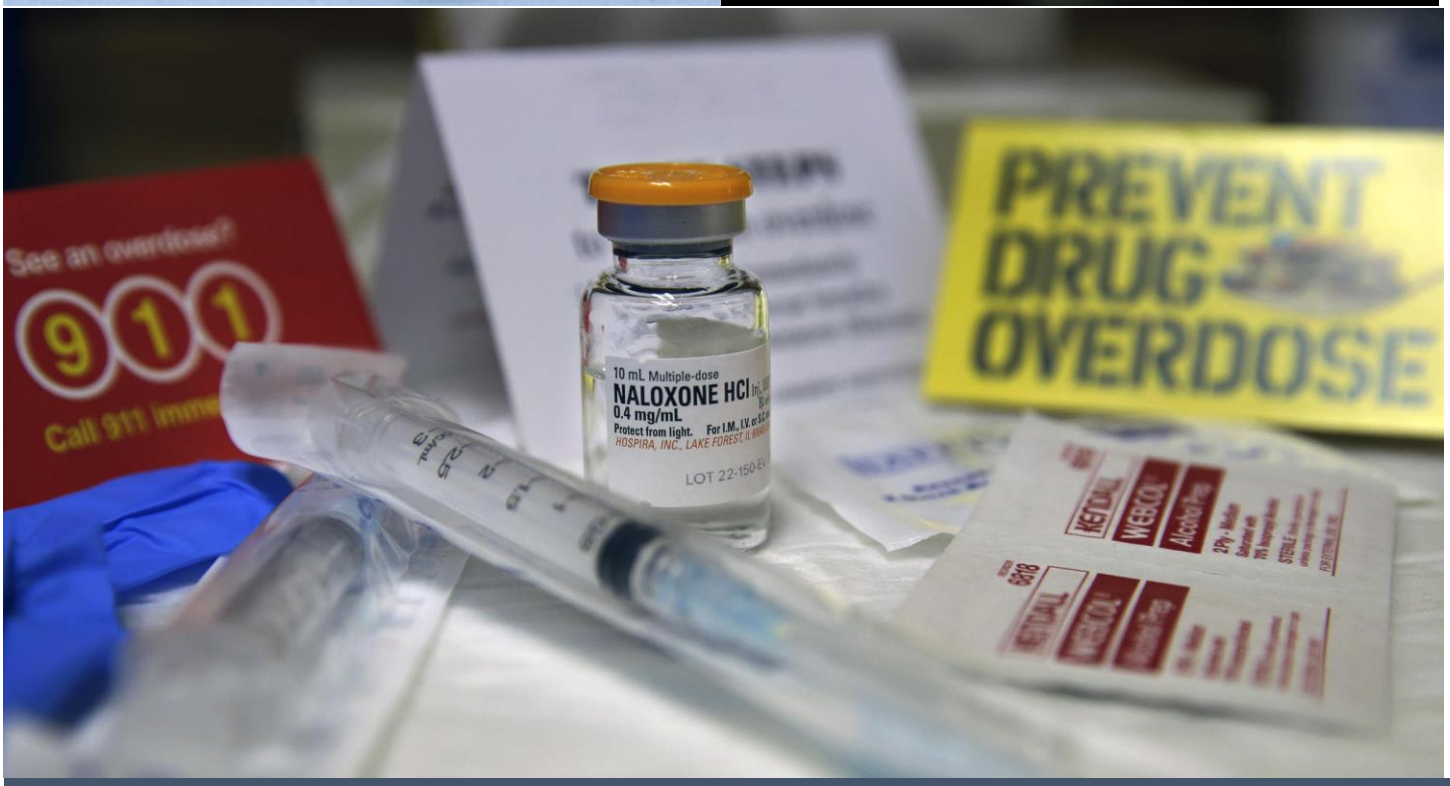


161554 - Work Plan Draft (As of 01-04-18)

2018-2022 WORK PLAN

INTRODUCTION

Drug overdoses, driven largely by overdoses related to the use of opioids, are now the leading cause of unintentional injury deaths in the United States. In order to stem the tide and reverse the 15 year trend in increasing drug overdose deaths a coordinated multi-disciplinary community participatory multi-facetted approach is needed to address this unprecedented public health crisis. This work plan serves as the City and County of Milwaukee's initial strategic plan for action.

Overview of Opioids

Opioids are a class of drugs that act on the body's opioid receptors including natural, semi-synthetic and synthetic opioids. Natural opioids include drugs such as morphine, which are derived from the resin of the opium poppy, semi-synthetic opioids such as hydrocodone and oxycodone, and synthetic opioids such as fentanyl and methadone. Opioids are often used medically to relieve moderate to severe pain, but can also be used or other conditions -for example, to suppress cough, to treat diarrhea and even to treat opioid use disorder. Opioids are very effective for treating severe pain such as that associated with cancer, post-surgery, or accident-related injuries. While opioids provide pain relief, they also cause physical dependence, respiratory depression, euphoria, reduced intestinal motility and other desired and undesired effects. Since these pharmacologic effects focus on blocking pain, opioids have high potential for misuse. (Substance Abuse Research Alliance, 2017)

Opioid drugs mimic the body's natural response to pain by stimulating the body's opioid receptors, most prominently the Mu (μ) receptors. Mu receptors account for most of the effects of opioids and are primarily located in the brain, spinal cord, peripheral nervous system, and intestinal tract. By stimulating the Mu receptors, opioids reduce the perception of pain by slowing down and blocking pain signal transmission to the brain while also triggering the release of dopamine, a neurotransmitter used in the brain's pleasure or reward system. When activated, dopamine produces a pleasurable and often euphoric feeling. Use of opioids for more than a short period of time leads to tolerance and physical and psychological dependence. This means opioid users must take larger doses of opioids over time to achieve the same effect. Additionally, opioid users must not stop taking these drugs abruptly, or they will experience withdrawal symptoms such as agitation, anxiety, muscle and bone pain, insomnia, vomiting or diarrhea. Withdrawal symptoms occur when the amount of opioids used decreases or stops. (Substance Abuse Research Alliance, 2017)

Overview of Cocaine

Cocaine is a powerfully addictive stimulant drug made from the leaves of the coca plant native to South America. Although health care providers can use it for valid medical purposes, such as local anesthesia for some surgeries, cocaine is an illegal drug. (NIDA, Cocaine, 2017)

Cocaine can be found in a number of forms, including white powder, paste, or solidified and rock-like (the latter commonly referred to as "crack cocaine"). Whatever the form, cocaine acts as a strong stimulant substance that can:

- Provide a rapid-onset, rewarding high.
- Speeds up various physiologic processes via its central nervous system effects.
- Influence both short- and long-term mental health.

Street dealers often mix it with things like cornstarch, talcum powder, or flour to increase profits. They may also mix it with other drugs such as the stimulant amphetamine.

Dependent on the method with which it is used—e.g., smoked, snorted or injected—cocaine can be quite rapidly acting. One of cocaine's effects in the brain is to increase dopamine release. Dopamine is a neurotransmitter that plays a role in the brain registering positive feelings, and "rewarding" the behaviors that led to those feelings to begin with. This increase of dopamine is, in part, what leads to the subjective "high" of cocaine use and its addictive power.

Cocaine's effects appear almost immediately after a single dose and disappear within a few minutes to an hour. Small amounts of cocaine usually make the user feel euphoric, energetic, talkative, mentally alert, and hypersensitive to sight, sound, and touch. The drug can also temporarily decrease the need for food and sleep. Some users find that cocaine helps them perform simple physical and intellectual tasks more quickly, although others experience the opposite effect.

The duration of cocaine's euphoric effects depend upon the route of administration. The faster the drug is absorbed, the more intense the resulting high, but also the shorter its duration. Snorting cocaine produces a relatively slow onset of the high, but it may last from 15 to 30 minutes. In contrast, the high from smoking is more immediate but may last only 5 to 10 minutes.

Short-term physiological effects of cocaine use include constricted blood vessels; dilated pupils; and increased body temperature, heart rate, and blood pressure. Large amounts of cocaine may intensify the user's high but can also lead to bizarre, erratic, and violent behavior. Some cocaine users report feelings of restlessness, irritability, anxiety, panic, and paranoia. Users may also experience tremors, vertigo, and muscle twitches.

Severe medical complications can occur with cocaine use. Some of the most frequent are cardiovascular effects, including disturbances in heart rhythm and heart attacks; neurological effects, including headaches, seizures, strokes, and coma; and gastrointestinal complications, including abdominal pain and nausea. In rare instances, sudden death can occur on the first use of cocaine or unexpectedly thereafter. Cocaine-related deaths are often a result of cardiac arrest or seizures. Many cocaine users also use alcohol, and this combination can be particularly dangerous. The two substances react to produce cocaethylene, which may potentiate the toxic effects of cocaine and alcohol on the heart.

The combination of cocaine and heroin is also very dangerous. Users combine these drugs because the stimulating effects of cocaine are offset by the sedating effects of heroin; however, this can lead to taking a high dose of heroin without initially realizing it. Because cocaine's effects wear off sooner, this can lead to a heroin overdose, in which the user's respiration dangerously slows down or stops, possibly fatally.

Over time cocaine alters the chemical pathways in the brain. Users may develop tolerances leading to higher doses and binge using. Regularly snorting cocaine can lead to loss of sense of smell, nosebleeds, problems with swallowing, hoarseness, and an overall irritation of the nasal septum leading to a chronically inflamed, runny nose. Smoking crack cocaine damages the lungs and can worsen asthma. People who inject cocaine have puncture marks called tracks, most commonly in their forearms, and they are at risk of contracting infectious diseases like HIV and hepatitis C

Risk for HIV and Hepatitis C

Drug intoxication and addiction can compromise judgment and decision-making and potentially lead to risky sexual behavior, including trading sex for drugs, and needle sharing. This increases an opioid or cocaine user's risk for contracting infectious diseases such as HIV and hepatitis C (HCV).

Injection drug users (IDUs) are the highest-risk group for acquiring hepatitis C (HCV) infection and continue to drive the escalating HCV epidemic. Each IDU infected with HCV is likely to infect 20 other people. (NIDA, Heroin Users At Risk, 2017) The risk related to infectious disease doesn't stop with transmission. Substance abuse places cocaine and opioid abuses at increased risk of significant morbidity and mortality from the infectious disease.

Cocaine users with HIV often have advanced progression of the disease, with increased viral load and accelerated decreases in CD4+ cell counts. Infection with HIV increases risk for co-infection with HCV, a virus that affects the liver. Co-infection can lead to serious illnesses—including problems with the immune system and neurologic conditions. Liver complications are very common, with many co-infected individuals dying of chronic liver disease and cancer. (NIDA, Cocaine Users At Risk, 2017)

The interaction of substance use, HIV, and hepatitis may accelerate disease progression. For example, HIV speeds the course of HCV infection by accelerating the progression of hepatitis-associated liver disease. Research has linked HIV/HCV co-infection with increased mortality when compared to either infection alone. Substance use and co-infection likely negatively influence HIV disease progression and the ability of the body to marshal an immune response.

