Quick Response Teams: An Innovative Strategy for Connecting Overdose Survivors to Healthcare and Social Services

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Faculty Disclosures

• Childs Robert, MPH — JBS International (A member of the Celerian Group) (Employee)

• Jennifer Lanzillotta-Rangeley, PhD, CRNA, has no financial relationships to disclose relating to the subject matter of this presentation.
Disclosure

• The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational use(s) of drugs, products, and/or devices (any use not approved by the US Food and Drug Administration)

• NACCME staff have no relationships to disclose relating to the subject matter of this activity

• This activity has been independently reviewed for balance
Learning Objectives

• Explain the history of QRTs, lessons learned, types of teams, and success rates

• Describe services provided to overdose survivors through QRTs

• Describe the implementation process for a QRT including funding mechanisms, policies and procedures, data collection, and client privacy concerns
Overview of Session

• Brief Background and History of Quick Response Teams
• Types of teams in OH and NC
• General Services Provided
• State Examples from OH and NC
• Implementation: funding/policies/data collection/privacy
• Q&A followed by open discussion
Background & History
It’s all about meeting people where they are at and connection.
Why Do People Use Drugs?

• **Personal Coping**
  - Pleasure
  - Drug dependence
  - Trauma history
  - Pain management
  - Mental health
  - Sleep-insomnia or trying to stay awake
  - Fitting in
  - Love
  - Money
  - Criminal record
  - Employment stress

• **Law Enforcement Issues**
  - Criminal record
  - Leaving jail/prison

• **Barriers to Treatment**
  - Lack of access to methadone/buprenorphine
  - Lack of health insurance
  - Criminal record
  - Money for treatment (transportation, cost of program, job loss, housing loss)
  - Childcare
  - Love

• **Societal/Institutional Disparities/Discrimination**
  - Racism
  - LGBTQI
  - Housing
  - Culture
  - Exposure to drug use practices
  - Supply issues around drugs
  - Cost of drugs (legal and illegal)

Source: People Who Use Drugs in NC & TN, Robert Childs, JBS International
Why Aren’t People Going to Treatment?

- Cost
- Loss of labor (your job)
- Loss of housing
- Stigma/shame
- Transportation barriers
- Lack of childcare options
- Lack of access to healthcare coverage
- Loss of partner/family relationships
- Lack of treatment options that provide for chronic pain management strategies
- Personal or a friend’s negative experience or negative perception of treatment
- Lack of medication-assisted treatment (MAT) options
- Lack of information that treatment exists
- Criminal history or pending criminal charges
- Ambivalence/lack of confidence about change
- Untreated mental health/trauma issues
- Gender/racial/cultural bias
  - Lack of services to female populations
  - Lack of services to trans populations
  - Lack of appropriate language services
  - Lack of culturally competent services/providers
  - Lack of LGBTQI-specialized services
- Hours of treatment service conflict with obligations
- Law enforcement/criminal justice practices that discount treatment diversion or treatment referral after incarceration
- Geographical access barriers
- Knowledge of sites
- Extended waiting lists for services

Source: People Who Use Drugs in NC and TN, Robert Childs (JBS), John Roberts (JBS)
10 AREAS of DISCRIMINATION against people who use drugs*

1. EMPLOYMENT
   - Exclusion/dismissal
   - Unfair drug testing

2. WELFARE
   - Drug testing of claimants
   - Welfare restrictions

3. EDUCATION
   - School suspension/exclusion
   - Restricted grant/loan eligibility

4. TRAVEL
   - Refusal of visas
   - Constraints on scripts
   - Passport confiscation

5. HOUSING
   - Refusal of tenancy applications
   - Eviction of tenants

6. FINANCES
   - Refusal of loans/contracts
   - Rejection of life insurance

7. DRIVING
   - Removal of driving license
   - Invalidation of insurance

8. PARENTHOOD
   - Prosecution
   - Child removal
   - Adoption restrictions

9. JUSTICE
   - Criminalisation
   - Conspiracy / incitement charges
   - Discredited evidence
   - Confiscation of assets
   - Incarceration
   - Cruelty in detention
   - Corporal punishment
   - Death penalty

10. HEALTH
    - Poor/no access to treatment
    - Mandatory treatment
    - Drug testing
    - Inadequate harm reduction

* This non-exhaustive list focuses on areas of discrimination against people who use scheduled/controlled drugs. Based on: Russell Newcombe (2013), INTOXPHOBIA - A Review of the International Literature on Discrimination against People who Use Drugs and A Charter of Rights for People who Use Drugs. With thanks to the Guyanese Harm Reduction Association for sharing.

#supportdontpunish
When Someone Overdoses

• 10% of people who experience a non-fatal overdose will be dead within two years
  • Source: The Commonwealth of Massachusetts Executive Office of Health and Human Services Department of Public Health, 2017

• Research has found that people who survive an overdose and who talk to someone following the event are more likely to seek and enroll in drug treatment services
  ▪ Source: Pollini, 2006
When Someone Overdoses

• Research states that when a direct connection is made, over just providing a handout with resources and self referral that the person who overdosed is *more likely* to follow up with drug user health and treatment services.
  – Source: D'Onofrio & Degutis, 2010

• Individuals who experience a non-fatal OD event are at elevated risk for OD in the future.
  – Source: O'Donnell, 2017

• Research respondents according to an evaluation of Massachusetts post overdose programs, cited organizational culture as a barrier to enhanced services and implementation of effective programs
  – Source: Formica, 2018
When Someone Overdoses

