Questions and Answers from the 2021 Virtual Comprehensive Opioid, Stimulant, and Substance Abuse Program National Forum

Questions that could not be addressed during the 2021 Virtual Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) National Forum due to time constraints were answered by the presenters following the event. The questions and corresponding answers are offered in this document, categorized by session.

November 16, 2021—Federal Partner Resources Panel

- *Moderator and Speaker:* Tim Jeffries, MSW, Senior Policy Advisor for Drug Policy, Bureau of Justice Assistance (BJA), Policy Division
- June Sivilli, Senior Advisor, Office of Public Health, Office of National Drug Control Policy
- Kathy Mitchell, M.Ed., Program Manager, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, Department of Justice
- Stacy Phillips, DSW, MSSW, Victim Justice Program Manager, Office for Victims of Crime
- Claire M. Brennan, B.S., Supervisory Diversion Investigator, Liaison Section Chief, Diversion Control Division, U.S. Drug Enforcement Administration
- Lori J. Ducharme, Ph.D., Health Scientist Administrator, National Institute on Drug Abuse
- Joe Liberto, M.D., National Mental Health Director for Substance Use Disorders, Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs
- Michelle Putnam, MPH, Team Lead, Office of Policy, Planning, and Partnerships, Division of Overdose Prevention, Centers for Disease Control and Prevention

Question: Can I get the link for the fact sheet you mentioned?

Answer:
Claire Brennan: The fact sheet can be found at www.dea.gov, under "Resources," about halfway down on the homepage.

Question: How can I spread the word on this public safety alert?

Answer:
Claire Brennan: You can download and share the fact sheet, and also share the website listed in the answer above.

November 16, 2021—Jail-Based Medication-Assisted Treatment (MAT) Programs: Common Elements, Unique Approaches

- *Moderator:* Becky Berkebile, M.A., Senior Program Associate, Advocates for Human Potential (AHP)
- Steve Durham, Assistant Director, Louisville, Kentucky, Metro Department of Corrections
- Stephanie Schmidt, M.A., Corrections Counselor and MAT Navigator, St. Louis County, Minnesota, Corrections
- Levin Schwartz, LICSW, Assistant Deputy Superintendent, Clinical and Reentry Services, Franklin County, Massachusetts, Sheriff's Office

Question: Can you tell us a little bit more about the MAT nursing staff members and their role?

Answer:
Steve Durham: Louisville Metro Department of Corrections (LMDC) has a health services vendor that provides full-time medical and mental health staff on site. The MAT nursing staff members at LMDC understand the importance of MAT and medications for opioid use disorder (MOUDs) as part of the treatment for persons with an opioid use disorder (OUD). Nursing staff members develop specific protocols for intake screening for potential MAT patients, the storage and dosing of our MOUDs, and—with security staff members' input—staff-designated specific housing locations for MAT patients within LMDC.

The MAT nursing staff collaborates with the Louisville Metro Department of Public Health and Wellness, our community methadone provider partner. The MAT nurses receive specialized training in MOUDs and MAT from both a local addiction medicine specialist and their inhouse clinical HSA. They ensure that our MAT patients receive their medications daily, and they take the time to get to know the patients under their care.

The nursing staff attempts to maintain consistent MAT care during the daily rounds and keep up with a patient who was not in the dorm during nursing rounds because that patient had a court appearance, a telehealth appointment, an attorney visit, or a scheduled event. Prior to discharge, nursing staff members work diligently to provide patients with their MOUD and/or a supply of their MOUD in their property so the patients have medication when leaving the facility.

Stephanie Schmidt: Our MAT nurse plays a very critical role within our jail MAT program. This position spearheads and manages our evaluation and treatment of MAT patients on a day-to-day basis. Particularly, the MAT registered nurse (RN) works with the entire team of medical and correctional staff members within the jail to identify potential candidates for MAT, triage and screen

these individuals, and then work with our medical providers regarding treatment strategies. Moreover, the MAT RN continues to provide surveillance visits and communication with MAT patients to ensure that they are managed well and to work with appropriate stakeholders regarding discharge planning and transferring care for these patients to community provider partners. Lastly, currently we have our MAT RN assist patients with self-administration of their MAT medication during weekdays.

Levin Schwartz: At the Franklin County, Massachusetts, Sheriff's Office (FCSO), the MAT nursing staff is involved from the beginning to the end of the process with patients: screening/assessments, lab orders, verification of the iCup™ drug screening device, obtaining the last-dose letter or checking the prescription monitoring program, and being in charge of medication dispensing during the MAT pass.