Substance abuse can lead to outbreaks of infectious disease. Such was the case in rural Indiana in 2015, when a state of emergency was declared when an outbreak resulted in nearly 225 cases of HIV being reported due to injection drug use. 400 cases of hep c

The table below provides the rates of Hepatitis C and HIV

Talk about HEP C and HIV In Milwaukee

Scope of the Public Health Crisis

Last year, roughly 64,000 people died from a drug overdose in the United States -- the largest annual increase in drug-related deaths ever recorded in our history. Overdoses are now the leading cause of death for Americans under the age of 50. The majority of drug overdose deaths (more than six out of ten) involve an opioid. (Rudd, Seth, Felicita, & Scholl, 2016) Since 1999, the number of overdose deaths involving opioids (including prescription opioids and heroin) quadrupled. (CDC, Understanding the Epidemic, 2017) From 2000 to 2015 more than half a million people died from drug overdoses. More than ninety Americans die every day from an opioid overdose. (CDC, Understanding the Epidemic, 2017)

We now know that overdoses from prescription opioids are a driving factor in the 15-year increase in opioid overdose deaths. The amount of prescription opioids sold to pharmacies, hospitals, and doctors' offices nearly quadrupled from 1999 to 2010, (US Department of Justice, 2011) (Paulozzi, Jones, Mack, & Rudd, 2011) yet there had not been an overall change in the amount of pain that Americans reported. (Chang H, Daubresse, KruszewskiSP, & Alexander, 2014) (Daubresse, Chang, Yu, & Viswanathan, 2013)

Wisconsin has been deeply impacted by the opioid crisis. According to the Wisconsin Department of Health Services, in 2016, 827 people died in Wisconsin of opioid overdose deaths caused by heroin, or prescription drugs, or both. From 2000 to 2016, the number of deaths in Wisconsin due to prescription opioids increased 600 percent, from 81 to 568 in 2016. Heroin overdose deaths increased 12 times, from 28 deaths in 2000 to 371 deaths in 2016.

Since 2005, Milwaukee County has seen a 495% increase in heroin related deaths. Over the last five years overdose deaths have consistently surpass homicides, motor vehicle accidents and suicides investigations completed by the Milwaukee County Medical Examiner office for non-natural death investigations. Yet, deaths only illustrate a small part of the effect the opioid epidemic has on the Milwaukee community. In fact, in 2015, for every death, there were more than 6 additional people who experienced an overdose that required naloxone, and multitudes more who were addicted but never overdosed. (Fumo, 2017)

Chart 1: Milwaukee County Non-Natural Deaths 2011-2017

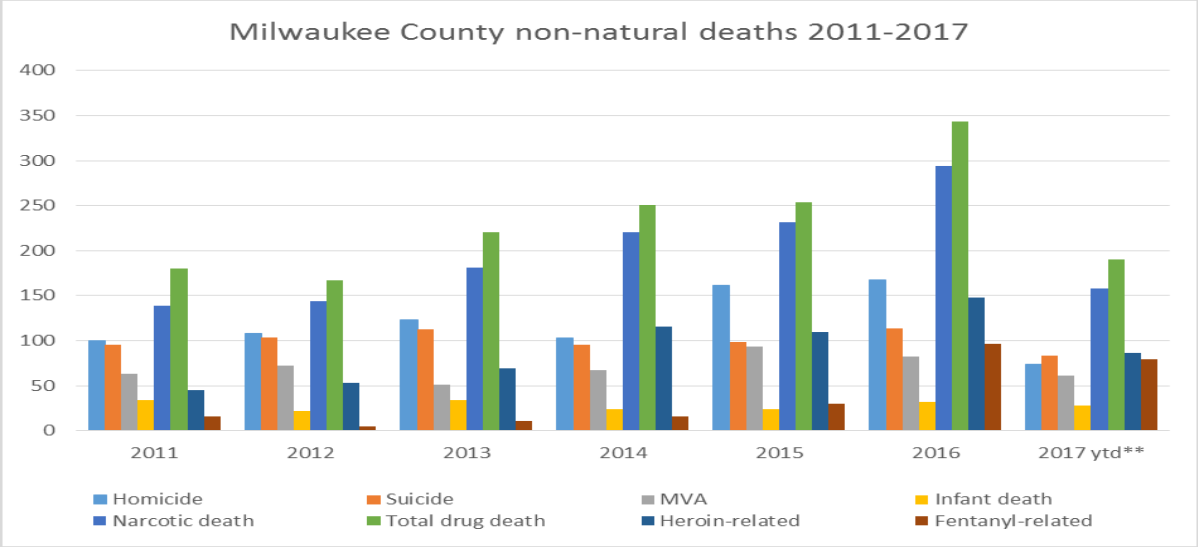


Chart 2: Opioid Related Overdose Deaths by Age Range for Years 2012-2016

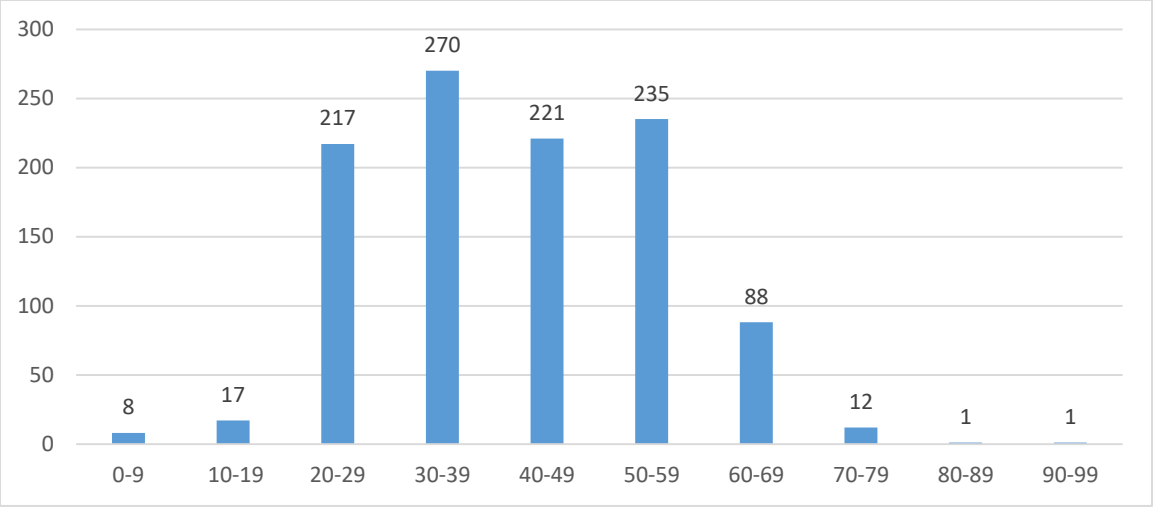


Chart 3: Opioid Related Overdose Deaths by Race / Ethnicity 2012-2016

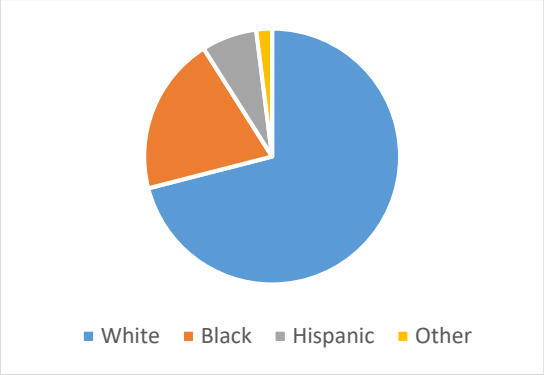


Chart 4: Opioid Related Overdose Deaths by Gender 2012-2016

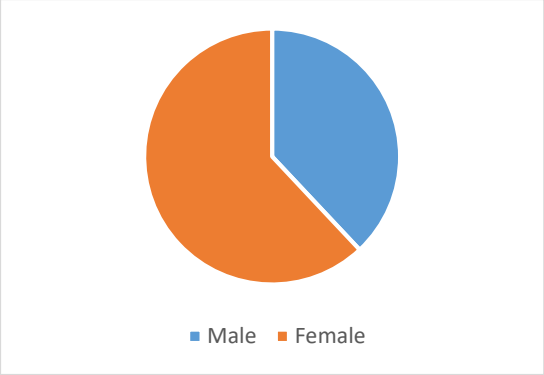


Figure x: Location of Opioid Related Overdose Deaths in Milwaukee County for Years 2013-2016

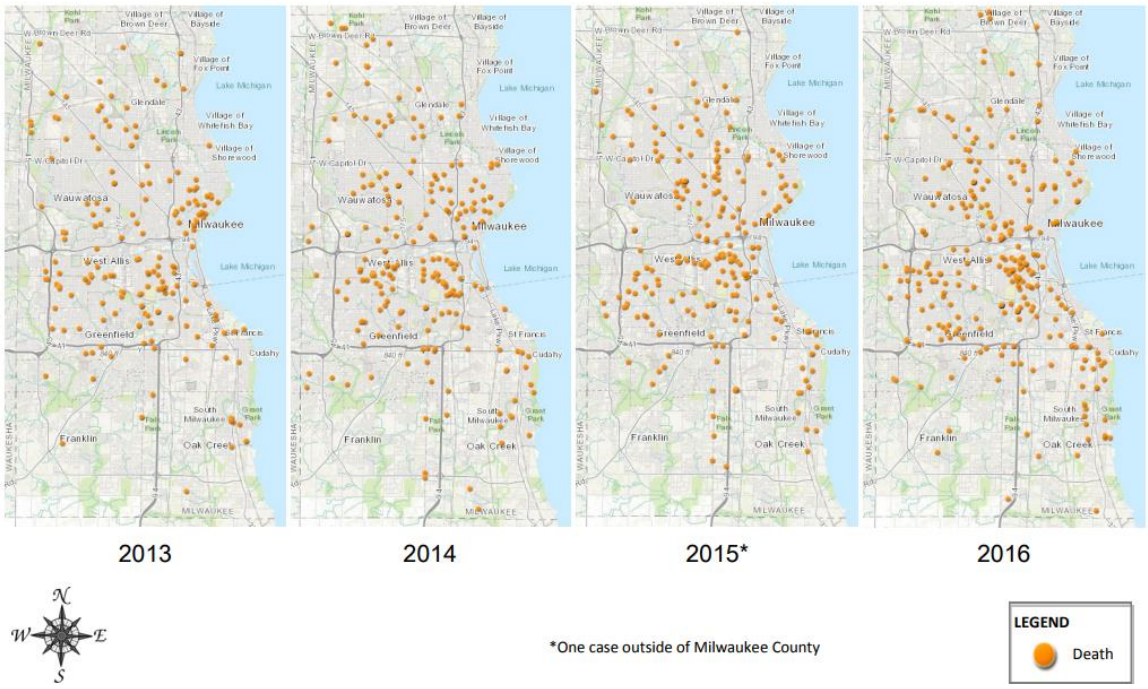
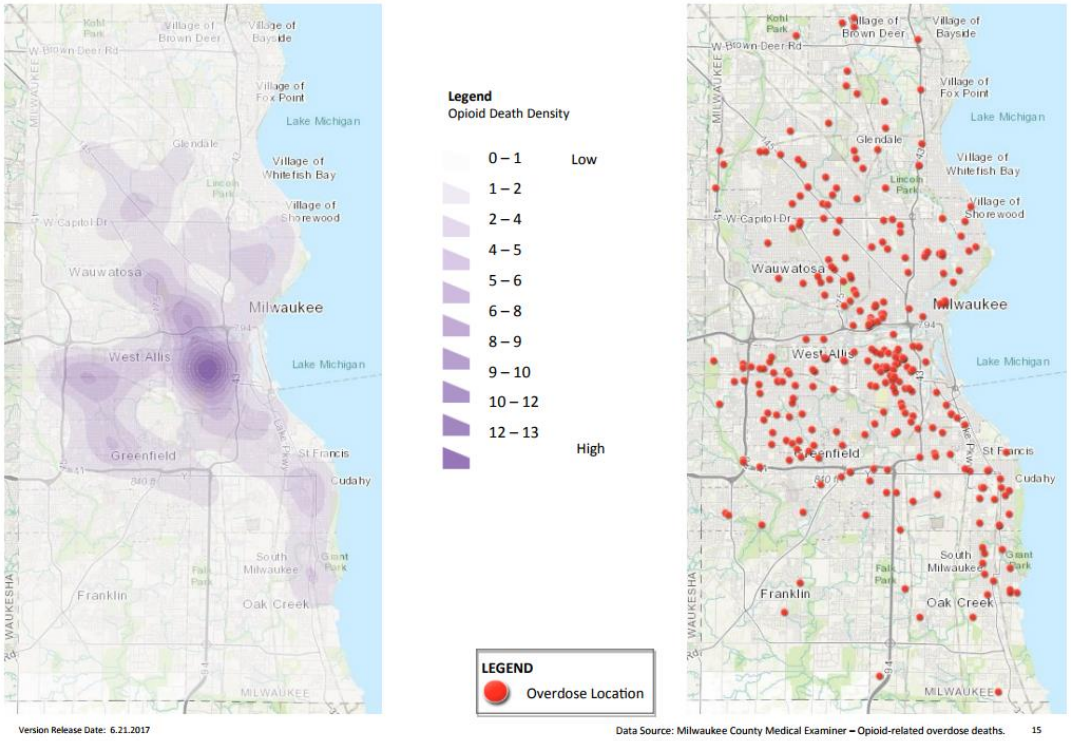


