

COMMUNITY-WIDE RESPONSE PLAN

TO THE

OPIOID EPIDEMIC

CAPITAL REGION BEHAVIORAL HEALTH COLLABORATIVE



December 2018

ASCENSION | EAST BATON ROUGE | EAST FELICIANA | IBERVILLE
POINTE COUPEE | WEST BATON ROUGE | WEST FELICIANA

INTRODUCTION

This plan represents our community's recommendations for responding to the opioid epidemic and the impacts that opioid abuse and addiction have on individuals, families, neighborhoods and communities. We have learned much through this process of community engagement and through the presentations made by people with direct experience and expertise.

For the past year and a half, Capital Area Human Services (CAHS) has taken the leadership role addressing the local impact of the opioid abuse epidemic through the Capital Region Behavioral Health Collaborative. The Collaborative has 14 years of experience, responding to community behavioral health and developmental disabilities needs through the linkage and education of provider organizations. During that time, the Collaborative has coalesced a regional response to multiple emergencies including Hurricanes Katrina, Rita, Isaac, Gustav and others, a deficit of mental health services in the East Baton Rouge Parish Prison, the need for training law enforcement in Crisis Intervention Team approaches, and the Great Flood and the shootings and civil unrest of 2016.

In its review of the opioid crisis, the Collaborative conducted monthly meetings that began in February 2017. The goals were multiple and designed to:

- educate the public and provider community about opioid abuse prevention,
- examine the risks for misuse, including special populations,
- understand the process of addiction,
- create increased access to evidence based care and harm reduction, and
- learn the best practices for recovery approaches.

These goals were met through the Collaborative meetings via presentations from local, state, and federal experts in law enforcement and other fields that included pharmacists, pain management specialists, addictionologists, medical experts in neonatology and obstetrics, community-based addiction recovery specialists, hospital-based and emergency medicine physicians, local harm reduction organizations involved in overdose reversal, emergency medical technicians, individuals with current heroin use, and family members of addicted loved ones who misuse opioids or who have died. The local media provided coverage for almost all of the presentations.

The Collaborative heard presentations that centered on nine topic areas needing to be addressed for a robust response, and those areas form the nine chapters of this plan. The "Community-wide Response Plan to the Opioid Epidemic" was developed, based on the expert presentations provided at the Collaborative meetings, a thorough literature review of national initiatives and input from individuals representing over 130 organizations who participated in the meetings and offered recommendations for local responses.

It is my hope that this plan will be used broadly by local entities who will match their mission to the recommendations contained in this plan.

Jan Kasofsky, PhD
Executive Director
Capital Area Human Services

Through this plan, we envision sectors to be mobilized to implement informal and formal linkages that can be institutionalized. While we felt it informative to present recommendations within the context of specific sectors, it became clear that the sectors must link to each other. This linkage is necessary for treatment providers to learn about the role of other specialists/providers to make necessary handoffs of patients so they access the continuum of care at appropriate times. Furthermore, and straight to the point, individuals who are caught in the web of opioid abuse and addiction, need to be supported and able to navigate the community-based network of treatment and recovery service providers.

Linking sectors requires a knowledge of, and value for, each other. Hospital-based providers must learn about the behavioral health continuum in the community, and that includes the recovery community; they need to develop referral relationships with the behavioral health community and use opportunities to encourage addicted individuals into choosing a life of recovery through motivational interviewing and cognitive behavioral therapy approaches. It is the time an individual experiences severe negative implications from their use, such as an arrest, incarceration, or a near-life ending situation that brings them into a hospital or inside of an ambulance, that these approaches are most apt to be heard. Employing and valuing the experience of peers, who have travelled the same harsh and tiring life, and can assist individuals to enter into, and maintain recovery, is a highly recommended resource in this fight.

Addiction is not a one-time event in a person's life; it is a chronic illness that must be managed by that individual for a lifetime.

One cannot minimize the long term negative effects on physical and mental health caused by an addiction, nor should one ever ignore the impact of the addiction on the entire family. Recovery is a very complicated life process that transcends whether or not a person relapses; overcoming legal and/or financial hurdles, while hard enough, doesn't start to address the negative impacts addiction has on familial and social relationships that may not be recoverable.

It is my strong belief that many who make it into recovery will need ongoing support via sponsors and intensive mental health support. We must address emotional and social isolation and feelings of rejection and guilt to make recovery desirable and possible. I fear that without this support, an individual will be at a greater risk for relapsing, overdosing, or an intentional suicide.

Family members of an individual who are dealing with addiction have long term emotional and sometimes serious financial difficulties caused by their loved one's addiction. These difficulties are real and must be addressed. Clearly, the opioid epidemic in the United States and our region will require vigilance across all sectors and among our community members and families for years to come.

It is my hope that this plan will be used broadly by local entities who will match their mission to the recommendations contained in this plan. This document can and should be used to document how a community can, and has, come together, with an identified lead, to make change. It should also be used by local entities to document resource needs to public and private, state and national funders.

I would like to acknowledge and thank Mayor President Sharon Weston Broome of East Baton Rouge Parish who recognized the importance of the work of these meetings and called upon CAHS and the Collaborative to develop a response plan to address the epidemic.

I also want to recognize all of the presenters and agencies, listed in the Acknowledgements that participated in the Capital Region Behavioral Health Collaborative during this planning process. It is with special gratitude that I acknowledge the Capital Area Human Services executive team members, Janzlean Laughinghouse, PhD, LCSW, Clinical Director of Addiction Recovery Services, and Vivian Gettys, RN, MPH, Prevention Division Director, for their leadership and skillful writing to formulate this plan, and for Rusty Jabour and Angela deGravelles for helping to establish the process and format for this plan. I offer an honorable mention for all of the detailed work provided by Karen Bray, Executive Staff Officer, that included meeting planning and organization and proofreading several versions of this plan.



Jan Kasofsky, PhD
Executive Director
Capital Area Human Services

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* denotes multiple presentations

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CAPITAL REGION BEHAVIORAL HEALTH COLLABORATIVE PARTICIPANT ENTITIES (MARCH 17, 2017 – JULY 19, 2018)

We extend a special thank you to all of the entities participating in the sessions and we apologize if your group has inadvertently been missed.

Acadia Health Care	Nurse Family Partnership
Acadiana Addiction Center	Prevention Program
Addiction Campuses	School Based Therapy Program
Addiction Counseling & Educational Resources, LLC	Capital Area Human Services District Board of Directors
Advocacy Center	Capital Area Reentry Coalition
Aetna	Capital Area Reentry Program
Alkermes	Capital Area United Way
American Addiction Centers	Cataldie Clinic
AmeriHealth Caritas-LA	Catholic Charities
ARCH Connections	Community Members
Ascension Counseling Center	Councilwoman Barbara Freiberg, East Baton Rouge Metropolitan Council
Ascension Parish Public Schools	Councilwoman Donna Collins Lewis, East Baton Rouge Parish Metropolitan Council
Ascension Parish School Board	Councilwoman Tara Wicker's Office, East Baton Rouge Parish Metropolitan Council
Baton Rouge Area Foundation	Covington Behavioral Health
Baton Rouge Business Report	Covington Police Department
Baton Rouge Clinic	Crisis Intervention Center
Baton Rouge Community & Technical College	CVS Minute Clinic
Baton Rouge Community College	deGravelles & Associates
Baton Rouge Comprehensive Treatment Center	Detox Center of Louisiana
Baton Rouge Detox	DIG Magazine
Baton Rouge District Nurses Association	Diversified Professionals, Inc.
Baton Rouge Fire Department	Drug Enforcement Administration Baton Rouge District Office, U.S. Department of Justice
Baton Rouge General	East Baton Rouge Emergency Medical Services
Baton Rouge Health District	East Baton Rouge Parish Mayor's Office
Baton Rouge Oxford Houses	East Baton Rouge Office of Public Defender
Baton Rouge Police Department	East Baton Rouge Parish Coroner's Office
Baton Rouge Primary Care Collaborative	East Baton Rouge Parish District Attorney Office
Baton Rouge Sickle Cell	East Baton Rouge Parish Juvenile Court
Baton Rouge Treatment Center	East Baton Rouge Parish Library
Big Buddy Program	Emergent Method
Blue Cross Blue Shield of Louisiana	EXCELth, Inc.
Blue Cross Blue Shield of Louisiana Foundation	Facing Addiction
Brentwood Hospital	Families Helping Families of Greater Baton Rouge
Bridge Center for Hope	Franciscan Missionaries of Our Lady University
Capital Area Human Services:	Governor John Bel Edwards' Office
Addiction Recovery Services	Gulf Coast Social Services
Capital Area Recovery Program	Healing Minds NOLA
Center for Adult Behavioral Health	Healthy Blue
Center for Gambling Treatment	
Children's Behavioral Health Services	
Developmental Disabilities Services	
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Iberville Parish Coroner
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Jefferson Parish Human Services Authority
KEPRO-QIO
Lael Christian Fellowship Church
Lane Regional Medical Center
Lifeline Behavioral Health
Lifeworks Psychiatry & Recovery
Louisiana Association of Substance Abuse
Counselors
Louisiana Commission on Law Enforcement
Louisiana Department of Child & Family Services
Louisiana Department of Corrections
Louisiana Department of Health
Louisiana Department of Health - Bureau of
Primary Care & Rural Health
Louisiana Department of Health - Medicaid
Louisiana Department of Health - Office of
Behavioral Health
Louisiana Department of Health - Office of Public
Health
Louisiana Department of Justice
Louisiana Department of Justice - Attorney
General
Louisiana Health & Rehab Center
Louisiana Health Care Quality Forum
Louisiana Healthcare Connections
Louisiana Public Health Institute
Louisiana Screening Brief Intervention and
Referral to Treatment (LA-SBIRT)
Louisiana State Board of Nursing
Louisiana State Nurses Association
Louisiana State Police Crime Lab
Louisiana State University LaHEC
Louisiana State University-Our Lady of the Lake
Psychiatry
Louisiana State University School of Social Work
Louisiana Workforce Commission-Louisiana
Rehabilitation Services
Mental Health America of Louisiana
Metro Health
Mirror of Grace
National Alliance on Mental Illness Baton Rouge
New Orleans Harm Reduction Network
New Orleans Health Department
No Overdose Baton Rouge
O'Brien House
Oceans IOP
Ochsner Medical Center
One Soul Delivered
Open Health Care Clinic
Orexo Pharmaceutical
Our Lady of the Lake Health Centers in Schools
Our Lady of the Lake Regional Medical Center
Parents of Addicted Love Ones
PediaTrust
Pocahontas House
Pointe Coupee General Hospital
Reality House
Resilient Baton Rouge
River Parishes Community College
River Place Behavioral Health Hospital
RKM Primary Care
Salvation Army
Southeast Community Health System
Southeastern Doctor of Nursing Practice
Southeastern Louisiana University Students
Southern University BRCC Practicum Student
St. Christopher's Addiction Wellness Center
The Advocate News Department
The Journey Home
The Rapides Foundation
The Serenity Center of Louisiana
Together Baton Rouge
United Health Care
UPLIFTD
Veteran's Administration
VIA LINK
Volunteers of America Greater Baton Rouge
WAFB 9 News
WBRZ 2 News
Woman's Community Rehabilitation Center
Woman's Hospital
WVLA 33 News

CHAPTER 1 - UNDERSTANDING ADDICTION AND REDUCING STIGMA

FACTS

- In 2018, the National Institute on Drug Abuse estimated that substance abuse cost the U.S. \$600 billion annually; however, every dollar invested in substance abuse treatment yields healthcare and criminal justice savings that exceed treatment costs in a ratio of twelve to one.
- Individuals who do not seek treatment show up in other systems such as child welfare, criminal justice, emergency rooms and primary health care clinics.
- Stigma against harm reduction interventions and limited access to medication-assisted treatment is particularly dangerous due to the likelihood of fatal overdose among opioid users.