• **#1 Goal** is the immediate safety of the person who overdosed
• Immediate access to evidenced based treatment, especially those using methadone and buprenorphine should be offered
• If treatment is not on the table, priority should be given to offer the person who overdosed the services that they want, because the primary goal should be about building connection and a relationship
• Maya Doe Simpkins, “Everything in the overdose crisis is about connection.”
  – Source: Simpkins, 2018
When Someone Overdoses

- According to overdose prevention researcher Maya Doe Simpkins, “Follow up services need to be reliable, trustworthy, believable and offer the person who uses drugs something they want.”
- **Things people want:** Syringe services, housing, employment, naloxone, drug checking test strips, condoms, food, legal services, insurance, love, care and support.
- **When people are ready:** Evidenced based treatment using methadone and buprenorphine should be offered and supportive communities.
- Follow-up services should not just be limited to the person who overdosed, but also their loved ones.
  - Source: Simpkins, 2018
- Be careful about mandated treatment, this can destroy trust and can double the local overdose death rate compared to a population that isn’t mandated treatment.
  - Source: The Commonwealth of Massachusetts Executive Office of Health and Human Services Department of Public Health, 2017
  - Source: Werb, 2015
Types of Teams
North Carolina - 9th most populous state - nearly 11 million people

Local control state – county-based

100 counties, two cities at 1 million each, handful of medium cities & the rest scattered
North Carolina - 9th most populous state - nearly 11 million people

Quick Response Teams in NC are mostly county based

Local control state – county-based
Unintentional overdose deaths involving illicit opioids* decreased from 2017 to 2018 while deaths involving stimulants increased.

A growing number of deaths involve multiple substances in combination (i.e., polysubstance use).

*Heroin and/or Other Synthetic Narcotics (mainly illicitly manufactured fentanyl and fentanyl analogues)

Technical Notes: These counts are not mutually exclusive; If the death involved multiple substances it can be counted on multiple lines; Unintentional medication, drug, alcohol poisoning: X40-X45 with any mention of specific T-codes by drug type; limited to N.C. residents


Analysis by NC Injury Epidemiology and Surveillance Unit
Statewide, the unintentional opioid overdose death rate is 13.6 per 100,000 residents from 2014-2018.

Technical Notes: Rates are per 100,000 N.C. residents, Unintentional medication and drug poisoning: X40-X44 and any mention of T40.0 (opium), T40.2 (Other Opioids), T40.3 (Methadone), T40.4 (Other synthetic opioid) and/or T40.6 (Other/unspecified narcotics) 
Analysis by NC Injury Epidemiology and Surveillance Unit
Syringe Exchange Programs (SEPs) start a conversation about an individual’s health

*Residents from an additional 38 counties without SEP coverage (and out of state) traveled to receive services in a SEP target county in N.C.

Technical Notes: There may be SEPs operating that are not represented on this map; in order to be counted as an active SEP, paperwork Must be submitted to the N.C. Division of Public Health

Source: N.C. Division of Public Health, Year 2 SEP Annual Reporting, June 2018

Analysis by Injury Epidemiology and Surveillance Unit
Counties with Post Overdose Response Programs* as of December 31, 2019

18 active Post Overdose Response Programs

*The Post Overdose Response Programs (or Rapid Response Teams) offer support, recovery resources and links to substance use disorder treatment options, overdose prevention education, naloxone, case management, and referrals to syringe exchange programs.

Source: North Carolina Harm Reduction Coalition
Analysis: Injury Epidemiology and Surveillance Unit
NC PORT As Defined By NC DHHS

• Post-Overdose Response Teams led a Paramedic and/or a harm reduction/peer specialist

• To prevent **repeat overdose** and **connect** to harm reduction, care, treatment and recovery supports, including housing or employment.

• **Meaningfully engage** with persons with lived experience or in recovery and other harm reduction specialist.

• Follow-up within 72 hours of non-fatal overdose event.
Types of PORT Models

* Formica et al. identified four distinct PORT types among the programs they studied in Massachusetts (1)

1) Multi-Disciplinary Team Visit – Police/Fire/EMS + Counselor/Social Worker/Outreach Worker
2) Police Visit with Referrals – Just Police
3) Clinician Outreach – Just Clinician (LCSW, Counselor, etc.)
4) Location-Based Outreach – No visit to person who overdosed

Types of PORT Models (cont’d)

• There are other models in operation i.e., programs that are more peer-focused
  – AnchorED and AnchorMORE in Rhode Island
    ▪ AnchorED dispatches peer support workers to ED patients
    ▪ AnchorMORE dispatches peer teams to communities with high rates of opioid OD (2)
  – GCSTOP in Guilford County, NC
    ▪ Programs are largely peer-led (PORT and syringe exchange)
Different Names for NC Teams

- Post Overdose Response Team (PORT)
- Rapid Response Team (RRT)
- Quick Response Team (QRT)
- Community Response Team (CRT)
- Saving Lives Response Team
Post-OD Response Team Essentials

- Working group of diverse community partners
- Case manager/linkage to care coordinator
- Good relationship with providers of all available services for PWUD (SUD/MH treatment providers, Harm Reduction organizations, etc.)
- Involvement of directly impacted people and Good relationship with PWUD (cultural competency)
- Harm Reduction framework
Picking Team Members

Why is it important to have the right team members?