Figure: Overdose Location for Opioid-Related Deaths in Milwaukee County, 2016



While the charts and figures on the previous pages illustrate that fatal overdoses were more likely to occur in older white males, it also shows that no group nor no corner of the county has been spared from the opioid epidemic. Opioid, heroin, and synthetic analog and cocaine use, addiction, and

overdose are problems that affect an increasingly wide demographic of residents of the City of Milwaukee and Milwaukee County, including pregnant women and newborns

The majority of those who die from opioid overdoses are found to have ingested multiple drugs that contributed to their death. Further, there has been a steep rise in fentanyl-related overdose deaths. Alarmingly, among those who survived their overdose after receiving Naloxone, approximately one-quarter did not access the EMS system. Of those who died from an opioid overdose, the majority were not identified until after it was too late to attempt resuscitation or administer Naloxone either because the victim was alone or thought to be sleeping.

The White House says the true cost of the opioid drug epidemic in 2015 was $504 billion, or roughly half a trillion dollars

In 2007, the economic cost of illicit drug use totaled more than $193 billion in the United States. The estimated direct and indirect costs attributable to illicit drug use are in four principal areas: crime, health, medical care and productivity. Wisconsin's share of this cost is estimated to be at least $2 billion based upon admissions to substance use treatment facilities. A separate 2001 study estimated the economic cost of heroin use alone in the United States at $21.9 billion or about $220 million in Wisconsin3. The recent resurgence of opiate-related problems has increased emergency room visits, crime, homicides, high school drop-outs and loss of employment and has public health, criminal justice and public policy officials concerned.

The situation has reach the level that the Centers for Disease Control and Prevention has characterized prescription opioid use as a public health epidemic in the United States, and on October 26, 2017 the President officially declare the opioid crisis a public health emergency.

Selected Drug Use, Past Year Alcohol Use Disorder, and Past Year Mental Health Measures in *Wisconsin*, by Age Group: Estimated Numbers (in Thousands), Annual Averages Based on 2014-2015 NSDUHs

Measure[1]	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Past Year Marijuana Use	584	63	201	320	521
Past Month Marijuana Use	334	34	109	190	300
Past Year Cocaine Use	77	3	31	43	74
Past Year Heroin Use	15	1	6	9	15
First Use of Marijuana[2,3]	57	24	27	6	33
ALCOHOL					
Past Month Alcohol Use	2,923	50	414	2,459	2,872
Past Month Alcohol Use (Individuals Aged 12 to 20)	155[4]	--	--	--	--
TOBACCO PRODUCTS					
Past Month Tobacco Product Use[5]	1,228	36	226	967	1,193
Past Month Cigarette Use	998	26	182	789	971
PAST YEAR ALCOHOL USE DISORDER[6]					
Alcohol Dependence	140	4	35	100	135
Alcohol Use Disorder	355	14	91	250	341
PAST YEAR MENTAL HEALTH ISSUES					
Major Depressive Episode[3,7]	--	61	66	222	288
Serious Mental Illness[3,8]	--	--	33	142	175
Any Mental Illness[3,8]	--	--	140	684	824
Had Serious Thoughts of Suicide[9]	--	--	52	132	184

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

NOTE: Estimated numbers appearing as 0 in this table mean that the estimate is greater than 0 but less than 500 (because estimated numbers are shown in thousands).

[1] In 2015, a number of changes were made to the NSDUH questionnaire and data collection procedures resulting in the establishment of a new baseline for a number of measures. Therefore, estimates for several measures included in prior reports are not available. For details, see Section A of the "2014-2015 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at http://www.samhsa.gov/data/.

[2] *First use of marijuana* (or the average annual number of marijuana initiates) = $X_1 \div 2$, where X_1 is the number of marijuana initiates in the past 24 months.

[3] For details, see Section B of the "2011-2012 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at http://www.samhsa.gov/data/.

[4] Underage drinking is defined for individuals aged 12 to 20; therefore, the "12+" estimate reflects that age group and not individuals aged 12 or older.

[5] Tobacco Products include cigarettes, smokeless tobacco (i.e., snuff, dip, chewing tobacco, or "snus"), cigars, or pipe tobacco.

[6] Alcohol Use Disorder is defined as meeting criteria for alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[7] Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which specifies a period of at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from adults aged 18 or older to produce an estimate for those aged 12 or older.

[8] Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) *Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders* (MHSS-SCID), which is based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness (SMI). Any mental illness (AMI) includes individuals in any of the three categories.

[9] Respondents were asked, "At any time in the past 12 months, did you seriously think about trying to kill yourself?" If they answered "Yes," they were categorized as having serious thoughts of suicide in the past year.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014 and 2015.

Intersection of Substance Abuse and Public Safety

The use of alcohol and drugs can negatively affect all aspects of a person's life, impact their family, friends and community, and place an enormous burden on American society. One of the most significant areas of risk with the use of alcohol and drugs is the connection between alcohol, drugs and crime.

Alcohol and drugs are implicated in an estimated 80% of offenses leading to incarceration in the United States such as domestic violence, driving while intoxicated, property offenses, drug offenses, and public-order offenses.

Our nation's prison population has exploded beyond capacity and most inmates are in prison, in large part, because of substance abuse:

- 85% of offenders have substance abuse issues (9)
- Approximately 60% of individuals arrested for most types of crimes test positive for illegal drugs at arrest.
- Alcohol, alone or in combination with another substance, is involved in the incarceration of 57% of all prisoners

The Wisconsin Department of Corrections estimates that 70% of state prisoners have a substance abuse addiction. In comparison, the Wisconsin Department of Health Services estimates the rate of dependence or abuse of illicit drugs in the general population as 3%. Data specific to Milwaukee is not available?

According to an article in the Journal of the American Medical Association, 80% to 85% of prisoners who could benefit from substance abuse treatment in prisons do not receive it.[81] Despite the preponderance of evidence showing that treatment reduces drug use and drug-related crime, the U.S. Office of Justice Assistance notes that only 15% of state prisoners receive treatment while incarcerated.

According to the Federal Bureau of Justice Statistics, over half of the U.S. prison population has mental health issues8 and an estimated 85% have substance abuse issues.9

The National Center on Addiction and Substance Abuse at Columbia University estimates that while 65% of U The Bureau of Justice Statistics found that 56% of U.S. prisoners had substance use dependence or abuse in the month prior to entering prison, and 32% of state prisoners committed their offense under the influence of drugs.27 A 2006 study concluded that adults were 12 times more likely to be involved in the criminal justice system if they had substance abuse issues than if they did not.28

The relationship between drugs and crime is complex, and one question is whether drug use leads people into criminal activity or whether those who use drugs are already predisposed to such activity. Many illegal drug users commit no other kinds of crimes, and many persons who commit crimes never use illegal drugs. However, at the most intense levels of drug use, drugs and crime are directly and highly correlated and serious drug use can amplify and perpetuate preexisting criminal activity.

There are essentially three types of crimes related to drugs:

- Use-Related crime: These are crimes that result from or involve individuals who ingest drugs, and who commit crimes as a result of the effect the drug has on their thought processes and behavior.
- Economic-Related crime: These are crimes where an individual commits a crime in order to fund a drug habit. These include theft and prostitution.
- System-Related crime: These are crimes that result from the structure of the drug system. They include production, manufacture, transportation, and sale of drugs, as well as violence related to the production or sale of drugs, such as a turf war.

While the FBI does not report drug-related crimes, they do report arrests due to drug abuse violations. In 2009, about 18% of U.S. prisoners were sentenced for drug-related offenses,[160] and in 2010, 13% of total arrests were directly due to drug abuse violations.[161] In Wisconsin, an increase in drug offenders accounted for more than 20% of the growth in incarceration from 1996 to 2006, and OWI offenders were responsible for more than 60% of the growth from 2001 to 2006.162

Many people who commit non-violent crimes have substance abuse and mental health issues. By report of the Substance Abuse and Mental Health Services Commission we know that 60% and 50% of inmates have a substance abuse or mental health issue, respectively,164 and that 33% of all inmates have co-occurring disorders.165 Meanwhile, 72% of those with substance abuse issues166 and 39% of those with mental health issues 167 commit non-violent crimes

The U.S. Drug Enforcement Agency has announced that Milwaukee will be the second of four cities in the Midwest to take part in a pilot comprehensive diversion control law enforcement and prevention "360 Degree Strategy" to help cities dealing with the opioid misuse and heroin epidemic linked to violent crime. The City of Milwaukee recognizes a need for taking a proactive and prevention-oriented approach to the assurance of public health and safety of the community. Many residents of the City and County who misuse or suffer from addiction to opioids, heroin, and synthetic derivatives, and cocaine are stigmatized from seeking treatment from medical providers. It is against this backdrop that Ald. Michael Murphy, representing the 10th District, sponsored the resolution creating this Task Force to develop and recommend meaningful evidence-based solutions to the growing problem of heroin, opioid, and cocaine misuse, addiction, and overdose.

https://www.ncadd.org/about-addiction/alcohol-drugs-and-crime

City-County Heroin, Opioid, and Cocaine Task Force

Perhaps most surprising is an April 2016 Kaiser Health Tracking Poll that found most Americans believe the federal government is not doing enough to combat recent increases in the number of people who are addicted to prescription painkillers (66%) or heroin (62%). The poll found similar public views regarding state governments and doctors who prescribe painkillers.
In short, there is compelling evidence that prescription pain relief opioids are driving the overdose epidemic. The highly addictive nature of these drugs has also fueled the subsequent explosion in heroin and other synthetic opioid use and overdose. The epidemic has touched persons from every walk of life in families, workplaces, and within community social networks.

At the urging of other Common Council members, cocaine, including crack forms, was also added to the charge of this task force. There is long-standing historical trauma related to the way in which the cocaine epidemic of the 1980s and 90s was handled, with mass incarceration and little focus on treatment. Deaths due to cocaine overdose are much fewer than those of opioids or heroin. According to data from the Milwaukee County Medical Examiner's office, from 2011-16, there were 97 deaths due to cocaine intoxication. Despite this number appearing low, it may not be the best measure of the severity of the problem in the Milwaukee community. Many heroin and opioid overdose victims also have cocaine present in their systems at the time of death. And Impact, a Milwaukee County treatment access point, has stated that it is seeing a slight increase in the number of people seeking treatment who identify cocaine or crack as their primary drug of choice. While cocaine and heroin differ significantly in their chemical make-up and how they affect the body, many of the interventions that focus on treatment and destigmatization of substance use disorder are likely to be beneficial to people regardless of their specific primary drug of use.