OVERVIEW

Stigma—negative attitudes and perceptions about people with substance use disorders—is pervasive in society, even among treatment providers and health professionals. Stigmatizing both the persons and the disorders leads to prejudicial attitudes and discrimination. This marginalization comes at a high cost to society and individuals. When compared to individuals with other less stigmatized illnesses, individuals with substance use disorders are less likely to acknowledge their illness and less likely to seek treatment because of the fear of rejection and being judged. Those seeking treatment for substance use disorders often encounter treatment providers and health professionals who lack a willingness to assess or treat the disorders, express attitudes that are dismissive and disdainful, and endorse treatment approaches that lack evidence of effectiveness, while being non-supportive of harm reduction and Medication-Assisted Treatment (MAT) interventions.

Public awareness and public education are vitally needed. Understanding addiction as a chronic disease will aid in the paradigm shift from viewing addiction as a moral failing to addressing the issue with urgency and compassion, according to former Surgeon General Vivek Murthy, M.D., in “Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health”. Similarly, Facing Addiction, a national non-profit organization, has adopted an advocacy action agenda that includes humanizing people with addictions, reforming public safety responses, and mainstreaming addiction services.

In addition to raising awareness, through education about the disease and the people who live with it, addressing stigmatizing language related to substance use, misuse, and substance use disorders is an integral part in engendering empathy for the millions of individuals affected by and impacted by the disease of addiction. One of the most serious issues caused by a wide-spread, negative view of people with substance misuse, abuse, or addiction, is the uneven approach to funding treatment by many insurers. This has led to the limited number of qualified providers and a limited number of evidence based treatment approaches. In fact, Louisiana statutes on parity received an “F” from several nationally-respected health equity research entities.

“Understanding addiction as a chronic disease will aid in the paradigm shift from viewing addiction as a moral failing to addressing the issue with urgency and compassion.”

Vivek Murthy, MD
Former Surgeon General

UNDERSTANDING ADDICTION AND REDUCING STIGMA

Recommendations	Action Items
I. Education (Public)	
A. Promote education to describe addiction as a long-term, chronic brain disease that is treatable and can be managed using evidence based treatment approaches.	<ol style="list-style-type: none"> 1. Utilize the following as points of information dissemination/meeting venues such as: the public library, the Mental Health Association, H.O.P.E. Council (Advisory Council on Heroin and Opioid Prevention and Education) website, and the Office of Behavioral Health website. 2. Highlight “Voices of Recovery” (stories of people in recovery). 3. Incorporate anti-stigma campaign into other scheduled events that are arts/music-oriented (musicians and artists as advocates). 4. Incorporate anti-stigma message into Recovery Month (September) activities. 5. Utilize service providers to disseminate information. 6. Develop an anti-stigma media campaign.
B. Provide information to the public and technical assistance to providers through the Capital Region Behavioral Health Collaborative.	<ol style="list-style-type: none"> 1. Provide Continuing Education Units (CEUs) to encourage participation in educational workshops on opioid use/misuse. 2. Create an electronic clearinghouse of resources and information that is readily accessible and up-to-date.
C. Provide education about diversion of drugs among family and friends and promote appropriate disposal of unused prescription opioids.	<ol style="list-style-type: none"> 1. Promote medication “Take Back” days and provide secure drop boxes for safe disposal and promote awareness of Food and Drug Administration (FDA) guidelines for safely discarding unused medications.
D. Raise public awareness regarding risk factors associated with genetics, environment, behaviors, co-morbid mental and physical health conditions, and protective factors that decrease the likelihood of developing a substance use disorder.	<ol style="list-style-type: none"> 1. Public awareness campaigns could be promoted by a diverse group of stakeholders within their own areas of practice and expertise (e.g. behavioral health providers, medical professionals, educators, prevention specialists, etc.).
E. Explain the urgency of addressing the opioid crisis based on the scope of the problem and the high mortality rate due to the rise of fentanyl and fentanyl analogues.	<ol style="list-style-type: none"> 1. Raise awareness of the opioid epidemic through public forums, other community-wide events, and through traditional and social media platforms.
F. Educate the public, health care professionals, and treatment providers about the correlation between Adverse Childhood Experiences (ACEs) and developing substance use disorders.	<ol style="list-style-type: none"> 1. Education on this topic can be provided at workshops and trainings where providers and professionals go for continuing education credits. The general public can be informed through schools, local service providers, and other community stakeholders.
II. Provider Training	
A. Provide education to health care professionals and treatment providers on the impact of stigma.	<ol style="list-style-type: none"> 1. Include stigma as a topic of discussion in required training for continuing education in various disciplines.

UNDERSTANDING ADDICTION AND REDUCING STIGMA

Recommendations	Action Items
B. Investigate evidence based approaches to reducing stigma toward substance abusers and incorporate them into training for health care professionals and treatment providers.	1. Ensure that training includes practical processes and procedures that health care providers can implement as strategies to reduce stigma in the treatment of individuals with opioid and other substance use disorders.
III. Policy/Advocacy	
A. Ensure that substance use disorders have parity with other health conditions for the purpose of health care coverage.	1. Recommend that the Louisiana Department of Insurance and the Louisiana Department of Health, Health Standards, implement full parity based on the federal law of 2008. Present lawmakers with empirical evidence of substance use disorder as a disease that requires a public health response.
B. Promote the widespread use of Evidence Based Practices (EBP) and programs for the treatment of opioid disorders, including harm reduction strategies and Medication-Assisted Treatment (MAT).	1. Educate service providers about empirical data that supports Medication-Assisted Treatment (MAT) and harm reduction, other evidence based treatment, for opioid use disorders and ensure evidence based programs are funded.
C. Increase the diversion of non-violent individuals, with low-level drug offenses, to treatment services rather than incarcerating them.	1. Institute more drug courts and continue to solicit law enforcement and criminal justice systems as partners in treatment and recovery.
D. Promote re-entry efforts by providing offenders with pre-release substance abuse treatment services and post-release peer support and continuing care.	1. These strategies could be developed in conjunction with other efforts implemented through the Criminal Justice Reinvestment Act of 2017.
E. Work to establish a legal framework and state-wide protections for the development of a comprehensive syringe access program with a range of harm reduction services, including syringe disposal, fentanyl testing, HIV testing, etc.	1. Research working international and national models that can be replicated in Louisiana and ensure they are provided safely and within the existing new laws.
F. Improve access to behavioral health services to vulnerable populations including individuals experiencing homelessness, veterans, women, youth, offenders, individuals with disabilities, and the elderly.	1. Direct outreach activities, in various settings, toward individuals who do not access services (e.g. outreach efforts on par with the Capital Area Re-Entry Program).
G. Advocate for the increased use of peer support specialists to improve self-management skills and address internalized stigma among substances users.	1. Recommend Medicaid and commercial insurance for reimbursement of peer support as a vital recovery support service.
H. Promote universal screening for substance use in health care settings.	1. Educate medical providers on the benefits of universal screening, such as increased access to services, greater identification of people who would not typically access treatment, and integrated care for their clientele.

CHAPTER 2 - PREVENTION SERVICES

FACTS

- In 2016, one Louisiana resident died every 29 hours from an opioid related overdose.
- In 2016, 1 in 5 high school seniors in the region did not perceive a risk of using prescription drugs not prescribed to them.
- Among people who misuse prescription pain relievers, more than 50% get them from friends and relatives.
- 1 in 4 people who receive prescription opioids long term in primary care settings struggle with addiction.

OVERVIEW

Utilizing prevention strategies that reduce risk factors and promote protections in various populations will prevent negative consequences associated with opioid abuse and addiction.

The role of prevention in the continuum of care related to the opioid epidemic is focused on reducing risk factors and promoting protective factors in various populations that will prevent negative consequences associated with opioid abuse and addiction. A variety of interventions are utilized to address identified needs of targeted populations that are categorized as universal, selective and indicated prevention strategies. Universal prevention strategies focus on the general population (those who have not been identified as showing signs of opioid misuse problems) by changing knowledge and attitudes that influence behavior. Media campaigns have been used to disseminate information to the community related to the opioid epidemic through mass media such as billboards, social media, TV and radio appearances and announcements, and video public service announcements. Educational programs using evidence based curriculums, town hall meetings, continuing education training, etc. have included topics such as risks of opioids, best practices for prescribing opioids, alternatives to opioids for pain management, and proper medication storage and disposal.

Selective prevention strategies use interventions that focus on individuals or sub-groups of a population who are at risk of developing opioid use disorders. Prevention strategies targeting women, pregnant women, incarcerated individuals, the homeless population, veterans and the LGTBQ population are important in order to optimally reach these sub-groups at risk for opioid misuse. Outreach to specific at-risk populations for educational programs is a strategy that is beneficial. Development and distribution of educational materials in the form of fact sheets, posters, and brochures and use of social media can be easily targeted to specific populations. Training presentations on topics such as, women and opioids, maternal opioid abuse and neonatal abstinence syndrome, and opioid addiction among veterans and incarcerated individuals have raised awareness about the unique needs of these populations.

