UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

C.A. No. 18-cv-11972-DJC

GEOFFREY PESCE,

Plaintiff,

v.

KEVIN F. COPPINGER, in his official capacity as Essex County Sheriff, AARON EASTMAN, in his official capacity as Superintendent of the Essex County House of Corrections - Middleton,

Defendants

DEFENDANTS KEVIN F. COPPINGER AND AARON EASTMAN'S MEMORANDUM OF LAW IN SUPPORT OF THEIR OPPOSITION TO PLAINTIFF'S MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I. STATEMENT OF THE CASE

Plaintiff has filed a two-count Complaint seeking both a Temporary Restraining Order and Preliminary and Permanent Injunctive Relief. Specifically, Plaintiff asks this Court to order the Defendants to provide Methadone to him upon his *possible future* admission to the Essex County Sheriff's Department ("ECSD"), alleging that the failure to provide same is both a violation of the Eighth Amendment to the U.S. Constitution pursuant to 42 USC Section 1983 (Count I) as well as a violation of the Americans with Disabilities Act ("ADA") (Count II).

Both because Plaintiff's request is not ripe for judicial consideration, and because he fails to establish the necessary conditions precedent for the issuance of the extraordinary relief requested, the motion must be denied.

II. STATEMENT OF THE FACTS

The Plaintiff suffers from opiate addiction—more specifically, "opiate use disorder"—(*Complaint, paragraph 51*) which he alleges can only be controlled medically by the use of an opiate replacement drug, Methadone, through what is referred to as "medicated assisted therapy" ("MAT"). (*Id*., paragraphs 3-4). Plaintiff has been on a Methadone treatment program since 2016 (*Id*.).

Plaintiff expects to serve a term of imprisonment of 60 days in ECSD beginning on December 3, 2018 or January 14, 2019 [1] (*Joint Statement Regarding Briefing and Hearing Schedule, p.2*) during which he will not have access to Methadone pursuant to his treatment program. Nonetheless, Plaintiff wants the Defendants to continue his Methadone treatment either at ECSD or transport him to a facility that can continue his Methadone treatment because right now ECSD "categorically and arbitrarily denies all male prisoners access to MAT for the treatment of opiate use disorder…and has no plans to alter this policy in the foreseeable future." (*Complaint, paragraph 43*).

III. STANDARD OF REVIEW

For injunctive relief to issue, a plaintiff must prove:

(1) that [he] has a substantial likelihood of success on the merits; (2) that [he] faces a significant potential for irreparable harm in the absence of immediate relief; (3) that the ebb and flow of possible hardships are in favorable juxtaposition (i.e., that the issuance of an injunction will

[1] The Plaintiff is a Defendant in Ipswich District Court where he is charged with driving with a suspended license, and which is scheduled for trial on January 14, 2019. However, Plaintiff is also a Defendant in Lynn District Court where he received probation on a charge of operating under the influence. Plaintiff anticipates he will be found guilty of a probation violation in the latter criminal case at his next court appearance in that matter, scheduled for December 3, 2018, and thereafter will be immediately incarcerated at ECSD. *See the parties Joint Statement Regarding Briefing and Hearing Schedule, p.2.*

not impose more of a burden on the non-movant than its absence will impose on the movant, (known as the balance of equities between the parties); and (4) that the granting of prompt injunctive relief will promote (or, at least, not denigrate) the public interest. *McGuire v. Reilly*, 260 F.3d 36, 42 (1st Cir. 2001).

IV. ARGUMENT

PLAINTIFF'S MOTION SHOULD BE DENIED BECAUSE HIS CLAIM IS NOT RIPE FOR ADJUDICATION AND HE HAS NOT ESTABLISHED THE NECESSARY CONDITIONS FOR INJUNCTIVE RELIEF

A. PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION IS NOT RIPE FOR DETERMINATION AT THIS TIME.

"Determining ripeness involves a dual inquiry: evaluation of both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration. Both prongs of the test must be satisfied, although a strong showing on one may compensate for a weak one on the other." *McInnis-Misenor v. Me. Med. Ctr.*, 319 F.3d 63, 70 (1st Cir. 2003). "[T]he critical question concerning fitness for review is whether the claim involves uncertain and contingent events that may not occur as anticipated or may not occur at all." *Ernst & Young v. Depositors Econ. Prot. Corp.*, 45 F.3d 530, 536 (1st Cir. 1995). "The hardship prong evaluates the extent to which withholding judgment will impose hardship -- an inquiry that typically turns upon whether the challenged action creates a direct and immediate dilemma for the parties. . . .This inquiry encompasses the question of whether plaintiff is suffering any present injury from a future contemplated event." *McInnis-Misenor, 319 F.3d 63 at 70* (citations and quotations omitted). "[P]remature review not only can involve judges in deciding issues in a context not sufficiently concrete to allow for focus and intelligent analysis, but it also can involve them in deciding issues

unnecessarily, wasting time and effort." *W.R. Grace & Co. v. United States EPA*, 959 F.2d 360, 366 (1st Cir. 1992).

In this case, Plaintiff's request for injunctive relief is based on uncertain future events that may or may not occur. There is uncertainty about what sentence the Plaintiff will receive at both his probation revocation hearing at Lynn District Court on December 3, 2018 and his criminal matter at Ipswich District Court on January 14, 2019. A continuance of that hearing or an outcome different than incarceration are possibilities. Given the uncertainty of what will occur on December 3, 2018 and January 14, 2019, this action is premature and should be dismissed.

B. PLAINTIFF CANNOT PROVE AN EIGHTH AMENDMENT NOR ADA VIOLATION OR THAT HE WILL SUFFER IRREPARABLE HARM

1. The Plaintiff has not demonstrated that he is likely to succeed on the merits of an Eighth Amendment or ADA Claim.

A denial of medical care claim requires evidence of deliberate indifference to a serious medical need of the inmate. See *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). "To succeed on an Eighth Amendment claim based on inadequate or delayed medical care, a plaintiff must satisfy both a subjective and objective inquiry: he must show first, 'that prison officials possessed a sufficiently culpable state of mind, namely one of 'deliberate indifference' to an inmate's health or safety,' and second, that the deprivation alleged was 'objectively, sufficiently serious.'" *Leavitt v. Corr. Med. Servs.*, 645 F.3d 484, 497 (1st Cir. 2011) (citing *Burrell v. Hampshire Cty.*, 307 F.3d 1, 8 (1st Cir. 2002)). "The standard encompasses a narrow band of conduct: subpar care amounting to negligence or even malpractice does not give rise to a constitutional claim, rather, the treatment provided must have been so inadequate as to constitute an unnecessary and wanton

infliction of pain or to be repugnant to the conscience of mankind." *Leavitt*, 645 F.3d at 497 (citations and quotations omitted). Jails are "by no means required to tailor a perfect plan for every inmate; while it is constitutionally obligated to provide medical services to inmates, these services need only be on a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards." *United States v. Derbes*, 369 F.3d 579, 583 (1st Cir. 2004) (citations and quotations omitted).

ECSD has determined the best course of treatment for heroin or other opioid addiction is to provide inmates with non-opioid treatment and programmatic services to address drug abuse so that when they return to the community they are drug-free, and will not re-offend, thus reducing recidivism. Detoxification, treatment, education and inmate accountability are its core themes. (*Affidavit of Jason Faro, para. 2*). Part of the treatment is MAT—but it is with the non-opioid drug Vivitrol because under federal law, Methadone is a Schedule II opiate that produces many of the same effects as heroin and thus users risk becoming tolerant of and physically dependent on the drug.[2] Deaths from opioids have increased more than 300% in the last 20 years.[3] Methadone in particular is responsible for nearly one in four opioid-related deaths.[4] In essence, continuing a user's addiction by simply switching to another dangerous drug does not get the user closer to being drug-free.

Moreover, opioids are addictive and misuse can cause addiction, overdose or death. Common Methadone side effects include dizziness, drowsiness, nausea, vomiting, and increased

[2] U.S. Department of Justice and Drug Enforcement Agency, *Drugs of Abuse, A DEA Resource Guide, 2017 Edition*, https://www.dea.gov/sites/default/files/sites/getsmartaboutdrugs.com/files/publications/DoA_2017Ed_Updated_6.16.17.pdf#page=44.
[3] Faul M., Bohm M., Alexander C., Methadone Prescribing and Overdose and the Association with Medicaid Preferred Drug List Policies — United States, 2007–2014. Centers for Disease Control and Prevention.
[4] Id.

sweating.[5] Fatal side effects can occur if used in combination with alcohol or other sedatives/central nervous system depressants. Methadone has also been known to cause a life-threatening heart rhythm disorder. Methadone has also been known to cause serotonin syndrome; symptoms include agitation, hallucinations, fever, sweating, shivering, fast heart rate, muscle stiffness, twitching, loss of coordination, nausea, vomiting, constipation or diarrhea. *Id.*

As such, the *Federal Bureau of Prisons Clinical Practice Guidelines for Detoxification of Chemically Dependent Inmates* does not make any recommendations with respect to Methadone maintenance treatment.[6] It states that "medical detoxification is considered the standard of care for individuals with opiate dependence."[7] Further, the *CDC Guideline for Prescribing Opioids for Chronic Pain* recommends that Methadone should not be the first choice for an extended-release/long acting opioid.[8] As such, and consistent with widely-accepted medical standards, *there is no correctional facility in Massachusetts providing Methadone to male inmates.*

Recent research data supports the fact that a MAT program that uses Vivitrol rather than an opioid like Methadone is effective. Results of a 2017 clinical trial published in the *Journal of American Medical Association* show a finding that an extended release of Vivitrol was as effective as opioids in maintaining short-term abstinence from heroin and other illicit substances, and should be considered as a treatment option for opioid-dependent individuals.[9]

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[5] https://www.webmd.com/mental-health/addiction/what-is-Methadone#1
[6] Fed. Bureau of Prisons, Clinical Practice Guidelines: Detoxification of Chemically Dependent Inmates 14-16 (Aug. 2009).
[7] 30 Id. at 14.
[8] Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1). https://doi.org/10.15585/mmwr.rr6501e1.
[9] See Exhibit A, *Journal of American Medical Association* "Effectiveness of Injectable Extended-Release Naltrexone vs Daily Buprenorphine-Naloxone for Opioid Dependence: A Randomized Clinical Noninferiority Trial"

Similarly, a 2017 clinical trial in the *Journal of Substance Abuse Treatment* concluded that taking Vivitrol prior to leaving jail for opioid use disorder increases the treatment retention rate as compared to commencing after release.[10] An article in the same publication in 2015 showed that the use of Vivitrol for both alcohol and opioid problems in Missouri prisoners showed that those receiving Vivitrol had longer duration of care and were more likely to become abstinent compared to opioid based substances.[11]

Moreover, an article in the *New England Journal of Medicine* in 2016 indicated that a trial study of extended release Vivitrol is effective for the prevention of relapse to opioid dependents. [12] A 2015 article in the *Journal of Acquired Immune Deficiency Syndromes* indicated the effectiveness of Vivitrol in maintaining viral suppression among incarcerated individuals living with HIV with opioid use disorder who are transitioning to the community.[13] A 2016 study concluded that in preventing opioid relapse, both Vivitrol and Buprenorphine were equally safe and effective. [14]

In addition, there are safety and security reasons for banning opioids at the Middleton

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[10] Exhibit B, *Journal of Substance Abuse Treatment* "Extended-release naltrexone for opioid use disorder started during or following incarceration ."

[11] Exhibit C, *Journal of Substance Abuse Treatment* "Extended-Release Naltrexone for Alcohol and Opioid Problems in Missouri Parolees and Probationers."

[12] Exhibit D, *New England Journal of Medicine* "Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders"

[13] Exhibit E, *Journal of Acquired Immune Deficiency Syndromes* "Extended-Release Naltrexone Improves Viral Suppression among Incarcerated Persons Living with HIV with Opioid Use Disorders Transitioning to the Community: Results of a Double-Blind, Placebo-Controlled Randomized Trial"

[14] Exhibit F, "Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention: a multicentre, open-label, randomized controlled trial ."

facility. The Plaintiff would not be provided Methadone as opioids are specifically prohibited from the ECSD because they are widely known to be coveted within populations of incarcerated individuals for their intoxicating effects. As outlined in the *Affidavit of Superintendent Aaron Eastman*, ECSD, like many jails and prisons nationwide, has experienced serious problems due to the presence of opioids. Opioids are so desired in the inmate population that inmates have been known to attempt to smuggle them in their dentures, to obtain them through contact visits, and even to have them diluted and mailed to them in the form of pictures and letters, or as part of the adhesive that seals envelopes. In addition, inmates are well-known to hoard medication that they are prescribed and administered within the jail through "cheeking" and other means. Inmates like the Plaintiff who are prescribed drugs for legitimate reasons have been known to willingly hide it and provide it to other prisoners. *Eastman Affidavit, paras. 14, 15.* And Plaintiff's desired alternative to treatment in the jail, i.e., transportation to a drug clinic, poses an increased risk of escape and/or third-party intervention. *Id., paras. 17, 18.* The *Eastman Affidavit* is intended simply for the purpose of demonstrating safety and security problems associated with the presence of opioids in incarcerated populations, and the lengths to which inmates will go to obtain them.

Even inmates describe controlled opioid treatment in jail as being both dangerous and ineffective. As recently as August of 2018, inmates in Barnstable County warned about the dangers of opioid treatment in jail (in this case, suboxone), calling it a "horrible idea to introduce into the facility" and one that led to "chaos—fights, gambling, people calling home to their families to try to get money so they could give it to another inmate to get suboxone…" *Exhibit G*; *see video at* *https://www.youtube.com/watch?v=UfORP9w47XA*).

At ECSD, inmates are first assessed by a medical professional upon admission to the facility. *Affidavit of Deanna Kiser, R.N.* Inmates who are addicted to opiates are provided with Motrin for pain, Bentyl for stomach cramps, Imodium for diarrhea, Zofran for nausea, Maalox for indigestion. *Id. at paras. 6.* All necessary accommodations to make their withdrawal as safe and comfortable as possible are implemented. *Id. at para. 7.* From their admission into the facility until withdrawal is complete, inmates are carefully monitored by medical staff. *Id.* Mental health clinicians, educators and program staff are also available to assist inmates in cleansing themselves from drug addiction and providing them with counseling, education and programming to assist in that process. *Faro, Kiser Affidavits.* Vivitrol is prescribed at the end of the addiction treatment program, after the inmate has completed withdrawal, received treatment, education and counseling, and been provided with continued post-incarceration rehabilitative and educational services to remain opioid-free. *Kiser Affidavit, para. 10.* Initial detoxification is important for a medically assisted treatment program employing Vivitrol. Vivitrol has been effective in allowing patients to transition back to community care for continued treatment of their opioid use disorder, while avoiding risk of diversion of medication within the correctional setting. *Affidavit of Donald Kern, MD, MPH, CCHP, para. 8.*

With the exception of withdrawal symptoms which can and will be medicinally managed during periods of incarceration, the only potential deleterious effect of discontinuing medically-assisted treatment is relapse. Because ECSD does not permit opiates in its facility, the only risk of relapse would be from illicitly obtaining those drugs while incarcerated. Once released, Plaintiff will be free to return to return to Methadone if he so chooses. Of course, ECSD's hope—indeed, its addiction treatment purpose—is to prepare the Plaintiff for an opioid-free future by

having him follow the recommended treatment of programming and rehabilitative services.

Tellingly, Plaintiff's argument for Methadone-based MAT does not critique ECSD's non-opioid MAT as being "so inadequate as to constitute an unnecessary and wanton infliction of pain or to be repugnant to the conscience of mankind" *Leavitt*, 645 F.3d at 497, but rather 1) promotes Methadone as the only appropriate standard of care for opioid addiction while ignoring all therapeutic and programmatic treatment and 2) suggests that the sudden cessation of Methadone will result in harm due to withdrawal. Ergo, says the Plaintiff, ECSD's non-Methadone treatment program violates both the *Eighth Amendment* and the *ADA.*

There is a reason for Plaintiff's lack of criticism of ECSD's addiction treatment program—it is highly successful. ECSD's addiction treatment program provides inmates individual medical, psychological, emotional, and spiritual care with the opportunity to safely withdraw from opiates and have an opportunity to start living a sober life –without being dependent on addictive medications such as Methadone. It is based on The Accountability Training Program Model, a modified therapeutic community approach first implemented at ECSD by Dr. Stephen K. Valle, Sc.D., MBA, a licensed psychologist and nationally recognized expert in the field of addiction treatment. *Affidavit of Stephen Valle.* It has proved so successful that it served as the foundation for ECSD's state-of-the-art Detoxification Unit for individuals seeking sentencing diversion. *Exhibit H.*

ECSD's non-opioid MAT program has been so successful that it was recently awarded a three-year $1.5M grant from the Department of Health and Human Services Substance Abuse and Mental Health Services Administration to continue with its Vivitrol MAT in the fight against opioid addiction. *Affidavit of William Gerke, Jr., para. 2; see also Exhibit I.* The grant is a

collaborative initiative undertaken by and between ECSD and Volunteers of America Massachusetts to address the growing need to expand and enhance medication assisted treatment and other recovery supports for incarcerated individuals with an opioid use disorder. *Gerke Affidavit, para. 3.* The hope is that by the third year, 250 new inmates will have been treated, with the main goals of the program to increase the number of inmates with opioid use disorder receiving Vivitrol and other psychological supports and integrated care services in Essex County, as well as decrease illicit opioid use and prescription opioid misuse. *Exhibit I.*

For these reasons alone—namely, that the ECSD program is both safe, successful, and medically recognized as a proper addiction treatment program—Plaintiff's *Eighth Amendment* and *ADA* claims must fail. Per below, however, there are two other reasons why Plaintiff's claims cannot succeed.

First, notwithstanding Plaintiff's hubristic claim that Methadone-based MAT is "the standard of care for opioid use disorder" (Complaint, para. 9), "*there is no constitutional right to Methadone*, and a [correctional facility] is under no obligation to provide it. …'medical detoxification,' . . . does not require the establishment of Methadone maintenance facilities at corrective institutions." *United States ex rel. Walker v. Fayette Cnty., 599 F.2d 573, 575 (3d Cir. 1979)* (citing *Norris v. Frame, 585 F.2d 1183, 1188 (3d Cir. 1978) (emphasis added).* In a similar case involving discontinuance of an inmate's Methadone treatment while in prison, the court in *Gaston v. Patel*, 2013 U.S. Dist. LEXIS 163966, noted:

> Plaintiff has no federal right to his desired treatment, drugs and drug dosages. ..Defendants managed Plaintiff's pain with prescription medications during Methadone detoxification. Plaintiff was not subjected to a "cold turkey" detoxification. Nothing

> suggests Defendants' protocol for Methadone detoxification
> was medically unacceptable and contrary to … purposes and policies. *Gastel at p. 9.*

Courts have consistently denied liability to sheriffs and correctional officers who fail to provide Methadone to inmates suffering from withdrawals. In *Cooley v. Prator, 290 Fed.Appx. 749, 753 (5th Cir. 2008),* an inmate who was addicted to prescription pain medication brought an *Eighth Amendment* claim against a county sheriff for failing to administer Methadone to treat her withdrawal symptoms. The court held that an individual who does not receive narcotic pain medication may foreseeably experience discomfort while incarcerated, but a sheriff failing to provide for these needs does not rise to indifference or even negligence. *Id.* Similarly, in *Davis v. Carter, 452 F.3d 686, 697 (7th Cir. 2006),* the court held that a county jail officer was not deliberately indifferent to an inmate's Methadone withdrawal symptoms, even though the officer knew the inmate needed Methadone treatment. *See also Love v. Thompson 2016 U.S. Dist. LEXIS 163343* (Plaintiff's claim that Defendants failure to provide him with a Methadone treatment does not constitute an *Eighth Amendment* violation and this claim is dismissed with prejudice).

Moreover, the fact that there is a disagreement between Plaintiff and Defendants' treatment decisions are not alone a basis for a medical indifference claim. "A difference of opinion between a prisoner-patient and prison medical authorities, and between medical professionals, regarding treatment does not give rise to a*[§] 1983* claim," *Franklin v. Oregon, 662 F.2d 1337, 1344 (9th Cir.1981; Sanchez v. Vild, 891 F.2d 240, 242 (9th Cir. 1989)* (summary judgment for defendants was properly granted because plaintiff's evidence that a doctor told him surgery was necessary to treat his recurring abscesses showed only a difference of opinion as to proper course of care where

prison medical staff treated his recurring abscesses with medicines and hot packs). Courts must exercise extreme caution when there is a dispute over the type of treatment. "[W]here a prisoner has received some medical attention and the dispute is over the adequacy of the treatment, federal courts are generally reluctant to second guess medical judgments and to constitutionalize claims that sound in state tort law." *Graham ex rel. Estate of Graham v. Cnty. of Washtenaw, 358 F.3d 377, 385 (6th Cir. 2004)* (quoting *Westlake v. Lucas, 537 F.2d 857, 860 n.5 (6th Cir. 1976)).*"

A similar fatal result awaits Plaintiff's ADA claim. To state a claim for a violation of Title II, a plaintiff must allege: (1) that he is a qualified individual with a disability; (2) that he was either excluded from participation in or denied the benefits of some public entity's services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits or discrimination was by reason of his disability. *Toledo v. Sanchez,* 454 F.3d 24, 31 (1st Cir. 2006). A disagreement with a reasoned medical judgment is not sufficient to state a disability discrimination claim. *Kiman v. N.H. Dep't of Corr.*, 451 F.3d 274, 285 (1st Cir. 2006). In this case, the Plaintiff is not arguing that he will be denied medical services. Instead, he is requesting that the court order that he receive specific medication. This is a disagreement with the method of treating a patient at the jail. Because the Plaintiff is not being excluded from a service or program because of his disability, he has not demonstrated that he is likely to succeed on the ADA claim.

Put simply, the issue before this Court involves a difference of opinion about how to treat Plaintiff's medical condition. ECSD has made the determination—albeit a different one from the Plaintiff—that its addiction treatment program is both safe, secure and successful, and that opioid replacement medications are not prescribed at the jail because of safety and security

concerns, and because their use runs contrary to the treatment and programming of ECSD's non-opioid MAT program. "[W]hen a plaintiff's allegations simply reflect a disagreement on the appropriate course of treatment, such a dispute with an exercise of professional judgment may present a colorable claim of negligence, but it falls short of alleging a constitutional violation. The care provided must have been so inadequate as to shock the conscience. *Feeney v. Corr. Med. Servs.*, 464 F.3d 158, 162 (1st Cir. 2006) (citations and quotations omitted).

2. Plaintiff will not suffer irreparable injury in the absence of injunctive relief.

"[T]he burden of demonstrating that a denial of interim injunctive relief would cause irreparable harm [is placed] squarely upon the movant." *Ross-Simons of Warwick, Inc. v. Baccarat, Inc.*, 102 F.3d 12, 18 (1st Cir. 1996). This is a substantial burden. *Id*. Plaintiff's irreparable harm claim is based on the immediate effects of withdrawal. As explained below , Plaintiff's "harm" is at best temporary and thus does not rise to the level of an irreparable injury.

This is not a case, as Plaintiff argues, of "immediate and arbitrary withdrawal" of any and all treatment, of Plaintiff going "cold turkey." Rather, Plaintiff will receive around-the-clock treatment from a staff of nurses and physicians. *Kiser Affidavit*. Plaintiff has provided no evidence whatsoever suggesting Defendants' protocol for Methadone detoxification is medically unacceptable and/or contrary to ECSD purposes and policies, merely his subjective belief that Methadone MAT is best for him and that he may suffer withdrawal symptoms.

The fact that Plaintiff may suffer opioid withdrawal symptoms also does not rise to an *Eighth Amendment* violation. See *Ramos v. Patnaude*, 640 F.3d. 485 (1st Cir. 2011) (holding that doctor who treated an inmate's heroin withdrawal with a pharmaceutical protocol which lasted a total of nine days was not deliberately indifferent); *United States v. Walker, 2013 CCA LEXIS 262*

United States Air Force Court of Criminal Appeals March 22, 2013, Decided ACM 37886 ("Although the process of detoxifying from Methadone was undoubtedly uncomfortable and painful, there is no evidence in the record that this process was conducted in a medically inappropriate manner or that the medical professionals' judgments were unreasonable."); *French v. Daviess County, Ky., 376 Fed.Appx. 519, 522 (6th Cir. 2010)* (no deliberate indifference in weaning prisoner off prescription narcotic using a weaker drug so as to minimize withdrawal symptoms). *Baker v. Stevenson,* 605 Fed. Appx. 514, 519-520 (6th Cir. 2015) ("The facts on hand indicate that the medical staff sought to gradually wean [Plaintiff] off Methadone rather than forcing him to go "cold turkey." *Cf. French, 376 F. App'x at 522* (contrasting a gradual detoxification protocol with an abrupt removal of an addictive drug so as to minimize withdrawal symptoms).

Plaintiff has not demonstrated that he will suffer irreparable harm if he is not granted injunctive relief, and thus has not met the burden of proving he is entitled to injunctive relief.

C. DEFERENCE MUST BE GIVEN TO THE DEFENDANTS' DISCRETION TO SET JAIL MEDICAL POLICY

1. The balance of equities favors Defendants and the public interest will not be adversely affected if injunctive relief is denied.

The court "must accord substantial deference to the professional judgment of prison administrators, who bear a significant responsibility for defining the legitimate goals of a corrections system and for determining the most appropriate means to accomplish them. . . . The burden, moreover, is not on the State to prove the validity of prison regulations but on the prisoner to disprove it." *Overton v. Bazzetta,* 539 U.S. 126, 132 (2003). This is in keeping with the proposition that "judicial restraint is especially called for in dealing with the complex and intractable

problems of prison administration." *Rogers v. Scurr,* 676 F.2d 1211, 1214 (8th Cir. 1982). In the matter of operating jails, the Court gives broad deference to correctional officers, who require "*substantial discretion* to devise reasonable solutions to the problems they face," including the detection and deterrence of contraband and weapons in their facilities. *Florence v. Board of Chosen Freeholders of Burlington*, 132 S.Ct. 1510, 1515; 182 L.Ed.2d 566, 574 (2012) (emphasis added). Maintaining security and preserving discipline are essential objectives that may require the limitation of constitutional rights of detainees, and determining whether a policy is reasonably related to a legitimate security interest is "peculiarly within the province and professional expertise of corrections officials." (132 S.Ct. 1517, 182 L.Ed.2d 576, quoting *Bell v. Wolfish* (1979) 441 U.S. 520, 99 S.Ct. 1861, 60 L.Ed.2d 447). Unless substantial evidence in the record indicates that officials have exaggerated their response to these challenges, "courts should ordinarily defer to their expert judgment in such matters." (132 S. Ct. 1517, 182 L.Ed.2d 576, quoting *Block v. Rutherford* (1984) 468 U.S. 576, 104 S. Ct. 3227, 82 L.Ed.2d 38 and *Bell*).

In Massachusetts, the Legislature has conferred on the sheriff broad authority over a house of correction. General Laws c. 126, § 16, states that "[t]he sheriff shall have custody and control of the jails in his county, and, …, of the houses of correction therein, and of all prisoners committed thereto . . . and shall be responsible for them." As the court noted in *Commonwealth v. Donahue,* 452 Mass. 256, 265 (2008), the

> "Legislature has mandated that administrators of county correctional facilities establish and maintain education, training, and employment programs for persons committed to these facilities. See G. L. c. 127, § 48. "Such programs shall include opportunities for academic education, vocational education, vocational training, other related prevocational programs and employment, and may be made available within correctional facilities…

In this case, the Plaintiff seeks the court to issue an order requiring the Defendant to provide the Plaintiff with a specific medication. Doing so would require the Court to override decisions of correctional authorities responsible for the safety, security, and efficient operation of the jail, which would adversely affect the public interest.

ECSD's decision not to provide opioid replacement medication is entitled to deference. "When evaluating medical care and deliberate indifference, security considerations inherent in the functioning of a penological institution must be given significant weight." *Kosilek v. Spencer*, 774 F.3d 63, 83 (1st Cir. 2014). "Prison administrators . . . should be accorded wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security." *Bell v. Wolfish*, 441 U.S. 520, 547, 99 S. Ct. 1861, 1878 (1979). "Such considerations are peculiarly within the province and professional expertise of corrections officials, and, in the absence of substantial evidence in the record to indicate that the officials have exaggerated their response to these considerations, courts should ordinarily defer to their expert judgment in such matters." *Pell v. Procunier*, 417 U.S. 817, 827 (1974). "In consequence, even a denial of care may not amount to an Eighth Amendment violation if that decision is based in legitimate concerns regarding prisoner safety and institutional security." *Kosilek*, 774 F.3d at 83.