The City-County Heroin, Opioid, and Cocaine Task Force (CCHOCTF) was established by Common Council File Number 161061 on January 18, 2017, to study the problem of rising prevalence of opioid, heroin, and synthetic analogs and cocaine (in both powder and crack form) misuse and addiction in Milwaukee, and to make evidence-based recommendations to reduce fatal and nonfatal overdose within the community.

The City-County Heroin, Opioid, and Cocaine Task Force is charged with investigating and making recommendations regarding ways to ensure long-term health and safety of City and County residents by reducing fatal and nonfatal overdose from misuse of opioids, heroin, and synthetic analogs, and cocaine (in both powder and crack form) through data-driven public health prevention approaches. (City of Milwaukee Resolution 161061).

The Milwaukee City-County Opioid, Heroin, and Cocaine Task Force Work Plan outlines the goals, strategies and actions that are being implemented by a number of stakeholders across diverse professional disciplines and communities. This working plan outlines both current efforts as well as new proposed actions to scale up response and will be regularly updated as the epidemic and response evolve over time.

PLAN OVERVIEW

The Milwaukee City-County Opioid, Heroin, and Cocaine Task Force Work Plan includes six priority goals:

1. Increase naloxone availability in the community
2. Enhance community-based options for easy, safe, and environmentally friendly medication disposal.
3. Promote community understanding of pain, pain management and substance abuse disorders to achieve a reduction in opioid exposure in order to reduce risk of individuals developing abuse of other medications including heroin and cocaine
4. Assure there is adequate access to timely, affordable, and quality services for substance use disorders.
5. Maintain and enhance availability and quality of timely data about heroine, opioids, and cocaine use, its outcomes and risk factors
6. Enhance collaboration between community-based initiatives and government agencies

Collectively, the goal, strategies and specific actions span across the social-ecological framework to target:

- Individuals: Those who use prescription opioids and/or heroin at any level of use or dependence ranging from the population as a whole to subset of the population such as adolescents or clients of syringe exchange programs. It also includes interventions targeting professionals such as healthcare care providers, pharmacists, first responders/law enforcement, social service providers and chemical dependency professionals.
- Neighborhood / Community such as schools, workplaces, organizations, peer support groups, and
- Society and Systems: Includes policies, financing structures, and information systems in medical, public health, criminal justice and other fields.

Proposed goals, activities and strategies under this work plan span the entire continuum of care to include:

- Prevention - Prevention, as defined by the SAMHSA Center for Substance Abuse Prevention (CSAP) is "A process that empowers individuals to meet the challenges of life by creating and reinforcing healthy behavior and lifestyles and by reducing the risks that contribute to alcohol, tobacco and other drug misuse and abuse.;
- Early Intervention - Early intervention aims to reduce the risk of harm and decrease problem behaviors that result from continued use of substances. The intent of the intervention is to take action that decreases risk factors related to substance use, abuse or dependency; enhance protective factors; and provide ongoing services, as appropriate; .
- Treatment – Treatment is intended to improve social functioning through complete abstinence from alcohol and drugs for individuals diagnosed with chemical dependency. Treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from substance abuse/dependency and is designed to help that person achieve and maintain sobriety, physical and mental health and a maximum functional ability; and
- Recovery – Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential.

Prevention and early intervention measures may vary in their recommendation for application. In coordination with SAMSHA, Milwaukee utilizes a continuum of care description developed by the Institute of Medicine to describe and track interventions at different levels of risk for substance abuse and mental health disorders. This classification suggests that populations receiving prevention and early intervention services can be defined in universal, selective and indicated categories.

- Universal measures target the general public or an entire population group without regard to individual risk
- Selective measures target individuals or groups considered at risk for substance abuse through membership in a particular segment of the population. This may include children of adults addicted to alcohol, students failing academically or individuals residing in neighborhoods with a high incidence of drug abuse.
- Indicated measures are utilized to prevent the onset of substance abuse in persons who do not meet medical criteria for addiction, but are displaying early danger signs. These early signs may include some use of alcohol and/or marijuana. Prevention services may be provided in family settings, school settings or community settings.

Successful completion of this work plan would translate into the following outcomes:

- An **increase in community knowledge** about the risk of drug use, opioid use disorders, and how naloxone maybe used to reverse opioid overdoses as measured by the estimated number of individuals reached through media, messaging or outreach campaigns. Specific target objectives include:
  - By 2022 educating /training xxx individuals related to the risk of opioids and cocaine
  - By 2022 training xxx individuals on the administration of naloxone
  - By 2022, 100% of you youth attending high school in Milwaukee County receiving substance abuse education
  - By 2018, 100% of municipalities in Milwaukee County contributing to outreach and education regarding substance use disorders, especially heroin, opioids, and cocaine.
  - By 2022, increase the number of agencies and doses of naloxone administered.
- A **change in attitudes and beliefs around drug use, dependency, and treatment** as measured by the number of community education programs conducted to destigmatize opioid use disorder and its treatment. Additional performance targets include:
  - educational programs,
  - By 2022, community health workers, peer health educators with lived experiences educate the general public in order
- A reduction in the access to opioids as measured as
  - Increase in number of fixed site medication drop boxes.
  - Increase in distribution of drug take back envelopes
  - Increase in drug take back events
- Improved access to treatment and harm reduction
  - Increase in funding to the city and/or county to address substance use disorders, especially heroin, opioids, and cocaine. **5% increase by 2022**
  - Reduction in recidivism to drug treatment court, where cocaine or heroin/opiates are identified as their primary drug of use.
  - Increase in number of EDs providing a warm hand-off into treatment or detox for those with substance use disorder. **100% of Milwaukee Co. EDs by 2022**
  - Increase in drug treatment court capacity.

- A reduction in the number of cocaine or opioid associated deaths as measured by the number of deaths recorded by the medical examiner's office. Specific target objectives include:
    - By 2022, stabilize or reduce the number of narcotic associated overdose deaths. By 2027 reduce the number associated overdose deaths by 50%.
    - By 2022, stabilize or reduce the number of drug involved homicides. By 2027 reduce the number drug involved homicides by 50%.
    - By 2027, decrease the need to administer naloxone. Decrease in the times naloxone is used by EMS, due to a lack of demand, not a lack of supply or availability.
    -

Use public health and law enforcement data to monitor trends and strengthen prevention efforts.

Establish and enhance stakeholder coalitions

Consider authorizing and providing support to syringe service and other harm reduction programs

Public Safety Strategies for Reducing the Illicit Supply of and Demand for Opioids

COORDINATION AND IMPLEMENTATION

Partners from all sectors are driving forward implementation of these strategies including city, county and state-level agencies and policy makers, professional associations, law enforcement, local health departments, service providers, community coalitions and many others.

The following stakeholders have participated on the taskforce:

Representing the City of Milwaukee

- **Bevan Baker, Chair,** *Commissioner of Health*
- **Ald. Michael Murphy,** *Common Council, Tenth District*
- **Ald. Khalif Rainey,** *Common Council, Seventh District*

Representing Milwaukee County

- **Hector Colon, Vice-Chair,** *Director of Department of Health and Human Services*
- **Karen Loebel,** *Deputy District Attorney*
- **Michael Lappen,** *Administrator of Behavior Health Division*
- **Brian Peterson,** *Medical Examiner*
- **Christine Westrich,** *Director of Office of Emergency Management*

Representing Intergovernmental Cooperation Council

- **CoryAnn St. Marie-Carls,** *Mayor of St. Francis*

Representing the Medical Profession

- **E. Brooke Lerner,** *Research Director, Medical College of Wisconsin Department of Emergency Medicine*

Representing the Non-Profit Sector

- **Marisol Cervera,** *United Community Center*

Representing the Community

- **Michael Macias,** *Grand Avenue Club, Resident Advisory Council*

Individual workgroups were formed to work on each of the seven priority goals. The workgroups were facilitated by Jessica Gathirimu and Angie Hagy of the City of Milwaukee Health Department

Goal	Workgroup Members	
1. Increase naloxone availability in the community	*Kyle Beyer*	*Janet Fleege*
	Christine Westrich	*Leah Redding*
	E. Lerner	*Rachel Cooper*
2. Enhance community-based options for easy, safe, and environmentally friendly medication disposal.	*Jason Smith*	*Kathy Schmitz*
	Jon Richards	*Ken Darling*
	Kathy Federico	*Michael Murphy*
3. Promote community understanding of pain, pain management and substance abuse disorders to achieve a reduction in opioid exposure in order to reduce risk of individuals developing abuse of other medications including heroin and cocaine	*Brett Fuller*	*Lisa Hass-Peters*
	Chip Morris	*Marisol Cervera*
	James Parnau	*Nzinga Khalid*
	Khalif Rainey	
4. Assure there is adequate access to timely, affordable, and quality services for substance use disorders.	*Christine Westrich*	*Leah Redding*
	Dana Thomson	*Michael Lappen*
	E. Lerner	*P. Gutierrez*
	Elizabeth Collier	*Tracey Hooker*
	Janet Fleege	
5. Maintain and enhance availability and quality of timely data about heroine, opioids, and cocaine use, its outcomes and risk factors	*Brian Peterson*	*Karen Domagalski*
	Christine Westrich	*Leah Redding*
	E Lerner	*Mallory O'Brien*
6. Enhance collaboration between community-based initiatives and government agencies	*Bevan K. Baker,*	*Hector Colon*
	CoryAnn St. Marie-Carls	*Lisa Bullard-Cawthorne*
	Dawn Mumaw	*Michael Lappen*
	Elizabeth Collier	*Nzinga Khalid*

Goal 1: Increase Naloxone Availability in the Community

1.1 Conduct an assessment of the availability of naloxone within the community (numbers, locations, organization, etc.)

Fatal overdose is the leading cause of death among those who misuse illicit drugs, exceeding mortality from HIV, hepatitis, or homicide. Overdose can be reversed with the timely administration of naloxone, an opioid antagonist medication without significant negative side effects.

The efficacy of naloxone is fundamentally time dependent. Death from overdose typically occurs within 1 to 3 hours, although earlier in some cases, leaving a brief window of opportunity for intervention. Between 64.6% and 97.4% of those who misuse drugs have reported witnessing an overdose, with respondents in one study recounting an average of 6 instances. Other surveys have reported that 58% to 86% of heroin-related overdoses occur in the company of others. (Kim, Irwin, & Khoshnood, 2009)

Making naloxone readily available in the community is a key strategy to preventing overdoses. First responders, parents, and educators should have easy access to naloxone and should have training in how to administer the drug. The current level of participation is unknown. An important first step in expanding access to naloxone is understanding where it currently is available and identifying where gaps may exist.

Action Plan / Timeline

- Recruit graduate intern(s) to complete survey and report
- Identify sampling strategy
- Develop a survey /interview tool
- Administer survey/compile interviews
- Analyze data
- Prepare report
- Present findings to workgroup

1.2 Support and expand naloxone training and distribution programs

Many myths or negative viewpoints on naloxone. Many different training providers, no standardized algorithm.