Indicated prevention interventions focus on individuals at high risk who have signs or symptoms of opioid use problems (prior to diagnosis of a disorder). Screening and intervention for substance use including opioids, known as Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence based approach that has been used by community agencies to identify individuals with signs of opioid abuse in need of referral for

further evaluation. A major training initiative in the State, LA-SBIRT, implemented by the LSU School of Social Work, has trained over 1,500 social work students and health professionals on SBIRT. Additional educational programs have been implemented that include topics such as neurobiology of addiction, recognizing signs of opioid abuse, screening and intervention methods, opioid addiction treatment, overdose reversal using naloxone, and resources for referral to treatment/support services.

Knowledge of risk factors and perception of harm along with protective factors influence whether individuals engage in risky behaviors such as opioid misuse. Education strategies to address the opioid crisis are primarily used to raise awareness and build support for prevention efforts. They can also increase knowledge about ways to prevent opioid misuse and overdose.

Regional efforts to address the prevention of opioid misuse/abuse include activities in schools, colleges, hospitals, first responder agencies, service providers and community-based coalitions. Coordination with statewide opioid targeted response projects, regional opioid prevention projects, and national campaigns such as “Drug Take Back” are ongoing. Education on best practices in order to increase knowledge and skills is a major goal of activities that have been initiated in the community utilizing prevention strategies.

PREVENTION SERVICES

Recommendations	Action Items
I. Public Awareness/Education	
A. Increase awareness, knowledge and skills about risks of opioid misuse/abuse (including overdose) and resources available.	<ol style="list-style-type: none"> 1. Implement opioid educational programs/media campaigns for adults, parents and senior citizens. 2. Collaborate with the Mental Health Association of Greater Baton Rouge initiative to implement a media campaign to address the opioid crisis. 3. Promote medication safety education (appropriate use, secure storage, and disposal). 4. Provide education on non-opioid pain management alternatives. 5. Promote emotional wellness and healthy living. 6. Develop a comprehensive resource directory of current initiatives, resources and best practice models and guidelines.
B. Target population: youth, women and girls, adults, parents, senior citizens	<ol style="list-style-type: none"> 1. Implement opioid educational programs/media campaigns for students in schools (including athletes) or through community groups. 2. Determine prevalent risk factors among students (e.g. depression) for targeted prevention strategies.
C. Special population: LGBTQ, Veterans, Incarcerated individuals, homeless persons	<ol style="list-style-type: none"> 1. Implement opioid educational programs/media campaigns for special populations.
II. Training	
A. Increase use of evidence based practices to identify persons at risk for opioid addiction and intervene with resources and support.	<ol style="list-style-type: none"> 1. Provide training and technical assistance targeted to healthcare providers and teachers. Consider a variety of teaching modalities to include webinars and in-person training that can easily accommodate needs (e.g. staff development days, teacher work days, etc.). 2. Provide technical assistance to providers interested in utilizing the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach. 3. Develop a comprehensive resource directory of current initiatives, resources and best practice models and guidelines.
III. Policy	
A. Ensure the problem is adequately understood by lawmakers for informed policy and funding needs.	<ol style="list-style-type: none"> 1. Inform policy makers about best practices in opioid use disorder prevention, treatment and funding needs.

CHAPTER 3 - LAW ENFORCEMENT, CRIMINAL JUSTICE REFORM AND CORRECTIONS

FACTS

- The opioid crisis is an escalating major issue facing law enforcement and correctional facilities.
- Data gathering, compilation, dissemination and communication by law enforcement with public health officials, emergency medical personnel and the judicial system is in its infancy and lack of data is hindering enforcement and a united response.
- Opioid distribution, laced with the deadly fentanyl, is escalating in the greater Baton Rouge region, causing major increases in opioid-related overdoses and deaths.
- All first responders must be equipped with naloxone to administer direct assistance on emergency calls and for their own safety.

OVERVIEW

“We’ve never seen anything like this before ... never anything so deadly.”

Brad Byerley, Assistant Special Agent in Charge, DEA Baton Rouge District Office, US Department of Justice

Law enforcement, the judiciary and the correctional system have each been heavily impacted by large numbers of individuals with an Opioid Use Disorder (OUD). While it is easy to understand how the opioid epidemic has driven up crimes such as illicit drug trafficking and distribution, thefts and prostitution, it’s important to note that officers are now facing a new role typically served by public health and social services professionals; addressing the societal impact on families, acting as a conduit for treatment, and administering life-saving naloxone to people who have overdosed. Law enforcement officers also face a risk of exposure to these powerful drugs through dermal or inhalation exposure.

Law enforcement officers have had to reassess their own stance on the treatment of the OUD or addicted individuals. Many departments now carry naloxone, the overdose reversal drug to save lives, which at times include the officers themselves, who come into contact with these substances through the efforts of their job. Across the country too, officers who once had strong feelings about the need to incarcerate these individuals for minor, non-violent crimes are learning about, and believing in, Medication-Assisted Treatment (MAT) and jail diversion programs to save lives and to provide real help to these individuals. Even within the correctional system, several municipalities are providing detoxification and real treatment in the jail, especially due to the limited number of available treatment programs in the community and given the large number of addicted individuals already in jail. Corrections officials understand that releasing an individual with an OUD back into the community without linking them to treatment and recovery supports, typically leads to re-incarceration, or death.

During this time of increasingly tight parish and state funding, there is enormous pressure on all publically funded departments, and this is especially true for small, rural law enforcement departments. Small towns are targeted by traffickers, and in some cases gangs, that are well aware that the enforcement budgets and staff are limited and therefore present little resistance to the trafficker’s distribution model. Limited law enforcement funding also impedes responses that involve pursuing drug traffickers far out of their community.

Interdiction of opioids is made even more complicated due to the use of the dark web on the internet where packages containing opioids can be delivered to homes, avoiding traditional drug smuggling and trafficking, and being purchased with virtual currencies. It is crucial that more officers be deputized to reduce the trafficking of these dangerous substances.

It is both a blessing and a curse that 54% of people who abused a painkiller in the last year got it from a friend or relative. This “sharing” of unused prescription drugs must be taken extremely seriously and these pills should be stored in a lock box by the person they were prescribed for, disposed of during law enforcement-led drug take back days, or dropped off at police stations, or other authorized secure collection sites. Setting these practices in place can be extremely supportive of decreasing the number of people at risk for addiction or overdose. It must be recognized that as prescription and diverted prescription drugs are harder to access for OUD individuals and addicts, street opioids, such as heroin, are typically the next step, as they are cheaper and easier to get; therefore, so this epidemic must include secondary prevention and proven treatment strategies.

Crime laboratories are continuously having to identify new substances and synthetic opioids. When new drugs are found to be in use on the streets and in communities, crime laboratories can immediately test them and inform the state’s Poison Control Center and the Department of Health to start the process of tracking and banning the drugs. It must be recognized that the only way to attack the threat to public safety and public health is through a combination of enforcement, regulatory, treatment and educational efforts.

LAW ENFORCEMENT, CRIMINAL JUSTICE REFORM AND CORRECTIONS

Recommendations	Action Items
I. Legal	
A. Longer jail time for distribution.	1. Work with legislators and judges to decrease the ease of selling in Louisiana.
B. Clarify laws so officers understand use of discretion to best serve individuals and the public.	<ol style="list-style-type: none"> 1. Protect participants and organizations/personnel engaged in legal safe needle exchange programs by ensuring officers fully understand existing laws. 2. Decriminalize the use of illicit substances; treat as a medical issue and mandate treatment when appropriate.
C. Address the public safety issue of impaired drivers.	1. Establish a public media campaign to warn the public of impaired driving (as done with alcohol), and ensure people who break the law are mandated into treatment when appropriate.
D. Ensure that State Police Lab can rapidly identify substances being used/abused for public safety and law development.	<ol style="list-style-type: none"> 1. Increase funding for law enforcement agencies and testing laboratories to enable illicit substances to be identified rapidly and monitored. 2. Ensure augmented funding to law enforcement officers and compliancy staff for expansion.
II. Opioid Diversion Prevention	
A. National Take-back Day, add more events during the year.	1. Ensure widespread participation in national and local takeback days, and additional permanent sites. Widespread messaging campaign needed. Connect message of the danger of diversion of appropriately prescribed medications and promote use of lock boxes for all medically needed opioids in households.
B. Ongoing public service messages to get unneeded/unsecured medications out of homes, with accessible and secured drop box availability.	
C. Expand funding for a larger deputized workforce and regulatory personnel in crime labs.	1. Recruit more law enforcement officers and compliancy staff for expansion.
III. Education	
A. Address officer and perpetrator safety related to exposure.	<ol style="list-style-type: none"> 1. Provide ongoing training on safe response to exposure and reversal of impact of new street drugs. 2. Provide personal protective equipment for officers to maintain health and safety. 3. Provide training on naloxone and other medications to protect health upon exposure.
B. Impart an understanding to law enforcement officers that Medication-Assisted Treatment (MAT) is the only safe treatment for opioid addiction. Harm reduction strategies save lives.	1. Provide training to law enforcement officers to appreciate the value and positive results of treatment. Train to decrease stigma. (Only about 15% of people with opioid use disorders are able to avoid relapse without Medication-Assisted Treatment (MAT).

