HPIO Addiction **Evidence** Project

Detailed policy scorecard

November 2019

Law enforcement and the criminal justice system

Purpose and overview

This detailed policy scorecard provides information about addiction-related policy changes enacted in Ohio from 2013 to 2018. The scorecard:

- Describes the current status of evidence-based policies, programs and practices in Ohio
- Rates the extent to which these policies and programs align with evidence on what works
- Rates the extent to which these policies and program are reaching Ohioans in need
- Identifies opportunities for improvement

For a summary of the scorecard's key findings and a description of the scorecard methodology, see the **full report**.

This document contains the following sections:

- Definitions of the detailed scorecard rating levels and a list of acronyms
- Tables that describe Ohio's implementation of evidence-based policies, programs and practices
- Tables that list the sources of evidence used to develop this scorecard

Definition of scorecard levels

	Ohio alignment with evidence	Extent of implementation reach in Ohio
Strong	Services, programs and policies being implemented in Ohio are highly consistent with the most rigorously evaluated and effective evidence-based approaches in this category.	Services and programs are being implemented throughout the entire state (statewide or > 80 counties), are reaching the majority of prisons (statewide or > 25 of 28 state prisons), are reaching a majority of intended groups of Ohioans and are funded at the level needed to implement widespread, effective programming with fidelity to the evidence-based model. Policies are being monitored, implemented and enforced as intended.
Moderate	Services, programs and policies being implemented in Ohio are mostly consistent with recommended evidence-based approaches in this category.	Services and programs are being implemented in at least 40-80 counties, are reaching a large number of prisons (14-24 state prisons), are reaching large numbers of intended groups of Ohioans and/or are funded adequately to meet current capacity and demand. Policies are likely being implemented and enforced as intended, although rigorous monitoring information may not be available.
Mixed	Ohio is implementing some services, programs or policies with "strong" or "moderate" alignment with evidence, but is also implementing a significant number of services, programs or policies with "weak" alignment.	Within this category, Ohio is implementing some services or programs with "strong" or "moderate" implementation reach but is also implementing a significant number of services or programs with "weak" implementation reach. Some policies are being implemented as intended and enforced, while others are not.
Weak	Ohio is implementing services, programs and policies that are not consistent with recommended evidence-based approaches within this category.	Services and programs are being implemented in fewer than 40 counties, are only reaching a small proportion of prisons (fewer than 14 state prisons), are only reaching a small proportion of intended groups of Ohioans, and/or funding is inadequate to meet demand. Policies are not being implemented as intended and/or are not being enforced.
Unknown/ More information needed	Adequate information to determine evidence alignment is not currently available.*	Adequate information to determine implementation reach is not currently available.*

*Note that this information may be available within specific counties, but is not available on a statewide basis.

Acronyms

General terms

Adult Basic Literacy Education (ABLE)
Addiction Treatment Program (ATP)
Community Based Correctional Facility (CBCF)
Crisis Intervention Team (CIT)
Drug Abuse Response Teams (DART)
General Assembly (GA)
General Educational Development (GED)
High Intensity Drug Trafficking Areas (HIDTA)
House Bill (HB)
Medication-Assisted Treatment (MAT)
Ohio Police Officer Training Academy (OPOTA)
Ohio Revised Code (ORC)
Opioid Use Disorder (OUD)
Overdose Detection Mapping Application Program (ODMAP)
Police Assisted Addiction and Recovery Initiative (PAARI)
Senate Bill (SB)
Syringe service program (SSP)
Quick Response Team (QRT)

Government agencies and data sources

Emergency Medical Services (EMS)
National Alliance of Mental Illness of Ohio (NAMI Ohio)
Ohio Department of Job and Family Services (JFS)
Ohio Department of Medicaid (ODM)
Ohio Department of Mental Health and Addiction Services (OMHAS)
Ohio Department of Public Safety (DPS)
Ohio Department of Rehabilitation and Correction (DRC)
Ohio Department of Youth Services (DYS)

Overdose reversal

Table 1. **Community services (intercept 0)**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Partnerships between public safety and public health agencies, including data sharing and privacy protections regarding overdose data	**Strong evidence alignment**	**Unknown implementation reach**	• Assess the extent to which local health departments are partnering with first responder agencies to access and utilize ODMAP data • Encourage all first responders and public health agencies to fully utilize ODMAP to mobilize more effective responses to overdose spikes and hot spots, and to facilitate follow-up to connect non-fatal overdose victims with treatment
	• Ohio HIDTA has facilitated use of ODMAP by first responders. ODMAP is an online application that provides near real-time data on drug overdoses, allowing public safety and public health agencies to identify and respond to spikes in overdose events and overdose "hot spots" within their jurisdiction. • First responders enter the following information into ODMAP for each overdose incident: date, time, location, fatal or non-fatal status, and how much naloxone was issued. • ODMAP does not collect personally identifying information about overdose victims. This enables information-sharing between agencies. • First responder agencies and authorized city/county/state public health personnel can view the Level 2 live ODMAP interface. This access allows public health agencies to monitor the daily entries on the system and coordinate with first responder members of local "Overdose Response Teams" to acquire victim information for potential follow up and intervention. • As of June 2019, 202 agencies in 68 counties are using ODMAP in Ohio. (**Click here** to see a list of participating agencies for Ohio.) • Each county determines the level on which they wish to participate on ODMAP. The number of counties that are proactively using ODMAP to facilitate information exchange and partnerships with local public health departments is unknown. • An informal review by Ohio HIDTA of ODMAP Participation Agreements found that at least 20 counties in Ohio have public health partners signed up for access to ODMAP.		
First responders supplied with and trained to administer naloxone	**Strong evidence alignment**	**Unknown implementation reach**	Identify a state-level entity to collect information about local law enforcement and first responder agency naloxone training and administration. Use the information to target training and resources designed to increase effective use of naloxone.
	• In 2016, Ohio State Highway Patrol troopers began carrying naloxone. • In 2016, OMHAS administered a two-year grant program to provide naloxone kits and training to local law enforcement, emergency personnel and first responders, distributed through local health departments. • Ohio EMS (a division of the DPS) provides online training materials on naloxone. • The percent of local law enforcement and EMS agencies that are supplied with and trained to administer naloxone in Ohio is unknown, although at least one EMS provider in 86 counties reported administering naloxone in 2018.		

Table 1. **Community services (intercept 0)** (cont.)