They ensure that medication is not diverted by adhering to the MAT dispensing protocol (e.g., mouth checks, observing the dose is taken correctly [different for methadone versus buprenorphine/naloxone], and dispensing a cracker after the medication has been administered). MAT nurses (as well as caseworkers and behavioral health staff) record observations of the MAT patients during the week, looking for observable signs of agitation, excitability, excoriation, inattention/distractibility, isolation, non-attendance in treatment, pressured speech, restlessness, sedation, slowed affect, slurred speech, sweating, unsteady gait, and watery eyes—which could provide information for the provider about dosing adjustments.

Nurses also coordinate with reentry services to ensure patients leaving on MOUD have an active appointment in the community upon release.

Question: So often buprenorphine, naltrexone, and methadone are discussed when we think of MAT. Is naloxone always a part of MAT, do you think? Should it be?

Answer:
Steve Durham: Many fatal opioid-related overdoses occur within the first two weeks of discharge, and therefore we believe Narcan is a necessary medication as a harm reduction measure. LMDC has an Overdose Education and Narcan Distribution Initiative through a partnership with the Louisville Metro Department of Public Health and Wellness. Narcan and MAT combined will prevent fatal overdoses in the community for those suffering from OUD, who may relapse, and should always be available for individuals who are receiving MAT or considered at risk for opioid overdose, especially during this period of exponential increase in opioid overdose fatalities due to the pandemic.

Stephanie Schmidt: Naloxone is always an important component to a MAT program. While we plan and implement treatment strategies for success with MAT, we always must be mindful of the potential for relapse and the accompanying danger that it can present to our patients. We believe that naloxone should be a staple product supplied to patients as they leave our jail facility, and we also believe that naloxone should be a component of any outpatient MAT program. Moreover, appropriate education should be delivered to MAT patients regarding the storage and use of

naloxone. If possible, ensure that important friends and family members of these patients are well versed in the use of naloxone.

Levin Schwartz: As one of the two active ingredients in Suboxone (buprenorphine/naloxone), naloxone is a component of medication to treat an OUD (MOUD, buprenorphine, naltrexone, and methadone). In my opinion, naloxone—on its own—is in a different category. It seems to me that MOUD is a form of therapy that, if used in conjunction with behavioral health treatment, can assist the individual in cultivating a life free from the grips of addiction. As a means to promote public safety and community health, naloxone—on its own—is a lifesaving drug that can be administered in the event that they themselves, or someone they are around, is experiencing an overdose from opioids. At FCSO, this medication is freely placed in OUD patients' property when they are leaving incarceration.

November 17, 2021—One Key to Program Success: How to Obtain Officer Buy-In for Your First Responder Diversion Program

- *Moderator:* Karen Maline, Project Manager, International Association of Chiefs of Police (IACP)
- Malik R.S. Ashhali, MSW, LCSW, LCAS, MAC, CSI, EAP, TF-CBT, Clinical Director/Clinical Supervisor, The Village Behavioral Healthcare Services, Inc.
- Assistant Chief Kevin Hall, Tucson, Arizona, Police Department

Question: Are there other types of diversion programs that are not pre-arrest, such as an outreach team following up after arrest? Can these also be successful?

Answer:
Malik R.S. Ashhali: Post-arrest outreach does not prevent involvement in the criminal justice system for the client, but these programs do have the potential to reduce recidivism. The goal of diversion is to prevent further involvement in the criminal justice system by referring individuals to mental health services.

Kevin Hall: Tucson does post-arrest outreach as part of their deflection program. Just like their peers do post-overdose outreach, they also go into the jail to try to connect individuals to treatment, which has had some success. Once their MAT clinic is notified of an individual's release time, peers from the clinic will go to the jail, pick up the individual, and take him or her straight to the MAT clinic.

You can build any program in your jurisdiction that you want. We have continued to add to our program, and our peers go out to our jail to meet with people who weren't deflected. Our Substance Use Response Team visits with these folks and tries to engage them to link them to treatment inside the jail. We've had success with that model. When we are told that individuals are about to be released, our 24/7 MAT clinic will show up with a peer to take them to treatment as soon as they are released. You can build that model in. We also built in a post-overdose Quick Response Team model where we review all of the non-fatal overdoses, and our team will try to engage individuals after the overdose incident. If the people don't want to engage or have anything to do with the peers, at least

the team can provide them with naloxone and harm reduction materials, as well as contact information to reengage when they feel like it. The point is, you can devise any kind of program you want and shouldn't be constricted by what other people do.

Karen Maline: In some locations, there is actual outreach being conducted by jail staff, and some sheriffs invite former inmates who started 12-step programs in the jail to continue their participation even post-release. (**Note:** For information on an array of outreach programs, contact the Center for Health and Justice at Treatment Alternatives for Safe Communities [TASC], BJA's COSSAP training and technical assistance [TTA] provider on first responder diversion.)

Question: How do you ensure equitable deflection if referrals are based on officer discretion?