LAW ENFORCEMENT, CRIMINAL JUSTICE REFORM AND CORRECTIONS

Recommendations	Action Items
IV. Jail Diversion/Jail Treatment/Re-entry Programs	
A. Utilize police, fire, other first responder stations and interactions as portals to access care.	<ol style="list-style-type: none"> 1. Ensure law enforcement officers/District Attorneys are versed in the facts of addiction and can offer assistance to treatment facilities through training/materials. 2. Model a Safe Station (Firefighters in Manchester, NH; Police Dept., Gloucester, MA) where people with opioid use disorders who want help are medically cleared and connected with recovery coaches that take them to treatment centers. Implement locally, the HOPE Program from St. Tammany Parish where first responders are seen as a support, not a hindrance, to treatment. 3. Fund peers as recovery coaches.
B. Establish alternatives to incarceration.	<ol style="list-style-type: none"> 1. Establish specialized Voluntary Treatment Centers and therapeutic Communities with Recovery Regime, Re-entry Program, and Vivitrol injection upon release and within jails (Kenton County, Kentucky). 2. Establish mandated treatment options.
C. Establish in-jail detox, tapering, treatment resources with local Sheriffs and with Louisiana Department of Corrections.	<ol style="list-style-type: none"> 1. Obtain sustainable funding for Capital Area Human Services jail-based program through the Comprehensive Opioid Abuse Site-Based Program (COAP Grant), work toward expanding it beyond the East Baton Rouge Parish Prison with funding in other parishes. 2. Add Vivitrol and Suboxone (buprenorphine) pre-release.
D. Establish linkage to treatment and referral processes for re-entry and offer Vivitrol and Suboxone (buprenorphine) prior to release.	<ol style="list-style-type: none"> 1. Engage and retain offenders upon re-entry to treatment and recovery services (Capital Area Human Services Peers into local jails to educate inmates on treatment options and access). 2. Dispense Vivitrol on release and connect to treatment, including parish jails and Louisiana Department of Corrections Re-entry staff (COAP Grant). 3. Enhance collaboration with treatment providers and police officers. 4. Review additional programs such as SHOUT from California.

CHAPTER 4: PRESCRIBING PRACTICES

FACTS

- In 2016, Louisiana had the fifth highest opioid prescription-per-capita rate in the U.S. at 110 per 100 residents, according to the Centers for Disease Control and Prevention.
- In the recent past, the medical profession was misinformed by the pharmaceutical companies regarding the benefit and addictiveness of opioids. Some unethical physicians and some unwitting physicians were used by patients for illegal trafficking of opioids.
- The adoption of pain as the fifth vital sign is seen as a factor in the overprescribing of opioids. A desire to attain positive patient ratings on the satisfaction surveys for insurance companies/payors has contributed to overprescribing.
- Because women are more likely to seek medical care and express their pain, the likelihood of women being prescribed opioids is significantly higher; the age group receiving the most prescriptions is 55 years old and older.
- In 2017, new laws were enacted by the Louisiana Legislature:
 - Act 76, to prevent “prescription shopping” with strengthened Prescription Monitoring Program, a database for doctors and pharmacists and a mandate for annual training on drug diversion, best practice prescribing of controlled substances and appropriate treatment for addiction;
 - Act 88 created a 13-member Advisory Council on Heroin and Opioid Prevention and Education (HOPE) to develop policy recommendations to combat opioid abuse;
 - Act 82 limited the first-time prescriptions of opioids to seven-day supplies. The law allows physicians to override the limit for patients with cancer, palliative or chronic pain conditions.

Physicians were told opioids were NOT addictive and so prescriptions and refills were provided without that concern. As it turns out, these powerful drugs are extremely addictive; even in as few as three to four days.

OVERVIEW

Louisiana is one of only eight states that has more opioid prescriptions than it has residents. According to the Centers for Disease Control and Prevention, in 2016, Louisiana had the fifth highest opioid prescription-per-capita rate in the U.S. at 110 per 100 residents.

There are many reasons for this high prescription rate. More than a decade ago, national news identified a high number of what were termed “pill mills” in the Greater New Orleans metropolitan area. It was found that physicians were being paid to legally write questionable prescriptions. These businesses supplied pills that were sold and used by many who were, or became, addicted. The statewide Prescription Monitoring Program, an electronic database whereby pharmacists could identify physicians with atypical prescribing practices and physicians could identify patients who were “doctor shopping”, was strictly voluntary at this time. Easy access and limited monitoring and regulation of these prescriptions paved the way to our present abuse of opioids.

Many patients are provided valid and justifiable prescriptions from reputable physicians to manage acute pain due to injury or surgery, due to chronic pain as seen with people with back injuries, to treat depression or Post-Traumatic Stress Disorder (PTSD), and many more are given these prescriptions as a sleep aid. Louisiana has a large number of individuals employed in agricultural and industrial jobs that are known to have high rates of injury and therefore possibly more in need of chronic pain management. This class of medications was seen as a panacea for all types of pain and for a variety of needs, even though they actually weren't always appropriate or effective for many of the patients who received them; physicians were led to believe they were safe and non-addicting.

In the past, prescribers were so concerned that people would become addicted to pain medication that many patients were under treated or didn't receive pain treatment at all. However, to correct this, the identification of pain as a fifth vital sign contributed to the widespread use and over prescription of opioids. Again, understanding that prescribers were told/made to believe, that the opioids were not addictive.

Happening at the same time within the medical establishment was the advent of patient satisfaction surveys. These surveys were collected by payers/insurers and made available on the internet. It is easy to understand now, that physicians were hesitant to discontinue medicines that their patients not only believed in, but felt they "needed". After receiving these highly addictive medications, it is also easy to understand that patients did not want their prescriptions to end. This placed physicians into a bind when they chose to discontinue these prescriptions, and it had ramifications on their practice rating and sometimes even led to security concerns.

Physicians were told opioids were NOT addictive and so prescriptions and refills were provided without that concern. As it turns out, these powerful drugs are extremely addictive; even in as few as three to four days.

Certainly, the medical profession played a role in the easy access of these very addictive drugs. They were misinformed by the pharmaceutical companies regarding their benefits and addictiveness. Some unethical physicians and some unwitting physicians were used by patients for illegal trafficking of these pills. There was a lack of oversight as to the extent physicians provided opioid prescriptions and there was pressure to address pain as the "fifth vital sign" as well as a desire to obtain positive ratings on the satisfaction surveys. All of these factors contributed to a less rigorous determination of the true need for a given prescription on top of the reality that physicians are not rigorously trained or offered a specialization in the proper treatment of pain.

PRESCRIBING PRACTICES

Recommendations	Action Steps
I. Laws	
A. Decrease the number of pills prescribed for the first opiate prescription from 7 days to 3-5 days.	<ol style="list-style-type: none"> 1. Determine support by local physicians and prescriber organizations and approach the Louisiana Legislature with an amendment to the current law. 2. If prescriber organizations support this, bring the amendment to legislators for consideration in the regular legislative session 2019.
B. Set a date limit on all short-acting opioid pain prescriptions at 7 days to be filled, down from the current 6 months.	<ol style="list-style-type: none"> 1. See A.1 & A.2.
C. Ensure anonymous reporting laws about prescriber abuses are confidential, easy to implement and do not impact a prescriber until an abuse is proven.	<ol style="list-style-type: none"> 1. Form a subcommittee of prescriber organizations to review existing law/process for ease in reporting and protection of the prescriber during investigation.
II. Prescriber Training and Education	
A. Expand prescriber training on pain management including the pharmacology of opioids and their addictive nature and the proper uses of Nonsteroidal Anti-inflammatory Drugs (NSAIDs) and non-pharmacologic therapies such as physical therapies and meditation.	<ol style="list-style-type: none"> 1. Coordinate with the deans of medical and allied health schools to ensure adequacy of training in pain management while in school and review the continuing medical education requirements added into law in 2017.
B. Expand prescriber training in the value and importance of behavioral health treatment and integrated care.	<ol style="list-style-type: none"> 1. Contact deans of the medical and allied health schools with a volunteer expert to make presentations on local drug treatment services to be included as a rotation during clinical training while in medical school. 2. Continue to push for payors to reimburse for behavioral health in primary care settings.
C. Create a consortium of specialists and a referral network for Obstetricians working with patients who abuse drugs; connect patients to a behavioral health professional.	<ol style="list-style-type: none"> 1. Woman's Hospital to provide comprehensive care coordinator for pregnant patients with opioid use disorders from time of referral until six weeks postpartum with a warm handoff to the appropriate treatment provider(s). 2. Capital Area Human Services (CAHS) to expand their annual update of local providers within their online referral manual for easy referral for counseling. 3. Encourage a behavioral health specialist to be part of the medical team for high risk pregnancies.
D. Schools of nursing should provide more education on signs of abuse and depression.	<ol style="list-style-type: none"> 1. CAHS to continue to engage and promote local schools of nursing to require rotations in behavioral health settings.

PRESCRIBING PRACTICES

Recommendations	Action Steps
E. Address over prescription of opioids in nursing homes for sedation.	1. Request payors to audit prescribing practices in nursing homes and to intervene in outlying prescribers. Capital Area Human Services should contact the Louisiana Department of Health, Health Standards, and CMS over this concern.
F. Consider a specialty training or a limit on who can prescribe pain medication for pain management.	1. Support specific residency training by local hospitals in pain management to promote specialty.
G. Offer continuing education units for pharmacists/physicians and other prescribers to address personal biases toward Medication-Assisted Treatment.	1. Request local hospitals to include this topic and presentation on harm reduction in their programs.
H. Prescribers should be trained in Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) techniques and utilize these when making referrals to behavioral health providers.	1. Contact deans of medical and allied health schools to add Cognitive Behavioral Treatment (CBT) training and motivational interviewing to initiate better dialogues with patients needing behavioral health treatment referrals.
III. Prescriber Practices	
A. Hospital systems and insurers/payors should form internal and cross-institutional, stewardship review/advisory teams to set standards on prescriptions by specialty and allowing for internal oversight among professionals and administrators.	1. This has been initiated through the Baton Rouge Health District and individual local hospitals.
B. Physicians should inform patients that pharmacists can partial fill prescriptions to limit the number of pills, but can fill the balance of the prescription within 30 days of the prescription issue date.	1. Capital Area Human Services to reach out to the Pharmacy Board to identify the need for this approach and how it will best be accomplished.
C. Create local referral networks to link prescribers to behavioral health treatment providers easily.	1. Work with Louisiana Department of Health, Office of Behavioral Health, on creating/updating regional treatment provider direction and communicating its existence through prescriber associations.
D. Physicians should screen patients for a substance abuse history or a history of suicide attempts and limit a prescription to 3 days and determine need for behavioral health treatment.	<ol style="list-style-type: none"> 1. Work with the Baton Rouge Health District and individual hospitals and prescriber associations to encourage use of standardized survey tool and provide referral information. 2. Link to local Continuing Medical Education (CME) events to offer screening tool to physicians. 3. Medical and allied health professionals should utilize cognitive behavioral therapy and Motivational Interviewing (MI) techniques when making referrals to behavioral health providers.