Evidence has shown that communities with higher access to naloxone and overdose training have significantly lower opioid overdose rates than those that do not. (Walley, 2013) Family and friends of opioid users have greater knowledge of opioid overdose and ability to respond appropriately after receiving training in naloxone administration than peers who learn about opioid overdose and naloxone via an information booklet. (Williams AV, 2014) Current or former opioid users who have received training in overdose response appear to identify overdose and recognize conditions when naloxone is appropriate as accurately as medical experts. (Green TC, 2008) Some studies suggest that opioid users who have participated in only a brief 5-10 minute training or learned naloxone administration through social networks can respond appropriately to an overdose. (Doe-Simkins M, 2014) (Behar E, 2014)

Training first responders such as police, firefighters, and EMTs to administer naloxone may reduce time to overdose rescue, possibly decreasing overdose-related injury and death. (Davis CS, 2014) Law enforcement officers

who participate in naloxone administration and overdose training report increases in knowledge and confidence in managing opioid overdose emergencies after program completion. (Wagner KD, 2016)

Action Plan / Timeline

- Complete environmental scan of the different training being provided related to naloxone administration.
- Standardize naloxone training
- Develop and maintain a toolkit of local resources related to the administration of naloxone
- Include messaging about naloxone in a comprehensive media plan

1.3 Support legislation that mandates the availability of naloxone or naloxone in specific community settings (schools, treatment centers, prisons/jails, dorms etc.).

Providing naloxone kits to laypeople reduces overdose deaths while being safe and cost effective. (Coffin PO, 2013) (Doyon S, 2014) U.S. and international health organizations recommend providing naloxone kits to patients in substance use treatment programs, individuals leaving prison and jail and laypeople who might witness an opioid overdose. (CDC, Opioid overdose prevention programs providing naloxone to laypersons–United States, 2014, 2015) As of 2014, the CDC reported that naloxone distributed to laypeople had resulted in more than 26,000 overdose reversals nationwide since 1996. (CDC, Opioid overdose prevention programs providing naloxone to laypersons–United States, 2014, 2015) Since 2006, Massachusetts has implemented an overdose education and naloxone distribution program that significantly reduced overdose deaths in the 19 communities. (Walley, 2013)

As of 2015, Wisconsin allows standing order prescriptions and third-party prescriptions of naloxone, and grants prescribers and lay administrators immunity from criminal prosecution and civil liability when prescribing, dispensing, distributing, or administrating naloxone (LawAtlas-Naloxone).

In 2014, 644 local opioid overdose prevention programs in 30 states and Washington, DC provided community members with naloxone kits and training in proper use (CDC MMWR-Naloxone 2015). Many states provide civil and criminal immunity for both prescribers and administrators (LawAtlas-Naloxone, Davis 2015).

In November 2015, a nasal spray method of administering naloxone was approved by the US Food and Drug Administration (FDA) along with the previously-approved injection method (US FDA-Naloxone 2015). As of January 2017, Kaléo, a pharmaceutical company, provides naloxone auto-injectors free of charge to qualifying non-profit organizations through their Product Donation Grants Program (Kaleo-Naloxone).

The Madison-Dane County Safe Community program offered overdose education and naloxone distribution trainings to the city of Madison Police Department in 2014 and has expanded training to the public (NSC-Dane County 2015). As of 2015, Wisconsin allows standing order prescriptions and third-party prescriptions of naloxone, and grants prescribers and lay administrators immunity from criminal prosecution and civil liability when prescribing, dispensing, distributing, or administrating naloxone (LawAtlas-Naloxone).

Action Plan / Timeline

- Explore the current law on where naloxone can be distributed and who can administer it.
- Utilize students to create policy briefs to support mandate
- Post policy briefs on website and distribute to policymakers to advocate for policy change
- Work with elected officials / legislative reference bureau to draft proposed ordinance changes if required

1.4 Facilitate an opportunity for those who utilize naloxone to identify barriers and recommendations for improved availability.

Action Plan / Timeline

- Develop consent form, focus group guides and obtain IRB approval
- Identify and recruit persons with SUD
- Conduct focus groups
- Analyze focus group findings and write report
- Present findings to taskforce

1.5 Establish a system the makes immediate linkages to recovery services following overdose reversal to reduce the potential for repeat overdose, and increase the likelihood of sustained recovery.

Having linkages to care following inpatient hospitalization has been shown to be associated with higher rates of completion of initiated aftercare (behavior therapy or self-help programs) during the week following detoxification.

Action Plan / Timeline

- Identify baseline practice

1.6 Advocate for federal mandate for public and private insurance coverage for both injectable and nasal formulations of naloxone.

Cost can serve as barrier to individuals obtaining their prescriptions. Injectable naloxone costs about $35 to $50 for two doses, and Narcan nasal spray costs $120 to $150 for two doses. In 2015, 11% of Milwaukee County residents reported not taking one or more of their prescription medications due to cost. That rate rises to 14% among households in the bottom 40% of income. To remove this barrier, states such as New York have enacted laws that have mandated insurance companies cover the costs of naloxone when prescribed to a person who is addicted to opioids and to his/her family member/s on the same insurance plan.

Action Plan / Timeline

- Identify student(s) to assist with project
- Identify insurance providers for current coverage practices including co-pay deductibles
- Review/identify insurance mandates in place in other jurisdictions
- Develop/propose revisions to ??? mandating coverage
- Develop policy brief supporting need for mandated coverage
- Outreach to policymakers / elected officials to support mandate

Goal 1 Performance Measures

Short Term Indicators	Source	Frequency
Number of people trained to identify and respond to opioid overdose		

Number of agencies who carry naloxone		
Number of points of access for naloxone		
Number of OD prevention train the trainers		
Long Term Indicators	**Source**	**Frequency**
Number of opiate associated deaths in the community	*MCME*	
Number of narcotic associated deaths in the community	*MCME*	

Goal 2: Enhance Community-Based Options for Easy, Safe, and Environmentally Friendly Medication Disposal.

2.1 Expand the number of fixed-site medication drop boxes to include all of Milwaukee County.

Studies found that about 80% of heroin users reported using prescription opioids for nonmedical reasons before beginning use of heroin. (Muhuri, Gfroerer, & Davies, 2013) Overall, these studies suggest a link between nonmedical use of prescription opioids and heroin, particularly among people with frequent nonmedical use, or people with prescription opioid use disorder. However, it is important to note that only a small percentage (less than 5% of people who use prescription opioids for nonmedical reasons) begin using heroin. Nationally, this small percentage translates to several hundred thousand new heroin users per year and should not be minimized. (Compton, Jones, & Baldwin, 2016)

Medication collection (events, mailings, drop boxes) have been studied in Maine, Hawaii, and Appalachia, and medication collection has been shown as an effective means of amassing significant quantities of medications, including controlled substances. (Stewart, et al., 2015) (Ma, Batz, & Juarez, 2014) (Gray & Hagemeier, 2012) Proper disposal of prescription medications is a key to limiting the opioid supply.

Evidence suggest that drug disposal programs with permanent collection receptacles may be more effective in preventing drug abuse and accidental poisoning than temporary, one day take-back events. (Ruhoy & Daughton, 2008) (Simons, 2010)

Federal law requires must be in pharmacy or law enforcement location

Currently medication drop boxes are located…. Insert map from Take back meds MKE

Therefore, strategies should be implemented to assure the safe effective disposal of prescription medications.

Medical Society has agreed to sponsor a med drop box, other businesses have been contacted but no other commitments yet.

Action Plan / Timeline

- Immediate
  - The MHD Substance Abuse and Injury Program Manager will obtain list of all pharmacies in Milwaukee County including contact information and addresses
  - The MHD Substance Abuse and Injury Program Manager will develop and maintain a map of drop box locations which will be posted to the MHD website
  - Inquire whether hospitals can have drop boxes in their pharmacies (Angie to check with Aurora, Jon to follow up w/Accession)
  - Check with police departments to assure they have drop boxes
  - Partner with Take Back Meds MKE to develop and distribute education materials on what is required to drop off medications at drop boxes
  - The Medical Disposal Workgroup will partner with Take Back Meds MKE to implement an "adopt a box" program for sponsorship
- 3 to 6 months
  - The Medical Disposal Workgroup will prioritize pharmacy locations based on where overdose deaths are occurring and lack of other drop box locations nearby

    - The Medical Disposal Workgroup will conduct outreach to priority pharmacy locations to garner sponsorship
    - The Medical Disposal Workgroup will collaborate with Take Back Meds MKE to develop an education campaign to promote safe medication disposal and obtain funding from private partners
- 6 to 12 months
    - The Medical Disposal Workgroup will identify and contact potential drop box sponsors

Timeline	Lead Person / Organization
Sep – Nov 2017	MHD will look to State Pharmacy Society, Dept of Safety and Professional Services and DOJ
	Med Disposal Workgroup Jon will develop 1-page overview of "adopt a box" program
Nov 2017	Kathy S. will call Children's and Jon will call Froedtert Determine if/who at health department who can contact people

2.2 Increase the frequency of single-day drug take back events from twice per year to four times per year.

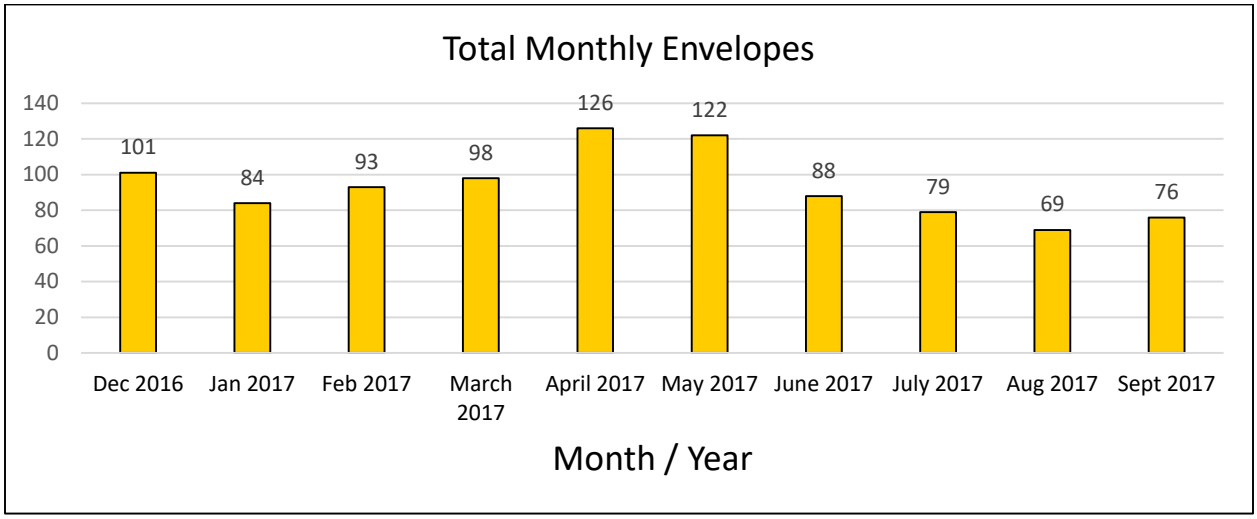
History of drug take back events in Milwaukee? – talk with Kathy F. at DEA and what has been captured MMSD and MPD

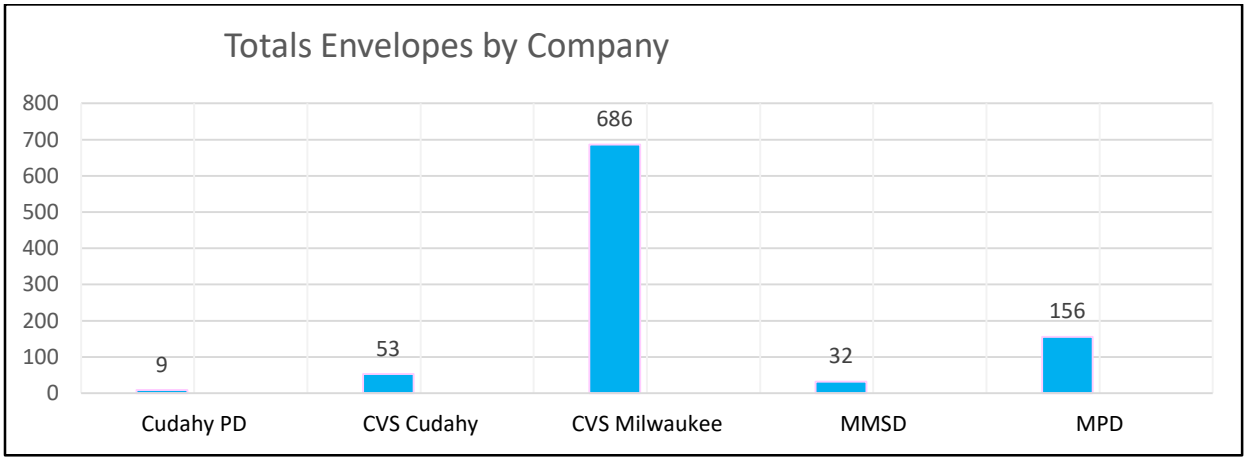
Coordinate across jurisdictions, individual police departments can do.