In sum and substance, the Plaintiff's Complaint is not that he is being denied medical treatment, *but that he is being denied the medical treatment of his and his own doctor's choice*. The Plaintiff cannot demonstrate that the jail policy of employing an alternate means of opioid-addiction treatment—which includes managing the risk of withdrawal symptoms—is an exaggerated response to the security and safety concerns of the jail. Jail administrators are

entitled to wide-ranging deference in adopting and enforcing their policies. Courts may not interfere in the exercise of the expert discretion of prison officials in the absence of the required showing. Given this deferential standard, the Plaintiff has not demonstrated that he is substantially likely to prove that he has been denied adequate medical care as that standard is analyzed under the *Eighth Amendment or ADA*.

D. THE MASSACHUSETTS LEGISLATURE HAS ADDRESSED THE ISSUE OF INMATE TREATMENT OF ADDICTION THROUGH PASSAGE OF CHAPTER 208 OF THE ACTS OF 2018

In August 2018, the Massachusetts legislature enacted "*An Act for Prevention and Access to Appropriate Care and Treatment of Addiction*."[15] (*Exhibit J*; hereinafter the "Act"). The Act establishes an opioid MAT pilot program created by the Department of Public Health in five specific counties across Massachusetts; Essex County is presently not one of them.[16] Further, the legislature explicitly delegated the sheriffs of these listed counties to implement the pilot program in collaboration with the Executive Office of Public Safety and Security and the Office of Medicaid (*Id*., *at Section 98 (a)*).

A county sheriff with jurisdiction over a county correctional facility participating in the pilot program must first develop an implementation plan for the pilot program before any drug is administered.[17] Such requirements, in relevant part, are listed below:

(i) best practices for the delivery of medication-assisted treatment and behavioral health counseling for opioid use disorder

[15] *MA LEGIS 208 (2018).*
[16] *MA LEGIS 208 s. 98(a) lists Franklin, Hampden, Hampshire, Middlesex, and Norfolk counties.*
[17] *S. 98(c)*

(ii) uniform guidelines to ensure the safety and security of correctional facility personnel and people in the custody of the facility during the administration of medication-assisted treatment and behavioral health counseling
(iii) the projected cost of providing medication-assisted treatment and behavioral health counseling
(iv) health insurance coverage, including Medicaid
(v) protocols for technical medical assistance that may be required by the department of public health, including appropriate personnel and physical space to safely administer medication-assisted treatment
(vi) the availability of appropriate community services after release, including a process for directly connecting a person upon release to an appropriate provider or treatment site in the geographic region in which the person will reside upon release in order to continue treatment
(vii) appropriate metrics for evaluating and tracking pilot program outcomes; and
(viii) any other information necessary to implement the pilot program

MA LEGIS 208 (2018), 2018 Mass. Legis. Serv. Ch. 208 (H.B. 4742) (WEST).

At this juncture, there are no "best practices," nor "uniform guidelines," nor "protocols," nor "appropriate metrics" in place—much less a "projected cost of providing medication-assisted treatment and behavioral health counseling…" Granting the Plaintiff's request to receive Methadone treatment *now*, without the infrastructure required by the Act in place, places an undue burden on ECSD and jeopardized the safety and security of the entire jail facility.

Further, the Act specifies that the pilot program shall be implemented "*not later than September 1, 2019*" (*Id., at section 98 (d)*). Plaintiff, if he pleads or is found guilty, would do so at his next hearing on December 3, 2018. His likely 60-day sentence would begin shortly after. No county in Massachusetts—especially one like Essex County that is not yet participating in the pilot program—is required under the Act to implement before September of next year. Plaintiff would be released long before the required implementation date, and so he should not be entitled to advanced Methadone treatment for a program that has not already begun.

V. CONCLUSION

For all of the foregoing reasons, Plaintiff's Motion for a Temporary Restraining Order and Preliminary and Permanent Injunction Relief should be denied.

Respectfully submitted
DEFENDANTS,
By their attorney,

/s/ Stephen C. Pfaff

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Date: October 19, 2018

CERTIFICATE OF SERVICE

I certify that on this day I caused a true copy of the above document to be served upon the attorney of record for all parties via CM/ECF

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Date: October 19, 2018 Stephen C. Pfaff

Essex County Sheriff Department's Detoxification Unit Guide

Kevin F. Coppinger, Sheriff

Essex County Sheriff's Department

Essex County Correctional Facility
Detox Unit

Essex County Sheriff's
Department

Referral Process

- ☆All referrals are generated through the courts
  - Judges
  - Probation
  - Defense Attorneys
  - District Attorney
  - Police
- ☆An ECSD staff member will be available to discuss potential referrals.

Reasons for Detox Unit

- Growth in pre-trial population and a lack of community detoxification beds are causing severe overcrowding in jails.
- Upon completion of the 28-day treatment, individuals may be able to dispose of their cases by utilizing other pre-trial tools as an alternative to incarceration.

Who is Eligible?

- ☆ Violation of Probation cases (i.e. dirty screens for opiates, other drugs and/or alcohol)
- ☆ Anyone presenting clear signs of addiction
- ☆ Probationers, who seem interested and/or invested in wanting help at no cost to them
- ☆ Crimes of violence and serious felony charges eliminate individuals from consideration.

Individualized Care

- Medical
  - After medical assessment, individuals may receive medication to assist with withdrawal symptoms.
- Psychological
- Emotional
- Spiritual
- Personal hygiene
  - Limited canteen available to purchase personal products
- Accountability
- Respect for others and the rehabilitation process

Unit Essentials

- Bedding:
  - 42 hospital style detoxification beds; conducive to rehabilitation
- Laundry
  - Services available daily
- Dietary Supplements: Aramark
  - Three meals per day
  - Juice, fruit and light snacks available on unit
- Recreation: on unit
  - Elliptical
  - Two stationary bikes

On-Unit Care

- ☆ Medical: NaphCare
  - Fully equipped medical suite
  - 24-hour medically trained personnel
- ☆ Psychological: AdCare
  - Individual counseling
  - Dual collaboration treatment plan created with Probation
  - On-staff treatment clinician
- ☆ Spiritual
  - Access to all religious services available at ECCF

Return to Court

After completion of 28 day detox:

- ☆Transportation provided by ECSD to the court
- ☆Individual treatment plan shared with Probation via email and hand-delivered to assist Judge, Assistant DA and court officials

Detoxification Unit Tracks

- Track I: Offenders that are NOT returned to incarceration at the ECSD, but are released with court-ordered conditions such as:
- Long-term treatment center admittance;
- Medically-assisted Treatment
- Level 2, 3 & 4 mandated Office of Community Corrections (OCC) day reporting
- Community Service and drug testing
- GPS Home confinement/work release and drug testing.

Detoxification Unit Tracks (cont.)

- Track II: Returned to custody.
- ECPRC
  - Mandatory drug testing
  - GPS supervision
  - Individual aftercare treatment plan until case is adjudicated.
- Pre-trial status (TRAC program)

Medically-Assisted Treatment

- Vivitrol – prescribed, injectable medication used to treat alcohol and opioid dependence
- Additional tool to supplement other forms of recovery treatment to provide better outcomes for sustained recovery
- Available to Pre-trial and Sentenced population upon release
- Requires education, counseling, medical clearance and scheduling of after-care follow-up appointment

ECSD & PAARI Recovery Coach Program

- One male and one female recovery coach assigned to ECSD Male and Female Detox Units – 10-20 hours/week
- Provide peer recovery support services to inmates to assist them in achieving sustained recovery
- Work collaboratively with ECSD Detox team and inmates to develop comprehensive treatment plan
- Address barriers to successful recovery and serve as a role model and advocate for Unit inmates

ECSD & PAARI Recovery Coach Program

- ☆ Conduct group meetings and meet one-on-one with individual inmates as assigned to encourage attendance and participation in recovery-oriented, self-help and pro-social groups
- ☆ In consultation with the ECSD Detox team, accompany inmates to court in order to provide support prior to and after court proceeding
- ☆ Benefits – links to recovery assets "beyond the walls"
  - Continuum of Community-based Recovery Care
  - Saving Lives & Families
  - Reducing Recidivism & Safer Communities

ECSD Detox Contacts

☆Middleton Facility (978)-750-1900

- Asst. Supt. Jim Petrosino ext. 3500/ c: 978-994-7718
- Program Director Jason Faro ext. 3519
- Assistant Program Director Darya Maslova ext. 3333
- Community Relations Coordinator Gary M. Barrett. ext.4302

ESSEX COUNTY
SHERIFF'S HEADQUARTERS
Kevin F. Coppinger, Sheriff

Department of Health and Human Services Substance Abuse and Mental Health Services Administration Targeted Capacity Expansion: Medication Assisted Treatment – Prescription Drug and Opioid Addiction (Short Title: MAT-PDOA)

ESSEX MAT PROGRAM

09/30/2018 – 09/29/2021

Award $1,574,010.00

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PROJECT NARRATIVE

Section A: Population of Focus and Statement of Need

A1. The Essex Medication Assisted Treatment (EMAT) project is a collaborative initiative between Volunteers of America Massachusetts (VOAMA) and the Essex County Sherriff's Department (ECSD) to address the growing need to expand and enhance medication assisted treatment (MAT) and other recovery supports for incarcerated individuals with an opioid use disorder (OUD). The EMAT population of focus is incarcerated individuals (detox/diversion, pre-trial, sentenced) drawn from all three of the ECSD correctional facilities: Middleton House of Correction (MHOC), Essex County Pre-release and Re-entry Center (ECPRC) and Women in Transition (WIT). The service area includes Essex County, Massachusetts, which is composed of 34 cities and towns and the greater Boston area. Massachusetts ranks as the 15th most populous state in the nation with 6,859,819 individuals as of July 2017[1]. As of the 2017 census, the total population of Essex County was 785,205[2], making it the third-most populous county in Massachusetts.

A2. SAMHSA's Treatment Episode Data Set (TEDS) identified Massachusetts as having one of the highest rates of primary treatment admissions for heroin and opioids per capita. It is also a state with the most dramatic increases for heroin and opioids. According to the 2017 TEDS, there were 82,517[3] admissions in Massachusetts, which is an increase of approximately 4,400 individuals or 5.3% from 2015 (78,117[4]). Compared to Tennessee, the 14th most populous state in the nation with 6,715,984 individuals as of July 2017[5], Massachusetts has a disproportionately higher number of substance abuse treatment admissions (470%) vs. Tennessee with 17,468 admissions. Opioid overdose in Massachusetts has consistently risen with a death rate of 36 per 100,000 residents in 2015 as compared to 13 per 100,000 nationwide. Opioid abuse and overdose disproportionately affect the incarcerated population. Compared with the rest of the adult population, the opioid-related overdose death rate is 130 times higher for persons released from prisons and jails, and this rate increased 13-fold between 2011 and 2015[6]. One in two deaths of recently incarcerated persons in Massachusetts were opioid related[7]. Approximately 85% of ECSD incarcerated individuals with a mental health diagnosis have a substance abuse problem, with opioids being the highest reported. In 2017 alone, there were ten overdoses within ECSD[8]. Without intervention, high recidivism and relapses among the population targeted in the proposed project are inevitable. Upon release, most offenders return to the same poor, crime-ridden neighborhoods and unstable circumstances from which they entered the correctional system. According to the Massachusetts Department of Corrections (MA DOC) 2016 Prison Population Trends[9], Essex County holds the second highest percentage of criminally sentenced MA DOC inmates released in the state (14%) next to Suffolk County (21%). The one-year

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[1] Census.gov
[2] "State & County Quick Facts". Essex County Population Estimates. July 1, 2017. United States Census Bureau. Retrieved 19 June 2018.
[3] https://wwwdasis.samhsa.gov/webt/quicklink/MA17.htm
[4] https://wwwdasis.samhsa.gov/webt/quicklink/MA15.htm
[5] Census.gov
[6] An Assessment of Fatal and Nonfatal Opioid Overdoses in MA 2017. MA Dept. of Public Health. Accessed 5/10/18 at https://www.mass.gov/files/documents/2017/08/31/legislative-report-chapter-55-aug-2017.pdf
[7] https://www.samhsa.gov/criminal-juvenile-justice/behavioral-health-criminal-justice
[8] ECSD Reporting
[9] http://www.mass.gov/eopss/docs/doc/research-reports/pop-trends/prisonpoptrends-2016-final.pdf

recidivism rate for inmates released from ECSD in 2016 was 44.04%[10]. The population of Lawrence, Haverhill and Methuen experience high rates of poverty (25.37%)[11] and violent crimes. According to the 2016 FBI crime data, Lawrence saw 740 violent crimes, Haverhill 593 and Methuen 158[12]. While MAT services are offered elsewhere in Essex County through private providers, they do not target services specifically for incarcerated individuals, which marks a clear gap in service. The ECSD processes approximately 25,000 incarcerated individuals on any given year; and, through the three correctional facilities, a Civil Process Division and three Offices of Community Corrections, ECSD houses up to 2,000 inmates at any time. Currently, ECSD only provides a medication assisted treatment, Vivitrol, to approximately 1,000 incarcerated individuals per year upon discharge. The proposed EMAT project builds capacity for VOAMA and ECSD to provide a system of care that includes psychosocial supports and integrated recovery services. MAT services in jails and prisons have saved lives in Rhode Island and New York, and they can do the same for the many inmates that fall within the ECSD jurisdiction. This EMAT project will build capacity and establish a model system of care that can be leveraged to rally more support at the state and local levels for continued expansion and replication elsewhere in the state.

Section B: Proposed Implementation Approach

B1. 250 unduplicated individuals will be served over the entire project period (70 in Year 1; 90 in Year 2; and, 90 in Year 3).

Goal 1: Build the capacity of Essex County to identify, screen, assess, enroll, track, and retain individuals into the full continuum of MAT services through infrastructure changes, and establish an integrated system of care among 13 public and private Task Force partners.

- Objective 1a: By the fourth month after the grant is awarded, the four new VOAMA staff members and all sub-contracted staff will be hired and trained on the project goals/ objectives and EBPs as needed, and the provision of the full continuum of MAT-services will begin.

- Objective 1b: By the first month after the grant is awarded, the Task Force partners will convene to enhance outreach and engagement strategies and make any necessary improvements to service delivery processes to ensure a full continuum of care that is based on the needs of each individual.

- Objective 1c: By the end of year 2, approximately 70% (300) of the 450 ECSD correctional officers will receive training on the signs of opioid use and symptoms of a potential overdose.

- Objective 1d: By the end of year two, technological improvements will be completed that automate and integrate the assessment tools (MSDP, LS/CMI and CAAPE-5) with the ECSD Offender Management System (OMS).

Goal 2: Increase the number of incarcerated individuals with OUD receiving MAT and other psychosocial supports and integrated care services in Essex County.

- Objective 2a: By the end of Year 3, 250 new clients will have received a Vivitrol shot upon discharge and other psychosocial supports and integrated care services as needed.

Goal 3: Decrease illicit opioid drug use and prescription opioid misuse among the project participants.

[10] ECSD Recidivism Report, 2016
[11] Census.gov
[12] https://ucr.fbi.gov/crime-in-the-u.s/2016/crime-in-the-u.s.-2016/topic-pages/offenses-known-to-law-enforcement

- Objective 3a: By the end of year 3, 85% of clients (250) will abstain from illicit opioid drug use and prescription opioid misuse at six-month follow-up.

Goal 4: Reduce the recidivism rate of the project participants through the provision of an integrated system of care that is specifically designed for each participant's needs.

- Objective 4a: By the end of year 3, 20% of clients (250) will not recidivate.

B2. SAMHSA grant funds will be primarily used to support direct services associated with the implementation plan, and VOAMA and ECSD will work closely with key personnel and Task Force partners to conduct the required and allowable activities described below. In 2014, the Essex County Mental Health and Justice Task Force (Task Force) was created, which includes many of the representatives from the partners assembled for the proposed EMAT project. The Task Force will play an integral role in the oversight and implementation of the activities and will support the development of new partnerships when possible. Integrating the VOAMA and ECSD assessment and reporting software systems are proposed infrastructure changes designed to build capacity to improve program monitoring and track outcomes. The full four-month start-up will be needed to convene the Task Force and hire and train four new project staff in evidenced-based practices. Key personnel who will make a substantial contribution to the execution of the required activities include the following: project director (full-time); re-entry coordinator (full-time); case manager (full-time); EHR analyst (part-time); a team of peer recovery coaches, grant evaluator (20%), nurse, and phlebotomist. The following evidenced-based practices for assessment and service implementation will be deployed: Level of Service Case Management Inventory (LS/CMI) and Comprehensive Addictions and Psychological Evaluation-5 (CAAPE-5), Motivational Interviewing (MI), Trauma Informed Care (TIC), Cognitive Behavioral Therapy (CBT), and Strengths-based Case Management (SbCM). As required by SAMSHA, Advance DATA 2000 training will be provided for nurse, phlebotomist, and any other relevant clinical staff.

MAT services will begin by the fourth month of the grant award. Each client will receive (1) education on MAT services, (2) assessment and blood work; (3) one Vivitrol shot (naltrexone) from within the Middleton House of Corrections on their day of release; Clients coming from ECSD's two other correctional facilities will need to be transported to the Middleton House of Corrections to receive their Vivitrol shot; (4) transportation directly to one of the partnering inpatient or outpatient substance abuse recovery providers in the community once he or she receives the Vivitrol shot. Additional Vivitrol shots may be dispersed to clients once they are connected with a MAT service provider in the community, but the frequency and duration of the Vivitrol shot services will be determined by the service provider and is dependent upon the individual's needs; and, (5) continued follow-up and on-going case management and incentives to foster program retention, data collection and long-term recovery.

The project director and re-entry coordinator will conduct the appropriate clinical assessments using LS/CMI and CAAPE-5 to determine which clients meet the diagnostic criteria for OUD relative to MAT, including determination of opioid dependence, a history of opioid dependence, high risk of relapse, and presence of co-occurring substance use and mental health disorders during the first week of each client's enrollment into the project. The LS/CMI[13] is a fully functioning case management tool and assessment that measures the risk and need factors of late adolescent and adult offenders. The single application provides the essential tools needed to aid professionals in treatment planning for and management of offenders in justice, forensic,

[13] https://www.mhs.com/MHS-Publicsafety?prodname=ls-cmi

correctional, prevention, and related agencies. The CAAPE-5[14] is a comprehensive diagnostic assessment interview providing documentation for substance-specific diagnoses based on DSM-5 criteria. In 20-35 minutes, the CAAPE-5 covers some of the more prevalent mental health conditions likely to impact recovery from substance use disorders and collects key demographic information associated with prognosis. The CAAPE-5 is also a screening and assessment for co-occurring substance use and mental disorders. The delivery or coordination of any services determined to be necessary for the individual with co-occurring disorders will be performed by the project director and re-entry coordinator. Clients with co-occurring disorders will be eligible to receive additional supports through VOAMA's Family Center, or the Men's and Women's Hello Houses, which have a 90% success rate in helping clients with a mental health disorder achieve recovery. The project director will check the state, county, or local Prescription Drug Monitoring Program (PDMP) where available for each new patient admission in compliance with any relevant state rules or regulations. Outreach and engagement strategies to increase participation in and access to MAT for diverse populations at risk for OUD will be identified and deployed by the 13 Task Force partners. ECSD correctional officers will deploy outreach and engagement strategies, and all 450 of the ECSD correctional officers will be eligible to receive extensive training from the Center for Social Innovation[15]. Task Force partners will meet at the beginning of each year of the project, during which time the project director will obtain a DATA waiver from all applicable practitioners.

This project will establish the funding mechanism and service delivery model needed to serve re-entering offenders residing in the rural and resource-limited communities of Lawrence, Haverhill, Methuen and Billerica, in addition to the rest of Essex County. The 13 Task Force partners will provide a robust suite of treatment and recovery support services to effectively identify, engage, and retain individuals in OUD treatment and facilitate long-term recovery. Partners include ECSD, Massachuetts Parole Board, Judge Lynn Rooney (Lawrence), Judge James LaMothe, Jr. (Lynn), Greater Lawrence Family Health Center, Lynn Community Health Center, North Shore Community Health, Middlesex Recovery, NaphCare, Police Assisted Addiction & Recovery Initiative (PARRI), Massachusetts Trial Court - Office of Probation, Lynn Police Department, and Advocates for Human Potential (AHP). In order to address any barriers including distance to providers, privacy concerns, missed time from work, child care, and access to transportation, VOAMA will work with partnering providers to identify and offer telehealth services as appropriate. Other innovative interventions designed to reach, engage, and retain clients in treatment and obtain data include the provision of $25 gift cards from AHP for clients who attend the 6-month follow up meetings.

Culturally and linguistically appropriate recovery support systems help people with mental and/or substance use disorders manage their conditions successfully, so VOAMA will include a provision of peer recovery support services designed to improve access to and retention in MAT and facilitate long-term recovery. These services will be provided through the re-entry coordinator and case manager and by a team of sub-contracted peer recovery coaches with the Police Assisted Addiction & Recovery Initiative (PAARI). The proposed project will provide recovery support services designed to help participants enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice. A full range of social, legal, and other services that facilitate recovery, wellness, and linkage to and coordination among service providers will ensure that

[14] https://www.changecompanies.net/products/?id=CT-V
[15] http://center4si.com/

each client's quality of life is improved. The implementation of evidenced-based recovery practices as well as the provision of education and on-going case management supports before, during, and after receiving the Vivitrol medication treatment will mitigate the risk of diversion and ensure the appropriate use/dose of medication. Providing the incarcerated individual with MAT options upon discharge will allow them to begin a process of therapeutic change, resulting in reduced drug use and criminal behavior post-incarceration. Continuing drug treatment in the community is essential to sustaining these gains. Even when inmates who have previously completed treatment programs recidivate, there is a longer period from release to re-arrest than for inmates who have not completed treatment programs.

Allowable Activities: The proposed project will provide substance use disorder (SUD) and opioid use disorder (OUD) and MAT trainings to correctional officers, and LS/CMI trainings for all key staff. VOAMA has had tobacco cessation programs in place for the past decade. The re-entry coordinator will also serve as the tobacco coordinator and he/she will receive training from Institute of Health and Recovery[16] as needed. A core component of the proposed project includes performing outreach and screening to identify incarcerated individuals who are within four months from release and may benefit from MAT services upon release from a jail or detention facility. People with OUD who are receiving MAT will receive education, screening, care coordination, risk reduction interventions, screening, testing, and counseling for HIV/AIDS, hepatitis, and other infectious diseases. These services will occur in tandem with the Greater Lawrence Family Health Center and Lynn Community Health Center because they offer the Ryan White HIV/AIDS Program (RWHAP), which provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured.

B3. Milestones Activities (Staff responsible)	Year One '18				Year Two '19				Year Three '20			
	Oct	Jan	April	July	Oct	Jan	April	July	Oct	Jan	April	July
Project Preparation												
Convene TF Partners and obtain DATA waivers (PD)												
Hire/orient/train project/evaluation staff (PD, TF, AHP)												
Refine & adapt treatment models, screening & assessment instruments (PD, AHP)												
Project Management												
Integrate program with other services (PD, RE, CM)												
Establish linkages to other services (PD, RE, CM)												
Conduct program review mtgs w/ project/eval team (PD, AHP)												
Incorporate evaluation findings into service delivery (PD, TF, AHP)												
Program Operations												
Supervise clinical & evaluation staff weekly (PD, AHP)												
Offer EBP Training & Education (PD, AHP)												
Begin screening and enrolling participants (ECSD, TRC)												
Begin offering clinical services (PD, RE, CL)												
Begin offering psychosocial supports and other services (PD, RE, CL, PRC, TF)												
Evaluation and Data Management												
Complete evaluation design, instrumentation, field												

[16] http://www.healthrecovery.org/trainings/

B3. Milestones Activities (Staff responsible)	Year One '18				Year Two '19				Year Three '20			
	Oct	Jan	April	July	Oct	Jan	April	July	Oct	Jan	April	July
procedures (AHP)												
Submit application to IRB for review (AHP)												
Recruit participants into evaluation (RC, CM, CL, TF)												
Administer GPRA, local measures (RC, CM, CL, AHP)												
Conduct secondary data analysis & document review (AHP)												
Collect Service/Referral Logs & EBP Fidelity Forms (AHP)												
Collect Training Surveys (PD, RC, CM)												
Conduct Site Visits (AHP)												
Initiate follow-up interviews at appropriate intervals (RC, CM, CL, AHP)												
Analysis and Reporting												
Data entry/cleaning/analysis (EHR, AHP)												
Transmit GPRA data to CSAT as required (EHR)												
Report evaluation results quarterly (AHP)												
Prepare SAMHSA reports/presentations (PD, AHP)												
Complete data analysis & final report (AHP)												
Collaboration/Community Involvement												
Establish Project Advisory Committee (PD, TF)												
Participate in quarterly PAC meetings (PD, TF, AHP)												
Participate in CSAT-sponsored grantee meetings (PD, AHP)												

Staff Key: PD=Project Director; RE- Re-entry Coordinator; CL=Clinical Staff; CM=Case Manager; PRC=Peer Recovery Coaches, EHR=EHR Analyst); AHP=Advocates for Human Potential; TF=Task Force

Section C: Proposed Evidence-Based Service/Practice

C1. The following EBPs will be delivered in tandem by VOAMA and ECSD and all pertinent sub-contractors: Level of Service/Case Management Inventory (LS/CMI)[17] is a validated assessment tool that will provide the project staff with the data and information they need to develop a streamlined and targeted re-entry plan pre/post-release specific to the client's needs and risk level. Comprehensive Addictions and Psychological Evaluation-5 (CAAPE-5) is a comprehensive diagnostic assessment interview providing documentation for substance-specific diagnoses based on DSM-5 criteria. In 20-35 minutes, the CAAPE-5 covers some of the more prevalent mental health conditions likely to impact recovery from substance use disorders and collects key demographic information associated with prognosis. Cognitive-Behavioral Therapy (CBT)[18] will teach the clients how to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and address a range of problems that often co-occur with it. Trauma Informed Care (TIC)[19]: Trauma-informed care principles will play a major role in the proposed project to minimize triggers, stabilize offenders, reduce critical incidents, de-escalate situations, and avoid restraint, seclusion, or other measures that may repeat

[17] https://www.mhs.com/MHS-Publicsafety?prodname=ls-cmi
[18] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral
[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3402099/

aspects of past abuse. Project staff will provide trauma-specific therapies—counseling models and curricula that are designed to promote trauma recovery. Clinical interventions for inmates will be relevant to the environment, culture, and relationships that incarcerated trauma survivors must navigate on a daily basis. Motivational Interviewing (MI): MI is a brief psychological treatment technique aimed at eliciting behavioral change (i.e. abstain from using alcohol and drugs) by helping clients explore and resolve ambivalence. VOAMA and other community partners have been formally trained to implement MI and will use their skills to train and support other staff. Depending on their needs, project staff deploying MI will meet with the client monthly. Strength-based Case Management: Through the development of a strong working alliance with the client, personal skills and assets are identified, client-centered treatment goals and a plan for achieving them are set, and the case manager helps the client resolve any client-identified barriers to treatment including transportation, child care, and social support. The intervention is time-limited and typically involves one to five sessions delivered in a flexible manner. Sessions usually last about 90 minutes to 2 hours.

No modifications will be made to the LS/CMI, CAAPE-5, CBT, TIC, MI or Peer Support. Although Strengths-based Case Management is expected to be no more than five sessions, the complexity of some the patients' needs may necessitate providing several more sessions. When undergoing formalized training in this model, technical assistance will be obtained to determine how best to make modifications without impacting the fidelity of the intervention.

Section D: Staff and Organizational Experience

D1. VOAMA is a 501(c)(3) charitable organization serving low-income, homeless, and vulnerable populations throughout the greater Boston area. VOAMA has been providing evidenced-based addiction services since 1970. Both the Men's Hello House and Women's Hello House offer a residential recovery program for individuals coping with drug and alcohol addiction; the program is designed to take from three to six months to complete with an average length of stay of 95 days. Hello House provides a structured environment for clients to learn and develop the tools necessary to live full lives, substance-free. While in the program, residents participate in recovery support groups (AA/NA/SMART Recovery, etc.), individual counseling, recovery education groups, and case management to address their unique needs. Clients are expected to obtain employment of at least 32 hours per week (or volunteer if on SSI/SSDI) while in the program to help move toward independence and cover treatment costs. Thirty percent of net income goes to treatment fees. Ninety percent of the Hello House program participants are referred to MAT services with outpatient clinics. VOAMA has been working collaboratively with the Essex County Sherriff's Department (ECSD) since 2013 and is currently a co-lead on the Essex Mental Health Diversion Program (EMHDP), which has created systemic change within the ECSD through the provision of treatment for offenders with mental health and co-occurring substance abuse and mental health disorders. VOAMA's role in the EMHDP is similar to the clinical role proposed for the EMAT project. The EMAT project is an outgrowth of that successful partnership and will continue to leverage each agency's area of expertise to address the growing need to expand and enhance MAT and other recovery supports for incarcerated individuals with an OUD. Letters of commitment from each of the 13 partners are included, and all partners have agreed to participate in quarterly Task Force meetings designed to foster effective communication, establish program linkages and cross-training activities, oversee the implementation, and monitor and evaluate the project.

D2. VOAMA will require that the project director and re-entry coordinator meet the following qualifications for hire: master's degree in psychology, social work, counseling or equivalent clinical/therapeutic field. A career track for appropriate state licensure (PhD, LICSW, LMHC) preferred, and two years of previous supervision experience with the target population is required, as well as experience with coordinated care planning in criminal justice. The case manager must meet the following qualifications: bachelor's degree in psychology, social work, counseling or equivalent clinical/therapeutic field. **Project Director:** This full-time position is responsible for conducting training and/or contracting with and supervising outside agencies to conduct training for staff and stakeholders. The project director will also oversee use of screening tools as well as the LS/CMI and CAAPE-5 assessments to ensure they are used with fidelity to their development and best use. He or she will also develop an individualized care plan for each inmate screened and evaluated, as well as coordinate with staff and stakeholders about the roles and responsibilities for effective supervision and services for inmates returning to the community. Finally, the project director will oversee Task Force partners, including the peer recovery coaches (PARRI), grant evaluator (AHP), and NaphCare staff. **Re-entry Coordinator:** This full-time position is responsible for coordinating reentry of EMAT inmates to the community, and will serve as the central point of referral contact among the project and community providers. Responsibilities include working closely with partner agencies to ensure participants are engaged and supported in services that include MAT and group and individual therapy. He or she will conduct further screening and assessments of referred inmates and assist in diagnostic evaluations under the direct supervision of the licensed project director. The re-entry coordinator will be responsible for oversight of the case manager and peer recovery coaches, data input, recordkeeping, and logs/notes for all program participants, ensuring that they meet the standards of the funding entity and the program evaluator. He/she will participate in individual service planning for inmates identified for the EMAT program and coordinate care with stakeholders across the criminal justice system and with collateral treatment providers in the community. He/she will also participate in post-release transition planning, including aftercare and supportive services, to ensure services address needs across life domains such as education, employment, and housing in addition to SUD and co-occuring disorder (COD) needs. He/she will have a case load of 10-15 clients at any given time. **Case Manager:** Under the supervision of the re-entry coordinator, the case manager is a full-time position which is responsible for conducting further screening and assessments of referred inmates, and for assisting in diagnostic evaluations under the direct supervision of the licensed project director. The case manager will ensure that data input, recordkeeping, and logs/notes for all program participants meets the standards of the program evaluator. He or she will participate in individual service planning for inmates identified for the EMAT program and coordinate care with stakeholders across the criminal justice system and with collateral treatment providers in the community. He or she will also participate in post-release transition planning, including aftercare and supportive services, to ensure services address needs across life domains in addition to SUD and COD needs. The case manager will also address and overcome barriers to services and supervision, including health insurance/health care and pro-social community linkages. He or she will closely coordinate services with peer recovery coaches, which includes documentation required for grant goals and evaluation. He/she will have a case load of up to 30 clients at any given time. **Electronic Health Records (EHR) Analyst:** This part-time position is a critical technical link between project operations, partners, external vendors, and consultants that provide or support EHR services. Critical technical links focus on effective use of two electronic health records EHR systems in

use at VOAMA and ECSD: LS/CMI and Offender Management System (OMS). The EHR Analyst must understand Structured Query Language and function as part of the operations team in the executive office, supporting quality assurance, continuous quality improvement, compliance, and measurement of outcomes. A team of **Peer Recovery Coaches** with Police Assisted Addiction & Recovery Initiative (PAARI) will provide peer recovery supports and help each person navigate MassHealth enrollment as well as obtain other recovery services needed in the community. Established in Massachusetts last year in direct response to the growing opioid epidemic, PAARI is a police-led addiction and recovery program. PAARI AmeriCorps members serve as recovery coaches or capacity building fellows, where they help build the capacity of law enforcement programs, prevent overdose deaths, and provide vital resources to community members with substance use disorders and their loved ones. **Nurse & Phlebotomist:** A full-time nurse and part-time phlebotomist will be contracted through NaphCare to assist with the deployment of the screening, testing, and administration of Vivitrol shots. **Grant Evaluator**: Advocates for Human Potential (AHP) will design and lead the performance assessment and evaluation. Dr. David Centerbar (0.25 FTE) has decades of evaluation experience and is currently the lead analyst on the evaluation of a CSAT-funded, five-site MAT-Precription Drug and Opioid Addicition (PDOA) program that works to engage and retain pregnant/post-partum women in integrated MAT services. AHP has served as the local or cross-site evaluator for dozens of SAMHSA projects, most focused on SUD, MAT/other treatment services, and criminal justice populations. Staff are skilled in working with community-based agencies to design and implement mixed-methods outcome, process, and performance/CQI components; establish procedures to collect client consent, maintain confidentiality, and manage and store data securely; develop data collection instruments/protocols/systems; integrate primary and secondary data to answer key questions; tailor protocols and procedures to be culturally competent; and report in timely and innovative ways to help improve programs and practice.

Section E: Data Collection and Performance Measurement

E1. The plan for EMAT data collection and performance measurement was developed based on the requirements of the FOA and the team's expertise in designing and implementing similar evaluations of MAT and other SAMHSA TCE grants. It is designed to determine the extent to which program goals, objectives, and outcomes are achieved and to support continuous quality improvement (CQI). It includes a strong conceptual framework with: (1) integrated process, outcome, and performance components; (2) a multi-level design that includes provider- and client-level inquiry; (3) a mixed-methods approach using qualitative and quantitative methods and analysis; (4) a cost-effective strategy for maximizing existing data; (5) a proven and comprehensive tracking plan that is rooted in decades of direct experience with the target population; and (6) a data-driven CQI process to capture and implement lessons learned and make program adjustments. AHP will: (1) serve as the grant evaluator (GE); (2) design the assessment; (3) oversee and participate in all methods; (4) provide training and oversight to ensure that data is complete, clean, and entered in SPARS within seven (7) days; (5) track clients and monitor interview windows to maintain required follow-up rates; (6) conduct analyses; and (7) develop reporting. AHP will finalize data collection protocols and consent forms in collaboration with EMAT staff and peer recovery coaches to ensure these materials reflect the language, norms, and values of the population. Informed consent and other procedures (Appendix D, Attachment 3) will be implemented to ensure confidentiality. Table 1 summarizes key data collection details and Table 2 describes how data will be managed, tracked, analyzed, and reported to assess performance and inform CQI efforts.

Table 1. Data Collection Details (Draft measures/tools (Attachment 2) to be finalized upon award)

Method; *Related Objective(s)*	**Data Collection Lead;** *Schedule*	**Source(s)/Domains/Description**
Client interviews *Obj a, d*	Program staff; *Intake, 3- & 6-mos, discharge*	Collected using the required GPRA Tool & supplemental questions tailored for EMAT. Includes characteristics & key outcomes (e.g., diagnoses, history of opioid dependence, relapse risk, abstinence from illicit opioids/other drugs/prescription opioid misuse, housing, employment, criminal justice system involvement, access to services/ engagement/retention, social connectedness; recidivism risk; experiences with MAT (e.g., initiation, duration, benefits, drawbacks, motivation)/ other services (e.g., enrollment supports/barriers); program satisfaction. Clients will be compensated at 3- & 6-months ($25 gift card for each).
Secondary analysis of clinical assessment/CJ/ admin data; *Obj b, d*	Program staff; *Ongoing; submit to AHP quarterly*	Compilation and analysis of clinical assessment (e.g., MSDP, LS/CMI, CAAPE-5), outcome, and existing administrative and corrections data from ECSD, OMS, and CareLogic EHR systems.
Service/referral logs & fidelity forms; *Obj a-c*	Program staff; *Ongoing; submit to AHP monthly*	Electronic logs/extracts capturing frequency, nature, duration of services/ medications; referrals; aftercare (e.g., recovery coaching, care mgmt); engagement; supports/barriers to access; EBP delivery/fidelity.
Site visits; *Obj a-c*	AHP eval staff; *Years 2 and 3*	Staff/stakeholder interviews & client focus groups; assesses progress/ successes, barriers, strategies to overcome those barriers, adjustments.
Document review; *Obj a-c*	AHP eval staff; *Quarterly*	Compilation of documents related to implementation, key activities, & progress in achieving program objectives.
Training surveys; *Obj d*	AHP eval staff; *Ongoing*	Web-based; # trained, topics, reaction, knowledge acquisition, application or incorporation of the training into on-the-job behavior.

Table 2: Management and Use of Data for Performance Assessment and Quality Control

Management: Extensive evaluation experience and strong technical capabilities allow AHP to support the secure collection, management, and analysis of a full range of qualitative/quantitative data. The EMAT data manager will be responsible for monitoring data collection, entry, and integrity and generating weekly status reports to be reviewed by the GE & EMAT PD/team. Staff will adhere to strict policies and procedures around data management and the secure storage of confidential data, including restricting access to data files and other materials as appropriate to protect privacy and ensure human subject protection. The analyst will monitor the cleaning of administrative data and be responsible for linking it to primary GPRA/other data to build a comprehensive client database for analysis.

Tracking: The GE will be ultimately responsible for tracking performance measures and measurable objectives, with the Data Manager overseeing day-to-day data collection and data checking activities.

Analysis: The GE & Analyst will conduct descriptive, bivariate, and multivariate quantitative analyses and qualitative coding/content analysis (e.g., develop a-priori hierarchical coding schemes to organize and reduce the data, expand and refine those through subsequent analysis, use the reduced, coded data to develop a range of text and graphic displays to identify patterns in the qualitative data by informant, theme/topic, and time point).

Reporting: Accessible, frequent, and actionable reporting is central to the evaluation, used to keep staff informed on progress and to support a regular feedback loop. The GE will lead the development of real-time data reports (e.g., data collection status) via a custom web-based dashboard; presentations to address project targets, lessons learned, and possible program revisions; and annual progress & final evaluation reports for SAMHSA.

Performance Assessment: Evaluation and program staff will review performance data quarterly to monitor and evaluate activities and processes and to assess progress made towards specified goals and objectives.

QI: Frequent reporting will inform program decisions, document progress, and assess impact on behavioral health disparities. With support from evaluation staff, program leadership will be responsible for determining when changes are made, when to consult stakeholders, and how to communicate changes.

Budget Narrative File(s)

* **Mandatory Budget Narrative Filename:** FY18_VOAMA_MAT_BNF.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

Volunteers of America Massachusetts (VOAMA)
BUDGET AND JUSTIFICATION

A. Personnel:

Position	Name	Key Staff	Annual Salary/ Rate	Level of Effort	Total Salary Charge to Award
Project Director	Vacant, to be hired within 60 days of project start date.	Yes	$65,000	1 FTE	$65,000
Re-entry Coordinator	Vacant, to be hired within 60 days of project start date.	Yes	$45,000	1 FTE	$45,000
Case Manager	Vacant, to be hired within 60 days of project start date.	Yes	$42,000	1 FTE	$42,000
EHR Specialist	Vacant, to be hired within 60 days of project start date.	Yes	$72,500	.1 FTE	$7,250
FEDERAL REQUEST (enter in Section B column 1, line 6a of SF-424A)					**$159,250**

JUSTIFICATION: VOAMA requests $159,250 to cover salaries for 3 FTE and 10% of 1 FTE key personnel who will deliver and coordinate services, training, and partnerships. All new will be hired within 60 days of the award period beginning. All salaries are based on VOAMAs pay scale, which reflects average salary ranges for similar nonprofits in the Boston area based on candidates' experience and qualifications. VOAMAs services team will consist of a Project Director, Re-entry Coordinator, Case Manager and EHR Specialist, who will work together to deliver treatment and services to 70 clients in year 1, 90 in year 2 and 90 in year 3 (250 total clients over three years).

Project Director: (1 FTE, TBD). This position is responsible for conducting training and/or contract with and supervise outside agency(ies) to conduct training for staff and stakeholders; Overseeing use of screening tools as well as the LS/CMI and CAAPE-5 assessments to ensure tools and assessments are used with fidelity to their development and best use; Developing with staff and stakeholders, an Individualized Care Plan for each inmate screened and evaluated, who may benefit from MAT; Coordinate with staff and stakeholders, roles and responsibilities for effective supervision and services for inmates returning to the community; and, Oversee Task Force partners, including the Peer Recovery Coaches (PARRI), Grant Evaluator (AHP), and NaphCare staff.

Re-entry Coordinator: (1 FTE, TBD). This position is responsible for coordinating reentry of EMAT inmates to the community, and serve as the central point of referral contact between the program and community providers. Responsibilities also include working closely with partner agencies to ensure program participants are engaged and supported in services that includes MAT, group and individual therapy. Conduct further screening and assessments of referred inmates, and assist in diagnostic evaluations under the direct supervision of the licensed Project

Director. Data input, recordkeeping and logs/notes for all program participants that meets the standards of the funding entity and the program evaluator. Participate in Individual Service Planning for inmates identified for the EMAT program; coordinate care with stakeholders across the criminal justice system and with collateral treatment providers in the community. Participate in post-release Transition Planning, including aftercare and supportive services, to ensure services address needs across life domains (education, employment, housing, etc.) in addition to SUD and COD needs. He/she will also help clients address and overcome barriers to services and supervision, including health insurance/health care and help ensure pro-social community linkages. He/she will manage a case load of 10-15 clients at any given time.

Case Manager: (1 FTE, TBD). Under the supervision of the Re-entry Coordinator, this position will be responsible for conducting further screening and assessments of referred inmates, and assist in diagnostic evaluations. Similar to the re-entry coordinator, he/she will be responsible for data input, recordkeeping and logs/notes for all program participants that meets the standards of the program evaluator; participating in Individual Service Planning for inmates identified for the EMAT program; coordinating care with stakeholders across the criminal justice system and with collateral treatment providers in the community; participating in post-release Transition Planning, including aftercare and supportive services, to ensure services address needs across life domains (education, employment, housing, etc.) in addition to SUD and COD needs; helping clients to address and overcome barriers to services and supervision, including health insurance/health care and pro-social community linkages; and, he/she will closely coordinate services with peer recovery coaches, which includes documentation required for grant goals and evaluation. The Case Manager will have a case load of 30 clients at any given time.

Electronic Health Records (EHR) Analyst: (10% of 1 FTE). This position is a critical technical link between project operations, partners, external vendors and consultants that provide or support EHR services. Critical technical links focus on effective use of two electronic health records (EHR) systems in use at VOAMA and ECSD (LS/CMI and OMS). This position must understand Structured Query Language and function as part of the operations team in the executive office, supporting quality assurance, continuous quality improvement, compliance, and measurement of outcomes.

B. Fringe Benefits:

Position	Name	Rate	Total Salary Charged to Award	Total Fringe Charged to Award
Project Director	Vacant, to be hired within 60 days of project start date.	20%	$65,000	$13,000
Reentry Coordinator	Vacant, to be hired within 60 days of project start date.	20%	$45,000	$9,000
Case Manager	Vacant, to be hired within 60 days of project start date.	20%	$42,000	$8,400
EHR Specialist	Vacant, to be hired	20%	$7,250	$1,450

	within 60 days of project start date.			
FEDERAL REQUEST (enter in Section B column 1, line 6b of SF-424A)				**$31,850**

JUSTIFICATION: VOAMA requests $31,850 to cover the employer-paid portion of 3 FTE key personnel's fringe benefits. VOAMA's organization's fringe benefits are composed of:

Fringe Benefit	Rate
FICA	7.65%
Health Benefits	12.35%
Total	20%

The fringe benefit rate for full-time employees for years one through three is 20%.

C. Travel:

Purpose	Destination	Item	Calculation	Travel Cost Charged to the Award
Staff Travel	Local	Mileage	$.545/mile x 250 miles/month x 12 months	$1,635
FEDERAL REQUEST - (enter in Section B column 1, line 6c of SF-424A)				**$1,635**

JUSTIFICATION: VOAMA requests $1,635 to support local staff travel to and from service sites including VOAMAs offices, and client's homes. The mileage is calculated at the current GSA rate of $0.545/mile at an average of 250 miles/month.

D. Equipment: N/A

FEDERAL REQUEST – (enter in Section B column 1 line 6d of form SF-424A) **$0**

E. Supplies:

Item(s)	Rate	Cost
Office Supplies	$15/month x 12 months x 3.1 FTE	$558
FEDERAL REQUEST – (enter in Section B column 1, line 6e of SF-424A)		**$558**

JUSTIFICATION: VOAMA requests $558 in funds for office supplies $15 per month x 12 months' x 3.1 FTE.

F. Contract:

Name	Service	Rate	Cost
NaphCare	MAT	Registered Nurse - $70,000/year x 1 FTE	$70,000
PAARI	Recovery Support	Personnel Fiscal Supervisor, Allie Hunter McDade - $84,000 x .05 FTE = $4,200 Recovery Coach Supervisor, Tito Rodriguez - $50,000 x .2 FTE = $10,000 Program Coordinator, TBD, 1 FTE - $5,000 stipend contribution Recovery Coaches, TBD, 3 PTE - $2,000 stipend contribution x 3 = $6,000 Total: $25,200 Fringe Benefits Fiscal Supervisor - $4,200 x 30% fringes = $1,260 Recovery Coach Supervisor - $10,000 x 30% fringes = $3,000 Program Coordinator and Recovery Coach fringes - $122,19/month x 12 months x 4 staff = $5,865 Total: $10,125 Travel Local Staff Travel - $.545/mile x 611.62 miles/month x 12 months = $4,000 Supplies Office Supplies - $250/month x 12 months = $3,000 Nasal NARCAN Kits - $75/kit x 80 kits = $6,000 Other Recovery Coach Training - $1,000/staff x 4 staff = $4,000 Resource Packet Development = $2,000	$54,325
Advocates for Human Potential	Data Collection & Evaluation	Personnel Lead Evaluator, David Centerbar - $79,969/year x .25 FTE (460 hours) = $19,969 Research Associate/Analyst, Denise Lang - $35.53/hour x 40 hours = $1,421 Data Systems Manager, Natasha Zaretskaya - $20.83/hour x 325 hours = $6,770 Total: $28,160 Fringe Benefits	$82,081

		$28,160 x 39.21% = $11,042 Travel Local Staff Travel - $.545/mile x 403.21 miles/month x 12 months = $2,637 Other Telephone Conferencing - $9/month x 12 months = $108 Overhead – ($39,202 salaries + fringes) x 38.38% = $15,046 G&A - ($54,248 salaries + fringes + overhead) x 44.02% = $23,880 Non-Labor Admin - $2,745 x 44% = $1,208	
TBD – TA Provider	Substance Abuse Training	$29.95/correctional officer x 300 correctional officers	$8,985
TBD – TA Provider	LS/CMI Training	$1,000/staff x 2 staff	$2,000
TBD-IT Services	EHR Upgrades	One-Time Fee	$12,500
FEDERAL REQUEST – (enter in Section B column 1, line 6f of-424A)			**$229,891**

JUSTIFICATION: VOAMA requests $229, 891 for contractors associated with MAT service delivery and training, which includes:

NaphCare will be contracted to provide a full-time Registered Nurse - $70,000/year who will provide the Vivitrol shots at the ECSDs Middleton House of Corrections.

Police Assisted Addiction & Recovery Initiative (PAARI) will be contracted to provide a team of Peer Recovery Coaches who will provide service linkages and on-going peer recovery supports. The PARRI team includes 0.5% of FTE Fiscal Supervisor; .20 FTE Recovery Coach Supervisor, 1 FTE Program Coordinator and 3 PTE Recovery Coaches. $54,325 is sought for salaries, wages and fringe, staff travel, supplies and training materials.

Advocates for Human Potential will be contracted to conduct a mixed-methods evaluation to assess the process and outcomes. Within the first three months, the Grant Evaluator will work with project staff and partners to map out core processes for service delivery using a partnership logic model. The Grant Evaluator (Dr. David Centerbar) will also train VOAMA staff on the tools and data collection protocols. Project personnel will collect all data, except for post-intervention and training surveys which the Grant Evaluator will administer and observations of staff and clients/training participants. He will analyze results and provide regular reports on progress, issues and trends, and both summative and formative evaluation findings. He will work with the Project Director and EHR Specialist to collect, analyze, and monitor reports, and compile accurate reports for SAMHSA and annual performance report deadlines. He will also

manage the evaluation activities to ensure timely completion. $82,081 is sought for salaries, fringe, travel, telehealth services, and indirect.

$8,985 is requested to provide substance abuse training to 300 correctional officers within ECSD.

$2,000 is requested to provide training to 2 staff on the LS/CMI assessment tool.

$12,500 is requested to contract with an IT provider to perform the technological infrastructure changes proposed with upgrading the EHR system, and syncing the LS/CMI assessment tool with the ECSDs Offender Management System (OMS).

G. Construction: NA

H. Other:

Item	Rate	Cost
IT Services	$40/month x 12 months x 3.1 FTE	$1,488
Telephone Services	$75/month x 12 months x 3.1 FTE	$2,790
Equipment Leases	$75/month x 12 months x 3.1 FTE	$2,790
Professional Liability	$5/month x 12 months x 3.1 FTE	$186
CAAPE-5 Assessments	$67.50/assessment x 10 assessment packages	$675
LS/CMI Assessments	One-Time Fee for 250 assessments	$780
Data Collection Incentives	$40/client x 70 clients	$2,800
Recovery Support Services	Average $142.43/client x 70 clients	$9,970
FEDERAL REQUEST (enter in Section B column 1, line 6h of SF-424A)		**$21,479**

JUSTIFICATION: VOAMA requests $21,479 in grant funds to cover various related costs necessary to achieving the project's goals and objectives. These include:
- IT Services valued at $40/month x 12 months x 3.1 FTE for a total of $1,488.
- Cell phones for 3.1 VOAMA project staff, valued at $75/month using current provider.
- Equipment leases for printing materials ($75/month x 12 months x 3.1 FTE).
- A portion of the Professional Liability insurance ($5/month x 12 months x 3.1 FTE).
- Funds to purchase the CAAPE-F and LS/CMI Assessments to be used by 250 clients.
- Funds to incentivize clients to engage in providing data. $40/client x 70 clients (includes $30 one-time gift card and up to two additional $5 gift cards when completing interviews.

- A set-aside for client support services to pay for copays, transportation, and other costs clients would encounter as barriers to participation, estimated at an average of $142.43 per person (70 clients) in year 1

I. Total Direct Charges

FEDERAL REQUEST – TOTAL DIRECT CHARGES - Section B column 1, line 6i of SF-424A	**$444,663**

J. Indirect Cost Rate:

Calculation	Indirect Costs Charged to Award
50.24% of personnel costs, based on VOAMA's federally-approved indirect cost rate agreement (attached) ($159,250 x .5024)	$80,007
FEDERAL REQUEST – (enter in Section B column 1, line 6j of-SF-424A)	**$80,007**

FEDERAL REQUEST – TOTALS (6k) will sum automatically on the SF-424A	**$524,670**

Proposed Project Period

a. Start Date: 09/30/2018 **b.** End Date: 09/29/2023

BUDGET SUMMARY

Category	Year 1	Year 2*	Year 3*	Total Project Costs
Personnel	$159,250	$159,250	$159,250	$477,750
Fringe	$31,850	$31,850	$31,850	$95,550
Travel	$1,635	$1,635	$1,635	$4,905
Equipment	$0	$0	$0	$0
Supplies	$558	$558	$558	$1,674
Contractual	$229,891	$232,191	$226,907	$685,989
Other	$21,479	$19,179	$24,463	$65,121
Total Direct Charges	$444,663	$444,663	$444,663	$1,333,989
Indirect Charges	$80,007	$80,007	$80,007	$240,021
Total Project Costs	**$524,670**	**$524,670**	**$524,670**	**$1,574,010**

***FOR REQUESTED FUTURE YEARS:**

Contractual

- In Years 2 and 3, NaphCare will hire a Phlebotomist to work in the Essex County Correctional Facilities 16 hours per week at $24 per hour. This raises NaphCare's request in Years 2 and 3 to $89,968 per year.
- In Years 2 and 3, Advocates for Human Potential, Inc. request increasing travel reimbursement to accommodate increasing participant numbers and workload to finish data collection by the end of the grant. Therefore, AHP's total request is $81,908 in Year 2 and $82,614 in Year 3.
- In Year 2, VOAMA only requests $5,990 for a TA Provider to train the remaining 200 correctional officers at Essex County Correctional Facilities. No TA dollars are requested in Year 3.
- VOAMA does not request funds for LS/CMI training or EHR upgrades in Years 2 and 3

Other

- VOAMA does not request CAAPE-5 or LS/CMI assessments in Years 2 or 3, as it will purchase them in bulk in Year 1.
- VOAMA requests $3,600 per year for data collection incentives in Years 2 and 3 to accommodate increased participant numbers.
- VOAMA requests $8,325 in Year 2 and $13,609 in Year 3 for Recovery Support Services based on the availability of funds.

INFRASTRUCTURE DEVELOPMENT BUDGET

Infrastructure Development	Year 1	Year 2	Year 3	Total Infrastructure Costs
Personnel	$0	$0	$0	$0
Fringe	$0	$0	$0	$0
Travel	$0	$0	$0	$0
Equipment	$0	$0	$0	$0
Supplies	$0	$0	$0	$0
Contractual	$12,500	$0	$0	$12,500
Other	$0	$0	$0	$0
Total Direct Charges	$12,500	$0	$0	$12,500
Indirect Charges	$0	$0	$0	$0
Total Infrastructure Costs	**$12,500**	**$0**	**$0**	**$12,500**

JUSTIFICATION: $12,500 is requested to perform technological infrastructure changes associated with updating the EHR system, and integrating the LS/CMI assessment tool into the

ECSD Offender Management System (OMS). Digitalizing the LS/CMI tool and integrating it into the OMS, will actually yield a cost savings. The maximum percentage of the budget that will be spent on infrastructure development for any budget period is 2.38% ($12,500/$524,670 – Year 1).

DATA COLLECTION AND PERFORMANCE MEASUREMENT BUDGET

Data Collection & Performance Measurement	Year 1	Year 2	Year 3	Total Data Collection & Performance Measurement
Personnel	$7,250	$7,250	$7,250	$21,750
Fringe	$1,450	$1,450	$1,450	$4,350
Travel	$0	$0	$0	$0
Equipment	$0	$0	$0	$0
Supplies	$0	$0	$0	$0
Contractual	$82,081	$81,908	$82,614	$246,603
Other	$4,255	$3,600	$3,600	$11,455
Total Direct Charges	$95,036	$94,208	$94,914	$284,158
Indirect Charges	$0	$0	$0	$0
Data Collection & Performance Measurement	**$95,036**	**$94,208**	**$94,914**	**$284,158**

JUSTIFICATION: AHP will design and lead the performance assessment and evaluation. AHP has served as the local or cross-site evaluator for dozens of SAMHSA projects, most focused on SUD, MAT/other treatment services, and criminal justice populations. Staff are skilled in working with community-based agencies to design and implement mixed-methods outcome, process, and performance/CQI components; establish procedures to collect client consent, maintain confidentiality, and manage and store data securely; develop data collection instruments/protocols/systems; integrate primary and secondary data to answer key questions; tailor protocols and procedures to be culturally competent; and, report in timely and innovative ways to help improve programs and practice. Proposed staff are also experts on applying tracking and retention strategies that result in high follow-up rates with hard-to-reach populations. Current relevant projects include (1) a state-wide evaluation of programs funded by the MA Department of Public Health to increase the capacity to initiate clients on MAT and effectively transition them to community-based MAT and support services and (2) evaluation work conducted under SAMHSA's State Targeted Response (STR) to the Opioid Crisis Grant program with the Illinois Department of Human Services' set of projects aimed at increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths. The proposed Grant Evaluator, Dr. David Centerbar (0.25 FTE), has decades of evaluation experience and is currently the lead analyst on the evaluation of a CSAT-funded, five site MAT-

PDOA program that works to engage and retain pregnant/post-partum women in integrated MAT services.
The maximum percentage of the budget that will be spent on infrastructure development for any budget period is 18.11% ($95,036/$524,670 – Year 1).

