Comprehensive Opioid Abuse Program Strategic Plan

April 2020

ARKANSAS

About This Strategic Planning Project

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Section 1. Introduction

Background

In 2018, the Bureau of Justice Assistance with the United States Department of Justice awarded the Arkansas Department of Finance and Administration-Intergovernmental Services (DFA) and Office of State Drug Director (OSDD) a Comprehensive Opioid Abuse Grant Program (COAP) Category 4: Statewide Planning, Coordination and Implementation Grant also known as the Comprehensive Opioid, Stimulant, and Substance Abuse Site-Based Program (COSSAP).

1) Develop a coordinated plan to assist localities in engaging and retaining offenders who abuse illicit or prescription opioids in treatment and recovery services; increase the use of diversion, and reduce the incidence of overdose death.

2) Provide financial support to localities to implement the strategies in the plan developed as part of Category 4a; and expand the use of alternatives to incarceration to engage individuals in treatment and recovery, focusing on best practice models.

The COAP strategic plan uses a data-driven, outcomes-based approach to identify priority problems and to recommend strategies that address opioid misuse in Arkansas. The Strategic Planning Workgroup in partnership with strategic planning consultants, from the University of Oklahoma's Southwest Prevention Center, conducted a needs assessment to determine the contributory causes of the opioid epidemic and the consequences of the epidemic. Although the Arkansas experience is the focus of this plan, national data is used to provide context. Additionally, qualitative data were collected from Peer Recovery Support Specialists in Arkansas to give further context about the strengths and challenges of the criminal justice system for those with substance use disorders (Appendix A).

The DFA, OSDD, and workgroup will implement the plan in partnership with up to twenty-five (25) sub-recipients at the local/community level. They will implement strategies to execute the following: treatment service engagement; prevention and education programs for youth; implementation of diversion or family court programming; and strategies to reduce the incidence of overdose deaths.

As part of the plan of action, the DFA, OSDD, and workgroup will review the comprehensive plan each fiscal year to make modifications and addendums as necessary. As a result of the annual assessment, they will document the overall outcomes of the goals, objectives, and strategies of the developed plan in an annual report disseminated to all partners. The implementation performance will be documented through submitted monthly/quarterly reports from the sub-recipients. After the federal funding has ended, plans are to sustain these efforts financially through the state's block grant for substance abuse prevention and treatment. The initiatives funded through sub-recipients will also be partially sustained through leveraging local resources.

Planning Approach

The strategic plan was developed in four phases over eight months beginning in September 2019. The four phases are needs assessment, priority selection, strategy identification, and plan development (Figure 1). Strategic planning consultants facilitated a planning process designed to directly engage workgroup members in developing the core elements of the strategic plan. The workgroup met monthly to provide input, review findings, and to shape the content.

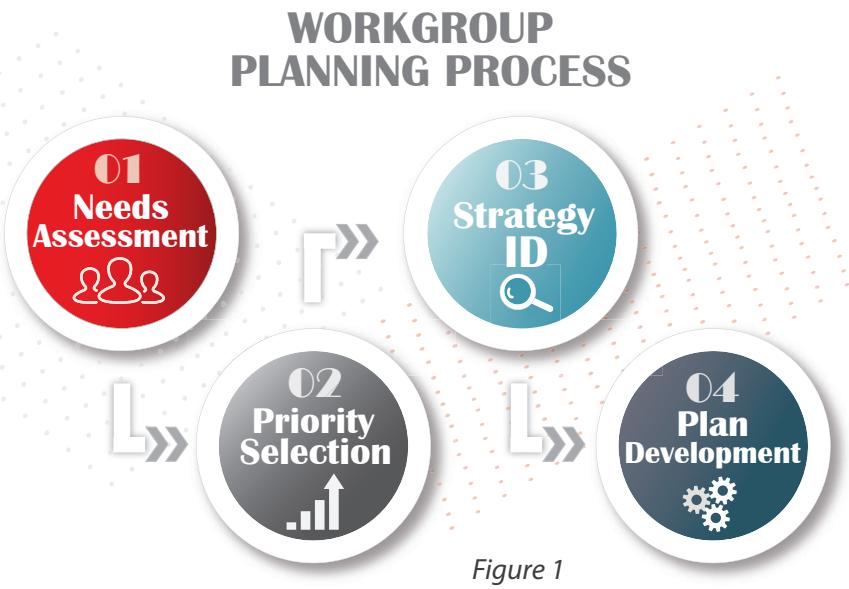


Figure 1

The Sequential Intercept Model (SIM) was used as a framework to direct the workgroup's selection of strategies.

The SIM is a conceptual model that informs community-based responses to justice-involved people with mental health and substance use disorders (SUD) (Figure 2). The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system.[1] The workgroup chooses to focus efforts on the following intercept points:

1) Law enforcement /emergency services
2) Post arrest: initial detention/initial hearings
3) Post-initial hearings: jail/prison, courts, forensic commitments.

These intercept points were selected based on the state's resources, readiness, and capacity to produce positive outcomes at the state and local levels. They also strongly inform the direction and execution of this strategic plan for the COAP Workgroup's successful substance use intervention and prevention in Arkansas.

Figure 2

[1] Munetz, M. R., & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. Psychiatric Services, 57(4), 544-549. doi:10.1176/appi.ps.57.4.544

Section 2. Needs Assessment

The purpose of this section is to provide a national overview of the opioid epidemic and outline the contributing and consequential factors for the opioid epidemic in Arkansas, in order to establish effective intervention and prevention approaches.

Opioids are a class of drugs that include heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others. Opioids can be highly addictive, and overdoses are common. Many people benefit from these drugs, but they can frequently be diverted for improper use. In 2013 and 2014, the National Survey on Drug Use and Health (NSDUH) reported 50.5% of people who misused prescription painkillers got them from a friend or relative for free, and 22.1% got them from a doctor. As tolerance increases, people may not be able to get their supply from the same source and then turn to the black market for drugs or use more risky substitutes like heroin.[2] Illicit use of any opioid—including the nonmedical use of prescription opioids and the use of non-prescription opioids—is a risk factor for overdose.[3]

Every day, more than 115 people die in the United States after overdosing on opioids (Figure 3). [4] The availability of synthetic opioids largely accounts for the increase in drug overdose deaths, which doubled between 2015 to 2016. In this time, rates of overdose deaths involving prescription opioids and heroin also increased by 10.6% and 19.5%, respectively, and rates of overdose deaths involving cocaine and psychostimulants increased by 52.4% and 33.3%. With the growing rates of overdose deaths due to substance use disorders, the need for effective intervention and prevention measures is all the more timely. [5]

Figure 3

[2] Substance Abuse and Mental Health Administration. (2019). Find help: ATOD [online article]. Retrieved from https://www.samhsa.gov/atod/opioids

[3] Johnson, E. M., Lanier, W. A., Merrill, R. M., Crook, J., Porucznik, C. A., Rolfs, R. T., & Sauer, B. (2013). Unintentional prescription opioid-related overdose deaths: Description of decedents by next of kin or best contact, Utah, 2008–2009. Journal of General Internal Medicine, 28(4), 522-529.

[4] Substance Abuse and Mental Health Administration. (2019). Find help: ATOD [online article]. Retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis

[5] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly. Overdose deaths involving opioids, cocaine, and psychostimulants, United States, 2015-2016. Retrieved from https://www.cdc.gov/mmwr/volumes/67/wr/mm6712a1.htm

Contributory Causes

As this section will show, substance use disorders present challenges to Arkansas. However, the state has a history of proactive measures to combat over-prescribing of opioids and opioid overdoses. Access to treatment and stigma around treatment for substance use disorder are key obstacles to successful prevention in Arkansas.

Over-Prescribing. Opioids serve a role in physicians' management of patient pain; however, high opioid prescribing puts patients at risk for addiction and overdose. The Centers for Disease Control and Prevention shows that when compared with national rates, at 93.5 vs. 51.4 per 100 people, Arkansas' prescription rates trend significantly higher than the national average (Figure 4).

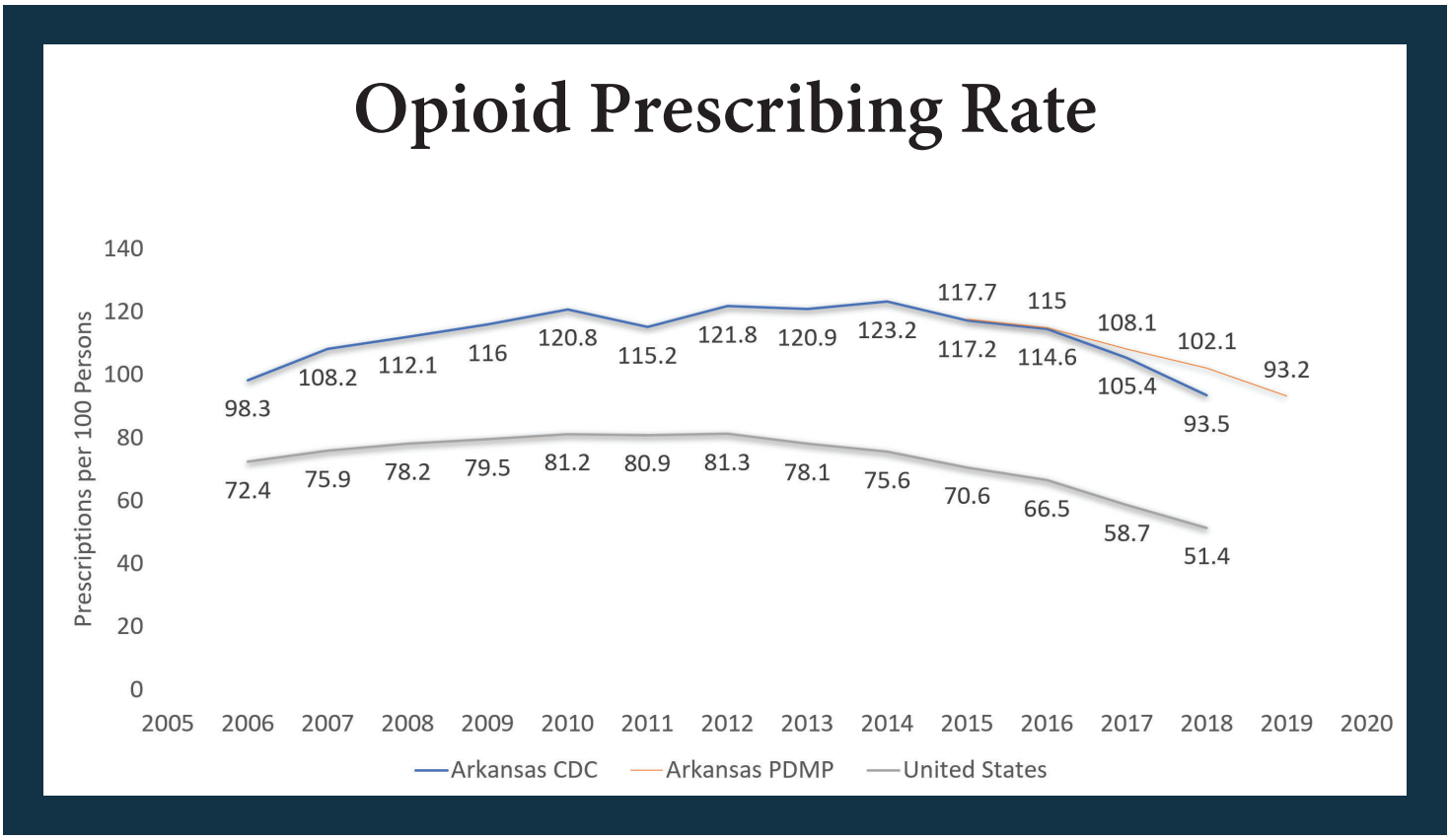


Figure 4

Although Arkansas is second in the nation in prescribing trends, there was a decline in the number of pills prescribed from 2015 to 2018 (Figure 5).

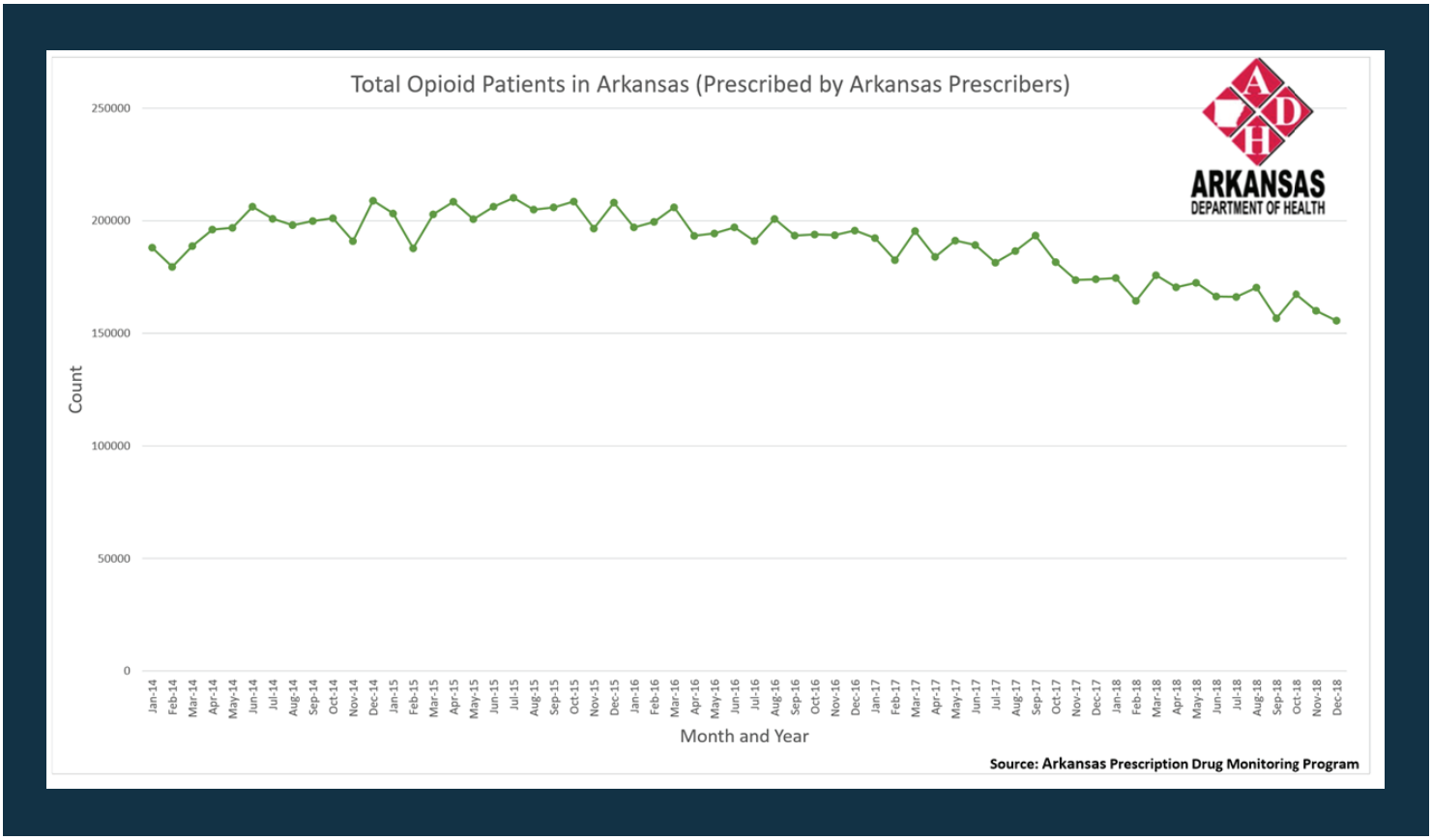


Figure 5

Within Arkansas, there are counties with a high prevalence of prescribing, according to the Arkansas Prescription Monitoring Drug Program.[6] In 2018, the overall opioid prescribing rate for Arkansas was 102.1 per 100 persons. Five counties had the highest prescribing rates statewide: Poinsett (165 per 100 persons), Stone (150 per 100 persons), Ouachita (148 per 100 persons), Lawrence (145 per 100 persons), and Pike (142 per 100 persons) (Figure 6).

[6] Arkansas Department of Health. (n.d.). Prescription drug monitoring program [oline article]. Retrieved from https://www.healthy.arkansas.gov/programs-services/topics/prescription-monitoring-program

To address the over-prescribing of opioids, Arkansas legislators passed legislation in 2011 to establish a statewide prescription drug monitoring program (PDMP). This database tracks controlled substances prescribed and dispensed to patients. Arkansas was also one of the first states to develop opioid prescribing guidelines for emergency room departments and hospitals, as well as taking steps to provide easier access to medications that reverse overdoses.

These guidelines were created to reduce prescription opioids in hospital emergency departments. By 2015, the state legislature placed similar guidelines in the Combatting Prescription Drug Abuse Act (Act 1208), requiring compliance by every hospital in the state. Then, in 2017, the Naloxone Protocol Act (Act 284) became law, making it easier for physicians and pharmacists to dispense naloxone to patients and caregivers without a prescription.[7] Naloxone is a medication that will rapidly reverse an opioid overdose. It can very quickly restore a normal breathing pattern to those overdosing.[8]

Opioid Prescribing Rate per 100 Persons

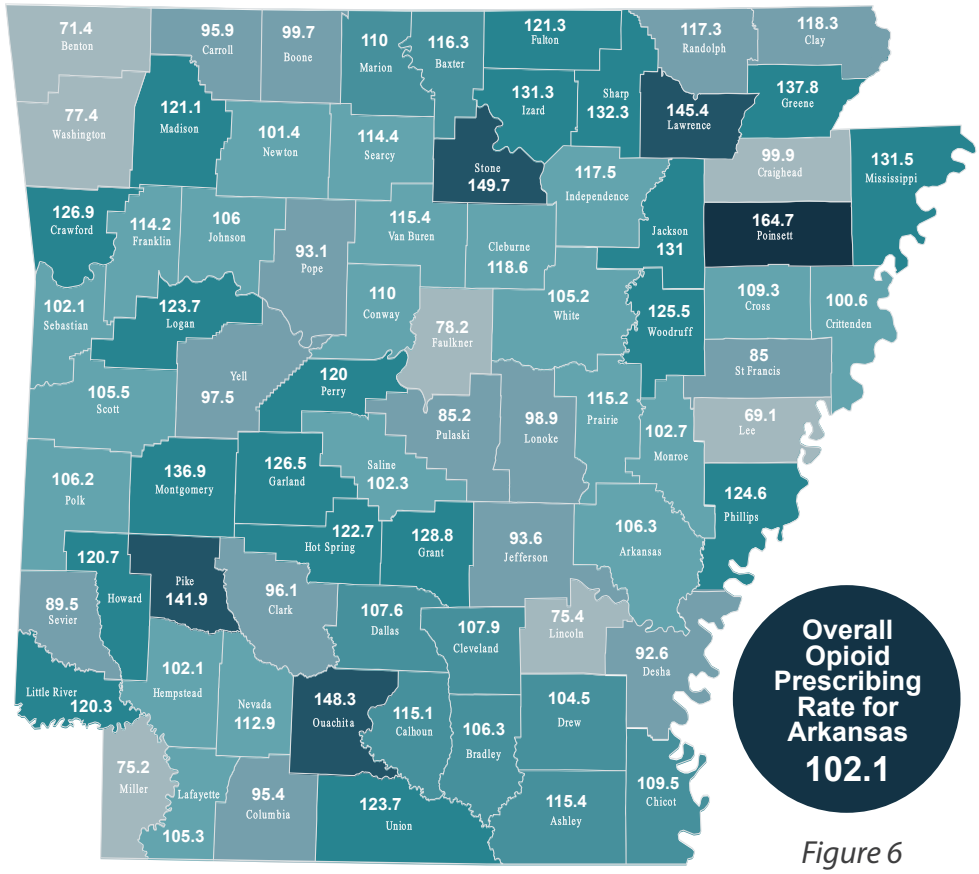


Figure 6

Access to Treatment. There are many reasons why treatment is not sought or obtained for Substance Use Disorder, chief among them, stigma and access to treatment facilities. According to 2019 estimates, less than 35 percent of adults with SUD had received treatment for opioid use in the past year (Jones and McCance-Katz, 2019),[9] and no national data sources are currently available to precisely estimate the share of those patients who are being treated with one of the three U.S. Food and Drug Administration (FDA)-approved medications.

[7] Criminal Justice Institute University of Arkansas. Naloxone protocol. Retrieved from https://www.cji.edu/resources/naloxone-protocol/

[8] National Institute on Drug Abuse. Opioid Overdose reversal with naloxone (Narcan, Evzio). Retrieved from https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio

[9] Jones CM, McCance-Katz EF. Co-occurring substance use and mental disorders among adults with opioid use disorder. Drug and Alcohol Dependence. 2019;197(1):78–82.

National estimates indicate that there is usually a gap of several years between the onset of SUD and entering treatment, and stigma surrounding seeking treatment presents a substantial barrier to seeking help. According to Link and Phelan (2001), "stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (p. 377). They assert people are stigmatized when "the fact that they are labeled, set apart and linked to undesirable characteristics leads them to experience status loss and discrimination" (p. 371).

Another obstacle to seeking treatment in Arkansas is the availability of treatment options and distance to those options from home. There are 41 facilities in Arkansas offering some Medication Assisted Treatment.[10]

In Figure 7, the availability of facilities with some Medication-Assisted Treatment (MAT) option is shown. MAT is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Counties with the highest availability across the state are Pulaski (8), Miller (3), Washington (3), Craighead (2), and Garland (2).

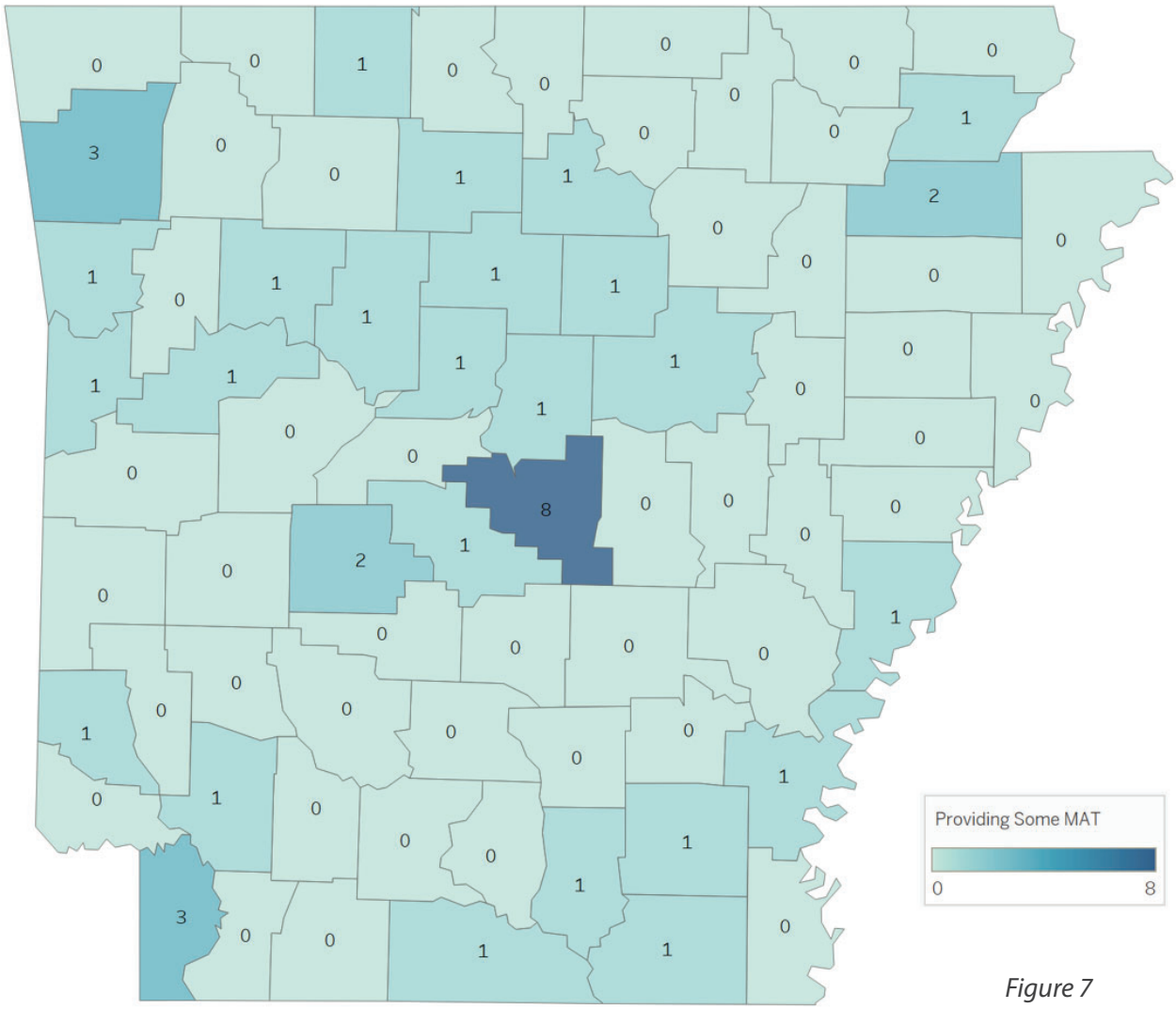


Figure 7

[10] Link B.G., & Phelan, J.C. (2001). Conceptualizing stigma. Annual Review of Sociology, 27, 363–385.