PRESCRIBING PRACTICES

Recommendations	Action Steps
E. All emergency room patients with an overdose, or those in an office visit with an opioid addiction, should receive a dose of naloxone or a prescription; they should also be referred for ongoing treatment for abuse. When appropriate prescribe buprenorphine for 3 days with referral to a treatment facility. Participating pharmacies need to ensure access to these medications.	1. A consortium of treatment providers should include hot spots such as emergency departments, pain clinics and police departments to ensure people get needed transitional treatment and are not left on their own to access needed services.
F. Prescribers need to offer alternatives to opioids for pain.	1. Patients need to be educated about alternatives. An easy guide to alternatives should be identified and provided to local prescribers.
G. When physicians are considering opioid script termination, physicians should consider tapering doses and/or refer patients for Medication-Assisted Treatment (MAT) to avoid the use of street drugs. Need plan of action to follow through.	1. See action step III E.1
IV. Patient Education	
A. Create a public campaign through a multi-media approach for all Louisiana residents to take more responsibility for the safe use of these medications.	1. Convenient and periodic “Take Back” campaigns with identified drop sites need to be promoted. 2. Materials on safe alternatives and safe use should be developed and disseminated to local clinics, medical practices and emergency departments.
B. Educate patients on the use of pain medicines and how to process pain and emotional issues without opioids.	1. Work to integrate patient education on behavioral health.
C. Educate the public on the number of treatment centers and Substance Use Disorder (SUD) treatment options locally.	1. Establish and maintain a local website listing all providers that is promoted to the general public.
D. Patients should know to request partial medication refills at the pharmacy with an understanding that the balance can be filled within 30 days of the prescription issue.	1. See III B Action Step.
V. Payors	
A. Provide full parity to cover behavioral health needs.	1. Parity is a 2008 federal mandate but poorly implemented in Louisiana. Work with the Louisiana State Department of Insurance and the Louisiana Department of Health to understand how this negatively impacts care and cost. 2. Capital Area Human Services has ongoing trials with Blue Cross Blue Shield and should enter into more collaboration to help expand coverage and create incentives for co-location of behavioral health providers.

PRESCRIBING PRACTICES

Recommendations	Action Steps
B. Patient satisfaction survey results are known to not be a valid indicator of patient care and results are impacted by the personal desires of a patient.	1. Medicaid and local private insurers should consider the impact of the opioid epidemic and dissatisfied patients' impact on provider scores and find a more valid way to evaluate care.
C. Support Medicaid payment for methadone.	1. Encourage LA Medicaid to cover methadone outside of the sole Opioid Treatment Program (OTP).
D. Support payors to cover both prescription and therapy for Suboxone.	1. Medication-Assisted Treatment (MAT) funders must mandate psychosocial support as an Evidence Based Practice with pharmaceutical support.
E. Support a shift at the Federal level for Medicare to ease restrictions to reimburse for post-surgical non-opioid pain treatment.	1. Request Louisiana Department of Health and the Louisiana Department of Insurance to write to Centers for Medicare & Medicaid Services (CMS) in support.
F. Support payors to cover complementary and non-opioid pain treatment.	1. Meet with major insurers on their interest in these alternatives and learn their concerns. Assist in educating providers/payors of Evidence Based Programs (EBP) and assist in establishing pilots with providers and payors.

CHAPTER 5 - HARM REDUCTION: OVERDOSE REVERSAL AND SYRINGE ACCESS

FACTS

- On April 5, 2018, U.S. Surgeon General, Jerome M. Adams, M.D., MPH, issued an advisory on naloxone and opioid overdose. The advisory emphasized the importance of naloxone and urged more people to learn how to use the drug and to keep it within reach; it also contained information for patients and the public, and information for prescribers, substance use disorder treatment providers, and pharmacists.
- In January 2018, Secretary Rebekah Gee, MD, MPH, renewed Louisiana's Standing Order for the Distribution or Dispensing of Naloxone or Other Opioid Antagonists, enabling individuals, across the state, to access naloxone at any pharmacy, without a prescription.
- Of the more than 64,000 drug overdose deaths in the United States, reported by the Centers for Disease Control in 2016, more than 42,000 involved opioids.
- In 2017, more than 72,000 people in the United States—nearly 200 a day—died from drug overdoses.
- At least two-thirds of America's 2017 fatal overdoses were linked to opioids, particularly deaths related to fentanyl and fentanyl analogs (synthetic opioids).

The distribution of naloxone and clean syringes are needed steps to save lives from opioid abuse.

OVERVIEW

Harm reduction is a set of policies, programs, and practices that aim to reduce the negative health, social, and economic consequences of alcohol and other drug use. Despite the public stigma and lingering professional bias against harm reduction strategies, empirical evidence supports their effectiveness in increasing education and motivating current substance users toward treatment. The distribution of naloxone and clean syringes are needed steps to save lives from opioid abuse.

Opioid overdoses can be reversed with naloxone, a medication that works by binding to the opioid receptors in the brain and pushing out the opioids that are causing the overdose. Current naloxone service capacity in this region includes No Overdose Baton Rouge, Be Safe Program, and Capital Area Re-entry Program—organizations which all distribute naloxone and provide overdose prevention and reversal training. Additionally, the Louisiana Department of Health, Office of Behavioral Health, through the State Targeted Response to the Opioid Crisis funding, has expanded access to naloxone by providing naloxone nasal spray kits to Local Governing Entities (LGEs), such as Capital Area Human Services, and opioid treatment programs for redistribution to at-risk clients and families. The Louisiana Department of Health Bureau of Emergency Management Services distributes free auto-injectors to emergency medical service departments statewide, and the Louisiana Attorney General's Office is providing vouchers to naloxone for first responders who request them. The vouchers can be redeemed for a single dose of naloxone at identified pharmacies.

Greater awareness of naloxone and overdose reversal training are needed to combat erroneous assumptions about the use of naloxone increasing drug use.

Syringe access for current harm reduction services in this region includes: No Overdose Baton Rouge, Be Safe Program and Capital Area Re-entry Program. Syringe access and exchange/disposal are two of the common practices in the harm reduction approach.

No Overdose Baton Rouge completed a comprehensive community needs assessment and formed a User Advisory Board. Findings from the survey and feedback from the Board identified the following service deficiencies and needs regarding overdose reversal, outreach, and syringe access:

- Major expansion of syringe access and disposal capacity
- Major expansion of overdose prevention training and naloxone distribution
- Major expansion of access to Medication-Assisted Treatment (MAT) such as Suboxone® (buprenorphine)
- Anti-stigma and cultural sensitivity training for all personnel in all provider agencies

Identified barriers include legal obstacles, such as:

- Act 40, which allows local governmental authorities to approve syringe access within their jurisdictions
- No explicit protection for needle exchange participants under the Baton Rouge Municipal Code, even though the Code authorizes the programs to operate and protect the organizations, and their employees and volunteers.
- Lack of funding and stigma against non-abstinence based treatment modalities

HARM REDUCTION: OVERDOSE REVERSAL AND SYRINGE ACCESS

Recommendations	Action Items
I. Education (Public)	
A. Expand overdose prevention training	1. Engage a diverse group of community stakeholders (e.g. community providers, medical personnel, law enforcement and other first responders, Department of Public Safety, family groups, and faith-based organizations).
B. Produce a flyer for distribution with state-funded naloxone kits (including referral sources, signs and symptoms of overdose, and instructions for administering naloxone).	1. Capital Area Human Services (CAHS) produced a flyer for distribution in Region 2 and will ensure that every individual who receives a naloxone kit from CAHS receives the flier.
C. Use the media to promote information and education.	1. Use press releases, press conferences, and press coverage at community events as a means to promote education and awareness.
D. Provide training to Probation & Parole officers for distribution of and education on naloxone.	1. Present information that will aid in the paradigm shift from punishment to preservation of life and referral to treatment, with the ultimate goal of reduced recidivism.
E. Determine what pharmacies are doing to educate customers on overdose prevention and the use of naloxone for overdose reversal.	1. Consult the Louisiana Pharmacy Board to determine what initiatives are going on among state pharmacists. 2. Reach out to small, private pharmacies to encourage distribution and education on naloxone. 3. Consult the pharmacy board for list of contacts.
II. I. Treatment Practices	
A. Establish outreach activities to place/instruct on naloxone.	1. Focused outreach activities should include, but not be limited to, the following: individuals with Opioid Use Disorders (OUD) who are leaving residential treatment and detox programs, individuals with OUD immediately prior to or immediately after their release from jails and prisons, individuals residing in homeless shelters and transitional housing, and family members and friends of people with OUD.
B. Conduct targeted outreach activities for naloxone distribution “hotspots” (70802, 70805, 70806), as identified by number of emergency medical service overdose reversal data. Probation/ Parole representatives suggested 70807, 70812 and 70817 as other zip codes for targeted outreach based on levels of substance use among individual offenders living in those areas as well as local universities and community colleges.	1. Targeted outreach efforts in these areas could include informational door hangers, a list of places where naloxone is available, and community events where naloxone will be distributed.

HARM REDUCTION: OVERDOSE REVERSAL AND SYRINGE ACCESS

Recommendations	Action Items
<p>C. Increase referrals from emergency department to behavioral health treatment providers.</p>	<ol style="list-style-type: none"> 1. Train emergency department staff on the use of Cognitive Behavioral Therapy and Motivational Interviewing (MI) techniques for use when making referrals. Ensure they know of reputable treatment resources. 2. Emergency department staff to offer Vivitrol and Suboxone (buprenorphine) to assist in compliance and limit cravings/fears of withdrawal. Ensure patients are connected to a behavioral provider for ongoing care.
<p>III. Policy/Advocacy</p>	
<p>A. Develop a plan for peer support specialists to coordinate with the Community. Paramedics to follow-up with individuals who have overdosed.</p>	<ol style="list-style-type: none"> 1. Develop Memorandums of Understanding with community providers so that peers can work with community paramedics—without violating confidentiality—to provide naloxone, support and information about harm reduction methods, and access to treatment and recovery supports.
<p>B. Develop a model for distribution of naloxone in emergency departments for patients who have overdosed.</p>	<ol style="list-style-type: none"> 1. Coordinate this effort with the Baton Rouge Health District so that administrators from all the major hospitals and medical systems have input in the development of the model.
<p>C. Focus buy-in efforts directed at taxpayers and lawmakers on saving lives.</p>	<ol style="list-style-type: none"> 1. Present empirical evidence on decreased mortality rates when harm reduction measures are implemented and raise awareness of successful models in other communities (nationally and internationally) that can be replicated.
<p>D. Promote widespread availability of naloxone & syringe access and disposal.</p>	<ol style="list-style-type: none"> 1. Use distribution sites as hubs to educate and motivate current users for treatment.

