

## **RESEARCH REPORT**

# Initial Assessment of the Comprehensive Opioid Abuse Program

## **Summary Final Report of Effectiveness**

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# 1. Introduction

It is difficult to overstate the devastating magnitude of the opioid epidemic in the United States over the last two decades. The opioid crisis, like the COVID-19 pandemic, has spared no one: opioid misuse strikes broadly and often lethally, without regard to income, age, or race (La Vigne et al. 2019). Unfortunately, recent data indicate the COVID-19 pandemic has only exacerbated the impact of the opioid crisis,<sup>1</sup> elevating the need for more information on effective strategies.

Effectively addressing the complex and ever-changing opioid crisis requires a cross-systems, collaborative, data-driven approach. Most jurisdictions, however, lack the resources and capacity to build such a framework and use it to reduce opioid overdoses and use. Recognizing this challenge, the Bureau of Justice Assistance (BJA) implemented the Comprehensive Opioid Abuse Program (COAP) in 2017, following authorization by the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114-198). BJA awarded the first round of COAP grants in Fiscal Years (FY) 2017 and FY2018. Fifty COAP grants were awarded in FY2017, with another 168 awards made in FY2018 and hundreds more awards made since then. In FY2017 and FY2018, COAP grants were awarded in six categories (box 1) spanning law enforcement–behavioral health co-responder models to medication-assisted treatment (MAT), and to information-sharing collaborations to identify overdose hot spots or establish overdose-fatality review boards. The six categories are described in more detail in appendix A.

### BOX 1

### COAP Grant Categories and Objectives: FY2017 and FY2018<sup>a</sup>

**Category 1. First Responder Partnerships.** Supports the development of multidisciplinary partnerships among law enforcement, behavioral health, medical professionals, and drug treatment and recovery providers to reduce fatal overdoses by linking people who have experienced an overdose to treatment.

**Category 2. Technology-Assisted Treatment Projects.** Supports states in piloting the use of technology to expand treatment for those who have limited access to treatment and recovery services because of geographic isolation.

**Category 3. System-Level Diversion Projects.** Supports implementation of pretrial and postadjudication diversion programs, specialized probation caseloads, jail-based treatment programs, community-based day report centers featuring peer recovery navigators, and other interventions.

**Category 4. Statewide Planning, Coordination, and Implementation Projects.** Supports the implementation of strategies to (1) reduce overdose deaths by formulating a coordinated plan between

the state administrative agency and the single state agency and (2) increase engagement in treatment and recovery services, prevention education, and diversion.

**Category 5. Harold Rogers Prescription Drug Monitoring Program (PDMP) Implementation and Enhancement Projects.** Supports the establishment of new PDMP programs and the enhancement of existing PDMPs, as well as the development of training materials and education. (This grant category is the subject of other ongoing analyses and thus was excluded from this analysis.)

**Category 6.** Public Safety Behavioral Health, and Public Health Information-Sharing Partnerships. Supports multidisciplinary projects aimed at leveraging and analyzing datasets from PDMPs, public health agencies, law enforcement, and other key sources to create a data-driven portrait of the opioid crisis for the purpose of designing relevant interventions.

<sup>a</sup> Nancy G. La Vigne, Janeen Buck Willison, Marina Duane, Cameron Okeke, Azhar Gulaid, Lisa Clemans-Cope, and Will Engelhardt, *Comprehensive Opioid Abuse Program Assessment: Examining the Scope and Impact of America's Opioid Crisis* (Washington, DC: Urban Institute, 2019).

COAP program goals and objectives are derived from the Sequential Intercept Model (SIM), which offers a conceptual framework for systematically assessing available community resources, determining critical service gaps, identifying opportunities to safely divert people from needless involvement in the criminal legal system,<sup>2</sup> and implementing reforms at six distinct justice decision points, or "intercepts" (Munetz and Griffin 2006). The COAP grant's six categories (box 1) closely align with the SIM's six intercepts: community services, law enforcement, initial detention or initial court hearings, courts and jails, reentry, and community corrections. Through these six categories, COAP seeks to advance four broad program goals (Kunkel 2019):

- Promote public safety and support access to treatment and recovery services in the criminal legal system.
- Strengthen the collection and sharing of data across systems to understand and address the impact of the opioid epidemic.
- Align and maximize resources across systems and leverage diverse program funding.
- Prevent opioid misuse; in 2020, in response to the changing nature of the opioid epidemic, BJA augmented this goal and its funding strategy to support initiatives aimed at addressing stimulant use as well as opioid misuse and changed the initiative's name to the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP).

In addition to funding, COAP grants provide peer-learning opportunities and training and technical assistance (TTA) support to states and local jurisdictions to develop, implement, measure, and sustain

strategies that address the opioid epidemic at the local level. The COAP Resource Center (now known as the COSSAP Resource Center) provides grantees with a robust array of content, supplemented by distance learning and resource dissemination.<sup>3</sup>

Finally, the COAP initiative has facilitated collaboration among BJA and other federal agencies on the front lines of the opioid crisis, such as the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control, the US Department of Agriculture, and the National Institutes of Health. BJA has collaborated with these agencies to host events and release joint publications. In 2019, BJA partnered with Arnold Ventures, a private philanthropic entity, to fund a nine-month planning grant, the Building Bridges between Jails and Community-Based Treatment (Bridges) initiative, to build local knowledge and capacity to expand jail-based MAT models and relevant postrelease services in 16 selected communities across 14 states;<sup>4</sup> these communities received tailored technical assistance and engaged with subject matter experts to advance MAT locally. As noted earlier, in 2020, the grant program changed its name to the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) to reflect the changing nature of the epidemic, including the rise in polysubstance use. Nearly 300 projects and demonstration sites have been funded across six program categories in recent years.

In 2019, the Urban Institute (Urban) received funding from BJA to assess the reach and impact of COAP, specifically whether the COAP initiative is associated with reductions in opioid misuse and fatal overdoses and increases in access to treatment and information sharing, in communities that received one of approximately 218 FY2017 and FY2018 COAP grants. Urban's 30-month Initial Assessment and Evaluation of the Comprehensive Opioid Abuse Program (box 2) documents and describes the scope of the opioid epidemic, examines the range of strategies employed by selected COAP grantees to tackle the opioid crisis in their communities, and analyzes grantee performance data submitted quarterly to BJA via the Performance Measurement Tool (PMT) questionnaire.

#### BOX 2

#### Urban Institute Initial Assessment and Evaluation of the Comprehensive Opioid Abuse Program

The COAP assessment aims to generate actionable information that can assist, improve, and sustain effective efforts to address the opioid crisis. Its core components and products include the following:

- An interim report to Congress on the scope and nature of the opioid crisis, including the multipronged approach the Office of Justice Programs in the US Department of Justice has taken to support communities and criminal justice stakeholders on the front lines of the epidemic.<sup>a</sup>
- A multisite process evaluation of up to 30 selected grantee sites, from both the COAP and the Bridges initiatives.<sup>b</sup> The evaluation describes and examines 28 grantees' COAP-funded strategies and Bridges planning work, including implementation experiences, outcomes, and lessons learned.<sup>c</sup>
- An analysis of COAP grantee performance data to gauge implementation progress and outcomes, such as reductions in opioid overdoses, reductions in overdose fatalities, and increases in treatment engagement and utilization at the community level.<sup>d</sup>
- This summary final report on the efficacy of the COAP grant program in equipping communities to address the opioid crisis, which synthesizes findings from the analyses of sites' Bureau of Justice Assistance performance data and actionable recommendations from the process evaluation. This report also presents lessons learned and provides recommendations for future efforts.

<sup>b</sup> In spring 2019, BJA asked Urban to broaden the project's scope to examine the effects of Bridges planning grants to gather additional information on these grantees. Five Bridges grantees were selected for the assessment in consultation with BJA. <sup>c</sup> Janeen Buck Willison and Will Engelhardt, *Initial Assessment of the Comprehensive Opioid Abuse Program: Findings and Recommendations from the Multisite Process Evaluation* (Washington, DC: Urban Institute, 2021).

<sup>d</sup> Mari McGilton, Janeen Buck Willison, Will Engelhardt, Colette Marcellin, and Rudy Perez, *Initial Assessment of the Comprehensive Opioid Abuse Program: Analysis of the COAP Grantee Performance Data* (Washington, DC: Urban Institute, 2021).

This report distills and summarizes findings from the assessment's multisite process evaluation of 23 COAP FY2017 and FY2018 grantees (16 from 2017 and 7 from 2018) and 5 Bridges planning grantees, and its analysis of performance data from 166 FY2017 and FY2018 COAP grantees; in-depth results of these two assessment components are detailed in separate reports (Buck Willison and Engelhardt 2021; McGilton et al. 2021). Consistent with the goals of the assessment, this report examines both the effectiveness of the COAP grant program with respect to advancing specific grantee outcomes and the aggregate impact of COAP overall, and explores the extent to which COAP funding

<sup>&</sup>lt;sup>a</sup> Nancy G. La Vigne, Janeen Buck Willison, Marina Duane, Cameron Okeke, Azhar Gulaid, Lisa Clemans-Cope, and Will Engelhardt, *Comprehensive Opioid Abuse Program Assessment: Examining the Scope and Impact of America's Opioid Crisis* (Washington, DC: Urban Institute, 2019).

and TTA enhanced grantee capacity, advanced cross-system collaboration and information sharing, and informed or changed justice system responses to opioid misuse and treatment access. It begins with a brief overview of the scope and nature of the opioid crisis to set the COAP initiative and this assessment in context. Subsequent sections present the assessment's methodology, followed by findings from the process evaluation and grantee performance analysis. It concludes with actionable recommendations for future program design and data collection, and a call for additional evaluation to confirm the promising outcomes identified here.

# 2. Overview of the Recent Opioid Epidemic

Opioid misuse rose to epidemic proportions in the last two decades with devastating consequences throughout the United States. In 2018, more than 10 million people reported misusing opioids and over 2 million suffered from an opioid use disorder (OUD), including roughly 526,000 people who experienced OUD related to heroin (SAMHSA 2019).<sup>5</sup> The number of fatalities from opioids has increased five-fold between 1999 and 2019 for a total of nearly 500,000 deaths.<sup>6</sup> Accounting for 70 percent of all drug overdose deaths in the US, the 49,860 people who lost their lives in 2019 includes roughly 14,000 fatalities that involved heroin, 14,000 that involved prescription opioids, and 36,000 that involved synthetic opioids (Mattson et al. 2021).<sup>7</sup> Deaths from fentanyl, a highly potent and increasingly popular synthetic opioid, were 12 times higher in 2019 than in 2013 (Mattson et al. 2021). The rate of overdose deaths also appears to have accelerated during the COVID-19 pandemic (CDC 2020) and analyses of death records indicate an increase in dual-drug overdoses, with one in five deaths involving both heroin and cocaine.<sup>8</sup> Despite the prevalence and risks of opioid misuse, only 18 percent of those who reported an OUD in 2019 received tailored treatment in the form of MAT (SAMHSA 2020).

Prescription drug misuse is highest among young adults 18 to 25 years old (NIDA 2020b), whereas opioid-related deaths are highest among adults ages 24 to 35 (Gomes et al. 2018). Men are also twice as likely as women to die from an opioid overdose (Gomes et al. 2018). In rural areas, OUD diagnoses are concentrated primarily among white people of middle age, while diagnoses in urban areas are distributed more equally across ages (FAIR Health 2017). Synthetic opioids in particular have caused an increase in overdose fatalities in urban Black communities.<sup>9</sup>

Some regions have been disproportionately affected by the epidemic, with regional trends shifting in recent years. West Virginia had the highest rate of fatal opioid overdose deaths in 2018, followed by Maryland, New Hampshire, Ohio, and Massachusetts.<sup>10</sup> Prescription misuse has historically been concentrated in rural areas in the east, but western states such as Oregon and Colorado had some of the highest rates of prescription misuse in 2017.<sup>11</sup> Fentanyl began driving the opioid epidemic in the Midwest and Appalachia before surging in the Northeast (Ciccarone 2018). For deaths related to synthetic opioids, the Northeast had the highest percentage and rate in 2019 but the smallest one-year increase, whereas the West experienced the largest increase (Mattson et al. 2021). No state experienced a significant decrease in synthetic opioid deaths from 2018 to 2019.

# 2.1 Causes of the Opioid Epidemic

The roots of the current opioid epidemic have been well documented, as outlined in Urban's interim report to Congress (La Vigne et al. 2019), beginning with the 1995 approval of OxyContin and the surge in overprescribing that followed (GAO 2003; Van Zee 2009). Although the rate of opioid prescribing fell in 2019 to the lowest level in 14 years, some counties still had rates six times higher than the national average, and 5 percent of counties reported enough opioid prescriptions dispensed for each person to have one.<sup>12</sup> The drug dependence and pain management related to opioid prescription misuse created a demand that contributed to the other primary pathways to the current crisis: the rise of heroin and the introduction of synthetic opioids (Ciccarone 2009; DEA 2018; Fink et al. 2018; Schueler 2017; Simoni-Wastila 2011). Transported through Mexico and produced mainly by drug cartels, heroin has been a cheaper and more easily accessible alternative to prescription opioids (Ciccarone 2009; DEA 2018; Fink et al. 2018; Simoni-Wastila 2011). Illicit fentanyl is the most common member of the synthetic opioid family; cheaper and easier to produce than heroin, its considerable potency makes it even more fatal—inhaling just 2 milligrams of fentanyl can be lethal (DEA 2016; O'Connor 2017). Suppliers often use fentanyl to cut heroin, leading users to fatally underestimate the strength of what they believe is street heroin (O'Donnell et al. 2017).

Multiple factors ranging from economic insecurity, to poor physical and mental health, to victimization and trauma have been shown to increase a person's vulnerability to opioid misuse. Research on the present OUD crisis points to a compelling link between underlying economic factors and increased access to prescription opioids. For example, low income and poverty, high income inequality, unemployment, and low educational attainment have been found to predict or increase the risk of opioid misuse and overdose deaths (Ghertner and Groves 2018; Hollingsworth, Ruhm, and Simon 2017; King et al. 2014; Monnat 2018; Zhou, Yu, and Losby 2018). Some have reasoned that these associations between poverty and substance use can be attributed to a lack of access to quality health care and substance use treatment.<sup>13</sup> A related explanation is that individuals employed in jobs with high rates of workplace injury, limited or no paid sick leave, and poor job security are more likely to incur injuries and be prescribed opioid medications—often leading to a cycle of substance use and overdoses (DPH 2018). In addition to workplace injuries, people experiencing chronic pain and postsurgical pain may be at higher risk of opioid misuse, particularly if taking high doses for a prolonged duration (Burcher, Suprun, and Smith 2018; Chou et al. 2014).

Similarly, untreated mental illnesses, such as depression and anxiety, can make people more likely to misuse substances such as alcohol and narcotics (Scherrer et al. 2016) and existing substance use disorders (SUDs) can make people more susceptible to opioid use and misuse (Sullivan et al. 2006). One

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such mental health challenge is post-traumatic stress disorder. Early evidence indicates that 41 percent of people with OUD have a lifetime history of post-traumatic stress disorder and 33 percent currently meet diagnosis criteria (Ecker and Hundt 2018). Regular users of opioids experience high rates of trauma or victimization, especially women (Darke et al. 2010; Jessell et al. 2017). There is evidence to support both hypotheses that opioid use is a means of self-medication for post-traumatic stress disorder symptoms and that substance use exposes users to higher rates of violence and trauma (Dahlby and Kerr 2020).

# 2.2 Evolution of the Current Opioid Epidemic

Today's opioid crisis differs from past drug epidemics in important ways. The current epidemic involves several kinds of opioids: prescription opiates, illicit opioids (heroin), and synthetic opioids such as fentanyl, carfentanil, and other analogs. These drugs proliferated in three distinct waves, reaching an increasing swath of Americans, creating new challenges, and resulting in a drug epidemic far more fatal than those of the past. Even before synthetic opioids, the rate of heroin overdoses had surpassed those of previous epidemics. The introduction of fentanyl exacerbated this trend, particularly as suppliers increasingly added it to heroin. Fentanyl-related fatalities began to rise in 2013 and within five years overtook heroin as the leading cause of opioid overdoses.<sup>14</sup>

The production of counterfeit pills laced with fentanyl has likely contributed to the massive increase in opioid overdoses and deaths since 2013 (DEA 2016). Largely produced in China, these counterfeit pills are identical to less-deadly prescription opioids, and the fentanyl additive can only be identified by lab tests. Another unique feature of the current opioid epidemic is a co-occurrence of opioids and illicit stimulants as revealed in toxicology reports from medical examiners and coroner offices (Jones, Einstein, and Compton 2018). In 2016, approximately 80 percent of overdose deaths involving a synthetic opioid included a mixture of two or more drugs, including alcohol (Jones, Einstein, and Compton 2018). One potential cause of increased opioid-stimulant polydrug use is the recent surge of cocaine and fentanyl mixtures in overall drug supplies.

