MINUTES
Opioid Advisory Group
Meeting

Boulder County Justice Center
Wednesday, April 12th, 2017

Attendees:

Name	Agency
Safety (Law enforcement, fire, jail etc.)	
Tylynn Leonard	20th District Court Probation Office
Christina Orlowski	Adult Integrated Treatment Courts
Curt Johnson	Boulder Police Department
Carol Helwig	Boulder County Public Health (BCPH)
Melanie Dreiling	Boulder County Sheriff's Office – Jail (BCSO)
Scot Williams	Boulder County Sheriff's Office (BCSO/BCDTF)
Marco Prospero	Community Justice Services
Randy Repola	CU Police Department
Ken Kupfner	District Attorney's Office
Elaina Shively	District Attorney's Office
Jeff Satur	Longmont Police Department
Jeff Goetz	Boulder County Sheriff's Office – Jail (BCSO)
Chad Dilworth	Community Justice Services
Treatment	
Karen Elias	Alkermes plc
Paul Egan	Behavioral Health Group (BHG)
Ana Swoboda	Behavioral Health Group (BHG)
Michele Ryan	Behavioral Health Group (BHG)
Jeff Jones	Family Recovery Solution
Mary Anne Ursich	Community Solutions
Prevention	
Talia Brown	Boulder County Public Health (BCPH) - Biostatistician
Kat Dailey	CU Health Promotion
Colt Smith	iThrive/Alternatives for Youth
Jen Korbelik	City of Boulder University Liaison
Carol Helwig	Boulder County Public Health Works Program
Community	
Kristen Dailey	Independent health advocate
Paul Egan	Behavioral Health Group (BHG)
Lauren Marek	Boulder County Public Health (BCPH)
James Gould	CU student, CU Students for Sensible Drug Policy (SSDP)
Robert Hastings	Chronic pain patient advocate
Ted Bradshaw	HR Director Alfalfas
Backbone Support	

Indira Gujral	Boulder County Public Health (BCPH)
Jamie Feld	Boulder County Public Health (BCPH)

Upcoming Meetings:

- Wednesday, May 17, 2-3:30pm – Boulder County Justice Center, Jury Assembly Room (Opioid Leadership Summit)
- Wednesday, June 21, 2:00-3:30pm- - Boulder Clerk and Recorder, 1750 33rd St., Houston Room
- Possible late May meeting to debrief Opioid Leadership Summit?

Successes:

- Stan Garnett and the District Attorney's Office received award from Healthy Futures Coalition for work addressing prevention and criminal justice reform.

- A Boulder County contingency Carol Helwig (Boulder County Public Health), Jeff Satur (Longmont PD), Stephanie Ragland (Boulder PD) are visiting Santa Fe Law Enforcement Assisted Diversion (LEAD) program May 22-23. Contact chelwig@bouldercounty.org if interested. Transportation by van is provided, but room and board/per diem is not covered.

- Community Justice Services (CJS) is leading a grant application with collaboration with the District Attorney's Office and Boulder County Public Health. Brian Ball is the lead Principal Investigator. Marco and Chad from CJS in attendance. We may be asking for letters of support from agencies. Deadline is 4/25.

- Law Enforcement Assisted Diversion (LEAD) proposal is going through the Joint Budget Committee to provide funding for LEAD in 4 local communities in Colorado. Boulder is considering applying if this approved.

- Kat Dailey – CU Health Promotion: At CU there has been a growing interest from both students and staff to learn about naloxone and talk about opioid misuse. BCPH in collaboration with iThrive (Colt Smith) provided training to both CU students and CU Wardenburg.

- Jeff Satur: Angel Initiative: Chronic alcoholic kicked out of all shelters, 57 hospital visits in a year. Volunteered to enter Angel Initiative (involuntary commitment through Office of Behavioral Health). 96 days sober and transitioning from Transitional Residential Treatment (TRT) to housing. Two people from AA giving him jobs, seeing his kid. 3

involuntary commitments (alcohol primarily). Withdrawal management paid money for cost of treatment. Received scholarship from Harmony House. Probably over $100k saved in costs – emergency room visits and police department interventions.

Review Collective Impact Strategy Sheet:

We are using a shared leadership model from all partners (prevention, treatment, community members, harm reduction, etc.

Concern: Businesses are affected uniquely by opioid misuse.