TECHNICAL ASSISTANCE – VOAMA will spend $10,985 on TA in Year 1 and $5,990 in Year 2, totaling $16,975 of the allowable $25,000.

OMB Number: 4040-0007
Expiration Date: 01/31/2019

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Completed on submission to Grants.gov	President/CEO
APPLICANT ORGANIZATION	DATE SUBMITTED
Volunteers of America of Massachusetts, Inc.	Completed on submission to Grants.gov

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Other Attachment File(s)

* **Mandatory Other Attachment Filename:** FY18_VOAMA_MAT_Bio_Sketches_Position_Desc.pdf

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Add Optional Other Attachment | Delete Optional Other Attachment | View Optional Other Attachment

Biographical Sketches and Position Descriptions

David B. Centerbar, Ph.D.

David B. Centerbar, Ph.D., is a senior scientist for Advocates for Human Potential's (AHP) Center for Research and Evaluation with more than 20 years of experience in designing and conducting studies and complex data analyses across a diverse range of investigation topics and populations. His data analysis experience includes management and analysis of primary and secondary data sources, including collected data using Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) Government Performance and Results Act (GPRA) data collection tools and the Transformation Accountability (TRAC) System National Outcome Measures (NOMs). He has also conducted evaluations of programs serving the needs of older adults and persons with disabilities (including consumer-directed care initiatives); older adults with multiple co-morbid conditions (including programs to improve health-related quality of life); adolescents, transition-aged youth, and young adults with substance use and/or co-occurring disorders; at-risk children, youth, and families; and opioid-involved pregnant and postpartum women receiving medication-assisted treatment (MAT). Dr. Centerbar has extensive training and experience working with experimental, quasi-experimental, quantitative, and mixed-methods research study designs. He also has expertise developing and implementing survey instruments and measurement tools and conducting complex data-analytic activities that employ a variety of approaches and tools. Dr. Centerbar has conducted research in academic and private research settings.

Selected Project Experience

State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PTL), Project PROMISE, SAMHSA (2017–present). Project PROMISE is a three-year program to serve 150 pregnant and postpartum women with opioid use disorders and their children. This Massachusetts State Pilot Grant Program is led by the Massachusetts Department of Public Health (MA DPH) Bureau of Substance Abuse Services (BSAS). AHP is the local evaluator for the program, and Dr. Centerbar is responsible for all quantitative data collection and analytic activities, using client interview data, MAT administrative data, program services data, and other data sources in evaluating program outcomes.

Illinois Intact Family Recovery Program (IFR), Administration for Children and Families (ACF) (2017–present). AHP is the local evaluator for IFR under its Regional Partnership Grant Initiative. IFR provides integrated substance use treatment services to families in four counties in northern Illinois, led by the Illinois Collaboration on Youth in partnership with the Illinois Regional Partnership, to increase the well-being, permanency, and safety of children; improve family recovery and stability; and increase system capacity and effectiveness. Dr. Centerbar is a member of AHP's evaluation team, which analyzes child, parent, and family outcomes over time between the comparison and intervention groups.

Moms Do Care Expansion, MA Health Policy Commission (HPC) (2016–present). The Moms Do Care expansion project expands the original Moms Do Care activities to two additional geographic regions of the state: one urban (Lowell) and one suburban (Beverly). Integrated MAT services will be provided to an additional 120 pregnant and postpartum women through this initiative. AHP is the evaluator for the program, and Dr. Centerbar is responsible for all quantitative data collection and analytic activities in support of the evaluation, including client baseline and follow-up interview data, MAT administrative data, program services data, provider perception surveys, and other data sources to be examined in evaluating the program outcomes.

Moms Do Care, SAMHSA (2015–present). The Moms Do Care project is an evaluation of a 3-year program to expand medical and behavioral health services systems' capacity to engage and retain

pregnant and postpartum women in integrated medication-assisted treatment services, coordinated delivery of health care, and addiction and recovery support services. Dr. Centerbar acts as project analyst for evaluation activities and is responsible for coordinating the collection of quantitative data required for the evaluation, including GPRA data, other client-level interview data, service logs, and administrative data, and analysis of these data with respect to project goals and outcomes.

Family Recovery Project—Southeast (FRP-SE), Massachusetts Department of Public Health (MA DPH) (2014–present). Dr. Centerbar acts as project lead and is responsible for all management and evaluation components of the local evaluation of the grantee's local implementation of the Regional Partnership Grants, Cohort II (RPGII) funded by the Children's Bureau (CB) of the Administration for Children and Families (ACF) of the U.S Department of Health and Human Services (HHS). He is also responsible for the facilitation of grantee reporting for the national cross-site evaluation of the RPGII program and is lead analyst for the local evaluation of the FRP-SE project's outcomes and impact studies.

Massachusetts Access to Recovery (MA-ATR), SAMHSA (2014–present). This four-year program provides recovery services to ex-offenders in Massachusetts. Dr. Centerbar's data analytic responsibilities include expertise for the development, implementation, and analysis of self-reported client survey data to assess the effectiveness of the career building initiative pre-employment programs on client readiness and preparedness for successful employment-seeking, career development, and related life skills.

Project YARD (Young Adult Recovery Destination) Recovery-oriented Systems of Care, SAMHSA CSAT (2012–2013). Dr. Centerbar served as lead analyst for the final evaluation of this three-year service expansion project to develop a recovery-oriented substance use disorder treatment and recovery center for transition age youth residing in the South Boston area of Massachusetts.

Program Evaluation for Assertive Adolescent and Family Treatment, SAMHSA CSAT (2012). Dr. Centerbar supported final data analysis and reporting of web-based implementation survey data related to evaluation of program implementation and outcomes for this CSAT-funded 14-site process and outcomes evaluation for the Family Centered Substance Abuse Treatment Grants for Adolescents and their Families program.

Selected Publications

O'Connor, D. M., Savageau, J. A., Centerbar, D. B., Wamback, K. N., Ingle, J. S., & Lomerson, N. J. (2009). Lesson in a pill box: Teaching about the challenges of medication adherence. *Family Medicine*, *41*(2), 99–104.

Professional Experience

Advocates for Human Potential, Inc., Sudbury, MA, *Senior Research Associate*, 2012–present

John Ware Research Group, Inc., Worcester, MA, *Research Scientist*, 2010–2011

UMass Medical Center for Health Policy Research, Shrewsbury, MA, *Project Associate*, 2007–2010

Education

Ph.D., Psychology, University of Virginia, Charlottesville, VA, August 2003

M.A., Psychology, University of Virginia, Charlottesville, VA, January 2001

B.S., Business Administration, University of Vermont, Burlington, VT, May 1982

Denise Lang, B.S.

Denise Lang, B.S., is a senior research associate at Advocates for Human Potential (AHP). Her expertise includes data collection management and training, data quality assurance, and establishing solutions that result in improved processes for collecting and reporting accurate data. She has managed data collection for several Substance Abuse and Mental Health Services Administration (SAMHSA)-funded treatment program evaluations; her project responsibilities included training program and research staff to conduct participant interviews and report service data, developing and implementing data collection tools and web-based survey instruments. Her work has focused on substance use, medication-assisted treatment (MAT) for pregnant and postpartum women, mental health, and housing and homelessness.

Ms. Lang has 11 years of social work experience with a focus on families, adolescents, and children, as well as adults receiving MAT, and those experiencing homelessness, who have serious mental illness, substance use disorders, or co-occurring disorders.

Selected Project Experience

Project Promise, SAMHSA (2017–present). Ms. Lang oversees field operations and data collection methods, including participant interviews and web-based staff surveys, as well as contributes to data presentations and reports for the evaluation of a pilot project implementing an intensive outpatient program for pregnant/postpartum women with substance use disorders and their children. Its goals are to support family-based services, integrate MAT, and enhance the statewide system's capacity to improve services to the target population.

Illinois State Targeted Response to the Opioid Crisis, SAMHSA (2017–present). Ms. Lang has developed, and will implement, a web-based, multilevel, statewide survey focusing on Illinois' strategic plan to address opioid use and fatal overdose.

Illinois Intact Family Recovery Program, U.S. Administration for Children and Families (ACF) (2017–present). Ms. Lang is responsible for programming the web-based survey for the Illinois Regional Planning Grant (RPG) Initiative and will assist with monitoring and downloading data.

Program Evaluation for the Extended Release Injectable Naltrexone (ERIN) Pilot Project, Massachusetts Department of Public Health Bureau of Substance Abuse Services (2016–present). Ms. Lang trains interview staff; oversees field operations and data management; and participates in data review, analysis, and interpretation for this state-funded evaluation of a pilot program to building capacity and support access to initiation of ERIN for treating substance use disorders.

Moms Do Care, SAMHSA Center for Substance Abuse Treatment (CSAT) (2015–present). Ms. Lang trains data collection staff and oversees field operations for the evaluation of a program to expand capacity to engage pregnant/postpartum women in MAT and integrated medical/behavioral health care. The project was expanded in 2017 to include two additional service sites funded through the MA Health Policy Commission.

Uniform Data Systems (UDS) for Health Centers, U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) (2013–present). Ms. Lang provides training/technical support regarding the annual collection of Bureau of Primary Health Care UDS data; she created elearning training modules used by health centers to prepare their UDS report.

Family Recovery Project—Southeast (MA FRP-SE), MA DPH (2012–2017). Ms. Lang trained program and evaluation staff to collect/report data; oversaw field operations; designed a web-based data collection system for an evaluation of an ACF-funded program providing evidence-based services to families and children affected by parental substance use.

Denise Lang, B.S.

Transformation Accountability System (TRAC), SAMHSA Center for Mental Health Services (CMHS) (2008–2013; 2015–2016). Ms. Lang trained CMHS grantees on the TRAC web-based data reporting and collection system; administration of the National Outcome Measures (NOMs) client-level measures; and reporting on Infrastructure Development, Prevention, and mental health promotion (IPP) grant activities.

Evaluation of Programs to Provide Services to Persons who are Homeless with Mental and/or Substance Use Disorders, SAMHSA CMHS/CSAT (2011–2016). Ms. Lang trained grantee staff on the administration of the project's supplemental client interview and reporting procedures and conducted secondary data analysis, conducted site visits and prepared issue briefs.

Evaluation of Adult Treatment Court Collaboration (ATCC), SAMHSA CMHS/CSAT (2011–2014). Ms. Lang designed web-based surveys to collect primary and secondary data and conducted site visits to examine the impact of infrastructure development activities.

Massachusetts Access to Recovery (MA-ATR), SAMHSA (2013). Ms. Lang designed web-based surveys to collect data from ATR providers/participants; she trained staff to launch and manage survey responses using Snap Surveys Web Host.

Program Evaluation for Assertive Adolescent and Family Treatment Program (AAFT), SAMHSA CSAT (2009–2012). Ms. Lang was grantee site liaison for a national evaluation of the implementation of the AAFT grant. She developed data collection tools and web-based surveys and conducted direct observation of grant activities, key informant interviews, and case study visits.

Treatment for Homeless Program Evaluation, SAMHSA CSAT/CMHS (2006–2011). Ms. Lang was a trainer and field coordinator for three program evaluations; she created training materials and trained interviewers on standardized interviewing, tracking techniques, and field safety.

Effective Adolescent Treatment (EAT) Program, SAMHSA CSAT (2004–2008). Ms. Lang was a field coordinator/data manager for a longitudinal evaluation of an evidence-based substance use treatment program; and liaised with Chestnut Health Systems for monthly data submission/edits.

Co-Occurring Disorders Initiative (CODI), SAMHSA CSAT (2001–2003). Ms. Lang coordinated field operations and conducted individual and focus group interviews for a longitudinal study of adults with co-occurring disorders (CODs) receiving methadone maintenance/detoxification services.

Professional Experience

Advocates for Human Potential, Inc., Sudbury, MA, *Senior Research Associate*, 2015–present; *Research Associate*, 2001–2003, 2004–2015

CODAC, Cranston and Providence, RI, *Substance Abuse Counselor, Methadone Treatment Program*, 2003–2004; *Group Facilitator, Batterers' Intervention Program*, 2003–2004

Community Care Services, Attleboro, MA, *Service Coordinator/Supervisor, Intensive Homebased Services*, 1998–2001; *Bilingual Caseworker, Intensive Homebased Services*, 1993–2001; *Residential Counselor, Transitional Living Program & The Attleboro Center*, 1999–2001

Community Healthlink, Oasis House, Worcester, MA, *Residential Counselor*, 1992–1993

Education

B.S., Psychology, University of Massachusetts, Amherst, MA, 1992

Natasha Zaretskaya, B.S.

Natasha Zaretskaya, B.S., works on multiple federally funded projects as a research assistant for Advocates for Human Potential's (AHP) Center for Research and Evaluation. Her responsibilities include tracking longitudinal study participants; conducting face-to-face client interviews; collecting data for the Government Performance and Results Act (GPRA)/National Outcome Measures (NOMs) performance measures; collecting, entering, and managing study data; maintaining project databases; maintaining client confidentiality by following standardized protocols; working closely with program staff; and providing general administrative support and assistance on various projects. Ms. Zaretskaya is experienced in collecting required GPRA/NOMs performance measures, achieving a collective 6-, 12-, 18-, and 24-month follow-up rate of 95.3 percent for adults experiencing chronic homelessness with co-occurring substance use disorders and mental health conditions.

Selected Project Experience

Program Evaluation for the Extended Release Injectable Naltrexone (ERIN) Pilot Project, Massachusetts Department of Public Health (MA DPH), Bureau of Substance Abuse Services (BSAS) (2016–present). As part of the response to the opioid epidemic in Massachusetts, DPH/BSAS is providing funding to 10 clinical stabilization service (CSS) programs to increase their capacity to initiate voluntary clients on ERIN and to effectively transition them to community-based services to continue their medication-assisted treatment (MAT) and support services. Ms. Zaretskaya is the lead interviewer and is responsible for contacting, recruiting, and enrolling clients into the evaluation; collecting release of information forms for eligible clients, conducting semi-structured interviews with participants at admission and follow-up interviews at 6 and 12 months' post-admission; and submitting/filing interview-related paperwork and ensuring interview/data collected is complete and accurately coded. Ms. Zaretskaya tracks the evaluation participants using a computer-based tracking system and other methods, including collaboration with ERIN staff, to ensure evaluation requirement completion within the timelines as well as participant retention in the evaluation. Additionally, Ms. Zaretskaya maintains the payment methods and records, serves as the ERIN site liaison, and provides data collection and evaluation logistics support.

Moms Do Care, Substance Abuse and Mental Health Services Administration (SAMHSA) (2015–present). The Moms Do Care project is an evaluation of a three-year program to expand medical and behavioral health services systems' capacity to engage and retain pregnant and post-partum women in integrated medication-assisted treatment (MAT) services, coordinated delivery of health care, and addiction and recovery support services. AHP serves as the local evaluator for this project under the Massachusetts Department of Public Health (MA DPH) Bureau of Substance Abuse Services (BSAS), supporting the data collection and performance measurement activities, including collection and reporting of required GRPA performance measures and local performance assessment over the life of the project to assess the degree to which project goals and outcomes are achieved. Ms. Zaretskaya is the lead interviewer and is responsible for tracking clients over a 6- to 12-month period, scheduling and conducting face-to-face interviews, collecting quantitative and qualitative data, and conducting data management activities.

Increasing Access to and Measuring the Benefits of Providing Behavioral Health Services in Massachusetts, Institute for Health and Recovery (IHR) (2014–2016). A two-year grant with IHR—in partnership with the Massachusetts Department of Housing and Development's Division of Housing Stabilization, Massachusetts Department of Public Health's FOR Families Program, and

Natasha Zaretskaya, B.S.

Massachusetts Department of Children and Families' Housing Unit—this project provides community-based, family-centered, trauma-informed behavioral health treatment for up to 250 families experiencing homelessness residing in hotels in Danvers, Chelmsford, Haverhill, and Methuen, Massachusetts. Ms. Zaretskaya is a data manager and her responsibilities include managing data collected by clinicians, tracking baseline and follow-up interviews over a six-month period, and creating data reports.

Family Recovery Project—Southeast (FRP-SE), MA DPH (2013–present). Ms. Zaretskaya is the lead interviewer for the evaluation of the Family Recovery Project—Southeast, a five-year Administration for Children and Families (ACF)-funded grant providing home-based treatment to families with substance use and co-occurring disorders in Fall River and New Bedford, Massachusetts. The program focuses on stabilizing families who have children in out-of-home placements or who are at imminent risk of removal from the home due to parental substance use. Ms. Zaretskaya's responsibilities include tracking clients over a six- to eight-month period, scheduling and conducting face-to-face interviews, collecting quantitative and qualitative data, and conducting data management activities.

Services in Supportive Housing, SAMHSA Center for Mental Health Services (CMHS) (2012–2014). Ms. Zaretskaya was the lead interviewer for the evaluation of Linking Treatment to Housing, a five-year CMHS-funded Services in Supportive Housing program. Her responsibilities included tracking clients over a 12-month period, scheduling and conducting face-to-face interviews, collecting quantitative and qualitative data, and managing data.

WorkFirst Demonstration Evaluation, hopeFound (now incorporated into Pine Street Inn) (2010–2012). Ms. Zaretskaya scheduled and conducted face-to-face qualitative interviews and acted as a qualitative data collector for this program, which aimed to increase housing retention and prevent homelessness among recently housed formerly homeless adults through career counseling, job search, and job retention services.

Selected Publications

Huntington, N., Aykanian, A., Zaretskaya, N., & Keller, S. (2014, November). *Evaluation results chartbook: Linking treatment to housing.* Sudbury, MA: Advocates for Human Potential, Inc.

Huntington, N., Rio, J., Aykanian, A., Keller, S., & Zaretskaya, N. (2013). *WorkFirst project evaluation results: A chartbook.* Sudbury, MA: Advocates for Human Potential, Inc.

Professional Experience

Advocates for Human Potential, Inc., Sudbury, MA, *Research Assistant II*, 2016–present, *Research Assistant I*, 2011–2016

Boston University Medical School, Boston, MA, *Summer Research Intern*, 2010

Education

M.S.W. (in progress), Simmons College, Boston, MA, expected 2018

B.S., Psychology, *cum laude*, University of Massachusetts Amherst, Amherst, MA, 2012

Volunteers of America
Massachusetts

Title: **Project Director**
Program: **Essex County Medication Assisted Treatment (EMAT)**
Reports To: **Chief Operating Officer (VOAMA)**
Coordinates with: **Essex County Sheriff's Department**

Function:
Conduct training and/or contract with and supervise outside agency(ies) to conduct training for staff and stakeholders on a) Substance use disorder (SUD) and Co-Occurring Disorder (COD) among inmates, b) use of screening instruments, c) referral/scheduling procedures for further assessments (or evaluations), and d) other trainings identified during the Project. Perform assessments or direct the Re-entry and Case Manager performing assessments of inmates interested in Medically Assisted Treatment (MAT). Oversee use of screening tools as well as the LS/CMI and CAAPE-5 assessments to ensure tools and assessments are used with fidelity to their development and best use. Develop with staff and stakeholders, an Individualized Care Plan for each inmate screened and evaluated, who may benefit from MAT. Coordinate with staff and stakeholders, roles and responsibilities for effective supervision and services for inmates returning to the community. Oversee program partners, which include the peer recovery coaches, research evaluator, and NaphCare staff.

Qualifications:
A master's degree in psychology, social work, counseling or equivalent clinical/therapeutic field, with appropriate state licensure (PhD, LICSW, LMHC). Supervisory status in licensed field preferred. Two years previous supervised experience with the target population: inmates with SUD or COD unmet needs required. Previous experience with coordinated care planning in criminal justice preferred.

Principal Activities:

1. Direct and supervise administrative, clinical and programmatic work of the Case Manager.
2. Conduct training for staff and stakeholders, as appropriate. Or, contract with outside agency(ies) for training, following policies and procedures of the ECSO.
3. Coordinate with Evaluator to identify or design brief screening tools suitable for use at Intake by Jail Intake Staff to screen intake inmates for further assessment using LS/CMI, CAAPE-5, and MSDP.
4. Direct and supervise work of staff and collaterals on administering (or directly administering) all tools, assessments, evaluations, and related scoring, data entry or progress note-taking.
5. Develop or oversee the development of Individual Care Plans, with staff, collaterals and stakeholders, for inmates recommended for diversion from pre-trial detainment.
6. Liaison with collateral care providers and stakeholders in the criminal justice system, to ensure clear roles and responsibilities, and produce coordinated supervision and services for inmates returning to the community.
7. Other duties as they may arise during the Project.
8. Maintain and expand the task force of jail staff and external stakeholders (DA, Parole, Probation, Police, MH and behavioral health providers, human services, etc.)

Volunteers of America
Massachusetts

Title: **Reentry Coordinator**
Program: **Essex County Medication Assisted Treatment (EMAT)**
Reports To: **Project Director**

Function:
This position is responsible for coordinating reentry of EMAT inmates to the community, and serve as the central point of referral contact between the program and community providers. The incumbent duties require close coordination, collaboration, tracking and monitoring of inmates to ensure success with their individualized service plan. Responsibilities also include working closely with partner agencies to ensure program participants are engaged and supported in services that includes MAT, group and individual therapy. Conduct further screening and assessments of referred inmates, and assist in diagnostic evaluations under the direct supervision of the licensed Project Director. Data input, recordkeeping and logs/notes for all program participants that meets the standards of the funding entity and the program evaluator. Receive training and exhibit proficiency administering the LS/CMI, CAAPE-5, and MSDP assessment tools. Participate in Individual Service Planning for inmates identified for the EMAT program; coordinate care with stakeholders across the criminal justice system and with collateral treatment providers in the community. Participate in post-release Transition Planning, including aftercare and supportive services, to ensure services address needs across life domains (education, employment, housing, etc.) in addition to SUD and COD needs. Address and overcome barriers to services and supervision, including health insurance/health care and pro-social community linkages.

Qualifications:
A Master's degree in psychology, social work, counseling or equivalent clinical/therapeutic field. Career track for appropriate state licensure (PhD, LICSW, LMHC) preferred. Two years previous supervised experience with the target population: inmates with SUD or COD unmet needs required. Practicum or internship placement/work may substitute for required experience. Previous experience with coordinated care planning in criminal justice preferred.

Principle Activities:

1. Conduct screenings, assessments and evaluations for referred inmates.
2. Keep accurate, verifiable and consistent notes, records, charts, logs and electronic data/files.
3. Assist in Individualized Care Planning; Collaborate with stakeholders in the criminal justice system and with collaterals in the local system of care for SUD and COD
4. Participate in Transition Planning and in post-release aftercare services and supports; address relevant life domains for referred inmates and remove barriers to securing coordinated supervision and service in the community.
5. Work with all ECSD and NaphCare staff, to plan services for referred inmates needed to succeed in maintaining sobriety and compliance with supervision and services in the community.
6. Provides oversight/compliance of Case Management services through a system of care
7. Maintains relationship and agreements within network of local service providers.
8. Other duties as they may arise during the Project.

Title of Position: Research Associate and Analyst

Duties and Responsibilities: The Research Associate will be responsible for working with the EMAT Data Manager to support all field and data collection operations and managing the collection and analysis of service/referral logs, EBP fidelity forms, site visits, document review, and training surveys.

Qualifications: The Research Associate should have a bachelor's degree or higher in social work, psychology, public health, or related field. They must have experience with data management, tracking, and conducting quantitative and qualitative analysis.

Supervisory Relationships: The Research Associate is supervised by the Grant Evaluator.

Skills and Knowledge Required: The Research Associate must have strong planning and organizational skills, strong communication skills, and excellent cross-cultural interpersonal skills. Experience with SAMHSA-funded evaluations and managing/analyzing GPRA and other program evaluation data is also required.

Amount of Travel, Other Special Conditions or Requirements: Travel to EMAT sites to attend meetings, facilitate focus groups, and conduct interviews.

Salary Range: $50,000-$65,000

Hours per Day or Week: 4 hours/week

Title of Position: Data Systems Manager

Duties and Responsibilities: The Data Systems Manager will design and support the implementation of web-based training surveys, the project's participant tracking database, and other data systems.

Qualifications: The Data Systems Manager must have a Bachelor's degree in social science, public health, or related field. Experience with SAMHSA-funded evaluations and managing/analyzing GPRA and other program evaluation data is also required.
They must have training and experience in working with Snap Surveys software and Access databases.

Supervisory Relationships: The Data Systems Manager is supervised by the Grant Evaluator.

Skills and Knowledge Required: The Data Systems Manager must be competent in the use of data collection software (e.g., Snap Surveys); database software (e.g., MS Access); analytic software (e.g., Stata) and qualitative analysis software (e.g., Dedoose).

Personal Qualities: The Data Systems Manger must have strong technical skills, excellent planning and organizational skills, strong communication skills, and excellent cross-cultural interpersonal skills.

Amount of Travel, Other Special Conditions or Requirements: N/A

Salary Range: $50,000-$68,000

Hours per Day or Week: <1 hour/week

Title of Position: Research Assistant

Duties and Responsibilities: The Research Assistant will provide general evaluation support including data entry and client tracking tasks.

Qualifications: The Research Assistant should have a bachelor's degree or higher in social work, psychology, public health, or related field. They must have training and experience in qualitative and quantitative data collection methods, analysis, and reporting and previous experience programming and conducting interview and survey protocols.

Supervisory Relationships: The Research Assistant is supervised by the Research Associate.

Skills and Knowledge Required: The Research Assistant must have strong planning and organizational skills, strong communication skills, and excellent cross-cultural interpersonal skills. Experience with SAMHSA-funded evaluations and collecting GPRA and other program evaluation data is also required.

Amount of Travel, Other Special Conditions or Requirements: Travel to EMAT sites to attend meetings, facilitate focus groups, and conduct interviews.

Salary Range: $40,000-$55,000

Hours per Day or Week: 8 hours/week

- Participants will be compensated $30 with a one-time gift card and $5 for up to two additional interviews they agree to participate in (for a total of $40 each) and individuals will receive payment regardless of whether they skip questions or choose not to complete the entire interview. AHP has used this level of incentive in past SAMHSA program evaluations and it has been approved by the IRB and SAMHSA as an appropriate level of compensation for the time it will take to complete the consent process, entire interview (including GPRA), and follow-up interview tracking form (approximately 40 minutes). As noted above, all eligible participants will be told about the voluntary nature of the evaluation interview(s) and that they are eligible for all program services regardless of their decision to participate (or not) in any of the evaluation interview(s). In other words, they do not need to complete the data collection component to receive services; every aspect of the local evaluation is completely voluntary. Participants will be told that they do not have to complete the interviews, do not have to answer questions they do not want to answer, and can end their participation at any time without negative consequences (i.e., do not have to complete follow-up interviews).
- For participant focus groups, we will pay each participant $10 for their time.
- All program participants, whether they agree to be part of the evaluation or not, will be informed that their program services are not contingent on participating in the evaluation or their answers to evaluation questions.

4. Data Collection

When considering the data collection processes described below, it is important to note that clinical program staff will be responsible for collecting most of the participant-level data. They will conduct the GPRA intake assessments and follow-up interviews with all participants. The evaluation team will oversee all data collection processes, provide training and support to clinical staff, and conduct focus groups, key informant interviews, and document/record review as part of the process/fidelity evaluation. They will also collect service and fidelity data and enter GPRA data on the SPARS website.

All data will be used for evaluation purposes, to provide feedback to program staff and stakeholders on outcomes and implementation to ensure continuous quality improvement. We propose methods that are both feasible and provide as limited a burden as possible on respondents. Proposed data collection methods include:

1) Client interviews at the time of intake with follow-up interviews at 3-months, 6-months, and program discharge will provide longitudinal, individual-level outcome & process data.
    - Interviews will be conducted in a location of the participant's choice that is safe and ensures privacy. The types of information that will be collected include: demographic information, substance abuse, mental health symptoms, social connectedness, physical health and questions about their satisfaction with staff /program (full details are in Section E, Table 1).
    - The in-person interviews are expected to last about 40 minutes. Participants will be informed that their participation is voluntary, and they may choose to not answer questions and are free to end the interview at any time. Participants are also informed that interviews are confidential, and study consent forms detail the steps

evaluators and trained interviewers take to maintain privacy, which is discussed further below.

2) Program Service and Referral Logs will provide detailed data on access, services, referrals, and timeliness. Participants will be asked for consent to share information on the amount and types of services they receive from the program as documented by program staff.

3) Key Informant Interviews will be used to assess implementation and service delivery activities designed to support program goals. Semi-structured, individual and group telephone interviews will be conducted as part of site visits in Years 2 and 3 with program leadership and staff.