Evidence-based policy, program or practice*	Ohio status (brief description of Ohio implementation)**	Opportunities for improvement
Law enforcement trained in addiction, mental health and stigma	**Weak evidence alignment** / **Unknown implementation reach** There are no requirements for law enforcement personnel to receive training on addiction, mental health or stigma. The number of Ohio law enforcement agencies that have voluntarily provided this training is unknown. See also: CIT in Table 2 below.	Require local law enforcement agencies to participate in training on addiction, mental health and stigma
Pre-arrest diversion: First responders refer offenders to addiction treatment	**Strong evidence alignment** / **Unknown implementation reach** **QRT/DART** • Quick Response Teams (QRTs), also referred to as Drug Abuse Response Teams (DARTs), pair first responders with behavioral health providers and other community partners to follow up with overdose survivors to engage them in treatment. • The Lucas County Sheriff's Department launched a DART program in 2014 and other Ohio communities have implemented similar programs. The SFY 2018-2019 state budget included **$3 million in grant funding** administered by the Ohio Attorney General's Office to local law enforcement agencies to expand implementation of the QRT/DART model around the state. Forty police departments were awarded funding. The percent of local law enforcement agencies implementing QRT/DART programs is unknown. **PAARI** • Based on a model developed by the Gloucester, MA Police Department, Police Assisted Addiction and Recovery Initiative (PAARI) provides support and resources to help law enforcement agencies create non-arrest pathways to treatment and recovery. • There are several PAARI sites in Ohio, primarily in Summit County.	• Evaluate the effectiveness of the SFY 2018-2010 Ohio Attorney General QRT/DART grant program. If it was successful in reaching intended outcomes, increase the number of local law enforcement agencies implementing QRTs/DARTs. • Assess the extent to which the QRT/DART model is being implemented across the state and identify a common set of process and outcome evaluation metrics that can be used to evaluate and improve these programs on an ongoing basis
Public safety and public health collaborate to support Syringe Service Programs (SSPs)	**Weak evidence alignment** / **Unknown implementation reach** • The statute allowing local health districts to establish bloodborne infectious disease prevention programs/SSPs (ORC 3707.57) specifies that the board of health must consult with law enforcement representatives before establishing such a program. While SSP employees and volunteers are provided some protections from criminal prosecution, there is no requirement for law enforcement to actively support SSPs, such as by referring drug users. • The Ohio Attorney General's office and the Department of Public Safety have not been involved in any efforts to foster collaboration between law enforcement and SSPs. • The extent to which law enforcement agencies are supporting and collaborating with SSPs in Ohio is unknown.	Identify a state-level entity to collect information about local SSPs, including information about collaboration with local law enforcement agencies. Use the information to target training and resources designed to increase effective collaboration

Table 1. **Community services (intercept 0)** (cont.)

Evidence-based policy, program or practice*	**Ohio status** (brief description of Ohio implementation)**		**Opportunities for improvement**
Good Samaritan law: Public education and implementation	**Moderate evidence alignment**	**Weak implementation reach**	Assess the impact of Ohio's Good Samaritan law, including the restrictions on Good Samaritan immunity, and adjust the law as needed so that bystanders are encouraged to call for help during an overdose Potential improvements include: • Expand the range of drug possession offenses that are covered • Evaluate the impact of Ohio's Good Samaritan law, particularly on the connection between overdose, screening and treatment • If the evaluation results are negative, meaning that people who overdose are not being screened and entering treatment within 30 days, consider removing 30 day requirement so that more people have access to immunity • Remove the provision of Ohio's Good Samaritan law that limits the number of times a person can be granted immunity • Include people who are on community control or post-release control among people who can be granted immunity • Increase public education about Ohio's Good Samaritan law so that people know that immunity may be available to them
	• Ohio's Good Samaritan law provides immunity from arrest, charge and prosecution for a minor drug possession offense for individuals who seek medical help for their own or another person's drug overdose. The person who has overdosed also has immunity from minor drug possession offenses. • Immunity is only granted if the person seeking immunity, within 30 days of seeking or obtaining assistance, "seeks and obtains a screening and receives a referral for treatment." • The Good Samaritan law applies only to individuals who have been previously granted immunity under the law not more than twice. People in community control or post-release control do not qualify for immunity. • Ohio law also requires EMS personnel or firefighters to disclose to law enforcement, upon request, the name and address of any person to whom they administered naloxone.		

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Table 2. **Law enforcement crisis de-escalation (intercept 1)**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Crisis Intervention Team (CIT) programs	**Strong evidence alignment** **Strong implementation reach** • Since 2001, OMHAS has provided block grant funding to the Criminal Justice Coordinating Center of Excellence, which acts as the statewide technical assistance center for CIT. • Several state-level partners have been involved in supporting the spread of the CIT model, including OMHAS, the Ohio Attorney General's Office and NAMI Ohio. • OPOTA includes 20 hours of crisis intervention training as a foundational introduction to CIT for new officers. • As of June 2019, all **88 Ohio counties** have at least one full-time peace officer who had completed CIT training. Most counties had 21% or more of their officers trained. • As of May 2019, **19 counties** had all law enforcement agencies in the county participating in CIT.	• Continue to increase the number of law enforcement agencies fully implementing the CIT model • Continue to provide technical assistance, training and evaluation support to law enforcement agencies to ensure fidelity to the CIT model and continuous quality improvement • Assess the extent to which CIT addresses the needs of people experiencing substance use disorder crises (in addition to or instead of a mental health crisis) • Strengthen training, as needed, to incorporate a focus on addiction and stigma
Law enforcement agency policies for responding to persons in crisis, including risk assessment, de-escalation and referrals to treatment	**Weak evidence alignment** **Unknown implementation reach** • Local law enforcement agencies are not required to have a policy on responding to persons in crisis or to report their policies to a state entity. • Law enforcement agencies can be voluntarily certified by the **Ohio Collaborative Community-Police Advisory Board**. The board has established 8 standards for certification, including standards for use of force, community engagement and bias-free policing which may be relevant to addiction-related crisis situations. However, there is not a standard specifically addressing crisis de-escalation. A list of certified law enforcement agencies is provided **here**.	• Require local law enforcement agencies to have a policy on responding to persons in crisis, including addiction-related crisis • Add a crisis de-escalation standard to the Ohio Collaborative Community-Police Advisory Certification Standards

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Table 3. **Drug supply disruption and reduction**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Interdiction of illicit drugs (no evidence available)	**N/A**	**Weak implementation reach**	
	• Launched in 2017, the Drug Incident Summary Collection Overview (DISCO) system is a data collection partnership between DPS, Ohio's 41 drug task forces and the El Paso Intelligence Center that provides Ohio task force commanders and federal law enforcement leaders with accurate, real-time statistics to support effective deployment of resources. • OMHAS and DPS have received federal funds for grants to local communities to support drug task forces. These grants typically cover a small number of counties.		