In addition to its potency, the third wave of synthetic opioids has proven to be particularly difficult to contain because of its diffuse supply network and distribution. Fentanyl is sourced from different distributors and produced in clandestine labs in the US or created in China and brought illegally into the US from Mexico or, less frequently, Canada (O'Connor 2017). Criminal enterprises have also increasingly distributed their illegal products online and through the mail, making them hard to detect and trace. Illicit online pharmacies use social media to market and sell opioids and other controlled substances, including fentanyl (Katsuki, Mackey, and Cuomo 2015; Mackey 2018).

The COVID-19 pandemic has exacerbated the opioid epidemic because of increased isolation and external stressors combined with decreased access to services. One study on drug testing and results found that weekly testing fell by as much as 70 percent at the start of the pandemic and that positive drug tests increased by 35 percent for fentanyl and 44 percent for heroin as well as for dangerous drug combinations (Niles et al. 2021). Another study analyzing electronic health records showed that people with a history of an SUD were 1.5 times more likely to contract COVID-19 than people without SUDs and that people with a history of OUDs were at the highest risk of those with SUDs for COVID-19, particularly if their OUD was recently diagnosed (Wang et al. 2020). Further, people with SUDs faced an increased risk of serious COVID-19 cases, such as hospitalization and death (Wang et al. 2020). Early evidence suggests that OUD overdose fatalities surged during the pandemic—the year ending in May 2020 saw the highest number of drug overdoses ever for a 12-month period<sup>15</sup>—but more data are needed before we can fully understand the intersection between the two crises.

## 2.3 Impact of the Opioid Epidemic

The impacts of the opioid epidemic are myriad and far reaching, affecting individuals and families, communities, human service and the justice systems, and the economy.

At the individual level, OUD negatively affects users' education, employment, and housing. Patients who reported opioid use during school indicated that they prioritized drug seeking over academic attendance and performance, leading to negative impacts on their education (Ellis, Kasper, and Cicero 2020). Individuals experiencing OUD are also more likely to be unemployed, with one study finding that unemployment levels were 389 percent higher for people who misuse opioids (Brewer 2017). Another study attributed a 43 percent decline in men's participation in the workforce between 1999 and 2015 to the increase in opioid prescriptions (Krueger 2017). Last, SUD and OUD are linked with increased risk for people to experience homelessness, experience longer stretches of homelessness, and experience homelessness at an earlier age (Cambioli et al. 2016; Linton et al. 2013; National Alliance to End Homelessness 2016).

People with OUD, in general, are at heightened risk of mental health challenges, self-harm, and suicide. Lifetime nonmedical opioid use has been associated with several mood disorders, such as depression,<sup>16</sup> anxiety, and bipolar disorder (Martins et al. 2012); according to one study, 10 percent of

people taking prescription opioids developed depression after one month (Scherrer et al. 2016). Evidence suggests both short- and long-term opioid use affect memory, concentration, and other executive functions (Gruber, Silveri, and Yurgelun-Todd 2007). Regarding self-harm, one study found that opioids were involved in more than 40 percent of suicide and overdose deaths in 2017 (Bohnert and Ilgen 2019). Another study of men and women in the US Veterans Health Administration found that OUD was associated more heavily with suicide than any other SUD (Bohnert et al. 2017).

Other individual health outcomes related to opioid misuse and dependency can include liver damage, malnutrition, and infectious disease, which in turn can cause sleep interruption, hormonal imbalance, weight gain, dental issues, and, in rare instances, organ failure (Nabipour, Said, and Habil 2014; Van Zee 2009). HIV, hepatitis C virus, skin infections, heart infections, and septic arthritis are the most common infectious diseases related to opioid use (Ronan and Herzig 2016; Wang, Zhang, and Ho 2011). Infectious diseases are particularly common among heroin users who engage in needle-sharing behaviors. Both opioids and the side effects of OUD, such as medical and nutritional neglect, can jeopardize pregnancy and the health of a fetus (Fischer 2000).

The harm caused by opioid misuse often extends to the well-being of users' children and families. The number of babies born with neonatal abstinence syndrome or opioid withdrawal syndrome from maternal opioid use during pregnancy increased more than five times between 2004 and 2014 to affect 32,000 newborns (Honein, Boyle, and Redfield 2019; Winkelman, Chang, and Binswanger 2018). Parents experiencing OUD may neglect their children's basic needs such as food and safe housing (Child Welfare Information Gateway 2014) and increase their child's exposure to and accidental poisoning from opioids (Winstanley and Stover 2019). While there is little research on the impact of parental opioid misuse specifically on children (Winstanley and Stover 2019), parental opioid misuse and child welfare involvement are highly correlated (Casey Family Programs 2018; Child Welfare Information Gateway 2014; Ghertner et al. 2018; HHS 2021; PCSAO 2017).

The larger economic costs to society include treatment, lost productivity, criminal activity and justice system involvement, and social welfare expenses, estimated at \$78.5 billion per year (Florence et al. 2016). Another study of 17 states found that OUD-related Medicaid expenditures increased 246 percent from 1999 to \$3.18 billion in 2013 (Leslie et al. 2019).

# 2.4 Intersection with the Criminal Justice System

As described in Urban's interim report to Congress (La Vigne et al. 2019), the criminal justice system has been a critical responder to the opioid epidemic. The illegality of some opioid use—particularly of heroin and fentanyl—create clear connections for both users and sellers to the criminal justice system. OUD is common among justice-involved populations regardless of offense, and law enforcement and other systems are frequently tasked with responding to overdoses and other ramifications of opioid misuse, including public safety concerns related to illegal drug use. As a result, justice system agencies and professionals play essential roles in reducing harm, increasing access to treatment and services for people with OUD, and building knowledge about the epidemic. Many jurisdictions have employed the SIM to identify key decision points at which to safely and effectively divert people with OUD away from the justice system and into community-based treatment or other services to address an individual's underlying behavioral health issues.

The criminal behavior stemming from the opioid epidemic has adversely impacted public safety. Medical providers who overprescribed opioids created an increased demand that exceeded supply following efforts to curb legal availability in the mid- to late-2000s (Fink et al. 2018; Simoni-Wastila 2011). As a result, opioid users moved to the illicit drug market, increasing demand and resulting in more illicit opioid trafficking (Quinones 2016). Although the current opioid epidemic has not been as violent or visible in the US as have past epidemics, —violence related to heroin trafficking has largely taken place outside the US and current distribution strategies have prevented the common buyer-seller and seller-seller conflicts of past epidemics—disputes over illegal opioid transactions have led to altercations, assaults, and homicides (Quinones 2016; Rosenfeld et al. 2017, Rosenfeld, Wallman, and Roth 2021).<sup>17</sup> Although there is little evidence that opioid users are more likely to commit crimes than people who use other illicit substances (Caulkins 2014; Darke et al. 2010), there is evidence that people with OUD are more likely to commit crimes than the general public (Disney, Hayward, and LaVallee 2010; French et al. 2000; Schenk, Eisenbarth, and Dixon 2020). People with OUD may commit crimes to obtain resources to purchase drugs, steal prescription medications, meet basic needs, or while under the influence of drugs (Caulkins and Kleiman 2014; Erensen et al. 2018).

People who use opioids have high levels of involvement in the criminal justice system (Winkelman, Chang, and Binswanger 2018). Although it is unclear what proportion of individuals are incarcerated for opioid-related offenses, nearly half a million people are incarcerated for drug offenses nationally (Sawyer and Wagner 2020). Arrest rates for drug possession, manufacturing, and sales between 1994 and 2014 show increases from 2002 to 2007, but have since leveled off (Snyder, Cooper, and Mulako-Wangota 2012). Drug use also remains high among people who are incarcerated, regardless of offense.

From 2007 to 2009, approximately 58 percent of those incarcerated in state prisons and 63 percent of those in jail met the criteria for drug dependence or misuse, with 26 percent of people incarcerated in prison and 28 percent of people in jail reporting having used opiates (Bronson et al. 2020). Regular heroin or opiate use was higher for incarcerated females than males and for white people than black people in prison, and for those incarcerated for property offenses than violent offenses (Bronson et al. 2020).

Given the scope of the crisis and overrepresentation of people with OUD in the criminal justice system, the justice system and the professionals within it are experiencing significant strain. The system has experienced challenges balancing caseloads given the volume and nature of these cases. One study, based on data from 2007 to 2016, calculated the total cost of the opioid crisis to the Pennsylvania state criminal justice system as approximately \$53 million per year for arrests, courts, and incarcerations (Zajac et al. 2019). While drug arrests have been stable, over half of surveyed chief justices and state court administrators rated the opioid epidemic's impact on their courts as "severe" (Bronson et al. 2020; Wakeman 2017). Criminal courts, struggling to maintain optimal caseloads, are encouraging individuals to engage with treatment and incorporating their findings into judicial decisions (Strom et al. 2011).<sup>18</sup> Family courts are swamped by the number of petitions seeking to remove children from homes because of parental OUD (NJOTF 2018). Medical examiners and forensics labs are also overburdened, leading to challenges with documenting opioid trends accurately and exceeding allowable autopsy caps.<sup>19</sup> Increases in demand for emergency interventions, opioid overdoses and fatalities, and repeated calls to assist the same people have placed tremendous physical and mental burdens on first responders, in some cases leading to compassion fatigue, post-traumatic stress disorder, and burnout (SAMHSA 2018).

Criminal justice responses to the opioid crisis include actions to control or reduce the supply and demand of opioids, as well as community- and correctional-based harm reduction efforts. Diverting people with OUD from the criminal justice system to treatment, through changes in law enforcement practices (e.g., diversion to treatment assessment and referral rather than to arrest and booking) may have helped reduce court burdens and jail population growth. For example, courts in Buffalo, New York, Cumberland County, Pennsylvania, Gila County, Arizona, and Brown County, Wisconsin, have opioid drug intervention courts that fast-track people with OUD into wraparound treatment before adjudicating their criminal cases (Lucas and Arnold 2019). In addition, some states, such as New York and Delaware, have passed laws making possession of heroin a misdemeanor, rather than a felony, to reduce burdens on the criminal justice system and facilitate access to treatment.<sup>20</sup>

Despite evidence showing the effectiveness of MAT, one study found that individuals referred for medication for OUD by criminal justice agencies were less likely to receive medications than those

referred by other sources (Khatri, Howell, and Winkelman 2021). One culprit could be widespread stigma around MAT, as indicated in one study of criminal justice professionals in Indiana (Andraka-Christou et al. 2019). Another small study found that law enforcement officers hold high levels of stigma toward people who misuse opioids, indicating a need for more training and education on opioid misuse to reduce stigma (Kruis, Choi, and Donohue 2020). Both studies identified education and MAT training as promising solutions for improving criminal justice responses to the opioid crisis.

Best practice dictates that correctional facilities (jails and prisons) should screen and assess people for OUDs, initiate and provide various treatment modalities, and mitigate the potential for overdose after release by facilitating and encouraging continued treatment in the community (ACA and ASAM 2018; Pew Charitable Trusts 2020). Adhering to these practices is a challenge, particularly in jails, which tend to be chronically underfunded, overpopulated, and understaffed. As a result, only a small percentage of people who need treatment receive it while incarcerated and the treatment provided is often inadequate, increasing the risk for fatal overdoses after release. Of the nearly 3,500 jails across the country, fewer than 200 jails in 30 states (or roughly 5 percent) have introduced MAT. Within this subset of 200, most facilities only offer one treatment modality: injected naltrexone (NSA and NCCHC 2018). The lack of MAT and reliance on withdrawal management as the only treatment modality can make people leaving jails more vulnerable to subsequent overdoses (Baumgartner and Brookes 2018; Binswanger et al. 2007). In addition, those who do not receive medications for OUD treatment exhibit greater risk of increased opioid use, criminal activity, and infectious disease transmission after release (NIDA 2020a).

To effectively address this complex public health issue, criminal justice systems and professionals must coordinate and collaborate across multiple public sectors as well as federal, state, and local governments. These collaborations support the sharing of data and coordination of efforts aimed at educating the public about the epidemic and enforcing laws. One review of joint criminal justice and health care interventions, particularly prearrest initiatives, found limited research on such approaches but promising findings of their effectiveness at improving treatment outcomes (Yatsco et al. 2020). Another recent example of a cross-sector initiative is the NIH's Justice Community Opioid Innovation Network, which seeks to expand and improve high-quality care for people with OUD in justice settings through researcher-practitioner partnerships.<sup>21</sup>

# 2.5 The Office of Justice Programs Response

The US Department of Justice's Office of Justice Programs (OJP) has made several investments to help communities and justice systems around the country meet the challenges presented by the opioid crisis. These grant programs span all aspects of the opioid crisis, including diversion and prosecution, treatment, patient and physician education, and prescription drug monitoring programs (PDMPs). Grants from OJP also support cross-system data sharing, as well as research and evaluation to monitor and assess both the opioid epidemic and the efficacy of various response strategies. In addition to COAP/COSSAP, BJA administers numerous grant programs that either directly or substantially address the opioid crisis, including the Adult Drug Court, Veterans Treatment Court, and other specialty drug court programs, the Residential Substance Abuse Treatment for State Prisoners program, and the Justice and Mental Health Collaboration Program. Other Office of Justice Programs agencies, including the National Institute of Justice, the Office for Victims of Crime, and the Office of Juvenile Justice and Delinquency Prevention also administer grants that seek to help youth and their families affected by the opioid epidemic, advance research and evaluation, and support forensic activities and local medical examiners. These efforts are detailed in Urban's interim report to Congress (La Vigne et al. 2019).

Although OJP has made several investments to assist communities in addressing the opioid epidemic, the current assessment focuses exclusively on exploring the scope and reach of the COAP grant program—BJA's most expansive opioid-focused grant program—including the strategies funded, technical assistance provided, and impact of COAP on the grantees and their respective communities.

# 3. Assessment Methods

The aim of Urban's initial assessment and evaluation was to generate actionable information that can assist, improve, and sustain effective efforts to address the opioid crisis (La Vigne et al. 2019). The 30-month assessment consisted of two components: a multisite process evaluation and quantitative analysis of grantee performance data. The process evaluation examined 28 selected COAP-funded and Bridges grantees to document their strategies and implementation experiences, including successes, challenges, and lessons learned from those efforts, and to evaluate the reach and "impact" of COAP in communities with FY2017 and FY2018 grant awards. The grantee performance analysis examined grantee reporting compliance, implementation experiences, and project operations, outputs, and outcomes using the data FY2017 and FY2018 COAP grantees submitted to BJA on a quarterly basis.

Through the process evaluation and grantee Performance Management Tool (PMT) data analysis, the assessment sought to answer four overarching questions:<sup>22</sup>

- 1. What impact did the COAP grantees have on reducing future overdoses among overdose survivors?
- 2. What impact did COAP grantees have on connecting their target population to treatment or recovery services?
- 3. What impact did the COAP grantees have on retaining their target population in treatment and recovery services?
- 4. What impact did researcher engagement have on COAP program outcomes?

To address these questions, the process evaluation and grantee PMT data analysis articulated and answered additional research questions as described in sections below.

# 3.1 Process Evaluation Methods

Data collection and analysis for the process evaluation spanned 11 months (September 2019 to July 2020) of the 30-month assessment. Figure 1 presents the process evaluation timeline and key activities.

#### FIGURE 1

#### **Process Evaluation Timeline**



Source: Authors' process evaluation of Bureau of Justice Assistance, Comprehensive Opioid Abuse Program.

Guided by an action research framework, the process evaluation documented and examined grantees' COAP-funded strategies and Bridges planning work to identify factors that influenced strategy development or planning efforts, as well as project implementation and operations, outcomes or milestones achieved, technical assistance needs and receipt, and lessons learned that could benefit the broader field and inform BJA's practices.

### 3.1.1 Research Questions and Methods

Box 3 lists the research questions guiding the process evaluation. Data sources included the following:

- review and analysis of grantee materials, including proposals and progress reports submitted to BJA, planning and implementation documents, presentations and training materials, and local evaluation data (aggregate) and reports
- 60-minute screening telephone interviews with 40 COAP and 16 Bridges grantees, identified by the BJA/Institute for Intergovernmental Research (IIR) team as top contenders for the multisite assessment, to explore and document project status and capacity for the multisite process evaluation
- virtual site visits and two in-person site visits to COAP and Bridges grantees to observe strategies in action and interview project stakeholders and research partners about the design,

planning, implementation, and operations of key strategies; data collection and reporting; outcomes; technical assistance needs and receipt; and lessons learned

- observations of stakeholder meetings and planning or implementation activities
- observations of COAP and Bridges conferences and symposia
- 60-minute individual and small-group interviews with designated COAP and Bridges TTA providers—Advocates for Human Potential, AEquitas, Altarum, IIR, JBS International, and Treatment Alternatives for Safe Communities (TASC)—to learn about the needs of COAP grantees, the scope and nature of TTA provided, any changes to TTA delivery mechanisms, and lessons learned

These data were then coded and analyzed using NVivo 11 qualitative coding software to identify themes derived from the interview protocol.