4) Client Focus Groups will be conducted in Years 2 and 3 to collect information on participant satisfaction with program services and suggestions for improvements or modifications. These results will be summarized and presented to the program and Advisory Committee to be used for quality improvement purposes.

5) Fidelity Checklists/Forms will be used to assess fidelity to key evidence-based practices. Data on frequency, length, topics covered, and components and strategies used will be assessed on an ongoing basis.

6) Document Review will provide rich, descriptive site information in a highly cost-effective manner. Documents related to implementation (e.g., client follow-up plans, QI/QA initiatives/results), the program's key activities, and progress in achieving goals will be collected and analyzed on an ongoing basis.

- The evaluation will not collect specimens, such as urine or blood.
- Samples/links of proposed instruments and protocols are included in Attachment 2, Data Collection Instruments/Interview Protocols.

5. Privacy and Confidentiality

The first obligation of project staff, whether clinicians or evaluators, is to maintain participants' privacy and confidentiality, except in instances where reporting is mandated. Both training and ongoing supervision of members of the clinical and evaluation staff will stress the importance of protecting the privacy and confidentiality of participants and procedures have been adopted to do so. Privacy and confidentiality will be assured in several ways, thereby limiting risks to participants:

- All participant interviews will be done privately, with a program staff member one-on-one with the participant.
- Regarding confidentiality of interview information, each participant will be assigned an identification code that will be used in place of his/her name.
- Data in electronic systems will be password-protected. All other documents will be kept in locked file cabinets.
- All clinical and evaluation staff will sign a statement pledging not to disclose either the identities or identifying characteristics of individual participants or any information disclosed during the interviews, except to their immediate supervisors when necessary.

- All members of the evaluation team have completed the federal training on confidentiality and protection of human subjects and each will sign an AHP document pledging to protect the confidentiality of participants. Individual names or other identifying information will not be included with interview/service data. A single identifying code will be substituted. A separate file linking this code, the individual name, and other identifying information will be maintained by each program staff member. This file will be password-protected and after the project, all copies of this file will be destroyed.
- Data entry of all information described above will be conducted by staff who will not have access to individual identifying information.
- All physical records will be stored in locked files with access restricted to key project and evaluation staff.
- The Consent Forms are designed to comply with HIPAA Requirements on protecting personal health information.
- GPRA data, which are data expected to be entered via the Internet (web) on a password-protected system, do not have personal identifiers.
- In reporting and publishing evaluation findings, no personal identifiers will be used.

6. Adequate Consent Procedures

The Evaluation Consent and Release of Information Forms (samples included in Attachment 3) are be designed to increase comprehension by having a simple large-type format and an understandable reading level, and by being available in the primary multiple language groups of the target population (administered by staff who are fluent in the primary languages of the target population). These forms as well as the Data Sharing Agreements will be finalized to comply with HIPAA Requirements on protecting personal health information.

The Informed Consent Form makes it clear that participation is voluntary. It also includes the following information:

- Goal of the evaluation and purpose of participation;
- Type of participation;
- Types of information that clinicians will share with evaluators;
- Explanation about need for contact information;
- Warning about possible risks of participation, including stressful questions and that evaluation staff are mandated reporters;
- Explanation of participants rights;
- Risks and benefits of participation; and
- Confidentiality protections.

Staff trained to conduct face-to-face interviews will obtain written informed consent from participants (all of whom must be at least 18 years old). The Interviewer will walk through the consent form with participants (reading it through where necessary), providing adequate time to raise and review questions, and ensuring that participants understand the forms. Participants are also given copies of the consent forms that they sign. Separate consents will be obtained for different stages and aspects of the project. These forms will include consents to be interviewed and to be contacted for follow-up interviews as well as a release between program staff and evaluators to provide the latter with GPRA/supplemental participant interview data and other

program data (e.g., admission and discharge dates, service participation, clinical assessments, administrative data) for analysis. Sample release and consent forms can be found in Attachment 3: Sample Consent Forms. As noted, individuals who do not choose to participate in data collection for the local evaluation are still permitted to participate in all project services.

The key informant interview and focus group consent forms will explain the voluntary nature of participation, the participant's right to stop and/or withdraw from data collection at any time, the anticipated use of the data, the procedures for maintaining confidentiality of the data, the potential risks and benefits, and contact information if there are any questions or concerns. The participant will sign and date the consent and be given a copy for their records.

In the informed consent process for each focus group, the group facilitator will verbally review the Informed Consent Form with the participants and provide copies of the consent forms for each participant. Training and ongoing supervision of evaluation staff will emphasize that entry into the evaluation must be voluntary and will include both information on and practice in the informed consent process.

7. Risk/Benefit Discussion

The purpose of the evaluation is to assess the effectiveness of program services and generate knowledge about how to improve services for adult offenders/ex-offenders with an OUD seeking or receiving MAT, who are returning to their families and community from incarceration in state and local facilities including prisons, jails, or detention centers. We do not anticipate major risks to either the physical or psychological health of participants. Risk in the form of psychological discomfort brought on by thinking or talking about mental health issues, trauma, substance use, criminal justice involvement, or other issues is possible. All efforts will be made to manage psychological discomfort through the following procedures: allowing participants to refuse to answer questions or to end participation at any time; training staff to handle adverse situations with program participants; and instructing the Interviewer to contact the clinician if the individual shows discomfort with the interview. Additional risks to individuals who participate in program services/evaluation activities include that a clinician or evaluation team member will learn about or witness something that requires mandated reporting; or that a clinician or evaluator will breach confidentiality. Steps taken to prevent such a breach are outlined above. For program staff and stakeholders interviewed as part of the evaluation, risks arise from revealing information that might be embarrassing or threatening to job security.

There are no direct benefits to participants who participate in the evaluation unless the payment they receive for completing interviews and focus groups is considered a benefit. As noted in the section on Absence of Coercion, payment for each data collection method is reimbursement for time and the rate of pay is not coercive. Possible benefits of participation are that some of the questions and discussions may help individuals clarify their service needs. In addition, participation in the evaluation may afford individuals an opportunity to help inform the development of services that better meet the needs of program participants. For staff and stakeholders participating in the evaluation, possible benefits are that some of the questions may help them clarify ways to strengthen services and service systems. Moreover, they may appreciate the chance to contribute to knowledge to help improve services for program participants.

Protection of Human Subjects Regulations

AHP has an IRB that requires the submission of all research and evaluation projects for assessment, per the regulations, whether a full, expedited or no IRB review is required. We anticipate following the same procedures for this project.

Attachment 1

Identification of at least one experienced, licensed mental health/substance abuse treatment provider organization:

- Volunteers of America Massachusetts
- NaphCare

List of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency, if it is a treatment or prevention service provider organization:

- Volunteers of America Massachusetts
- Essex County Sheriff's Department
- NaphCare
- Police Assisted Addiction & Recovery Initiative
- Massachusetts Trial Court – Office of the Commissioner of Probation
- Massachusetts Parole Board
- Hello Houses for Men and Women
- Advocates for Human Potential, Inc.
- Lynn Community Health Center
- Middlesex Recovery
- North Shore Community Health
- Greater Lawrence Family Health Center
- Lawrence District Drug Court

Volunteers of America Massachusetts

TI-18-009

Essex County Sheriff's Department

20 Manning Ave
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Middleton, MA 01949-2807

Kevin F. Coppinger
Sheriff

Telephone 978-750-1900
www.essexsheriffma.org

June 27, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Craft:

Please accept this letter of commitment for the grant application being submitted by Volunteers of America Massachusetts (VOAMA) for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services at the Essex County Sheriff's Department (ECSD), Massachusetts for persons with an opioid use disorder (OUD) seeking or receiving MAT.

VOAMA has collaborated with ECSD to serve these clients through the Essex County MAT, (EMAT) Program, that will provide 250 pretrial and sentenced inmates comprehensive MAT services pre- and post -release for a successful re-entry from opioid use upon release.

As evidence of ECSD's commitment to this project, we will collaborate with VOAMA and our partners to expand and enhance MAT and recovery support services for inmates at our three correctional facilities. We will provide space in our facilities for VOAMA's Project Director and Recovery Coordinator to work with inmates and MAT providers to coordinate treatment and reentry services. We commit to ensuring that all correctional officers in our facilities receive training and education on SUD and MAT. We will also maintain and expand our working task force of jail and external stakeholders to continually improve all treatment and reentry services and programming for our inmates. Finally, ECSD commits to collecting and sharing applicable data with VOAMA and the evaluators in a timeframe that will meet all HHS/SAMHSA deadlines. Darya Maslova is the Assistant Director of Programs and will provide internal oversite of the EMAT project, valued at approximately $75,000.

It is Essex County Sheriff's Department's distinct pleasure to participate in this project alongside VOAMA and the ECSD as it aids HHS/SAMHSA/CSAT in its efforts to promote community-based substance abuse treatment and recovery services for individuals and families in every community.

Sincerely,

Kevin F. Coppinger
Sheriff

Proudly serving the communities of Essex County

AMESBURY • ANDOVER • BEVERLY • BOXFORD • DANVERS • ESSEX • GEORGETOWN • GLOUCESTER • GROVELAND
HAMILTON • HAVERHILL • IPSWICH • LAWRENCE • LYNN • LYNNFIELD • MANCHESTER-BY-THE SEA • MARBLEHEAD
MERRIMAC • METHUEN • MIDDLETON • NAHANT • NEWBURY • NEWBURYPORT • NORTH ANDOVER • PEABODY
ROCKPORT • ROWLEY • SALEM • SALISBURY • SAUGUS • SWAMPSCOTT • TOPSFIELD • WENHAM • WEST NEWBURY

June 26, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Craft:

Please accept this letter of commitment for the grant application being submitted by Volunteers of America Massachusetts (VOAMA) for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services at the Essex County Sheriff's Department (ECSD), Massachusetts for persons with an opioid use disorder (OUD) seeking or receiving MAT.

VOAMA has collaborated with ECSD to serve clients with opioid addiction through the Essex County MAT (EMAT) Program, that will provide 250 pretrial and sentenced inmates comprehensive MAT services pre and post release for a successful re-entry from opioid use upon release.

NaphCare is the medical service provider for the ECSD. Currently, NaphCare coordinates all medical aspects of the Vivitrol injection to ECSD clients. NaphCare is committed to working with VOA and ECSD to administer the EMAT program. NaphCare will assist in the coordination of medical care pre-injection; to include labs, education, consent, and allergy testing to Naltrexone. NaphCare will work with VOA EMAT Program Director to ensure each client has been provided all appropriate Vivitrol medical services for release. When able, NaphCare will assist the researchers in data collection measures.

It is NaphCare's distinct pleasure to participate in this project alongside VOAMA and the ECSD as it aids HHS/SAMHSA/CSAT in its efforts to promote community-based substance abuse treatment and recovery services for individuals and families in every community.

Sincerely,

Michael Medeiros
Health Services Administrator
NaphCare, Inc.

POLICE ASSISTED ADDICTION & RECOVERY INITIATIVE

June 29, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Director Craft:

As Executive Director of the Police Assisted Addiction Recovery Initiative (PAARI), I am writing this letter of commitment for submission with the application being filed by Volunteers of America Massachusetts (VOAMA) in collaboration with the Essex County Sheriff's Department under the *Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA)* grant program. The funding sought will be used to expand/enhance access to medication-assisted treatment (MAT) services for individuals in the care, custody and control of the ECSD at its facilities, both pre and post release.

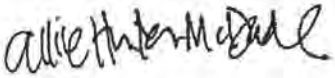
In November 2017, PAARI and the ECSD launched a partnership when two PAARI Recovery Coaches, one each in the male and female Detox Units, were embedded as part of the ECSD Detox team. Our Recovery Coaches use their training, lived experience and their connections to community resources to promote recovery, encourage hope, optimism, and healthy living. Under the subject grant proposal, we will engage 1 full-time Program Coordinator and 3 part-time Recovery Coaches to provide both pre and post release services to both pre-trial and sentenced inmates at Essex County Correctional Facilities (ECCF). Our Recovery Coaches will also provide critical support to help incarcerated individuals navigate systems of care and break down the obstacles to evidenced-based treatment.

Under the grant proposal, the ECSD will be adding another tool to the "recovery coach toolbox" by providing the PAARI Recovery Coaches training on the LS/CMI assessment process and its use. The Recovery Coaches and the VOAMA and ECSD team will work

with a clearer picture based on the LS/CMI assessment when connecting individuals to community-based resources tailored to the specific needs of individual participants/inmates. The Recovery Coaches will be better equipped to provide access to treatment on demand and long-term follow up support to help individuals with opioid use disorder navigate systems of care.

PAARI remains committed to its partnership with the ECSD and looks forward to working with VOAMA as we collaborate to address the opioid epidemic raging in Essex County and across the Commonwealth and nation. The utilization of the LS/CMI assessment tool can only increase chances of success for the male and female participants/inmates seeking sustainable recovery with MAT as they return to their communities thereby – saving lives, families, communities and costs with an attendant reduction in recidivism.

Sincerely,



Allie Hunter McDade
Executive Director
mobile: (508) 212-9831
allie@paariusa.org

MASSACHUSETTS TRIAL COURT
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ONE ASHBURTON PLACE
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EDWARD J. DOLAN
COMMISSIONER

TEL: (617) 727-5300
FAX: (617) 727-5333

June 26, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Craft:

Please accept this letter of commitment for the grant application being submitted by Volunteers of America Massachusetts (VOAMA) for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services at the Essex County Sheriff's Department (ECSD), Massachusetts for persons with an opioid use disorder (OUD) seeking or receiving MAT.

VOAMA has collaborated with ECSD to serve clients through the Essex County MAT Program, that will provide 250 pretrial and sentenced inmates comprehensive MAT services pre and post release for a successful re-entry from opioid use upon release. The Massachusetts Probation Service commits to provide referrals to the program, support recommendations in court; at times presenting the re-entry plan and advocating for the plan in open court, in front of the judge, with the Assistant District Attorney, as well as, collaborate with pre-release service provider, VOAMA, to provide seamless transition services in the community. When able assist the researchers in data collection measures.

It is the Massachusetts Probation Service's distinct pleasure to participate in this project alongside VOAMA and the ECSD as it aids HHS/SAMHSA/CSAT in its efforts to promote community-based substance abuse treatment and recovery services for individuals and families in every community.

Sincerely,

Edward J. Dolan
Commissioner

The Commonwealth of Massachusetts
Executive Office of Public Safety and Security
PAROLE BOARD
12 Mercer Road
Natick, Massachusetts 01760

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Charles D. Baker
Governor

Karyn Polito
Lieutenant Governor

Daniel Bennett
Secretary

Paul M. Treseler
Chairman

June 26, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Craft:

Please accept this letter of commitment for the grant application being submitted by Volunteers of America Massachusetts (VOAMA) for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services at the Essex County Sheriff's Department (ECSD) in the Commonwealth of Massachusetts for persons with an opioid use disorder (OUD) seeking or receiving MAT.

VOAMA has collaborated with ECSD to serve clients through the Essex County MAT Program, that will provide 250 pretrial and sentenced inmates comprehensive MAT services pre and post release for a successful re-entry with relapse prevention services upon release. The Massachusetts Parole Board (MPB) commits to provide referrals to the program. The MPB has Transitional Parole Officers located in the ECSD facility who will work with VOA staff in coordinating MAT resources. The MPB highly supports the use of Vivitrol for parolees with OUD treatment needs. The aforementioned program aligns with the public safety and re-entry goals of this agency.

It is the MPB's distinct pleasure to participate in this project alongside VOAMA and the ECSD as it aids HHS/SAMHSA/CSAT in its efforts to promote community-based substance abuse treatment and recovery services for individuals and families in every community.

Sincerely,

Paul M. Treseler
Chairman

Volunteers of America
Massachusetts

Peter Raskin
Chairman

Thomas L. Bierbaum
Chief Executive Officer

June 27, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Craft:

Please accept this letter of commitment for the grant application being submitted by Volunteers of America Massachusetts (VOAMA) for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services for persons with an opioid use disorder seeking or receiving MAT.

VOAMA's Hello Houses for Men and Women are dedicated to returning men and women to the community sober, employed, and committed to an ongoing recovery process. Hello House Residential Recovery Programs are comprehensive substance abuse treatment program for men and women attempting to cope with drug and alcohol addiction. The programs are designed to take from **three to six months** to complete with an average length of stay of 95 days. Our goal is to reintegrate residents back into their families and community as sober, fully functioning citizens who are employed and committed to an ongoing recovery process. Specifically, VOAMA has collaborated with our Hello Houses to serve clients through our DOJ BJA Justice and Mental Health Collaboration Program, through which Hello House has offered diversion services focused on mental health, substance abuse, and co-occurring disorders to participants.

As evidence of the Hello Houses' commitment to this project, they will accept referrals of program participants and offer a full array of inpatient recovery support services, including intensive clinical case management, monthly on site medication evaluation, individual one-on-one counseling, and a three phase program including one hour a week of group counseling. These services are valued at approximately $160.00 per participant per day.

It is the Hello Houses' distinct pleasure to participate in this project alongside VOAMA as it aids HHS/SAMHSA/CSAT in its efforts to promote community-based substance abuse treatment and recovery services for individuals and families in every community.

Sincerely,

Tom Bierbaum, President and CEO
Volunteers of America Massachusetts

ADVOCATES FOR HUMAN POTENTIAL, INC.

ahpnet.com

June 12, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Re: Targeted Capacity Expansion: Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA)

Dear Mr. Craft,

Please accept this letter of commitment for the grant application being submitted by Volunteers of America Massachusetts (VOAMA) for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to MAT services for persons with an opioid use disorder (OUD) seeking or receiving MAT.

Advocates for Human Potential, Inc. (AHP) will support VOAMA by designing and leading the performance assessment outlined in the proposal. AHP is a nationally-recognized leader in advancing evidence-based behavioral health treatment and recovery services through evaluation and research, TA and training, system and program development, and knowledge development and dissemination. Areas of focus include addictions and substance use, mental health, criminal justice, health care, housing/homelessness, and workforce development. Staff offer an impressive array of evaluation skills; content knowledge; experience working directly with individuals with OUD; demonstrated skill in managing and conducting evaluations in real-world conditions; and repeated success in collecting high quality baseline and follow-up data.

It is AHP's distinct pleasure to participate in this project alongside VOAMA as it aids HHS/SAMHSA/CSAT in its efforts to promote community-based substance abuse treatment and recovery services for individuals and families in every community.

Sincerely,

Neal A. Shifman
President and CEO

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Lynn COMMUNITY health CENTER 269 UNION STREET • LYNN, MASSACHUSETTS 01901-1314 • (781) 581-3900 • FAX (781) 598-1050

June 25, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Craft:

Please accept this letter of commitment for the grant application being submitted by Volunteers of America Massachusetts (VOAMA) for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services at the Essex County Sheriff's Department (ECSD), Massachusetts for persons with an opioid use disorder (OUD) seeking or receiving MAT.

VOAMA has collaborated with ECSD to serve clients through the Essex County MAT Program, that will provide pretrial and sentenced inmates comprehensive MAT services pre and post release for a successful re-entry from opioid use upon release. Lynn Community Health Center was established to offer comprehensive health care of the highest quality to everyone in our community, regardless of ability to pay. Being a Ryan White Grant recipient, LCHC is able to address the impact of HIV/AIDS in Greater Lynn, one of the communities disproportionally affected by the disease.

At LCHC, we recognize the importance of working with men and women coming back into our community and offering them the resources and skills they need to successfully reintegrate into society. LCHC has been working closely with Essex County staff in developing aftercare plans for incarcerated MAT recipients, specifically scheduling follow up appointments prior to release. Working closely with Essex County Sheriff's Department in coordinating MAT services for re-entering offenders provides them with the best chance of recovery and reduces recidivism.

It is Lynn Community Health Center's distinct pleasure to participate in this project alongside VOAMA and the ECSD as it aids HHS/SAMHSA/CSAT in its efforts to promote community-based substance abuse treatment and recovery services for individuals and families in every community.

Sincerely,

Kiame Mahaniah, MD
Chief Executive Officer

Middlesex Recovery, P.C.
20 Tower Office Park, Woburn, MA 01801
P: 781-305-3300 | F: 781-305-3227
Brian O'Connor, MD

June 29, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Director Craft:

I am writing this letter of commitment and support for submission with the application being filed by Volunteers of America Massachusetts (VOAMA) in collaboration with the Essex County Sheriff's Department (ECSD) under the *Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA)* grant program. The funding sought will be used to expand/enhance access to medication-assisted treatment (MAT) services for individuals in the care, custody and control of the ECSD.

VOAMA has collaborated with ECSD to serve clients through the Essex County MAT Program, that will provide pretrial and sentenced inmates comprehensive MAT services pre and post release for a successful re-entry from opioid use upon release. I founded Middlesex Recovery in 2010 to provide consistent, patient-centered, office-based care to a broad spectrum of patients, who are afflicted with substance abuse disorder (SUD). Our MAT program is part of a comprehensive management program that includes psychosocial support and one-on-one counseling with LMHC's and LICSW's. I have made staff training presentations for ECSD personnel at its Middleton facility on SUDs and methods of treatment.

At Middlesex Recovery, we recognize the importance of working with men and women returning to their community and offering them the resources and skills they need to successfully reintegrate into society. Middlesex has an established working relationship with staff at the ECSD collaborating to develop aftercare plans for incarcerated MAT recipients, specifically scheduling follow up appointments prior to release. Coordinating MAT services for re-entering offenders with the ECSD is consistent with our mission to continuously form innovative treatment plans to maximize positive outcomes for individuals. In the case of individuals being released by the ECSD, there is also the potential for the attendant benefit of a reduction in recidivism.

It is with great enthusiasm that Middlesex Recovery joins this project alongside VOAMA and the ECSD and their other collaborators to promote community-based substance abuse treatment and recovery services for individuals being released by the ECSD to communities across the region.

Sincerely,

Brian O'Connor, M.D.
Board Certified Addiction Specialist
President, Middlesex Recovery, P.C.

NSCH
NORTH SHORE COMMUNITY HEALTH

July 2, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Craft:

I am writing this letter of commitment and support for submission with the application being filed by Volunteers of America Massachusetts (VOAMA) in collaboration with the Essex County Sheriff's Department (ECSD) under the *Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA)* grant program. The funding sought will be used to expand/enhance access to medication-assisted treatment (MAT) services for individuals in the care, custody and control of the ECSD, both pre and post release

VOAMA has collaborated with ECSD to serve clients through the Essex County MAT Program, that will provide pretrial and sentenced inmates comprehensive MAT services pre and post release for a successful re-entry from opioid use upon release. North Shore Community Health, Inc. (NSCH) was established to provide access to medical services to under-served populations in the cities of Salem, Peabody and Gloucester. NSCH and its health centers have evolved and respond to emerging needs in the communities we serve.

At NSCH, we recognize the importance of working with men and women coming back into our community and offering them the resources and skills they need to successfully reintegrate into society. NSCH has collaborated with Essex County staff in developing aftercare plans for incarcerated MAT recipients, specifically scheduling follow up appointments prior to release. NSCH and the ECSD also work together as part of the Gloucester High Risk Task Force formed by the city to coordinate efforts to aid its residents in battling the opioid epidemic raging across Essex County. Working closely with Essex County Sheriff's Department in coordinating MAT services for re-entering offenders with the ECSD will provide them with the best opportunity for sustained recovery, and the community may benefit through a reduction in recidivism and be safer.

NSHC enthusiastically joins this project team alongside VOAMA and the ECSD and their other collaborators to promote community-based substance abuse treatment and recovery services for individuals being released by the ECSD to communities in our service areas.

Thank you for considering my thoughts on the matter.

Sincerely,

Maureen Gebhardt LICSW

Maureen Gebhardt, LICSW
Director of Behavioral Health
North Shore Community Health
302 Washington Street
Gloucester, MA 01930
(978) 236-0227

Administrative Offices
One Griffin Brook Drive, Suite 101 • Methuen, Massachusetts 01844-1865
(978) 725-7400 • TTY (978) 689-6438 • Fax (978) 687-3726

July 2, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Craft:

Please accept this letter of support for the grant application being submitted by Volunteers of America Massachusetts (VOAMA) for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services at the Essex County Sheriff's Department (ECSD), Massachusetts for persons with an opioid use disorder (OUD) seeking or receiving MAT.

VOAMA has collaborated with ECSD to serve clients through the Essex County MAT Program, that will provide pretrial and sentenced inmates comprehensive MAT services pre and post release for a successful re-entry from opioid use upon release.

Greater Lawrence Family Health Center provides primary care services, including Office-Based Addiction Treatment (MAT) to 60,000 individuals in the Merrimack Valley. GLFHC has been working closely with Essex County staff to develop aftercare plans for incarcerated MAT recipients, specifically scheduling follow up appointments prior to release. Working closely with Essex County Sheriff's Department in coordinating MAT services for re-entering offenders provides them with the best chance of recovery and reduces recidivism. As a Federally Qualified Health Center (FQHC), the provider of record for more than half the residents of Lawrence, and the regional Ryan White grantee, GLFHC addresses the impact of the HIV/AIDS in Greater Lawrence, one of the communities disproportionally affected by the disease.

Greater Lawrence Family Health Center is also an applicant for the Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant, but proposes to serve a population that is not incarcerated, working with the ECSD to reach individuals upon release. Efforts by GLFHC and the ECSD are part of a continuum of care to address the opioid crisis, which has disproportionately affected the Merrimack Valley of Massachusetts. GLFHC recognizes the need to begin MAT services during incarceration and the benefits of doing so, but cannot (due to current scope of project) provide MAT services to this particular population.

Therefore, it is Greater Lawrence Family Health Center's distinct pleasure to offer this letter of support for this project to promote community-based substance abuse treatment and recovery services for individuals and families in every community.

Sincerely,

Saifur Rahman
Chief Operating Officer

JUDGE'S LOBBY

Telephone: 978-687-7184
Telefax: 978-691-5131

Trial Court of the Commonwealth
District Court Department
Lawrence Division

Fenton Judicial Center
2 Appleton Street
Lawrence, MA 01840-1525

June 26, 2018

Christopher Craft, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Craft:

Please accept this letter of support for the grant application being submitted by Volunteers of America Massachusetts (VOAMA) for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services at the Essex County Sheriff's Department (ECSD), Massachusetts for persons with an opioid use disorder (OUD) seeking or receiving MAT.

VOAMA has collaborated with ECSD to serve clients through the Essex County MAT Program that will provide pretrial and sentenced inmates comprehensive MAT services pre and post release for a successful, free from substance use. re-entry upon release.

I am the Presiding Justice of the Lawrence District Court and I also oversee the Drug Court. Since the male and female detoxification units opened in 2016, we have been working very closely with the staff and have found their work to be an invaluable resource to both our court in general and the drug court specifically. We have been able to provide both defendants and probationers who must be detained based on their history with immediate treatment for their addictions. The information that accompanies these individuals upon their return date to court allows us to make better informed decisions about further detention and/or additional treatment needs. Rather than just warehousing people, we have been able to provide them with much needed services and a better plan to help them in their recovery and reduce the rate of recidivism.

Realizing the number of incarcerated pretrial offenders in need of diversion programs is greater than there are beds available in the detox, ECSD has opened the Pre-Trial Reentry Unit, which focuses on providing services to a greater number of pretrial inmates.

This collaborative initiative between VOAMA and ECSD to address the growing need to expand and enhance medication assisted treatment (MAT) for inmates and re-entering offenders with an opioid use disorder works in concert with the Detox and Pre-Trial Reentry services offered by the Sheriff's Department.

Through these initiatives as well as the relationships that the Essex County Sheriff's Department has established with the clinical and reentry service providers and its partnership with non-profit organizations within the communities they serve, the Lawrence District Court is able to offer offenders with a comprehensive reentry plan that gives them a better chance for success.

It is the Lawrence Drug Court's distinct pleasure to participate in this project alongside VOAMA and the ECSD as it aids HHS/SAMHSA/CSAT in its efforts to promote community-based substance abuse treatment and recovery services for individuals and families in every community.

Sincerely,

Lynn C. Rooney
First Justice

Statement of Assurance

As the authorized representative of Volunteers of America Massachusetts, I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- Official documentation that all mental health/substance use disorder treatment provider organizations: 1) comply with all local (city, county) and state requirements for licensing, accreditation and certification; OR 2) official documentation from the appropriate agency of the applicable state, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist. (Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation, and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)
- For tribes and tribal organizations only, official documentation that all participating mental health/substance use disorder treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation, and certification; OR 2) documentation from the tribe or other tribal governmental unit that licensing, accreditation, and certification requirements do not exist.