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Criminal justice system

Table 4. **Initial detention and initial court hearings (intercept 2)**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Mental health and substance use disorder screening: Jail booking and/or pretrial	**Weak evidence alignment**	**Moderate implementation reach**	• Inspect all Ohio jails to assess whether mental health and substance use disorder screening is occurring upon intake • Revise the jail standards to include specific focus on screening for substance use disorder using evidence-based screening tools • Improve data collection and reporting so that information about the extent to which Ohio jails are providing effective substance use disorder screening and treatment is readily available for transparency, accountability and quality improvement purposes
	• Jail standards (ORC 5120.10 and OAC 5120:1-10-09) require that all full-service jails screen inmates for physical and mental health conditions upon arrival, including "use of alcohol and drugs," although not specifically for substance use disorder. • The DRC Bureau of Adult Detention (BAD) is responsible for monitoring jail compliance with the **Minimum Standards for Jails.** • Analysis of 2016 jail inspection reports found that 34% of jails were not in compliance with the mental health screening standard. • 2018 inspection reports for some county jails are posted on the **BAD website**, although there is no recent reporting that summarizes this data to describe overall rates of compliance with the mental health screening standard for 2017 or 2018. • Of the 36 counties with posted **2018 jail inspection reports**, 32 are in compliance with this requirement. Four (Adams, Coshocton, Huron and Scioto) are not.		

Table 4. **Initial detention and initial court hearings (intercept 2)** (cont.)

<table>
<tr><th>Evidence-based policy, program or practice*</th><th colspan="2">Ohio status**</th><th>Opportunities for improvement</th></tr>
<tr><td rowspan="2">Pretrial diversion, including Intervention in Lieu of Conviction (ILC) and Targeted Community Alternatives to Prison (T-CAP)</td><td>Moderate evidence alignment</td><td>Unknown implementation reach</td><td rowspan="2">• Increase the utilization of pretrial diversion and ILC for defendants with substance use disorder and mental health disorders
• Focus treatment in pretrial and diversion settings on immediate needs, such as housing, transportation, economic support, and vocational placement and training
• Reduce the number of factors that make offenders ineligible for pretrial diversion and ILC
• Require prosecutors and judges to use standard guidelines when assessing whether an offender has access to pretrial diversion programs, including ILC</td></tr>
<tr><td colspan="2">Pretrial diversion
• Pretrial diversion is administered by prosecutors, with approval by the presiding judge.
• Some defendants are not eligible for pretrial diversion because they are specifically excluded in the ORC. Exclusions include repeat or dangerous offenders, defendants charged with a violent offense and defendants charged with most drug offenses.
• In 2018, SB 66 expanded eligibility for pretrial diversion to defendants with misdemeanor drug and paraphernalia possession charges. Prosecutors must still permit their participation.

Intervention in lieu of conviction (ILC)
• ILC is administered by courts.
• Beginning in 2014, if the court has reason to believe that drug or alcohol use by the offender was a factor leading to the criminal offense, the court will look into whether the offender should be given treatment rather than a conviction.
• Defendants are not eligible for ILC if they are charged with certain offenses, including any 1-3-degree felony and certain serious drug-related offenses, including 1-4-degree felony trafficking and 1-2-degree felony possession.
• Defendants are also ineligible for ILC if they are charged with crimes involving a person sixty-five years of age or older, permanently and totally disabled, under thirteen years of age, or a police officer on duty.
• There is no statewide data system that tracks how often pretrial diversion and ILC are used.

Targeted Community Alternatives to Prison (T-CAP)
• The SFY 2018-2019 budget created and included funding for the T-CAP program, which diverts low-level, non-violent felony offenders to jail or CBCF instead of prison.
• Ten counties have been required to participate since July 2018, and the other 78 counties can apply for T-CAP grant funding voluntarily.
• In SFY 2018, 48 counties participated in T-CAP. That number increased to 56 counties in SFY 2019.</td></tr>
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Table 4. **Initial detention and initial court hearings (intercept 2)** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Limit money bail and implement risk assessment	**Weak evidence alignment**	**Weak implementation reach**	• Implement the recommendation from the 2017 Ohio Criminal Sentencing Commission **Bail And Pretrial Services Report** to utilize the Arnold Foundation's "Public Safety Assessment" tool, or some other validated tool, to gauge individual defendants' suitability for release or detention pending trial • Implement forthcoming recommendations from the Task Force to Examine the Ohio Bail System • Collect data on and evaluate the impact of bail reform on crime rates and SUD-related outcomes
	• Ohio utilizes a money bail system and has not implemented risk assessment as a tool for pretrial release and detainment decisions. • In 2017, the Ohio Criminal Sentencing Commission released a **bail and pretrial services report**, which recommended utilizing the Arnold Foundation's "Public Safety Assessment" tool, or some other validated tool, to gauge defendants' suitability for release or detention pending trial. • In 2019, the Ohio Supreme Court began convening the Task Force to Examine the Ohio Bail System. • The purpose of the task force is to examine Ohio's bail system under Criminal Rule 46 (the criminal procedure rule relating to bail) and make recommendations that will ensure public safety and the accused's appearance at future court hearings, while protecting the presumption of innocence.		

Table 5a. **Courts, including specialized dockets and mandatory sentencing (intercept 3)**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Specialized docket programs to encourage non-violent offenders to seek treatment	Strong evidence alignment	Moderate implementation reach	• TraExpand ATP and/or Specialized Docket Subsidy Program funding to all specialty dockets • Continue to create new specialized dockets, including drug courts, mental health courts and family dependency courts so that Ohioans in all counties have access to these dockets • Evaluate the impact of specialized dockets and provide technical assistance to assist courts with continuing quality improvement of these dockets
	• There are **256 specialized dockets** in the state of Ohio, including 180 drug courts. • There are specialized dockets in 64 Ohio counties. • OMHAS provides funding to specialized dockets in 55 counties through three programs: The Addiction Treatment Program (ATP), the Specialized Docket Subsidy Program, and the Legacy Drug Court program. These programs fund addiction treatment, recovery supports and administrative costs for the courts. • In 2017, 76 two-year Justice Reinvestment and Incentive Grants were approved for County Common Pleas and local Municipal Courts. $10 million of the total is distributed to address opiate addiction with the criminal justice-involved population.		
Drug courts-Screening: standardized screening instruments; screen for mental health issues and history of trauma; risk assessment; priority for high risk offenders	Strong evidence alignment	Strong implementation reach	• Collect data from each specialized docket about what screening and assessment tools are being used • Collect data from each specialized docket about the number of court participants that screen positively from mental illness, addiction and trauma
	• In order to be certified by the Ohio Supreme Court as a specialized docket, courts must meet a series of Specialized Dockets Standards. • The Specialized Dockets Standards specify that courts must promptly assess participants and refer them to the appropriate services. • Each drug court utilizes an appropriate treatment provider to clinically assess participants for substance use disorder, mental health disorders and trauma. • Drug courts in Ohio also assessment criminal risk; the Supreme Court does not prescribe which assessment tool must be used.		
Drug courts-Participants placed in treatment immediately following eligibility screening	Strong evidence alignment	Strong implementation reach	• Collect data that measures length of time that it takes for drug court participants to be placed in treatment • Provide technical assistance to assist courts with continuing quality improvement of these dockets, including shortening the time it takes to place participants in treatment
	Per the Specialized Dockets Standards from the Ohio Supreme Court, participants must be placed as soon as possible in appropriate treatment services and programs and under reporting supervision to monitor compliance with court requirements.		