Action Plan / Timeline

- Identify funding source / partner with HMOs or DOJ
- Facilitate discussions encouraging police departments to organize take back events
- Promote take back events to partners and included messaging regarding fixed drop box locations

2.3 Promote the use of drug mail-back programs





Action Plan / Timeline

- Immediate
  - Obtain and distribute envelopes to elected officials office and community organizations (Alders, county officials, community organizations)
  - Increase awareness on how to obtain additional envelopes made available, have a box dropped off at
  - Advocate for requirement to publicize take back envelopes in all pharmacies
- 3 to 6 months
  - Explore seeking funding from pharma on assistance on media on safe disposal of medication
- Facilitate discussions encouraging police departments to organize take back events
- Promote take back events to partners and included messaging regarding fixed drop box locations

2.4 Develop a comprehensive health education campaign to 1) promote the importance and availability of safe & environmentally friendly medication disposal and 2) increase public awareness of the danger of keeping unused prescription medication in their home

Surveys suggest that community campaigns to raise awareness about drug take-back events increase use of disposal programs as well as result in conversations with children about the dangers of prescription drug abuse. (Yanovitzky , 2016)

Action Plan / Timeline

- Immediate
  - Partner with Take Back My Meds MKE to execute a communication plan including a social media campaign that is simple, direct, and consistent for medication disposal
  - Present Take Back My Meds MKE plan to full Task Force
  - Develop joint statement/policy regarding preferred methods of medicine disposal
  - Obtain and maintain funding to support campaign – 150,000 per 24 month period
- 3 to 6 months
  - Assure brochures from the Take Back My Meds MKE and DOJ are available at pharmacies, health clinics, funeral homes, senior centers, rehab facilities, dentist offices, and community agencies.
- 12 to 24 months
  - Evaluate campaign impact, a report is generated

Goal 2 Performance Measures

Short Term Indicators	**Source**	**Frequency**
Number of drop box sponsors		
Number of businesses providing incentives for those who drop meds off		
Long Term Indicators	**Source**	**Frequency**
Number of fixed site medication drop boxes		

Goal 3: Promote Community Understanding of Pain, Pain Management and Substance Abuse Disorders to Achieve a Reduction in Opioid Exposure in Order to Reduce Risk of Individuals Developing Abuse of Other Medications including Heroin and Cocaine.

3.1 Immediately launch a community informed/engaged health promotion campaign focused on prevention and destigmatizing substance use disorder, and to promote seeking treatment.

The concept of stigma describes the powerful, negative perceptions commonly associated with substance abuse and addiction. Stigma has the potential to negatively affect a person's self-esteem, damage relationships with loved ones, and prevent those suffering from addiction from accessing treatment. In a study done by Johns Hopkins Bloomberg School of Public Health, the general public was more likely to have negative attitudes towards those dealing with drug addiction than those who were dealing with mental illness. Additionally, researchers found that people don't generally support insurance, housing, and employment policies that benefited people who were dependent on drugs. (Desmon & Morrow, 2014)

Stigma is a public health issue — it contributes to high rates of death, incarceration, and mental health concerns among dependent populations

More than 40 percent of people who struggle with addiction also have another mental health challenge of some kind—and most of those people never end up seeking treatment or services. In many cases, people turn to substances as a way to self-medicate for these untreated illnesses, or to help them cope with the trauma or emotional distress they face in their lives.

Misunderstandings and misperceptions regarding the causes, manifestations, and effective treatments for opioid use disorder and its co-occurring conditions result in stigma and missed opportunities for treatment.

Messages communicated through the media influence how the public thinks and behaves. Communications strategies—public education, social marketing, media advocacy, and media literacy—can be used to influence community norms, increase public awareness, and attract community support for a variety of prevention issues. XXXXXXX

Consider expand light and unite red campaign to be introduced in January – get materials out now, continue to refine as you go, need things, can't wait!

Action Plan / Timeline

- Immediately
  - Launch campaign using light and unite red as the framework
  - Develop/engage a community advisory panel for future campaign development (MHD partner with Milwaukee Heroin Diaries)
- Six to nine months

    - Evaluate light and unit red campaign impact
    - Identify community knowledge attitudes and beliefs (to follow up on first wave of campaign to look for refinement)
    - Identify/develop a social media plan / comprehensive media plan.
- 12 months
    - Audience testing of health promotion campaign and assure community participatory design in the health promotion campaign
- 18 months
    - Launch phase 2 of media campaign
- 24-36 months
    - Evaluate campaign materials and campaign impact, continue to refine and update plan based on feedback

3.2 Monitor and promote already existing community programs that focus on stigma reduction and peer support.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA):

"*Peer support services are delivered by individuals who have common life experiences with the people they are serving. People with mental and/or substance use disorders have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer this support, strength, and hope to their peers, which allows for personal growth, wellness promotion, and recovery.*

Research has shown that peer support facilitates recovery and reduces health care costs. Peers also provide assistance that promotes a sense of belonging within the community. The ability to contribute to and enjoy one's community is key to recovery and well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives."

Peer recovery support services help prevent relapse and promote sustained recovery from mental and/or substance use disorders (SUD), and examples can include: peer mentoring or coaching, peer recovery resource connecting, recovery group facilitation, and building community/social networks. Street-based reach-in programs allow peers to provide harm reduction and referral to recovery support services to others suffering from substance use disorder or opioid use disorder. Recovery support services may include medication-assisted treatment (MAT), housing resources and care coordination. Peer recovery support services are services that are designed and delivered by people who, themselves, have experienced both substance use disorder and recovery. These services can include peer counseling, career counseling, and support groups.

Action Plan / Timeline

- Immediately
    - Support and promote the inventory being done by COPE to have better awareness of community programs and efforts. Disseminate COPE in conjunction with health promotion campaign
    - Distribute the red crisis books within the community
    - Promote/support COPE as a hub of community resources, support a single point of information
    - Conduct town hall meetings to obtain community input on how a warm handoff system would work including developing a standard definition of what constitutes a warm hand off as well as explore on the utilization of technology in that process (Milwaukee Heroin Diaries)
    - Conduct town hall meetings to obtain community input on how to best utilize community health workers in substance abuse work (such as connecting individuals with care following overdose keeping individuals in care, addressing other social needs, etc.)

    - Identify marketing channels (format / location / time) for communication messaging to those with addiction.
- 9 to 12 months
    - Arrange screenings of "Chasing the Dragon" within the community, along with structured dialogue after.
- 24 to 36 months
    - Create a texting line related to initiatives

3.3 Monitor and promote school-based initiatives to reduce illicit substance use and/or recreational drug use.

Although substance misuse may occur at any age, adolescence is a particularly high-risk period. The majority of adults who have been diagnosed with a substance use disorder started use during adolescence. (Johnston, 2014) Providing evidence-based interventions, including educational activities and social supports, can delay early use and stop the progression from use to addiction. (Griffin KW, 2010)

Cost-benefit estimates show that effective school-based substance abuse prevention programs save $18 for every $1 spent on these programs.[WIHer14] When dealing with the complexities of SUDs, it is clear that school-based prevention strategies are not the only effective means for delaying initiation, thereby reducing the likelihood of progression to substance abuse and addiction. In addition, prevention of heroin needs to start upstream. Initiating alcohol, nicotine and marijuana use at an early age remains a primary predictor of a later SUD. Prevention programs need to be introduced to youth early and often in order to reduce the likelihood of early substance use initiation.

The Centers for Disease Control and Prevention conducted the National School Health Policies and Practices Study in 2014, and found that 66.7 percent of middle schools and 86.9 percent of high schools require that students receive instruction on alcohol or other drug use prevention. There are multiple repositories of evidence-based prevention programs. One such repository is SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). (SAMSHA, 2017) According to this registry, there are 132 interventions specific to providing children and youth with substance use disorder prevention and substance use disorder treatment education. (AZ Dept. of Health Services, 2017)

Current Status

- Not sure what schools are doing county wide

Action Plan / Timeline

- 6 months
    - Conduct a survey to identify existing school based curriculums being used countywide (public and private) in order to form an inventory
- 6 to 12 months
    - Advocate that schools adopt evidence informed and evidence based curriculum for drug abuse
- 12 to 24 months
    - Engage students to create a video clips to educate their piers around drug abuse
    - Educate school staff on drug abuse and identifying the signs of drug abuse
    - Train school staff on the use of naloxone
    - Train students to be peer counselors

3.4 Conduct outreach to healthcare providers regarding evidence-based pain management and substance-use disorder treatment.

By educating physicians, nurse practitioners, physician assistants, and other health care professionals about the risks of prescription opioid painkillers and best practices for judicious prescribing — including guidelines that encourage doctors to avoid opioid painkillers except when necessary, and to use the lowest possible dose for the shortest amount of time — we can prevent future opioid overdose deaths.[NYC]

Action Plan / Timeline

3.5 Promote initiatives to identify and treat mental health and other issues that might lead to substance use

3.6 Monitor and promote safe prescribing, storage, and disposal practices for opioids to both physicians and the public

Goal 3 Performance Measures

Short Term Indicators	**Source**	**Frequency**
Number of informational contacts with members of the print, broadcast (radio and TV), and on-line media		
Long Term Indicators	**Source**	**Frequency**
Illicit Drug Use in the Past Month and Illicit Drug Use Other Than Marijuana in the Past Month among Persons Aged 12 or Older	National Survey on Drug Use and Health	*Annually*
Cocaine Use in the Past Year among Persons Aged 12 or Older	National Survey on Drug Use and Health	*Annually*
Nonmedical Use of Pain Relievers in the Past Year among Persons Aged 12 or Older	National Survey on Drug Use and Health	*Annually*
Ever used cocaine (any form of cocaine, such as, powder, crack, or freebase, one or more times during their life)	Youth Behavioral Risk Factor Survey	
Ever used heroin (also called "smack," "junk," or "China white," one or more times during their life)	Youth Behavioral Risk Factor Survey	
Ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	Youth Behavioral Risk Factor Survey	
Number of individuals seeking treatment for opioid use disorder		

Goal 4: Assure there is Adequate Access to Timely, Affordable, and Quality Services for Substance Use Disorders.

Effective treatment strategies for managing recovery from opioid use disorders include behavioral therapies, medication, and psychosocial supports. Evidence-based behavioral therapies may be used alone or in combination with medication management, along with other services and supports. Long-term continuing care services have been demonstrated to be the most significant factor in extended sobriety and relapse prevention.