- Ted Bradshaw of Alfalfa's identified a need for means for employees to have access to treatment opportunities (signs to post in store that can link people to treatment) either employees or customers who may be using.
- Employees don't want to lose their job, don't feel open to come to their boss.
- People possibly connect at businesses, meet dealers and perpetuate use.
- Targeting hot spots through fliers, educational information.
- Insurance options for employees that could be accessible (if people felt less stigmatized and open about their struggle with addiction).
- Stigma may prevent current users from identifying to employers.
- Active employee may be considered a risk to the customer so as an employer you are in a different mindset because their business can be affected, they can lose profit; there may a cost to dealing with the situation.
- Concerns for tenants in building. Caldwell Sullivan, local realtor, has been voicing concerns over overdose deaths in his apartment property that houses university students.

Identifying solutions for the business sector

- Need for resource guide?
- Target leaders of businesses to be open and accepting to addiction so employees don't feel stigmatized.
- How to inform strategies in the bigger picture? Need a system that connects all partners. People using employee assistance programs. Certain industries may be more stigmatizing than others.
- Area that is missing is bridging the gap from treatment to recovery. Need to move from being in treatment to being a functioning member of society. Need a direct link to connect people with housing, jobs, support. Message needs to be put out there that people who use drugs need support. Will take a lot of correct messaging.
- Business needs to be a separate category. Police reports (people overdosing in public bathrooms at businesses). Overdoses at a restaurant during his shift. Business needs to be a separate category to target business specifically.

- Community involvement could be an umbrella term for incorporating business as community involvement.
- CU student (harm reduction): Businesses providing naloxone training? Provide more trainers, people on the ground that could go out to other sites and train business on using naloxone. Employers usually require first aid training, include naloxone in this.
- Alfafas: Need reassurance that businesses wouldn't be held liable. Good Samaritan law education.

Concerns about referrals:

- Difficult to get interns at Community Solutions to provide resource and referrals. Interns need to be able to look up facilities that clients can go and see. Changing language so productive referrals are made. Not separating treatment, prevention, but making it more collaborative.
- Employee Assistance Programs (EAP) programs need a minimum of 2 years of training, same with addiction counsellors. Infiltrate training programs that train EAP specialists vs addiction counselor. Make this a core curriculum so everyone has access to providing pertinent resources.

Need to add housing and job support:

- Community side (Jeff Satur): Housing and job support needs to be incorporated (under community involvement)
- Need to add 'Recovery' beyond 'Treatment'

Need to add family systems:

- Family systems isn't clearly represented, should be added to treatment group. One of the most important needs because so valuable to the livelihood of the client. Limited resources for people who need family counseling.
- Supporting families through primary prevention to harm reduction (not just people in treatment).
- Family Solutions has created an online HIPAA community where family members can listen and engagement is voluntary. $45/mo up to 6 people in a household.
- Where are the resources? If client has a whole family using, there aren't resources to treat entire family. So additional need to place person in an environment where people aren't using. Client in treatment going back to family who is still using will be harder to keep clean. This can be placed under awareness raising.
- Clients could be estranged or part of family dynamic is a common story. Parents started using and that is initiating children to use (generational component). Outcome= generation of people who do not use when their parents are using.

Plan for May Opioid Leadership Summit

Table-Top Exercise - System mapping: What can we do in specific scenarios when people are in crisis?

Scenario: A woman is arrested for use and minor possession of heroin and wants help to stop use. She is incarcerated at the local jail and tells the health staff she would like treatment, but bonds out too soon for any jail services to get started. She violates her bond due to failing to complete substance abuse monitoring and as a result her bond is revoked and her legal consequences escalate.

Small Group Discussion:

Using the scenario, start from the beginning of the story and identify opportunities where you or your agency could make a difference in this woman's life. For each of the questions below, ask yourselves, what concerns do you have? What supports does your agency have to assist this person? What can you bring to the table?

1. What are the consequences of being arrested for minor possession? What could have been done differently?
2. What may be some motivators for this individual? Are there external motivators? Internal motivators? Both?
3. What opportunities exist at the jail?
4. What may happen once the person is bonded out?
5. What are the consequences of violating her bond? What factors may have contributed to her violating her bond?
6. How can we better support this individual without escalating the issue?