CHAPTER 6 - PAIN MANAGEMENT

FACTS

- An estimated 100 million Americans live with some degree of serious or chronic pain.
- There has been a dramatic increase in deaths in the United States due to opioid overdoses that parallels the prescribing of opioids for pain management for the past 25 years.
- Opioid use and misuse affects two public health issues: how to reduce pain and how to lessen the rising abuse and overdose rates from prescription opioids and illicit opioids, like heroin.
- Exercise, physical therapy, and meditation have proven benefits in the areas of function, and coping with pain. Health care providers are now seeking new approaches for long-term pain with a combination of treatments.

OVERVIEW

In the United States between 2011 and 2015 overdose deaths due to illicit use of opioids tripled while deaths due to prescription opioids remained stable; this reflects the increasing number of people with opioid use disorder who moved to illicit forms of opiates/opioids due to constraints on access to legally prescribed medications, prescribing practices, and regulations. The goal of pain management is to use the least amount of medication possible, being aware of the risk associated with opioids, the use of appropriate medication and non-medication options, and promoting patient functioning.

The sensation of pain is very complex and encompasses more than just physiological pain; there are other comorbid factors such as emotional, psychological, sociological and interpersonal factors, as well as activity/functional demands on an individual that impact one's recognition of, and ability to tolerate pain. Addressing the needs of tens of millions of people living in the United States with an opioid use disorder requires an understanding of the available classes of pharmacologic agents available to prescribers that includes short and long acting opioids and non-narcotic medications such as nonsteroidal anti-inflammatory drugs (NSAIDs); there are several effective non-pharmacologic approaches such as Cognitive Behavioral Therapy, physical and massage therapies, meditation, acupuncture, yoga, aroma therapy and others. The push towards integrated care that co-locates behavioral health providers within physical health clinics is seen as a best practice to address better coping with physiological pain, and pain tied to emotional, or psychological issues. Integrated care or coordinated referrals to a substance abuse treatment provider can also address patient needs with existing substance abuse/dependency disorders that requires detoxification, weaning off of substances, or ongoing dosing.

Aside from prescriber knowledge of the need for and safety of using appropriate pharmacologic agents to treat pain, it is crucial that they incorporate mitigation strategies into their treatment approaches to prevent misuse of the opioids. Pain relief is often a gateway to opioid abuse, and the longer a patient is maintained on these medications,

The push towards integrated care that co-locates behavioral health providers within physical health clinics is seen as a best practice to address better coping with physiological pain, and pain tied to emotional, or psychological issues.

the risk for dependency increases. Mitigation strategies give the prescriber and the patient tools to avoid risks these medications may pose. These strategies include screening all patients for potential misuse, pain contracts for all moderate to high risk patients that includes a discharge risk tied to abuses, initial and routine urine drug screens, mental health referrals for high risk patients, and the use of weaning/detox if stopping therapy is indicated due to misuse. Reassessments and documentation should be an ongoing process of the mitigation plan.

PAIN MANAGEMENT

Recommendations	Action Items
I. Pain Management Education/ Practices	
A. All local prescribers who manage pain are trained in best practices for prescribing, and avoiding and managing addiction.	<ol style="list-style-type: none"> 1. Ensure training of local prescribers on 2017 guidelines for management of chronic, non-malignant pain, World Health Organization (WHO) Prescribing Ladder. Use best practices to screen for & avoid addiction and manage/refer treatment for addiction. 2. Follow-up training on use needed.
B. Allow methadone to be used outside of federally designated clinics.	<ol style="list-style-type: none"> 1. State level efforts to be made to solicit Centers for Medicare and Medicaid Services (CMS) to approve methadone for use to treat appropriate pain by prescribers outside of over the counter medications.
C. Physicians should consider the use of legalized medicinal cannabinoids to treat appropriate pain.	<ol style="list-style-type: none"> 1. Ensure training of local physicians on appropriate screening and prescribing/monitoring medicinal cannabinoids for pain.
D. Technical assistance/consultation	<ol style="list-style-type: none"> 1. Identify a noted local expert in pain management willing to create a consortium of prescribers to accept referrals and consult. 2. Pursue widespread use of national consultation sites.
E. Prescribers to be aware of, and provide referrals to respected alternative pain management providers.	<ol style="list-style-type: none"> 1. An updated link to local alternative pain management providers is marketed mailed/emailed to local prescribers with a description of what they provide.
F. Prescribers to be aware of, and provide referrals to respected mental health/addictive disorders treatment providers. Encourage co-location with behavioral health providers	<ol style="list-style-type: none"> 1. An updated link to local mental health/addiction treatment providers is marketed, mailed/emailed to local prescribers with a description of what they provide. 2. A behavioral health fair is organized for local prescribers and office staff for continuing medical education training.
G. Prior to establishing practices, prescribers are more fully trained in non- and pharmacologic approaches to evidence based practices (EBP) in pain management.	<ol style="list-style-type: none"> 1. Coordinate with the deans of medical and allied health schools to ensure adequacy of training in non- and pharmacologic alternative Evidence Based Practices (EBPs) of pain management.
H. Prescribers to be trained in Cognitive Behavioral Therapy and Motivational Interviewing (MI) for more effective referrals for behavioral health providers.	<ol style="list-style-type: none"> 1. Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) training to be taught in medical and allied health schools. Deans to be contacted.
II. I. Availability/Payment of Alternative Pain Management Treatment	
A. Expand health insurers' ability to pay for evidence based, non-opioid pain management.	<ol style="list-style-type: none"> 1. Encourage health plans and government payors to explore the effectiveness of evidence based integrative medicine/allopathic (massage, yoga, mindfulness, meditation, physical therapy, acupuncture, Cognitive Behavioral Therapy).
B. Expand emotional and psychological supports within (pain) prescriber settings.	<ol style="list-style-type: none"> 1. Provide financial incentives for pain treatment providers to integrate behavioral health into their clinics.

PAIN MANAGEMENT

Recommendations	Action Items
C. Improve ease by which pain treatment providers make successful referrals to mental health, addiction, physical, and complementary medical providers.	1. Payors reimburse for, or provide financial incentives for care managers to assist in successful referral to non-opioid pain management.
D. Address transitional care/partnerships across sectors.	1. Create opportunities for prescribers who address pain management to interact and form referral relationships with behavioral health and non-traditional providers. Care managers/recovery coaches will need to be involved and be reimbursed.
III. Policy/Advocacy	
A. Patients and their families will be knowledgeable about the responsibility/risk of opioid use.	1. Pain management patients are educated on a “no tolerance” response by their prescriber should they abuse their medications. Patients and family members are educated on the use of naloxone or overdose reversal (and are provided it along with prescriptions of opioids). They are also educated on issues around safe storage and risks of prescription diversion.
B. Patients make informed choices of non-opioid options.	1. Pain management patients are educated on proven successes with non-opioid medications, behavioral health, complementary and allopathic therapies, and understand that pain is impacted by physiologic, emotional, psychological (anticipation), and sociological factors.
C. Enlist the support of non-medical, community opinion makers to spread the word that non-opioid pain management is effective in many (not all) cases.	1. Enlist the participation by educators, community leaders, the faith community and other sectors to educate adults and children/adolescents of non-opioid alternatives and their effectiveness for treating many types of pain.

CHAPTER 7 - DETOXIFICATION, MEDICATION-ASSISTED TREATMENT (MAT) AND SUPPORTIVE COUNSELING

FACTS

- Detoxification is not treatment and, in fact, can increase the risk of fatal overdose if individuals are not referred to follow-up treatment, due to decreased tolerance after a period of abstinence from opioids.
- Medication-assisted treatment is proven to be effective for increasing treatment retention, reducing opioid use and risky behaviors associated with the transmission of HIV and Hepatitis C, decreasing overdoses, and cutting mortality rates among people with opioid use disorders.

OVERVIEW

There is a wide array of therapeutic approaches and methods for the treatment of opioid disorders. Options for treatment include individual and group psychotherapy, Cognitive Behavioral Therapy (CBT), motivational enhancement therapy, abstinence-based approaches, and Medication-Assisted Treatment (MAT). Treatment selection should be determined based on considerations such as patient preference and past experience, access to the treatment setting, risk of overdose, interest, and suitability for MAT.

Opioid withdrawal management is an integral service in the treatment continuum. While detoxification is not a stand-alone treatment strategy, it is often the first service that individuals with opioid use disorders receive as they begin life in recovery. Detox can be supported in outpatient environments, as well as traditional residential settings, and can use both opioid and non-opioid medication in the management of opioid withdrawal symptoms.

Inpatient and outpatient treatment can both be used successfully in the treatment of opioid use disorders. Both modalities have benefits and pose challenges. Determination of the appropriate setting should be based on acuity.

While MAT is a proven, effective therapy for the treatment of Opioid Use Disorders (OUD), there continues to be a “treatment gap” in the use of the approach among treatment providers. The Louisiana Department of Health, Office of Behavioral Health reported that 90% of the providers who are DATA Waived (Drug Addiction Act of 2000, permits qualified physicians to prescribe specific narcotic medications) to provide MAT, do not provide that treatment option. Barriers to the use of MAT include stigma, personal and professional bias against pharmacotherapy—often seen as “trading one drug for another”—regulatory restrictions on medication and prescribing, lack of DATA Waived providers, etc. There are also many DATA Waived providers who can prescribe the medications, but who do not have the personnel to provide supportive counseling and behavioral therapy.

Resolving these issues would remove barriers to treatment and ensure the availability of the range of services available on the continuum of care in substance abuse treatment.

Detox can be supported in outpatient environments, as well as traditional residential settings, and can use both opioid and non-opioid medication in the management of opioid withdrawal symptoms.