Table 5a. **Courts, including specialized dockets and mandatory sentencing (intercept 3)** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Drug courts- Appropriate treatment duration (6-18 month) and focus on outpatient treatment, with residential treatment reserved for most at-risk participants	**Unknown evidence alignment**	**Unknown implementation reach**	Collect and report data that measures treatment duration for drug court participants
	• There is currently no data that measures treatment duration for drug court participants. • Starting in July 2019, drug courts must report this information to the Ohio Supreme Court. As of November 2019, a public report has not yet been released.		
Drug courts- Evidence-based practices in addiction care, including MAT	**Moderate evidence alignment**	**Unknown implementation reach**	• Collect data that measures whether drug courts are including MAT in treatment plans for participants, and if so, which types of MAT are being utilized • Require compliance with the MAT guidance document as part of the Specialized Dockets Standards
	• The Specialized Dockets Standards require courts to provide services that meet individualized needs, incorporate evidence-based practices, are gender responsive, culturally appropriate, and address co-occurring disorders. • In 2016, the Ohio Supreme Court released a guidance document for the use of MAT in drug courts: **Principles for the Use of Medication Assisted Treatment (MAT) in Drug Courts** • The language of the document is permissive and courts are not required to follow the guidance. • The Ohio Supreme Court has proposed that compliance with the MAT guidance be added as a certification standard for all specialized dockets, but that change has not yet occurred.		
Drug courts- Aftercare services and a recovery management plan post-graduation	**Unknown evidence alignment**	**Unknown implementation reach**	• Collect data that measures whether drug courts offer aftercare services and/or recovery management plans post-graduation, and if so, what those services and plans entail • Provide technical assistance to drug courts who do not offer aftercare services and/or recovery management plans so that all graduates have access to these services
	There is currently no data that measures what types of aftercare services and/or recovery management plans drug courts offer post-graduation.		

Table 5a. **Courts, including specialized dockets and mandatory sentencing (intercept 3)** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Reduce mandatory sentencing, which prevents the possibility of alternative sentencing programs and/or parole	**Mixed evidence alignment**	**Mixed implementation reach**	Reduce the prevalence of mandatory sentencing requirements in the Ohio Revised Code
	• During the 130th-132nd General Assemblies, Ohio strengthened and added several mandatory sentences to the Ohio Revised Code. • For example, in 2018, SB 1 required an additional mandatory prison term for drug trafficking, possession, or aggravated funding of drug trafficking when the drug involved is a fentanyl-related compound. • Some mandatory sentencing was reduced from 2013-2018. For example, prior to 2018, courts were required to sentence offenders to community control for one year after a fourth- or fifth-degree felony. SB 66 removed that requirement.		

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Table 5b. **Prisons, including addiction screening and treatment (intercept 3)**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Naloxone in prisons: Stock medication and train personnel to administer naloxone	**Strong evidence alignment**	**Strong implementation reach**	Ensure ongoing compliance with required use of naloxone in state prisons
	According to a **DRC policy** effective Feb. 2019, all DRC employees are required to be trained initially upon hire and annually on naloxone administration, storage and record keeping (SB 319; ORC 3707.562, 4729.514, 4731.943).		
Hepatitis C screening education and awareness, particularly for people at high risk, including injection drug users (consistent with USPSTF recommendation)	**Weak evidence alignment**	**Unknown implementation reach**	Create an integrated state plan to reduce hepatitis C transmission and reinfection, similar to the Ohio HIV Prevention and Care Integrated Plan, with an emphasis on incarcerated populations within Ohio
	• There are no significant, statewide efforts led by ODH, OMHAS or ODM to increase awareness, prevention, screening or treatment of hepatitis C. • State prisons are not consistently testing for, managing and treating hepatitis C among people who are incarcerated.		
State prisons- SUD screening: Screen newly incarcerated persons for addiction and mental disorders using evidence-based screening tools	**Strong evidence alignment**	**Unknown implementation reach**	Assess the extent to which state prisons are appropriately screening newly-incarcerated persons for addiction and mental disorders and if needed healthcare services are then adequately provided to those who screen positive
	• DRC is responsible for providing healthcare services to state prison inmates. • DRC and OMHAS partnered to create the Bureau of Correctional Recovery Services, which treats offenders with SUD. Screening is included in the regimen of treatment. Offenders at reception institutions receive **screening for AOD use history** with the Texas Christian University Drug Screening V Instrument. • There is no data to measure the extent to which SUD screening and treatment are being provided to people in Ohio prisons.		
State prisons- Continuation of SUD treatment, including MAT: For individuals who had been receiving addiction treatment prior to incarceration, evaluate whether treatment can continue within the prison or jail, including maintenance of MAT and/or psychosocial treatment	**Strong evidence alignment**	**Unknown implementation reach**	Assess the extent to which state prisons are appropriately providing evidence-based SUD treatment, including MAT
	• DRC is responsible for providing healthcare services to state prison inmates. • DRC and OMHAS partnered to create the Bureau of Correctional Recovery Services, which treats offenders with SUD. Prisons offer a variety of SUD treatment services (including intensive outpatient, recovery maintenance and therapeutic communities), although not all services are available at every facility.		

Table 5b. **Prisons, including addiction screening and treatment (intercept 3)** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Re-assess incarcerated people with SUD prior to reentry and determine if MAT is appropriate	**Strong evidence alignment**	**Strong implementation reach**	Evaluate the DRC naltrexone program and, based on the results of the evaluation, consider: • Removing the educational session requirement if it creates a barrier for some individuals receiving naltrexone upon release • Tracking outcomes for individuals post release, including drug use, overdose and recidivism after participating in the naltrexone program
	• In 2017, ORC piloted the use of MAT at three correctional facilities for eligible individuals preparing to reenter Ohio communities. • Since July 2018, all Ohio prisons have been utilizing naltrexone in their facilities. • Offenders with OUD are referred to an educational session and provided an opportunity to opt in or out of the program. Approximately two-thirds of eligible offenders received naltrexone injections upon release in 2018.		
Train corrections professionals on the nature of addiction, evidence-based treatment and stigma	**Weak evidence alignment**	**Moderate implementation reach**	Require jail and prison staff to participate in training on the nature of addiction, evidence-based SUD treatment and stigma
	• Jail standards (ORC 5120.10 and OAC 5120:1-10-09) do not include any requirements for staff training on addiction. • DRC utilizes a variety of training platforms that include addiction-related topics. The largest component of that training focuses on the identification of acute intoxication, medical response and drug identification. • A committee was recently formed with DRC that will work to merge the trainings related to addiction and include training related to stigma.		