#### BOX 3

#### **Process Evaluation Research Questions**

- What is the nature of the grantee's opioid issues and how does the proposed intervention/initiative address them?
- What is the policy, fiscal, and cultural (organizational) context in which COAP interventions/initiatives are implemented?
- What factors affected the grantee's design interventions/initiatives?
- What legislative or fiscal policies and agency practices guide, govern, or impede COAP grantees and their progress?
- What is the grantee's theory of change for its COAP intervention (site level) or initiative (state level)?
- What are the key programmatic elements of the grantee's intervention/initiative, and what specific populations are targeted?
- What factors facilitated or impeded implementation and operations, such as policy or leadership changes, staff and partner turnover, low case flow, and limited program capacity?
- What are the common features of sites selected, and have these grantees received funding/assistance for similar efforts in the past?
- What collaborative structures were created or enhanced by COAP?

- How has COAP funding affected cross-system and agency-level collaboration and coordination, information sharing, and service delivery to affected populations? What is the evidence for increased collaboration, data sharing, analysis, and monitoring?
- How has COAP funding affected local law enforcement operations, diversion options, prosecutions, and cross-systems use of technology for detection, enforcement, and treatment? What is the evidence for improved operations?
- What are the perceived impacts of COAP at the system, agency, program, and participant levels?
- Relevant to Category 1–3 grantees, were designated evidence-based practices such as screening, assessment, and eligibility criteria implemented with fidelity?
- Relevant to Category 1–3 grantees, how many people were treated or diverted? How many completed treatment or the diversion program successfully? How many did not?
- What training and technical assistance was needed and delivered? Were trainings implemented with fidelity? What factors affected the uptake of training?
- What lessons can be learned for implementation success and sustainability?

## 3.1.2 Grantee Site Selection

Site selection was an iterative process. Working from a BJA-maintained spreadsheet containing key characteristics and progress indicators for all FY2017 and FY2018 COAP grantees, Urban presented BJA and IIR with 40 candidate sites for consideration in early July 2019. This initial candidate pool took into account grantees' key characteristics, including geographic clusters and distribution across the COAP grantee categories. Although BJA and IIR affirmed Urban's initial selections, they asked Urban to expand the project's scope to also consider 16 newly awarded Bridges grantees and examine their planning experiences. As such, site selection expanded to consider a pool of 56 candidate sites.

Between October 2019 and early December 2019, we interviewed project coordinators (and other stakeholders designated by the sites) in 50 of the 56 grantees (40 COAP and 16 Bridges grantees, representing 51 discrete communities) nominated and vetted jointly by BJA, IIR, and Urban. These interviews explored the implementation status of COAP grantees (e.g., Were programs or projects operational and if so, for how long? Had there been any significant obstacles or impediments to implementation?). Interviews with Bridges planning grantees focused on the status and outcomes of the grantees' planning processes. Urban then coded and analyzed these interview transcripts and categorized the grantees into three groups: "recommended for assessment," "has potential for assessment," and "not recommended for assessment." Grantees recommended for assessment

presented compelling evidence of steady implementation progress or being operational with stable partnerships; well-defined interventions or initiatives; reliable data and solid analytic capacity; and an openness to evaluation. Using this rubric, Urban submitted a list of 30 grantees to BJA in mid-December 2019. Selections were finalized in early January 2020. BJA and Urban issued a joint email to grantees in early January 2020 notifying them they had been selected for the process evaluation and inviting them to participate. Site visit scheduling began shortly thereafter.

The final process evaluation sample consisted of 5 Bridges grantees, and 23 COAP grantees. The 23 COAP grantees consisted of 16 grantees from the FY2017 cohort and 7 grantees from the FY2018 cohort, and spanned five of the six COAP grant categories. Specifically, the process evaluation sample consisted of five Category 1 grantees, three Category 2 grantees, eight Category 3 grantees, one Category 4 grantee, and six Category 6 grantees (see appendix A for detailed descriptions). Figure 2 shows the distribution of process evaluation grantees by state. Appendix B provides thumbnail descriptions of the process evaluation sample's 28 COAP and Bridges grantees.

#### FIGURE 2





Source: Authors' analysis of grantee data from Bureau of Justice Assistance, Comprehensive Opioid Abuse Program.

## 3.1.3 Data Collection

Site visits spanned March to July 2020. Although we planned to conduct in-person site visits to each grantee, only two were completed before the onset of the COVID-19 pandemic. With communities nationwide under strict stay-at-home orders, the project quickly pivoted from in-person to virtual site visits using videoconferencing platforms such as Zoom and Microsoft Teams. We visited 28 of the 30 grantees invited to participate in the process evaluation (one grantee declined and another could not be reengaged in site visit planning efforts as the pandemic persisted) and conducted more than 125 interviews with approximately 189 stakeholders, including leadership and frontline staff from behavioral health agencies, correctional and judicial systems, treatment providers, faith communities, and county and city officials. The project team also conducted semistructured phone interviews with 16 staff across the six designated COAP and Bridges TTA providers (see box 3). These 60-minute interviews asked about grantee TTA needs, the scope and nature of assistance provided to grantees, any changes to TTA delivery mechanisms, and lessons learned. Oral consent was obtained prior to each interview.

In addition to the interview data, we collected and reviewed program materials and reports, aggregate project data, and any evaluation materials available from local research partners.

### 3.1.4 Limitations

There are limitations to consider when contemplating the process evaluation's findings.

Foremost, the evaluation focused only on FY2017 and FY2018 grantees, the first two cohorts of COAP grantees, and does not capture the experiences of later grantee cohorts; it is unclear how the initial grantee cohorts and current grantee cohorts are similar or different. Relatedly, Urban's site selection drew from a limited candidate pool identified by BJA and IIR as well suited for evaluation. While it is unclear how well the 28 grantees forming the process evaluation sample represent the broader COAP and Bridges grantee cohorts, the performance analysis suggests their implementation experiences and progress mirror those of the broader cohorts.

Second, the process evaluation drew on qualitative data to document grantee implementation experiences and progress but does not definitely demonstrate if the grantees' initiatives achieved measurable change.

Third, the process evaluation occurred, by design, well into the grantees' project periods when programs were operational and stable. However, this means Urban did not observe implementation challenges or progress firsthand but had to rely on archival documents and stakeholders' recollections.

Finally, the COVID-19 pandemic limited data collection. Urban's project researchers could conduct only two in-person site visits before the pandemic; both afforded the opportunity to observe the grantees' COAP projects in action (i.e., attend a community ride-along with a site's quick response teams and a treatment program graduation) that virtual site visits could not. While virtual site visits allowed the project's researchers to collect valuable information, they limited the scope of information that could be gathered.

# 3.2 Grantee Performance Analysis Methods

The grantee performance analysis explored seven key questions about grantee performance, implementation, outputs, and outcomes as listed in box 4.

#### BOX 4

#### **Grantee Performance Analysis Research Questions**

- To what degree were grantee reporting requirements and programmatic milestones met, and to what extent did this vary by grantee category or fiscal year?
- To what extent did grantees implement programs, policies, and interventions with fidelity, including meeting important project milestones?
- Did early compliance with reporting requirements lead to stronger fidelity?
- Did noncompliance with fidelity reduce impact on outcome measures related to opioid misuse?
- Were some types of interventions more effective (likely to report desired outcomes) than others?
- What were the reported needs and challenges grantees faced, and what gaps remain in TTA and knowledge development?
- To what degree are BJA resources distributed to the geographic areas, populations, and interventions in greatest need?

Urban also mined the PMT data to examine patterns of grantee collaboration and partnerships, the scope of grantee planning and implementation activities, use of data and research, obstacles encountered, and TTA receipt (box 5).

#### BOX 5

#### **PMT Reporting**

Each COAP grantee was required to submit quarterly data on grant activities to BJA semiannually (i.e., grantees are to provide two quarters of data at each semiannual submission) using the PMT, a guided online questionnaire. Under the PMT 1.0 questionnaire, all COAP grantees were obligated to submit a common questionnaire and a category-specific questionnaire each semiannual reporting period but could report quarterly if they preferred.

From October 2017 to August 2019, the PMT 1.0 consisted of 31 forced-choice and open text questions across the common questionnaire and category-specific questionnaires. The common questionnaire contained questions relevant to every COAP grant category, such as funding information, service area information, stakeholder involvement, TTA receipt, postgrant sustainability efforts, and general grant goals and progress. The category-specific questionnaires captured data about activities and goals relevant to each grant category, such as coordination with victim services by Category 1 grantees; use of technology for service delivery, including screening and assessment, and medication management by Category 2 grantees; implementation of diversion programs, including recovery support and treatment, by Category 3 grantees; state action planning activities by Category 4 grantees; and research- and evaluation-supported activities by Category 6 grantees.

In September 2019, BJA launched a revised version of the PMT questionnaire (PMT 2.0), which remained in use as of December 2020. Both the structure and content of the PMT 2.0 differed from that of the PMT 1.0. Unlike the two-questionnaire format of the PMT 1.0, the PMT 2.0 is a single questionnaire, comprising 81 items, that all COAP grantees populate. Additionally, while many items in the PMT 2.0 were adapted from the PMT 1.0 common and category-specific questionnaires, the PMT 2.0 includes some nuanced but important variations in question wording and response options. For example, in the PMT 1.0 questionnaires, Category 1–3 grantees were asked to report if they referred people to *substance use treatment services*, but in the PMT 2.0 questionnaire, all categories of grantees are asked to report if they refer people to *substance use and co-occurring treatment services*. Additionally, under the PMT 2.0, all COAP grantees now answer the same questions regardless of relevance to the grantee. Because of the differences between PMT 1.0 and PMT 2.0 datasets were evaluated separately.

## 3.2.1 Analytic Approach

Urban analyzed PMT data for 166 FY2017 and FY2018 COAP grantees in five of the six COAP grant categories (Categories 1–4 and 6). The rationale for focusing on these specific COAP grantees was twofold. Foremost, the FY2017 and FY2018 COAP grantees—the grant program's initial award cohorts—offered the longest periods of performance under which to solidify operations, generate short-term outcomes, and gather the multiple waves of performance data necessary to detect potential trends. Second, Category 5, which consists of PDMP grantees, had been the focus of separate ongoing analyses; BJA therefore recommended excluding it from this analysis.

BJA provided Urban's project team with two COAP PMT datasets:

- In August 2020, a PMT 1.0 dataset consisting of 166 COAP grantees, with data spanning eight quarterly reporting periods for FY2017 grantees (October 2017 to September 2019) corresponding to the first two project years of that cohort's grants, and four quarterly reporting periods for FY2018 grantees (October 2018 to September 2019) reflecting the first project year of that cohort's grants
- 2. In October 2020, a PMT 2.0 dataset with data for 160 FY2017 and FY2018 COAP grantees spanning October 2019 to June 2020, representing three quarterly reporting periods

The number of grantees reporting each quarter fluctuated considerably: between 31 and 36 of the 50 FY2017 grantees submitted data in any given quarter, while between 113 and 127 of the 168 FY2018 grantees submitted data in any reporting quarter. The number of completed items also varied by quarter and grantee. Table 1 provides the distribution of COAP grantees in the sample by category type and fiscal year, across both PMT 1.0 and PMT 2.0.

#### FY2017 Grantees Reporting FY2018 Grantees Reporting Total COAP Awards FY2017 FY2018 (N = 50)**PMT 1.0 PMT 2.0 PMT 1.0 PMT 2.0** (N = 168)35 33 Category 1 12 37 12 12 2 7 Category 2 2 2 7 7 32 Category 3 8 32 8 8 32 5 14 2 2 9 9 Category 4 23 Category 5 11 n/a n/a n/a n/a Category 6 12 47 12 12 47 43 Total 50 159<sup>a</sup> 36 36 130 124

### Distribution of FY2017 and FY2018 COAP Grantees Reporting PMT Data (Categories 1–4 and 6)

**Source:** Authors' analysis of grantee data from Bureau of Justice Assistance, Comprehensive Opioid Abuse Program. **Notes:** COAP = Comprehensive Opioid Abuse Program. n/a = not applicable. PMT = Performance Measurement Tool. Category 5 has been the focus of separate ongoing analyses and is thus excluded from this analysis.

<sup>a</sup> The 168 FY2018 COAP grantees included nine Innovative Prosecution Solutions and Policing grantees, which were excluded from the analysis. Therefore, this column only totals to 159.

Based on sample PMT data and discussions with BJA staff, Urban submitted an analysis plan to BJA in June 2020 that envisioned merging multiple data files to create a continuous longitudinal dataset that would support a variety of descriptive and inferential analyses. The analysis plan proposed to generate descriptive statistics on COAP grantee characteristics, goals, activities, strategies, implementation challenges, and outcomes, and to compare grantee performance within categories and across fiscal years to identify meaningful variations in grantee experiences and performance. We also proposed to conduct correlation and regression analyses to establish and explore relationships between implementation challenges, grant activities, and outcomes. Last, the analysis plan proposed to compare the performance of the 23 COAP grantees selected for the assessment's process evaluation to the broader FY2017 and FY2018 grantee cohorts to gauge how typical the experiences of those 23 process evaluation grantees might be.

## 3.2.2 Limitations

TABLE 1

Changes to the structure and content of the PMT questionnaire in late 2019 limited the analysis in several ways.

Foremost, the PMT 1.0 and PMT 2.0 datasets could not be readily combined. Subtle changes in question wording meant that items did not align across datasets, while changes in variable names required an extensive crosswalk and verification process that time did not permit. As such the window into project operations was limited.

Second, changes to the PMT items made it particularly difficult to compare data across the two datasets and detect true changes in grantee performance. Specifically, analysts could not be certain whether the changes in the data reflected true differences among groups and over time, or whether the data changed because the questions changed.

Third, COAP grantees were technically required to complete the PMT every quarter, though not all did so, which resulted in uneven data across reporting periods. Among the 166 FY2017 and FY2018 grantees that submitted data in the PMT 1.0 dataset, between 12 and 20 percent missed at least one reporting period. About 10 percent of FY2017 and FY2018 grantees missed at least one of the three reporting periods captured in the PMT 2.0 dataset; the first quarter in each dataset registered the most submissions. Further, grantees were not required to respond to every PMT item or provide a reason for missing entries (e.g., skipping a question because it was an optional reporting period, the question did not apply, or the grantee did not collect the data to answer the question), making it difficult to verify valid skips. Therefore, the analysis had to exclude grantees from comparisons when data were missing for key elements rather than evaluate their reasons for not providing an answer. Uneven responses and incomplete data across report periods also made it difficult to determine the extent to which grantees met their reporting requirements and milestones, and to evaluate changes.

Fourth, the number of grantees reporting in each category and in each award year fluctuated. This fluctuation limited both trend analyses and the ability to detect statistically significant differences over time, as most statistical analysis tests require equal groups of moderate sizes to ensure that averages reflect the true average of the population being studied and that any comparisons are realistic and commensurate. Many comparison groups in this analysis were small and uneven (e.g., because of the expansion of the COAP grant, the PMT 1.0 data contained 36 FY2017 grantees compared with 130 FY2018 grantees), making the averages and proportions used to evaluate change over time and between groups unlikely to reflect the majority of COAP grantees. Additionally, the group sizes (FY cohort, category, etc.) were too small to evaluate relationships between reporting, activities, obstacles, and outcomes.

Last, logical inconsistencies were also prevalent in the data. For example, no grantees reported serving tribal areas in the PMT 1.0 dataset, yet both FY2017 and FY2018 COAP grantee cohorts included tribal grantees, as did both PMT datasets. It is unclear if the inconsistency resulted because these grantees did not respond to the tribal-specific item or because of some other reason. While BJA contractors spend significant time verifying and cleaning the data after each semiannual grantee submission, this process was truncated for the last submission of PMT 2.0 data (January–June 2020) because of COVID-19 hardships.

These limitations precluded the analyses necessary to fully answer some key research questions (the extent to which grantees met their reporting requirements, implementation progress, etc.), yet the PMT data do provide insights about how grantees report information, their project activities and early implementation experiences, and the impact of COAP. Further, analyses detected some statistically significant (p = .05) changes in grantee performance (activities, challenges, outputs, etc.) over time consistent with expanded operations and services. Appendix C provides output from those statistical significance tests.

# 4. Summary Assessment Findings

To examine the implementation experiences, operations, outputs, and outcomes of the initial two cohorts of COAP grantees, this 30-month assessment analyzed performance data for 166 COAP FY2017 and FY2018 grantees and collected critical contextual information for 28 COAP (N = 23) and Bridges (N = 5) grantees' strategies, and planning and implementation experiences, early outcomes, and perceived impacts through its multisite process evaluation. The projects undertaken by the 28 COAP and Bridges' grantees that composed the process evaluation sample are detailed in the assessment's process evaluation report (Buck Willison and Engelhardt 2021). Full findings from the analysis of grantee PMT data are detailed in a separate report (McGilton et al. 2021).

The following sections summarize findings from the project's two key assessment components. Process evaluation findings and themes specific to COAP are presented first, followed by themes and findings specific to the Bridges grantees; results from the grantee PMT analysis are presented next. Recommendations follow each set of findings.

# 4.1 COAP Process Evaluation Findings

The 23 grantees forming the process evaluation sample represented 11 states, including some of those hardest hit by the opioid epidemic. These grantees employed a range of strategies and engaged a wide cross-section of community-based providers, community members, and behavioral health and justice system actors to advance their COAP-funded strategies. Below, we describe grantees' implementation challenges and successes, early outcomes, and lessons learned from their implementation experiences; the impacts of the COVID-19 pandemic, technical assistance these grantees requested and received, and the perceived impacts of being a COAP grantee are also discussed.