DETOXIFICATION, MEDICATION-ASSISTED TREATMENT (MAT) AND SUPPORTIVE COUNSELING

Recommendations	Action Items
I. Education Training	
A. Provider campaign and training on best prescribing, treatment, and recovery practices, with a focus on harm reduction.	<ol style="list-style-type: none"> 1. Incorporate these topics into the required annual continuing education that providers must have and offer credits. 2. Offer some of these topics in free, for-credit trainings that are paid with grant funding and/or offered by Louisiana Department of Health, Office of Behavioral Health. 3. Contact deans of medical and allied health schools to incorporate harm reduction into curriculum.
II. Capacity-Building	
A. Increase the number of methadone and Suboxone providers and coverage by Medicaid and private insurers.	<ol style="list-style-type: none"> 1. Recommend that the Federal Drug Administration remove regulatory barriers to make methadone more easily accessible and the Centers for Medicare and Medicaid Services pay for the medication. Offer incentives for providers to become DATA waived.
B. Integrate the use of Vivitrol (naltrexone) into abstinence-based inpatient, outpatient, and residential programs.	<ol style="list-style-type: none"> 1. Use the Capital Regional Behavioral Health Collaborative as a resource to provide technical assistance and support to abstinence-based programs that want to begin Medication-Assisted Treatment (MAT). 2. Promote evidence based practices through knowledge of and use of nationally accepted sites.
C. Increase capacity for withdrawal management services for opioid users (medically-monitored and ambulatory).	<ol style="list-style-type: none"> 1. Address issues of an inadequate workforce by providing technical assistance and support to providers who want to begin Medication-Assisted Treatment (MAT) and recommend Medicaid and commercial insurance cover medication costs.
D. Evaluate the feasibility of establishing supervised-injection sites as a means to reduce mortality and connect users to treatment.	<ol style="list-style-type: none"> 1. Research successful national and international models that can be replicated in the state to ensure safety and legality. 2. Address the ethics and the legalities of such sites. 3. Make the sites comprehensive by: offering referral to treatment, overdose prevention education and overdose reversal training, distributing naloxone, and providing counseling and testing for HIV, sexually transmitted diseases and infections, syringe access/exchange, and fentanyl test strips.
E. Increase medication-assisted treatment availability by connecting DATA Waived providers to behavioral health professionals who can provide supportive counseling for their patients receiving pharmacotherapy to treat opioid use disorders.	<ol style="list-style-type: none"> 1. Create referral networks to ensure all biopsychosocial aspects are incorporated.

**DETOXIFICATION, MEDICATION-ASSISTED TREATMENT (MAT)
AND SUPPORTIVE COUNSELING**

Recommendations	Action Items
F. Increase medication-assisted treatment access in rural communities.	1. Explore the use of telehealth and telemedicine where there are a limited number of providers and transportation is a barrier to accessing services.
G. Expand routes to treatment by using non-traditional referral sources.	1. Replicate similar “one-stop shop” facilities such as Haven for Hope in San Antonio, Texas and non-traditional referrals from law enforcement through programs like Operation Angel in St. Tammany Parish.

CHAPTER 8 - TREATMENT OF PREGNANT WOMEN AND NEONATAL ABSTINENCE SYNDROME (NAS)

FACTS

- The national prevalence of Opioid Use Disorder among women giving birth in hospitals increased from 1.5 cases per 1,000 deliveries in 1999 to 6.5 per 1,000 deliveries in 2014.
- In Louisiana, in 2015, there was an estimated 384 newborns (5.9 per 1,000 births) that were diagnosed with Neonatal Abstinence Syndrome (NAS) as compared to 79 newborns (1.3 per 1,000 births) in 2005.
- Newborns with NAS stay in the hospital for an average of 16.9 days compared to 2.1 days for those without NAS. The hospital costs for newborns with NAS are \$66,700 on average compared to \$3,500 for those without NAS.

OVERVIEW

Identifying opioid use during pregnancy along with co-morbid psychiatric conditions and providing interventions for both mother and infant is vital for optimal perinatal outcomes and reduced healthcare costs.

Maternal Opioid Use and Neonatal Abstinence Syndrome (NAS) is a significant and rapidly growing public health concern that is directly related to the national opioid epidemic. Identifying opioid use during pregnancy along with co-morbid psychiatric conditions and providing evidence based interventions for both mother and infant is critical for optimal perinatal outcomes and reduced healthcare costs.

Specialized Medication-Assisted Treatment (MAT) for opioid dependence during pregnancy as part of comprehensive prenatal care is associated with the most successful outcomes. Methadone and Suboxone® (buprenorphine) are the two maintenance medications that are currently used during pregnancy in the U.S. Methadone has been the “gold standard” for treating opioid use disorders in pregnant women since the 1970’s, but must be administered in a registered opioid treatment program that also includes counseling and urine toxicology testing. Suboxone® (buprenorphine) can be prescribed by certified physicians in office-based settings. The goal of medication-assisted treatment is elimination of opioid seeking behaviors, cessation of illicit opioid use, stabilization of the intrauterine and physical environment, and compliance with prenatal care to enhance pregnancy outcomes. Long term behavioral health disorder treatment and supportive services are recommended to prevent relapse and maintain addiction recovery.

Neonatal Abstinence Syndrome (NAS) is a group of symptoms in newborn infants exposed to a variety of substances in utero, including opioids, caused by withdrawal of these substances at birth. NAS resulting from withdrawal of opioids is a medical condition characterized by high pitched and excessive crying, irritability, poor sleep, sweating, poor feeding, respiratory distress, seizures, tremors, and other clinical signs. Symptoms usually develop within 72 hours of birth, but may develop anytime in the first week of life, including after hospital discharge. Not all opioid-exposed infants develop NAS, but they can fall along a continuum of withdrawal symptoms ranging from mild to severe. The diagnosis of NAS is made by observing and scoring the clinical signs of neonatal withdrawal using a validated tool such as the Finnegan Neonatal Abstinence Scoring Tool. Treatment consists of pharmacologic and non-pharmacologic interventions depending on the clinical signs and individual needs of the infant.

TREATMENT OF PREGNANT WOMEN AND NEONATAL ABSTINENCE SYNDROME (NAS)

Recommendations	Action Steps
I. Prevent Unintended Pregnancy of Women While Using Opioids (Legal or Illicit).	
A. Improve public knowledge of risks associated with maternal opioid use and community resources.	<ol style="list-style-type: none"> 1. Increase public awareness about a healthy lifestyle and prevention of opioid misuse to support reproductive health. 2. Educate the public on the dangers of using opioids during pregnancy and availability of community resources using a multi-media approach.
B. Reinforce the role of primary care providers in preventing maternal opioid use.	<ol style="list-style-type: none"> 1. As part of preconception health for women of reproductive age, providers should discuss a reproductive life plan. 2. Educate providers on the dangers of using opioids during pregnancy and about community based programs to assist their patients. Use cognitive behavioral therapy and Motivational Interviewing (MI) when making referral for treatment. 3. Providers should implement universal verbal screening/brief intervention among all women of reproductive age for substance use (including opioids), depression, and domestic violence and referral for treatment as indicated using a caring and non-judgmental approach.
II. Screening, Brief Intervention, and Referral to Treatment	
A. All providers should screen women of child bearing age for social and behavioral risks.	<ol style="list-style-type: none"> 1. Primary care providers should implement universal verbal screening/brief intervention among all pregnant women for substance use (including opioids), depression, and domestic violence and referral for treatment as indicated using a caring and nonjudgmental approach. 2. Primary care providers should implement interventions to address perinatal mood and anxiety disorders utilizing community mental health resources as indicated (addressing a major risk factor for opioid abuse).
III. Perinatal Services	
A. Medical and allied health schools, student training and those in practice should improve knowledge and implement non-stigmatizing approaches in caring for pregnant and parenting women.	<ol style="list-style-type: none"> 1. Incorporate information about Evidence Based Practices (EBP) for Opioid Use Disorder (OUD) during pregnancy/NAS into academic curricula for medical students and residents, nurses, and allied health professionals as well as in continuing education for licensed practitioners. 2. Increase access to multi-disciplinary integrated behavioral and medical care utilizing best practices for pregnant women and their families affected by opioid addiction. 3. Improve interagency coordination of care for pregnant women with opioid use disorder and co-morbid mental health conditions. 4. Strengthen systems of care and support for the family to address needs of a child with NAS. 5. Increase capacity for community supports for pregnant/parenting women with opioid use disorders (e.g. peers, faith-based organizations, support groups, etc.).

TREATMENT OF PREGNANT WOMEN AND NEONATAL ABSTINENCE SYNDROME (NAS)

Recommendations	Action Steps
IV. Policy and Payor Implications	
<p>A. Insure that payors adequately cover needed services for pregnant women.</p>	<ol style="list-style-type: none"> 1. Increase payor reimbursement for medication-assisted treatment and care management services associated with high-risk pregnancies. 2. The Louisiana Department of Insurance and the Louisiana Department of Health must enforce existing federal mental health parity laws regarding insurance reimbursement for behavioral health services, including substance use disorder treatment.
<p>B. Increase adherence to parity laws by insurers.</p>	<ol style="list-style-type: none"> 1. See A.1. and A.2. above.
<p>C. Avoid criminalization/incarceration of pregnant substance abusing women by offering mandatory alternative treatment.</p>	<ol style="list-style-type: none"> 1. Advocate for policies to implement evidence based strategies outside the legal system to address needs of women with addictions and reduce fears of criminalization.

CHAPTER 9 - RECOVERY SERVICES AND COMMUNITY SUPPORTS

FACTS

- Recovery Support Services (RSS) provide social supports for persons with opioid use disorder(s) that would otherwise not be available.
- Providing information and referrals in a timely manner to access available resources are of the utmost importance.
- The funding stream for these services via federal/state government reaches less than 20% of those individuals who seek them. Included in those funding streams are Medicaid, the Substance Abuse Prevention and Treatment (SAPT) Block grant, the Access to Recovery (ATR) program grant, Louisiana Opioid State Targeted Response (STR) Initiative, the Recovery Community Services Program (RCSP) grant, Comprehensive Opioid Abuse Site Based Program (COAP) grant, Drug Court program, Pre-trial Release program, and other funding streams that are community, faith-based and from the private sector.

Support groups and peer services can provide information and guidance to those who have to face complicated medical and legal challenges.

OVERVIEW

Recovery has come to mean that a person is taking control of his/her life, managing one's health, creating stable places to live and work, creating purpose and meaning in one's daily life, mending relationships and becoming connected to one's community. Recovery Support Services (RSS) specifically refers to non-clinical services that assist individuals and families working towards recovery from substance abuse conditions. These services aim to improve social support and connectedness. Peer recovery services and other forms of social support are some of the most effective paths to maintaining recovery. Additionally, support groups and counseling can be critical to addressing the co-occurring depression, anxiety and other mental health issues that can accompany a transition to a life without drugs. The toll that addiction takes on a person and his/her family can be immense, but recovery is possible, and even more likely, when a person's sense of connectedness is nurtured.