- Some flexibility based on your community resources – keep in mind the tasks that need to be completed by the team

- Incorporate the unique context/status/situations of your community

- Think about your interview panel

- Consider giving a TSOP type scenario for all disciplines selected (not just EMS/Fire)
Primary vs. Secondary Team Members

• May have primary team members that provide the initial post OD response that make up the team
• May also have secondary team members that are PART of the team and provide supportive services
• It is important to make people feel they are a part of the team and have roles clearly defined
• Think of how you get buy in from all partners
Peer Support Specialists/People with Lived Experience

• Terminology
• NC Definition - Peer Support Specialists are people living in recovery with mental illness and/or substance use disorder and who provide support to others who can benefit from their lived experiences.

• https://pss.unc.edu/
Certified Peer Support Specialists

The North Carolina Certified Peer Support Specialist Program (CPSS) provides acknowledgment that the peer has met a set of requirements necessary to provide support to individuals with mental health or substance use disorder.

• https://pss.unc.edu/
Background

• Developed in Colerain, Ohio

• **Purpose:** *connect high-risk overdose survivors to treatment and recovery services*

• “Naloxone-plus” model of pre-arrest diversion
<table>
<thead>
<tr>
<th>Comparison of Highland County, Ohio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highland County, Ohio</td>
</tr>
<tr>
<td>Ohio</td>
</tr>
<tr>
<td>United States</td>
</tr>
</tbody>
</table>

*Highland County Data from County Health Rankings and Roadmaps. 2019.*
QRT Team Composition

Teams are comprised of 3 or more people
  • Law enforcement
  • Fire
  • EMS
  • Peer mentors
  • Other healthcare professionals

Highland County QRT (Rural, MUA)
  • Police led

Other Ohio Rural QRTs
  • Peer led model
  • Police led model
Colerain QRT

From its start in 2015 through the end of 2019, QRT crews have made nearly 500 follow-up visits to overdose patients.

More than half of those visits ended up with the person seeking treatment for their SUD.

What is Harm Reduction?

Any Positive Change
- Reduces negative consequences, from managed use to abstinence
- Meets people “where they’re at”

Reality Based
- Accepts, for better or worse, that drug use is part of our world.
- Does not minimize real, tragic harms of illicit drug use.

How It Works
- Non-judgmental, non-coercive collaboration.
- Quality of life as standard for success, not necessarily cessation of use.

Empowering
- People who use drugs are primary agents of change.
- Gives people who use drugs a real voice in policies

Social Justice
- Recognizes social inequalities increase harms
- Works to abolish racialized drug policies and dismantle oppressive systems

Image Used with Permission from Indiana Recovery Alliance
What Is Harm Reduction?

• Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use, drug policy, drug laws, sex work, sex worker policy, and sex worker-related laws.

• Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs and sex workers.

Sources: http://www.harmreduction.org and https://www.hri.global/what-is-harm-reduction
What Is Harm Reduction?

• Harm reduction
  – Focuses on positive change
  – Non-judgmental care
  – Fights discrimination
  – Does not require abstinence
  – Is not against abstinence
  – Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use

Sources: www.harmreduction.org and www.hri.global/what-is-harm-reduction
Harm Reduction Principles via Harm Reduction International

1. Respecting the rights of people who use drugs and sex workers
2. A commitment to evidence
3. A commitment to social justice and collaborating with networks of people who use drugs and sex workers
4. The avoidance of stigma
   - *Meet people where they are at*
   - Use respectful language

Source: www.hri.global/what-is-harm-reduction
Goals of Harm Reduction via Harm Reduction International

1. Keep people alive and encourage people to work on healthy behavior change
2. Reduce the harm of sex work and drug laws/policies
3. Offer alternatives to approaches that seek to prevent or end drug use
   – Access to methadone and buprenorphine
   – Access to programs that reduce/end drug use
   – Care that is not forced/coerced

Source: www.hri.global/what-is-harm-reduction
SSP Benefits

- Lower incidence of HIV infection by up to 80% and hepatitis C infection by up to 50%
- Participants are 5x more likely to enter drug treatment than non-participants
- Users of SSPs are 3x more likely to stop injecting drugs
- Decrease law enforcement needle stick injuries by 66%
- Decrease crime by 11% through programs that connect people who use drugs to public and private social services
- Improve community by helping to eliminate improper disposal

Source: NC Harm Reduction Coalition Syringe Exchange Fact Sheet and MMWR
Syringe Exchange Starts a Conversation

Syringe Exchange Services

- Educational Materials
- Syringe and Supply Access
- Secure Disposal
- Naloxone Kits and Referrals
- Consultations and Referrals

- Safer Use Education
- Support Groups and Advocacy
- Medical and Social Services, Referrals
- Overdose Prevention
- HCV, HIV Testing and Care

- Post-Overdose Response
- ED Care Linkages
- Endocarditis, Sepsis Education, Counseling
- MAT Access
- Expanded Sexual Health

*People who use exchanges care about their health*
SSPs Should Work to Distribute:

- Non-judgmental care
- Syringes
- Cottons/filters
- Cookers
- Tourniquets, Alcohol pads, Sterile water
- Ascorbic acid
- Condoms
- Naloxone
- Drug checking strips, such as fentanyl test strips
- Food, clothes, toothbrushes, blankets, etc.
- Info on local methadone/buprenorphine access, housing, counseling, and mental health services
- Assistance in acquiring identification cards
- Legal information on syringe, 911 Good Samaritan, and naloxone laws
- Other supplies that local users request

A pre-packed SSP kit from Wilmington SSP
Model SSP

• **Ensure low threshold access to services**
  – Maximize access by number of locations and available hours
  – Ensure anonymity of participants

• **Promote secondary syringe distribution**
  – Train and support peer educators
  – Do not impose limits on number of syringes