Answer:
Kevin Hall: We have a pretty robust evaluation going on through the University of Arizona. They did a process evaluation and are finishing up an impact evaluation as well as a cost benefit analysis of the program. So, through them, we are able to measure everything from basic demographics—who is being deflected—to decision making. The officers have to fill out a survey every time they deflect someone or arrest someone who could have been deflected. We are trying to capture their decision-making processes regarding why they did or did not deflect, which is why we know that in the beginning, about 50 percent of the people they made contact with said, "I don't have a problem," or "I don't want to get sick [from detoxification], so just take me to jail." We've been able to get that number down by training our officers in motivational interviewing.

There is no discretion about taking the survey, so we are able to measure demographics on who is being deflected and who isn't, and we're able to make a determination on how equitable the deflection strategy is. In the beginning of the program, we saw some disparities. We brought that to the attention of the officers and made some tweaks, and now it's gone the other way so that populations of color are being deflected at higher rates than we would expect.

It is important to note that officer discretion is a very important part of the program. Discretion is key to success because it gives our officers the ability to walk through an investigation and then determine whether that person should or should not go to jail. We'd be taking a tool away from officers that they've always had, which would create animosity toward the program we would prefer not to have.

Question: What does your process look like? How easy is it for officers?

Answer:
Kevin Hall: Whatever you build, it has to be easier for officers than booking and arrest. When officers are in a situation in which charges would be filed, they conduct an investigation to determine what charges should be filed, and if at that time they determine that the individual is ready for

treatment, they engage in a conversation about the deflection program. Once there is an agreement between the individual and the officer, the officer simply transports them to one of the clinics, usually our 24/7 MAT clinic, which has an "officer-only" entrance. The officer walks the individual in, and there usually is about a ten-minute wait while a quick intake is done. Then the officer can leave.

Our research has shown that a deflection takes about 45 minutes as opposed to about 77 minutes for an arrest and booking.* We wanted to build in transport so that the clinic would pick up the individual because Tucson is so large and it takes some time to transport them, but the clinic simply doesn't have the capacity to have a driver available full-time to transport people back to the clinic. So, the officers find it is quicker to take them. There can be positive benefits that come from that long ride together, especially if officers are trained in motivational interviewing or are otherwise good at the deflection process. There is a lot of positive reinforcement on the decision that individual made and on what treatment will look like. Officers that may not be as bought in to the program just drive people to the clinic with very little conversation. It's still a work in progress.

(*Another benefit of a deflection for officers: If charges are not filed, neither the individual nor the "arresting officer" has to show up in court at a later date to follow up on the booking.)

Karen Maline: We had to skirt this question due to time restraints during the panel session, but Assistant Chief Hall did mention that Tucson is a BJA Learning Site for first responder deflection. Representatives from interested programs can either fill out a form on the COSSAP website or contact Ben Ekelund at the Center for Health and Justice at TASC, which facilitates the Law Enforcement/First Responder Diversion and Referral Mentoring Initiative, and get federal assistance to visit Tucson (once travel is allowed again). The mentorship program is also available virtually so that programs can benefit from the knowledge and experience of mentor sites. A video about the Tucson Police Department's active outreach program can be viewed at https://www.youtube.com/watch?v=l2J7bgqHASw. There are also news stories available on YouTube.

Question: Can you give more detail on how you incentivize officer participation in deflection?

Answer:
Kevin Hall: This goes back to using videos, newsletters, or whatever the agency uses to highlight success stories and show officers who do deflection in a positive light. Within the agency or the program, you can send a blast email. Cops are people too and like getting that attention, especially if they're doing something that gets the attention of the chiefs and merits comment. We send patrol officers who are doing deflection in a meaningful and thoughtful way to outside training and sometimes out-of-state training. They started to identify officers who were really good at deflection and started sending them to opioid seminars, symposiums, and things like that.

We created a Life Saving Award and made it almost as prestigious as the "Scarlet Shield" for someone who is injured in the line of duty, or a medal of honor or merit. When we saw a true overdose reversal, where people were not breathing or were turning blue, and the officer administered Narcan

and brought those people back, they would get a Life Saving Award. We recognized those officers department wide and in the media, and their body-worn camera footage was provided to the media. Cops, no matter how cynical they are, joined the force to help people and save lives, and when that is highlighted to that degree—it makes a huge impact on all of them—and they realize it is a significant program.

Even providing additional time off, like ten hours of administrative leave, is a very big deal to officers. They get a longer weekend and more time to spend with their families. Anything you can do along your own guidelines and the policies of your agency—you can be as imaginative and creative as you want to be.

Question: Our program is in a community where none of the 150-plus officers are required to live within the city limits, and they do not, thus being viewed as "not part of" the community. Do you think that this is a major obstacle?