## 4.1.1 Implementation Outcomes

Many COAP process evaluation grantees were able to point to tangible outputs and initial outcomes related to project implementation. The metrics these grantees reported suggest their COAP strategies were advancing the grant's intended objectives.

**Increased outreach and reduced opioid overdoses.** Many grantees credited COAP funding with enhancing their ability to respond to the crisis and pointed to both the number of people served and reductions in opioid-related overdoses as evidence of the grant's impact. One Category 1 grantee, for

example, reported a 40 percent reduction in suspected opioid overdose 911 calls and a 24 percent reduction in fatal overdoses between 2017 and 2018, which stakeholders attributed largely to implementation of their COAP-funded quick response teams (QRTs). Other Category 1 grantees reported referring and serving hundreds of individuals through their projects: one had referred 205 people to peer support specialists through their COAP-funded initiative, of which approximately 35 percent went on to participate in a peer support program. Another Category 1 grantee, which distributed Narcan kits and linked people who had overdosed to peer recovery coaches, reported serving 2,080 patients between October 2017 and Spring 2020, with staff engaging directly with approximately 1,500 patients; the project had also referred 175 patients to OUD treatment and given 245 patients Narcan kits. Another Category 1 grantee (FY2017) also reported distributing Narcan kits to hundreds of people at risk of experiencing an opioid overdose, and that site's stakeholders likewise credited their QRT's work in the community with reducing the stigma tied to SUDs.

**Increased connections to OUD treatment.** Category 2 and 3 grantees reported similar progress with respect to assessing, referring, and treating people with OUD. One FY2017 Category 2 grantee, for example, reported that 159 people had been assessed by a clinician and referred to treatment, and 133 people had engaged in treatment as of November 2019 using technology for remote service delivery. In addition to these numbers served, the grantee had successfully established a "broadcast site" and equipped eight other day report centers with the technology for virtual MAT assessment and treatment. As of July 2020, the broadcast site had not experienced any overdose fatalities during the grant period—a remarkable achievement. A Category 3 FY2017 grantee, which provides nearly 12 months of holistic treatment services including peer support and employment resources to people with OUD and SUD, had received 94 referrals and enrolled 62 clients in treatment in its first 18 months of operation; initial data suggest solid participation in treatment and services. As of the process evaluation site visit, another Category 3 grantee was actively engaging approximately 60 people (two 30-client caseloads) in MAT, spanning the county jail and the community.

**Expanded education and training.** The Category 4 grantee engaged Policy Research Associates to train local stakeholders on the SIM and to facilitate the SIM mapping process locally. Stakeholders from across the state participated in July 2019 to attend the training, resulting in a network of trainers that can assist communities in using the SIM to identify critical treatment gaps and set priorities for filling those gaps. Attended by a broad cross-section of criminal justice and behavioral health practitioners, as well as first responders, hospital representatives, and community-based providers, the two-day training helped stakeholders identify and fill gaps, and brought stakeholders together to strengthen local efforts. In turn, some Category 6 grantees had partnered with state universities to offer webinars on

prescribing behaviors and opioid misuse, and to implement a statewide media campaign, Dose of Reality, to educate key stakeholders and the general public about opioid misuse. One grantee reported hosting approximately 450 Dose of Reality events with more than 7,500 participants; preliminary results of the pre-post training survey pointed to a "statistically significant change" in participant attitudes after taking the training. Other Category 6 grantees had convened regular meetings, routinely received and analyzed opioid use and overdose data from multiple agencies, and generated analyses and reports that tracked drug hot spots and mapped fatal and nonfatal overdoses—both of which informed resource and practice decisions.

### 4.1.2 Implementation Challenges

The most common implementation challenges reported across categories were funding delays, hiring delays, and staff turnover. Data collection and reporting to BJA was also a common challenge: many found the system hard to navigate and some of the required data ancillary to their initiatives. In addition to these cross-cutting challenges, grantees also reported challenges specific to their funding category, such as technology constraints, policy barriers, lack of buy-in, and resistance to MAT.

#### **COVID-19 EFFECTS ON IMPLEMENTATION**

Numerous grantees reported modifying or delaying operations because of COVID-19 restrictions, although many were able to pivot nimbly to continue operations despite the unprecedented challenges the pandemic imposed.

A common COVID-19-related implementation challenge that affected grantees was diminished project capacity as key partners, such as public health agencies, refocused operations on the pandemic. Grantees across categories also reported another common impact of the pandemic: an increase in SUD-related deaths because of COVID-related isolation. Many grantees had developed alternate methods for contacting and engaging with potential clients during the pandemic to mediate the impacts of isolation.

For many Category 1 grantees, COVID-19 slowed or temporarily halted the direct, in-person contact at the center of their QRTs and naloxone distribution efforts. COVID-19 restrictions also impeded assessment and treatment referrals, and impacted service utilization as some people declined to enroll in treatment.

COVID-19 also presented some minor challenges for the Category 2 grantees, although these grantees were better positioned to provide services virtually, having implemented the necessary

technology infrastructure to do so. Still, these grantees faced their own challenges, particularly in communities with limited bandwidth, where increased Wi-Fi use taxed already fragile networks.

Category 3 grantees moved operations to virtual spaces, including video meetings and conference calls, which required adjusting activity levels accordingly.

Two Category 6 sites halted the implementation of their in-person activities because of COVID-19, such as the core trainings and in-person interviews conducted by their opioid overdose mortality review boards. Another grantee found that many partner agencies consisted of "skeleton crews" as the pandemic became more widespread. This reality delayed the data analysis and reporting central to the grantee's initiative.

### 4.1.3 Data and BJA Reporting Requirements

All COAP grantees were required to gather and submit semiannual data using the PMT, but as detailed in Urban's report *Initial Assessment of the Comprehensive Opioid Abuse Program: Analysis of the COAP Grantee Performance Data* (McGilton et al. 2021), grantees reported on different data points depending on their COAP category. Grantees also collected and tracked a wide range of data that varied according to their specific initiative. Urban's process evaluation explored grantees' experiences collecting, using, and reporting these data and found that grantee experiences varied.

All five Category 1 grantees in the process evaluation sample reported using local data to identify clients, track outcomes, and report on their COAP-funded initiatives (as did Category 2 and 3 grantees). Because accurate and timely data were essential to Category 1 program operations, most grantees maintained a spreadsheet or online database accessible to core team members such as project coordinators, treatment providers, and evaluation partners; many collected basic demographic data, outputs, and process indicators.

Data were also central to Category 6 grantees' projects. These grantees generally tracked prescribing trends, geographic hot spots, opioid-related hospitalization, comorbidity, and mortality by opioid type to monitor trends while obtaining a fuller picture of the opioid crisis. Analyses of these data also helped to inform broader opioid responses. Category 6 grantees also tracked substances other than opioids, such as cocaine and other stimulants, to detect changes in use patterns. Common data sources used by Category 6 grantees included emergency medical services (EMS), the coroner's office, PDMPs, nonfatal opioid overdose data from hospitals, arrest data, and conviction data from court systems. Common data-use goals included producing accessible, centralized data sources for public and agency
use, as well as targeting resources (e.g., overdose prevention specialists, syringe programs, peer supports, trainings, and targeted media campaigns) to the most pressing issues. Although these grantees made great strides in accessing key data, they noted that some data were more difficult to access than others because of agency or federal polices such as HIPAA or because of entrenched data silos. Feedback loops were also critical for Category 6 grantees (i.e., reporting the data collected and analyzed to key audiences, especially in high-need communities), and dissemination strategies included data briefs, data dashboards, and sharing information in public health record systems.

#### **BJA REPORTING REQUIREMENTS**

All grantees reported submitting data to BJA's PMT system, as required by the COAP grant. Many grantees, however, encountered challenges with the system and submitting accurate data. Grantees also expressed concerns that not all required PMT data were directly relevant to their COAP projects.

Across COAP categories, grantees expressed concerns that the required PMT data did not align well with their grant-funded activities and frustration that more relevant data they collected could not be shared with BJA because the PMT system could not accommodate it. Some grantees also reported that some PMT questions did not fit the scope of their initiatives while other items were too specific. Still others noted that the PMT system did not generate data or reports they could use to manage their projects or monitor progress; these grantees hoped future reporting systems would produce more useful reports given the amount of time spent reworking the data for submission into the COAP portal.

The PMT system also received mixed reviews. Many grantees reported a steep learning curve to use the PMT system accurately and critiqued it as "not especially user friendly." Other stakeholders reported spending considerable time and resources to rebuild their data management systems to align with BJA's reporting requirements, only to find that BJA had made substantive changes to the types of data requested. At the same time, some stakeholders found the BJA reporting process to be fairly straightforward and thought the required data adequately captured their project's process, progress, and challenges. However, these grantees reported they were already collecting the required data at outset of the project, which may account for their perspective on the PMT. Still others appreciated the multiple options they had for sharing information, such as submitting report narratives and presentations.

Grantees recommended that future reporting systems generate reports and data that both BJA and grantees can use to monitor progress and measure outcomes. Some also recommended augmenting the system so grantees could better document the scope of their activities and accomplishments, as well as explain any inconsistencies in their data or why data may be missing.

#### **RESEARCH PARTNERS**

Although it was not required, 11 of the 23 COAP evaluation grantees, spanning Categories 1 to 4, partnered with local researchers to conduct formal evaluations, assist with data collection, or conduct data analyses. None of the Category 6 grantees engaged a separate evaluation partner given the scope of their initiatives, which were oriented toward data analyses and reporting.

Two Category 1 grantees partnered with local evaluators to collect data and measure outcomes related to their COAP initiative; one partnered with researchers at a local university and the other engaged a local researcher. Each regularly provided the grantees with data. For example, one Category 1 grantee engaged a local program evaluator to collect data on overdoses and overdose fatalities from the county's fire department, EMS, and medical examiner and compile overdose reports (including client contact information) shared nightly with the program's service provision partner to inform the dispatch of peer specialists.

Only one Category 2 grantee had a formal evaluation partner, and that researcher was conducting a process evaluation of the grantee's strategy. In contrast, another Category 2 grantee reported completing an internal program evaluation annually, but those reports are not publicly available.

Seven of the eight Category 3 grantees in the process evaluation sample engaged evaluation partners. Some retained local evaluation firms. Most partnered with researchers at local universities to conduct process and outcome evaluations that would answer critical questions about program performance and inform sustainability efforts. Some Category 3 grantees relied on their research partners to collect data they otherwise could not obtain or to provide analytic support (i.e., analyze their program data).

The process evaluation's one Category 4 grantee also retained an evaluator to study the impact of local programs funded under its COAP grant and to assess the fidelity of implementation. At the time of the site visit, the grantee's local research partner was tasked with developing evaluation plans with each of the local sites and helping them navigate data collection, as well as conducting quarterly analyses for the grantee.

Uniformly, grantees valued the insights their research partners offered. Stakeholders in one grantee site credited their external evaluator with giving them an objective view of the program.

### 4.1.4 Receipt of Training and Technical Assistance

Four principal TTA providers—IIR, AHP, Altarum, and Brandeis University—provided FY2017 and FY2018 COAP grantees with virtual and in-person TTA on a range of analytic and programmatic topics relevant to the successful implementation of their COAP strategies.<sup>23</sup> Core TTA topics include performance measurement and management; peer recovery supports to enhance substance use treatment and recovery; MAT, telehealth treatments, naloxone administration, and overdose prevention programs to reduce opioid misuse and overdose fatalities; support for PDMPs; and multisector collaboration to promote best practices.

IIR performs several critical functions for COAP: it coordinates TTA work across selected providers, conducts virtual peer learning exchanges via monthly COAP affinity group webinars, administers national grantee meetings, and coordinates resource dissemination. It also operates and maintains the COAP (now COSSAP) Resource Center website and related content.

AHP delivers targeted TTA to Category 1-4 grantees in collaboration with three partners: Treatment Alternatives for Safe Communities (Category 1), the Center for the Application of Substance Abuse Technologies (Category 2), and the Crime and Justice Institute (Categories 3 and 4). Altarum helps COAP grantees implement best practices and promising approaches related to peer recovery support services. Brandeis University's Heller School for Social Policy and Management operates and maintains the virtual PDMP TTA center in partnership with IIR. The center maintains a research clearinghouse that offers research and evaluation resources and data-related guidance. The center also provides training tools, technical guidance, resources, and TTA to advance data exchange via *RxCheck* and PDMP data sharing through the Prescription Monitoring Information Exchange National Architecture. Additionally, the center provides a comprehensive array of services, including expert consultations, meeting facilitation, and issue briefs on topics such as PDMP best practices, innovations, evaluation, and performance measurements.

Two other organizations, AEquitas and JBS International, also provide TTA to COAP grantees. A national technical assistance provider staffed primarily by former prosecutors, AEquitas provides legal research and guidance to organizations and localities around the role of prosecution. AEquitas has worked with three COAP grantees (across grant categories) that had grant components focused on prosecuting people who trafficked opioids. AEquitas also conducted webinars for COAP grantees focusing on prosecution best practices for opioid related cases. JBS International delivers technical assistance to public and private sector stakeholders across multiple topical areas with the goal of creating sustainable change in health care, social services, and education to improve people's lives. JBS

International has worked with eight COAP grantees focused on responses to people who experienced victimization; these grantees spanned multiple COAP categories. JBS International also conducted site visits to each of the eight grantees, as well as a roundtable event, in connection with one BJA conference.

#### **GRANTEE TTA NEEDS**

COAP TTA providers characterized the needs of COAP grantees as highly dependent on the nature and scope of the grantees' work. For example, TTA providers working with COAP-funded QRTs noted that these collaborations are "relatively new" so the grantees required foundational guidance on crafting data-sharing agreements and establishing approaches for outreach to and engagement with people who recently experienced opioid overdoses.

In contrast, grantees implementing MAT typically needed assistance around the administration of specific medications or treatments, which required different expertise from the TTA provider. Still other grantees needed legal guidance and requested assistance around justice responses to people with opioid use needs. Because of these specific TTA needs, TTA providers reported that it was helpful when they could conduct one-on-one engagement with grantees to assess their needs and develop implementation plans to advance the grantees' goals.

Finally, TTA providers also mentioned that grantees frequently requested help connecting with peer sites. Specifically, grantees regularly asked to be connected with peer organizations and jurisdictions implementing similar approaches so they could learn from other grantees. Our interviews with COAP grantees only served to reinforce the premium stakeholders placed on peer learning opportunities.

### **TTA PROVIDER APPROACHES**

COAP TTA providers reported using similar strategies to deliver technical assistance to COAP grantees. Generally, these strategies included broad-based TTA to grantees attending COAP-related conferences organized by BJA and IIR; peer learning communities, facilitated by some TTA providers, with selected grantee categories; and targeted technical assistance to address grantee requests submitted through the TTA portal on COAP's public-facing website. TTA providers also reported assisting sites via telephone contact, in-person site visits (before the pandemic), and webinars and online trainings.

TTA providers appreciated the benefits of each TTA strategy. Grantee conferences were viewed as an effective way to connect with a wide range of grantees, while the peer learning communities enabled TTA providers to support grantees with similar focuses and, likely, similar needs. Because learning communities were entirely voluntary, sustaining grantee engagement could be a challenge. Finally, all four core COAP TTA providers reported delivering some level of TTA to grantees via requests submitted through the COAP resource center website.

TTA providers also greatly appreciated the chance to work directly with grantees to support them in their efforts, providing phone consultations and site visits in some cases. Several TTA providers reported that grantees' work was innovative and challenging and often new to their community, suggesting that the TTA providers' support and guidance could hold real benefit for the sites. Several TTA providers, however, mentioned that requests for consultations and visits were "few and far between" and they often wished there was more appetite for TTA.<sup>24</sup>

#### **COAP GRANTEE TTA EXPERIENCES**

Indeed, few COAP process evaluation grantees reported receiving TTA. Only two of the five Category 1 grantees reported receiving TTA for their COAP-funded initiative. One grantee received assistance from Altarum on best practices around implementing motivational interviewing while another grantee received technical assistance from an individual consultant during the first year of their COAP grant. Although most Category 1 COAP grantees did not use formal technical assistance from an external TTA provider, they employed some type of training or peer learning to improve implementation or operations of their COAP-funded initiatives.

One Category 2 grantee site reported receiving TTA from Altarum, its assigned BJA TTA provider, to plan training with the grantee's certified peer recovery advocates. The training focused on the role of peer recovery advocates in criminal justice settings, including the boundaries and ethics of peer recovery advocates who would work with the court. As of the process evaluation site visit, the grantee had also submitted a TTA application via the COAP TTA portal for assistance developing a prescriber forum for partners delivering MAT to opioid court participants, but this request had been denied.

Unlike other COAP grantees, several Category 3 grantees reported having requested and received COAP-funded TTA. Several had received "light touch" TTA during early implementation. Requests focused on reducing barriers to treatment and how to incorporate peer recovery specialists in this work. Category 3 grantees that received TTA from COAP TTA providers reported positive experiences, describing the TTA providers as resourceful and helpful in identifying solutions to implementation challenges and providing innovative approaches to topics such as peer support models that were new to the grantees. Stakeholders also appreciated that COAP TTA providers shared their knowledge of successful models across the country and brought a range of skills and expertise to the TTA engagement. Still other grantees recounted how their COAP TTA provider paired them with an

experienced "mentor program" to assist with peer recovery support services, which also helped the grantees build new partnerships, including with faith-based organizations and faith communities.