Some recovering people lose hope when faced with common life circumstances that they feel they must face alone and without support. Support groups and peer services can provide information and guidance to those who have to face complicated medical and legal challenges. For example, wrap-around services, systems of care set up to address the needs of a person and his/her family in a holistic manner, can prevent crises from arising and interfering with someone's progress. This might include the bringing together of a person with family, peers, medical professionals, and case managers to address the challenges to a person's ongoing recovery. The ongoing needs of a person in recovery can be neglected once initial crises are past. It's easy to feel a sense of relief when someone makes a commitment to recovery. But, it should be remembered that recovery never happens in isolation. To see recovery happen on a community-scale, supports and services need to exist to encourage connectedness and give hope to people as they address their problems.

RECOVERY SERVICES AND COMMUNITY SUPPORTS

Recommendations	Action Items
I. Assess Community Resources	
<p>A. Identify existing Recovery Support Services (RSS) resources: Self-care practices, family, housing, employment, transportation, education, clinical treatment for both substance abuse (i.e., Opioid Use Disorder and mental health disorders, primary healthcare support groups, legal services, dental care, spirituality, recreation, social networks, and alternative support services).</p>	<ol style="list-style-type: none"> 1. Map the existing access to RSS. 2. Compile data base of available RSS resources in the region to be disseminated to all entities and stakeholders providing services to persons with Opioid Use Disorder (OUD).
<p>B. Identify missing RSS resources and potential funding sources and providers.</p>	<ol style="list-style-type: none"> 1. Once gaps of RSS are identified, ensure the community is made aware of what they are and bring them to the attention of the Capital Region Behavioral Health Collaborative or other invested organizations/agencies to assist in identifying local and state/federal funding resources for appropriate providers. 2. Provide access to evidence based practices/best practices such as supported employment, supportive housing, and peer operated services that have proven to be effective and efficacious. 3. Provide linkage to stakeholders and community providers to access funding to fill gaps for insufficiently available RSS.
II. Education/Communication	
<p>A. Make the public and providers aware of the need for RSS and its importance in sustaining recovery.</p>	<ol style="list-style-type: none"> 1. Create strategies to disseminate RSS information to people directly affected and to families and caregivers of persons with Opioid Use Disorder (OUD). 2. Use compiled data base of available RSS resources to be distributed in communities, professional setting, and institutions identified as high volume entities for persons presenting with OUD. 3. Provide information that includes provision of health and wellness information, educational assistance, help in acquiring new skills, ranging from life skills to employment readiness and restoration of citizenship. 4. Provide education venues for professionals, communities, families, and caregivers on RSS practices that have been proven to work best for persons with OUD (e.g. holistic peer recovery, evidence based case management, non-interrupted continuum of care, peer mentoring, and peer led recovery groups).

RECOVERY SERVICES AND COMMUNITY SUPPORTS

Recommendations	Action Items
III. Linkage and Navigation	
<p>A. Establish recovery coaches/peer/navigators/case managers</p>	<ol style="list-style-type: none"> 1. Educate public and professionals of the role of recovery along a change continuum and the role of peers in supporting lifestyle change along the continuum of care/change. 2. Provide information to the public and professionals on RSS providers and coaches through the Capital Region Behavioral Health Collaborative. 3. Provide evidenced-based case management to include assistance in obtaining services from multiple systems. 4. Provide referral service, and access to coaches/navigators/peers through various federal, state and private funding sources. 5. Provide peers and case managers to assist in completing applications and obtaining entitlements. 6. Provide peer/coach/case managers during, and after clinical treatment.
IV. Connectedness	
<p>A. Establish opportunities for connectedness within the community.</p>	<ol style="list-style-type: none"> 1. Provide information on RSS social support to help people in early recovery feel connected and enjoy being with others, especially in recreational activities in alcohol and drug-free environments. 2. Achieve connectedness through assistance with identifying and accessing instrumental recovery support resources such as the following: <ul style="list-style-type: none"> • Entitlements • Educational assistance • Child care • Transportation • Clothing • Life skills • Employment readiness • Restoration of Citizenship • Provision of health and wellness • Local recovery support groups • Leadership skill development • Recreational activities • Information and referral services • Dental care • Legal assistance • Spirituality outlet • Reduced stigma environments • Primary healthcare • Linkage to and coordination of services • Recovery learning circles • Vocational training • Job placement assistance

RECOVERY SERVICES AND COMMUNITY SUPPORTS

Recommendations	Action Items
	<ul style="list-style-type: none"> • Job readiness training • Basic academic remedial literacy training • College and university training • On-the-job-training • On-the-job-supports • Job search assistance <p>3. Provide persons in recovery opportunity to establish connectedness in their community by linking them to resources through information or connect them through sponsors, peers, etc. that assist in becoming independent, enjoy being with others, participate in mainstream society, and opportunity to have quality of life.</p> <p>4. Ensure individuals with Opioid Use Disorder (OUD), and their families and loved ones understand the long term impact of addiction on them individually and as a family unit and that they get the treatment and emotional support needed for a healthy and quality personal/family life.</p>

APPENDIX AND RESOURCES

The following are resources made available to the Capital Region Behavioral Health Collaborative. They include opioid presentations and data sources as well as additional links from Capital Area Human Services and the Louisiana Department of Health.

These resources can be accessed at realhelpbr.com/opioidplanpresentations.

Chapter 1 - Understanding Addiction and Reducing Stigma

- [Opioids \(Neurobiology/Action of Opioids in The Brain\) by Jan Laughinghouse, PhD, 11-29-2017](#)
- [Behavioral Health Collaborative Presentation by Jan Kasofsky, PhD, 11-17-2017](#)
- [Facing Addiction-Community Organizing Basics by Michael King, Director of Outreach and Engagement, Facing Addiction, 11-17-2017](#)

Chapter 2 - Prevention Services

- [Recognize The Risk Presentation by Vivian Gettys, RN, MPH & Kristian Dobard, JD, 3-1-2018](#)
- [COAP Power Point for EBR Category III by Javonna Jones, MSW, January 2018](#)
- [Prevention Strategies to Address the Unique Needs of Women by Vivian Gettys, RN, MPH, 11-29-2017](#)

Chapter 3 - Law Enforcement, Criminal Justice Reform, and Corrections

- [Focus on the War on Drugs and Recovery by Tim Lentz, MCJ, Chief of the Covington Police Department, 7-19-2018](#)

Chapter 4 - Prescribing Practices

- [Baton Rouge Health District Addresses Opioids by Suzy Sonnier, MPH, 5-4-2018](#)
- [Medicaid Opioid Presentation by Sue Fontenot, Pharmacist, September 2017](#)
- [Succeeding With A Moving Health System Target by Kristin Woodlock, RN, MPA, October 2017](#)
- [Opioid Stewardship at Ochsner by Marianne Maumus, MD, Hospitalist, Department of Hospital Medicine, Opioid Stewardship Team, Ochsner Health System](#)

Chapter 5 - Harm Reduction: Overdose Reversal and Syringe Access

- [Narcan Statistics – Years \(2009 Thru 2017 \) by Rintha Batson, East Baton Rouge Emergency Medical Services, 11-29-2017](#)
- [Louisiana’s Heroin Epidemic and the Overuse of Opioids by Dr. William “Beau” Clark, MD, 11-29-2017](#)
- [Narcan 2009-2016 usage and Zip Code by Rintha Batson, East Baton Rouge Emergency Medical Services, 11-17-2017](#)

APPENDIX AND RESOURCES

- [Syringe Access and Overdose Prevention Programs in Baton Rouge by Logan Kinamore, 11-17-2017](#)
- [Harm Reduction 101 \(Revised\) by Logan Kinamore, 8-25-2017](#)

Chapter 6 - Pain Management

- [Pain Management by Mary Raven, MD, FAAHPM and Lan H. Pham, MD, OLOL Hospitalist and Palliative Care Medicine Services, 4-8-2018](#)

Chapter 7 - Detoxification, Medication-Assisted Treatment (MAT) and Supportive Counseling

- [MAT – Medication-Assisted Treatment by Janzlean Laughinghouse, PhD, 5-4-2018](#)
- [COAP Power Point for EBR Category IV by Javonna Jones, MSW, Louisiana Department of Health, Office of Behavioral Health, 5-4-2018](#)
- [Components of Medication-Assisted Treatment \(MAT\) by Louis Cataldie, MD, September 2017](#)
- [Managing Opioid Coverage CAHS BH Collaborative 9-2017 by Brice Mohundro, Pharm D, BCAP, September 2017](#)
- [MAT implementation CAHSD by Arwen Podesta, MD, ABPN, FASM, ABIHM, September 2017](#)

Chapter 8 - Treatment of Pregnant Women and Neonatal Abstinence Syndrome

- [Families Impacted by Neonatal Abstinence Syndrome by Twanda Lewis, MEd, 4-8-2018](#)
- [Overview of the Comprehensive Opioid Abuse Site Based Program \(COAP\) grant by Javonna Jones, MSW, 4-8-2018](#)
- [Maternal Substance Abuse and NAS by William “Dorie” Binder, MD, 1-11-2018](#)

Chapter 9 - Recovery Services and Community Supports

- [Recovery Support Services by Joseph Pete, PhD., 5-4-2018](#)

Other resource links:

- [Louisiana Opioid Data and Surveillance System](#)
- [Frequently Asked Questions](#)
- [Online naloxone \(Narcan\) training video](#)
- [Changes in the Brain Due to Opioid Use by Louis Cataldie, M.D., who has worked in the field of addiction medicine for more than 30 years.](#)
- [Medication-Assisted Treatment: An Overview by Capital Area Human Services Program Director for Addiction Recovery Services Jan Laughinghouse, PhD, LCSW.](#)

APPENDIX AND RESOURCES

- LA-SBIRT Screening, Intervention and Referral to Treatment by Betsy Wilks, LCSW-BACS, ACSW, BCD, Project Manager for the federally-funded LA Screening, Brief Intervention, and Referral to Treatment (LA-SBIRT) program.
- Pregnancy Opioid Use Disorder Case Management Program by Woman's Hospital Vice President of Perinatal Services Cheri Johnson, RNC-OB, BSN.



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Capital Area Human Services provides behavioral health, addiction recovery and developmental disabilities services in the parishes of Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana.