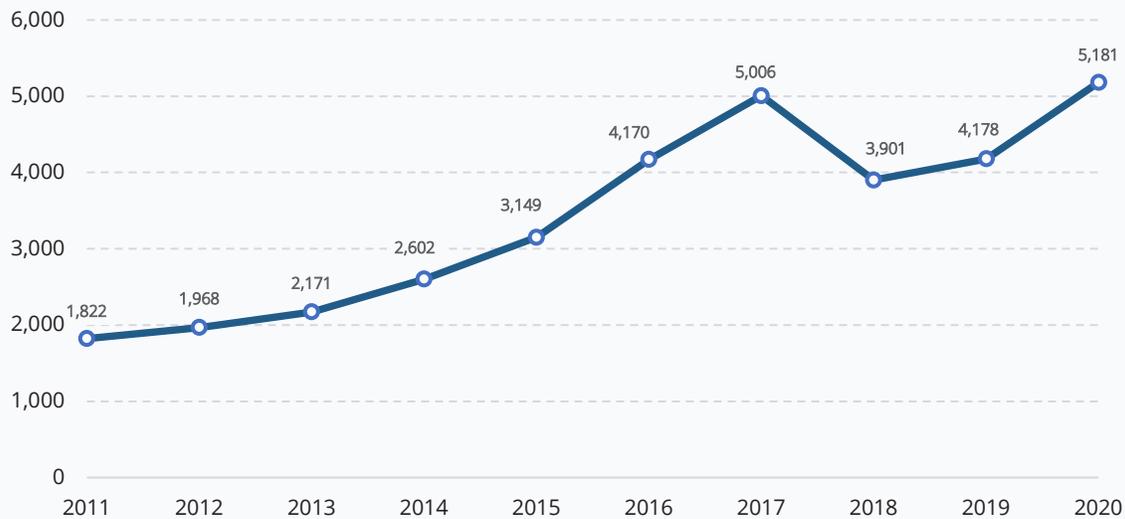


UNINTENTIONAL OVERDOSE DEATHS Ohio Residents and Non-Residents, All Drug Types



Source: Ohio Department of Health

Note: 2021 data not yet available

The number of people in Ohio dying from unintentional overdose rose dramatically during the COVID-19 pandemic, as displayed in the figure below. Data from the Ohio Department of Health shows a sharp increase (24%) in the number of fatal overdoses in 2020, compared to 2019. This is the highest annual number of fatal overdoses in Ohio, eclipsing the previous peak of 5,006 fatalities in 2017.

Efforts to address Ohio’s high overdose rate showed notable success in 2018 and 2019, as the number of deaths in 2018 declined 22% from 2017, following continuous year-over-year increases. Although fentanyl, alone or in combination with other drugs, caused the majority of fatal overdoses (81% in 2020), methamphetamine-caused deaths rose steadily in recent years.

Recommended Court Response

In response to this data, the following recommendations are encouraged for courts in an attempt to respond to the overdose crisis:

- I. Employ the Risk-Need-Responsivity (RNR) model;
- II. Refer individuals to (or develop) a certified specialized docket;
- III. Support substance-use disorder (SUD) treatment (MAT, education, counseling); and
- IV. Deploy overdose prevention, reversal, and treatment strategies.

I. Employ the Risk-Need-Responsivity (RNR) Model

Courts should utilize the Risk-Need-Responsivity (RNR) model to improve outcomes for justice-involved drug users. No program or intervention can be expected to work for everyone and providing too much or the wrong kind of services fails to improve and may worsen outcomes.

Court programs may place excessive burdens on some participants which may interfere with their engagement in productive activities, like work or school. This is the conceptual foundation for a body of evidence-based principles referred to as the RNR model.

- **RISK** is “who” you should target with increased time and services;
- **NEED** is “what” criminogenic, dynamic needs or risk factors to address with services and interventions; and
- **RESPONSIVITY** is “how” to best meet the needs of justice-involved persons identified through standardized assessments.

This model is shown to significantly improve outcomes, reduce recidivism, and enhance public safety (Andrews, 2016).

Ideally, risk factors are assessed on a continuum from low to high, relating to potential recidivism. Individuals with higher levels of risk to recidivate are matched with programs based on their needs (Andrews, 2016).

Any inaccurate applications of the RNR model can lead to the delivery of unmatched services or delivery of matched services in the wrong sequence. OhioCourt.edu offers a course ([Introduction to Risk Assessment 2021](#)) explaining the basic principles of the RNR model and how to use the model to inform decisions regarding court-involved individuals.

II. Refer Individuals to (or Develop) a Certified Specialized Docket

The Rules of Superintendence for the Courts of Ohio ([Sup.R.36.02-36.28](#)) allow local courts to create specialized dockets, a particular session of court offering a therapeutic-oriented judicial approach to provide court supervision and appropriate treatment to individuals. Courts should refer individuals with substance-use disorders (SUD) to their local certified specialized docket or start a specialized docket in their jurisdiction if no such docket exists. Specialized dockets act as anti-stigma education via peer networks, increase engagement in treatment, and reduce recidivism in drug-using populations (Marlowe, 2010). [Step-by-step guidance](#) is available for specialized-docket certification.

III. Support Substance-Use Disorder (SUD) Treatment (MAT, Education, Counseling)

Individuals must receive SUD treatment based on a standardized assessment of treatment needs. Treatment providers are trained and supervised to deliver a continuum of evidence-based interventions documented in treatment manuals, with each treatment based on an individual's specific disorder.

When appropriate, courts should refer to the [Supreme Court of Ohio's Principles for the Use of Medication Assisted Treatment \(MAT\) in Drug Courts](#) regarding the coordination of medical professionals assessing for the appropriate medical intervention, and should show no preference to type of medication.

Specifically, communities should work within the jails to implement a MAT-release protocol. Protocols could include methadone and buprenorphine for individuals incarcerated while actively using opioids, naltrexone injections in jail, trauma-informed counseling, and connection to treatment prior to release to reduce potential deadly overdose upon release.

Treatment for opiate-use disorder (OUD) is a multifaceted relapse prevention program for those working to manage addiction to opiates. The standard of treatment for OUD includes assessment to determine a course of treatment and the appropriateness of MAT. MAT is used to treat

the physical symptoms of opioid addiction, as well as the parallel symptoms of medical and/or mental health disorders. MAT includes FDA-approved medications for OUD in conjunction with ongoing assessments with the prescribing medical doctor, as well as parallel clinical evidence-based interventions.

The three medications approved for the treatment of OUD in the United States include methadone (an opioid agonist), buprenorphine/Suboxone® (a partial agonist), and naltrexone/Vivitrol® (an opioid antagonist). Methadone and buprenorphine are long-acting opioid medications preventing withdrawal and decreasing opioid cravings, drug seeking, and drug use. Naltrexone is a non-opioid medication that blocks the effect of opioids in the body.

Approximately 75% of individuals with OUD relapse within three months of release from incarceration, with less than 10% entering treatment (McGreevey and Forkey, 2019). Additionally, this same population dies by overdose at very high rates, with one study reporting this occurs as high as 129 times that of death by overdose than the general population (World Health Organization, 2014).

Relapse rates also are high for individuals exiting rehabilitation programs. A study examining relapse after exiting residential detox showed opioid-relapse rates as high as 91%, with 59% of those occurring within the first week of release (Smyth et al. 2010).

Conversely, MAT shows a significant impact on overdose and relapse rates. In the article "The Impact of the Opioid Crisis on U.S. State Prison Systems," the authors examined multiple studies on incarcerated individuals treated with MAT programming while in jail or prison and subsequent inmate recovery post-release. Their findings show the majority of individuals increased community-treatment engagement and reduced illicit opioid and injection-drug use due to MAT. In one study, individuals connected to methadone post-release had a 65% lower risk of recidivism than individuals who were not treated with methadone (Scott et al, 2021).

Matching the medical and clinical criteria of the individual with the indicated form of MAT prior to release reduces the risk of overdose in the transitory period, while increasing the likelihood of further productive engagement in programming (Scott et al. 2021).

In the context of treatment, relapse is not necessarily a failure of treatment, but a moment in an individual's life where healthy-coping strategies are overwhelmed, resulting in a return to maladaptive coping through drug use. A treatment response to relapse examines the stressors, thought/emotional patterns, and underlying unaddressed

trauma which caused a return to maladaptive functioning. These often center around the examination of experiences within an individual's life.

Many evidence-based treatments address the specific thought and emotional patterns of addiction as comorbidity mental-health issues, such as depression, anxiety, trauma, and social-emotional malnourishment. The studies "Childhood Trauma and Health Outcomes in Adults with Comorbid Substance Abuse and Mental Health Disorders" (Wu et al. 2010) and "Examining Perceived Stress, Childhood Trauma, and Interpersonal Trauma in Individuals with Drug Addiction" (Garami et al. 2018) indicate underlying childhood trauma and adult trauma play significant roles in substance abuse and addiction.

IV. Deploy Overdose Prevention, Reversal, and Treatment Strategies

For those where abstinence is not an immediate and/or feasible goal, deploying fentanyl testing strips (an overdose prevention strategy) and naloxone/Narcan® (life-saving medication to reverse a potentially fatal overdose) can reduce instances of overdose and fatality associated with substance misuse. Courts should partner with community efforts to supply at-risk communities with effective overdose-prevention interventions.

Collaborating with local alcohol, drug addiction, and mental health boards (ADAMH) or existing community efforts will allow courts to become a presence in areas with high opiate use. These efforts should include supplying individuals being released from incarceration with evidence-based overdose prevention interventions, such as fentanyl testing strips and naloxone/Narcan®.

Relapse during the course of addiction treatment is common. Across various types of drugs, the rate of relapse can range from 40-60% within one year of treatment. (McLellan et al, 2000). Relapse for individuals receiving opioid treatment is higher on average, with one study finding an average relapse rate of 63% for short-term inpatient treatment, 14% for long-term inpatient treatment, and 28% for outpatient treatment. At six months, relapse rates increased to 77% for short-term inpatient treatment, 59% for long-term inpatient treatment, and 61% of outpatient treatment (Nunes et al, 2017).

Overdose through relapse requires an examination of relapse, both as a process and its occurrence during treatment. Relapse rates, overdose rates, and death rates should not be conflated: not all those who relapse overdose, and not all overdoses are fatal. There are several

evidence-based strategies to prevent overdoses such as SUD treatment (i.e., medication-assisted treatment, education, counseling); providing individuals being released with overdose interventions, such as fentanyl testing strips (prevention); and educating and coordinating distribution of naloxone/Narcan® (overdose treatment).

The recommendations put forward in this brief are strictly for the prevention and treatment of overdose and do not represent a shift away from the objective of long-term abstinence programming.

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