Stakeholders affiliated with the Category 4 grantee received TTA to conduct SIM workshops via Policy Research Associates, a TTA provider with which the site contracted directly. Policy Research Associates used a train-the-trainer model to teach stakeholders and the evaluator to conduct SIM workshops with local jurisdictions.

Category 6 grantees, overall, did not engage TTA providers individually and did not identify any unmet needs. Category 6 grantees did, however, report positive experiences with the COAP webinars and conferences offered by BJA and its TTA providers; they found the peer learning with other grantees across the country to be invaluable.

### 4.1.5 Reported Impacts of the COAP Initiative

Grantees reported a range of tangible effects tied to their COAP grant projects, including increased service capacity, increased knowledge building, enhanced collaboration, increased analytic capacity, and increased information sharing. They also credited their COAP grants with contributing to important infrastructure developments and attitudinal shifts. Grantees universally viewed the COAP initiative and its financial, technical, and substantive resources as instrumental in allowing them to effectively address the opioid crisis in their communities.

- Increased capacity. Foremost, grantees credited COAP with increasing local capacity in several ways. In some grantee sites, the COAP initiative built capacity by funding new programs or expanding treatment options. Some grantees implemented new technology to make treatment more accessible to people with OUD in rural or previously underserved areas. Others used COAP funding to build new data capabilities that allowed more strategic and targeted planning and deployment of resources.
- Knowledge development and innovation. Grantees also reported that COAP resources helped them educate stakeholders about opioid misuse and treatment options, which reportedly led to increased buy-in for efforts such as naloxone distribution, MAT, diversion to treatment, and alternatives to incarceration. Resources such as COAP grantee conferences and webinars, which received high marks from grantees, also reportedly helped stakeholders build knowledge and increase expertise. Finally, grantees reported that COAP funding spurred innovation and built expertise as key partners were exposed to new knowledge, approaches, and tools.

- Enhanced and expanded collaboration. Universally, grantees credited COAP with enhancing collaboration. For some grantees, COAP projects brought new partners to the table. For others, COAP projects strengthened existing partnerships. Stakeholders also observed that their COAP initiatives provided opportunity and structure for more intentional collaboration. This collaboration helped reduce barriers among providers and information silos between agencies.
- Increased data and information sharing. Multiple grantees credited COAP with enhancing information and data exchange among partners, including more routine data sharing, data analysis, and data use, which allowed stakeholders to be more responsive to time-sensitive issues.
- Shifts in attitudes. Stakeholders in multiple grantee communities credited their COAP-funded work with shifting community attitudes about the opioid crisis, including the nature of substance use and treatment, and reducing stigma. Outreach and education across communities helped shift public opinion as more people learned the science of substance use disorders. Stakeholders believed this effort also increased support for naloxone distribution and other measures.

### 4.1.6 Lessons Learned and Recommendations

Grantees described various lessons learned in implementing COAP initiatives and offered recommendations for communities conducting similar work, including the following:

Build appropriate partnerships and cultivate relationships. Identifying the right partners to participate in the initiative and building strong, collaborative relationships was a key theme across grantees regardless of category. For Category 1 grantees, building relationships included thoughtfully engaging with law enforcement agencies and officers and partnering with agencies that housed the data needed to identify and conduct outreach to the target population (e.g., EMS), as well as groups with the skills and expertise to add value to an initiative (e.g., mental health agencies and certified peer recovery coaches). One Category 2 grantee also emphasized the importance of recognizing and respecting the baseline beliefs and values of key partners, which may differ greatly from one another (e.g., behavioral and public health stakeholders may hold different views on substance misuse than justice system stakeholders), and understanding the parameters of partner policies. Finally, grantees highlighted the importance of engaging partners who are passionate about the work being done, providing robust training on new programs or technology (e.g., the Overdose Detection Mapping Application Program), and

having an evaluator embedded within the program and thus better positioned to observe operations and provide feedback. For many grantee stakeholders, the importance of team composition (and partnerships broadly) could not be overstated.

- Take a holistic approach to addressing substance misuse. A holistic approach requires partnerships across multiple systems and areas of expertise to address the root of addiction and treat the whole person, as well as to offer multiple treatment options. "Holistic" also means attending to a range of needs and removing barriers to treatment. One grantee emphasized the importance of transportation: a lack of transportation to bring people to treatment, doctor's appointments, or the workforce was the main barrier to success. Finally, grantees emphasized the importance of offering a holistic approach to recovery, including multiple treatment options and, for the many clients who decline treatment, harm reduction programs and services.
- Maintain open communication. Stakeholders emphasized the importance of open communication between partners to ensure continuity of care for clients. This strategy can also impact implementation.
- Engage peers. Many grantees emphasized the important roles people with lived experience, such as peer recovery coaches or peer recovery support specialists, play in COAP initiatives. The lived experience of peers and their expertise brings critical knowledge that can improve service outreach, delivery, and engagement, and make programs and interventions more accessible and effective for the people they seek to serve.
- Engage researcher partners. Most grantees struggled with data access or data-quality issues, but grantees that engaged research partners typically found it easier to access data sources, conduct analyses, and use the data.
- Stay flexible. Stakeholders noted the importance of staying flexible and open-minded as implementation progresses to counteract misunderstandings, build collective understanding, and nimbly shift direction or make modifications as needed.
- Be aware of policy and technical constraints. Category 2 and Category 6 grantees noted the importance of understanding the legal and policy context when implementing technology-oriented or data-sharing initiatives, considering that policies such as HIPAA, Medicaid, and data-sharing and user agreements can hinder implementation. Partner learning curves and general technical issues (e.g., inadequate Wi-Fi, participants' access, interpersonal limitations of virtual platforms) may also affect implementation progress.

- Build in time to negotiate data agreements. Getting data use agreements in place can be a slow process, and receiving the necessary permissions to access data and manage confidentiality and HIPAA issues takes time. Grantees should factor these negotiations into their project timelines.
- Designate a skilled project director. According to stakeholders, strong coordination and project management skills are indispensable for these projects. A dedicated project director who keeps the big picture in mind but tracks the details of implementation and maintains the project's momentum is critical.
- Pursue peer learning. Grantees reported that peer learning, both within the COAP grantee network and locally, helped stakeholders better understand the ecosystem in which they were implementing their projects. This collective learning helped stakeholders improve operations and implementation.
- Invest in and use data. Sharing data is of limited use if the underlying data do not include information critical for decisionmaking. In many jurisdictions, grantees found that their data did not capture the nuances of the opioid epidemic. For example, grantees noted that many people use multiple substances but data systems would only allow them to capture opioid use. Tapping into existing resources can be a solution. A few grantees mentioned working with local High Intensity Drug Trafficking Areas networks to access their unique data. Also, although COAP projects often created unique datasets, at least one grantee found that national datasets can sometimes answer the same questions more easily than collecting local information in a piecemeal fashion.

## 4.2 Bridges Process Evaluation Findings

Bridges planning grants were designed to help communities establish or expand the use of MAT through TTA coaching delivered in concert with an intensive nine-month planning process. Planning grants helped grantees narrow their focus, improve connections between service systems, and promote stakeholder education and buy-in around MAT.

The five Bridges grantees selected for the process evaluation were located in four states: Maine, Montana, New Jersey (2), and Virginia. As discussed below, several had some form of MAT in place before the Bridges planning grant and used the grant's TTA resources to expand their programs (i.e., to offer additional types of medication or to reach additional populations) and for at least one grantee, the Bridges grant helped stakeholders advance plans to fully implement MAT in their jail. Despite their different contexts, stakeholders from these sites shared similar reflections on the grant's impact on their efforts.

### 4.2.1 Bridges Planning Progress

Multiple sites discussed MAT education as an initial planning activity, and many sites found TTA particularly useful in assisting with this portion of the work. Sites' planning led to tailored approaches based on local priorities and tangible action plans that could be implemented after the planning period concluded. Stakeholders typically viewed their Bridges TTA calls and conferences as helpful activities that exposed them to new knowledge and resources. New jail-based MAT policies and practices helped sites enhance capacity to establish or improve local access to MAT. Thumbnail descriptions of the Bridges planning grantees and their planning progress are provided in appendix B.

### 4.2.2 Reported Impacts of the Bridges Planning Grant Initiative

Stakeholders across the five Bridges sites identified several positive impacts from the nine-month planning grant. Examples included increased collaboration and information sharing, as well as expanded partnerships and exposure to new knowledge and tools to increase MAT options. Others credited the Bridges planning grant with helping them build local capacity and expertise, enhance collaboration, and leverage new resources. Further, as a result of the planning process, Bridges grantees identified new policies and best practices to implement to more effectively respond to the opioid epidemic. In some cases, grantees were also able to leverage federal, local, or private funding to implement services or hire staff. Some also credited the initiative with positioning them to implement and sustain the plans that resulted, which was largely attributed to the implementation funding BJA and Arnold Ventures provided grantees after the nine-month planning period concluded. Additional impacts included the following:

- Increased capacity. Like the COAP grantees, the Bridges planning grantees identified numerous ways in which the grants enhanced local capacity to establish and expand MAT in local jails. These opportunities included MAT training and education for correctional officers, which broke down preconceived negative ideas about this form of treatment and increased staff buy-in; targeted technical assistance to help identify planning priorities and action steps; and enhanced treatment options to serve people in local jails who had OUDs.
- Increased collaboration. According to stakeholders, their Bridges grants helped break down
  organizational and informational silos by enhancing communication and coordination,

expanding partnerships, and strengthening cross-systems collaboration among multiple agencies.

- Enhanced knowledge and expertise. Bridges TTA resources increased stakeholder knowledge, and the multidisciplinary nature of the planning process afforded stakeholders a "hands on" opportunity to learn about the policies, work, and services of partner agencies. Working directly with people incarcerated in the local jail also increased partners' understanding of the nature of opioid misuse.
- Expanded access to resources. Through the Bridges planning grants, stakeholders accessed new resources to address the local opioid epidemic. Some stakeholders became aware of new grants. Others reported that their success with the Bridges planning grant gave them greater credibility when asking for local government funds and increased influence in obtaining local resources. Some grantees used their Bridges planning grant to leverage local resources to hire new staff, adding capacity to treatment programs.

### 4.3 Grantee Performance Analysis Findings

Analyses of performance data for the 166 FY2017 and FY2018 COAP grantees for which data were available suggest the majority were operational by the end of their first project year and were functioning in accordance with their stated goals and objectives.<sup>25</sup> Many employed multiple strategies and engaged an array of partners to advance their projects and build multidisciplinary partnerships. Although these grantees encountered numerous obstacles, analyses suggest they reached thousands of people affected by the opioid crisis—linking people with OUDs to needed treatment, and their family members and friends to supports and training.

### 4.3.1 Summary of PMT 1.0 Analyses

Overall, the amount of information grantees submitted for the PMT 1.0 increased substantially as their grants progressed, as did planning and implementation activities. While some of these increases were statistically significant, it is difficult to know what the underlying change signifies with respect to program implementation or outcomes.

Analyses of the PMT 1.0 dataset also indicate that the number of people who received recovery support services and SUD treatment across Category 1–3 grantees and who participated in diversion and alternatives to incarceration from Category 3 grantees grew over the grantees' first project year.

Although few Category 1–3 grantees reported subsequent overdose events, those that did reported small numbers relative to the number of people served. Category 4 and 6 grantees registered similar increases in activity, but that progress was typically limited to half those grantees.

Grantees also reported using more strategies to meet their project objectives as the first year of project implementation progressed. Increases in grant activity coincided with increases in both obstacles and TTA receipt, although TTA provision was limited to a small number of grantees. Finally, most grantees were highly satisfied with their TTA interactions, though they mentioned that scheduling travel was challenging.

Analyses comparing the implementation experiences, outputs, and outcomes of FY2017 and FY2018 COAP grantee cohorts found four statistically significant differences with respect to program operations and collaboration: FY2017 grantees identified more partners as actively engaged and were more likely to use data analyses to inform their projects than FY2018 grantees. However, FY2017 grantees used significantly fewer criminal justice decision points for program entry and referral mechanisms than their FY2018 counterparts. The two grantee cohorts were, on balance, similar on all other data indicators.

Finally, analyses comparing the broader FY2017 and FY2018 COAP grantee cohorts to Urban's COAP process evaluation sample of 23 COAP grantees found several statistically significant differences in grantee implementation experiences over the first project year. The nature of these differences (i.e., the data indicators) was similar to the above cohort analysis, with the grantee subset using significantly more criminal justice entry points, larger referral networks, and more actively engaged partners, and conducting more assessments and referrals to treatment than the broader COAP cohort. Yet, the process evaluation sample made significantly fewer referrals to recovery support services and reported significantly longer gaps from referral to treatment. While notable, the implementation experiences and Year 1 project performance of the subset grantees were, on balance, similar to the broader COAP cohort on remaining indicators. This suggests that the experiences of the 23 grantees selected for the assessment's process evaluation are similar to the broader cohort of COAP FY2017 and FY2018 grantees (i.e., at least their experiences are not discernably different), and that the themes and lessons learned from the process evaluation around implementation, collaboration, information sharing, and sustainability may reasonably extend to other COAP grantees.

### 4.3.2 Summary of PMT 2.0 Data Analysis

Grantee reporting increased markedly with the advent of the PMT 2.0 questionnaire: nearly all grantees submitting data in the PMT 2.0 dataset responded to each question—a vast improvement over the PMT 1.0 dataset. The reason for this is unclear but could be attributed to grantees having more experience with the PMT and more data to report (i.e., both FY2017 and FY2018 were in their second project year or beyond); the shift from the PMT 1.0 to the single PMT 2.0 questionnaire may also have been a factor.

The majority of grantees in the PMT 2.0 dataset were operational and those that were not cited delays in hiring and funding, as well as impacts related to the COVID-19 pandemic. Operational grantees reported using multiple strategies to advance their project goals, which closely mirrored the objectives of their respective COAP grant categories.

Numerous challenges impacted grantee program operations and service delivery, including lowerthan-anticipated referrals, bureaucratic restrictions, limited treatment availability, and delays from the COVID-19 pandemic. Nonetheless, the PMT 2.0 data suggest that grantees delivered a wide range of services and reached a considerable portion of people in their respective communities in need of services and programming. For example, at the third PMT 2.0 data submission, grantees collectively reported referring 3,876 people to recovery supports or substance use treatment, with 2,809 people receiving services. Additionally, 2,138 people were trained in naloxone administration, and 4,421 people had at least one contact with a case manager. Across the board, grantee data suggest that trainings, referrals, and direct services reached thousands of people.

Although fewer grantees submitted data on collaboration over time, the number of stakeholder partners rated as highly collaborative increased; this may suggest that project partnerships solidified as projects matured. Further, few grantees in the PMT 2.0 dataset reported project team changes. A sizeable share of grantees (upward of two-thirds) engaged research partners and reported using data to enhance operations or address their problem focus; this is consistent with the PMT 1.0 data.

Finally, just 10 percent of grantees submitting PMT 2.0 data reported TTA receipt—roughly half the share reporting TTA receipt in the PMT 1.0 dataset. Grantees that received TTA rated their TTA providers as knowledgeable and responsive, and were generally satisfied, if not very satisfied, with the TTA. It is unclear if TTA provision was limited or just underreported (i.e., grantees were unsure what "counted" as COAP TTA provision); process evaluation findings indicate that TTA provision, overall, was limited.

### 4.3.3 Recommendations

This analysis of grantee performance data, and the data limitations described earlier, yielded five recommendations to improve data capture, reporting, and analyses.

- Add response options to account for nonresponse and require answers to all items (i.e., build in quality controls). Because grantees were not required to respond to each element of the questionnaires, there was a large amount of missing information in the PMT datasets. The reasons for these missing data were unclear. Adding response options to questions that account for nonresponses (e.g., does not pertain to the grant objective, not collecting the information needed to answer, no access to the information needed to answer) will address this gap and allow for more complete and informative analyses. Likewise, requiring responses to each item of the PMT questionnaire by building in controls (i.e., "skip and fill") will increase the amount of information provided and the consistency of data entered, as well as enhance the ability to conduct robust and reliable analyses. Full information on all questions at each reporting period may help grantees and funders detect issues and needs early in the grant and respond accordingly.
- Add questions on project impact and sustainability for regular reporting, not just at the close of the grant. Asking grantees to report on perceived and actual project impact and sustainability planning from the outset may facilitate early sustainability efforts, as well as encourage sustained tracking of early gains (perceived impact). Doing so may also help grantees identify areas of need. Last, collecting such data may help grantees establish data-sharing practices earlier in the project and promote data-driven decisionmaking.
- Add community- and people-oriented questions. The PMT 1.0 questionnaires included several questions regarding the number of people who received services and programming, however, many of these questions were removed in the PMT 2.0 questionnaire. Neither PMT included questions about the characteristics (age groups, for example) of the people or communities served. Yet, including such questions may yield information that would help grantees assess and refine services and programming to ensure interventions are best suited to those populations in need.
- Employ strategies to enhance grantee reporting and data use. One strategy for increasing grantee reporting and the quality of data captured is to analyze and present aggregate, anonymized data. BJA might hold a webinar or disseminate a brief report to grantees following grantees' scheduled data submissions to model how data can be used to inform their work, as

well as help them gauge their progress relative to other grantees. Doing so may help grantees identify new ways to use the data they report and increase the quality of the data reported.