In Table 1, other treatment variables in Arkansas for the opioid epidemic are presented, namely, the number of providers (including RNs and PAs) authorized to treat opioid dependency with buprenorphine. There are 349 providers in Arkansas who can use MAT to treat SUD. The low numbers of providers statewide with access to successful MAT options further exacerbates the substance use epidemic in Arkansas.

Table 1. Treatment Variables in Arkansas for the Opioid Epidemic (2018)[11]

Variable	Number Nationally	Number in Arkansas
Facilities providing substance abuse services	13,135	120
Providers licensed to administer buprenorphine	69,980	349
Facilities providing some Medication Assisted Therapy (MAT)	5,832	26

349
Medication-Assisted Treatment (MAT) Providers in Arkansas

[11] amfAR, The Foundation for AIDS Research. (2019). Arkansas opioid epidemic [online data tool]. Retrieved from http://opioid.amfar.org/AR#data-explorer

Trauma/Self-Medicating/PTSD. Adverse Childhood Experiences (ACEs) are said to have a profound impact on future health, including the use of substances and mental health disorders. The negative effects of ACEs are even thought to be inter-generational. Designed in 1994 by researchers at Kaiser Permanente and the Centers for Disease Control, the original ACE study developed a diagnostic tool for assessing the likelihood of long-term health, substance abuse, and mental health. When using the tool, an ACE score was generated by an individual responding "yes" to having experienced any of the following prior to the age of 18: physical abuse; emotional abuse; sexual abuse; domestic violence; growing up with a household member who abuses substances; living with a mentally ill/suicidal household member; experiencing the incarceration of a household member; loss of a parent; emotional neglect; or physical neglect (Felitti et al., 1998).[12] The ACEs survey has been found to be highly accurate and, more importantly, it is estimated that in the United States, 61% of men and 51% of women report exposure to at least one lifetime traumatic event.[13]

61% of men
51% of women
report at least one lifetime traumatic event

The National Survey of Children's Health provides another look at childhood trauma and adverse experiences. The survey is funded and directed by the Health Resources and Services Administration (HRSA) and the Maternal and Child Health Bureau (MCHB). As seen in Table 2, the data from the NSCH survey provides a point of comparison between the U.S., Arkansas, and surrounding states, showing Arkansas above the national average on all questions.

Table 2. Percentage of Adverse Childhood Experiences in the United States, Arkansas, and surrounding States[14]

ACE	U.S.	AR	TX	OK	MO	LA	TN	MS
a. Parent or guardian who got divorced or seperated	25	30	27	29	28	30	26	32
b. Lived with anyone who was mentally ill, suicidal, or severely depressed	8	10	7	10	12	8	8	8
c. Lived with anyone who had a problem with alcohol or drugs	9	13	11	10	10	10	11	11
d. Saw or heard parents or adults slap, hit, kick, punch one another in the home	6	9	7	6	7	6	6	10
e. Parent or guardian served time in jail	8	12	9	12	9	14	12	10

[12] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V.,…Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) Study. *American Journal of Preventative Medicine,* 14(4), 354–364.

[13] SAMHSA-HRSA Center for Integrated Health Solutions. (2019). Trauma [online article]. Retrieved from https://www.integration.samhsa.gov/clinical-practice/trauma

[14] National Survey of Children's Health (2016-present). Retrieved from https://www.childhealthdata.org/browse/survey

Consequences

This section relates to the consequences of taking opioids. There are several consequences discussed, including hospital stays, arrest, family disruption, overdose and death.

Opioid-Related Hospital Use (Inpatient Stays). The prevalence of opioid-related inpatient hospital stays provide insight into the need for prevention measures. Hospital stays and emergency department (ED) visits, including opioid-related hospital use, are identified by any diagnosis (all-listed) in the following ranges of ICD-10-CM and ICD-9-CM codes: F11 and T40 series.[15] F11 series includes opioid-related disorders (except F11.21). T40 series includes poisoning by, adverse effect of, and underdosing of narcotics and psychodysleptics [hallucinogens]; poisoning accidental, intentional self-harm, assault, undetermined, and adverse effect (except heroin). A seventh digit indicates initial, subsequent encounter, sequela. Codes include opium, heroin, other opioids, methadone, other synthetic narcotics, unspecified narcotics, and other narcotics.

[15] Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID) 2008 to 2016 (all available data as of 8/22/18). Inpatient stays include those admitted through the emergency department. Retrieved from https://www.hcup-us.ahrq.gov/faststats/OpioidUseServlet?radio-3=on&location1=US&characteristic1=01&setting1=IP&location2=&characteristic2=01&setting2=IP&expansionInfoState=hide&dataTablesState=hide&definitionsState=hide&exportState=hide

In Figure 8, Arkansas shows an increasing trend in opioid-related hospital use from 2008 to 2017.

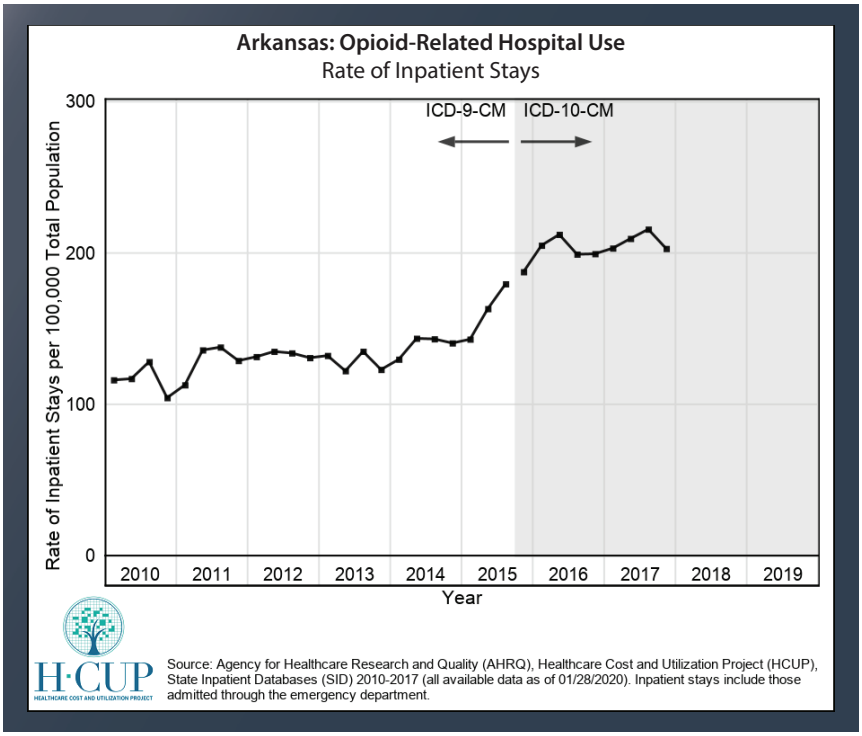


Figure 8

The national opioid-related hospital use appears to plateau after 2015 for inpatient stays (Figure 9).

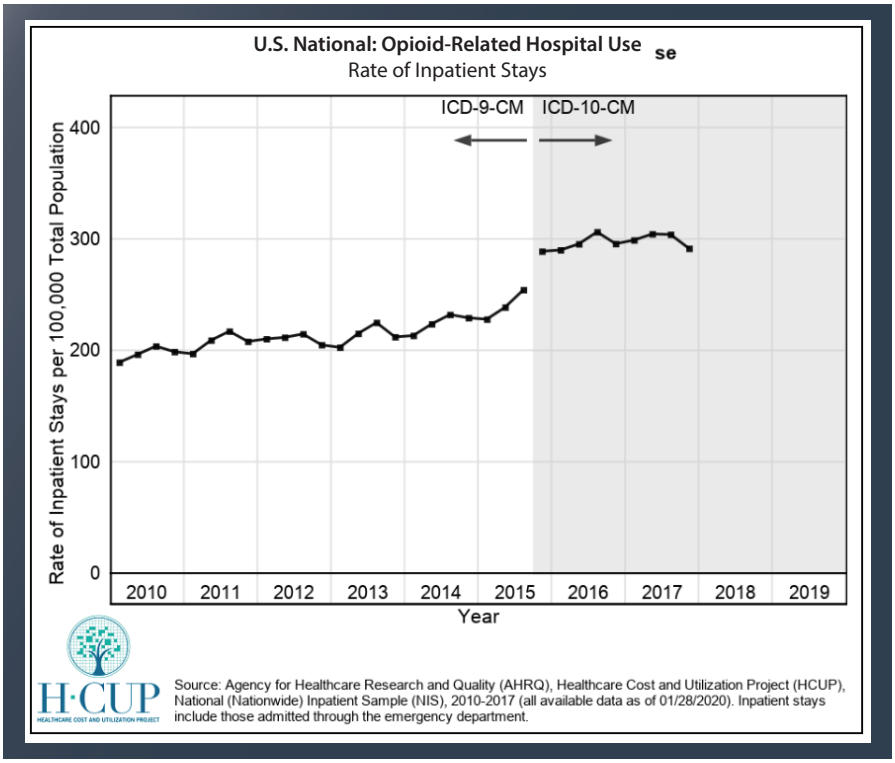


Figure 9

Figure 10 shows the rate of emergency department visits for Arkansas.[16] A steady increase is shown from 2013 until a drop in 2016.

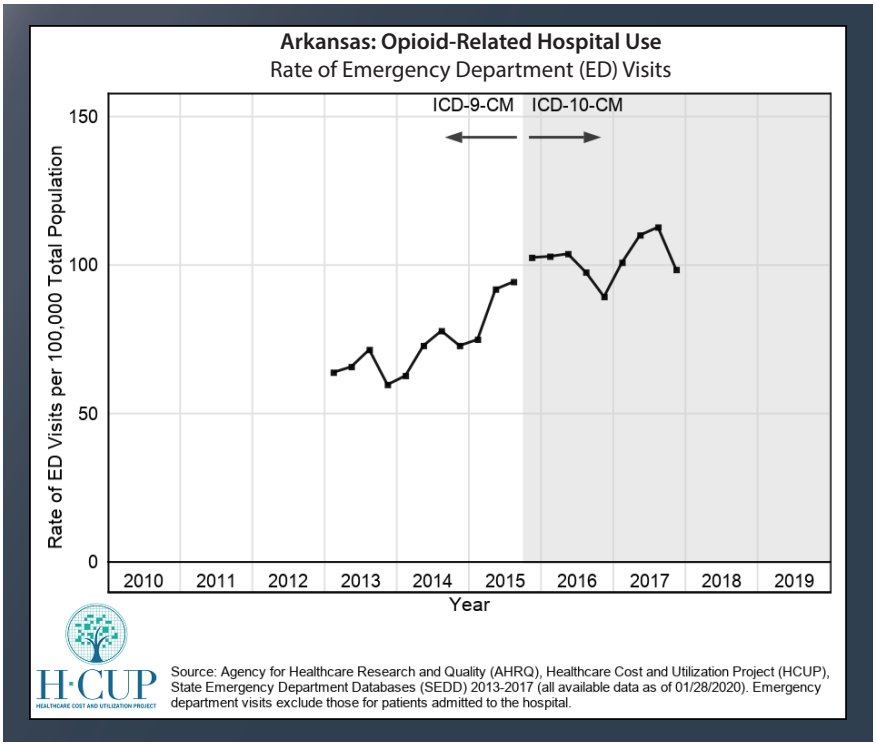


Figure 10

The national rate of emergency department visits for opioid-related hospital use shows historically an increasing trend before decreasing in 2017 (Figure 11).

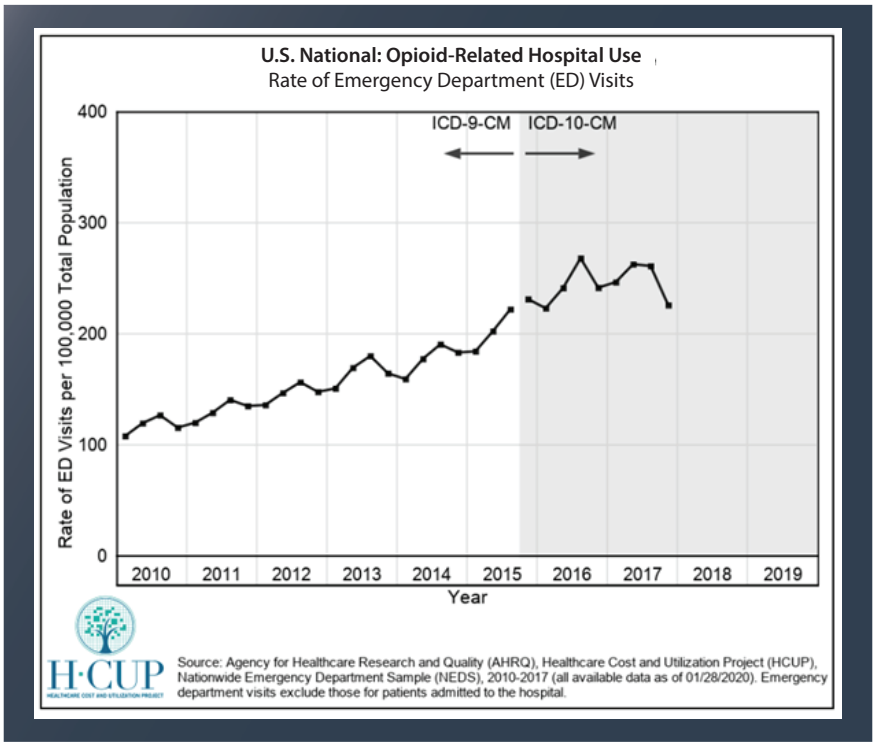


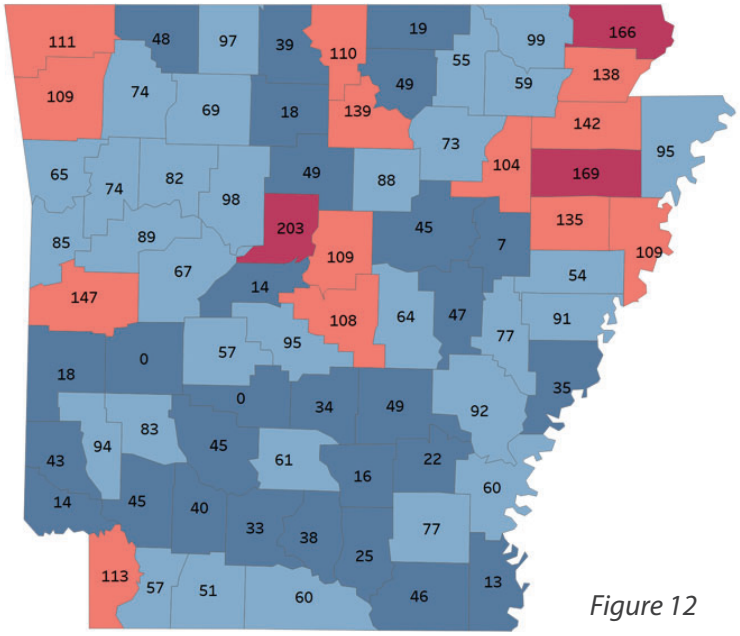
Figure 11

[16] Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID) 2008 to 2016 (all available data as of 8/22/18). Inpatient stays include those admitted through the emergency department. Retrieved from https://www.hcup-us.ahrq.gov/faststats/OpioidUseServlet?setting1=ED&location1=AR

Possession, Arrest, and Incarceration. Figures 12, 13, and 14 represent the number of illegal drug possessions and drug selling in Arkansas per 10,000. Conway, Poinsett, Clay, Scott, and Craighead counties are hot spots for drug possession, while Craighead, Greene, Crittenden, Poinsett, and Howard counties are hot spots for drug selling. The data do not specify the drug in possession at the time of arrest.

Drug Possession In Arkansas per 10,000 (2018)

Conway 203
Poinsett 169
Clay 166
Scott 147
Craighead 142



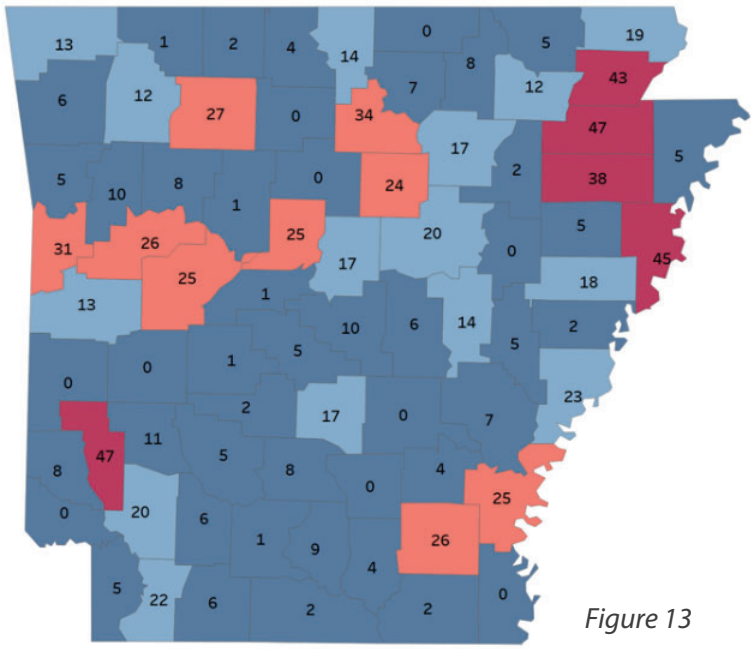
SUM
(Possession Rate per 10,000)

0 2 3

Figure 12

Drug Selling In Arkansas per 10,000 (2018)

Craighead 47
Howard 47
Crittenden 45
Greene 43
Poinsett 38



SUM
(Selling Rate per 10,000)

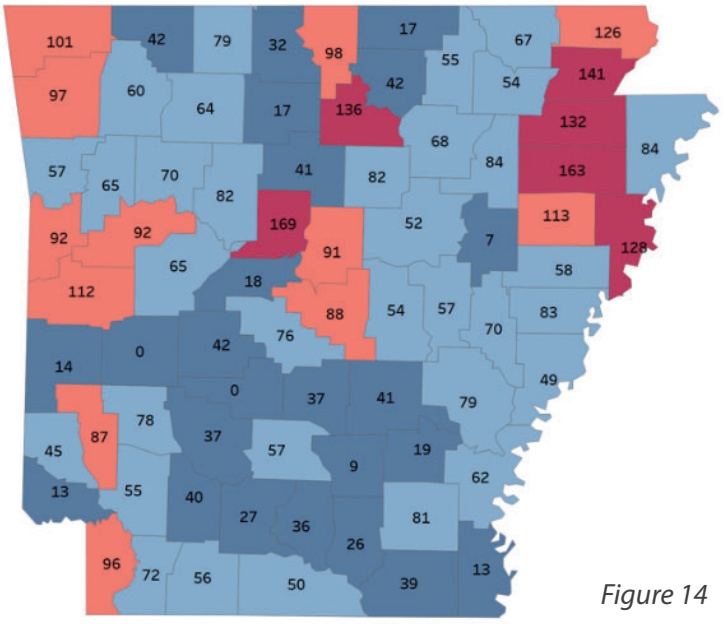
0 47

Figure 13

Drug arrests per 10,000 were mostly located in Conway, Poinsett, Greene, Stone, and Craighead counties.

Drug Arrests In Arkansas per 10,000 (2018)

Conway 169
Poinsett 163
Clay 141
Stone 136
Craighead 132



SUM
(Total Drug Arrest Rate per 10,000)

0 169

Figure 14

Over the previous decade, drug-related arrests declined nationwide, conversely, it began to increase in 2015. (Figure 15).[17]

Uniform Crime Report National Drug-Related Arrests

Figure 15

In 2019, the American Civil Liberties Union (ACLU)[18] stated that over the last few decades, Arkansas' prison population grew dramatically, even as the U.S. prison rate decreased by 8%. In fact, Arkansas has the fourth highest rate of imprisonment, with the state incarcerating 598 people per 100,000 residents.[19] As of June 30, 2018, Arkansas imprisoned a total of 17,972 people.[20] Table 3 shows between 2018 and 2019, 40,222 criminal charges in Arkansas were substance misuse/abuse related. Furthermore, over 18,000 cases were filed against 16,669 individuals. Of the original charges filed in this period, there were 19,583 guilty outcomes.

[17] Federal Bureau of Investigation. Uniform Crime Report. Retrieved from https://www.fbi.gov/services/cjis/ucr

[18] American Civil Liberties Union. (2019). Blueprint for smart justice: Arkansas [online report]. Retrieved from https://50stateblueprint.aclu.org/assets/reports/SJ-Blueprint-AR.pdf

[19] Bronson, J., & Carson E. A. (2019, April). Prisoners in 2017 [online statistical tool]. Retrieved from https://www.bjs.gov/content/pub/pdf/p17.pdf.

[20] Arkansas Department of Correction (2018). Annual Report FY 2018 [online report]. Retrieved from https://adc.arkansas.gov/images/uploads/ADC_FY18_Annual_Report_BOC_Approval_12_20_2018_Edit_3-28-19.pdf.

Table 3. Criminal Filings Related to Substance Abuse (2018-2019)		
Criminal Filings Related to Substance Abuse	Charges Filed	40,222
	Cases Filed	18,410
	Distinct Individuals Charged	16,669
Guilty Outcomes from Previous Charges Filed		19,583

Arkansas had the fastest-growing state prison population in the nation between 2012 and 2017, and Arkansas' prison population is projected to increase by 28 percent between 2016 and 2026.[21] In 2018, there were 8,503 admissions to Arkansas prisons, many of which were related to substance use and abuse. In fact, one in 10 admissions were for residential burglary, one in 20 were for simple possession of fewer than 2 grams of a Schedule I or II controlled substances, narcotics, methamphetamine, or cocaine, and another one in 20 were for manufacturing, delivery, or possession of a controlled substance. An additional 5% of admissions were for robbery.

Child Neglect. In 2005, Arkansas legislators passed a bill known as Garrett's Law (GL), named for a baby supposedly born with methamphetamine in his system. Under the law, mothers of newborns testing positive for illegal drugs are presumed to be guilty of parental neglect under the state's civil code.[22] The number of GL reports accepted for investigation has consistently increased since the law's inception. During the State Fiscal Year (SFY) 2018, 1,280 GL reports were received, an increase of 3% from the previous year. The number of GL reports received annually has more than tripled since SFY 2006, increasing, on average, by 7% per year from SFY 2006 through SFY 2011. From SFY 2012 through SFY 2018, however, the number of GL reports increased at nearly twice that rate, at an average of 13% per year. This increase suggests the intensifying SUD epidemic in Arkansas and the need for intervention (Figure 16).[23]

1,280
Garrett's Law reports were received in 2018

[21] American Civil Liberties Union. (2019). Blueprint for smart justice: Arkansas [online report]. Retrieved from https://50stateblueprint.aclu.org/assets/reports/SJ-Blueprint-AR.pdf
[22] J Hendren. (2018, June 7). Garrett's law monitors babies born with illegal drugs in their systems [online RSS feed]. Retrieved from https://www.arkansas.gov/senate/newsroom/index.php?do:newsDetail=1&news_id=724
[23] Children's Research Center. Summary of Garrett's law referrals for SFY 2018. Arkansas Department of Human Services. Division of Children and Family Services.

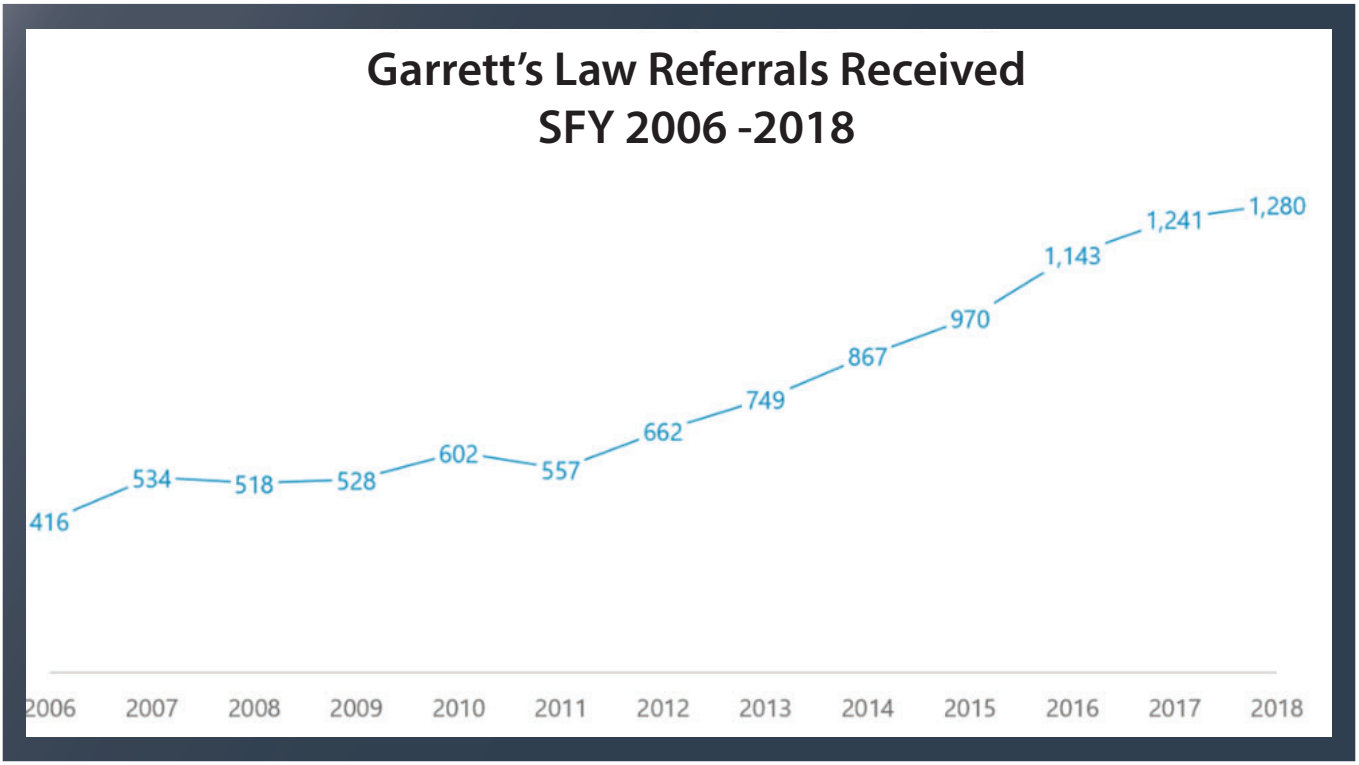


Figure 16

The prevalence of removal from the home nationally is showing a similar increasing trend from 2000 to 2016. The National Center on Substance Abuse and Child Welfare state that "the increase of opioids misuse has been described by long-time child welfare professions as having the worst effects on child welfare systems that they have seen" (Figure17).[24]

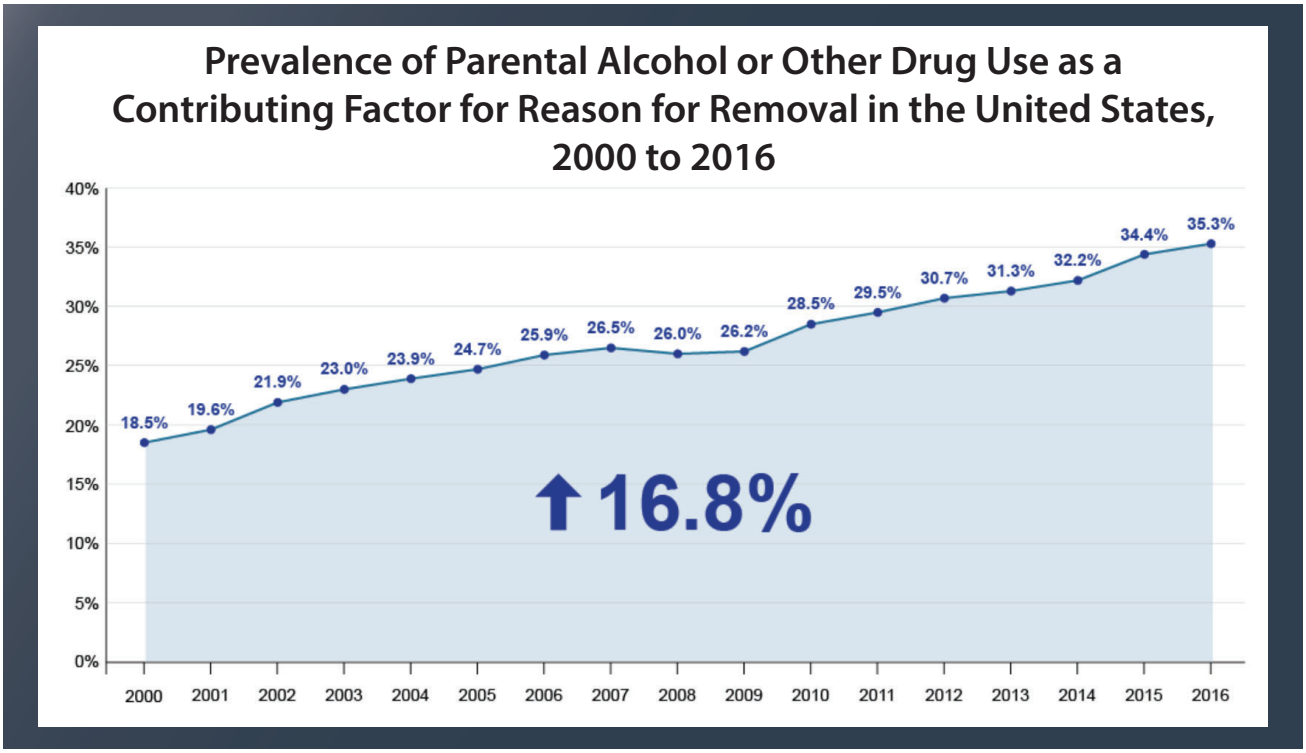


Figure 17

[24] National Center on Substance Abuse and Child Welfare. (2020). Child welfare and alcohol and drug use statistics [online article]. Retrieved from https://ncsacw.samhsa.gov/research/child-welfare-and-treatment-statistics.aspx

Naloxone Administration and Death Rates. Naloxone is a medication administered to rapidly reverse an opioid overdose. Opioids affect the breathing rate, and when Naloxone is administered, it binds to the opioid receptors and can reverse the effects (National Institute on Drug Abuse, 2018).[25] Naloxone is a life-saving medication that can lead to the person with SUD receiving treatment and potentially recovering. In Arkansas, the most frequently provided Naloxone administrations by First Responders and Emergency Management System are in six counties: Johnson, Independence, Perry, Pulaski, Woodruff, and Nevada (Figure 18).

Naloxone Administration Rates per 100,000 (2018)

Pulaski 104
Johnson 90
Nevada 88
Perry 86
Woodruff 82
Independence 81

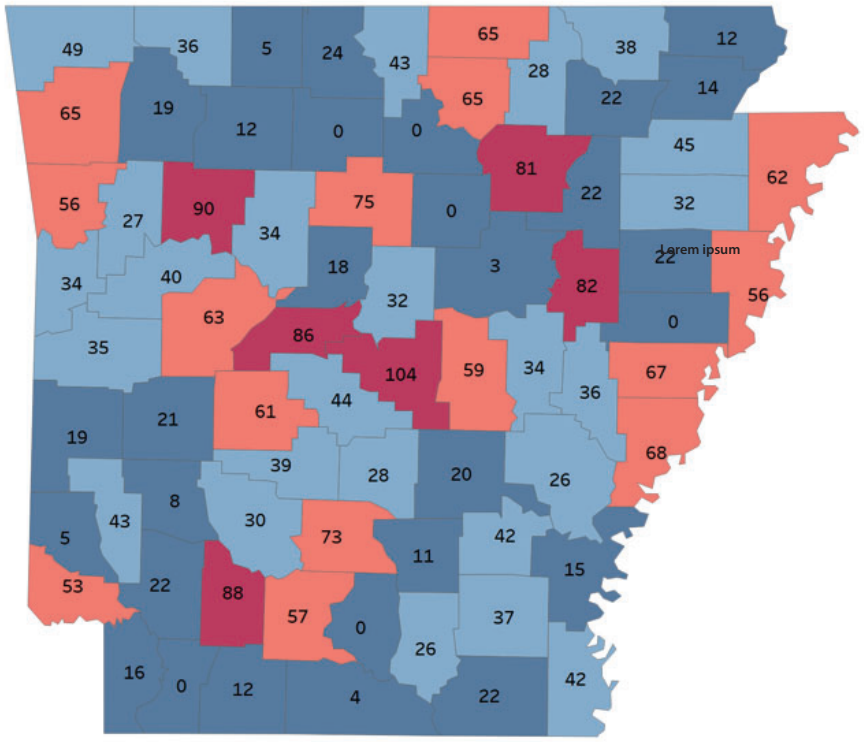


Figure 18

[25] National Institute on Drug Abuse. (2018, April). Opioid Overdose reversal with Naloxone: What is Naloxone? [online article]. Retrieved from https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio

Nationally, the number of drug overdose deaths involving any opioid has steadily increased since 1999 (Figure 19). In Arkansas, the Arkansas Foundation for Medical Care (AFMC) reported opioid-related death rates per 100,000 by county (Figure 20). Counties with the highest opioid-related death rates are Woodruff, Ashley, Crawford, Cleveland, and Crittenden counties.