Individuals face a range of obstacles preventing them from entering or gaining access to substance abuse treatment, including lack of knowledge regarding access to services; shame and stigma; denial of substance use disorder or substance misuse; costs and lack of insurance/Medicaid; transportation; treatment waiting lists; and prior negative treatment experiences.

4.1 Determine the current access and capacity for medically assisted treatment (MAT) for those with an opioid use disorder.

Current Status:

- List of approved prescribers available at xx, and the number they can prescribe any of the methadone /suboxone because of DEA registration
- Won't be able to id # who provide vivitrol
- Vivitrol has other uses so not reliable
- Requires pre-authorization and waiting can result in relapse, not always covered, providers can be out of network
- Providers may not be aware, may not have a place to send patients for counseling that goes along with meds
- Currently being considered by the state
- Lack of information / misinformation

Action Plan / Timeline

- 3 to 6 months
    - Conduct surveys/interviews to identify baseline capacity to provide MAT to both insured and uninsured individuals
- 6 to 12 months
    - Develop "dummies guide to billing" / FAQ related to MAT
    - Interview opiate treatment programs such as Community Treatment Centers Clinic (CTC) - Acadia Healthcare / Clean Slate to understand best practices around MAT (lessons from the field)
- 12 to 24 months
    - Advocate for changes in the ability to bill insurance (public and private) for MAT including an expedited approval process for coverage (remove pre-authorization)
    - Educate providers MAT through the creation of a physician mentorship program
    - Educate consumers/families on MAT

4.2 Expand residential treatment capacity and funding.

Short-term residential programs provide intensive but relatively brief treatment based on a modified 12-step approach. These programs were originally designed to treat alcohol problems, but during the cocaine epidemic of the mid-1980s, many began to treat other types of substance use disorders. The original residential treatment model consisted of a 3- to 6-week hospital-based inpatient treatment phase followed by extended outpatient therapy and participation in a self-help group, such as AA. Following stays in residential treatment programs, it is important for individuals to remain engaged in outpatient treatment programs and/or aftercare programs. These programs help to reduce the risk of relapse once a patient leaves the residential setting.

Many don't understand residential treatment, simply often viewed as the fix-all. Current waitlist is 150, expansion is not a solution
Medicaid won't pay if over 16 beds, state has applied for waiver, won't hear until 2019.
Need to create a bridge for people coming out of residential or people who don't need residential but need a place to stay while they get clean

Provide residential in clinically effective manner, with step down program. Sober housing programs

Action Plan / Timeline

- Immediate
  - Advocate for residential treatment becoming a Medicaid reimbursable service
  - Advocate for changes in Medicaid reimbursement for residential treatment (IMD)
  - Identify if state is reimbursing for community based residential care DHS 75-14, and Medically Monitored residential DHS 75-11
- 3 to 6 month
  - Identify if MAT can be started during residential treatment
  - Advocate for coverage for in-home therapy as a step-down measures
  - Advocate for coverage of transportation to AA or group therapy meetings
- 12 to 24 months
  - Provide stakeholder and community education about residential treatment (benefits, length, who, etc.)
  - Advocate for policies that support housing as healthcare
  - Advocate for safe and affordable housing for families, and people with substance use issues

4.3 Reduce wait-time for admission into treatment.

Current Status:

Many myths surrounding the idea of wait times. Three week waiting period, or on hold for new referrals so it maybe difficult. Insurance type sometimes influences whether or not the individual will be admitted.

Action Plan / Timeline

- HMOs to develop a case management model for persons with substance use disorders
- Develop a provider report card to track admission times

- Advocate to prohibit provider enrollment caps that limit access based upon insurance provider / insurance status
- Identify the number of individuals who fail to get admitted within Behavioral health has targeted wait times of 7 to 14 days Provide data on average wait times
- Advocate to increase reimbursement rates for title 19 to increase incentive to join Community Comprehensive Services (reduce financial dis-incentive to take clients)
- Advocate for providers to enroll in CCS – with CCS there is no wait time/but can't refuse service- CCS reimbursement rates are higher

Just not enough residential beds, seeing an increase in uninsured, Milwaukee doesn't have any contracts with Methadone or Suboxone clinics. – obtain data on substance abuse and uninsured, so there is a waiting period – reach out to Milwaukee county

4.4 Enhance care management of those identified with a substance use disorder moving from ED admission to treatment.

A review of emergency medical data from Massachusetts between 2013 and 2015 found that 1 in 10 persons administered naltrexone by EMS were dead within 1 year. Thirty five percent of those from a subsequent opioid overdose. Administration of naloxone does not treating the underlying problem, more must be done to get persons administered naloxone into treatment at the time of emergency medical services.

Action Plan / Timeline

- Immediate
  - Assess what information is being provided in emergency rooms and at needle exchange sites regarding treatment/recovery services (*Check in with social workers, or nurses, 211 has AODA councilors not sure , some information is being handed out)*
- 6 to 12 months
  - Develop standard set of materials to be distribute (card?) when individual is revived with resources on how/where to access to treatment
- 12 to 24 months
  - Advocate for the development of community health worker model to create capacity for warm hand off
- 24 to 36 months
  - Advocate to increase in number of EDs providing a warm hand-off into treatment or detox for those with substance use disorder

4.5 Expand aftercare and relapse prevention initiatives, including sober housing and jobs programs.

Long-term residential treatment provides care 24 hours a day, generally in non-hospital settings. The best-known residential treatment model is the therapeutic community (TC), with planned lengths of stay of between 6 and 12 months. TCs focus on the "resocialization" of the individual and use the program's entire community—including other residents, staff, and the social context—as active components of treatment. Addiction is viewed in the context of an individual's social and psychological deficits, and treatment focuses on developing personal accountability and responsibility as well as socially productive lives. Treatment is highly structured and can be confrontational at times, with activities designed to help residents examine damaging beliefs, self-concepts, and destructive patterns of behavior and adopt new, more harmonious and constructive ways to interact with others. Many TCs offer comprehensive services, which can include employment training and other support services, onsite. Research shows that TCs can be modified to treat individuals with special needs, including adolescents, women, homeless individuals, people with severe mental disorders, and individuals in the criminal justice system

Action Plan / Timeline

- 6 to 12 months
  - Research best practices on sober housing
  - Conduct a symposium on sober housing for policy -makers and community to educate/inform and gain input on a sober housing strategy.
- 12 to 36 months
  - Advocate for change in health policy to accept housing as healthcare, including removing barriers for payment/ contracts for sober housing payment
  - Advocate for the expansion of sober housing living facilities based on Oxford Model
  - Explore the development of a step down process for individuals moving from sober housing to independent living (transitional housing)

4.6 Evaluate the potential to implement other harm reduction interventions.

In addition to death and overdose, persons who inject opioids are at risk for infectious disease transmission including HIV and Hepatitis C There were 84 HIV diagnoses among injection drug users (IDUs) in Wisconsin between 2007-2011 . HCV, which can lead to cirrhosis and liver cancer, is primarily transmitted by injection drug use. In the United States, there is an ongoing epidemic of HCV infection among young adults who inject drugs. In Wisconsin, reports of acute HCV infection in young adults have increased. In 2013, 78% of people with new HCV infections reported injection drug use.

Syringe exchange programs are important for preventing the spread of infectious diseases such as hepatitis and HIV. Currently in Milwaukee County only 2 syringe exchange programs are

Supervised injection services (SIS) are health services that provide a safe and hygienic environment where people can inject pre-obtained drugs under the supervision of trained staff. One of the main goals of SISs is to reduce overdose deaths. There are over 90 SISs worldwide and there have been no deaths recorded at any of these

services. Rather, there have been fewer overdose deaths reported following the implementation of these services. (Fischer, 2002)

No such facility currently operates in the United States, but a new cost-benefit analysis conducted by the Bloomberg School of Public Health and published in the May 2017 issue of Harm Reduction Journal, suggests that a single safe consumption space in Baltimore would annually prevent 5 percent of overdose deaths and save $6 million in costs related to the opioid epidemic. There are campaigns underway to open supervised consumption spaces in Seattle, San Francisco, Philadelphia, New York, and Baltimore. (Rienzi, 2017)

Action Plan / Timeline

ARCW does a lot of testing, so do the residential treatment programs

ARCW maybe the only site that does needle exchange in the region, strong demand

Need to identify if driving high risk behavior and risk of hepatitis C and HIV,

New initiative through coordinated entry program through benedict center

- Needle exchange?
- Safe injection sites?
- Encourage Distribution of Naloxone to Patients Receiving Opioids

4.7 Ensure 211 has sufficient resources to decrease wait times and the need for call backs among those who are requesting assistance with finding opioid treatment.

Goal 4 Performance Measures

Short Term Indicators	**Source**	**Frequency**
Percentage of individuals entering criminal justice system screened for SUD		
Percentage of individuals entering the criminal justice system with SUD offered treatment rather than incarceration		
Number of individuals able to be served in TAD / drug treatment court		
Recidivism in drug treatment court, where cocaine or heroin/opiates are identified as their primary drug of use.		
Long Term Indicators	**Source**	**Frequency**
# of SUD providers		
# of MAT persons who can be served (at capacity)		
Increase in number of EDs providing a warm hand-off into treatment or detox for those with substance use disorder		
Number of drug involved homicides		
Number of drug involved homicides		
Incarceration rate by race/ethnicity		

Revocation rate		
Property crime rate		
Violent crime rate		

Goal 5: Maintain and Enhance Availability and Quality of Timely Data about Heroin, Opioids, and Cocaine Use, its Outcomes and Risk Factors

Evidence-informed decision making involves the use of research evidence along with expertise, existing public health resources, knowledge about community health issues, the local context and community, and the political climate. Quality, accessible, timely and reliable data is essential for providing evidence for decision-making as well as evaluation of intervention outcomes. Obtaining and maintaining data about the current status of heroin, opioid, and cocaine use in Milwaukee is essential to targeting interventions at those most at risk and maximizing limited resources.

Talk with BHD – what are their data needs – how do we quantify access to care issues? What about treatment issues?
Talk w/Beth Collier-regarding bed count issue
Measure of success – data is available and utilized to measure goals and evaluate outcomes

5.1 Assure children of Milwaukee routinely participate in the YBRFS

The Youth Risk Behavior Surveillance System (YRBSS) is conducted every other year and monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including—

- Behaviors that contribute to unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity

Information collected on drug use includes:

- Ever used marijuana
- Tried marijuana before age 13 years
- Currently used marijuana
- Ever used synthetic marijuana
- Ever used cocaine
- Ever used ecstasy
- Ever used heroin
- Ever used methamphetamines
- Ever took steroids without a doctor's prescription
- Ever took prescription drugs without a doctor's prescription
- Ever used inhalants
- Ever injected any illegal drug
- Were offered, sold, or given an illegal drug on school property
- Usually used marijuana by smoking it
- Ever used hallucinogenic drugs

Data can be accessed online at https://nccd.cdc.gov/youthonline/App/Default.aspx however data for Milwaukee and Wisconsin is not available for 2015

Wisconsin and Milwaukee specific data not provided in last YBRFS due to insufficient data collection.

Action Plan / Timeline

- Immediate
  - Outreach to schools to get greater participation
  - Working with department of health to assure adequate participation
  - Note- check to see what schools participate, include private schools if possible – diversify participation if possible
- 3 to 6 months
- 12 to 24 months

5.2 Support identification of funding to modernize toxicology testing equipment at Milwaukee County Medical Examiner's Office (MCMEO).