Allow for longer assessment periods and more grantee cohorts. The structure of the PMT datasets and the timing of the analysis did not permit evaluation of the initial COAP grantees' full project period or performance. Additional analyses should be performed when all COAP FY2017 and FY2018 grants have concluded to examine changes in performance and milestones over time. Further, this analysis only examined two COAP grantee cohorts. Subsequent cohort analyses should be performed once complete data are available on more recent COAP grantee cohorts. Doing so will offer a fuller picture of the scope and nature of the initiative's reach (i.e., activities and services) and impacts.

# 5. Conclusion and Recommendations

The assessment sought to answer four broad questions about the impact of the COAP grant program on opioid misuse, including overdoses and overdose fatalities, access to OUD treatment and recovery services, treatment engagement and retention, and researcher engagement on COAP grant program outcomes. Although several limitations (e.g., missing data, inconsistent reporting, changes to the structure and content of the grantee reporting mechanisms) precluded the analysis necessary to fully answer some key questions about grantee performance and impact, our analysis of grantee performance data combined with findings from the process evaluation found encouraging evidence that COAP had positioned grantees to positively impact the opioid crisis at the local level. In addition, the assessment also provided critical context about grantee implementation progress and challenges such as data collection, analysis, and reporting.

# 5.1 Did COAP Reduce Overdoses, Increase Access to Services, and Enhance Treatment Engagement?

Analyses of PMT 1.0 and PMT 2.0 performance data for the 166 COAP FY2017 and FY2018 grantees for which data were available suggest the majority were operational by the end of their first project year and were functioning in accordance with their stated goals and objectives. Many employed multiple strategies and engaged an array of partners to advance their projects and build multidisciplinary partnerships. These findings were substantiated by the process evaluation.

Although COAP grantees encountered numerous obstacles, our analyses indicate that COAP grantees, particularly Category 1–3 grantees (i.e., those engaged in direct outreach and service delivery), had reached thousands of people affected by the opioid crisis—linking people with OUDs to needed recovery services and treatment and linking their family and friends to supports and training. Highlights include the following data points:

In their first project year, 73 percent of COAP Category 1 grantees reported receiving referrals following an overdose, conducting treatment assessments, and linking people who had experienced an overdose to recovery support and treatment services. At the same time, 80 percent of Category 1 grantees reported referring people to recovery support services and 53 percent reported training a total of 1,116 people on how to administer naloxone following an overdose. Further, across these grantees, 828 people had been referred to a Category 1

grantee first responder partnership for substance abuse treatment, of which 753 were assessed and 461 received substance abuse treatment. Just 17 percent of Category 1 grantees reported data on subsequent overdoses but among those that did, the numbers were low; it is unclear, however, whether the small number of subsequent overdoses is a measure of program impact or a function of incomplete data. The process evaluation's examination of selected Category 1 grantees found evidence that subsequent overdoses were low: one Category 1 grantee reported a 40 percent decline in suspected overdoses and a 24 percent decline in fatal overdoses during its first project year.

- Nearly three-quarters of grantees in Category 2, which used technology such as tablets and video platforms to facilitate remote delivery of substance abuse treatment services, reported assessing and referring 184 people to treatment in their first project year, of which 24 percent engaged in services. Analyses of grantees' PMT 2.0 data indicated these numbers also increased over time. However, only one grantee reported data on subsequent overdose events; it is not clear why reporting was so limited.
- Between 24 and 35 percent of Category 3 grantees, which typically used their COAP funds to implement new interventions such as MAT or expanded existing treatment programs, had referred clients to recovery support services, linked them to peer recovery services, conducted assessments, and administered MAT in their first project year. About 50 percent of Category 3 treatment referrals resulted in treatment engagement: approximately 776 of the 1,547 people referred to diversion programs, alternatives to incarceration, recovery support services, MAT or SUD treatment engaged in those services. Further, the time between referral and treatment receipt averaged three days—a very short window. Category 3 grantees that provided MAT typically offered clients two or three types: methadone, buprenorphine, and naltrexone. Performance data indicate that these grantees assessed 257 people as appropriate for MAT, of which 60 percent (*N* = 155) received at least one dose. Like other category grantees, relatively few grantees reported data on subsequent overdoses (overdoses following treatment or services), making it difficult to draw any inferences about possible impact.

These numbers primarily increased in the PMT 2.0 dataset, which captured portions of the grantees' second year of operations, but some then plateaued—which may have coincided with the end of the grantees' project. Of the 160 grantees in the PMT 2.0 dataset, nearly half (49 percent) reported in their first PMT 2.0 data submission providing recovery support services to a total of 3,459 people, with roughly equal shares providing these services at their third PMT 2.0 data submission. The most common recovery support services grantees offered were peer support or coaching (33 percent), case

management (31 percent), and transportation (20 percent). At their third PMT 2.0 submission, half of all grantees (81 grantees) reported providing recovery support services to a total of 2,300 people—a sizeable increase from their first year of operations as recorded in the PMT 1.0 dataset.

Although Category 4 and 6 grantees did not engage in direct services, these grantees engaged in activities that also impacted the ability of their communities to address the opioid crisis. During their first project year, the Category 4 grantees submitting PMT 1.0 data reported using up to 28 different strategies in formulating their coordinated state-level plans to reduce overdose deaths and increase access to OUD treatment. The most common strategies used by these grantees' state plans were initiating or enhancing pretrial diversion programs (13 percent); initiating or enhancing jail-based programming (13 percent); initiating or enhancing court-based diversion or alternatives programs (13 percent); expanding access to MAT (13 percent); initiating or enhancing peer recovery support coaches (13 percent); and building partnerships between criminal justice, public health, treatment providers, and other partners (13 percent).

During their first project year, approximately 70 percent of Category 6 grantees reporting PMT data had established multidisciplinary action groups, composed of 1 to 26 partners that were actively engaged in the work. It is unclear why 30 percent were unable to form these groups. At the fourth quarter, the most common obstacles reported were access to data (34 percent), followed by technology challenges (22 percent) and confidentiality concerns (20 percent). These may be key reasons. Few grantees—just 13—had completed their problem analysis by the fourth quarter, but nearly 40 percent had engaged a research partner to help with data collection and analysis and planned to use the results to inform their strategies. Qualitative findings from the process evaluation indicated that Category 6 grantees formed strong collaborations that produced critical cross-system analyses for policymakers, agency leaders, and local practitioners and conducted extensive education and outreach around opioid misuse and treatment.

While the PMT data did not support the type of analyses necessary to definitively answer questions about whether the COAP initiative reduced opioid overdoses and fatalities or increased treatment access and engagement, the performance data suggest that COAP grantees delivered critical treatment and support services to hundreds of people in their communities.

# 5.2 What Impact Did Researcher Engagement Have on COAP Program Outcomes?

Both the assessment's process evaluation and performance data analysis suggest that a sizable share of COAP grantees engaged external research partners and reported benefits in doing so.

Upward of two-thirds of grantees in the PMT 1.0 dataset reported engaging research partners and using data to enhance operations or address their problem focus during their first project year. Likewise, 11 of the 23 COAP process evaluation grantees, spanning Categories 1 to 4, partnered with local researchers to conduct formal evaluations, assist with data collection, or conduct data analyses. None of the Category 6 grantees engaged a separate evaluation partner given the scope of these initiatives, which were oriented toward data analyses and reporting.

Many grantees partnered with researchers at local universities, while others engaged local evaluators. In both cases, research partners helped grantees collect data and measure outcomes related to their COAP initiative. Many grantees relied on their research partners to access data they otherwise could not or to provide analytic support (i.e., analyze program data). For example, one grantee relied on a research partner to collect data on overdoses and overdose fatalities from the county's fire department, EMS, and medical examiner and compile overdose reports (including client contact information) that informed the dispatch of peer specialists. Grantees also engaged researchers to evaluate their programs. Several Category 3 grantees in the process evaluation sample, for example, engaged evaluation partners to conduct process and outcome evaluations that would answer critical questions about program performance and inform sustainability efforts. Most formal evaluation efforts were well under way but not yet complete at the time of the assessment's process evaluation and as such, final results were not available.

The process evaluation's one Category 4 grantee also retained an evaluator to assess the impact of local programs funded under its COAP grant and the fidelity of implementation. At the time of the site visit, the grantee's local research partner was tasked with developing evaluation plans with each of the local sites and helping them navigate data collection, as well as conducting quarterly analyses for the grantee.

While most grantees struggled with data access or data quality issues, grantees that engaged research partners typically found it easier to access data sources, conduct analyses and use the data. Uniformly, grantees valued the insights their research partners offered and the data and analysis they could provide. Stakeholders in one grantee site credited their external evaluator with giving them an

outside view of the program. These observations suggest that research partners played a valuable capacity-building role with grantees.

# 5.3 In What Other Ways Did COAP Influence Grantee Sites?

Our findings suggest both the COAP and Bridges grant programs had a positive impact on grantees and their communities. In the case of COAP grantees, the initiative funded a diverse array of programs, interventions, collaborations, and approaches—many of which could offer data indicating these strategies were positively affecting people with OUD by increasing access to treatment and recovery supports or advancing the critical data sharing and analysis necessary to accurately track and respond to the changing nature of the opioid epidemic. Similarly, the Bridges planning initiative achieved its goals of helping communities establish or expand MAT to reach more people, particularly those involved in the criminal legal system. Both sets of grantees identified important ways in which these two grant programs increased stakeholder capacity and knowledge in ways that communities could build on.

## 5.4 What Are the Actionable Recommendations?

The assessment yielded several actionable recommendations for program developers, funders, and policymakers related to implementation barriers, data and data reporting, and TTA provision.

- Remove implementation barriers tied to budget approval. Grantees routinely cited funding delays, protracted budget-approval processes, and hiring delays—with the latter likely exacerbated by the former—as common challenges that hampered project start-up and implementation. Some grantees reported funding delays of up to 12 months. To reduce these implementation barriers, funders should consider how best to expedite the award and budget process to ensure that grantees have timely access to the resources necessary to build project infrastructure (hire staff, engage partners) and deliver services.
- Expand technical assistance to address grantee challenges in establishing research partnerships and negotiating data-sharing agreements. Most grantees struggled with data access or data-quality issues, but grantees who engaged a research partner typically found it easier to access data sources, conduct analyses, and use the data. Although a sizeable share of grantees engaged research partners, analyses of the PMT data indicate that solidifying these

partnerships took considerable time: most weren't finalized until the fourth quarter of the project's first year. This delay may signal a technical assistance need tied to selecting and engaging an evaluation partner or how to draft a suitable scope of work. In turn, many grantees also reported challenges with negotiating data-sharing agreements and accessing data; this may also suggest that technical assistance is needed to help grantees develop and execute memoranda of understanding or data-use agreements. Doing so may reduce barriers around data reporting and analysis, and alleviate implementation delays tied to data access and data sharing.

Relatedly, Category 2 and Category 6 grantees noted the importance of understanding the legal and policy context when implementing technology-oriented or data-sharing initiatives, considering that policies such as HIPAA, Medicaid, and data-sharing and user agreements can hinder implementation. Partner learning curves and general technical issues (e.g., inadequate Wi-Fi, participants' access, interpersonal limitations of virtual platforms) may also affect implementation progress. Expanding TTA to address these issues may be warranted and welcomed.

- Enhance grantee data reporting systems. Grantees reported numerous challenges around accessing and using the PMT questionnaires and data portal. In addition, grantees expressed concern that the PMT items did not capture the scope of their activities and did not generate metrics that informed their projects. To increase the quantity and quality of grantee reporting, BJA could consider adding response options to questions that account for nonresponses (e.g., does not pertain to the grant objective, not collecting the information needed to answer, no access to the information needed to answer); engage grantees in the design of performance metrics to ensure the most relevant and reportable data elements are captured; add community- and people-oriented questions that capture the characteristics (age groups, for example) of the people or communities served; add questions on project impact and sustainability for regular reporting throughout the grant period, rather than just the enddate; and employ strategies that enhance grantee progress, outputs and outcomes within categories to allow grantees to gauge their progress and learn what strategies other grantees may be successfully using.
- Allow for longer assessment periods and more grantee cohorts. The structure of the PMT datasets and the timing of the analysis did not permit evaluation of the initial COAP grantees' full project period or performance. Additional analyses should be performed when all COAP

FY2017 and FY2018 grants have concluded to examine changes in performance and milestones over time. Further, this analysis only examined two COAP grantee cohorts. Subsequent cohort analyses should be performed once complete data are available on more recent COAP grantee cohorts. Doing so will offer a fuller picture of the scope and nature of the initiative's reach (i.e., activities and services) and impacts.

- Explore low TTA uptake. Both TTA providers and grantees reported few requests for TTA and limited TTA engagement outside of COAP grantee conferences and webinars. Grantees gave high marks to these COAP TTA resources and those that did directly engage with COAP TTA providers expressed high levels of satisfaction with their knowledge, responsiveness, expertise, and resources. It is unclear why few grantees reported needing or requesting TTA receipt or why few stakeholders beyond grantee project directors were aware of the COAP/COSSAP resource website. This may suggest that more frequent "marketing" and messaging to grantees about available COAP TTA resources is needed.
- Offer more peer learning opportunities. Grantees reported that peer learning, both within the COAP grantee network and locally, helped stakeholders better understand the ecosystem in which they were implementing these projects. These collective learnings helped stakeholders improve operations and implementation. BJA might consider how to advance peer learning opportunities throughout their demonstrations through peer affinity groups, grantee-specific convenings (in addition to broader initiative conferences), and even regional convenings to allow stakeholders who are implementing similar strategies or facing similar issues to learn from one another

In summary, the 30-month assessment points to promising evidence that the COAP initiative positioned grantees to positively impact local opioid misuse (reduce overdoses and fatalities) and increase access to treatment and recovery support services, as well as divert people with OUD away from unnecessary and counterproductive legal system involvement. Grantees credited COAP and Bridges resources with helping them build the capacity, knowledge, and support necessary to implement new strategies or expand existing interventions to meet the needs of people with OUDs. Insights from their implementation experiences offered several insights for future grant initiatives related to implementation, data reporting and use, and technical assistance needs and provision.

# Appendix A. COAP FY2017 and FY2018 Grant Categories and Grantees

The Comprehensive Opioid Abuse Program (COAP), BJA's signature initiative to address the opioid epidemic, was established in 2017 following the 2016 Comprehensive Addiction and Recovery Act (Public Law 114-198) and renamed as the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) in 2020. The COAP/COSSAP initiative provides grants and technical assistance at the state, local, and tribal levels to support community-driven, cross-system solutions to the opioid crisis. As of 2019, nearly 300 projects and demonstration sites had been funded across six program categories: (1) first responder partnerships; (2) technology-assisted treatment projects; (3) system-level diversion projects; (4) statewide planning, coordination, and implementation projects; and (6) public safety, behavioral health, and public health information-sharing partnerships.

In FY2017 and FY2018, the COAP grant program made 218 awards across six categories. These 218 grantees spanned 47 of the nation's 50 states and one US territory (Guam).<sup>26</sup> The goals and objectives for each COAP category are briefly described below.

## Category 1. First Responder Partnerships

The objective of COAP Category 1 is to support county, city, and tribal government entities in designing and implementing comprehensive local responses to the opioid epidemic. Although communities may pursue various interventions, the emphasis is on diversion programs led by law enforcement and first responders that link people facing low-level, nonviolent charges to community-based treatment and behavioral health services instead of custodial arrest. In FY2017, Category 1 focused on outreach programs to reduce fatal overdoses, specifically models that would link people who experienced a nonfatal overdose to treatment or recovery support services via law enforcement partnerships with peer recovery coaches and drug treatment providers. In FY2018, Category 1 retained its emphasis on multidisciplinary partnerships—among law enforcement, behavioral health providers, medical professionals, and drug treatment and recovery providers—to divert people into treatment and services. But the COAP solicitation also broadened those partnerships to include victim services and child welfare, a change reflecting the recognition that children often witness an overdose or may otherwise be affected by drug use at home.

In the COAP grant program's first two years, which is the focus of this assessment, BJA made nearly 50 Category 1 awards—12 in FY2017 and 37 in FY2018—including 5 awards to federally recognized tribes. Project periods were 24 to 36 months, and funding ranged from \$300,000 in FY2017 to \$500,000 in FY2018. Grantees used these awards to "establish coordinated multidisciplinary response teams that include law enforcement and other first responders, treatment providers, and/or peer recovery specialists" (other team members may include child welfare providers, public health providers, hospital-based program providers, prosecutors, and the courts) to implement prearrest or postarrest diversion programs targeting people with OUD who commit low-level crimes (BJA 2018, 8). Prominent diversion programs highlighted by the COAP solicitation for this category include the Police Assisted Addiction and Recovery Initiative, Quick Response Teams (QRTs), Drug Abuse Response Teams, STEER (Stop, Triage, Engage, Educate and Rehabilitate), and LEAD (Law Enforcement Assisted Diversion).