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Table 5c. **Jails, including addiction screening and treatment (intercept 3)**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Naloxone in jails: Stock medication and train personnel to administer naloxone	**Weak evidence alignment**	**Unknown implementation reach**	• Assess the extent to which local jails are administering naloxone • Require all jail employees to be trained on naloxone administration, storage, and record keeping
	• There is no requirement for local jail employees to be trained in naloxone administration and the percent of local jails in Ohio that stock naloxone and train staff on naloxone administration is unknown. • In 2014 (HB 367), law enforcement agencies and services entities, including courts, probation departments, halfway houses, prisons, jails and community residential centers, were exempted from licensure as a terminal distributor of dangerous drugs with respect to naloxone.		
Hepatitis C screening education and awareness, particularly for people at high risk, including injection drug users (consistent with USPSTF recommendation)	**Weak evidence alignment**	**Unknown implementation reach**	Create an integrated state plan to reduce hepatitis C transmission and reinfection, similar to the Ohio HIV Prevention and Care Integrated Plan, with an emphasis on incarcerated populations within Ohio
	• There are no significant, statewide efforts led by ODH, OMHAS or ODM to increase awareness, prevention, screening or treatment of hepatitis C. • Jail across Ohio are not consistency testing for, managing and treating hepatitis C among people who are incarcerated.		
Jails- medically-managed withdrawal For detainees with active SUD, monitor signs and symptoms of withdrawal and medically manage withdrawal in an evidence-based way	**Weak evidence alignment**	**Moderate implementation reach**	• Provide technical assistance to jails to develop evidence-based policies and protocols for medically managed withdrawal services consistent with the ASAM National Practice Guideline • Improve data collection and reporting so that information about the extent to which Ohio jails are providing effective care for detainees and inmates in withdrawal is readily available for transparency, accountability and quality improvement purposes
	• Jail standards (ORC 5120.10 and OAC 5120:1-10-09) require that all full-service jails develop specific policies and protocols to address inmate symptoms of intoxication or detoxification of alcohol or other drugs. They must establish specific criteria for immediately transferring inmates experiencing "life-threatening intoxication (overdose) or detoxification symptoms to a hospital or detoxification center." It is unknown, however, the extent to which these locally-developed policies and protocols align with evidence-based medically managed withdrawal as recommended by the American Correctional Association and ASAM joint policy statement. • The DRC Bureau of Adult Detention (BAD) is responsible for monitoring jail compliance with the Minimum Standards for Jails. • Analysis of 2016 jail inspection reports found that 29% of jails were not in compliance with intoxication/detoxification standard. • 2018 inspection reports for some county jails are posted on the BAD website, although there is no recent reporting that summarizes this data to describe overall rates of compliance with the mental health screening standard for 2017 or 2018.		

Table 5c. **Jails, including addiction screening and treatment (intercept 3)** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Jails- Continuation of SUD treatment, including MAT For individuals who had been receiving addiction treatment prior to incarceration, evaluate whether treatment can continue within the prison or jail, including maintenance of MAT and/or psychosocial treatment	**Weak evidence alignment**	**Unknown implementation reach**	• Assess the extent to which jails are offering evidence-based SUD treatment services, including provision of MAT • Improve data collection and reporting so that information about the extent to which Ohio jails are providing evidence-based SUD treatment, including MAT, is readily available for transparency, accountability and quality improvement purposes
	• **Jail standards** (ORC 5120.10 and OAC 5120:1-10-09) require that all full-service jails "provide the opportunity for alcohol and drug abuse treatment." There is no requirement that the treatment be evidence-based, including MAT. • There appears to be a great deal of variation in the types of treatment opportunities provided in jails in Ohio. **Information gathered** on 19 Ohio counties by the Criminal Justice Coordinating Center of Excellence in 2017 found that medication access in jails varied widely from county to county. In recent years, there have been several state-level efforts to increase access to SUD treatment in jails: • In 2015, OMHAS provided $3 million in grants to address behavioral health needs in jails in 38 counties (Criminal Justice and Behavioral Health Linkage Grants Initiative). Thirty-four counties also received grants in SFY 2019 when the program was expanded. • In 2016, ODPS (Office of Criminal Justice Services) directed $244,000 to help fund drug treatment projects in prisons, jails and community corrections facilities (federal funding). In 2017, ODPS directed an additional $345,000 to fund drug treatment projects in prisons, jails and community corrections facilities.		
Train corrections professionals on the nature of addiction, evidence-based treatment and stigma	**Weak evidence alignment**	**Moderate implementation reach**	Require jail and prison staff to participate in training on the nature of addiction, evidence-based SUD treatment and stigma
	• **Jail standards** (ORC 5120.10 and OAC 5120:1-10-09) do not include any requirements for staff training on addiction. • DRC utilizes a variety of training platforms that include addiction-related topics. The largest component of that training focuses on the identification of acute intoxication, medical response and drug identification. • A committee was recently formed with DRC that will work to merge the trainings related to addiction and include training related to stigma.		

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Table 6. **Reentry, including connections to treatment, job training and recovery services (intercept 4)**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Prisons— Educate incarcerated people with SUD about unintentional overdose, and provide individuals with naloxone before release	**Strong evidence alignment**	**Strong implementation reach**	• Monitor and evaluate the Narcan at Release Project and make adjustments as needed to increase the efficacy of the program • Include the offender's support system (family, friends, etc.) in the naloxone education and training process to better align with the evidence
	• DRC operates the Narcan at Release Project, which provides overdose education and naloxone to prison inmates upon completion. • The Narcan Release Project began as a pilot program in three facilities in 2018. As of July 2019, this program expanded to include all prisons. • Inmates also receive information regarding recovery risks, OUD treatment options/ programs and community resources.		
Jails— Educate incarcerated people with SUD about unintentional overdose, and provide individuals with naloxone before release	**Weak evidence alignment**	**Unknown implementation reach**	• Offer overdose education, training and naloxone to people exiting jails • Collect data regarding how many jails stock naloxone and provide it to people upon release
	• There is no state-level information about the percent of Ohio jails that stock naloxone or provide it to people upon release. • Using OMHAS Community Linkage Grant funds, jails sometimes offer MAT, such as naltrexone, as a harm reduction measure when people are released from jail.		
Ensure that incarcerated people have health insurance coverage upon reentry, including Medicaid coverage if eligible	**Strong evidence alignment**	**Strong implementation reach**	• Continue to provide funding for DRC and DYS to offer access to Medicaid and SSI/SSDI application assistance • Strengthen partnerships with inmates and managed care representatives post-release to encourage and ensure utilization of SUD treatment
	• In 2014, ODM and DRC launched the **Medicaid Pre-Release Enrollment Program**, which connects people with behavioral health needs to Medicaid and access to needed services and treatment as they transition from prison back into the community. • In 2013, OMHAS and the Social Security Administration partnered to assist youth being released from DYS (who are at least 18 years of age who have a severe and persistent mental illness) to apply for SSI/SSDI prior to release. • DRC and DYS facilitate the Community Linkage Program, which assists eligible participants in applying for Social Security and Medicaid benefits.		
Create an individualized reentry plan tailored to the needs of each incarcerated person with SUD	**Moderate evidence alignment**	**Strong implementation reach**	• Enforce the use of standardized reentry plan practices across all DRC facilities for each person exiting the prison system • Monitor and enforce the inclusion of connections to treatment and recovery supports in the reentry plans for formerly incarcerated people with SUD
	• All people released from prison and CBCFs to supervision have a case plan based on the Ohio Risk Assessment Survey (ORAS) and the individual's needs. • Parole and probation officers work with individuals on the objectives in their case plans.		