Answer:
Kevin Hall: It may not be a major obstacle, but it is an obstacle that can be overcome. A lot of it depends on the leadership and the culture of the agency. In Tucson, they identify with the city whether they live there or not. Even if they don't live within the city, they say, "I'm from Tucson."

It's something that an agency should be aware of and address. It is also an attitude. If you police the community like they are your neighbors and if you go to calls at schools as if they are the schools that your children go to, then that just organically occurs. But if you treat people like they are not part of your community, that's when you have issues.

A lot of it is based on perception of the ownership of the officers and their beliefs in the community they serve and what that looks like. The relationship a police department has with its community may not have anything to do with whether or not officers live directly in that community or not.

Malik R.S. Ashhali: If you don't live in my community, I don't think you're invested. You don't live here; you just work here. But like Chief Hall said, you can overcome that. You can convince me. Just because you don't live there doesn't mean you can't invest in my community. That's where that non-enforcement contact and attending those neighborhood association meetings and other community events can change residents' perceptions. Changing perception and establishing relationships and trust take time, hard work, and consistency. Don't dismiss community members' concerns; address them head on and be sincere.

Kevin Hall: . . . And it has to be authentic.

Question: Do you find data to be motivating and convincing? Or are people wary or overwhelmed by it?

Answer:
Kevin Hall: You have to have the data. If you're not building your decisions off data, then that's a perilous path to go down. And many times, we do a good job of collecting data, but data needs context and data needs storytelling. Most people are not statisticians, and it's not that they don't want data—it's that they don't always have the time or capacity to understand it. So, you have to give it context and tell a story with it to make it effective.

Karen Maline: Data *collection*—knowing what data to collect and how to collect it—can be overwhelming to practitioners. Look for a research partner who understands data collection and reporting. You have to find people who understand the program and believe in the work. But it also comes down to capacity, trust, and in-person contact. You need to be able to make course corrections based on the data. Look to local universities, and don't overlook community colleges.

Karen Maline: Here is a link to a webinar IACP did for COSSAP on Making Data-Driven Decisions to Enhance Your Diversion or Deflection Program.

See https://heal.nih.gov/research/research-to-practice/jcoin and https://www.centerforhealthandjustice.org/chjweb/tertiary_page.aspx?id=68&title=Justice-Community-Opioid-Innovation-Network-(JCOIN) for information on the Justice Community Opioid Innovation Network (JCOIN) and the work JCOIN is doing to bring together communities and research partners to evaluate implementation and delivery efforts of opioid misuse and opioid use disorder treatment and related services in justice settings

Question: If I want to focus on prevention, where should I start?

Answer:
Kevin Hall: Is the question about how to prevent drug use in the first place or how to prevent overdoses? To prevent drug use, focus on pre-K through middle school students, which goes back to adverse childhood experiences, trauma, and food insecurity.

If you're trying to prevent overdoses, look to harm-reduction strategies to make people safer users, like syringe access programs, fentanyl testing strips, and naloxone access programs.

Malik R.S. Ashhali: We need to strengthen communities and family. We also should be treating substance use disorder (SUD) as a public health issue. Athletes and other famous people are starting to talk about mental health disorders (MHD) now, which is starting to reduce the stigma surrounding MHD.

We need the same kind of attention for SUD. We need to let people who have SUD know that they have value, that they can be treated, and that they are supported.

In New York City, they have Drug Safe Zones—places where people with SUDs can use drugs in a controlled environment so they're not using dirty needles and spreading disease or overdosing. There are case workers and social workers who can navigate people into treatment when they are ready.

Question: How do you work around officer turnover or new political officeholders (e.g., sheriff, chief, mayor) to keep momentum going?

Answer:
Kevin Hall: Once the program takes off, has been written into policy, and has been evaluated, it takes on a life of its own. Elected officials see that this is reform and is the future of policing. I've had zero push-back in our county, except from the sheriff.

Question: Can you still run a program without top-down (such as chief-level) support?

Answer:
Kevin Hall: It would be enormously difficult because you wouldn't have policy-level support for the program. You must have someone with the authority to write policy to make the program.

Karen Maline: In many jurisdictions, deflection and diversion programs are run by other justice system agencies, public health departments, opioid task forces, or behavioral health organizations. In these cases, when designing and planning the program, program administrators should bring law enforcement to the table, ask for their perspectives and ideas, and create partnerships as early as possible to create a sense of ownership in the program and garner support from agency leadership. Also, if law enforcement agencies aren't administering a program, it may be a good idea to hire a program manager with a background in law enforcement who understands law enforcement culture, is accepted by officers, believes in and can explain the program to officers, and can even create and conduct training on how to implement the program in the field.

Question: How do you overcome resistance in communities that just do not trust police and do not want to work with them? How can police reach individuals in those communities and start to build trust there?

