, and relationship-building between partners.
3. Training
   - Provide all program personnel training in harm reduction, principles of addiction and recovery, motivational interviewing, and compassionate and non-judgmental care.
4. Goal-setting
   - Select goals with input from key stakeholders.
   - Choose goals that are explicit and measurable, such as reducing overdoses and increasing enrollment in treatment.

Implementation Tips

1. Participant privacy
   - Develop a plan for identifying program participants that protects their individual privacy.
   - Consider an enrollment strategy that requires consent before conducting home visits or revealing an individual's overdose experience to others.
2. Outreach strategy
   - Teams conducting outreach should be multidisciplinary and include a healthcare provider.
   - Outreach teams that enter a community discreetly (i.e., not in uniforms or marked cars) may be better received. This should be balanced with the safety of the team.
   - Teams should clearly introduce themselves and the purpose of the visit.
   - Incorporate place-based outreach, in addition to person-specific outreach, to accommodate people who are unhoused.
   - Promote Good Samaritan Laws that increase use of 911 and leave behind naloxone to reduce fatal overdose risk.
3. Treatment and recovery supports
   - Help individuals enroll in health insurance.
   - Link participants with as many social supports as needed or requested (e.g., housing, transportation, job training, educational support, meals, etc.).
   - Pair participants with recovery coaches who can provide emotional and logistical support.
   - Make counseling available to participants, but not a requirement for medication.
   - When treatment appointments are not immediately available, connect participants with pre-treatment facilities.

Evaluation Tips

- Develop an evaluation plan before the program begins.
- Select evaluation questions that align with program objectives.
- Solicit input from program participants on program approaches (e.g., when to make contact, how to make contact, how to compose an outreach team) and their impact on intended outcomes.

SECTION

VI

Safe Stations

What are Safe Stations?

Safe stations leverage firehouses and other public services to engage individuals with opioid use disorder (OUD) in the treatment system. Individuals who wish to be linked to care present at a station, thus initiating the process.

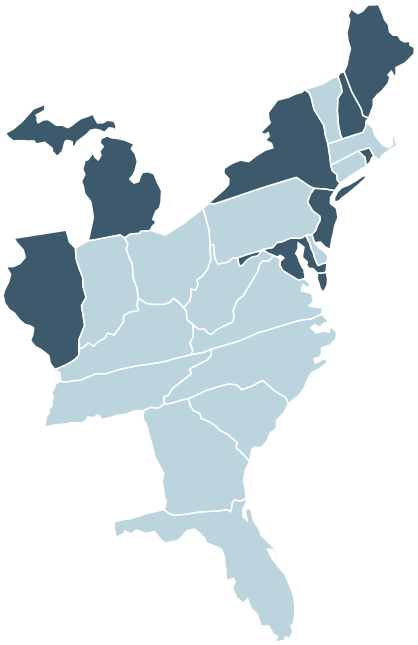
Allowing individuals to set their own goals is a principle of effective relationships with persons who use drugs.[47] Safe stations align with this principle because they capitalize on moments of high motivation and personal goal-setting and provide access to treatment when individuals request it.[57] This approach stands apart from other public safety-led linkage to care programs that capitalize on encounters with the criminal justice system, regardless of individual readiness.

What We Already Know

- Evidence for the effectiveness of safe stations is anecdotal.
- Firehouses are widely distributed in communities, making them accessible for people in need, often more so than treatment facilities.[57]
- In Gloucester, Massachusetts, individuals reported using a safe station because it was both easily accessible and a bridge to treatment.[12]
- Process evaluations of safe stations make the following recommendations:[57, 58]
  - Operate 24/7
  - Engage patients earlier and more frequently with peers
  - Improve service capacity by linking with stabilization units
  - Link to free services
  - Provide low-threshold access (e.g., no waiting lists)
  - Serve as central access point
  - Foster respectful and non-judgmental attitudes among personnel

Did you know?