Table 6. **Reentry, including connections to treatment, job training and recovery services (intercept 4)** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Provide incarcerated people with education, employment and life skills training to maximize success post-release	**Strong evidence alignment**	**Strong implementation reach**	Require a minimum level of service or standard programming to ensure everyone entering/exiting a CBCF has access to basic evidence-based programs that can aid in their success post release
	• The Ohio Central School System is a school district operating within DRC. The purpose of the school system is to "provide educational programs for prisoners to allow them to complete adult education courses, earn Ohio certificates of high school equivalence, or pursue vocational training." • DRC offers high school equivalency programs, GED and ABLE, to inmates at all prison facilities. DRC also provides career-technical training and apprenticeships in 136 areas. The availability of each training program **varies by facility**. • **CBCFs** provide a wide variety of educational services, workforce development programs, parenting classes, anger management classes, mental health services and substance abuse programs. • **Therapeutic Communities Programs** address alcohol and drug addictions, in conjunction with criminal behavior, during incarceration. They are operated inside DRC facilities and provide six to 12 months of recovery services to build life skills in a residential setting. • The Bureau of Correctional Recovery Services within OMHAS operates the AOD Intensive Program Prison, which is a 90-day program focusing on education, training, work, SUD treatment, community service, conservation work and/or other intensive programming. • SAMHSA awarded the state of Ohio a $7 million Access to Recovery (ATR) grant to provide vouchers for recovery support services and treatment services to more than 4,300 criminal justice-involved adults and military service members. The grant period started in May 2015 and ended in April 2018.		
Assist incarcerated people with building and maintaining family relationships in order to maximize success post-release	**Moderate evidence alignment**	**Moderate implementation reach**	Extend the program to offer participation prior to release to better align with the evidence which includes visitation, video conferencing and programming for children
	• Citizen Circles create partnerships that promote positive interaction and accountability for offenders upon release. Offenders and their families develop relationships with members of the community and together develop a plan to help the offender become accepted as a productive citizen and member of the community. • DRC facilities offer visitation and many offer video conferencing services, but additional resources like programming for children are limited to certain facilities.		
Ensure continuity of behavioral health treatment upon release, including in-reach by community-based treatment providers	**Strong evidence alignment**	**Moderate implementation reach**	Expand the Criminal Justice and Behavioral Health Linkage Grants to all 88 counties
	• In 2017, DRC and OMHAS launched the Medication-Assisted Addiction Treatment pilot program to increase access to MAT prior to release from prison. • This voluntary program provides inmates with an initial dose of naltrexone prior to release and connects them to healthcare providers to ensure continuity of care post release. • OMHAS developed the Criminal Justice and Behavioral Health Linkage Grants which funds programs in 63 counties that supports the transition from prison for people with mental illness and/or SUD. These partnerships encourage collaboration between the criminal justice system and behavioral health systems to improve continuity of care.		

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Table 7. **Community corrections (intercept 5)**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Train probation and parole officers to work with people with addiction, and when possible, create specialized caseloads for people with co-occurring addiction and mental illness	**Moderate evidence alignment**	**Strong implementation reach**	• Increase training on addiction and working with offenders with substance use disorder to the required probation officer training and continuing education requirements for probation officers • Expand specialized caseloads for people with co-occurring addiction and mental illness
	• In 2011, HB 86 (129th General Assembly) included provisions to develop minimum standards for the training of adult probation and parole officers. • New officers are trained through the Ohio Supreme Court and all probation officers have to complete 20 hours of continuing education annually. • This training includes a module about drug testing, addiction and working with offenders who are addicted to opioids. This module outlines the evidence and best practices related to addiction, including MAT. • According to the Ohio Supreme Court, many courts have specialized probation and parole officers, including specialties in substance abusing and mentally ill offenders.		
Require the use of parole guidelines, particularly guidelines that include risk and needs assessment tools	**Weak evidence alignment**	**Weak implementation reach**	Require the Parole Board to use guidelines that include an evidence-based risk assessment tool as a key factor in assessing risk and readiness for parole
	• The **Ohio Parole Board Handbook** was updated in January 2019. • Parole in Ohio is subject to the absolute discretion of the Parole Board. The Parole Board conducts release consideration hearings monthly for all incarcerated people who are parole-eligible. • The handbook states that the analysis of each individual case should include consideration of the statistical estimate of an offender's risk to reoffend, but that the board should also consider the offender's criminal history and parole history, the offender's ability to control his or her behavior (including the offender's substance abuse history), whether the offender has taken programming appropriate to his or her risk level, the offender's behavior in prison and while on supervision in the community, the degree to which the offender demonstrates that he or she has changed and the quality of the offender's release plan.		
Match conditions of parole to the assessed risk and need of the individual	**Moderate evidence alignment**	**Strong implementation reach**	• Tailor conditions of parole to avoid generic or unrealistic conditions. Conditions of parole should be dynamic and correspond to the changing needs of the individual throughout the term of supervision • Ensure that conditions of parole address both the criminogenic needs of the individual, as well as their basic needs, such as housing, food, transportation and medical and behavioral health services
	• The Adult Parole Authority, Ohio Parole Board and probation officers in Ohio use the Ohio Risk Assessment System (ORAS) to assess likelihood of future crimes by adult offenders on parole and probation. • The Ohio Parole Board and/or the sentencing court have discretion about which post-release control sanctions to impose on individuals after release from prison. • In order to determine what sanctions to impose, the Parole Board or court must review the results of ORAS, as well as the person's criminal history, juvenile court adjudications, if any, and the record of the person's conduct while in prison. • The only sanctions required by Ohio law are that the person on parole must abide by all laws, may not possess a firearm and may not leave the state without written permission from the Adult Parole Authority.		