Signature of Authorized Representative

6/21/18

Date

Attachment 2: Data Collection Instruments/Interview Protocols

a) Level of Service/Case Management Inventory (LS/CMI) (draft attached)

b) Massachusetts Standardized Documentation Project (MSDP) (draft attached)

c) Comprehensive Addictions and Psychological Evaluation - 5 (CAAPE-5) (draft attached)

d) Supplemental Participant Interview Questions (draft attached)

e) Fidelity Tools (Motivational Interviewing draft attached; additional fidelity tools will be determined upon award)

f) Service and Referral Logs (drafts attached)

g) Key Informant Interview Guide (draft attached)

h) Client Focus Group Script and Questions (draft attached)

**Will also use CSAT GPRA Client Outcome Measures for Discretionary Programs (GPRA Tool)*

Volunteers of America Massachusetts LSC100

Offender Name _____ Gender M F Age _____ Date of Birth ____/____/____ TI-18-009
mm / dd / yyyy

Identifying Number _____ Interviewer _____ Interview Date ____/____/____
mm / dd / yyyy

LS/CMI QuikScore™ Form
Level of Service/Case Management Inventory
D.A. Andrews, Ph.D., James L. Bonta, Ph.D., & J. Stephen Wormith, Ph.D.

The LS/CMI assessment is a quantitative survey of offender attributes and situations relevant to decision-making regarding level of service. Some items are in a no/yes format, and some are in a 3–0 rating format, based on the following scale:

3: A satisfactory situation with no need for improvement
2: A relatively satisfactory situation with some room for improvement
1: A relatively unsatisfactory situation with a need for improvement
0: A very unsatisfactory situation with a very clear and strong need for improvement

Place an X over the appropriate response for each item, whether it is a yes, no, or a rating number. The responses will transfer through to the scoring sheet beneath for quick tallying of the LS/CMI subcomponent scores and total score. If the section is a strength for the offender, place an X in the Strength box. Refer to the *LS/CMI User's Manual* or *LS/CMI Scoring Guide* for guidelines on rating items. When there is insufficient information to respond, circle the item number. *Complete and score Section 1 before completing Sections 2 to 8.*

Section 1: General Risk/Need Factors

1.1 Criminal History

No Yes 1. Any prior youth dispositions (number ___) or adult convictions (number ___)?
No Yes 2. Two or more prior youth/adult dispositions/convictions?
No Yes 3. Three or more prior youth/adult dispositions/convictions?
No Yes 4. Three or more present offences (number ___)?
No Yes 5. Arrested or charged under age 16?
No Yes 6. Ever incarcerated upon conviction?
No Yes 7. Ever punished for institutional misconduct or a behavior report (number ___)?
No Yes 8. Charge laid, probation breached, or parole suspended during prior community supervision?
Strength? ☐

1.2 Education/Employment

When in the labor market (either in the community or long-term imprisonment with work opportunities):

No Yes 9. Currently unemployed?
No Yes 10. Frequently unemployed?
No Yes 11. Never employed for a full year?

School or when in school:

No Yes 12. Less than regular grade 10 or equivalent?
No Yes 13. Less than regular grade 12 or equivalent?
No Yes 14. Suspended or expelled at least once.

For the next three questions, if the offender is a homemaker or pensioner, complete question 15 only. If the offender is in school or working, complete 15, 16, and 17. If the offender is available for the labor market but is unemployed and not in school, rate 0 for 15–17.

3 2 1 0 15. Participation/Performance.
3 2 1 0 16. Peer interactions.
3 2 1 0 17. Authority interaction.
Strength? ☐

1.3 Family/Marital

3 2 1 0 18. Dissatisfaction with marital or equivalent situation.
3 2 1 0 19. Nonrewarding, parental.
3 2 1 0 20. Nonrewarding, other relatives.
No Yes 21. Criminal—family/spouse.
Strength? ☐

1.4 Leisure/Recreation

No Yes 22. Absence of recent participation in an organized activity.
3 2 1 0 23. Could make better use of time.
Strength? ☐

1.5 Companions

No Yes 24. Some criminal acquaintances.
3 2 1 0 25. Some criminal friends.
No Yes 26. Few anticriminal acquaintances.
3 2 1 0 27. Few anticriminal friends.
Strength? ☐

1.6 Alcohol/Drug Problem

No Yes 28. Alcohol problem, ever.
No Yes 29. Drug problem, ever.
3 2 1 0 30. Alcohol problem, currently.
3 2 1 0 31. Drug problem, currently. Specify type of drug(s) _____

If a current alcohol/drug abuse problem exists, complete the following:

No Yes 32. Law violations.
No Yes 33. Marital/Family.
No Yes 34. School/Work.
No Yes 35. Medical or other clinical indicators? Specify _____
Strength? ☐

1.7 Procriminal Attitude/Orientation

3 2 1 0 36. Supportive of crime.
3 2 1 0 37. Unfavorable toward convention.
No Yes 38. Poor, toward sentence/offence.
No Yes 39. Poor, toward supervision/treatment.
Strength? ☐

1.8 Antisocial Pattern

No Yes 40. Specialized assessment for antisocial pattern.
No Yes 41. Early and diverse antisocial behavior. *Item a, plus at least one of b, c, or d. Indicate all that apply.*

a. Severe problems of adjustment in childhood, as indicated by school and social welfare records, or arrested or charged under age 16. (5)
b. Official record of assault/violence.
c. Escape history from a correctional facility, unlawfully-at-large.
d. Charge laid, probation breached, or parole suspended during prior community supervision. (8)

No Yes 42. Criminal attitude. *At least one of the following items. Indicate all that apply.*

a. Supportive of crime. (36)
b. Unfavorable toward convention. (37)
c. Poor, toward supervision/treatment. (39)

No Yes 43. Pattern of generalized trouble. *At least four of the following items. Indicate all that apply.*

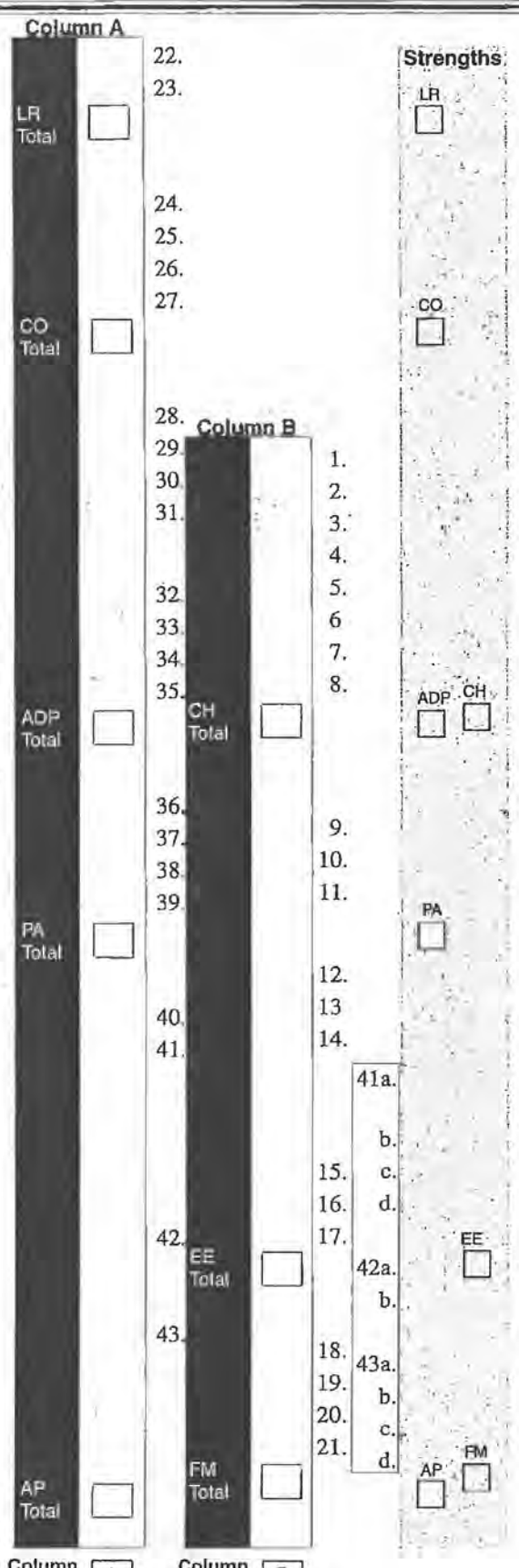
a. Financial problems. 3 2 1 0
b. 3 or more address changes last year. (# ____)
c. Never employed for a full year. (11)
d. Less than regular grade 10 or equivalent. (12)
e. Suspended or expelled at least once. (14)
f. Nonrewarding, parental. (19)
g. Could make better use of time. (23)
h. Few anticriminal friends. (27)

Strength? ☐

Volunteers of America Massachusetts

Offender Name _____ Gender M F Age _____ Date of Birth ____/____/____ TI-18-009
mm / dd / yyyy

Identifying Number _____ Interviewer _____ Interview Date ____/____/____
mm / dd / yyyy



1. To find the eight LS/CMI subcomponent scores, count the number of Xs above each Total box (e.g., LR Total) in the unshaded sections of Columns A and B, and write the sum in each Total box. Note that Xs in the darkened parts of Columns A and B are not counted.

2. Sum the LR, CO, ADP, PA, and AP Totals to find the Column A Total, and sum the CH, EE, and FM Totals to find the Column B Total.

3. Lastly, add the Column A and B Totals to obtain the LS/CMI Section 1 Total Score. Refer to the ColorPlot™ Profile to compare the Section 1 Total Score to the male and female offender norms.

Items with circled numbers have been omitted. Note that the Strengths and responses to items 41a to 41d, 42a to 42c, and 43a to 43h also transfer to this page, but do not affect the Section 1 Total Score.

Number of prior youth dispositions ☐ Number of prior adult convictions ☐

Type of drugs used ☐

Number of present offences ☐

Number of times punished for institutional misconduct ☐

Clinical indicators of drug problems ☐

LS/CMI Section 1 Total Score

A + B = ☐

Financial Problems 3 2 1 0

Number of address changes ☐

Scale Acronyms
LR = Leisure/Recreation
CO = Companions
ADP = Alcohol/Drug Problem
PA = Procriminal Attitude/ Orientation
AP = Antisocial Pattern
CH = Criminal History
EE = Education/Employment
FM = Family/Marital

Section 2: Specific Risk/Need Factors

Circle the appropriate response for the following items.

2.1 Personal Problems with Criminogenic Potential

No Yes 1. Clear problems of compliance (specific conditions).
No Yes 2. Diagnosis of "psychopathy."
No Yes 3. Diagnosis of other personality disorder.
No Yes 4. Threat from third party.
No Yes 5. Problem-solving/self-management skill deficits.
No Yes 6. Anger management deficits.
No Yes 7. Intimidating/controlling.
No Yes 8. Inappropriate sexual activity.
No Yes 9. Poor social skills.
No Yes 10. Peers outside of age range.
No Yes 11. Racist/sexist behavior.
No Yes 12. Underachievement.
No Yes 13. Outstanding charges.
No Yes 14. Other. Specify _____

2.2 History of Perpetration

Sexual Assault

No Yes 1. Sexual assault, extrafamilial, child/adolescent—male victim.
No Yes 2. Sexual assault, extrafamilial, child/adolescent—female victim.
No Yes 3. Sexual assault, extrafamilial, adult—male victim.
No Yes 4. Sexual assault, extrafamilial, adult—female victim.
No Yes 5. Sexual assault, intrafamilial, child/adolescent—male victim.
No Yes 6. Sexual assault, intrafamilial, child/adolescent—female victim.
No Yes 7. Sexual assault, intrafamilial, adult—spouse/partner victim.

Nonsexual Physical Assault and Other Forms of Violence

No Yes 8. Physical assault, extrafamilial—adult victim.
No Yes 9. Physical assault, intrafamilial—child/adolescent victim.
No Yes 10. Physical assault, intrafamilial—adult partner victim.
No Yes 11. Assault on an authority figure.
No Yes 12. Stalking/harassment.
No Yes 13. Weapon use.
No Yes 14. Fire setting.

Other Forms of Antisocial Behavior

No Yes 15. Impaired driving.
No Yes 16. Shoplifting.
No Yes 17. White collar crime.
No Yes 18. Gang participation.
No Yes 19. Organized crime.
No Yes 20. Hate crime.
No Yes 21. Terrorist activity.

Section 3: Prison Experience—Institutional Factors

To be completed for inmates only (skip to Section 4 for non-inmates). Circle the appropriate response.

3.1 History of Incarceration

Past Incarceration

No Yes 1. Last classification maximum.
No Yes 2. Last classification medium.
No Yes 3. Last classification minimum.
No Yes 4. Past federal incarceration.
No Yes 5. Past state/provincial incarceration.
No Yes 6. Past classification unknown

Present Incarceration

No Yes 7. Protective custody.
No Yes 8. Treatment recommended/ordered. Specify _____
No Yes 9. Misconduct/behavior report during current incarceration. Number _____
No Yes 10. Administrative segregation.
No Yes 11. Security management concerns. Specify _____

3.2 Barriers to Release

No Yes 1. Community supervision inappropriate due to specific risk/need factors identified in Section 2. Specify reason _____
No Yes 2. Insufficient community supports for release (lack of accommodation, treatment services, family support, criminogenic community, etc.). Specify reason _____
No Yes 3. Notoriety of offence. Specify reason _____

Section 4: Other Client Issues

Complete this section by circling the appropriate response. For items 16 to 20, circle all that apply.

Social, Health, and Mental Health

No Yes 1. Financial problems.
No Yes 2. Homeless or transient.
No Yes 3. Accommodation problems.
No Yes 4. Immigration issues.
No Yes 5. Parenting concerns.
No Yes 6. Health problems (HIV, AIDS, etc.).
No Yes 7. Physical disability.
No Yes 8. Learning disability.
No Yes 9. Fetal Alcohol Spectrum Disorder (FASD).
No Yes 10. Depressed.
No Yes 11. Suicide attempts/threat.
No Yes 12. Low self-esteem.
No Yes 13. Shy/withdrawn.
No Yes 14. Diagnosis of serious mental disorder.
No Yes 15. Other evidence of emotional distress. Specify _____
No Yes 16. Victim of family violence. Past Current Physical Sexual Emotional Neglect
No Yes 17. Victim of physical assault. Past Current
No Yes 18. Victim of sexual assault. Past Current
No Yes 19. Victim of emotional abuse. Past Current
No Yes 20. Victim of neglect. Past Current
No Yes 21. Other. Specify _____

Section 5: Special Responsivity Considerations

Responsivity factors reflect differences in learning styles and/or personal interests and are not to be interpreted as risk, need, or problematic characteristics. Circle the appropriate response to these special responsivity factors.

No Yes 1. Motivation as a barrier.
No Yes 2. Engages in denial/minimization.
No Yes 3. Interpersonally anxious.
No Yes 4. Woman, gender-specific issues.
No Yes 5. Cultural issues.
No Yes 6. Ethnicity issues.
No Yes 7. Low intelligence.
No Yes 8. Communication barriers.
No Yes 9. Mental disorder.
No Yes 10. Antisocial personality/psychopathy.
No Yes 11. Other. Specify _____

Section 6: Risk/Need Summary and Override

This section summarizes the offender's scores and assesses the need for client-based or administrative/policy overrides. Consider all information from Sections 1 to 5 in making an override decision.

6.1 Score-Based Risk/Need Level

Total LS/CMI Score _____ (from Section 1)

Score-based LS/CMI Risk/Need Level _____ (see Score-Based Risk/Need Level Guide, below)

Score-Based Risk/Need Level Guide

Risk/Need Level	Very Low	Low	Medium	High	Very High
Total Section 1 Score	0–4	5–10	11–19	20–29	30–43

6.2 Client-Based/Clinical Override

Use the client-based/clinical override? No Yes

List the reasons for *lowering* security/supervision levels or releasing clients. Refer to the strengths in Section 1.

List the reasons for *increasing* security/supervision levels or not releasing clients. Refer to Sections 2 through 4.

6.3 Administrative/Policy Override

Use the administration/policy override? No Yes

If Yes, specify reason. _____

6.4 Final LS/CMI Risk/Need Level

After considering any need for a client-based or administrative/policy override, circle the appropriate risk/need level.

Final Risk/Need Level Very Low Low Medium High Very High

Section 7: Risk/Need Profile

To obtain a risk/needs profile, transfer the subcomponent scores from the Section 1 scoring page, and circle the appropriate values in the table below.

Risk/Need	CH	EE	FM	LR	CO	ADP	PA	AP	Total	R/N1	Override
Very High	8	8–9	4	—	4	7–8	4	4	30+	Very High	Very High
High	6–7	6–7	3	2	3	5–6	3	3	20–29	High	High
Medium	4–5	4–5	2	1	2	3–4	2	2	11–19	Medium	Medium
Low	2–3	2–3	1	—	1	1–2	1	1	5–10	Low	Low
Very Low	0–1	0–1	0	0	0	0	0	0	0–4	Very Low	Very Low

CH = Criminal History
EE = Education/Employment
FM = Family/Marital
LR = Leisure/Recreation
CO = Companions
ADP = Alcohol/Drug Problem
PA = Procriminal Attitude/Orientation
AP = Antisocial Pattern
Total = Total, Section 1
R/N1 = Score-Based Risk/Need Level
Override = Risk/Need Level if Override used

Section 8: Program/Placement Decision

Complete 8.1 for institutional offenders or 8.2 for community offenders. If the offender has not yet been sentenced, complete 8.3. Section 8.4 should be completed for all offenders.

8.1 Institutional Offenders

Recommendation/Decision Minimum Medium Maximum

Release Recommended No Yes

Institutional Placement _____

Comments _____

8.2 Community Offenders

Recommendation/Decision Minimum Medium Maximum

Program Placement _____

Comments _____

8.3 Presentence Report

Comments _____

_____

8.4 Summary of Findings

_____

_____

_____

Notes

Authorization and Sign-off

Assessor

Assessor's Name _____ Signature _____ Date ____ / ____ / ____
mm / dd / yyyy

Assessor's Position _____ Recommendation/Decision _____

Explanation (if different from above) _____

Authorization

Authorizing Name _____ Signature _____ Date ____ / ____ / ____
mm / dd / yyyy

Authorizing Position _____

MSDP

Person's Name (First MI Last):	Record #:	Date of Admission:
Organization/Program Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Transgender

Presenting Concerns (In Person's /Family's Own Words)

Referral Source:
Reason for Referral:

What Occurred to Cause the Person to Seek Services Now (Note Precipitating Event, Symptoms, Behavioral and Functioning Needs):

Living Situation

What is the person's current living situation? (check one)
☐ Rent ☐ Own ☐ Friend's Home ☐ Relative's/Guardian's Home ☐ Foster Care Home ☐ Respite Care ☐ Jail/Prison
☐ Homeless living with friend ☐ Homeless in shelter/No residence ☐ Other:

☐ Residential Care/Treatment Facility: ☐ *Hospital* ☐ *Temporary Housing* ☐ *Residential Program* ☐ *Nursing/Rest Home* ☐ *Supportive Housing*

At Risk of Losing Current Housing ☐ Yes ☐ No Satisfied with Current Living Situation ☐ Yes ☐ No

Comments (Include environmental surroundings and neighborhood description):

Family History

Family History and Relationship, Parental/ Familial Caretaker Obligations:

Pertinent Family Medical, MH and SU History:

Developmental History and Status:

Social Support

Friendship/Social/Peer Support Relationships, Pets, Community Supports/Self Help Groups (AA, NA, SMART, NAMI, Peer Support, etc.):

Religion/Spirituality and Cultural/Ethnic Information:

Person's Name (First MI Last):	**Record #:**

Legal Status and Legal Involvement History

Does Person Served have a Legal Guardian, Rep Payee or Conservatorship? ☐ No ☐ Yes; **If yes, complete and attach the Legal Status Addendum**

Is there a need for a Legal Guardian, Rep Payee or Conservatorship? ☐ No ☐ Yes / Explain:

Does the person have a history of, or current involvement with the legal system (i.e., legal charges)? ☐ No ☐ Yes; **If yes, complete and attach the Legal Involvement and History Addendum**

Education

Highest Level of Education Achieved: ☐ GED ☐ HS Grad ☐ College ☐ Vocational Training ☐ Graduate Degree Highest Grade Completed:

Person's Preferred Learning Style(s): ☐ Visual ☐ Auditory ☐ Verbal ☐Written ☐ Learn by doing
Currently Enrolled in Educational Program?: ☐ No ☐ Yes; **If yes, complete and attach Education Addendum**
Is person interested in further education or assistance in education?: ☐ No ☐ Yes; **If yes, complete and attach Education Addendum**

Employment and Meaningful Activities

Employment Status/Interests:

☐ Never Worked Currently Employed? ☐ No ☐ Yes; If yes, length of employment:
(If not currently employed) – Person served wants to work? ☐ No ☐ Yes ☐ Uncertain / Comments:
Does the person want help to find employment or vocational training? ☐ No ☐ Yes / Comments: **If yes, complete Employment Addendum**

Meaningful Activities (Community Involvement, Volunteer Activities, Leisure/Recreation, Other Interests):

Income/Financial Support

How does the person describe her/his current financial situation? ☐ Comfortable/ living within means
☐ Occasional struggle with finances ☐ Often struggles with finances ☐ Financial struggles are a major source of stress
Comments:

Do you receive any sources of financial assistance? ☐ SSI ☐ SSDI ☐ Food Stamps ☐ Contributions from family or friends
☐ Disability ☐ Child Support ☐ Veterans Benefits
☐ TAFDC ☐ EAEDC ☐Other:

If yes, Type and Amount:

Military Service

☐ **None Reported** - If None Reported, skip to the Substance Use / Addictive Behavior History Section

Military Status:	**Date of Discharge:**
☐ Active ☐ Veteran	**Type of Discharge:** ☐ 1. Honorable ☐ 2. General (under Honorable Conditions ☐ 3. Other than Honorable ☐ 4. Bad Conduct ☐ 5. Dishonorable Reason:

Is a complete Military Service assessment needed? ☐ No ☐ Yes; **If yes, complete and attach Military Service Addendum**

Addictive Behavior and Substance Abuse History

Does person report a history of, or current, substance use or other addictive behavior concerns (i.e., alcohol, tobacco, gambling, food)? ☐ No ☐ Yes;. **If yes, complete and attach Addictive Behavior History/SA Addendum.**

Person's Name (First MI Last):	Record #:

Mental Health and Addiction Treatment History

Type of Service	Dates of Service	Reason	Name of Provider/ Agency:	Inpatient/ Outpatient	Completed
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes
	/			☐ In ☐ Out	☐ No ☐ Yes

Efficacy of past and current treatment:

Psychiatric History (including past diagnoses):

Source(s) of Information: ☐ Person Served ☐ Significant other/Family member(s) ☐ Service Provider(s)
☐ Case Manager ☐ Written records ☐ Other:

Physical Health

PCP, Medical Specialist and Dentist Name, Credentials, Specialty	Telephone Number	Fax Number	Address	Date of Last Exam

MSDP

Person's Name (First MI Last):	Record #:

Physical Health Summary

OR ☐ Refer to Attached Physical Health Assessment

Bureau of Substance Abuse Services (BSAS) Programs must complete the MSDP Infectious Disease Risk Addendum and the BSAS TB Assessment

Allergies: ☐ No Known Allergies ☐ **Yes, list below:**

Food: Medication Allergies and Medication Sensitivities (including OTC, herbal):
Environmental:

Physical Health Summary: (Include health history, chronic conditions, significant dental history, and current physical complaints that may interfere with the person's served functioning.)

Does the person use complimentary health approaches (e.g. natural products, mind-body practices, yoga)? ☐ Yes ☐ No
If yes, please describe:

Does the person wish to consider using complimentary health approaches and want help finding a provider? ☐ Yes ☐ No ☐ NA
If yes, please describe:

Sexual History/Concerns:

Pain Screening:
Does the person experience pain currently? ☐ Yes ☐ No Has the person experienced pain in past few months? ☐ Yes ☐ No
Describe the type, frequency, duration, intensity, identified cause, any limitations to functioning and what helps relieve the pain:

Nutritional Screening: (check all that are reported)
☐ Special diet? (e.g. diabetic, celiac) Follows special diet? ☐ Yes ☐ No ☐ Medications affecting nutritional status
☐ Weight gain/loss of 10 pounds or more without specific diet ☐ Change in appetite
☐ Binging ☐ Purging ☐ Use of laxatives ☐ Intense focus on weight, body size, calorie intake, exercise

Beliefs, perceptions, attitude, behaviors regarding food:

Physical Health Summary and Recommendations:
If person has not had physical exam in past year, or if person has reported pain without a determined cause, or if person has reported eating disordered behaviors that are not being medically followed:
☐ Referral for physical exam ☐ Referral for Nutritional Assessment
☐ Person declined exam (reason): ☐ PCP contacted

Medication Summary

Medication information and history of adverse reactions: (Include what medications work well and have worked well previously, any adverse side effects, why person doesn't take meds as prescribed and/or which one(s) the person would like to avoid taking in the future):

Is the person served currently taking any medication ☐ No ☐ Yes; If yes, complete and attach the Medication Addendum

Advanced Directive

Does the person have advanced directive established ☐No ☐Yes
If yes, what type? ☐ Living Will ☐ Power of Attorney ☐ Health Care Proxy ☐ Other:
If no, does the person wish to develop them at this time? ☐No ☐Yes / If yes, follow agency's procedure for completion

Trauma History

Does person report a history of trauma? ☐ No ☐ Yes
Does person report history/current family/significant other, household, and/or environmental violence, abuse or neglect or exploitation?
☐ No ☐ Yes
If the answer to either of the above questions is yes, complete and attach the Trauma History Addendum.

Person's Name (First MI Last):	**Record #:**

Mental Status Exam – (WNL = Within Normal Limits) (**) – ***If Checked, Risk Assessment is Required***

Appearance/ Clothing:	☐ WNL	☐ Neat and appropriate	☐ Physically unkempt	☐ Disheveled	☐ Out of the Ordinary	
Eye Contact:	☐ WNL	☐ Avoidant	☐ Intense	☐ Intermittent		
Build:	☐ WNL	☐ Thin	☐ Overweight	☐ Short	☐ Tall	
Posture:	☐ WNL	☐ Slumped	☐ Rigid, Tense	☐ Atypical		
Body Movement:	☐ WNL	☐ Accelerated	☐ Slowed	☐ Peculiar	☐ Restless	☐ Agitated
Behavior:	☐ WNL	☐ Cooperative	☐ Uncooperative	☐ Overly Compliant	☐ Withdrawn	☐ Sleepy
	☐ Silly	☐ Avoidant/Guarded/ Suspicious	☐ Nervous/ Anxious	☐ Preoccupied	☐ Restless	☐ Demanding
	☐ Controlling	☐ Unable to perceive pleasure	☐ Provocative	☐ Hyperactive	☐ Impulsive	☐ Agitated
	☐ Angry	☐ Assaultive	☐ Aggressive	☐ Compulsive	☐ Relaxed	
Speech:	☐ WNL	☐ Mute	☐ Over-talkative	☐ Slowed	☐ Slurred	☐ Stammering
	☐ Rapid	☐ Pressured	☐ Loud	☐ Soft	☐ Clear	☐ Repetitive
Emotional State-Mood (in person's words):	☐ WNL	☐ Not feeling anything	☐ Irritated	☐ Happy	☐ Angry	☐ Hostile
	☐ Depressed, sad	☐ Anxious	☐ Afraid, Apprehensive			
Emotional State-Affect	☐ WNL	☐ Constricted	☐ Changeable	☐ Inappropriate	☐ Flat	
	☐ Full	☐ Blunted, unvarying				
Facial Expression	☐ WNL	☐ Anxiety, fear, apprehension	☐ Sadness, depression	☐ Anger, hostility, irritability		
	☐ Elated	☐ Expressionless	☐ Inappropriate	☐ Unvarying		
Perception:	☐ WNL					
Hallucinations-	☐ Tactile	☐ Auditory	☐ Visual	☐ Olfactory	☐ Command **	
Thought Content:	☐ WNL					
Delusions-	☐ None Reported	☐ Grandiose	☐ Persecutory	☐ Somatic	☐ Illogical	☐ Chaotic
	☐ Religious					
Other Content-	☐ Preoccupied	☐ Obsessional	☐ Guarded	☐ Phobic	☐ Suspicious	☐ Guilty
	☐ Thought broadcasting	☐ Thought insertion	☐ Ideas of reference			
Thought Process:	☐ WNL	☐ Incoherent	☐ Decreased thought flow	☐ Blocked	☐ Flight of ideas	
	☐ Loose	☐ Racing	☐ Chaotic	☐ Concrete	☐ Tangential	
Intellectual Functioning:	☐ WNL	☐ Lessened fund of common knowledge	☐ Impaired concentration	☐ Impaired calculation ability		
Intelligence Estimate -	☐ Develop. Disabled	☐ Borderline	☐ Average	☐ Above average	☐ No formal testing	
Orientation:	☐ WNL	**Disoriented to:**	☐ Time	☐ Place	☐ Person	
Memory:	☐ WNL	**Impaired:**	☐ Immediate recall	☐ Recent memory	☐ Remote memory	☐ Short Attention Span
Insight:	☐ WNL	☐ Difficulty acknowledging presence of psychological problems		☐ Mostly blames other for problems	☐ Thinks he/she has no problems	
Judgment:	☐ WNL	**Impaired Ability to Make Reasonable Decisions:**		☐ Mild	☐ Moderate	☐ Severe**
Past Attempts to Harm Self or Others:	☐ None Reported	☐ Self**	☐ Others**			
Self Abuse Thoughts:	☐ None reported	☐ Cutting**	☐ Burning**	☐ Other:		
Suicidal Thoughts:	☐ None reported	☐ Passive SI**	☐ Intent**	☐ Plan**	☐ Means**	
Aggressive Thoughts:	☐ None reported	☐ Intent**	☐ Plan**	☐ Means**		

Comments:	

Revision Date: *1-30-17*

MSDP

Person's Name (First MI Last):	Record #:

Person's Served Strengths/Abilities/Resiliency
(Skills, talents, interests, aspirations, protective factors)

Personal Qualities: (Examples: open, friendly, engaging, motivated, loyal, resourceful, caring, thoughtful)	
Living Situation: (Examples: has maintained long-term stable housing, gets along with living companions)	
Financial/Employment/Education: (Examples: graduated HS, attended college, currently working, hx of working, multiple work skills)	
Health: (Examples: consistent good health, exercises regularly, self cares for health issues as directed by physician, eats nutritional foods)	
Leisure/Recreational/Community Involvement: (Examples: plays a sport, belongs to social group, attends gym, volunteers for Red Cross)	
Natural Supports: (Examples: Family members, clergy, close friends, neighbors, advisors)	
Spirituality/Culture/Religion: (Examples: enjoys religious services, participates in cultural events, meet regularly with rabbi)	

Assessed Needs Checklist Including Functional Domains

Activities of Daily Living
CN = Current Need Area
PD = Person Desires Change Now

CN	PD		CN	PD		CN	PD	
☐	☐	Housekeeping/Laundry	☐	☐	Money Management	☐	☐	Transportation
☐	☐	Housing Stability	☐	☐	Personal Care Skills (includes Grooming/ Dress)	☐	☐	Problem Solving Skills
☐	☐	Grocery Shopping/ Food Preparation	☐	☐	Exercise	☐	☐	Time Management
☐	☐	Medication Management	☐	☐	Safety/Self Preservation			
☐	☐	Other:						

Current Needs Selected Above as Evidenced By:

CAAPE-5™

Comprehensive Addictions And Psychological Evaluation – 5

Norman G. Hoffmann, Ph.D.

Name: _____

ID #: _____ Interviewer: _____

Date of Birth: ____ / ____ / ____ (month / day / year) Current Date: ____ / ____ / ____ (month / day / year)

1. Gender:
   - ___ (1) Male
   - ___ (2) Female

2. How old are you? ___ ___ years

3. In which ethnic grouping would you classify yourself?
   - ___ (1) Hispanic / Latino
   - ___ (2) African-American
   - ___ (3) Native American
   - ___ (4) Native Hawaiian / Pacific Islander
   - ___ (5) Asian
   - ___ (6) Middle Eastern
   - ___ (7) Caucasian / White
   - ___ (8) Multiracial / Biracial / Other

4. What is your current marital status?
   - ___ (1) Never married
   - ___ (2) Divorced
   - ___ (3) Separated
   - ___ (4) Widowed
   - ___ (5) Living as married
   - ___ (6) Married

5. **If ever married, ask:**
   How many times have you been married? ___

6. What is the highest degree you have earned?
   - ___ (1) No high school diploma earned
   - ___ (2) High school diploma or GED
   - ___ (3) Vocational/technical/business school grad.
   - ___ (4) Associate degree
   - ___ (5) Bachelor's degree
   - ___ (6) Master's degree
   - ___ (7) Doctoral-level degree

7. What is your current employment status?
   - ___ (1) Working full time for pay (35 hr./wk. or more)
   - ___ (2) Working part time for pay (< 35 hr./wk.)
   - ___ (3) Unemployed
   - ___ (4) Not working for pay by choice
   - ___ (5) Disabled
   - ___ (6) Retired

8. What is your primary job type when working for pay?
   - ___ (1) Professional
   - ___ (2) Upper-level management / business owner
   - ___ (3) Mid-level management
   - ___ (4) Sales / marketing
   - ___ (5) Supervisory
   - ___ (6) Craft / skilled trades / technical
   - ___ (7) Office / white collar / clerical
   - ___ (8) Transportation / equipment operator
   - ___ (9) Laborer / unskilled worker
   - ___ (10) Service worker (waiter / waitress)
   - ___ (11) Domestic worker (housekeeper, etc.)
   - ___ (12) Military service
   - ___ (13) Other (specify) _____

9. In what range was your personal income in the past year?
   - ___ (1) $10,000 or less
   - ___ (2) $10,001 to $20,000
   - ___ (3) $20,001 to $35,000
   - ___ (4) $35,001 to $60,000
   - ___ (5) $60,001 to $90,000
   - ___ (6) Over $90,000

10. When did you last use [name substance]?

Name each substance group including local terminology where appropriate.

Code according to the most recent use:
0 = Never used
1 = Not used for more than 12 months
2 = Used within the past 12 months, but not during past 6 months
3 = Used within the past 6 months, but not during past month
4 = Used in past month
5 = Used within the past week
6 = Used within the past 24 hours

For each substance used in the past month, record number of days used.

Tobacco
0 1 2 3 4 5 6 __ __ days

Alcohol
0 1 2 3 4 5 6 __ __ days

Marijuana
0 1 2 3 4 5 6 __ __ days

Cocaine (powder or crack)
0 1 2 3 4 5 6 __ __ days

Amphetamines / stimulants
0 1 2 3 4 5 6 __ __ days

Sedatives / tranquilizers
0 1 2 3 4 5 6 __ __ days

Heroin / opioids
0 1 2 3 4 5 6 __ __ days

Hallucinogens / PCP
0 1 2 3 4 5 6 __ __ days

Inhalants
0 1 2 3 4 5 6 __ __ days

Other substance (specify) _____
0 1 2 3 4 5 6 __ __ days

If no substance use is reported go to Item 48.

One pass option: If only one or two substances are used, the probes for problems in the past 12 months can be asked for each substance.

Two pass option: If multiple substances are used, the general question can be asked without naming a substance. Circle "no" or "yes" above the left column, and ask the next question. Once all the questions in this section are covered, return to the first "yes" question and do the probes for specific substances.

11. [U] - Have you ever spent more time using [name substance] than you intended to?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drugs _____	0 1 2 3+

12. [N] - Have you ever neglected some of your usual responsibilities because of using [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drugs _____	0 1 2 3+

13. [C] - Have you ever wanted to cut down on your use of [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drugs _____	0 1 2 3+

14. [O] - Has anyone ever objected to your use of [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drugs _____	0 1 2 3+

15. **[P]** - Have you ever found yourself thinking a lot about using [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drugs _____	0 1 2 3+

16. **[E]** - Have you ever used [name substance] to relieve emotional discomfort, such as sadness, anger, or boredom?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drugs _____	0 1 2 3+

If no positive responses to Items 11-16, skip to Item 48.

Any positive response to the UNCOPE (Items 11-16) suggests a possible problem. Two or more positive responses to Items 11-15 indicates at least a mild substance use disorder, and four or more at least a moderate use disorder if the positive findings pertain to the same substance. A positive response on Item 16 may indicate self-medication.

Continuation of the interview is required to cover content necessary to confirm a diagnosis.

Criterion 1: Unplanned use, more use, or longer time using

(Includes Item 11)

17. Have you ever drank or used more than you had intended?

If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Criterion 2: *Desire and/or attempts to restrict use*

(includes Item 13)

18. Have you ever set rules to control your drinking or drug use? **[If no to all, skip the next item]**

If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

19. Have you ever failed to follow rules to control your drinking or drug use?

If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Criterion 3: Spending a great deal of time using

20. **A.** On a typical Friday, or last day of work for the week, how many hours do you spend drinking or using drugs and getting over the effects of use? __ __

B. For a typical Saturday and Sunday, or two days when you don't work, how many total hours do you spend drinking or using and recovering from use? __ __

C. When you drink or use during a typical work day, such as Monday through Thursday, how many hours would you typically spend drinking or using and recovering from use. __ __

D. During a typical week, on how many weekdays do you drink or use drugs? __

Estimated hours of use during a typical week equals A + B + (C x D). __ __

Hours of use can be calculated after the interview.

21. Have you ever found yourself planning your activities around being able to drink or use drugs?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

22. Have you ever stayed intoxicated on alcohol or high from drugs for more than a day at a time?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Criterion 4: Craving or strong compulsion to use
(Includes Item 15)

23. Have you ever had a strong craving to drink or use drugs?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

24. Has the desire to drink or use a drug ever been so strong that you couldn't resist drinking or using?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Criterion 5: Role fulfillment failure
(Includes Item 12)

25. Have you ever missed work or school because of your drinking or drug use?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

26. Have you ever had any work or school problems related to your drinking or drug use?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

27. Have you ever had any financial problems related to drinking or drug use?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Criterion 6: Social or interpersonal problems (Includes Item 14)

28. Have you ever been violent or hit anyone while drinking or using drugs?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

29. Has your drinking or drug use ever harmed a relationship with someone you cared about?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

30. Have you ever had conflicts with anyone over matters that might have been related to your drinking or drug use?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Criterion7: Sacrifice activities because of use

31. Have you ever skipped any family or social functions because of your drinking or drug use?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

32. Have you ever given up or reduced any activities so that you could drink or use drugs?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

33. Has you ever missed any work opportunities or work related activities because of alcohol or drug use?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Criterion 8: Dangerous behaviors

34. Have you ever injected a drug to get high?
If the response is yes, ask:
Did you inject [name substance]?

no	yes		times in past 12 mo.
0	1	Cocaine	0 1 2 3+
0	1	Heroin or other opioids	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Other drugs _____	0 1 2 3+

35. Have you ever driven any type of motor vehicle when you may have been intoxicated or under the influence?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

36. Have you ever done risky things while drinking or using where being under the influence was dangerous?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Criterion 9: Medical or psychological contraindication

37. Have you ever had any physical problems that might have been caused by drinking or drug use?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

38. Have you ever continued to drink or use drugs when you had a physical problem or illness that might be made worse by use?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

39. A. Have you ever not remembered things you said or did while drinking or after drinking?

no	yes		times in past 12 mo.
0	1		0 1 2 3+

39. B. Have you ever not remembered things you said or did when using other drugs?

no	yes		times in past 12 mo.
0	1		0 1 2 3+

40. Have you ever drunk or used despite experiencing emotional or psychological problems that might have been caused by or made worse by drinking or drug use?
If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Criterion 10: Tolerance

If no alcohol use is reported in past year, skip to Item 43.

41. When you drink, how many standard drinks do you usually have? A standard drink would be 12 oz. of beer, glass of wine or 1.5 oz. of liquor.
    ___ (1) 9 or more
    ___ (2) 7 or 8
    ___ (3) 5 or 6
    ___ (4) 3 or 4
    ___ (5) 1 or 2

42. Have you ever been able to drink about a fifth of liquor or 20 beers or 3 bottles of wine in a day?

no	yes		times in past 12 mo.
0	1	----------	0 1 2 3+

43. Have you ever found that you could drink or use more than you once did? That is, did it take more to get intoxicated or high?
    If yes, ask: Does that apply to [name substance]?

ever no	ever yes		in the past 12 mo. no	in the past 12 mo. yes
0	1	Alcohol	0	1
0	1	Marijuana	0	1
0	1	Cocaine	0	1
0	1	Amphetamines / stimulants	0	1
0	1	Sedatives / tranquilizers	0	1
0	1	Heroin / opioids	0	1
0	1	Hallucinogens / PCP	0	1
0	1	Inhalants	0	1
0	1	Other drug _____	0	1

44. Have you ever found that you didn't get the same effect with the same amount of alcohol or drug?
    If yes, ask: Does that apply to [name substance]?

ever no	ever yes		in the past 12 mo. no	in the past 12 mo. yes
0	1	Alcohol	0	1
0	1	Marijuana	0	1
0	1	Cocaine	0	1
0	1	Amphetamines / stimulants	0	1
0	1	Sedatives / tranquilizers	0	1
0	1	Heroin / opioids	0	1
0	1	Hallucinogens / PCP	0	1
0	1	Inhalants	0	1
0	1	Other drug _____	0	1

Criterion 11: Withdrawal

45. Have you ever had shakes, sweating, nausea, fatigue, runny nose, insomnia, or any other ill effects after stopping or cutting down on drinking or drug use?
    If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

46. Have you ever had a drink or used drugs to ease a hangover or reduce other ill effects of use?
    If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Legal problems: Not a DSM-5 criterion

47. Have you ever been arrested, ticketed, or detained by any law officers for any reason related to your alcohol or drug use?
    If yes, ask: Does that apply to [name substance]?

no	yes		times in past 12 mo.
0	1	Alcohol	0 1 2 3+
0	1	Marijuana	0 1 2 3+
0	1	Cocaine	0 1 2 3+
0	1	Amphetamines / stimulants	0 1 2 3+
0	1	Sedatives / tranquilizers	0 1 2 3+
0	1	Heroin / opioids	0 1 2 3+
0	1	Hallucinogens / PCP	0 1 2 3+
0	1	Inhalants	0 1 2 3+
0	1	Other drug _____	0 1 2 3+

Comments:

Major Depressive Episode

48. Has there ever been at least a two-week period when you felt depressed, blue, or sad?

___ (0) No ___ (1) Yes

49. Have you ever had at least a two-week period when you lost interest in almost all activities or were unable to get pleasure from almost anything?

___ (0) No ___ (1) Yes

If both Item 48 and Item 49 are "no," skip to Item 59.

50. How recently have you had a two-week or longer period of feeling depressed or when you lost interest in things?

___ (1) In the past 2 months
___ (2) 3 to 6 months ago
___ (3) 7 to 12 months ago
___ (4) Over a year ago

The following questions refer to your experiences during these periods.

51. Did you have trouble getting to sleep and staying asleep or did you find yourself sleeping a lot?

___ (0) No ___ (1) Yes

52.A. Did you lose your appetite or lose weight without dieting?

___ (0) No ___ (1) Yes: **skip to Item 53**

52.B Did you gain weight without intending to do so?

___ (0) No ___ (1) Yes

53. Did you have trouble thinking or concentrating?

___ (0) No ___ (1) Yes

54. Did you have little energy or were easily fatigued most days?

___ (0) No ___ (1) Yes

55. Did you feel worthless or guilty?

___ (0) No ___ (1) Yes

56. Were you agitated, or did you find your movements unusually slowed?

___ (0) No ___ (1) Yes

57. Did you have any thoughts of death, dying, or suicide?

___ (0) No ___ (1) Yes

58. Did such periods of depression or loss of interest occur when you were not using alcohol or other drugs?

___ (0) No ___ (1) Yes, when not using

Manic Episode

59. At any time in your life, have you ever experienced at least a week when you felt unusually happy or "on top of the world" for no reason?

___ (0) No ___ (1) Yes

60. During a period of a week or more were you unusually agitated or irritable?

___ (0) No ___ (1) Yes

61. Has there been a period of a week or more where you had so much energy that you needed little or no sleep for at least several days?

___ (0) No ___ (1) Yes

If Items 59 through Item 61 are "no," skip to Item 69.

62. How recently have you had such a period of at least a week when you felt on top of the world or needed little sleep?

___ (1) In the past 2 months
___ (2) 3 to 6 months ago
___ (3) 7 to 12 months ago
___ (4) More than a year ago

The following six questions refer to your experiences during these periods of elevated or irritable mood.

63. Were you distractible; that is, was it hard to keep your mind focused on a topic or task?

___ (0) No ___ (1) Yes

64. Was there ever a period of at least a week when your thinking seemed speeded up or when you could hardly keep up with your thoughts or they seemed jumbled?

___ (0) No ___ (1) Yes

65. Were you more talkative than usual or did you feel a need to keep talking?

___ (0) No ___ (1) Yes

66. Did you feel you could do almost anything or did you feel very important?

___ (0) No ___ (1) Yes

67. Did you do something you regretted later, such as spending a lot of money, engaging in out of character sexual behavior, or making bad decisions?

___ (0) No ___ (1) Yes

68. Have these types of episodes always been associated with alcohol or drug use or have they happened when you were not using?

___ (0) Only with use ___ (1) When not using

Panic

69. Have you ever experienced a distinct period of intense fear or discomfort in the absence of any real danger?

___ (0) No ___ (1) Yes

If no, skip to Item 76.

70. How may such periods have you experienced in the past 12 months? ___ ___ panicky periods

Score one criterion for each positive response coded "1"

71. During such a period, have you experienced choking, shortness of breath, or smothering sensations?

____ (0) Neither
____ (1) Choking only
____ (1) Shortness of breath / smothering

72. Did you feel dizzy, lightheaded, or faint?

___ (0) No ___ (1) Yes

73. During a period of fear, did you experience sweating, shaking, or trembling?

____ (0) None
____ (1) Sweating
____ (1) Shaking or trembling

74. Did you have nausea or stomach distress, chest pains, or a pounding heart?

____ (0) None
____ (1) Nausea or stomach distress
____ (1) Chest pains
____ (1) Pounding or racing heart

75. During such a period, were you afraid of going crazy or dying?

____ (0) Neither
____ (1) Going crazy / losing control
____ (1) Dying

Comments:

Posttraumatic Stress

76. Have you ever experienced or witnessed a traumatic event that involved possible death or serious injury?

___ (0) No ___ (1) Yes

77. Has learning about a violent or life threatening accident or event involving a family member or close friend ever caused you distress?

___ (0) No ___ (1) Yes

If both Item 76 and Item 77 are "no," skip to Item 89.

78. Do the memories of that experience keep coming back into your mind? (Criterion B)

___ (0) No ___ (1) Yes

79. Have you ever had more than one distressing dream about that past stressful event or time? (B)

___ (0) No ___ (1) Yes

80. Have you ever felt as though the event was happening again? (B)

___ (0) No ___ (1) Yes

81. Have you ever experienced intense distress when something reminds you of the stressful event? (B)

___ (0) No ___ (1) Yes

82. Have you actively avoided thoughts or feelings associated with the event? (Criterion C)

___ (0) No ___ (1) Yes

83. Do you avoid places or things that remind you of the event or otherwise avoid such memories? (Criterion C)

___ (0) No ___ (1) Yes

84. Are you unable to remember some parts of the event or stressful time? (Criterion D)

___ (0) No ___ (1) Yes

85. Have you been more withdrawn since the event, or less interested in activities you used to enjoy? (D)

___ (0) No ___ (1) Yes

86. Since the event, have you found it hard to be happy or to feel positive about the future? (D)

___ (0) No ___ (1) Yes

87. Since the event, have you had trouble sleeping, concentrating, or dealing with anger? (Criterion E)

___ (0) No ___ (1) Yes

88. Since the event, are you more easily startled? (E)

___ (0) No ___ (1) Yes

Anxiety and Phobias

89. Do you tend to worry about things or possible events when others might say there is no good reason to worry?
___ (0) No ___ (1) Yes

90. Are you often anxious about things or possible events even though others say there is no danger or problem?
___ (0) No ___ (1) Yes

91. Do you have problems concentrating or forgetting things because you are anxious?
___ (0) No ___ (1) Yes

92. Do you frequently feel nervous, keyed up, or on edge?
___ (0) No ___ (1) Yes

93. Are you afraid of going into open areas, public places, or away from home even when there is no real physical danger?
___ (0) No ___ (1) Yes

94. Does your avoidance of situations or things interfere with your life?
___ (0) No ___ (1) Yes

Obsessions / Compulsions

95. Are you repeatedly bothered by ideas, thoughts, or impulses that seem to come from nowhere?
___ (0) No **Skip to #97** ___ (1) Yes **Ask #96**

96. Do you have to do something to control or make these thoughts or impulses go away?
___ (0) No ___ (1) Yes

97. Do you spend a lot of time on activities necessary to overcome thoughts or impulses?
___ (0) No ___ (1) Yes

98. Do any thoughts or the activities to control them interfere with your daily life?
___ (0) No ___ (1) Yes

99. Do you have to do things again and again in the same exact way to reduce stress and anxiety or to keep something bad from happening?
___ (0) No ___ (1) Yes

Conduct Disorder

100. Before the age of 13, did you skip school a number of times?
___ (0) No ___ (1) Yes

101. Did you run away from home overnight at least twice?
___ (0) No ___ (1) Yes

102. Before the age of 15, did you start physical fights with others more than once or twice?
___ (0) No ___ (1) Yes

103. Did you ever use a gun, knife, club, or other weapon in more than one fight?
___ (0) No ___ (1) Yes

104. Before the age of 15, did you ever deliberately destroy someone's property?
___ (0) No ___ (1) Yes

105. Did you set fires with the intention of causing damage?
___ (0) No ___ (1) Yes

106. Did you ever do cruel things to people or animals?
___ (0) No ___ (1) Yes

107. Did you frequently lie to get things you wanted?
___ (0) No ___ (1) Yes

108. Before the age of 15, did you ever force others to give you things that belonged to them?
___ (0) No ___ (1) Yes

109. Did you ever break into a home or car to steal or steal something without confronting the victim?
___ (0) No ___ (1) Yes

ASPD

110. Since the age of 15, have you ever done dangerous things just for the thrill or the fun of it?
___ (0) No ___ (1) Yes

111. Since the age of 15, did you often do things for which you could have been arrested?
___ (0) No ___ (1) Yes

112. Since the age of 15, have you been arrested for a criminal offense?
___ (0) No ___ (1) Yes

113. Since the age of 15, have you ever lied or conned people to get what you wanted?
___ (0) No ___ (1) Yes

114. Since the age of 15, have you done things impulsively without thinking ahead to consequences?
___ (0) No ___ (1) Yes

115. Since the age of 15, have you been involved in any fights?
___ (0) No ___ (1) Yes

116. Since the age of 15, have you ever been unable to pay bills or debts because you had spent the money on something else?
___ (0) No ___ (1) Yes

Paranoid Personality

117. Do you tend to hold a grudge?
___ (0) No ___ (1) Yes

118. Have you frequently been concerned that someone may be trying to harm or control you?
___ (0) No ___ (1) Yes

119. Have you ever been suspicious about the loyalty or trustworthiness of family or friends?
___ (0) No ___ (1) Yes

120. Have others ever suggested that you are easily offended?
___ (0) No ___ (1) Yes

Schizoid Personality

121. Do you prefer doing things alone?
___ (0) No ___ (1) Yes

122. Are you a loner; that is, you don't need or want close friendships?
___ (0) No ___ (1) Yes

123. Do you rarely experience strong emotions?
___ (0) No ___ (1) Yes

Borderline

124. Do you find that your mood can change quickly?
___ (0) No ___ (1) Yes

125. Are your friendships more intense than those of most people?
___ (0) No ___ (1) Yes

126. Do your friendships tend not to last very long?
___ (0) No ___ (1) Yes

127. Do you frequently experience feelings of emptiness or boredom?
___ (0) No ___ (1) Yes

128. Are you or have you been afraid of being abandoned by someone you care about?
___ (0) No ___ (1) Yes

129. Have you done impulsive things that caused you problems?
___ (0) No ___ (1) Yes

Dependent Personality

130. Have you had difficulty making decisions without advice or reassurance from others?
___ (0) No ___ (1) Yes

131. Have you found it more comfortable to let others make important decisions?
___ (0) No ___ (1) Yes

132. Do you frequently agree with people even when you think they are wrong just to avoid offending them?
___ (0) No ___ (1) Yes

133. Are you uncomfortable when you are alone?
___ (0) No ___ (1) Yes

134. Do you have trouble starting or doing things on your own?
___ (0) No ___ (1) Yes

135. Are you willing to do most anything to get support and reassurance from people you care about?
___ (0) No ___ (1) Yes

Obsessive-Compulsive Personality

136. Would you say you are a bit of a perfectionist?
___ (0) No ___ (1) Yes

137. Do you tend to keep things even when you have no immediate use for them?
___ (0) No ___ (1) Yes

138. Are you a person who pays close attention to details?
___ (0) No ___ (1) Yes

139. When you work with others, do you tend to be in charge or see to it that the others do things right?
___ (0) No ___ (1) Yes

140. Are you a harder worker than most people?
___ (0) No ___ (1) Yes

Psychosis Indications

141. Have you ever heard voices when no one was there?
___ (0) No ___ (1) Yes

142. Have you ever smelled, tasted, or felt something touching you and there was nothing around to cause it?
___ (0) No ___ (1) Yes

143. Have you ever seen things others could not see?
___ (0) No ___ (1) Yes

If all Items 141 – 143 are "no" end the interview.

144. Have you ever had these experiences when you were **not** using alcohol or drugs?
___ (0) No ___ (1) Yes

145. Have you ever heard voices or seen things at a time when you were **not** drifting off to sleep or just waking up?
___ (0) No ___ (1) Yes

146. Have you ever thought you had special powers, such as being able to read people's minds, predict the future, or move objects with your mind?
___ (0) No ___ (1) Yes

End Interview

Complete observation after interview.

147. Is speech disorganized or idiosyncratic (peculiar)?
___ (0) No ___ (1) Yes

148. Does this individual manifest unusual behaviors or mannerisms?
___ (0) No ___ (1) Yes

149. Is affect flat or inappropriate to the situation?
___ (0) No ___ (1) Yes

150. Is motor activity unusual – either stiff, nearly immobile, or inappropriately active?
___ (0) No ___ (1) Yes

COMMENTS

Experiences with MAT & Vivitrol

E1. **What was the date of your first Vivitrol shot? [FOR THIS TREATMENT EPISODE]**

[ ] (MM/DD/YYYY)

Haven't had it yet ..... 1 Go to E3

DK ..... 2 Go to E3

RF ..... 3 Go to E3

E2. **What was the date of your last/most recent Vivitrol shot?**

[ ] (MM/DD/YYYY)

DK 1

RF 2

E3. **Do you expect to take your next (or first) dose of Vivitrol?**

YES ..... 1 Go to E5

NO 2

DK ..... 3 Go to E5

RF ..... 4 Go to E5

E4. **[IF NO] Why not?**

[ ]

E6. **Sometimes people experience barriers to treatment. Using CARD 4, please tell me how much you disagree or agree with each of the following statements.**

		Disagree Strongly	*Disagree*	*Uncertain*	*Agree*	*Agree Strongly*	*DK*	*RF*
a.	I will lose my friends if I go to treatment.	1	2	3	4	5	6	7
b.	Friends tell me not to go to treatment.	1	2	3	4	5	6	7
c.	People will think badly of me if I go to treatment.	1	2	3	4	5	6	7
d.	Someone in my family does not want me to go to treatment.	1	2	3	4	5	6	7
e.	My family will be embarrassed or ashamed if I go to treatment.	1	2	3	4	5	6	7
f.	I have had a bad experience with treatment.	1	2	3	4	5	6	7
g.	I am afraid of what might happen in treatment.	1	2	3	4	5	6	7
h.	I am afraid of the people I might see in treatment.	1	2	3	4	5	6	7
i.	I am too embarrassed or ashamed to go to treatment.	1	2	3	4	5	6	7
j.	I do not like to talk in groups.	1	2	3	4	5	6	7
k.	I hate being asked personal questions.	1	2	3	4	5	6	7
l.	I do not like to talk about my personal life with other people.	1	2	3	4	5	6	7
m.	I have things to do at home that make it hard for me to get to treatment.	1	2	3	4	5	6	7
n.	It will be hard for me to find a treatment program that fits my schedule.	1	2	3	4	5	6	7
o.	I am moving too far away to get treatment.	1	2	3	4	5	6	7
p.	I do not know where to go for treatment.	1	2	3	4	5	6	7
q.	I have difficulty getting to and from treatment.	1	2	3	4	5	6	7
r.	I will have to be on a waiting list for treatment.	1	2	3	4	5	6	7
s.	I have to go through too many steps to get into treatment.	1	2	3	4	5	6	7

Barriers to treatment may include cost, transportation, finding a provider or program, or having enough time for appointments.