Group comments:

- A skilled assessor/case manager does not currently exist as a position in the jail. Need a systems navigator. Woman needs to be assessed for motivation.
- After being given an assessment by a nurse, can be referred as having an opiate addiction. A more comprehensive assessment in jail is needed to see what resources may be eligible for.
- There are many ways to measure readiness to change ('sincerity' or 'motivation') with accuracy to find which level of care is least invasive.
- Lot of resources available to fill gaps but getting them connected to each other at the right time is the challenge.
- Judges can only order bond components that have treatment if the client complies to it. Judges can do substance use monitoring. If someone wants to go to treatment, that can be a condition of the bond. This usually only occurs for wealthy individuals (DA's

consent to a bond if person has an option to go to treatment and consents to that). There is no way to get people into treatment who cannot pay for it. Therefore there is a need for a patient navigator and funding resources.

- Providing education about Angel Initiative that clients can get involved with. How do we connect clients to treatment who cannot afford it or do not have the resources to find a treatment facility?

How do we educate our community so they are aware enough to know that someone needs help?

- Redefine priority population (not just pregnant women, injection drug users). More criteria to consider. Target group needs to be created.
- Juvenile system is a good model because any minor could say that they want treatment as a condition of their bond. Youth also have a case manager that meet them in jail and follow them throughout the process, getting them connected with housing, school and family. Juveniles are viewed differently than adults. They get second chances whereas adults do not. However, juveniles are still being brought into criminal justice system before they can be diverted.
- Lots of access points where professionals could be trained to intervene. Could train professionals (police, parks, teachers) in harm reduction and substance abuse intervention and referral to get people moving towards treatment. Motivational interviewing for emergency room doctors, police, various community members who interact with target population.
- CU: training is being done for teachers on how to recognize these problems. Integrating health and wellness in the schools/universities.
- Identifying different intercepts. One place is for people facing their 1st arrest. Once they are in the jail then there is an opportunity to not release them until case management is done. There is prosecution wiggle room. Identifying different intercept areas: assessment of resources in the jail, case management resources in community. Ability to link resources together. Someone who can do validated assessment and find best treatment match for individuals would be beneficial.
- Need more than one person to do this job in the jail? Too high of a workload?
- When you are assessing someone with an opioid addiction is that different tool than other substances? Need to make sure the right people are getting into the program.
- EDGE program: Need a similar case worker that works with addiction issues that can assess on the scene. Potentially a link to EDGE? Expand what EDGE is doing.
- Bring intervention to the whole community instead of having just one person in the jail. Communication blast that case information is sent to all treatment facilities. One facility accepts the case and agrees to take it on. This is done until someone accepts case.
- To put this system in place (above) would be very difficult, could be done, but not sure what the outcome would be. Community Justice Services (CJS) touches a big portion of this problem. Currently average 600 intakes a month in the jail and 600 releases a

month. Majority of these ask for treatment, but limited resources available. Person is scenario is going to have a short bond, difficult to address in short time period. 10% of their time could be what we are addressing. 90% would be different avenues that this group isn't discussing.

- Too late for some people, but not for some people, especially young people who had an injury.
- How much more can we add into the system after people are diverted from the jail? Need extrinsic motivation, be diverted, or be charged?
- Student at CU may not be an injury but could be culture of school. Different entry points for different populations.
- Middle of the wheel needs to be our ask (case management for multiple settings).
- Community approach, but need to focus on one FTE in the jail. Do a good job of identifying people in the jail who need treatment. Provide resources and get comprehensive assessment means not sending clients back into same factors that brought them there in the first place. Get people the people the resources they need before they leave the jail. Drug supervision, substance abuse monitoring, treatment in lieu of jail, put them on Medicaid. Angel incentive can also work this FTE. FTE would be employed by criminal justice service.
- Information is being identified but not passed along. Missed connections because each person in own separate system. Need someone to pass on information so probation and other partners involve.
- Directors from multiple agencies are creating a software system (in progress) between public health, jail, MHP etc. so all providers and community members could talk to each other about clients (HIPPAA compliant). People getting drugs from multiple doctors, or multiple doctors. So something like a PDMP for substance abuse clients.
- Information sharing needs to be staffed well enough to do something with it.
- MHP crisis center is 24/7. Position is not going to be 24/7, so looking at resources so there is availability to walk people directly over to where they need to be.