• **Maximize responsiveness to characteristics of the local IDU population**
  – Adapt planning activities and service modalities to subgroup

• **Provide or coordinate the provision of other health and social services**

• **Include diverse community stakeholders in creating a social and legal environment supportive of SEPs**

SSP Practices to Avoid

• Supplying single-use syringes
• Limiting frequency of visits and number of syringes
• Requiring one-for-one exchange
• Imposing geographic limits
• Restricting syringe volume with unnecessary maximums
• Requiring identifying documents
• Requiring unnecessary data collection

Naloxone

- Non-addictive prescription medication reverses opioid overdose (OD)
- Distribution is associated with up to a 50% drop in OD fatalities (British Medical Journal)
- Administer via intramuscular injection or nasal spray
- Cannot be misused or cause overdose
- Restores breathing and consciousness
- **Onset:** 1 to 3 minutes
- **Duration:** 30 to 90 minutes
Naloxone Programs Should:

- Provide naloxone for free
- Provide naloxone immediately to person requesting the medicine
  - Do not send people to a secondary site such as a pharmacy
  - Use the standing order model
- Have very short trainings
  - Under 5 min
  - Time should not be a barrier
  - People do not need to be trained more than 1x unless they request it
- Give people access to refills on demand
- Give people extra kits to give to their household and peer network
  - “Who else in your social network needs a naloxone kit, who you could give one to?”
- Be non-stigmatizing
- Provide local resource sheet in naloxone kits, including 911 Good Sam/naloxone info, MAT info, harm reduction info and mental health care info.
• Dan Bigg and the Chicago Recovery Alliance started the first community naloxone program.

• Photo Credit: Greg Scott, Chicago Recovery Alliance
State Examples of Services
NC Focus Areas

PREVENTION • TREATMENT • RECOVERY

Before it’s too late.
NC PORTs – Key Responsibilities

- Medical assessment, monitoring & potentially clearance (physical risks for Intravenous Drug Use – (IVDU) & provider limitations)
- Sexual Transmitted Infections (STI) testing
- Teach harm reduction techniques and TOLERANCE
- Link/provide with harm reduction supplies including naloxone
- Discuss/link to treatment & recovery options
- Case Management/wrap around services (housing, employment, judicial involvement, medical care, entitlements/SOAR, etc.)
Current Assessment for MH/SUDs

- Discussion about how we currently assess mental health and substance use issues
- What, if anything, are we missing?
- ESO Solutions (EMS)
- EMS Charts (EMS)
- Others?
<table>
<thead>
<tr>
<th>BRIEF MENTAL HEALTH EXAM (Observed during assessment)</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
</tr>
<tr>
<td>Casual dress, normal grooming and hygiene</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Attitude</td>
<td></td>
</tr>
<tr>
<td>Calm and cooperative</td>
<td></td>
</tr>
<tr>
<td>Resistant</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td></td>
</tr>
<tr>
<td>No unusual movements or psychomotor changes</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td></td>
</tr>
<tr>
<td>Normal rate, tone, volume, without pressure</td>
<td></td>
</tr>
<tr>
<td>Rapid</td>
<td></td>
</tr>
<tr>
<td>Pressured</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Affect</td>
<td></td>
</tr>
<tr>
<td>Normal range (full range of normal emotions)</td>
<td></td>
</tr>
<tr>
<td>Labile (rapid and dramatic shifts in outward emotional expressions, laughing/criing)</td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td></td>
</tr>
<tr>
<td>Tearful</td>
<td></td>
</tr>
<tr>
<td>Constricted (restricted affect, lesser degree than blunted)</td>
<td></td>
</tr>
<tr>
<td>Blunted (severe reduction in intensity of emotional response, lesser degree than flat)</td>
<td></td>
</tr>
<tr>
<td>Flat (lack of emotional expression)</td>
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<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Mood</td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td></td>
</tr>
<tr>
<td>Anxious</td>
<td></td>
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<tr>
<td>Irritable</td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td></td>
</tr>
<tr>
<td>Elevated</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Thought Process</td>
<td></td>
</tr>
<tr>
<td>Goal-directed and logical</td>
<td></td>
</tr>
<tr>
<td>Disorganized</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Perception</td>
<td></td>
</tr>
<tr>
<td>No hallucinations or delusions during interview</td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td></td>
</tr>
<tr>
<td>Catatonia</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
</tr>
<tr>
<td>Sleeping too much</td>
<td></td>
</tr>
<tr>
<td>Sleep disturbances</td>
<td></td>
</tr>
<tr>
<td>Number of days?</td>
<td></td>
</tr>
<tr>
<td>Orientation</td>
<td></td>
</tr>
<tr>
<td>A &amp; O x (time, place, person, situation)</td>
<td></td>
</tr>
<tr>
<td>Disoriented</td>
<td></td>
</tr>
<tr>
<td>Past History</td>
<td></td>
</tr>
<tr>
<td>History of MI/SUD/IDD (circle)?</td>
<td></td>
</tr>
<tr>
<td>Yes □ No □ Inpatient Treatment □ Outpatient Treatment</td>
<td></td>
</tr>
<tr>
<td>Self-harm</td>
<td></td>
</tr>
<tr>
<td>History of self-harming behaviors</td>
<td></td>
</tr>
<tr>
<td>Yes □ No □ If yes, describe:</td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td></td>
</tr>
<tr>
<td>History of violence to others</td>
<td></td>
</tr>
<tr>
<td>Yes □ No □ If yes, describe:</td>
<td></td>
</tr>
</tbody>
</table>
# Substance Use Disorder Assessment

### Substance Use

<table>
<thead>
<tr>
<th>Current Impairment (Drugs and/or Alcohol): Note potential signs of impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive/ belligerent</td>
</tr>
<tr>
<td>Unable to sit straight</td>
</tr>
<tr>
<td>Obnoxious/mean</td>
</tr>
<tr>
<td>Other: Inappropriate sexual advances</td>
</tr>
</tbody>
</table>

### Withdrawal: Note any potential symptoms of withdrawal and last time experienced?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Seizures</td>
</tr>
<tr>
<td>Headaches</td>
</tr>
<tr>
<td>Hallucinations</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Twitching/ Tremor</td>
</tr>
<tr>
<td>Shortness of Breath</td>
</tr>
<tr>
<td>Sweating</td>
</tr>
<tr>
<td>Other: Racing heart/ Palpations</td>
</tr>
</tbody>
</table>

### Blood Alcohol Concentration (BAC): Alco-Sensor/Breathalyzer - No food/drink for 20 mins. prior to administration

<table>
<thead>
<tr>
<th>BAC ≤ 0.20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Behavioral Health Provider or ARCA</td>
</tr>
<tr>
<td>BAC &gt; 0.20 and &lt;.35 (based on sxs)</td>
</tr>
<tr>
<td>Contact Old Vineyard, Daymark's BHUC, FBC</td>
</tr>
<tr>
<td>BAC &gt; 0.35</td>
</tr>
<tr>
<td>Transport to local Emergency Department</td>
</tr>
</tbody>
</table>

### Substance Use Treatment Addendum

#### Issues that need to be discussed with Substance Use Treatment Provider

<table>
<thead>
<tr>
<th>Registered sex offender</th>
<th>Communicable disease</th>
<th>Has legal guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant</td>
<td>Non-ambulatory/ Unsteady gait</td>
<td>Sleep apnea and use CPAP</td>
</tr>
<tr>
<td>Open cut, sore, wound</td>
<td>Inability to care for self</td>
<td>Intellectual or developmental disability</td>
</tr>
<tr>
<td>Unmanaged HTN</td>
<td>Unmanaged diabetes</td>
<td></td>
</tr>
</tbody>
</table>

#### Legal Related Issues

- Does the pt have a pending court date?  
  - Yes  
  - No  
  - Court date(s):

- Is the pt on probation?  
  - Yes  
  - No  
  - Probation Officer:

- Does the pt have an ankle monitor?  
  - Yes  
  - No

- Has the pt been convicted of any sex crimes?  
  - Yes  
  - No

- Recent history of violent behavior?  
  - Yes  
  - No  
  - If yes, explain:

- Does the pt have an active warrant?  
  - Yes  
  - No  
  - If yes, explain:

### Substance Use Information

- Drug of addiction:  
  - Last use:

- Other drugs used:  
  - Amount used:

- Length of episode:  
  - Route:

- Age of 1st use:  
  - Route:

- Secondary drug(s):  
  - Last use:

- Length of episode:  
  - Amount used:

- Age of 1st use:  
  - Route:

- CIWA Score:  
  - COWS Score:

- History of seizures?  
  - Yes  
  - No  
  - Last:

- If seizure disorder, is client on medication?  
  - Yes  
  - No

- History of DTs?  
  - Yes  
  - No  
  - Last:

- Number of episodes:

- Nicotine use?  
  - Yes  
  - No  
  - Amount:

- Emergency Contact:  
  - Phone #:
### Key Resource Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Justice</td>
<td>Medical Clinics</td>
</tr>
<tr>
<td>Dental Clinics</td>
<td>Mental Health &amp; Substance Use / Addiction</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Prescription Assistance</td>
</tr>
<tr>
<td>Family, Peer or Crisis Support</td>
<td>Shelters &amp; Homeless Resources</td>
</tr>
<tr>
<td>Financial Assistance</td>
<td>Transportation</td>
</tr>
<tr>
<td>Food Assistance</td>
<td>Veterans</td>
</tr>
<tr>
<td>Hospitals</td>
<td>Other</td>
</tr>
</tbody>
</table>
Rural QRT

Connection to Treatment Services

Medical Care

Transportation

Infectious Disease Testing
Harm Reduction Services in Ohio

• Tremendous growth in the last 5 years
• Naloxone distribution
  – Layperson distribution
  – Online naloxone delivery
• Syringe Service Programs
  – Growth from 4 to 19 SSPs in 4 years
• Advocacy
• MAT
  – Expansion
  – Slow culture change – understanding the variety of treatment modalities

Photo Credit: T. Turner-Bicknell
More work to be done…

- Implementing harm reduction services:
  - Primary care
  - QRTs
  - Correctional facilities
  - PrEP programs
  - Increasing HIV and HCV testing
Challenges to Implementation:

- Key stakeholders not public health experts
- Misconceptions
  - Encouraging drug use
  - Syringe exchange illegal
- Stigma associated with PWID
  - Not in my backyard
- Criminalization of drug use provides an excuse for poor public health response
- Divergent public policies
  - Legal SSPs vs. paraphernalia laws
How do we build capacity…

• Education, Education, Education

• Partnerships
  – Law enforcement
  – Housing
  – Food
  – Harm reduction, treatment, and recovery
  – Legal

• Recruit people with lived experience
  – Story telling – educating stakeholders
  – Peer outreach-paid positions
Evaluation

- Data collection by Cordata®
- No standard data collection instrument
Bunker, Wayne 08/02/1978 (39 years, Male)
(513) 456-3234  Mobile number listed is the mother's

Mother's name is Carmen go through Carmen for all follow up appointments

06/04/2017

Drug Overdose
Region:
Is Primary Diagnosis: No
Go to event

Status: Active - Uncontrolled
Provider:

Diagnoses

Outbound Referrals
Appointments

Jun Jul Aug

2017
Example of Weekly Report

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Count</th>
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<tbody>
<tr>
<td>New cases</td>
<td>3</td>
</tr>
<tr>
<td>Referred to treatment</td>
<td>3</td>
</tr>
<tr>
<td>Connected to treatment</td>
<td>0</td>
</tr>
<tr>
<td>Completed interactions</td>
<td>5</td>
</tr>
<tr>
<td>Total interactions</td>
<td>10</td>
</tr>
<tr>
<td>Open cases no activity</td>
<td>64</td>
</tr>
</tbody>
</table>

[https://care.cordatahealth.com](https://care.cordatahealth.com)
Quick Response Team Evaluation

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Total QRT Encounters</th>
<th>% QRT Encounters Referred to Treatment</th>
<th>% QRT Encounters Connected to Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region-Wide</td>
<td>767</td>
<td>19%</td>
<td>23%</td>
</tr>
<tr>
<td>Jurisdiction A</td>
<td>106</td>
<td>40%</td>
<td>27%</td>
</tr>
<tr>
<td>Jurisdiction B</td>
<td>80</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Jurisdiction C</td>
<td>62</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Jurisdiction D</td>
<td>52</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Jurisdiction E</td>
<td>198</td>
<td>18%</td>
<td>22%</td>
</tr>
<tr>
<td>Jurisdiction F</td>
<td>133</td>
<td>35%</td>
<td>20%</td>
</tr>
<tr>
<td>Jurisdiction G</td>
<td>88</td>
<td>14%</td>
<td>7%</td>
</tr>
<tr>
<td>Jurisdiction H</td>
<td>45</td>
<td>4%</td>
<td>0%</td>
</tr>
</tbody>
</table>

There are a number of factors that can affect these outcomes, including:

- Treatment accessibility and availability
- Demographics of the population, and various barriers to treatment.
- Time between overdose and QRT encounter
- Effectiveness of communication and information sharing between QRT partners
- Experience/training of law enforcement and fire/EMS partners
Addiction Recovery Resources

TREATMENT SERVICES LOCAL

Cincinnati Behavioral Health Service
(513) 954-7020
http://www.cbhs.org/

Joseph House
http://josephhouse.com/
(513) 841-2985
Treatment, Housing, Veterans

LifePoint Solutions
(513) 931-6300
http://www.lifepointsolutions.com/
Counseling

LightHouse Youth Services Inc
(513) 487-7181
(513) 223-3950
http://www.lgy.org/
Treatment

New Direction Treatment Services
(513) 542-7121
http://www.newdirectiontreatment.com/

Adolescent Substance Abuse Programs
(513) 792-1272
http://nancinc.com/
Treatment, Outpatient

The Children's Home of Cincinnati
(513) 272-2880
http://www.childrenshomethc.org/
Treatment, Outpatient

The Crossroads Center
(513) 475-5359
www.thecrossroadscenter.com/
Treatment, Inpatient, Outpatient

Cincinnati Teen Challenge
(513) 248-0452
www.cincinnatiteenchallenge.org/
Treatment, Inpatient, Faith Based

TREATMENT SERVICES LOCAL

Beckett Springs
(513) 962-9500
http://www.beckettsprings.com/

Camelot Community Care
(513) 963-5800

Abraxas Counseling Center
(513) 221-4500
http://www.abraxas.com/facility-search/cm/74_at-62
Treatment, Inpatient

Squier Recovery Services
(513) 996-7054
http://www.squierrecovery.org/
Treatment, Inpatient

Hillcrest Training School
(513) 552-1200
Treatment, Housing - Criminal

City Gospel Mission
(513) 345-2094
http://citygospelmission.org/
Treatment, Inpatient

Drop In Center
Shelter (513) 723-0643x127
Recovery (513) 962-1951

Recovery Resource Packet
Colerain Township, Ohio

Center for Chemical Addictions Treatment (CCAT)
(513) 381-6672
http://www.ccartreatment.org/

Tellair House
(513) 281-2273
http://www.tellairhouse.org/
Treatment, Housing

Bethesda Hospital
(513) 309-6130

The Ridge Addiction Recovery Center
866-902-9646
http://www.addictiontreatmentcenter.com/
Treatment, Inpatient

Northland Center
(513) 753-9564
http://www.northlandaddictiontreatmentcenter.com/
Treatment, Outpatient

DECLARE Therapy Center LLC
(513) 854-7050
http://declaretherapycenter.com/
Treatment

Central Clinic
(513) 651-9950
http://www.centralclinic.com/

First Step House
(513) 961-4663
http://www.firststephouse.org/
Treatment – Women & Children

Gateway Recovery
(513) 861-0125
http://gatewayrecovery.com/
Treatment, Inpatient

Outlines

Addiction Services Council
Clermont County Crisis Helpline
Substance Abuse Mental Health Service Administration (SAMHSA)
Narcotics Anonymous

513-281-7880
513-553-7183
1-800-601-HELP
addictionservicescouncil.org
www.12STEP.org
findtreatment.samhsa.gov
www.nancinc.com

Addiction Recovery Resources

<table>
<thead>
<tr>
<th>HOTLINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction Services Council</td>
</tr>
<tr>
<td>513-281-7890</td>
</tr>
<tr>
<td>Substance Abuse Mental Health</td>
</tr>
<tr>
<td>Service Administration (SAMHSA)</td>
</tr>
<tr>
<td>Narcotics Anonymous</td>
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<tr>
<td>addictionservicescouncil.org</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

What is Addiction?

A neurological impairment that leads to continuous repetition of a behavior despite adverse consequences.

People with Addiction do things that defy explanation. Despite all the bad things that happen or could happen when they take drugs, they continue to seek out, procure and imbibe in substances that their brain craves. This craving is so intense, the brain justifies irrational behavior that might include theft, prostitution, starvation, neglect, and reckless actions.

It is a chronic relapsing disease, the same as diabetes or asthma.

Addiction is a disease. It has specific symptoms that are created by using drugs. It is Chronic because there is no cure. With treatment, an addict can be in recovery and manage their disease, but they will never fully be free. It is relapsing, addicts that are clean for short and long periods of time will find "Triggers" that cause their brain to seek out old stimuli that include drugs.

Physiological dependence occurs when the body has to adjust to the substance by incorporating the substance into its normal functioning. This creates the tolerance and withdrawal effects.

The "High" that is achieved from drugs, results from flooding the brain with dopamine. The brain adjusts to these abnormal levels to replace balance. This new balance, or tolerance, requires the greater quantities of the drug to create a "High". This cycle progresses quickly and the new balance requires a continuous presence of the drugs. Without the presence of the drugs the brain and the body go into withdrawal.

How do I treat Addiction?

The first step in treatment is realizing you have a disease. This is not a personal failing or a choice, but a medical disease.

Get Education. Understanding the genetic, behavioral and environmental causes and the physiological, and psychological effects of this disease will help you, and your family as you progress through treatment. www.CommunityRecoveryProject.org is a great place to start.

Get help. There are treatment facilities for the disease. This can include medical treatments that can help mitigate the effects of withdraw and support you in the early stages of recovery. Space at treatment facilities can be tight, and costly. Don’t panic, don’t give up. There are some that take Medicaid, there are some that offer ‘Scholarships’. If you can’t get into treatment, get support. That can help you until you can get treatment.

Get Support. Don’t try to overcome the disease of addiction alone. There are people who understand the disease, understand the road you have traveled and know the road you must take. Their love, understanding and support will carry you through recovery, each and every day. Support can come from hotlines and professionals but the best support is found in groups. Narcotics Anonymous, Alcoholics Anonymous, Not One More, and SMART Recovery are a few examples.

Recovering from the disease of addiction is difficult, but with knowledge, desire, love and support you can overcome the cravings, the drugs, the disease.

Responding before an Overdose

QRT Teams harm reduction referrals:
- Increase peer participation in QRT teams
- Ongoing access to naloxone
- Syringe service programs
  - 19 programs in Ohio
- Infectious disease testing services
- Primary health care/mental health services
What’s New in Highland County: Hospital Referrals

Hospital can refer patients to QRT

– Often to facilitate treatment referral

– Ohio law allows QRT referral as part of care continuum. QRT does not access patient’s chart
What’s new in Highland County: Community Referrals

The QRT team is beginning to accept referrals from family members to initiate visit
Implementation
Including Stakeholders

• Opportunity for stakeholders to respond to polysubstance overdose to work together to reduce overdose mortality
• Law enforcement, EMS, fire
• Social services, advocacy groups, reentry groups, harm reduction, treatment programs that support all versions of MAT, recovery groups, legal support programs, food security programs, transportation programs and mental health
Post Overdose: Specific Services for People Who Will Continue to Use Drugs

• Team: Include a harm reduction outreach worker with lived experience
• Direct Services
  – Naloxone
  – Syringe access and injection supplies
  – Smoking/snorting risk reduction supplies
  – Drug checking strips
  – Transportation plan
• Key Resources:
  – When ready, connect individual to mental health supports and MAT
  – Information on MAT, Recovery Supports, Housing, Food Access, Legal Council
  – Transportation plan
Post Overdose: Specific Services for People Looking for Treatment

- **Team:**
  - Include a harm reduction/MAT program outreach worker, ideally with lived experience
- **Direct Services**
  - Naloxone for individual and those they live with (the person can’t naloxone themselves if they return to use)
  - Information on harm reduction services if they return to use
  - Directly link person to MAT care program that matches their income and insurance needs
  - Transportation plan
- **Key Resources:**
  - When ready, connect individual to mental health supports
  - Information on Harm Reduction, MAT, Recovery Supports, Housing, Food Access, Legal Council
  - Transportation services overview
Program Keys

• Finding the right staff
  – Staff with compassion and humanistic
  – Being able to connect with people
  – Non-stigmatizing language
  – Non-judgmental
  – Making sure they are trained and open to more training
    • Harm reduction, SUD, naloxone distribution, mental health, trauma, communication, compassion, stigma, MAT, recovery resources, housing resources, healthcare resources, referral to care, local services.
  – Source: Formica 2018
Figure 1. Example Rapid Response Program in North Carolina

1. Opioid overdose with Naloxone administration

2. EMS paramedics on scene obtain patient consent for follow-up and to share contact information with Rapid Response Program team

3. Rapid Response Team follow-up within 5 days
   - Counsel on treatment options
   - Screen for repeat overdose risk
   - Explore harm reduction goals
   - Encourage entry into substance use disorder treatment or adoption of enhanced harm reduction actions
   - Refer to supportive services and other community resources as needed
   - Assess if others in the household are in need of treatment or referrals

4. Ongoing patient contact via in-person visits, social media, phone calls, text messages, and emails
   - Reinforce harm-reduction messages
   - Monitor engagement with treatment options
   - Frequency and duration of contact at the discretion of the Rapid Response Team

- Rapid Response Team members include a Certified Peer Support Specialist with expertise in substance abuse and a Licensed Behavioral Health Specialist.
- A behavioral health service provider in the community is contracted by the City to oversee and administer the program.

- Monthly reports submitted to Oversight Committee
  - Number of referrals from EMS
  - Number of self or indirect referrals
  - Number of follow-up contacts attempted
  - Number follow-up contacts completed
  - Number of refusals
  - Number entering treatment and type of treatment
  - Number engaged in treatment at initial contact
  - Number of additional household members requesting services

Source: Austin, 2018
Figure 2. Example Rapid Response Program in North Carolina

1. EMS or law enforcement respond to a 911 call and identify a behavioral health concern, including opioid overdose.

2. EMS or law enforcement radio for Community Paramedicine response.

3. Community Paramedics respond quickly to the scene:
   - General case management using standard protocols, assessment tools, and resource sheets
   - Educate on treatment and harm reduction options
   - Screen for psychosocial concerns
   - Refer to supportive services and other community resources as needed.

4. Mobile Crisis conducts follow-up within 24-48 hours:
   - Reinforce harm-reduction messages
   - Monitor engagement with treatment options
   - Frequency and duration of contact at the discretion of the Mobile Crisis team.

Source: Austin, 2018
Laws Impacting Programs

• 911 Good Samaritan Laws
  – Example: Georgia
  – Special Issue: Probation and Parole
  – Special Issue: Forced Treatment
• Naloxone
• Drug Test Strip Distro
• Syringe Access and Injection/Smoking Supply Paraphernalia
• Regional MAT Law
• Forced Treatment
• Mandated Reporting
• Health Data Sharing
• Local Pre-Arrest Programs such as LEAD
  – Source: Robert Childs, JBS International

NC’s former Republican Governor at bill signing ceremony for harm reduction
QRT Training

• Core Correctional Practice (CCP)
  – 2.5 days of training

• Effective Practices in Community Support for Influencers (EPICS-I)
  – 3-day training
    • QRTs as coaches
    • Influencers
  – QRTs as trainers of influencers
Build a **RELATIONSHIP:**

They need to know you **CARE**

Engage individual and family

Develop a strategy

Link individual to treatment

Follow up
State Examples of Implementation
Key Steps for PORT Implementation

- Build overdose data reports
- Create/adopt forms - assessment
- Release of information
- Alternate destination plan
- Identify team members and onboarding
- Work with MCO / behavioral health partners
- Develop / join community group
Marketing & Buy-In

• From the beginning,
  – Think of how you are going to market this team to the community
  – How will you get community buy-in
  – There may be some controversy!
  – Anticipate the issues and develop strategies and data so that you are prepared
Confidentiality

• Police reports
• Proper authorizations
  – Release of Information (ROIs)
  – HIPAA
  – 42 CFR part 2
  – Individual vs. Agency ROIs
• Team information sharing
  – Memorandum of Understanding (MOUs)
  – Memorandum of Agreement (MOAs)
Sample Release of Information – Two Versions

For the purpose of this dual disclosure of information in [Care Coordination/Disability Information/Insurance Processing/Treatment Planning/Case Coordination/Legal Proceedings/Other] and [Care Coordination/Disability Information/Insurance Processing/Treatment Planning/Case Coordination/Legal Proceedings/Other]...
Funding a Program

• How do you intend to fund your program?
  • Hospital-based vs. county funded agency
  • Grants
  • Service definitions
  • Other options
  • Community Health Workers
  • Maintenance of Effort (MOE) – County $
  • DSS (assisting SWs to job description)
  • Public Health (EPOC point of care testing)
Funding

Many Governmental Agencies are Willing Contributors

- SAMHSA
  - 21st Century CURES
  - CARA
- DOJ
- Attorney’s General
- Energy and Commerce Committee
- Governor’s Council
QRT Funding in Ohio

The **Drug Abuse Response Team**

**Grant Program**

- Funding started in 2017
- Reimburses some of the personnel and other costs for local law enforcement or government agency teams that deploy in response to overdoses and other effects of the opioid epidemic
- 2019 Funding $1.3 million
Rural QRT Funding

9 Teams in Ohio
Economic Impact Studies

**Ross County, Ohio**
- Rural county of 77,000 people
- OD Deaths up from 19 in 2009 to 44 in 2016
- Children in foster services now 75% from 40%
- Budgets for Family services up to $2.4M from $1.3M
- Similar increases in autopsy and toxicology costs

**Middletown, Ohio**
- About 50,000 residents
- Recently measured the overall cost of just responding to an overdose
  - 911 call
  - Emergency response
  - Naloxone administration
  - Transport to ED
- Responses cost between $1200 and $2000 each
- They spent ~$1.5M
Economic Impact: OD

Average Initial Medical Costs per overdose ER visit:

$15,000

55 – 85% of medical costs are unable to be paid by individual resources – often absorbed by the healthcare facility

Most Conservative Estimate:

$15,000 x 55% = $8,250

Contributes to increased healthcare cost for the community
Key Sources Cited

Key Sources Cited


Key Sources Cited


Quick Response Teams: An Innovative Strategy for Connecting Overdose Survivors to Healthcare and Social Services

Robert Childs, MPH
JBS International

Jennifer Lanzillotta-Rangeley, PhD, CRNA
University of Cincinnati