Table 7. **Community corrections (intercept 5)**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Allow individuals on parole to accrue earned credit during their supervision to reduce time to completion of their sentence	**Weak evidence alignment**	**Weak implementation reach**	Implement an earned credit system for individuals on post-release control, similar to the system for individuals who are incarcerated
	• Ohio law (ORC 2967.193) includes an earned credit system for people incarcerated in state prisons, allowing offenders to earn credit to reduce time to completion of their sentence. • The earned credit system within state prisons impacts when offenders become eligible for parole, but there is no earned credit system in Ohio that reduces the allows offenders to earn time off of their sentence in the community post-release. • The Adult Parole Authority (APA) may review an individual's behavior under post-release control sanctions at any time and determine that more restrictive or less restrictive sanctions are appropriate. The APA may also recommend that the Parole Board or court increase or reduce the duration of post-release control.		
Response to parole violations should be swift, certain and proportionate	**Moderate evidence alignment**	**Unknown implementation reach**	• Collect aggregate, state-level data on responses to parole violations and evaluate whether those responses are proportionate to the violations • Apply sanctions for violating parole in conjunction with addiction treatment interventions in order to reduce recidivism
	• In 2017, Ohio's Community Control statute (ORC 2929.15) was amended to cap how long people can spend in prison for technical violations of community supervision. Felony 4 violations were capped at 180 days and felony 5 violations at 90 days. • SB 66 (132nd General Assembly) authorizes courts to impose a new term of up to six months in a community-based correctional facility, halfway house, or jail as a penalty for a felony offender who violates a community control sanction condition. • There is no data collected at the state level that tracks responses to parole violations in an aggregate way.		
Community-based sanctions should be maximized before custodial sanctions are considered	**Moderate evidence alignment**	**Unknown implementation reach**	• Collect aggregate, state-level data on responses to parole violations and evaluate whether those responses are proportionate to the violations • Apply sanctions for violating parole in conjunction with addiction treatment interventions in order to reduce recidivism
	• Prior to 2018, the ORC specified that if a person on post-release control had repeatedly committed violations of post-release control sanctions, the parole board or court must consider a prison term sanction. This language was removed by SB 66 (132nd General Assembly). • A prison term must still be considered when the person on post-release control committed a violation involving (1) a deadly weapon or dangerous ordnance, (2) physical harm or attempted serious physical harm to a person, or (3) sexual misconduct. • There is no data collected at the state level that tracks responses to parole violations in an aggregate way.		

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Evidence sources

Law enforcement

Table 8. **Community services (intercept 0)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Partnerships between public safety and public health agencies, including data sharing and privacy protections	Johns Hopkins Bloomberg School of Public Health, 2018	**Ten Standards of Care: Policing and The Opioid Crisis**
First responders supplied with and trained to administer naloxone	Johns Hopkins Bloomberg School of Public Health, 2018	**Ten Standards of Care: Policing and The Opioid Crisis**
	The National Center for Addiction and Substance Abuse, 2017	**Ending the Opioid Crisis: A Practical Guide for State Policymakers**
Law enforcement trained in addiction, mental health and stigma	Johns Hopkins Bloomberg School of Public Health, 2018	**Ten Standards of Care: Policing and The Opioid Crisis**
	The National Center for Addiction and Substance Abuse, 2017	**Ending the Opioid Crisis: A Practical Guide for State Policymakers**
	The President's Task Force on 21st Century Policing, 2015	**Final Report of the President's Task Force on 21st Century Policing**
Pre-arrest diversion: First responders refer offenders to addiction treatment	Washington State Institute for Public Policy Benefit-Cost Results	**Police diversion for low-severity offenses (pre-arrest)**
	Johns Hopkins Bloomberg School of Public Health, 2018	**Ten Standards of Care: Policing and The Opioid Crisis**
	The National Center for Addiction and Substance Abuse, 2017	**Ending the Opioid Crisis: A Practical Guide for State Policymakers**
Public safety and public health collaborate to support Syringe Service Programs (SSPs)	Johns Hopkins Bloomberg School of Public Health, 2018	**Ten Standards of Care: Policing and The Opioid Crisis**
Good Samaritan law: Public education and implementation	Johns Hopkins Bloomberg School of Public Health, 2018	**Ten Standards of Care: Policing and The Opioid Crisis**

Table 9. **Law enforcement crisis de-escalation (intercept 1)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Crisis Intervention Team (CIT) programs	Substance Abuse and Mental Health Administration, 2018	**Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide**
	The President's Task Force on 21st Century Policing, 2015	**Final Report of the President's Task Force on 21st Century Policing**
Law enforcement agency policies for responding to persons in crisis, including risk assessment, de-escalation and referrals to treatment	International Association of Chiefs of Police, 2018	**Responding to Persons Experiencing a Mental Health Crisis**
	The President's Task Force on 21st Century Policing, 2015	**Final Report of the President's Task Force on 21st Century Policing**

Table 10. **Drug supply disruption and reduction**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Interdiction of illicit drugs (no evidence available)	N/A	N/A

Table 11. **Initial detention and initial court hearings (intercept 2)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Mental health and substance use disorder screening: Jail booking and/or pretrial	Substance Abuse and Mental Health Services Administration (SAMHSA), 2015	**Screening and Assessment of Co-occurring Disorders in the Justice System**
	Substance Abuse and Mental Health Services Administration, 2005	Substance Abuse Treatment for Adults in the Criminal Justice System **Chapter 7: Treatment Issues in Pretrial and Diversion Settings**
Pretrial diversion, including Intervention in Lieu of Conviction (ILC) and Targeted Community Alternatives to Prison (T-CAP)	Substance Abuse and Mental Health Services Administration, 2005	Substance Abuse Treatment for Adults in the Criminal Justice System **Chapter 7: Treatment Issues in Pretrial and Diversion Settings**
Limit money bail and implement risk assessment	University of Pennsylvania Law School, Legal Scholarship Repository, 2017	**Bail Reform: New Directions for Pretrial Detention and Release**

Criminal justice system

Table 11. **Initial detention and initial court hearings (intercept 2)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Mental health and substance use disorder screening: Jail booking and/or pretrial	Substance Abuse and Mental Health Services Administration (SAMHSA), 2015	**Screening and Assessment of Co-occurring Disorders in the Justice System**
	Substance Abuse and Mental Health Services Administration, 2005	Substance Abuse Treatment for Adults in the Criminal Justice System **Chapter 7: Treatment Issues in Pretrial and Diversion Settings**
Pretrial diversion, including Intervention in Lieu of Conviction (ILC) and Targeted Community Alternatives to Prison (T-CAP)	Substance Abuse and Mental Health Services Administration, 2005	Substance Abuse Treatment for Adults in the Criminal Justice System **Chapter 7: Treatment Issues in Pretrial and Diversion Settings**
Limit money bail and implement risk assessment	University of Pennsylvania Law School, Legal Scholarship Repository, 2017	**Bail Reform: New Directions for Pretrial Detention and Release**