Additionally, consistent with the expanded scope of Category 1 in FY2018, 9 grant awards, cofunded by BJA and the Office for Victims of Crime, to support children affected by the opioid epidemic. These grants are designed to help children cope with trauma and build resilience.

### Category 2. Technology-Assisted Treatment Projects

Category 2 COAP grants support states in piloting the use of technology "to expand treatment and recovery support opportunities to legal system-involved individuals with OUDs who have limited access to treatment and recovery services due to geographic isolation" (BJA 2018, 11). Nine states received Category 2 funding in FY2017 and FY2018. Awards ranged from \$500,000 to \$1 million, and projects spanned up to 36 months. Examples of Category 2 technology projects include the use of tablets, mobile devices, and secure internet-enabled devices for monitoring medication compliance and sobriety among legal system-involved people with SUDs. Other project activities include increasing access to treatment in carceral spaces, facilitating real-time case management and peer recovery support services for individuals who are incarcerated, and conducting substance use and behavioral health assessments of people in rural jails or on community supervision in remote areas.

## Category 3. System-Level Diversion Projects

In FY2017 and FY2018, 40 awards were made under COAP Category 3. These grants support state, local, and tribal government organizations in designing a continuum of system-level diversion options that address at least two legal system decision points embodied in the SIM. Successful FY2017 and FY2018 Category 3 recipients proposed strategies that addressed each sequential intercept. Grantees used Category 3 funds to implement pretrial and postadjudication diversion programs; specialized probation caseloads for people with OUD, featuring peer recovery navigators and naloxone distribution; jail-based treatment programs; community-based day report centers offering overdose survivors access to basic health services, mentoring, life skills programming, and agriculture and artisan training; and myriad other interventions and activities, such as conducting countywide sequential intercept mapping to identify additional intervention points for people with OUD. Category 3 projects were typically 36 months in duration.

# Category 4. Statewide Planning, Coordination, and Implementation Projects

Category 4 COAP grants support initiatives that identify gaps in policy or practice specific to the opioid crisis, and that are jointly planned and implemented by the state administrative agency responsible for legal system planning and the single state agency for substance use services. Category 4 funding supports two categories of activities: (1) formulating a coordinated plan between the state administrative agency and the single state agency that promotes diversion to local treatment for people with OUD and mechanisms to increase treatment engagement and retention, and that reduces overdose deaths (Subcategory 4a); and (2) supporting localities to increase engagement in treatment and recovery services, provide prevention education programs for youth, increase the use of diversion programs (including family drug court), and reduce overdose deaths (Subcategory 4b). Subcategory 4b also gives priority consideration to applicants that engage representatives in child welfare, public safety, and probation and parole. Between FY2017 and FY2018, 15 awards totaling \$10.6 million were made to expand state and local models of public health, behavioral health, and public safety information sharing and collaboration.<sup>27</sup>

## Category 5. Harold Rogers Prescription Drug Monitoring Program (PDMP) Implementation and Enhancement Projects

Recipients of Category 5 COAP grants may use funds to establish or enhance a current PDMP. State PDMPs "collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners" (PDMP TTAC 2018, 1). As such, state PDMPs are repositories of critical information that can help officials charged with enforcing drug laws and overseeing the lawful distribution of controlled substances; aid in education, research, and misuse prevention; enhance patient care; inform substance use prevention and treatment strategies; and support cross-system collaborations among criminal justice, public health, and treatment stakeholders.

COAP Category 5 grant recipients receive up to \$750,000 and may use these funds to establish a PDMP or enhance an existing PDMP. Funds may also be used to develop training materials, produce and disseminate educational materials, facilitate data exchange, improve data quality, expand monitoring to additional substances, and evaluate the effectiveness of the PDMP. Projects may span 24 months. Between FY2017 and FY2018, BJA made 34 COAP Category 5 awards totaling more than \$19 million. These grants supported various activities, including public education and awareness campaigns, data integration between PDMPs and electronic health records, and improvements to data quality and reporting (Kunkel 2019).

# Category 6. Public Safety, Behavioral Health, and Public Health Information-Sharing Partnerships

Grants awarded for COAP Category 6 funded multidisciplinary projects aimed to leverage and analyze datasets from PDMPs, public health agencies, law enforcement, and other key sources to create a datadriven portrait of the opioid crisis and design relevant interventions. Projects undertaken by the 58 Category 6 award recipients consisted primarily of initiatives led by universities and state departments of health that will advance the use of data. Proposed activities include establishing an opioid and heroin data center; creating a multisector regional community of practice to better ascertain the context of the local opioid crisis; designing and disseminating data dashboards that integrate and report on relevant indicators such as fentanyl and heroin distribution, naloxone administrations, and fatal and nonfatal overdoses; and improving PDMP exchanges across states.

# Appendix B. COAP Process Evaluation Grantees

The final process evaluation sample consisted of 5 Bridges grantees and 23 COAP grantees. The 23 COAP grantees consisted of 16 grantees from the FY2017 cohort and 7 from the FY2018 cohort, and spanned five of the six COAP grant categories. Specifically, the process evaluation sample included five Category 1 grantees, three Category 2 grantees, eight Category 3 grantees, one Category 4 grantee, and six Category 6 grantees. Category 5 has been the focus of separate ongoing analyses and thus, was excluded from this analysis.

## Category 1. First Responder Partnerships

The process evaluation sample consisted of five COAP Category 1 grantees from Erie County, New York; Huntington, West Virginia; Kenosha County, Wisconsin; Kenton County, Kentucky; and Marion County, Indiana. Each grantee had received a FY2017 COAP award and, therefore, was approaching its final grant year when the process evaluation site visits occurred. Consistent with the goals of Category 1, these grantees used their COAP grant funding to establish and support multidisciplinary opioid response partnerships between law enforcement, first responders, and behavioral health agencies to quickly link people who had experienced an overdose to treatment and recovery services. These grantees employed the following opioid response strategies:

- Erie County, New York, used its COAP funding to implement the Opioid Overdose Outreach Program, which leverages the Erie County Opioid Epidemic Task Force to reduce opioid misuse and overdose fatalities by linking individuals who have experienced an opioid overdose to treatment, and by documenting and distributing real-time information on overdose events. Further, the program supports the proactive use of Prescription Drug Monitoring Programs (PDMP) to enhance clinical decisionmaking and reduce the improper use of controlled substances.
- Huntington, West Virginia, established a multidisciplinary Quick Response Teams (QRT) with its COAP funding, replicating a model first used in Colerain, Ohio. The initiative is led by the City of Huntington/Cabell County EMS in partnership with the Huntington Police Department, local behavioral health providers, and the faith community. QRT teams work in the Huntington community each weekday to engage with individuals shortly after a drug overdose event,

connecting them to treatment services with the goals of reducing overdose deaths and increasing treatment engagement. Each of Huntington's QRT teams is staffed by an EMS paramedic, a mental health professional, a law enforcement officer, and a local faith leader. Researchers at Marshall University are evaluating the impact of the QRTs.

- Kenosha County, Wisconsin, implemented the Kenosha County Opioid Overdose Reduction Project, which uses peer support specialists to link survivors of opioid overdose to treatment and work with the county's Opioid Task Force to provide resources to other departments within the community.
- Kenton County, Kentucky, used its COAP funding to establish QRTs and increase the distribution of naloxone kits across eight counties in northern Kentucky and to individuals released from the Kenton County Detention Center. The grant also supports a local evaluation partner and data analysis of the local opioid epidemic.
- Marion County, Indiana, used its COAP award to launch a collaboration between Marion County's Health and Hospital Corporation and the Indianapolis Metropolitan Police Department to increase awareness about the opioid crisis and public access to naloxone via the Safe Syringe Access and Support Program. The program also engages directly with people who have been admitted to the emergency department because of an opioid overdose.

## Category 2. Technology-Assisted Treatment Projects

The process evaluation sample consisted of three Category 2 grantees: the Indiana Family and Social Services Administration; the New York State Unified Court System, and the West Virginia Division of Justice and Community Services. Consistent with the goals of Category 2, each of these three grantees used innovative technology to expand treatment and recovery support services in designated target areas. The Indiana Family and Social Services Administration and the New York State Unified Court System are both FY2018 grantees The West Virginia Division of Justice and Community Services, a FY2017 grantee, was further along in implementation than the other two sites at the time of the process evaluation. These grantees' COAP-funded strategies are described below:

The Indiana Family and Social Services Administration expanded an existing but relatively new mobile response program in Southern Indiana through the enhanced use of technology. This expansion also added new law enforcement partners. This COAP grant involved collaboration between the Indiana Family and Social Services Administration Division of Mental Health and Addiction, Choices Coordinated Care Solutions, Centerstone, and Relias. The goals of the project are to increase access to SUD treatment in rural Indiana by expanding existing mobile response services to people with OUD/SUD in seven counties, as well as to provide screening, assessment, and treatment to legal system-involved people through the use of data and technology (e.g., Zoom accounts, iPads, laptops). The Division of Mental Health and Addiction also worked with Relias to provide the seven county consortia with a data dashboard to track trends and outcomes related to OUD risk and develop data-driven goals and strategic plans.

- The New York State Unified Court System sought COAP funding to improve communication between the courts and the New York State Office of Alcoholism and Substance Abuse Services to reduce client risk and to work with MAT providers to offer telecourt services for court-involved people in residential treatment programs. Although this initiative was new, the effort built upon existing, long-standing relationships between these court offices and providers.
- The West Virginia Division of Justice and Community Services partnered with West Virginia Department of Health and Human Resources to implement a "broadcasting" site—the Jefferson County Day Reporting Center—that facilitates delivery of telehealth treatment services, including MAT treatment, to people with OUD in remote areas. The broadcasting site allows licensed clinicians (psychiatrists and psychologists) in one part of the state to assess SUD needs, develop treatment plans, prescribe medications, and make treatment referrals to SUD treatment services for people at day report centers in rural areas via remote technology. Under the grant, eight satellite day report centers have implemented the telehealth technology necessary to enable their clients to receive MAT and case management.

### Category 3. System-Level Diversion Projects

The process evaluation sample includes eight Category 3 grantees across the FY2017 and FY2018 COAP cohorts: Camden County, New Jersey (FY2017); Cook County, Illinois (FY2018); Erie County, New York (FY2018); three Franklin County, Ohio, awards (one FY2017 and two FY2018); Hamilton County, Ohio (FY2017); and Logan County, West Virginia (FY2017). Consistent with the goals of Category 3, each grantee planned to implement or support pretrial and court-based diversion programs, community supervision, or reentry, as described below.

• The **Camden County, New Jersey,** Department of Correction, the lead agency for this grant, introduced a two-phase initiative called the Camden County Opioid Abuse Diversion Program.

Under Phase 1, stakeholders conducted a systemwide assessment to identify gaps in MAT provision in the Camden County Correctional Facility. Under Phase 2, the county implemented wraparound case management and MAT for individuals with OUD that began prerelease and continued in the community after release; through COAP, Camden County also added peer recovery specialists to the OUD reentry case management team.

- Cook County, Illinois, assessed policies that impact health systems and patients with opioid use, and used findings from those assessments to develop a pilot screening tool for people with poor mental health and SUDs. The county also trained probation officers on how to administer and use the tool.
- Erie County, New York, is broadening the scope of screening tools so that all individuals with pending sentences will be screened for an SUD. Individuals reaching the predetermined threshold will be referred to the county's opioid unit. On arrival, peer navigators link individuals to substance use treatment and services. The goal is to connect those individuals with treatment as quickly as possible; on average, the county is now connecting people to treatment within one or two weeks, rather than the 30 days it took previously. The county also conducts overdose mapping as part of the grant.
- Franklin County, Ohio, received three COAP Category 3 grants, each allowing the site to address a specific need in the community. Under Franklin County's FY2017 grant, stakeholders used COAP funds to implement a Safe Station model. Operated from within a local fire station, Safe Station provides people in need of OUD treatment with round-the-clock access to treatment services. Narcan and naloxone are also distributed through Safe Station to reduce fatal overdoses. The county used its FY2018 COAP funds to expand and enhance Pathways, an eight-week cognitive behavioral therapy program offered to women in the Franklin County jail. The site was expanding Pathways to men and had anticipated a February 2020 start; COVID-19 delayed the program's rollout. Franklin County's third Category 3 award, made to the Franklin County Municipal Court in FY2018, funded expansion of its Courthouse MAT Program, including hiring additional staff. Courthouse MAT connects people with alcohol or opioid related offenses to MAT services in the community through a weekly onsite clinic; the clinic administers Vivitrol injections to people released from jail who would like to start MAT.
- The Hamilton County, Ohio, Board of County Commissioners previously held a Comprehensive Addiction and Recovery Act grant that helped foster COAP grant activities by identifying response and treatment gaps along the SIM. COAP funds established a fully operational QRT inside a 20-bed community engagement center, with the goal of connecting

recently overdosed individuals to services such as counseling, case management, MAT, and other services. The engagement center also provided services for people in need, if the only residential treatment program in the area is at capacity.

 Logan County, West Virginia, used its COAP grant to establish a new, innovative, and holistic three-phase Fresh Start program to assist people with OUDs. Fresh Start combines SUD treatment, including recovery and coping skills, with community mentorship, peer support, and job skills to promote recovery and stability.

# Category 4. Statewide Planning, Coordination, and Implementation Projects

The Tennessee Department of Mental Health and Substance Abuse Services FY2017–funded project was the only Category 4 grantee selected for the process evaluation. Category 4 funding supports the implementation of two strategies: (1) reduce overdose deaths by formulating a coordinated plan between the state administrative agency and the single state agency, to promote diversion to local treatment and increase treatment engagement and retention; and (2) support localities to increase engagement in treatment and recovery services, provide prevention education programs for youth, and increase the use of diversion strategies such as family drug court programming.

Consistent with that aim, the Tennessee Department of Mental Health and Substance Abuse Services applied for a COAP grant, initially to decrease legal system involvement among Tennesseans who struggle with OUDs. Funding sought to enhance a statewide plan as well as TTA to support local implementation of the strategies developed. Funding was also to be distributed to communities most impacted by the opioid epidemic through Recovery Court Programs, community-based behavioral health providers, and support in the areas of assessment, diversion, prevention, early intervention, and treatment services. The project's primary goals were to address opioid overdoses, address gaps around prevention, make services available for the community at large, provide resources and reentry support for those leaving jail, and help the people stay connected with resources once they have them.

# Category 6. Public Safety, Behavioral Health, and Public Health Information-Sharing Partnerships

Category 6 COAP grantees leverage datasets to create a portrait of the opioid crisis in their communities. The process evaluation sample consists of six Category 6 grantees (four from FY2017 and two from FY2018): the Arkansas Department of Health; the Erie County, New York, Opioid Mortality Review Board (Erie County OMRB); the Mississippi Department of Health; the Supreme Court of Ohio; the Tennessee Department of Health; and the University of Kentucky Research Foundation. University researchers and departments of health across five states collaborated to create data hubs and data collaboratives, review boards, and working groups to analyze overdose data and identify trends in opioid misuse. Grantees also used COAP funding for behavioral health and prescriber education throughout their states. Grantees employed the following strategies:

- The Arkansas Department of Health used its FY2017 COAP grant to create a data hub and implement targeted prevention efforts such as data-driven training, outreach, and media campaigns. Through the grant, the department joined several collaborative initiatives with other departments and organizations across the state, and incorporated PDMP data into community and provider trainings, in reports, and in media campaigns.
- Erie County, New York, established its OMRB with COAP funds. The county's goal was to better understand the causes and risk factors around opioid misuse. The OMRB is a component of the Erie County Opiate Epidemic Task Force which was established in 2016. The OMRB was based on the well-established Infant Mortality Review process (developed in the 1990s) and leveraged the data-sharing partnerships of the Erie County Opiate Epidemic Task Force. The county's objectives were to use the information and insights gained from the OMRB to inform policy and practice related to overdose prevention and mortality. A partnership between the Erie County Department of Health, the Erie County Medical Examiner's Office, and the University of Buffalo, the OMRB team is staffed by a nurse, a project assistant, and a peer navigator. The team contacts next of kin, interviews the deceased's family and friends, and collects the deceased's medical records to form a holistic picture of the deceased's life and identify potential risk factors for opioid misuse that may be used to prevent future opioid deaths.
- The Mississippi Department of Health established a state opioid and heroin data center to better leverage data and inform the adoption of interventions and promising practices to reduce both inappropriate prescribing and the number of opioid fatalities in the state. The

project is a collaboration between the state's Board of Pharmacy, Bureau of Narcotics, Department of Health, and Department of Mental Health, with the University of Southern Mississippi. The project has three key components: the Mississippi Opioid and Heroin Data Collaborative, epidemiological reports, and white papers on opioid policy. All three support the project's focus on storytelling that makes data more accessible to stakeholders. COAP funds were used to hire a full-time epidemiologist. The project has produced 18 epidemiological reports and three white papers that have been used to inform state policy.