Answer:
Malik R.S. Ashhali: Gain their trust by letting your behavior speak louder than your words. The existence of diversion or deflection programs goes against the narrative of police just arresting folks. It's different. Take advantage of opportunities for non-enforcement engagement with community

members. Be consistent despite resistance. Don't be afraid to talk about the resistance in forums and really listen. Validate community members' feelings and engage in trusting behaviors consistently.

Kevin Hall: I think the way to overcome resistance is to be authentic in applying your program over time. People see that it's not going away and that you're trying to engage with the vulnerable—that you're trying to help them—not arrest them and ruin their lives, but you're trying to help them deal with a disease. Over time, I think, this erodes the resistance you see and starts to build trust. But that's a long-term goal to achieve, and it takes more than a deflection program to do that. You have to do it in a variety of areas. You can't do damaging things in other areas and then depend on a deflection program alone to build trust.

Malik R.S. Ashhali: Non-enforcement engagement is the *key*.

Question: You talked about celebrating your victories, including the small ones. What are some examples of ways your team celebrates them?

Answer:
Karen Maline: In the presentation, Chief Hall discussed celebrating small victories like first successful deflection, first overdose reversal, time saved versus arrest, etc. Some of those are highlighted in the traditional media and social media, while others are celebrated by providing awards—like lifesaving awards and letters of commendation to officers.

Question: How were the mental health support teams in your program formed, deployed, and sustained?

Answer:
Karen Maline: Here are some resources that will provide more information on Tucson's Mental Health Support Team (MHST):

- Website: https://www.tucsonaz.gov/police/mental-health-support-team-mhst
- 25-minute video from Tucson Thrive: https://www.thriveinthe05.com/calendar/2020/5/15/resource-cafe-with-the-tucson-police-departments-mental-health-support-team
- Document: The Tucson Mental Health Investigative Support Team (MHIST) Model: A prevention focused approach to crisis and public safety
- Document: The Tucson MHIST Model: A proactive approach to crisis prevention and public safety via the development of Mental Health Investigative Support Teams

Question: How do you incorporate your peers?

Answer:
Kevin Hall: While our peers are employed by our behavioral health and treatment partners, they are fully embedded in the department and work on the same floor with our officers and detectives. This was very controversial at first, because three out of the four peers had felony convictions, but it was the type of trust-building exercise they needed to do to move policing ahead, and it was very innovative.

The lived experiences and the credible voices that these people bring, not only to the officers they work with but also to the people they reach out to, are invaluable. They are a fully engaged part of the team. Recently, the outreach team received an award at a statewide law enforcement summit, and the peers went up with the officers to accept the award, which was beneficial for people to see because the peers don't look anything like cops. But there they were, working with officers and doing really good work and receiving a statewide award for it. They are treated no differently than the officers and detectives with whom they work.

Question: Do you have a community advisory board? If so, how often do they meet, and how do they support and advise your work?

Answer:
Kevin Hall: We have a number of community advisory boards, including the Citizens' Community Police Advisory Board, our Force Review Board (which includes citizens from the community), and the Chief's Advisory Board. If you're talking strictly about pre-arrest deflection, we have a collaborative board, which is a group of service providers who are engaged service providers who are not our partners at this time but still want to be part of the collaboration, and community members and police officers. They meet monthly, and there is information shared back and forth. Some of the concerns about equity were brought up very early on, and I would highly encourage anyone who has not brought the community on board to be part of any of these kinds of initiatives to do so. Sometimes we get narrowly focused in our own little world, so it is highly valuable to include that perspective.

November 17, 2021—Coordination of Medication-Assisted Treatment Upon Release From Incarceration

- *Moderator:* Jennifer Christie, M.A., Senior Program Associate, AHP
- Danielle Mimitz, M.Ed., LMHC, Mental Health Clinical Supervisor, Opioid Treatment Program Director, Hampden County, Massachusetts, Sheriff's Department
- Ericka Turley, Ed.D., MSW, Substance Use Disorder Services Manager, King County, Washington, Public Health Department, Jail Health Services
- Keisha Williams, R.N., MSN, BSN, CCHP, Director of Nursing, Hampden County Sheriff's Department

Question: How is the King County Jail's release support program funded?

Answer:
Ericka Turley: We have a mixture of state funds, local sales tax revenue, and federal grant funding.

Question: With so many different entities working together to track this data on those exiting incarceration, what tips do you have to make it a smooth process?

Answer:
Ericka Turley: I am not sure if this question is related to the process of tracking data or the process of exiting incarceration, but I am thinking it is asking about tracking data for outcome reporting. When working across entities, I would say one of the most important things is to establish data sharing agreements, a data analysis plan, and to identify common unique identifiers across systems. This could be the booking number and a combination of the participant's name and date of birth. Our county requires us to report our data on a quarterly basis with the participant's unique medical identification number, name, social security number, and date of birth. The data is sent to a performance evaluation unit whose sole job is to collect data for evaluation purposes.