Table 12a. **Courts, including specialized dockets and mandatory sentencing (intercept 3)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Specialized docket programs to encourage non-violent offenders to seek treatment	The National Center for Addiction and Substance Abuse, 2017	**Ending the Opioid Crisis: A Practical Guide for State Policymakers**
Drug courts- Screening: standardized screening instruments; screen for mental health issues and history of trauma; risk assessment; priority for high risk offenders	American University Bureau of Justice Assistance Drug Court Technical Assistance Project, 2014	**A Technical Assistance Guide for Drug Court Judges on Drug Court Treatment Services**
Drug courts- Participants placed in treatment immediately following eligibility screening	American University Bureau of Justice Assistance Drug Court Technical Assistance Project, 2014	**A Technical Assistance Guide for Drug Court Judges on Drug Court Treatment Services**
Drug courts- Appropriate treatment duration (6-18 month) and focus on outpatient treatment, with residential treatment reserved for most at-risk participants	American University Bureau of Justice Assistance Drug Court Technical Assistance Project, 2014	**A Technical Assistance Guide for Drug Court Judges on Drug Court Treatment Services**
Drug courts- Evidence-based practices in addiction care, including MAT.	American University Bureau of Justice Assistance Drug Court Technical Assistance Project, 2014	**A Technical Assistance Guide for Drug Court Judges on Drug Court Treatment Services**
	National Association of Drug Court Professionals, 2018	**Adult Drug Court Best Practice Standards**
Drug courts- Aftercare services and a recovery management plan post-graduation	American University Bureau of Justice Assistance Drug Court Technical Assistance Project, 2014	**A Technical Assistance Guide for Drug Court Judges on Drug Court Treatment Services**
Reduce mandatory sentencing, which prevents the possibility of alternative sentencing programs and/or parole.	The National Center for Addiction and Substance Abuse, 2017	**Ending the Opioid Crisis: A Practical Guide for State Policymakers**

Table 12b. **Prisons, including addiction screening and treatment (intercept 3)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Naloxone in prisons: Stock medication and train personnel to administer naloxone	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
Hepatitis C screening education and awareness, particularly for people at high risk, including injection drug users (consistent with USPSTF recommendation)	U.S. Preventive Services Task Force, 2013	Final Recommendation Statement Hepatitis C: Screening
State prisons- SUD screening Screen newly incarcerated persons for addiction and mental disorders using evidence-based screening tools	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
	National Reentry Resource Center, 2018	Best Practices for Successful Reentry for People Who Have Opioid Addictions
State prisons- Continuation of SUD treatment, including MAT For individuals who had been receiving addiction treatment prior to incarceration, evaluate whether treatment can continue within the prison or jail, including maintenance of MAT and/or psychosocial treatment	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
Re-assess incarcerated people with SUD prior to reentry and determine if MAT is appropriate	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
Train corrections professionals on the nature of addiction, evidence-based treatment and stigma	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals

Table 12c. **Jails, including addiction screening and treatment (intercept 3)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Naloxone in jails: Stock medication and train personnel to administer naloxone	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
Hepatitis C screening education and awareness, particularly for people at high risk, including injection drug users (consistent with USPSTF recommendation)	U.S. Preventive Services Task Force, 2013	Final Recommendation Statement Hepatitis C: Screening
Jails- medically-managed withdrawal For detainees with active SUD, monitor signs and symptoms of withdrawal and medically manage withdrawal in an evidence-based way	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
Jails- Continuation of SUD treatment, including MAT For individuals who had been receiving addiction treatment prior to incarceration, evaluate whether treatment can continue within the prison or jail, including maintenance of MAT and/or psychosocial treatment	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
Train corrections professionals on the nature of addiction, evidence-based treatment and stigma	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals

Table 13. **Reentry, including connections to treatment, job training and recovery services (intercept 4)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Prisons- Educate incarcerated people with SUD about unintentional overdose, and provide individuals with naloxone before release	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
	National Reentry Resource Center, 2018	Best Practices for Successful Reentry for People Who Have Opioid Addictions
Jails- Educate incarcerated people with SUD about unintentional overdose, and provide individuals with naloxone before release	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
	National Reentry Resource Center, 2018	Best Practices for Successful Reentry for People Who Have Opioid Addictions
Ensure that incarcerated people have health insurance coverage upon reentry, including Medicaid coverage if eligible	American Correctional Association and American Society of Addiction and Medicine, 2018	Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals
	National Reentry Resource Center, 2018	Best Practices for Successful Reentry for People Who Have Opioid Addictions
Create an individualized reentry plan tailored to the needs of each incarcerated person with SUD	U.S. Department of Justice, 2016	Roadmap to Reentry: Reducing Recidivism through Reentry Reforms at the Federal Bureau of Prisons
	National Reentry Resource Center, 2018	Best Practices for Successful Reentry for People Who Have Opioid Addictions
Provide incarcerated people with education, employment and life skills training to maximize success post-release	U.S. Department of Justice, 2016	Roadmap to Reentry: Reducing Recidivism through Reentry Reforms at the Federal Bureau of Prisons
Assist incarcerated people with building and maintaining family relationships in order to maximize success post-release	U.S. Department of Justice, 2016	Roadmap to Reentry: Reducing Recidivism through Reentry Reforms at the Federal Bureau of Prisons

Table 13. **Reentry, including connections to treatment, job training and recovery services (intercept 4)** (cont.)

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Ensure continuity of behavioral health treatment upon release, including in-reach by community-based treatment providers	American Correctional Association and American Society of Addiction and Medicine, 2018	**Joint Public Correctional Policy Statement on the Treatment of Opioid Use Disorders for Justice Involved Individuals**
	U.S. Department of Justice, 2016	**Roadmap to Reentry: Reducing Recidivism through Reentry Reforms at the Federal Bureau of Prisons**
	National Reentry Resource Center, 2018	**Best Practices for Successful Reentry for People Who Have Opioid Addictions**

Table 14. **Community corrections (intercept 5)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report or guideline
Train probation and parole officers to work with people with addiction, and when possible, create specialized caseloads for people with co-occurring addiction and mental illness.	National Reentry Resource Center, 2018	**Best Practices for Successful Reentry for People Who Have Opioid Addictions**
Require the use of parole guidelines, particularly guidelines that include risk and needs assessment tools	University of Minnesota Robin Institute of Criminal Law and Criminal Justice, 2018	**Modernizing Parole Statutes: Guidance from Evidence-Based Practice**
Match conditions of parole to the assessed risk and need of the individual	University of Minnesota Robin Institute of Criminal Law and Criminal Justice, 2018	**Modernizing Parole Statutes: Guidance from Evidence-Based Practice**
Allow individuals on parole to accrue earned credit during their supervision to reduce time to completion of their sentence	University of Minnesota Robin Institute of Criminal Law and Criminal Justice, 2018	**Modernizing Parole Statutes: Guidance from Evidence-Based Practice**
Response to parole violations should be swift, certain and proportionate	University of Minnesota Robin Institute of Criminal Law and Criminal Justice, 2018	**Modernizing Parole Statutes: Guidance from Evidence-Based Practice**
Community-based sanctions should be maximized before custodial sanctions are considered	University of Minnesota Robin Institute of Criminal Law and Criminal Justice, 2018	**Modernizing Parole Statutes: Guidance from Evidence-Based Practice**