- The Supreme Court of Ohio established the Regional Judicial Opioid Initiative to promote data sharing and collaboration with 17 judges in seven other states (Illinois, Indiana, Kentucky, Michigan, Tennessee, North Carolina, and West Virginia). The grant also supports a project director from the National Center for State Courts, cross-state data collection, and two pilot projects: Project ECHO and Telehealth. These pilot projects were identified as promising approaches and selected following data analysis by the initiative's research partner. The regional initiative, which pre-dates the COAP grant, did not have the benefit of a single executive director.
- The Tennessee Department of Health's COAP project built on prior work funded under a Harold Rogers PDMP grant (awarded in 2016) and two grants from the Centers for Disease Control. The project's goals are to improve coordination and collaboration among typically siloed agencies, link all relevant data sources on overdoses in the state, and use those data to guide decisions on policy and programs.
- The University of Kentucky Research Foundation's COAP project is a mix of research and training that takes advantage of the enactment of Kentucky Senate Bill 32 (SB 32) to test its impact, after this legislation added the drug gabapentin to the controlled substance schedule and mandated the addition of drug conviction data to the PDMP. Specifically, project researchers are evaluating the implementation and short-term impact of SB 32 to provide a basis for intermediate and long-term outcome evaluations. The project has five primary goals: (1) to evaluate the impact of SB 32 on prescriber and dispenser behaviors and patient health outcomes; (2) to develop and provide continuing education for prescribers and dispensers on the content and interpretation of conviction data within KASPER (Kentucky All Schedule Prescription Electronic Reporting), a controlled substance prescription monitoring system; (3) to estimate state-level prevalence and changes in gabapentin prescribing and characterize the demographic and clinical characteristics of individuals prescribed gabapentin; (4) to analyze datasets for identification of emerging drugs of abuse, populations at risk for drug misuse and

overdose, and hot spots for questionable controlled substance prescribing or use; and (5) to sustain the work of the state-level multiagency, multidisciplinary action team and practitioner-researcher collaborations.

### **Bridges Process Evaluation Grantees**

Five of the 16 Bridges grantee communities were selected to participate in this process evaluation: Camden County, New Jersey; Chesterfield County, Virginia; Cumberland County, Maine; Hudson County, New Jersey; and Lewis and Clark County, Montana. The focus of each Bridges planning grantee is detailed below.

- The Camden County Department of Corrections used its Bridges grant to strategize ways to effectively deploy MAT programming within the Camden County Correctional Facility. The department's goal was to increase the use of MAT for people who are incarcerated and who were not already on MAT and to improve coordination and collaboration between community providers and jail to provide a continuum of care for opioid users. The department received TTA in the form of meetings with people from two conferences led by BJA and IIR as part of the Bridges grant. The Bridges TTA to Camden expanded over time into monthly calls. To achieve their goals, the department convened a planning group and developed an action plan to strengthen and fine-tune their MAT programming. The action plan has 12 objectives: (1) individual counseling, (2) continued MAT education with correctional facility staff, (3) MAT education for medical staff, (4) addressing short length of stay, (5) strengthening reentry identification, (6) telehealth, (7) certification of the correctional facility's opioid treatment program, (8) crisis stabilization, (9) data and information sharing, (10) discharge planning, (11) increased prescribing capacity, and (12) engagement of stakeholders not yet at the table.
- Chesterfield County, Virginia, began efforts in 2014 to understand and mitigate harms caused by the opioid crisis. The county formed a collaborative group with partners from justice and health sectors, which provided a strong foundation for the 2019 Bridges planning work. Members of this group participated in Bridges TTA, including monthly peer learning calls and attendance at both the August 2019 and January 2020 BJA- and IIR-led Bridges conferences. The Bridges grant funded treatment expansion, as well as community and agency stakeholder education on the benefits of MAT. Project plans have not changed since the initial action planning phase, and the grantee reports that it is on track to achieve its goals.

- Cumberland County, Maine, met every two weeks and revised its action plan as part of its Bridges work. As an initial task, the county's Bridges stakeholders developed a services road map to identify which initiatives, resources, and gaps existed. As needs were identified, the collaborative partnership grew to 15 agencies. These new partnerships spurred planning and implementation. For example, the jail implemented formal MAT policies and standard operating procedures, and currently supplies in-house MAT (e.g., Suboxone) and transports people who are incarcerated to receive MAT (e.g., Vivitrol). Cumberland County identified three primary goals of their Bridges planning grant: (1) to establish collaborative relationships between county leaders, community service providers, and the jail; (2) to create a plan for MAT expansion within the county jail; and (3) to create a seamless, warm hand-off between the county jail and the community for those who need or are receiving MAT.
- Hudson County, New Jersey's, process began with action planning, including task force meetings between the Hudson County jail, prerelease services, and a community-based treatment provider to continue services provided in the jail. The task force will launch a Supporting Treatment for Addiction Recovery and Success (STARS) mobile outreach program. STARS includes a mobile outreach vehicle to provide people with resources, and inform them about the services available in the community. Bridges TTA was conducted through Arnold Ventures and BJA early on; the providers were able to identify service gaps, advise the county, and engage with them regularly. Hudson County also participated in bimonthly TTA videoconferences with an IIR liaison and Bridges peer learning and support.
- Lewis and Clark County, Montana's, grant team has been meeting, going through a work plan, and engaging in peer learning. They also plan to hire a licensed addiction counselor in the jail, working on memoranda of understanding with two federally qualified health centers, ensuring they have standard operating procedure in the jail, and changing the job description for the prescribing doctor or nurse practitioner in the jail to ensure support for MAT. Key elements of the county's grant include identifying people already on MAT and connecting them to MAT in the community, developing a peer support specialist program, and developing induction opportunities for peer support specialists at the facility. The county shared that its TTA provider has been helpful in highlighting the importance of MAT, checking on the work plan, and keeping them focused and moving forward. The county also created a data-tracking plan, intending to collect data on people being booked in jail, prevalence of OUDs, and reports to medical staff.

# Appendix C. Statistical Significance Tests

### TABLE C.1

### PMT 1.0 Data Change Between First and Fourth Report

	First Report		Fourth Report		. P
	n	x	n	x	
Common questionnaire					
At least one set of stakeholders showed high collaboration	148	0.600	148	2.550	0.0005*
Encountered at least one project obstacle	148	0.510	148	1.810	0.353
Used at least one strategy (sometimes/frequently)	148	1.510	148	5.840	0.00302*
Category 1 specific questionnaire					
Used at least one entity to identify and refer	41	0.927	41	5.420	0.059
Number referred to substance abuse treatment	41	1.980	41	20.20	0.03737*
Number assessed for substance abuse treatment	41	1.560	41	18.40	0.306
Number received substance abuse treatment	41	1.370	41	11.20	0.121
Days between referral and substance abuse treatment	41	0.317	41	5.740	0.164
Number had contact with a case manager within 30 days	41	2.020	41	23.80	0.254
Number referred to recovery support	41	14.70	41	54.70	0.115
Number received recovery support	41	14.50	41	44.30	0.087
Number of individuals who received naloxone training	41	4.290	41	27.20	0.478
Category 3 specific questionnaire					
Number of involved working group partners	34	0.676	34	7.240	0.02885*
Number referred to recovery support	34	0.000	34	5.500	0.397
Number received recovery support	34	0.000	34	5.060	0.384
Category 6 specific questionnaire					
Number of involved action group members	54	2.320	54	12.30	0.03541*

Source: Authors' analysis of data from Bureau of Justice Assistance, Comprehensive Opioid Abuse Program.

**Notes:** PMT = Performance Measurement Tool. Means and averages are only reported when three or more reports were present in the analysis.

\* statistically significant
### TABLE C.2

### PMT 1.0 Data Differences between Award Years

	FY2017		FY2018		Р
	n	x	n	x	
Categories 2, 3 specific questionnaires					
Number of program entry points	40	1.000	132	1.290	0.03*
Number of mechanisms for referral	40	0.475	132	0.765	0.02575*
Categories 3, 4 specific questionnaires					
Number of involved working group partners	76	6.620	136	4.110	0.00088*
Category 6 specific questionnaire					
Number of involved action group members	48	13.500	168	6.790	0.00086*

Source: Authors' analysis of data from Bureau of Justice Assistance, Comprehensive Opioid Abuse Program.

**Notes:** PMT = Performance Measurement Tool. Means and averages are only reported when three or more reports were present in the analysis.

\* *p* < 0.05

#### TABLE C.3

### PMT 1.0 Data Differences between the 23 Process Evaluation Grantees and COAP Cohorts

	Process Evaluation Sample		COAP Cohorts		P
	n	x	n	x	
Categories 1, 2, 3 specific questionnaires					
Used at least one entity to identify and refer	72	3.750	348	2.660	0.01969*
Number referred to substance abuse treatment	72	11.900	348	9.340	0.01185*
Number assessed for substance abuse treatment	72	12.400	348	7.620	0.03155*
Number received substance abuse treatment	72	7.780	348	4.630	0.02671*
Days between referral and substance abuse treatment	72	3.830	348	2.580	0.01447*
Number referred to recovery support	72	16.900	348	23.200	0.01998*
Number received recovery support	72	11.900	348	18.500	0.01196*
Categories 2, 3 specific questionnaires					
Number of program entry points	36	4.280	176	0.847	0.0048*
Number of mechanisms for referral	36	1.810	176	0.580	0.00055*
Category 6 specific questionnaire					
Number of involved action group members	47	16.300	211	9.140	0.00018*
Activities researcher assisted	47	2.150	211	0.744	0.00018*
Interventions data informed	47	0.872	211	0.412	0.00022*
Activities researcher assisted	47	2.150	211	0.744	0.00018*

**Source:** Authors' analysis of grantee data from Bureau of Justice Assistance, Comprehensive Opioid Abuse Program.

**Notes:** PMT = Performance Measurement Tool. Means and averages are only reported when three or more reports were present in the analysis. Figures in this table count each site's multiple data points.

\* *p* < 0.05

## Notes

- <sup>1</sup> Josh Katz and Margot Sanger-Katz, "It's Huge, It's Historic, It's Unheard of: Drug Overdose Deaths Spike," The Upshot, *New York Times*, July 14, 2021.
- <sup>2</sup> This report uses the term "criminal legal system" in place of "criminal justice system" consistent with an emerging trend in the broader field and to more accurately reflect system functioning. It also uses "criminal legal-involved" rather than "criminal justice involved" to refer to people who are system involved.
- <sup>3</sup> "Comprehensive Opioid, Stimulant, and Substance Abuse Program Resource Center," Bureau of Justice Assistance, https://www.cossapresources.org/.
- <sup>4</sup> The 16 selected communities are in Florida, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan (2), Minnesota, Montana, New Jersey (2), North Carolina, Oregon, Tennessee, and Virginia. Naples, Florida, was added as a 16th community following the announcement (personal communication from BJA, June 12, 2019).
- <sup>5</sup> This report follows the CDC's definitions of opioid misuse, dependence, and opioid use disorder. Misuse is defined as the use of illegal drugs and the use of prescription drugs in a manner other than as directed by a doctor, such as use in greater amounts, more often, or for longer than told to take a drug, or use of someone else's prescription. Dependence occurs when the body adjusts its normal functioning around regular opioid use, and unpleasant physical symptoms occur when medication is stopped. Opioid use disorder is a problematic pattern of opioid use that causes significant impairment or distress. "Commonly Used Terms," CDC, January 26, 2021, https://www.cdc.gov/opioids/basics/terms.html.
- <sup>6</sup> "Overdose Death Rates: Trends and Statistics," NIDA (National Institute on Drug Abuse), revised January 29, 2021, https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates.
- <sup>7</sup> "Overdose Death Rates," NIDA.
- <sup>8</sup> "Overdose Death Rates," NIDA.
- <sup>9</sup> Peter Jamison, "Pure Incompetence," Washington Post, December 19, 2018, https://www.washingtonpost.com/ graphics/2018/local/dc-opioid-epidemic-response-african-americans/; Marisa Peñaloza, "The Opioid Crisis Is Surging in Black, Urban Communities," Morning Edition, NPR, March 8, 2018, https://www.npr.org/2018/03/ 08/579193399/the-opioid-crisis-frightening-jump-to-black-urban-areas.
- <sup>10</sup> "Overdose Death Rates," NIDA.
- <sup>11</sup> "Opioid Addiction, Death, and Treatment: The Latest Analysis of the Data," USA Facts, accessed June 27, 2019, https://usafacts.org/reports/opioid-addiction-deaths-treatment-data.
- <sup>12</sup> "US Opioid Dispensing Rate Maps," CDC, last reviewed December 7, 2020, https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.
- <sup>13</sup> Nora Volkow, "Addressing the Opioid Crisis Means Confronting Socioeconomic Disparities," Nora's Blog, NIDA, October 25, 2017, https://www.drugabuse.gov/about-nida/noras-blog/2017/10/addressing-opioid-crisismeans-confronting-socioeconomic-disparities.
- <sup>14</sup> "Overdose Death Rates," NIDA; "US Drug Overdose Deaths Continue to Rise; Increase Fueled by Synthetic Opioids," CDC, press release, March 29, 2018, https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html.
- <sup>15</sup> "Overdose Deaths Accelerating during COVID-19: Expanded Prevention Efforts Needed," CDC, press release, December 17, 2020, https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html.

- <sup>16</sup> Kathleen Smith, "Depression and Opioid Abuse," Psycom, last updated November 25, 2018, https://www.psycom.net/depression.central.opioid.abuse.html.
- <sup>17</sup> Larry Eichel and Octavia Howell, "Philadelphia's Drug-Related Homicides Continue to Rise," PEW Charitable Trusts blog, September 28, 2017, https://www.pewtrusts.org/en/research-andanalysis/articles/2017/09/28/philadelphias-drug-related-homicides-continue-to-rise.
- <sup>18</sup> Nick Castele, "2020 to Be a Busy Year for Opioid Lawsuits," 90.3 WCPN Ideastream, December 4, 2019, https://news.wosu.org/ideastream/2019-12-24/2020-to-be-a-busy-year-for-opioid-lawsuits.
- <sup>19</sup> Stephanie Dias and Brian Holsey, "Challenges in Measuring Fentanyl Analogs: Advice from the Front Lines," *Clinical Laboratory News*, AACC Laboratories, May 1, 2018, https://www.aacc.org/publications/cln/articles/ 2018/may/challenges-in-measuring-fentanyl-analogs-advice-from-the-front-lines; Christine Vestal, "Opioid Overdoses Swamp Medical Examiners," PEW Charitable Trusts blog, July 6, 2017, http://pew.org/2uqUb31; Dave Collins, "Overdose Deaths Overwhelm Medical Examiner, Coroner Offices," *AP News*, June 23, 2016, https://apnews.com/08e507efe2b440fb81eda5278f5c05c5.
- <sup>20</sup> There is also a growing movement to use involuntary civil commitment as a way to ensure detoxification and enable access to MAT, despite the limited and often conflicting evidence of its effectiveness (Christopher et al. 2015; Werb et al. 2016).
- <sup>21</sup> The NIH Helping to End Addiction Long-Term Initiative supports the Justice Community Opioid Innovation Network to study responses to OUD in justice settings through a national survey, research on new approaches, and secondary data analyses ("Justice Community Opioid Innovation Network," NIH, August 4, 2020, https://heal.nih.gov/research/research-to-practice/jcoin).
- <sup>22</sup> The decision to limit the scope of the assessment to COAP categories 1–4 and 6 rendered the fifth question of the COAP assessment solicitation, which focused on Category 5 grantees (prescription drug monitoring programs), moot.
- <sup>23</sup> BJA selected additional TTA providers to serve subsequent cohorts of COAP grantees.
- <sup>24</sup> Limited TTA receipt among FY2017 and FY2018 COAP grantees may reflect BJA's early approach to TTA provision: BJA did not require COAP grantees to participate in TTA, and TTA providers initially were instructed not to actively reach out to grantees. As such, early in the COAP grant program, TTA providers could only respond to grantee requests for TTA and could not educate grantees about available TTA resources. According to TTA providers, BJA later adopted a different approach, asking its COAP TTA providers to proactively reach out to new or recent grantee cohorts and engage them directly on a recurring basis. As a result, COAP grantees in the FY2019 and FY2020 cohorts may have different TTA experiences and have received TTA at a higher rate than the FY2017 and FY2018 grantees that were the focus of this assessment.
- <sup>25</sup> Bridges planning grantees were not required to submit PMT performance data to BJA; therefore, the grantee performance analysis focuses only on COAP grantees.
- <sup>26</sup> Twelve states (Alabama, California, Indiana, Missouri, Mississippi, New Jersey, New York, Ohio, Pennsylvania, Tennessee, Washington, and Wisconsin) have received more than six FY2017 or FY2018 COAP awards, with Ohio receiving 16 awards covering five of the six COAP categories. Profiles of the 50 FY2017 COAP grantees are available on the BJA website ("Comprehensive Opioid, Stimulant, and Substance Abuse Program: Overview—About the Program," https://bja.ojp.gov/program/cossap/overview?Program\_ID=72). Brief descriptions of all COAP grantees can be found on the COSSAP Resource Center website ("Site-Based Grants," https://www.cossapresources.org/Program/SiteGrants).
- <sup>27</sup> Information from the grant awards selector at "Other APIs," OJP, https://external.ojp.usdoj.gov/selector/ solicitations.

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