For tracking data on a program level, we use our electronic medical record software (Epic) to track participant meetings, referrals, and appointments.

Question: Does either program have data on retention in MAT post release and/or criminal recidivism data?

Answer:
Ericka Turley: King County has an evaluation plan that will be looking at program outcomes, matching person-level data to several systems including emergency departments, emergency services/emergency medical technicians, publicly funded treatment data, jail usage, and mortality rates. We just started collecting data, though, so I cannot provide actual data at this point. Sorry!

Question: What is your best suggestion for tracking if not using the opioid treatment program (OTP) assistant program?

Answer:
Ericka Turley: We are providing cash incentives for attending MOUD provider appointments with the idea that it will increase treatment retention. Doing this gives participants the incentive to provide follow-up information.

Question: In terms of cash incentives, does that mean providing gift cards or actual cash?

Answer:
Ericka Turley: When we first started, we purchased no-fee debit cards and distributed those. However, we just transitioned to a U.S. Bank product called ReliaCard. This works like a pre-paid debit card where we can add additional funds to the card remotely. Essentially, we add funds to our U.S. Bank account and draw from there each time we load funds onto someone's card.

November 17, 2021—Making Connections With Individuals in Need in Rural Areas

- *Moderator:* Kathy Rowings, J.D., Senior Research Associate, Institute for Intergovernmental Research
- Sharon Lincoln, Community Opportunity, Network, Navigation, Exploration, and Connection Team (CONNECT) Operations Coordinator, Opioid Task Force of Franklin County, Massachusetts, and the North Quabbin Region
- Debra L. McLaughlin, Coordinator, Opioid Task Force of Franklin County and the North Quabbin Region
- Alison Proctor, CONNECT Interim Project Manager, Opioid Task Force of Franklin County and the North Quabbin Region
- Christopher Williams, Project Coordinator, Rural Responses to the Opioid Epidemic, Memorial Regional Health

Question: Do your different agencies work within the community to improve stigma language in recovery? If so, how (e.g., using negative/positive drug screen versus clean/dirty)?

Answer: In addition to reducing the number of opioid-related overdoses in our rural region, the Opioid Task Force of Franklin County and the North Quabbin Region is committed to promoting destigmatizing language in the community. In September, we convened a topical call entitled "Language Matters: Changing the Way We Talk About Addiction" with Dr. John Kelly, founder and director of the Recovery Research Institute, which is part of Massachusetts General Hospital, and peer leaders with lived experience from local peer-based recovery centers. The topical call explored the history of stigma against people who use substances and charged the group to use more trauma-informed, person-centered language. This was part of recognizing National Recovery Month, which the Opioid Task Force of Franklin County and the North Quabbin Region participates in annually. As a result of this presentation, a Language Matters Campaign will be launched in 2022, which will focus on a combination of trainings and public awareness efforts to expand the knowledge of individuals in a variety of settings (e.g., medical, criminal justice, retail) to use evidence-based and non-stigmatizing language in their everyday interactions with their patients, clients, or customers.

Further, peer leaders are at the crux of CONNECT, which is our post-opioid overdose and follow-up outreach program. They are actively involved in the community, conducting in-person post-opioid overdose follow-up visits and encouraging recovery or other wellness supports as desired. These

mechanisms, in concert with individuals who have lived experience, help foster a more recovery-friendly community.

Question: You mentioned that harm reduction kits are available to those who need them. What is done to assess need? Do people merely ask for them?

Answer: Through the Franklin County Sheriff's Office and federal grant funding, we were able to facilitate a bulk purchase of Narcan to disperse to first responders across our 30-town region free of charge. Peer leaders are also equipped with harm reduction kits to distribute at the time of an in-person post-opioid overdose follow-up visit to the individual experiencing an overdose and their loved ones. This allows individuals to be prepared with Narcan and other related safer injection supplies, in the event of a subsequent opioid-related overdose. Additionally, the Opioid Task Force of Franklin County and the North Quabbin Region regularly hosts Narcan trainings with Tapestry Health, the regional harm reduction provider, where Narcan is available to participants at no cost. We aim to provide harm reduction supplies in an equitable manner and reduce the gaps in services through our many community partnerships.

Question: Do any of your communities struggle with only having an abstinence-based recovery pathway versus things like harm reduction, MAT, etc.?

Answer: Franklin County and the North Quabbin Region is relatively receptive to harm reduction, MAT, and other related recovery services. Tapestry Health enhances the presence of harm reduction in our rural region through syringe services, treatment referrals, and much more. While methadone access remains a widely debated topic, our region has several clinics that dispense methadone to patients. The Opioid Task Force of Franklin County and the North Quabbin Region also convenes a monthly Methadone Workgroup that advocates for equitable methadone access and legislation at the state and federal levels. In addition, the Franklin County Sheriff's Office operates a robust reentry program and offers MAT to patients who are incarcerated. We recognize that there are multiple pathways to recovery. The CONNECT Community Information and Resources Packet is composed of various resources and gives individuals the autonomy to choose which recovery pathway they may be interested in pursuing.

November 18, 2021—Navigating Confidentiality in First Responder Deflection

- *Moderator:* Benjamin Campbell, M.A., Administrator, First Responder Consulting and Training, Center for Health and Justice (CHJ) at Treatment Alternatives for Safe Communities (TASC)
- Sally Friedman, J.D., Vice President of Legal Advocacy, Legal Action Center (LAC)
- Michael Graziano, MPA, Project Director, Center of Excellence for Protected Health Information (CoE-PHI)
- Anita Marton, J.D., Senior Vice President/Deputy Director, LAC

- Jacqueline Seitz, J.D., Health Privacy Lead, CoE-PHI
- Scott M. Wells, J.D., Privacy Law Compliance Senior Associate, CoE-PHI

Question: Is the Health Insurance Portability and Accountability Act of 1996 (HIPAA)/Part 2 extended to deceased individuals?

Answer: Yes. Part 2 protects information indefinitely. The HIPAA Privacy Rule protects the individually identifiable health information about a decedent for 50 years following the date of death of the individual. (See https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/health-information-of-deceased-individuals/index.html.)

Question: Does a mental health emergency count under the medical emergency waiver for Part 2?

Answer: It could. The medical emergency provision under Part 2 applies to a "bona fide" medical emergency. While Part 2 does not define what constitutes a "bona fide medical emergency," in the 2020 amendments, the Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that "'bona fide medical emergency' most often refers to the situation in which an individual requires urgent clinical care to treat an immediately life-threatening condition (including, but not limited to, heart attack, stroke, overdose) . . . ." That could include a mental health emergency.

Question: Can you give an example of when sharing aggregate information would not be allowable?

Answer:

- Under Part 2, sharing aggregate information is *not* allowed if it reasonably identifies an individual as applying for, seeking, or receiving SUD services from a Part 2 program. ***"Patient identifying information"*** is an individual's name, address, social security number, fingerprints, photograph, or similar information from which a patient's identity can be determined with reasonable accuracy either directly or by reference to other information. 42 CFR § 2.11.

    - An **example** would be a list of individuals, by name or by any of the identifying information referenced above, and the fact that such individuals were patients of a Part 2 program or had an SUD.

- Under HIPAA, sharing aggregate information is *not* allowed if it identifies an individual and relates to the individual's past, present, or future physical or mental health, healthcare, or payment for healthcare. "Individually identifiable health information" includes any information created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse related to the individual's health and that can reasonably identify the individual. (45 CFR § 164.501).

HIPAA's list of identifying data points includes all of the information referenced above under Part 2, plus the following: all geographic subdivisions smaller than a state; birth date; admission date; discharge date and/or date of death; telephone and fax numbers; email addresses; medical record numbers; health plan beneficiary numbers; account numbers; certificate/license numbers; vehicle identifiers and serial numbers; device identifiers and serial numbers; Web Universal Resource Locators (URLs); Internet Protocol (IP) address numbers; fingerprints, voice prints, and any other biometric identifiers; photographs; and any other unique identifying characteristic, number, or code. 45 CFR § 164.514(b)(2)(i). HIPAA also protects all of this information regarding the patient's relative, employer, and household members. *Id*.

- An example of prohibited disclosure of aggregate data would be a list of individuals' addresses or birth dates and any health information about them.

Question: Are there organizations that agencies can consult for help in developing their deflection program data sharing policies? Hiring lawyers for this could be prohibitive for many agencies.

Answer: The Center for Health and Justice (CHJ) at Treatment Alternatives for Safe Communities (TASC).

Question: Is it okay to share with other officers that a person successfully completed treatment?

Answer: The answer depends on how the officer making the disclosure obtained the information about the person's completion of treatment. If the information came from the patient, then the disclosure is permissible. If the information came from a Part 2 program, then the officer could only redisclose it with written patient consent, on a consent form that complies with Part 2.

November 18, 2021—Applying Overdose Detection Mapping Application Program (ODMAP) Data to Community Overdose Responses

- *Moderator:* Allison Burrell, MPH, ODMAP Program Manager, Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA)
- Haley Hershey, MPH, Epidemiologist, Metro Public Health Department of Nashville and Davidson County, Tennessee
- Josh Love, MPH, Epidemiologist, Metro Public Health Department of Nashville and Davidson County
- Pamela A. Mautte, M.S., NCHES, CPS, Director, BHcare, Alliance for Prevention and Wellness

Question: Did you encounter pushback from harm reduction advocates when trying to increase participation in ODMAP because the address data could be used by police to target individuals for

drug-related crimes? If so, how did you address the concern of having address data in the ODMAP system?

Answer:
Haley Hershey and Josh Love: No, we have not received pushback from harm reduction advocates at the local level to date. Part of the new policing strategy in Nashville is not focused on targeting individuals for drug-related crimes, but, rather, focusing efforts on individuals selling large quantities of narcotics, seizing incoming narcotics, and disrupting distribution networks.

Question: In case study #2, you mention the caveat that other privacy laws may apply. Can you provide an example?

Answer:
Haley Hershey and Josh Love: In public health practice, data security and confidentiality guidelines typically stipulate to what degree data (especially geospatial) should be shared publicly. This is further restricted when using particular data, such as data related to HIV/AIDS and persons with substance use disorder. For example, when releasing public-facing reports, we implement suppression rules practiced by the state health department to ensure any data provided cannot be used to identify an individual. Therefore, we are always very cognizant and careful when releasing spike-related information. Needless to say, it is challenging to strike a balance between being descriptive and protecting individuals while operating within the bounds of data security and confidentiality.

Question: Can you repeat the name of the law enforcement database that is updated weekly and publicly available? How can we access it?

Answer:
Haley Hershey and Josh Love: https://data.nashville.gov has publicly accessible data and information. One data set that is publicly available is the Metro Nashville Police Department Incidents.

Question: What have been or are challenges and barriers to establishing a surveillance system and an effective acute response?

Answer:
Haley Hershey and Josh Love: There are several barriers:

1. Gaining access to different data sources, like fire/emergency medical services (EMS) or medical examiner data, can be difficult—as a primary principle of data is protecting individuals' privacy and ensuring those who have access to it are using it for the intended use. Gaining access to different data sets is based on relationship building and establishing trust between public safety, public health, and harm reduction agencies. When gaining access to

different data sources, we must establish that our team's efforts center on saving lives, that any data received will be used for that purpose, and that the entity allowing us data access has full awareness of when and how the data is being used.

2. Establishing an acute response can be difficult when data from public health and public safety can be input with a delay or with missing information. This can make identifying a true spike or ascertaining actionable information on an increase or cluster of overdose incidents a challenge. Having delayed or limited data further complicates how a spike is communicated to partners and what actions they will be able to take.

Question: What has been the community feedback on the data to action initiatives, like the spike alert texting program or the fire/EMS post-overdose follow-up?

Answer:
Haley Hershey and Josh Love: Regarding both initiatives, there has been positive community response that data analysis efforts are being translated to provide community-focused services. However, ensuring our programs are widely known and used by community members has proven more difficult, and some feedback has been based in surprise that Nashville offers these services.

Question: How do you build an effective response to acute overdose events with many partners, like public safety, prevention partners, and fire/EMS?

Answer:
Haley Hershey and Josh Love: We, as the Overdose Response Program at the Metro Public Health Department, act as data analysts and information distributors. When we analyze data about a suspected spike in overdose activity, we will then communicate pertinent information to various partners via email or phone call. Public safety and prevention partners have established protocol and action for responding to overdose incidents that they have established themselves; we inform their response but do not direct it.

Question: Who were your community partners that helped break down barriers?

Answer:
Pamela A. Mautte: The community partners that helped to break down barriers included some parents and school parent-teacher association (PTA) members, elected officials/aldermen, the health department, the Sex Workers Alliance Network, police, and our officer and public health analyst from HIDTA.

Question: How does the Narcan training and distribution work?

Answer:
Pamela A. Mautte: We have done both in-person and virtual Narcan training. We do some education on the opioid crisis—background, overdose risk factors, how to identify an overdose, how Narcan works and how to administer Narcan, recovery position, safe storage of medication, and disposal—and we also include Question, Persuade, and Refer (QPR) suicide prevention training. We then sign out kits to participants or have them meet us (if the training was virtual) for pickup. We provide them with a kit containing two to four milligrams of Narcan nasal spray, a bag, and a cardiopulmonary resuscitation (CPR) mask.

Question: Who was responsible for developing the plan and moving initiatives forward?

Answer:
Pamela A. Mautte: The plan was developed through a subcommittee of, at the time, the Mayor's Task Force—now the Harm Reduction Task Force (my agency, HIDTA representatives, the health department, first responders, the Sex Workers Alliance Network, and local business owners). When a new mayor was elected, the task force name changed, but the work has continued, along with bimonthly meetings.

Question: Do you have a webpage or article about the kiosks?

Answer:
Pamela A. Mautte: Please see https://www.newhavenindependent.org/article/syringe_disposal_kiosks_coming_to_town/.
It was modeled after the daisy kiosks in New York City. We will be adding information on our website at www.apw-ct.org.