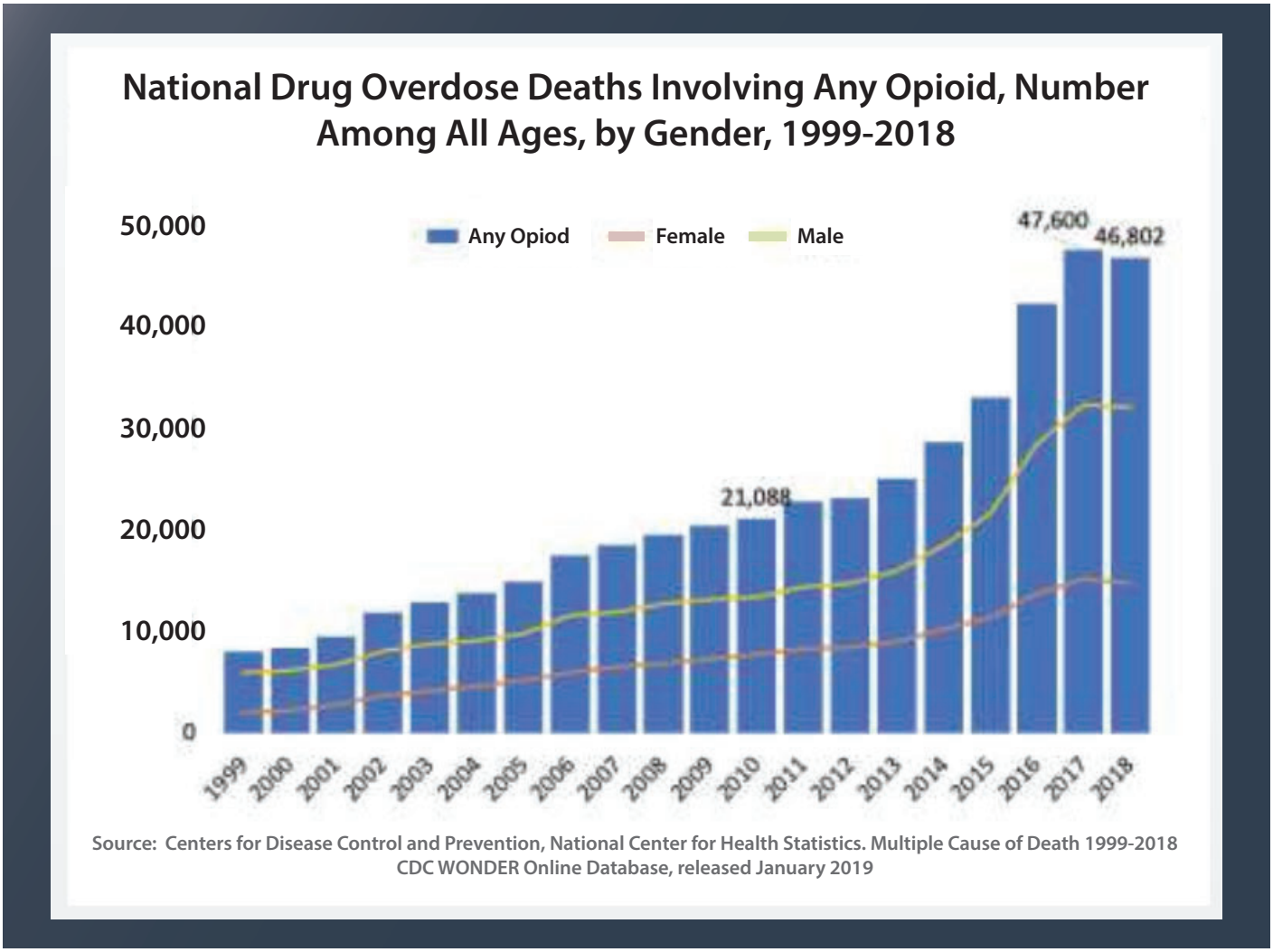


Figure 19

Opioid-Related Death Rate per 100,000 by County (2018)

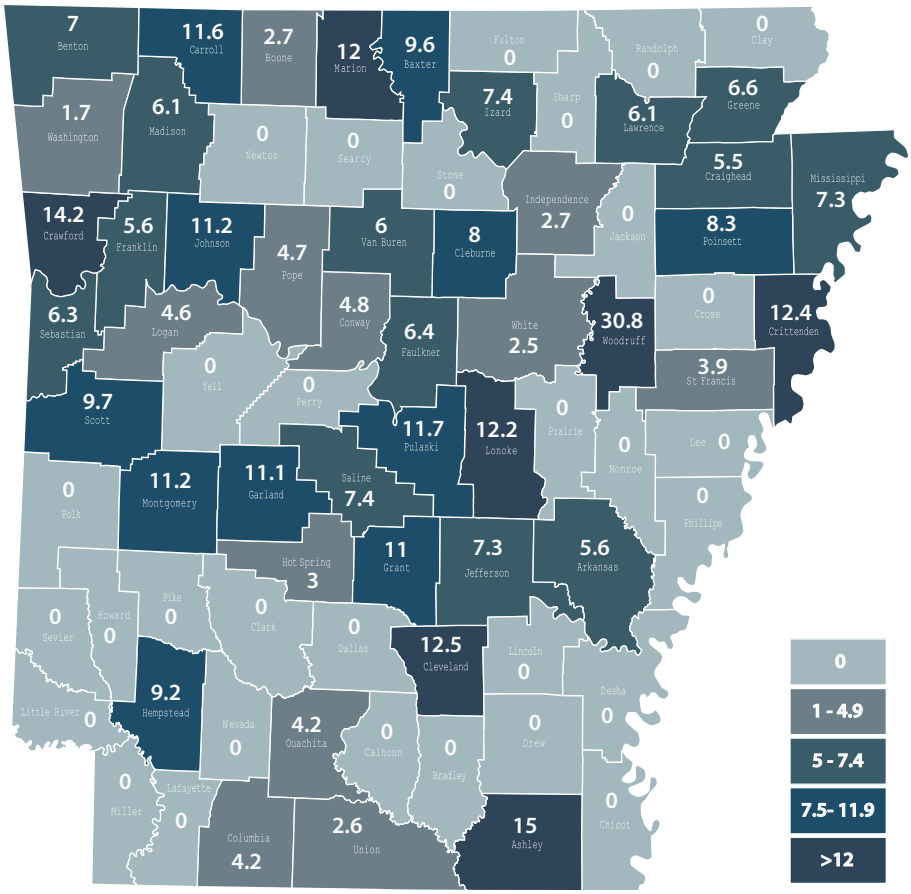


Figure 20

County	Opioid-Related Death Rate
Woodruff	30.8
Ashley	15.0
Crawford	14.2
Cleveland	12.5
Crittenden	12.4

192
Drug Overdose Deaths per Day in the U.S.

Needs Assessment Summary

The needs assessment summary is a brief overview of the data collected during the COAP workgroup's needs assessment phase.

1) The number of opioid prescriptions issued monthly from Arkansas prescribers to Arkansas patients is on the decline, going from roughly a little over 250,000 opioid prescriptions per month in 2014 to close to 220,000 opioid prescriptions per month in the later portions of 2018. That is a 12% decrease in opioid prescriptions in 4 years.
2) Data show that when Arkansas rates are compared with national rates, Arkansas' prescription rate is significantly higher than the national average (e.g., in 2017 108.1 vs. 58.7 per 100 people). According to the Centers for Disease Control and Prevention, in 2017, Arkansas ranks 2nd in the U.S. for over-prescribing opioid medications, at an average of 105.4 opioid prescriptions per 100 people, only behind Alabama.
3) In 2016, 46% of Arkansans aged 18 and older filled at least one prescription for a controlled substance and enough opioids, depressants, and stimulants were sold for every person in Arkansas to take about 100 pills each during the year. Opioids outrank depressants and stimulants in the top-selling prescription drugs by class. In 2018, the overall opioid pill-prescribing rate for Arkansas was 102.1 per 100 persons. The counties of Poinsett (165 per 100 persons), Stone (150 per 100 persons), Ouachita (148 per 100 persons), Lawrence (145 per 100 persons), and Pike (142 per 100 persons) had the highest prescribing rates across the state.
4) Inpatient stays and emergency department (ED) visits, including opioid-related hospital use, are identified by any diagnosis (all-listed) in specific ranges of ICD-10-CM and ICD-9-CM codes: F11 and T40 series. Arkansas shows an increasing trend from 2008 in opioid-related inpatient hospital use.
5) Adverse Childhood Experiences (ACES) are said to have a profound impact on future health, including the use of substances and mental health disorders. The data show that Arkansas is above the national average on all questions in the ACEs survey.
6) The rate of emergency department visits for opioids in Arkansas shows a steady increase from 2013 until a decrease in 2016.
7) Hot spots for drug possession were Conway, Poinsett, Clay, Scott, and Craighead counties, while hot spots for drug selling were Craighead, Greene, Crittendon, Poinsett, and Howard counties. Drug arrests per 10,000 were mostly located in Conway, Poinsett, Greene, Stone, and Craighead counties.
8) Arkansas imprisoned 598 people per 100,000 residents, the fourth-highest imprisonment rate in the nation. As of June 30, 2018, Arkansas imprisoned a total of 17,972 people." Data show that 40,222 criminal charges were files that were related to substance abuse. Cases were filed against 18,410 of those charges, with 16,669 distinct individuals being charges. Of the original charges files, there were 19,583 guilty outcomes from the charges filed.

9) In 2018, there were 8,503 admissions to Arkansas prisons. That year, one in 10 admissions were for residential burglary; one in 20 for simple possession of less than 2 grams of Schedule I or II controlled substances, narcotics, methamphetamine, or cocaine; and another one in 20 were for manufacturing, delivery, or possession of a controlled substance. An additional 5 % of admissions were for robbery. Arkansas had the fastest-growing state prison population in the nation between 2012 and 2017, and Arkansas' prison population was projected to increase by 28 percent between 2016 and 2026.

10) The number of Garrett's Law (GL) reports accepted for investigation has tripled since the law's inception in 2006 to combat child neglect due to substance abuse. On average, reports increased 7% from SFY 2006 to SFY 2011, then at nearly twice that rate through SFY 2018, when 1,280 GL reports were received.

11) In Arkansas, the most frequently provided Naloxone administrations by first responders and the emergency management system are in Johnson, Independence, Perry, Pulaski, Woodruff, and Nevada counties.

12) In Arkansas, the Arkansas Foundation for Medical Care (AFMC) reported opioid-related death rates per 100,000 by county. The highest opioid-related death rates are in Woodruff, Ashley, Crawford, Cleveland, and Crittenden counties.

Section 3. Strategies

This strategic plan, so far, has presented the evidence for intervention measures to alleviate the substance use disorder epidemic in Arkansas. This section describes the broad overall direction for the COAP initiative. The nature and scope of each goal are defined and supported by objectives and strategies. Objectives represent expected results that are needed to achieve progress toward each goal. State and community-level strategies describe how goals and objectives will be accomplished under each objective.

The goals, objectives, and strategies were developed through the priority selection and strategy identification phases, during which the DFA, OSDD, and workgroup identified thirty-three (33) potential priorities. Appendix B describes the prioritization process, of those priorities five (5) were selected: stigma, support and recovery services, overdose response, law enforcement capacity building, and data collection. Appendix C defines the types of strategies sub-recipients will implement.

As the group's readiness and resources increase, the DFA, OSDD, and workgroup will address other priorities listed and identify objectives and strategies to reducing overdose death and engaging in treatment and recovery services those justice-involved Arkansans with a potential substance use disorder.

COAP Strategic Priorities	COAP Goals
Strategic Priority 1: Stigma	Goal 1: Reduce stigma associated with persons with substance use disorders through law enforcement and community education efforts.
Strategic Priority 2: Support and Recovery Services	Goal 2: Increase substance use disorder treatment support for justice-involved persons and their families.
Strategic Priority 3: Overdose Response	Goal 3: Improve overdose investigation response by law enforcement agency personnel.
Strategic Priority 4: Law Enforcement Capacity Building	Goal 4: Increase awareness about the opioid crisis and law enforcement/community strategies through building capacity and providing education.
Strategic Priority 5: Data Collection	Goal 5: Enhance and build linkages across state and local level data collection systems.

Strategic Priority 1 | Stigma

***Goal:* Reduce stigma associated with persons with substance use disorders through law enforcement and community education efforts.**

Stigma is a significant barrier to persons with a substance use disorder (SUD) seeking treatment. Stigma refers to attitudes and beliefs that lead people to reject, avoid, or fear those they perceive as being different. Addressing stigma as a risk factor for justice-involved persons with a SUD is an overarching strategic goal that touches upon all the others in the strategic plan.