The Milwaukee County Medical Examiner's Office is the medicolegal death investigation entity serving Milwaukee County, a mixed urban and suburban jurisdiction, including Milwaukee, Wisconsin, and 18 surrounding municipal units. Milwaukee County has a population of approximately one million, and comprises a geographic area of over 200 square miles.

Each year, the office investigates 3,500 cases and assumes jurisdiction in approximately 2,100 cases. Autopsies are performed on about 50% of these cases. The ME office also serves as a major forensic pathology resource for a portion of southeastern Wisconsin, generating an additional 250-300 autopsies from other death investigation jurisdictions.

A 12% increase in autopsy cases this year is being largely primarily driven by opioid-related deaths. If annual caseloads go over 325 cases per pathologist, the MCMEO risks there accreditation status with the National Association of Medical Examiners.

Adequate staffing and equipment are pivotal in the MCMEO's ability to respond to the opioid crisis. Additional pathologist and forensic chemist workforce is needed to perform the tests to confirm the presence of opioid and other drugs. Equipment is also needed to provided law enforcement and public health timely situational awareness about what drugs are causing the fatal deaths in the community. Having an advanced mass spectrometer instrument on site would mean test results for opioids and other drugs would be available in within 24 hours, rather than having to send things out and wait several weeks

Once the personnel and equipment is obtained, it must be maintained.

Action Plan / Timeline

- Immediate
  - Advocate for inclusion of equipment (mass spectrometer) and personnel (sixth pathologist and forensic chemist) in 2018 county budget
- 6 to 24 months
  - Advocate for adequate ongoing funding to maintain staff and equipment

5.3 Support efforts to streamline and collate data from multiple sources (OEM, BHD, MCMEO, PDMP, etc.)

In 2017 in Milwaukee City/County there is not a single central repository for data related to substance use disorders. A number of websites, such as Milwaukee Community Opioid Prevention Effort (Milwaukee COPE) bring together a number of data sources (https://mkecope.com/portfolio/the-opioid-epidemic/) they are not comprehensive and do not attempt to join datasets from the various disciplines to look at risk factors, morbidity and mortality across data sets.

Having accurate and reliable data is essential in that it allows us to have an understanding of the scope and nature of the opioid issue problem. It also allows the Taskforce to targeted limited resources on prevention efforts which are most likely to have a measureable impact in our community.

Action Plan / Timeline

- 3 months
    - MCW to create data-hub to link ARCW, medical examiner, and EMS data on monthly basis looking at risk factors, morbidity and mortality
    - Substance Abuse Manager Inventory all available data sources, including non-traditional partners.
- 6 to 12 months
    - Communication between partners is enhanced through periodic review of shared data in the hub
    - All taskforce participants / Substance Abuse Manager Assure data is available from partners website or it's clear how data can be requested from those partners
    - Substance Abuse Manager Maintain /post inventory on a centralized website
    - Substance Abuse Manager Assure relevant data included periodic assessments such as community health assessments

5.4 Increase frequency of data reporting made available to stakeholders and general public.

Coordinated collated report – biannual report
Some measures on the COPE site either need to add/maintain COPE

Action Plan / Timeline

Initial 3 to 6 months

- Develop template framework for review and approval by taskforce
- Advocate to create open datasets whenever possible
- Create / publish an online dashboard of key performance indicators related to achievement of this plan

Every 6 months

- Periodic report every six months to include progress on goals and strategies

5.5 Support community service providers in gathering and reporting data such as naloxone distribution and medicine collection

A collaborative information sharing environment that breaks down silos across agencies is essential to better understanding trends in order to target interventions and support a comprehensive local response.

Action Plan / Timeline

3 to 6 months

- Track trends in naloxone distribution
- Track medication collection by location, type, collection method, quantity
- Increase law enforcement, human services, forensic labs and public health expert collaboration and understanding of state drug data trends, patterns, implications and threats (e.g., drug monitoring initiatives,).
- Ensure that law enforcement data is shared with public health.

Goal 5 Performance Measures

Short Term Indicators	Source	Frequency
Long Term Indicators	**Source**	**Frequency**

Goal 6: Enhance Collaboration Between Community-Based Initiatives and Government Agencies.

6.1 Support opportunities for continued shared learning of new initiatives and best practices

In the prevention field, collaboration allows for partners with different perspectives to work together towards solving a common problem. This approach leverages the expertise of multiple groups and increases the likelihood that their collective efforts will bring about change

- Light Unite Red is actively bringing together local health departments to promote each other's efforts. COPE has an ongoing inventory of local efforts.
- Need additional skill building
- Lack of coordination / communication
- Multiple venues depending upon perspective – ICC/WALHDAB

Action Plan / Timeline

- 6 months
  - Map communication channels to community members/agencies for collaboration
- 12 months
  - Develop a website or location to exchange information between groups?
  - Advocate for collaboration between taskforce and groups in the county
  - Have a joint event to show collaborative effort taking on substance use disorders (wake up rooms) leveraging ICC funds and to highlight
- 12 to 24 months
  - Build capacity for community participatory design and engagement through cross discipline training opportunities
  - Increase awareness across agencies/organizations of community engagement activities

6.2 Increase leverage funding opportunities through collaboration.

Strong partnerships enable agencies to more effectively respond to the interwoven challenges that individuals and families experience when addressing substance use disorders. Through partnerships, community stakeholders can share data, align programs in new ways, create more comprehensive strategies and share resources in ways that maximize funding and save money/leverage resources and result in more competitive applications for funding.

Action Plan / Timeline

- 6 months
  - Identify baseline funding within county
- 6 to 12 months
  - Explore doing a shared service agreement for local health departments, include opioid death reviews in collaboration with the county
- 12 to 24 months
  - Implement opioid death review collaboration between local health departments and BHD
  - Create a grant writing workgroup to identify and collaboratively apply to one or more grant applications related to substance abuse.
    - If available, utilize grant writing professionals to facilitate collaboration and enhance quality of applications.
    - Investigate obtaining students to work on grant development and grant management

6.3 Provide opportunities for community input and engagement.

Engaging community members in problem-solving solutions to issues that affect them is one of the fundamental principles of public health. The most effective way to achieve public health goals, especially the elimination of disparities in health status, is to actively engage those experiencing the problems in every aspect of addressing them.

Action Plan / Timeline

- Immediate
  - Conduct community listening sessions to get input on initial draft of the work plan
- 6 to 12 months
  - Engage Community Advocates as the convener of the substance abuse coalition
  - All Task Force members and those that they partner with ensure community voice (focus groups, advisory panels, &/or peer worker, etc.) are included in every grant proposal
  - Obtain asset maps completed by local health departments as part of CHIP process
  - Advocate for inclusion of substance abuse questions in MHCP CHNA (both community survey and key informant survey)
- 12 to 24 months
  - MHD Substance Abuse and Injury will recruit graduate students to facilitate a series of key informant interviews and/or stakeholder focus group sessions to include: leaders of youth, youth, law enforcement and prevention and health care providers to gain input on goals, strategies, and actions
- 36 months
  - MHD Substance Abuse and Injury will update and revise work plan based on input provided.

6.4 Work to adopt a collective impact framework to guide substance abuse work activities county wide.

Collective Impact is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change. The Collective Impact approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. The approach calls for multiple organizations or entities from different sectors to abandon their own agenda in favor of a common agenda, shared measurement and alignment of effort. Unlike collaboration or partnership, Collective Impact initiatives have centralized infrastructure – known as a backbone organization – with dedicated staff whose role is to help participating organizations shift from acting alone to acting in concert. The five common elements of a collective impact partnership are:

1. All participants have a common agenda for change including a shared understanding of the problem and a joint approach to solving it through agreed upon actions.
2. Collecting data and measuring results consistently across all the participants ensures shared measurement for alignment and accountability.
3. A plan of action that outlines and coordinates mutually reinforcing activities for each participant.
4. Open and continuous communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
5. A backbone organization(s) with staff and specific set of skills to serve the entire initiative and coordinate participating organizations and agencies.

Action Plan / Timeline

- **Steps for creating collective impact?**

Goal 6 Performance Measures

Short Term Indicators	Source	Frequency
Long Term Indicators	**Source**	**Frequency**
Increase in involvement from every municipality to contribute to outreach and education regarding substance use disorders, especially heroin, opioids, and cocaine		

WHEDA should study expanding permanent supportive housing through Low Income Housing Tax Credits or other tools to provide homeless or inadequately housed individuals with substance abuse disorders the support they need to achieve and retain housing stability.

Goal 7: Law enforcement and the criminal justice system is actively working to reduce the availability of addictive substances while treating addiction as a disease.

7.1 Create a mechanism for the community to be able to anonymously report suspected drug trafficking / drug houses

See something say something campaign?

7.2 Establish a collaborative information sharing environment across city/county law enforcement agencies.

Leverage assets from partner entities to improve data collection and intelligence sharing.
Expand statutory tools for prosecuting major distributors.
Expand law enforcement partnerships and data access to better target over-prescribers.

7.3 Advocate for treatment alternatives to revocation for drug related offenses to probation violations.

7.4 Advocate for the expansion/adequate funding of treatment alternative diversion programs ("drug courts") as a cost effective alternative to incarceration.

Drug offenders and drunk drivers accounted for 80 percent of the growth in Wisconsin prisons since 1996. Drug courts are six times more likely than prison programs to keep offenders in treatment long enough for them to get better. Individuals recently released from correctional settings are up to 130 times more likely to die of an overdose than the general population, particularly in the immediate two weeks after release.[drugpolicy.org59]

The Wisconsin Department of Corrections estimates that 70% of state prisoners have a substance abuse addiction. In comparison, the Wisconsin Department of Health Services estimates the rate of dependence or abuse of illicit drugs in the general population as 3%.[HIA72]

Treatment Alternative Diversion (TAD) pilot programs were established in seven Wisconsin counties in 2007, but currently get less than $1 million a year in state funding. The pilot programs have been highly effective at reducing prison recidivism as well as treating substance abuse and mental health issues, but they barely scratch the surface of statewide need. According to the Wisconsin Department of Corrections, the average cost of putting someone behind bars for one year is about $32,000. But a state report evaluating TAD's first four years found that even in the most expensive alternative programs, the average annual cost per participant is $7,551. The Wisconsin Office of Justice Assistance estimates that every dollar spent on treatment alternative programs saves almost $2 in criminal justice costs. By that yardstick alone, increased investment of $75 million in alternatives to prison would yield an annual savings of almost $150 million. [HIA Report]

Increased investment by Wisconsin in problem-solving courts and other programs to keep low-risk, non-violent offenders out of prison would likely reduce crime, strengthen families and communities, improve public health and begin to correct racial inequities in the state criminal justice system, according to a wide-ranging study of the impacts of alternatives to incarceration. More funding for prison alternatives is also likely to reap significant savings on public safety, health care and social services.[HIA Report]

We have an adult treatment drug and a family drug treatment court in Milwaukee County, and also a vets drug treatment court, so there are options, don't have an OWI court. – Talk with Janet Fleege on this. Talk with Justice Point, Family – talk

Action Plan / Timeline

7.5 Advocate that prisoners be adequately treated for SUD while incarcerated, including providing MAT when appropriate.

Despite the preponderance of evidence showing that treatment reduces drug use and drug-related crime, the U.S. Office of Justice Assistance notes that only 15% of state prisoners receive treatment while incarcerated.[HIA82]

Don't see a counselor individually in DOC, did have a pilot project at MSDF working with them to get them there first shot of vivitrol prior to release.

Action Plan / Timeline

- Provide MAT in Criminal Justice Settings, Including Jails/Prisons and Drug Courts

Action Plan / Timeline

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