The idea for safe stations emerged when a firefighter invited a family member struggling with an OUD to take refuge in his fire station while they figured out the next step.[33]



Programs We Examined

To be included, programs had to:

- Welcome individuals seeking assistance in finding treatment or services related to OUD.
- Partner with public health organizations to ensure the provision of these services.
- Refrain from using information collected about individuals for investigative purposes.
- Ensure linkage to care within 24 hours.

We identified safe stations in 9 states. Below, we summarize findings from 8 programs surveyed (highlighted on the map), including 2 where program observations were conducted.

Safe stations are either housed in fire departments or police departments. In 1 state, both a county's fire and police departments serve as safe stations. Notably, a few program features only pertain to the police department-based safe stations, as indicated on page 38.

Program Basics

Goals

All safe stations share the explicit goal of linking people with opioid use disorders (OUD) to care and treatment services. Success of this goal is defined as initiation or completion of treatment, reduced drug use, and fewer overdose deaths.

Programs located in police departments also indicate criminal justice-related goals (e.g., to reduce crime or divert charges).

Scope, Funding, and Staffing

Safe stations serve all community members seeking assistance with OUD. 2 programs restrict eligibility to adults only.

In the past year, programs reported serving as few as 11 individuals and as many as 1,800. Police department-based safe stations are on the lower end of the spectrum. The program with the lowest uptake also connects individuals to care with a phone hotline after they present at the station. This suggests that face-to-face interaction and support may attract participants. Additional differences in safe stations based on the number served are presented below.

Table 5.1. A comparison of 2 safe stations

NUMBER SERVED	11	1,800
Department type	Police	Fire
Hours of operation	Monday-Fridays, 7am-2pm and 24-hour hotline	24/7
Procedures vary based on when participant arrives	Yes	No
Formal intake procedure	No	Yes
Who screens	Addiction counselor via phone hotline	Peer supporter called to fire station
Transport to care	No	Yes
Follow-up	Health department calls 30 days after presenting at station	Peer supporter follows-up throughout treatment

All programs reporting on the demographics of participants indicate that the vast majority are white (75-90%), young (average age 30-36), and male (55-90%). Depending on the burden of the local overdose epidemic, programs may be failing to reach all risk groups.

The majority of safe stations:

- Are unsure about future funding.
- Have few, if any, paid staff.
- Use volunteers, called “angels,” if they are located in police departments.

Program budgets range from $5,000 to $200,000. Programs can keep costs low as they are housed in an existing department, expand the role of existing staff, and link to existing services. Stipends for coordinators, “angels,” or recovery coaches, if offered, are typically a program’s greatest expense. Other budget items include transportation to care for participations and program advertising.

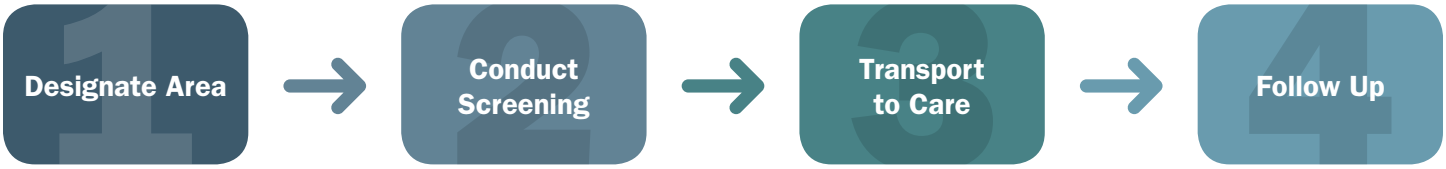
Staff Preparation

Police officers and firefighters in safe stations generally receive an orientation on the program aims, participant intake procedures, staff roles, and other program information. “Angels,” peer recovery coaches, and case managers also receive training on the below topics. All staff working in departments housing safe stations would benefit from this more comprehensive training because they interact with participants and other people with OUD in the community.

- Principles of addiction and evidence-based treatment
- Overdose prevention
- Serving people with mental health issues
- Available treatment options and community resources for people with OUD

Steps of Linkage to Care

Most safe stations have established a linkage to care continuum, shown below. We discuss each step in turn.



1. Designate Area

Safe stations capitalize on individual readiness by designating areas where people can go for services the moment they want to take action. The process begins when an individual arrives and requests care. Most safe stations are open 24/7, although some police-based safe stations have limited hours of operation. 1 program provides transportation to the safe station, making it more accessible to some.

It is important that individuals know about safe stations in their community, which can be done via local media, online advertising, and connections with organizations serving people who use drugs. By advertising, programs can also make potential participants aware of the protections offered by the program.

- Many safe stations have department-level policies that protect individuals against arrest for intoxication or possession when they are seeking care.
- A best practice is having local prosecutors sign off on these policies or codifying them into state law to ensure protections.
- Individuals should be informed of these protections (or lack thereof) when they present at the station.

Upon entering the station, an individual undergoes an intake procedure with a firefighter or police officer. Individual-level information, including name, contact information, and substance use history, is collected. This may inadvertently provoke fear and mistrust of public safety among individuals who use drugs. In 1 program, a peer supporter conducts intake, which avoids this issue.

Many police department-based programs also run participant names through a law enforcement database and take those with actionable warrants into custody. While this may be required by law or else implemented to protect officer safety, it is also a deterrent and likely prevents many who could benefit from linkage to care from entering a safe station. Fear of arrest or prosecution is a substantial barrier to services for people who use drugs.[59] Programs will need to balance such protocols with ones that attract and serve those who could benefit from program participation.

2. Conduct Screening

Standard intake and screening procedures do not exist. Participants are generally paired with a firefighter, police officer, or volunteer called to the station who does the screening and assessment and works with the individual to identify appropriate care. This 1-on-1 dynamic can build trust and helps individuals maintain a sense of privacy, increasing satisfaction and engagement with the program.

In programs where firefighters are the first point of contact, they begin by assessing vital signs and addressing any complaints. They dispatch an ambulance for transport to an emergency department, if acute medical care is needed.

The best case scenario is that procedures do not vary based on when an individual presents at a station, so the quality of care is consistent. At a minimum, programs should keep individuals engaged and comfortable until linkage can be provided. Examples include:

- Providing a kit with water, snacks, and a blanket
- Transporting the individual to a stabilization unit

Regardless of who screens the individual and identifies the appropriate treatment provider, it is essential that the person have a strong understanding of addiction and treatment and include the individual in decisions. Shared decision-making is recommended for helping people with OUD.[60, 61]

In most programs, screening and assessment are conducted at the safe station. In 1 program, a recovery coach transports the individual to a hospital where a clinician does the assessment to determine the best treatment option. The extent to which this delays linkage should be examined, as compared to having the recovery coach screen and link.

The screening process is also used to determine insurance status, assist with insurance enrollment, if needed, and identify the need for wraparound services, including food stamps, housing, and mental health services. Providing this assistance improves linkage success.[56]

3. Transport to Care

All safe stations link to MAT. Additional services include stabilization units, sober living facilities, legal assistance, and wraparound services.

Programs have various procedures for transporting individuals to care:

- Transport by "angels" or recovery coaches in unmarked cars
  - **Pros:** Provides continued support for individuals and reduces fear and mistrust associated with marked public safety vehicles
  - **Cons:** May require waiting for "angel" or recovery coach
- Partnerships with rideshare companies (i.e., Lyft)
  - **Pros:** Ensures that transportation is readily available
  - **Cons:** Can be costly
- Transport by public safety officers in marked cars
  - **Pros:** Ensures that transport is readily available; may provide continued support for individuals transported by the same officer who did intake
  - **Cons:** Can be stigmatizing; can exacerbate fear and mistrust associated with marked vehicles
- No standard transport system but provide assistance (e.g., cab fare, bus vouchers, bikes)
  - **Pros:** Ensures that some transportation assistance is available
  - **Cons:** Provides no support for individuals en route to care; provides a less direct route to care

As demand for safe stations increases, delays in getting individuals to care become more common. Most programs are able to link to care within 24 hours, even it is initially not the most appropriate care for the individual. For example, an individual may be transported to a stabilization unit until a spot in an inpatient facility providing MAT becomes available. A lack of appropriate MAT-based treatment options is the bottleneck causing delays.

4. Follow Up

Only 3 programs follow up with patients and help promote retention in care. These are all police-based safe stations that differ by who conducts the follow-up and when.

WHO CONDUCTS FOLLOW-UP	WHEN FOLLOW-UP IS CONDUCTED
Police officer	Only if appropriate care isn't initially available
Health department after receiving individual information from police	30 days after presenting at safe station
Case manager	Regular follow-up maintained during and after treatment

Linkage to care works best when peers help individuals navigate care and case managers provide follow-up along the way.[55] This includes providing appointment reminders, escorting to care, and addressing barriers to service initiation and retention.

Tracking Success

Programs define success in linking individuals to care as completion of treatment, reduced drug use, and reduced mortality. Therefore, the following program indicators are used to track program success.

- Number of individuals entering safe station
- Proportion completing intake
- Proportion completing screening
- Proportion transported to care
- Time from arrival at safe station to initiation of treatment
- Proportion enrolled in treatment within 12 months
- Proportion retained in treatment after 12 months
- Number of fatal and non-fatal overdoses

Evaluation of safe stations is needed to determine which program strategies are associated with these measures of success. Records from safe stations programs, triangulated with treatment records and individual follow-up, could answer evaluation questions, including:

- What are the barriers and facilitators to treatment completion among safe stations participants?
- What forms of staff preparation lead to participant satisfaction?
- Which screening and intake procedures lead to program success?
- Which method of transporting individuals is associated with the best program outcomes?

Quick Tips for Safe Stations

This guide seeks to assist anyone involved in the design, implementation, and evaluation of safe stations aimed at linking people with opioid use disorder (OUD) to evidence-based care.

Design Tips

1. Treatment capacity
   - Identify all available community-based treatment options in your area, including the provision of all 3 medications commonly used to treat OUD, and highlight any gaps in care.
   - Build a network of social service agencies that provide treatment and recovery support services.
2. Local partnerships
   - Identify community partners who have a stake in your program, including law enforcement and other public safety professionals, drug treatment and social service providers, emergency department personnel, case managers, recovery coaches, and housing specialists, among others suited to your local context.
   - Host regular meetings to foster communication, trust, and network building.
3. Training
   - Provide all program personnel training in harm reduction, principles of addiction and recovery, motivational interviewing, and compassionate and non-judgmental care.
4. Goal-setting
   - Select goals with input from key stakeholders.
   - Choose goals that are explicit and measurable, such as reducing overdose deaths, reducing arrests for low-level offenses, and increasing treatment enrollment.

Implementation Tips

1. Low threshold services
   - If possible, allow individuals to enter safe stations at any time.
   - If possible, minimize the use of legal eligibility requirements.
2. Needs assessments: These are best when conducted in person by a trained professional.
3. Treatment and recovery supports
   - Help individuals enroll in health insurance.
   - Link patients with as many social supports as needed or requested (e.g., housing, transportation, job training, educational support, meals, etc.).
   - Pair patients with recovery coaches who can provide emotional and logistical support.
   - Make counseling available to participants, but not a requirement for medication.
   - When treatment appointments are not immediately available, keep individuals engaged and comfortable by providing food and blankets or transportation or a stabilization unit.
4. Legal protections
   - Establish policies that protect individuals against arrest when seeking treatment and care at a safe station.
   - Advertise programs in the community and raise awareness about the legal protections in place.

Evaluation Tips

- Develop an evaluation plan before the program begins.
- Select evaluation questions that align with program objectives to determine if intended program goals are being met.
- Solicit input from program participants to help answer evaluation questions.

SECTION

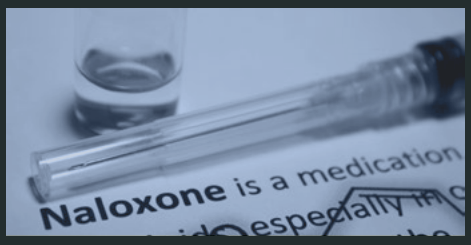
VII

Recommendations

Based on the synthesis of the data collected and the existing literature on linkage to care for people with opioid use disorder (OUD), we identified 6 cross-cutting recommendations. Many of these have been highlighted above.

Use and develop evidence

- Implement existing evidence-based linkage to care practices for people with OUD.
- Help build evidence for how public safety-led programs can effectively link people to care by conducting program evaluations.
- In the absence of evidence-based practices, draw on experiental knowledge and the perspectives of people who use drugs.



Don't lose sight of overdose prevention

- Individuals involved in the criminal justice system are at higher risk of overdose upon release if they are not linked to care.
- All linkage to care programs serving individuals with OUD must provide overdose prevention education and naloxone, particularly when there are challenges in accessing care or when people in care are at risk of relapsing.

Ensure staff and partners receive training on addiction and recovery

- Many programs consider such training a best practice, since it cultivates prepared, compassionate, and competent staff.
- The quality of trainings, certifications, and staff meetings may need improvement and standarization.

Use multidisciplinary teams that include a healthcare provider

- A multidisciplinary team helps meet an individual's muliple needs and provides comprehensive care.
- Linkage to care is a health-related intervention; therefore, healthcare providers should be involved in the process.

Compensate and support staff

- This includes peer specialists, who often play a critical role in linkage to care, follow-up, and ongoing support.
- Ensure staff are compensated and supported in ways that mitigate the emotional burden that comes with this role.

Meet individual needs

- Ensure individuals are linked to care that meets their individual needs by offering all 3 types of MAT and keeping enrollment in treatment voluntary.
- Remove individual barriers to treatment (e.g., insurance status, geographical location) and recovery (e.g., sanctions that bar employment).

Appendix 1. Summary of Data Collected, by State and Program Type

APPENDIX 1. SUMMARY OF DATA COLLECTED, BY STATE AND PROGRAM TYPE

STATES IN ORS	PRE-ARREST DIVERSION	DRUG COURT	LINKAGE TO CARE UPON RELEASE FROM INCARCERATION	POST-OVERDOSE OUTREACH	SAFE STATION
Connecticut	●	◆◆	●		
Delaware		●	●	●	
Florida	●	●	○	○	
Georgia	○	◆◆			
Illinois	◆◆	●	○	●	●
Indiana	◆◆	◆◆	◆◆	●	
Kentucky	◆◆	●	◆◆	◆◆	
Massachusetts		◆◆	◆◆	◆◆	○
Maryland	●	◆◆	●	●	●
Maine		◆◆	○	●	●
Michigan	●	◆◆	●	◆◆	◆◆
New Hampshire		◆◆	●	◆◆	◆◆
New Jersey	○	◆◆	◆◆	●	●
New York	●	○	●	●	●
North Carolina		●	◆◆	○	
Ohio	●	●	●	●	
Pennsylvania	◆◆		◆◆	◆◆	○
Rhode Island	●			●	●
South Carolina			◆◆		
Tennessee	◆◆	◆◆	◆◆	◆◆	
Virginia		●	●		
Vermont		◆◆	◆◆	◆◆	
West Virginia	◆◆	◆◆	●	●	
Program identified	15	20	21	19	9
Program surveyed	13	19	18	17	8
Observation completed	6	12	9	8	2

○ Program identified in state only

● Program identified and surveyed

◆◆ Program identified, surveyed, and observation completed

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