Objective 1.1 *By June 30, 2022, promote current state and local efforts to reduce stigma.*

Objective 1.1 State-Level Strategies
Strategic 1.1.1 Require sub recipients to address stigma among law enforcement agency personnel.
Strategy 1.1.2 Promote resources to build law enforcement agency personnel's capacity to address stigma.

Priority 1 Recommended Community-Level Strategies

- **Providing Information -** Utilize established community networks to promotes anti-stigma media, among consumers, family members, and the larger public about mental health issues.
- **Providing Information -** Enhance the partnerships between law enforcement and peer recovery support specialist.
- **Enhancing Skills -** Provide anti-stigma education and resources to law enforcement personnel and individuals within a community.
- **Providing Support -** Enhance the ability of law enforcement personnel and the community to develop and initiate responses to addiction-related stigma.
- **Enhancing Access/Reducing Barriers -** Expand programs that address stigma as a risk factor for engaging justice-involved persons with a SUD in treatment and recovery.
- **Enhancing Skills -** Support and provide crisis intervention training that informs law enforcement about alternatives to arrest and incarceration of individuals with a SUD.

Strategic Priority 2 | Support & Recovery Services

Goal:* *Increase substance use disorder treatment support for justice-involved persons and their families.

Law enforcement plays a critical role in referring justice-involved persons with an SUD and their families to prevention and treatment interventions. This component of service reduces incarceration and promotes recovery among those who are justice-involved with a substance use disorder.

Objective 2.1 *By June 30, 2022, provide resources for persons with a SUD and their families.*

Objective 2.1 State-Level Strategies
Strategic 2.1.1 Develop and promote a registry of opioid assessment/substance abuse treatment service providers to enhance referral networks for the public and healthcare providers.
Strategy 2.1.2 Promote Arkansas Take Back (https://www.artakeback.org/) web-site as a resource for opioid prevention, treatment, and recovery information in their established communication channels.

Objective 2.2 *By June 30, 2022, increase awareness and support of diverse community groups on best practices for state and local-level prevention, treatment, crisis stabilization, and recovery efforts.*

Objective 2.2 State-Level Strategies
Strategic 2.2.1 Provide faith groups and civic organizations with opioid-related resources on their role in recovery support for persons with a SUD and their families.
Strategy 2.2.2 Require COAP sub recipients to coordinate with local prevention and recovery community coalitions to engage the faith groups and civic organizations in prevention and treatment, crisis stabilization, and recovery efforts.

Objective 2.3 *By June 30, 2022, enhance the accessibility of prevention, treatment, and recovery information for law enforcement and individuals with SUD.*

Objective 2.3 State-Level Strategies
Strategic 2.3.1 Provide public information and education about the admission priorities and availability of treatment for all federal and state priority populations at state-funded treatment programs.
Strategy 2.3.2 Promote and provide training and resources on pre-arrest diversion strategies as an alternative to incarceration for individuals with a SUD.

Objective 2.4 *By June 30, 2022, promote the expansion of drug courts to integrate drug treatment services with justice system case processing.*

Objective 2.4 State-Level Strategies
Strategic 2.4.1 Engage key drug court representatives in the COAP workgroup.
Strategy 2.4.2 Provide and promote training that supports drug court programs, integrating court and treatment functions and adhering to best practice standards.

Objective 2.5 *By June 30, 2022, expand programs for pre-booking and post booking treatment alternatives to incarceration.*

Objective 2.5 State-Level Strategies
Strategic 2.5.1 Promote jail-based treatment services to reduce recidivism.
Strategy 2.5.2 Provide and promote training to law enforcement agency personnel and staff on evidence-based standards of care for jail based treatment services.
Strategic 2.5.3 Identify funding for jails to establish jail-based treatment services.
Strategy 2.5.4 Establish a network between jail-based treatment facilities to share data and leverage financial and organizational resources.

Priority 2 Recommended Community-Level Strategies

- **Change Consequences -** Combine treatment with incentives and sanctions.
- **Enhance Access/Reduce Barriers -** Establish mandatory and random drug testing, and aftercare programs.
- **Provide Support -** Engage the faith community in prevention, treatment, and recovery efforts.
- **Modify/Change Policy -** Establish a clear protocol for follow-up with justice-involved persons who have been identified as having a SUD or in need of specialized treatment.
- **Modify/Change Policies -** Advocate for the expansion of or establish jail-based services for treatment of opioid dependency.

Strategic Priority 3 | Overdose Response

Goal: ***Improve overdose investigation response by law enforcement agency personnel.***

Overdose investigation and response by a multidisciplinary team, which includes peer recovery support specialists; have proven to play a pivotal role in preventing additional overdoses and providing people who use and their families with treatment and recovery support resources. Overdose investigation teams engage in overdose prevention activities, respond to overdoses, investigate opioid diversion, and refer to treatment.

Entities receiving COAP funds will be required to partner with peer recovery support specialists when conducting overdose investigations.

Objective 3.1 *By June 30, 2022, require sub-recipients to form or enhance a multidisciplinary post-overdose response investigation teams that include law enforcement and peer recovery support specialists.*

Objective 3.1 State-Level Strategies
Strategic 3.1.1 Issue Request for Proposal (RFP) requiring sub recipients to partner with, form, or enhance local-level multidisciplinary post-overdose response teams.
Strategy 3.1.2 Collaborate with state peer recovery network to develop overdose investigation response teams.
Strategy 3.1.3 Provide training and technical assistance on evidence-based practices for collaborating with, forming, or enhancing local-level multidisciplinary post-overdose response teams.

Objective 3.2 *By June 30, 2022, develop or adopt and implement a coordinated post-overdose investigation protocol for law enforcement agency personnel and peer recovery support specialists.*

Objective 3.2 State-Level Strategies
Strategic 3.2.1 Convene first responders, peer recovery support specialists, medical professionals, treatment professionals, attorneys, Prescription Drug Overdose Advisory Council representatives to develop a comprehensive and coordinated post-overdose response protocol.
Strategy 3.2.2 Disseminate post-overdose response protocol to law enforcement agency personnel and peer recovery support specialists statewide.
Strategy 3.2.3 Provide training and technical assistance on how to use the post overdose response protocol.

Objective 3.3 *By June 30, 2022, enhance the skills of law enforcement agency's personnel to work effectively with peer recovery support specialists.*

Objective 3.3 State-Level Strategy
Strategic 3.3.1 Promote training and technical assistance opportunities for law enforcement and peer recovery support specialists on evidence-based practices for collaborative action.

Priority 3 Recommended Community-Level Strategies
• **Provide Support -** Engage peer recovery support specialist in overdose investigations. • **Provide Information -** Use mass media to provide information, change perceptions and promote strategic action in support of prevention approaches. • **Enhance Access/Reduce Barriers -** Implement best practices related to opioid abuse prevention and treatment. • **Enhance Access/Reduce Barriers -** Advocate for the expansion of community-based services for the treatment of opioid dependency. • **Enhance Access/Reduce Barriers -** Partner with, form, or enhance local-level multidisciplinary post-overdose response teams. • **Enhance Skills -** Train law enforcement agency personnel to respond to calls where mental illness and substance use may be a factor. • **Enhance Skills -** Act as a useful resource for schools in drug education programs and take part in community education about drugs. • **Provide Information -** Provide post-overdose information to persons with SUD and their family members.

Strategic Priority 4 | Law Enforcement Capacity Building

Goal: ***Increase awareness about the opioid crisis and law enforcement/community strategies through building capacity and providing education.***

Awareness and professional capacity building education provide law enforcement agency personnel with the skills and critical analysis to respond to an event involving an overdose or manage interaction with a person with a potential SUD.

Objective 4.1 *By June 30, 2022, increase the capacity of COAP funded law enforcement agency personnel to use practice and evidence-based strategies to address the opioid crisis in the community they serve.*

Objective 4.1 State-Level Strategies
Strategic 4.1.1 Enhance law enforcement awareness of the opioid epidemic and treatment options statewide and locally.
Strategy 4.1.2 Develop and disseminate toolkits addressing opioids and other substances.

Objective 4.2 *By June 30, 2022, increase law enforcement agency personnel's awareness and understanding of existing laws and regulations that support individuals with an opioid-related SUD and their family members.*

Objective 4.2 State-Level Strategy
Strategic 4.2.1 Develop and disseminate toolkits on applicable state and federal laws related to opiates and other substances.

Priority 4 Recommended Community-Level Strategies
• **Enhance Access/Reduce Barriers** - Form or join an opioid response task force. • **Provide Information** - Disseminate user-friendly fact sheets for education and training purposes on applicable state and federal laws. • **Provide information** - Provide opioid-related capacity building opportunities for their community.

Strategic Priority 5 | Data Collection

***Goal:* Enhance and build linkages across state and local level data collection systems.**

Data sharing between law enforcement, treatment, and primary healthcare systems is essential for shepherding justice-involved persons with a SUD out of the criminal justice system and into community social service support networks. Improving data sharing across systems will also help law enforcement plan and implement better policies and practices.

Objective 5.1 *By June 30, 2022, increase the use of linked data sets under defined confidentiality controls to improve knowledge of trends and design appropriate interventions.*

Objective 5.1 State-Level Strategies
Strategic 5.1.1 Define the specific purposes for which law enforcement will use treatment and healthcare data.
Strategy 5.1.2 Support a state-level data-sharing collaborative including law enforcement, treatment, primary healthcare, and other social services networks.
Strategy 5.1.3 Develop and implement a data-sharing plan that includes tracking drug overdoses with law enforcement, treatment, healthcare representatives and other social services networks.
Strategy 5.1.4 Promote the use of the Arkansas COAP category 6 state-level public safety, behavioral health, and public health information-sharing system.

Objective 5.2 *By June 30, 2022, support the use of the real-time suspected overdose data surveillance system, Overdose Detection Mapping Application Program (ODMAP).*

Objective 5.2 State-Level Strategies
Strategic 5.2.1 Require sub-recipients to use the real-time suspected overdose data surveillance system ODMAP.
Strategy 5.2.2 Provide access to training and technical assistance to support sub recipients use of the real-time suspected overdose data surveillance system ODMAP.

Priority 5 Recommended Community-Level Strategies

- **Provide Information -** Utilize local data to inform, influence, and advocate for prevention, treatment, and recovery services for justice involved individuals and their families.
- **Enhance Access/Reduce Barriers -** Use data to focus resources among justice involved individuals.
- **Enhance Access/Reduce Barriers -** Use data to determine gaps within the justice system and make systemic improvements.
- **Provide Support -** Utilize real-time suspected overdose data surveillance system ODMAP.

Appendix A

Survey of Peer Recovery Support Specialists

In November 2019, contact was made with Jimmy McGill, Recovery Coordinator with the Office of Arkansas Drug director, to plan and implement a survey of Peer Recovery Support Specialists (PRSS) in the state of Arkansas. The purpose of the survey was to understand how the PRSSs viewed the life of those who have substance use disorders and were justice-involved. Only 18 responses were collected from the survey out of 310 certified PRSSs in the state of Arkansas. Therefore, a small sample size is a survey limitation. Figure 21 shows the number of trained PRSS in each county.

Questions and Analysis.

Question 1. What resources (i.e., services, programs) exist within the justice system to help those with a substance use disorder get the assistance they need for recovery?

Key responses: *Pathway to Freedom, Exodus (2), Doors Program, Prison Fellowship Academy, Principles and Applications for Life, SOAR, A.P.A.R.T., Think Legacy, Center for Women in Transition, Good Grid, Therapeutic Community, One on One Counseling Sessions (2), Counseling, Substance Abuse Treatment Programs (9) (SATP), Drug Courts (5), Alcoholics Anonymous*

Number of Trained Peer Recovery Support Specialists Per County
Last updated February 25, 2020

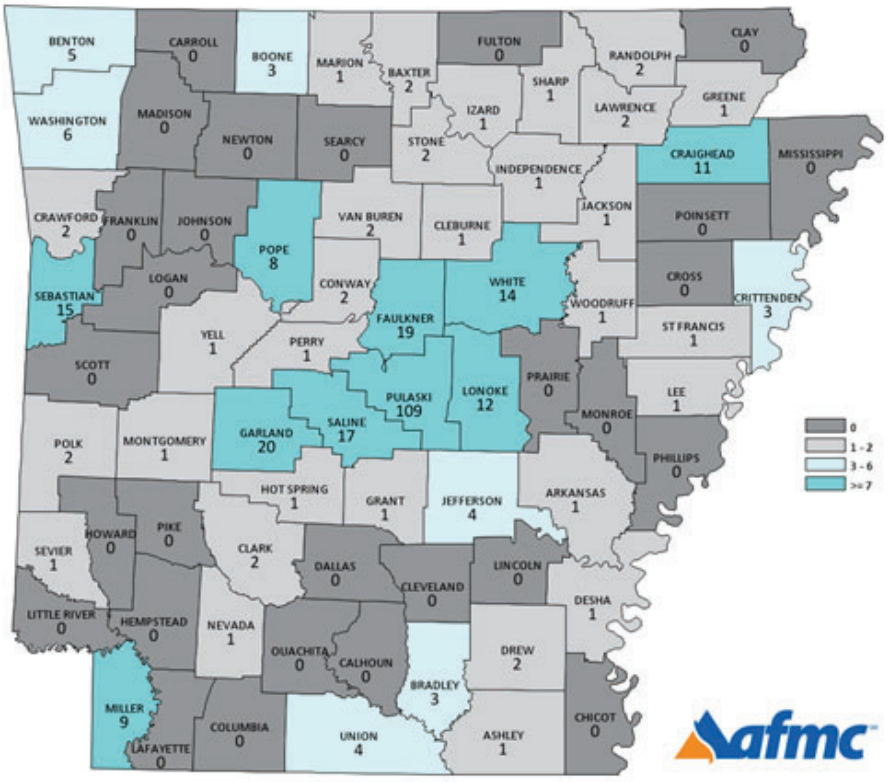


Figure 21

Other programs mentioned: *Inpatient treatment, random drug screens, church, resource guide, intensive outpatient, grants*

Question 2. What resources (i.e., services, programs) do not exist within the justice system that would have helped you to recover from a substance use disorder?

Answers fell into the following themes: *Essentials, Programs, and Life Skills.*
Essentials: A place for mom and baby, housing, transportation, immediate shelter (2), medication, food

Programs: *More Peer Support Recovery Specialists (12), Counseling/Therapists (5), More funding (4)*

Life Skills: *reentry style classes, dealing with anxiety, self-esteem workshops, guest speakers with lived experience, mental health services, employment readiness, transition advice, substance use class, learning a trade, treatment for whole family, aftercare*

Appendix B

Priorities for Change and Recommendations by the COAP Workgroup

On January 21, 2020, the COAP Workgroup participated in a prioritization exercise. At a previous meeting, the group was presented titled, "A Needs Assessment of the Opioid Addiction Issue in Arkansas." The purpose of the exercise was to consider all data sources and determine the next steps for strategic planning. On the day of prioritization, the COAP Workgroup and Facilitator reviewed the data presented at the last meeting.

To initiate discussion, two questions were posed to the group:

1) Is there anything new (data) in your work that could update what we know?
2) What most captivates you about the data from the presentation or your own knowledge that you might share with someone who was not aware of the opioid issue in Arkansas?

Next, a list of criteria was provided that should be used to consider whether a problem (or data) should be prioritized.[26] These criteria are:

a) What is the cost and/or return on investment if the problem were prioritized?
b) Are there any solutions available to combat and intervene with the problem?
c) What is the impact or size of the problem on individuals, society?
d) Are there available resources, such as time, money, equipment to solve the problem?
e) Is there an urgency among stakeholders to solve the problem?
f) Is the problem possible to change?

The COAP Workgroup was then asked to brainstorm a list of problems that could be prioritized and put forth for strategic planning in the next phase. The group was encouraged to brainstorm problems that might be considered for prioritization for the COAP Strategic Plan. The group generated the following list:

1) Linking treatment data to admissions, arrest, and death at the patient level
2) Individuals/Organizations lack knowledge about community resources
3) Lack of professional communication
4) Lack of general awareness about the opioid crisis
5) Stigma
6) Lack of understanding about the socio-demographics of those who are addicted to opioids
7) Mental Health
8) The cycle of drug abuse and child abuse

[26] National Association of County and City Health Officials. (n.d.). Guide to prioritization techniques [online guide]. Retrieved from https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

9) Lack of a call to action for the community instead of just more awareness and understanding the stage of readiness for the call to action and make a change
10) Disposal practices of opioids
11) Lack of faith-based services
12) Sustainability of Naloxone services with first responders
13) Lack of housing for treatment and recovery
14) Lack of knowledge about where treatment options
15) Lack of communication/understanding roles for the patient
16) Mandating accountability of the treatment centers related to the quality of services (e.g., money oriented, waiting lists)
17) Lack of trust in Evidence-based practices
18) Lack of DEA waiver certification in treatment/prescribers
19) Use of jails as treatment facilities
20) Availability of effective treatment and recovery
21) No Peer Recovery Services in 28 counties in the state
22) Lack of understanding of professional's roles for effective recovery
23) Only 4 crisis stabilization units
24) Lack of referrals to crisis stabilization units
25) Crisis stabilization units act only for mental health services
26) The inability for others (than law enforcement) to bring to crisis stabilization units
27) Individuals' fear of seeking treatment and losing profession/career
28) No support/services for the family of those who are addicted
29) No follow-up after overdose investigation
30) Gaps in providing resources (e.g., no follow up) after emergency medical services, hospital stays
31) Over-prescribing opioid prescriptions
32) Physicians' attitudes toward Prescription Drug Monitoring Program
33) Over-prescribing opioids per person

After brainstorming came to an end, the group was provided an index card on which to vote for their top 5 problems. The voting method used was the MoSCoW Technique.[27] The members were asked to rank first a problem that must be prioritized. Additionally, they were asked to rank second the problem that should be done, third, a problem that could be done and is preferred but not necessary right now. The COAP Workgroup was asked to consider fourth and fifth place for those that might be considered for future execution (Table 4).

[27] S Korolev (2019 March 6). MoSCoW method: How to make the best of prioritization [online blog]. Retrieved from https://railsware.com/blog/moscow-prioritization/

Table 4. MoSCoW Description for Prioritization		
MoSCoW Component	**Description**	**Place**
MUST	Mandatory that we do this	1st
SHOULD	Of high priority	2nd
COULD	Preferred but not necessary right now	3rd
WOULD	Can be considered for future execution	4th and 5th

The results of the voting with prioritization are shown in Table 5. The vote tally by item is provided in Table 6.

Table 5. Prioritized Problems of the COAP Workgroup			
Prioritized	**Number in List**	**Problem**	**Number of Votes**
1	5	Stigma	12
2	28	No support/services for the family of those who are addicted.	6
3	1	Linking treatment data to admissions, arrest, and death at the patient level.	5
4	31	Overprescribing opioid prescriptions.	4
5 (tied)	7	Mental Health	3
	9	Lack of a call to action for the community instead of just more awareness and understanding the stage of readiness for the call to action and make a change.	3
	16	Mandating accountability of the treatment centers related to the quality of services (e.g., $ oriented, waiting lists).	3

Table 6. Complete List of Voting by Problem

Problem	Number of Votes
1. Linking treatment data to admissions, arrest, and death at the patient level	5
2. Individuals/Organizations lack knowledge about community resources	2
3. Lack of professional communication	1
4. Lack of general awareness about the opioid crisis	0
5. Stigma	12
6. Lack of understanding about the socio-demographics of those who are addicted to opioids	1
7. Mental Health	3
8. The cycle of drug abuse and child abuse	2
9. Lack of a call to action for the community instead of just more awareness and understanding of the stage of readiness for the call to action and make a change	3
10. Disposal practices of opioids	1
11. Lack of faith-based services	0
12. Sustainability of Naloxone services with first responders	0
13. Lack of housing for treatment and recovery	1
14. Lack of knowledge about where treatment options	2
15. Lack of communication/understanding roles for the patient	0
16. Mandating accountability of the treatment centers related to the quality of services (e.g., $ oriented, waiting lists)	3
17. Lack of trust in Evidence-based practices	1
18. Lack of DEA waiver Certification in Treatment/Prescribers	1
19. Use of jails as treatment facilities	2
20. Availability of effective treatment and recovery	2
21. No Peer Recovery Services in 28 counties in the state	2
22. Lack of understanding of professional's roles for effective recovery	2
23. Only 4 crisis stabilization units	1
24. Lack of referrals to crisis stabilization units	0
25. Crisis stabilization units act only for mental health services	0
26. The inability for others (than law enforcement) to bring to crisis stabilization units	0
27. Individuals fear of seeking treatment and losing profession/career	1
28. No support/services for the family of those who are addicted	6
29. No follow-up after overdose investigation	0
30. Gaps in providing resources (e.g., no follow up) after Emergency Medical Services, hospital	1
31. Over-prescribing opioid prescriptions	4
32. Physicians' attitudes toward PDMP	0
33. Over-prescribing opioids per person	0

Appendix C

Definition of Seven Strategies for Effective Community Change

1) Providing Information – Educational presentations, workshops or seminars or other presentations of data (e.g., public announcements, brochures, dissemination, billboards, community meetings, forums, web-based communication).

2) Enhancing Skills – Workshops, seminars or other activities designed to increase the skills of participants, members and staff needed to achieve population level outcomes (e.g., training, technical assistance, distance learning, strategic planning retreats, curricula development).

3) Providing Support – Creating opportunities to support people to participate in activities that reduce risk or enhance protection (e.g., providing alternative activities, mentoring, referrals, support groups or clubs).

4) Enhancing Access/Reducing Barriers- Improving systems and processes to increase the ease, ability and opportunity to utilize those systems and services (e.g., assuring healthcare, childcare, transportation, housing, justice, education, safety, special needs, cultural and language sensitivity).

5) Changing Consequences (Incentives/Disincentives) – Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for desirable behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges).

6) Physical Design – Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density).

7) Modifying/Changing Policies – Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).[28]

[28] 7 Strategies to Effective Community Change. (n.d.). Retrieved from http://www.preventmedabuse.org/about-the-tool-kit/7-strategies-to-effective-community-change/#.XpUeRchKiUk

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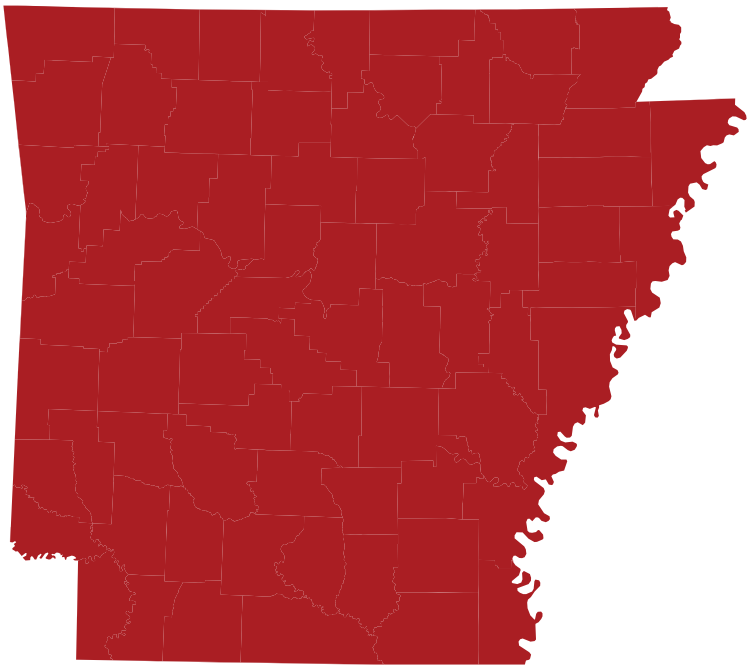

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