E7. **What would you say is the main barrier to your treatment with Vivitrol?**

Health insurance	01	Not knowing where to go	06
Cost	02	None/no barriers	07
Transportation	03	DK	08
Child care	04	RF	09
Wait time to enroll in a program	05	Other	10

PLEASE DESCRIBE "OTHER"

E8. **Using CARD 5 (on a scale from 0 to 10), how confident are you that you will be able to continue with this VIPS program?**

0 - Not at all confident	01
1	02
2	03
3	04
4	05
5 - Confident	06
6	07
7	08
8	09
9	10
10 - Very confident	11

E9. **Have you experienced any of the following side effects from Vivitrol in the past month?**

*SKIP to E11 if hasn't had shot yet.

		YES	*NO*	*DK*	*RF*
a.	Injection site reaction (bruising, etc.)	1	2	3	4
b.	Nausea	1	2	3	4
c.	Fatigue	1	2	3	4
d.	Headache	1	2	3	4
e.	Other	1	2	3	4

PLEASE SPECIFY

E10. **Have you noticed any benefits (since starting Vivitrol)? To what degree do you feel like it's working?**

E11. **Do you have any concerns about Vivitrol?**

E12. **How would you describe the attitudes of service providers (e.g., counselors, case managers, recovery coaches, psychiatrists) toward your use of Vivitrol?**

E13. **Using CARD 6, please tell us how much you agree or disagree with each of the following statements.**

		Strongly Disagree	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*	*DK*	*RF*
a.	Vivitrol has been proven to help people stay off opiates/alcohol.	1	2	3	4	5	6	7
b.	Vivitrol helps to take away the craving for opiates/alcohol.	1	2	3	4	5	6	7
c.	I don't think Vivitrol helps people stay off opiates/alcohol.	1	2	3	4	5	6	7
d.	Vivitrol causes dangerous side effects.	1	2	3	4	5	6	7
e.	Vivitrol is bad for you physically.	1	2	3	4	5	6	7
f.	It is safe to take Vivitrol.	1	2	3	4	5	6	7
g.	Taking Vivitrol is only replacing one addiction with another.	1	2	3	4	5	6	7
h.	People taking Vivitrol aren't really clean/sober.	1	2	3	4	5	6	7
i.	Vivitrol is a treatment that gives you a "high" just like heroin or pills/alcohol.	1	2	3	4	5	6	7

Experiences with VIPS

EP1. **Using CARD 8, on average, how many times have you had contact with VIPS in the past 90 days?**

None 1
Once 2
2 to 3 times 3
4 to 6 times 4
More than 7 times 5
DK 6
RF 7

EP2. **Do you have plans to meet with VIPS staff in the next month?**

YES 1
NO 2
N/A 3
DK 4
RF 5

EP3. **Do you know what types of assistance this staff person can give you?**

YES 1
NO 2
N/A 3
DK 4
RF 5

EP4. **Using CARD 9, how much has this staff person provided you with any help/assistance since you first met with her/him?**

Not at all 1
A little bit 2
Moderately 3
Quite a bit 4
Extremely 5
N/A 6
DK 7
RF 8

EP4a. Do you expect to have any follow-up with VIPS staff after you leave this facility?

YES	1	Go to EP4c.
NO	2	Go to EP4b.
DK	3	Go to EP5.
RF	4	Go to EP5.

EP4b. [IF NO] Why not? *Record reason, then skip to EP5 below.

EP4c. [IF YES] Using CARD 12, how often do you expect to (or have plans to) ...

	Never	Once in the next few months	1-2 times per month	Once a week	2-3 times a week	Daily	DK	RF
Meet in-person	1	2	3	4	5	6	7	8
Talk by phone	1	2	3	4	5	6	7	8
Other types of contact	1	2	3	4	5	6	7	8

IF OTHER, PLEASE SPECIFY

EP4d. As part of this follow-up with VIPS staff, what types of assistance do you hope to receive from him/her after you leave this facility?

EP5. Would you recommend VIPS to a friend who was in the same situation you were in when you entered the program?

EP6. What are the top three benefits of the VIPS program?

EP7. What are the top three drawbacks or limitations of the VIPS program?

Service Needs & Perceptions

Now I'd like to ask about some types of services you may have received in the past 6 months. First I'd like to know if you needed any of the services I mention (in the past 6 months). Then, if so, I will ask you if you received the service.

SN1. **In the past 6 months, did you need...**	YES	NO	DK	RF	**Did you receive it?** YES	NO	DK	RF
a. Medication Assisted Treatment (MAT), like methadone, Suboxone, or Subutex for an opioid use disorder?	1	2	3	4	1	2	3	4
b. Outpatient substance use treatment, like individual or group counseling?	1	2	3	4	1	2	3	4
c. Inpatient detoxification services for substance use?	1	2	3	4	1	2	3	4
d. Residential substance use treatment?	1	2	3	4	1	2	3	4
e. Emergency room treatment for substance use?	1	2	3	4	1	2	3	4
f. Outpatient mental health services, like individual or group counseling?	1	2	3	4	1	2	3	4
g. Inpatient mental health treatment (hospital or residential)?	1	2	3	4	1	2	3	4
h. Emergency room treatment for mental health issues?	1	2	3	4	1	2	3	4
i. Psychiatric medication (like seeing a psychiatrist or other doctor or medical practitioner for psychiatric medication)?	1	2	3	4	1	2	3	4
j. Group or individual counseling for trauma, abuse, domestic violence, PTSD or related issues?	1	2	3	4	1	2	3	4
k. Self-help or other peer recovery supports (AA, NA, other peer support)?	1	2	3	4	1	2	3	4
l. Services from a medical doctor for a health problem?	1	2	3	4	1	2	3	4
m. A prescription from a medical doctor for pain management?	1	2	3	4	1	2	3	4
n. Treatment from a doctor or other health professional to stop smoking?	1	2	3	4	1	2	3	4
o. Child care while attending substance use, mental health or medical appointments?	1	2	3	4	1	2	3	4

Functioning & Recovery

The next set of questions asks about how you are doing in various areas of your everyday life.

F1. **For each of the following questions, please select the one answer that is most true for you RIGHT NOW. Using CARD 10, please indicate if you:** *Strongly Agree, Agree, Disagree, or Strongly Disagree* **with each statement.**

		Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*	*DK*	*RF*
a.	My living situation feels like a safe home to me.	1	2	3	4	5	6
b.	I have people I trust whom I can turn to for help.	1	2	3	4	5	6
c.	I have at least one close mutual (give-and-take) relationship.	1	2	3	4	5	6
d.	I am involved in activities I find meaningful.	1	2	3	4	5	6
e.	I have enough income to meet my needs.	1	2	3	4	5	6
f.	I am learning new things that are important to me.	1	2	3	4	5	6
g.	I am in good physical health	1	2	3	4	5	6
h.	I have a positive spiritual life/connection to a higher power.	1	2	3	4	5	6
i.	I like and respect myself.	1	2	3	4	5	6
j.	I'm using my personal strengths, skills or talents.	1	2	3	4	5	6
k.	I have goals I'm working to achieve.	1	2	3	4	5	6
l.	I have reasons to get out of bed in the morning.	1	2	3	4	5	6
m.	I have more good days than bad.	1	2	3	4	5	6
n.	I have a decent quality of life.	1	2	3	4	5	6
o.	I control the important decisions in my life.	1	2	3	4	5	6
p.	I contribute to my community.	1	2	3	4	5	6
q.	I am growing as a person.	1	2	3	4	5	6
r.	I have a sense of belonging.	1	2	3	4	5	6
s.	I feel alert and alive.	1	2	3	4	5	6
t.	I feel hopeful about my future.	1	2	3	4	5	6
u.	I am able to deal with stress.	1	2	3	4	5	6
v.	I believe I can make positive changes in my life.	1	2	3	4	5	6

Satisfaction

The next questions are about how satisfied you feel with different parts of your life. After you hear each question, please tell me how satisfied you currently feel by using CARD 11 and responding "very satisfied," "satisfied," "mixed," "dissatisfied," or "very dissatisfied."

S1. **Currently, how satisfied are you with...**

		Very satisfied	*Satisfied*	*Mixed*	*Dissatisfied*	*Very dissatisfied*	*DK*	*RF*
a.	the level of physical intimacy (sexual activity) in your relationships?	1	2	3	4	5	6	7
b.	your family relationships?	1	2	3	4	5	6	7
c.	your general level of happiness?	1	2	3	4	5	6	7
d.	where you are living?	1	2	3	4	5	6	7
e.	how your life is going so far?	1	2	3	4	5	6	7
f.	your school or work situation?	1	2	3	4	5	6	7

The next questions are about how you feel about the staff in the VIPS program. Please answer the next questions using yes or no.

S2. **Are you satisfied that the staff in the VIP program...**

	YES	NO	DK	RF
a. did a good job?	1	2	3	4
b. were fair with clients or patients?	1	2	3	4
c. explained the rules of the program?	1	2	3	4
d. had the time to see you?	1	2	3	4
e. respected clients or patients?	1	2	3	4
f. (staff) and you agreed on what your problems were?	1	2	3	4
g. explained what your treatment was supposed to accomplish?	1	2	3	4
h. asked for your opinions about your problems and how to solve them?	1	2	3	4
i. (staff) and you agreed on what to do about your alcohol and other drug use?	1	2	3	4
j. helped you do something about your alcohol and other drug use?	1	2	3	4
k. (staff) and you agreed on what to do about your other problems?	1	2	3	4
l. helped you do something about your other problems?	1	2	3	4
m. were sensitive to your cultural background?	1	2	3	4
n. gave you enough help for now?	1	2	3	4

Appendix H: Motivational Interviewing Fidelity Measure

DATE: PRACTITIONER: REVIEWER:

This checklist provides a summary of basic skill in Motivational Interviewing. As a reviewer, follow the below steps to complete the checklist.

1. Observe the practitioner and place a check in appropriate box: Yes = behavior observed, No = behavior not observed, NA = non-applicable, and an observation section to report notes if needed.
2. Review the findings with the practitioner.
3. Develop a plan for attempting and/or maintaining checklist behaviors.

Behavior	Yes	No	NA	Observations
Avoided roadblocking				
Demonstrated attending skills				
Demonstrated following skills				
Demonstrated reflecting skills				
Rolled with resistance				
Expressed empathy				
Supported self-efficacy				
Highlighted discrepancies				
Utilized costs/benefits worksheet				
Completed readiness ruler				
Completed willingness ruler				
Completed able ruler				
Cued change talk				
Discussed behaviors in daily, short-term, and long-term timeframes				
Utilized change worksheet				
Additional behaviors:				

EMAT

Service Log *(Draft, to be finalized upon award)*

Participant's Name: _____

EMAT Staff Name: _____ Telephone: _____

WHEN	WITH WHOM		HOW LONG	NATURE OF CONTACT		WHAT	SERVICES DELIVERED
Include only non-casual contacts	*Enter all codes that apply* **1**=participant **2**=participant's partner/spouse **3**=participant's child/ren **4**=other family or friend **5**=EMAT staff **6**=ECSO staff **88**=other collateral provider		*Round to nearest 5 mins*	**1**=in person **2**=by phone (not message) **3**=by mail **88**=other; specify type of contact *Enter all codes in Nature column; if other then specify in 2nd column*		*Enter code for topic(s) addressed (all that apply). See list of codes on next page.*	*Enter code for services delivered. If Other service indicated, please specify the type of service delivered. See list of codes on next page.*
Date	With Whom	If other provider, specify	Length (in mins)	Nature	If other, specify	Topic	Services Delivered Code
__/__/0_							
__/__/0_							
__/__/0_							
__/__/0_							
__/__/0_							
__/__/0_							
__/__/0_							
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__/__/0_							

CODE LIST

CODES FOR TOPICS:

1 = medical issue (note: not of participant's child)
2 = alcohol/other drug abuse issue
3 = violence/abuse/trauma
4 = eating disorder or other self-harming behavior
5 = mental health issue
6 = psychiatric medication
7 = legal assistance (note: not custody issues of participant's child)
8 = housing or assistance finding a place to live
9 = educational or vocational/job assistance
10 = benefits/entitlements (public assistance, welfare, Medicaid, Social Security, etc.)
11 = participant's child's issue (note: not parenting issue or custody issues)
12 = parenting issue
13 = criminal justice
14 = insurance
15 = GPRA data collection
16 = MAT
17 = interpersonal relationships
88 = other, please specify

CODES FOR SERVICES DELIVERED:

Services

Treatment Services
T1= Screening
T2 = Brief Intervention
T3 = Brief Treatment
T4 = Referral to Treatment
T5 = Assessment
T6 = Treatment/Recovery Planning
T7 = Individual Counseling
T8 = Group Counseling
T9 = Family/Marriage Counseling
T10 = Co-Occurring Treatment/Recovery Services
T11 = Pharmacological Interventions
T12 = HIV/AIDS Counseling
T13 = Other Clinical Services
TO = Specify Other Clinical Services

Case Management Services
CM1 = Family Services (Including Marriage Education, Parenting, Child Development Services)
CM2 = Child Care
CM3A = Pre-Employment Service
CM3B = Employment Coaching
CM4 = Individual Services Coordination
CM5 = Transportation
CM6 = HIV/AIDS Service
CM7 = Supportive Transitional Drug-Free Housing Services
CM8 = Other Case Management Services
CMO = Specify Other Case Management Services

Medical Services
MS1 = Medical Care
MS2 = Alcohol/Drug Testing
MS3 = HIV/ AIDS Medical Support & Testing
MS4 = Other Medical Services
MSO = Specify Other Medical Services

After Care Services
AC1 = Continuing Care
AC2 = Relapse Prevention
AC3 = Recovery Coaching
AC4 = Self-Help and Support Groups
AC5 = Spiritual Support
AC6 = Other After Care Services
ACO = Specify Other After Care Services

Peer-To-Peer Recovery Support Services
PP1 = Peer Coaching or Mentoring
PP2 = Housing Support
PP3 = Alcohol-and Drug-Free Social Activities
PP4 = Information and Referral
PP5 = Other Peer-to-Peer Recovery Support Services
PPO = Specify Other Peer-to-Peer Recovery Support

Education Services
E1 = Substance Abuse Education
E2 = HIV/AIDS Education
E3 = Other Education Services
EO = Specify Other Education Services

EMAT Referral Log *(draft, to be finalized upon award)*

Participant's Name: _____

Name of EMAT staff: _____ Staff's Telephone: _____

WHEN	FOR WHOM	AGENCY TO WHICH REFERRED	TYPE OF SERVICE	DATE OF APPT.	APPT. KEPT	ACCOM-PANIED BY EMAT
Enter date referral made	*Enter all codes that apply* 1=participant 2=participant's partner/ spouse 3=participant's child/ren	*Enter name of agency*	*Enter code for type of referral. See code list at bottom of page.*	*Enter date of appointment*	*Enter code* 1=yes 2=no 99=DK	*Enter code* 1=yes 2=no
Date	For Whom	Agency	Type	Date	Appt. Kept	With EMAT Staff
__/__/0_				__/__/0_		
__/__/0_				__/__/0_		
__/__/0_				__/__/0_		
__/__/0_				__/__/0_		
__/__/0_				__/__/0_		
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__/__/0_				__/__/0_		
__/__/0_				__/__/0_		
__/__/0_				__/__/0_		
__/__/0_				__/__/0_		
__/__/0_				__/__/0_		
__/__/0_				__/__/0_		

CODES FOR TYPES OF SERVICE:

1 = medical treatment (note: not of participants' child)
2 = alcohol/other drug abuse treatment
3 = violence/abuse/trauma treatment
4 = eating disorder or other self-harming behavior treatment
5 = mental health issue
6 = psychiatric medication prescription or check
7 = legal assistance (note: not for custody issues of participant's child)
8 = housing or assistance finding a place to live
9 = educational or vocational/job assistance
10 = benefits/entitlements (public assistance, welfare, Medicaid, Social Security, etc.)
11 = participant's child's services (note: not parenting services or custody-related services)
12 = parenting services
13 = criminal justice
14 = insurance
15 = MAT
16 = interpersonal relationships
88 = other, please specify

EMAT Evaluation
KEY INFORMANT/STAFF INTERVIEW PROTOCOL

Introduction
Thank you for participating in this interview about EMAT. The purpose of this interview is to learn more about the implementation of the program and any suggestions you may have about how to improve it. The general goal is to understand the program's efforts, successes, challenges, and needs. We want to learn from your efforts and welcome an open and frank discussion with you.

Before we start, I would like you to read and sign the Key Informant Interview Consent Form. It outlines the purpose of the evaluation and interview, any risks associated with participation, and our obligation to protect your confidentiality.

In reporting this information, I want to assure you that your responses will be confidential. No identifying information will be linked to your individual responses. Our final report will aggregate responses into themes and if we use any direct quotes, they will never be connected with any individual's name.
[Stop & allow respondent to read/sign consent form]

I want to encourage you not to reveal any information that breaks client confidentiality, that you would find embarrassing, or that might jeopardize your job if it were accidentally revealed.

There are no right or wrong answers to any of the questions in the interview. Your opinions are valuable and your answers are appreciated. Please remember that your participation in this interview is voluntary. You are free to refuse to answer any question you do not want to answer, and you can stop participating in the interview at any time. Thank you again for taking the time to do this interview and contribute information that will be useful in improving services. Do you have any questions about the evaluation, this meeting, or the consent form before we begin?

KEY INFORMANTS

1. What agency do you work for, what is your current job title, where are you located, and what are your job responsibilities?

2. How long have you worked in that capacity?

3. What role do you play/how do you interact with EMAT?

4. Has EMAT implemented services as expected, or have there been changes from the original plan? If so, what changes and why?

5. How has the way you do your work changed as a result of EMAT?

6. What impact has the project had on the individuals it serves?

7. What contextual changes (e.g., in the partnering agencies, budgets, public policies) have

happened in the past year that have impacted the services provided or the individuals participating in EMAT?

8. What suggestions do you have about how better to address the needs of the program's target population?

9. Is there anything else you that you would like to add?

EMAT STAFF

1. How long have you worked for EMAT? What role do you play in the program? What are your job responsibilities?

2. What are the unique characteristics of the population you're serving? Based on the understanding of their need, what are the unique program features?

3. Which of these do you think have been most helpful?

4. Have there been any significant changes (either positive or negative) over the past year in the way services are planned or delivered to this population? What sorts of changes?

5. Do you think these approaches/activities are making a difference? What are your most significant accomplishments? What are the most important barriers?

6. What impact has the program had on the individuals it serves?

7. What is "success" in the program?

Vision for the Future

1. What do you believe you need in order to proceed as effectively as possible with your efforts to provide/improve services for your clients?

2. What type of training or support have you received in your role? What more do you need?

3. What do you see as the most important outcomes for EMAT? At the end of this grant, what do you hope will be accomplished?

4. Is there anything else you that you would like to add?

Thank you so much for talking with me about your work and this program.

AHP
Advocates for Human Potential, Inc.

Attachment 3: Sample Consent Forms *(to be finalized upon award)*

EMAT—Release of Information Form

This form is a release of information authorizing EMAT to release non-identifying statistical information from you to provide to our evaluator, Advocates for Human Potential, Inc. (AHP) and to our funder, the Substance Abuse and Mental Health Services Administration (SAMSHA). This information is formally called GPRA (Government Performance and Results Act) data and allows AHP to evaluate our services and the government to understand what the broad client characteristics are for each program that receives funding.

- ☐ This GPRA information we collect from you will be provided to Advocates for Human Potential, Inc., 490 Boston Post Road, Sudbury, MA 01776. I hereby authorize VOAMA/ECSO/EMAT to release this data.
- ☐ I understand that VOAMA and AHP abide by Federal Confidentiality Regulations (42 CFR Part 2, July 1, 1975) which protect the confidentiality of my records and that information contained therein cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand that some data is submitted anonymously to the funding source to gather information to improve services for others.
- ☐ I understand that this consent is subject to revocation by me at any time upon written request. Otherwise, this consent will automatically expire on ____ / ____ / _____.

(one year from today)

Participant's signature Witness (if applicable)

Attorney's signature (if applicable) Date
(Section 2.35)

Sample Consent to Participate in the EMAT Evaluation
Advocates for Human Potential, Inc., 490-B Boston Post Road, Sudbury, MA 01776

VOLUNTEERS OF AMERICA MA (VOAMA)
441 Centre Street
Jamaica Plain, MA 02310
Matthew Marrano, Principal Investigator

ADVOCATES FOR HUMAN POTENTIAL, INC. (AHP)
490 Boston Post Road
Sudbury, MA 01776
David Centerbar, Ph.D., Grant Evaluator

This form is asking for your consent to participate in an evaluation study of EMAT. The evaluation will help us learn more about how well the program is working. The process through which you learn about the evaluation and make your decision to participate is called informed consent. We will explain the evaluation to you, and you will have the opportunity to ask any questions you might have about it before you make your decision. If you decide to participate, you will sign this form and a copy will be given to you. If you decide not to participate in the activities described in this consent form, you are still eligible to participate in EMAT. Any services you may be receiving will not be affected in any way by your decision.

What are you asking me to agree to?
If you agree to participate today, you will be asked to:

- sign this informed consent;
- complete an intake interview;
- allow us to contact you for follow-up interviews (*you are not obligated to participate in those interviews*);
- complete a Locator Form to help us find you for follow-up purposes; and
- allow us to release interview and other information to our evaluator, Advocates for Human Potential, Inc. (AHP). The data will only be used to evaluate the effectiveness of our program.

Intake and Follow-up Interviews
If you agree to participate in this evaluation:

- ✓ We will plan to interview you at intake, in about three months and six months from now, and at program discharge. These interviews will collect information about your housing, alcohol and drug use, mental health, trauma, and other items related to how well you are doing.
- ✓ Your initial interview for this project will be the one conducted by EMAT program staff today.
- ✓ We will also ask to interview you in about 3 and 6 months from now and when you leave the program. During these interviews, you have the right to refuse to answer any question, to skip any interview, and to decline to participate.

Information from Program Records
Evaluation staff will also have access to certain information in your records. Program information will include the date of your enrollment in the program, the date of discharge, services and referrals that you receive, and contact information.

Reimbursement for Participation

We recognize that your time is valuable. At each interview, you will receive $30 in gift cards.

How will my information be protected?
Records created as part of this project are kept confidential and are protected by federal laws regarding the confidentiality of substance abuse treatment records as well as the Health Insurance Portability and Accountability Act. Staff are required to report suspicion of child neglect or child abuse and medical information in cases of medical emergency and will report circumstances in which a client may be a risk to themselves or others.

We have taken several steps to protect your information. These are 1) all staff have been trained to understand the need for privacy and to keep your answers (locator data excluded) completely separate from the records that identify who you are, 2) the information about your identity and all the data with your answers are kept in two separate files that are only linked through a unique ID number, 3) records are stored in locked, secure offices, and 4) only data on groups of people is reported.

What are the risks of the project?
You will be asked to disclose personal information about your history, thoughts, and feelings. You may find this stressful or upsetting and/or may have unexpected reactions to questions. If you do not want to answer any questions, you do not have to. You may take breaks during the interview or stop the interview altogether at any time. While your information will be kept confidential, there are a few exceptions to the rule of confidentiality in research. Staff members are obligated to report if a client being interviewed is in immediate danger of harming him/herself or threatens to harm another person, if there is evidence of child abuse or neglect, or if there is evidence of elder abuse.

Are there any benefits to me or to others if I participate?
While there are no direct benefits from participating in the evaluation, the information learned is intended to be used to improve services. Knowledge gained in the evaluation may help others in the future.

Whom do I call if I have questions or problems?
If you have any questions or comments about this informed consent or this evaluation, or if you would like to withdraw from participation in this evaluation at any time, please contact the Project Director, X, at XXX-XXX-XXXX. If you have any questions about your rights, please contact Terri Tobin, Ph.D., Director of Research and Evaluation, Advocates for Human Potential, Inc. (AHP), 978-261-1436.

Agreement to Participate

- This evaluation has been explained to me. I have had the opportunity to ask questions concerning all aspects of the project. I am aware that I can refuse to answer any question without having to explain why. I am aware that I may choose not to participate or to withdraw from this evaluation at any time without penalty.
- I agree to provide contact information and be contacted for follow-up interviews; however, I understand that I am not obligated to participate in the follow-up interviews.
- I understand my records are protected by federal confidentiality regulations. This means that my information cannot be shared without my written consent unless the law allows it. Reasons that it could be shared is under court order from a judge, or if harm to you, harm to others, or child or elder abuse or neglect become a concern.

- I understand that I can cancel this consent at any time except to the extent that action has been taken in reliance on it. This consent will automatically expire one year after completion of EMAT.
- I understand that all study records will be destroyed five years after the project ends.
- I understand that I can still receive EMAT services or other services I may be eligible for even if I do not allow my information to be used for the evaluation.
- I have been given a copy of this form.

Participant: By signing below, I hereby **agree_____/ do not agree_____/ (check one)** to participate in the above-described project and to the use and disclosure of my protected health information for evaluation purposes.

_____ _____
Participant Date

Tape Recording:

The interviewer has_____/has not_____ been asked to tape record (audio) this interview. The tape recording will be heard by a supervisor who must insure that all interviews are conducted in a standardized way and will be erased after use. Please sign if you agree to allow this tape recording.

_____
Signature of Participant

For the interviewer:

I have discussed the EMAT evaluation with the above-named individuals and in my judgment, all consent requirements have been satisfied.

_____ _____ _____
Signature of Individual Obtaining Consent Name in print Date

NaphCare
Your independent health care choice.

Essex County Correctional Facility
20 Manning Ave Middleton, MA 01949
Medical Department – Phone 978-750-1900 EXT: 3461 / Fax 978-777-9975

Vivitrol® (naltrexone extended release injection) Consent Form

I_____, ID Number_____ Date of Birth_____ do hereby voluntarily apply and consent to participate in the Vivitrol Pre-Release Pilot Program. I am requesting Vivitrol® (naltrexone extended release injection) Therapy as a treatment for alcohol and opioid dependence. I understand that, as far as possible, precautions will be taken to prevent any complications or ill effects on my health. I further understand that it is my responsibility to tell the Physician/Nurse in the program as much as I can about my health. It is my responsibility to seek medical attention immediately if any reaction occurs to Vivitrol® or if any changes occur in my health status. As a participant, I freely and voluntarily agree to adhere to the treatment protocol as follows:

1) I understand that medication alone is not sufficient treatment for managing my disease. After I am released, I agree to participate in the outpatient treatment program offered by the designated community clinic.

2) I understand that Vivitrol® (naltrexone extended release injection) is being prescribed as part of a comprehensive treatment plan for my alcohol and/or opiate dependence.

3) I agree to keep, and be on time, for my scheduled appointment at the community clinic. If I cannot keep the appointment, I will call to cancel and reschedule.

4) I agree to have a blood specimen taken for assessment of liver function prior to beginning VIVITROL therapy.

5) I agree to actively participate in one individual counseling session at ECCF prior to beginning VIVITROL therapy.

6) I understand that I will be prescribed Naltrexone (the pill form of VIVITROL) for up to three days prior to beginning VIVITROL therapy. This trial is to assess for any adverse effects of the medication. I understand that I am to inform the medical staff if I experience any side effects during this time.

7) I understand that I will receive the first injection of VIVITROL on the day of my release.

8) I understand that Vivitrol® is well-tolerated in the recommended doses, but may cause liver injury when taken in excess or in people who develop liver disease from other causes. If I experience excessive tiredness, unusual bleeding or bruising, pain in upper right part of my stomach that lasts more than a few days, light-colored bowel movements, dark urine, or yellowing of the skin or eyes, I will stop taking Vivitrol® immediately and see my doctor as soon as possible.

9) I understand that this medication can cause allergic pneumonia and I should seek medical care for the following symptoms: shortness of breath, coughing, and wheezing that are persistent.

10) I understand that the common side effects of this medication are: sleepiness, headache, dizziness, vomiting, joint pain, muscle cramps, cold symptoms, poor sleep, and decreased appetite.

11) I understand that serious allergic reactions can occur to this medication including skin rash, shortness of breath, feeling dizzy/faint, chest pain, swelling of face, eyes, tongue, and mouth. I should seek medical care for any of these symptoms that persist after the injection.

12) I understand that I will undergo a urine drug screen before taking the Vivitrol tablets for three days, and then before the Vivitrol injection on the day of release.

13) I understand that I need to be free of all opioid agents at least 7-14 days before receiving this injection; otherwise the injection may cause significant opiate withdrawal symptoms that can even require treatment in a hospital setting.

14) I understand that I should not take Vivitrol® if I am pregnant or if I am contemplating pregnancy.

15) I understand that the community health clinic offering follow-up treatment can terminate my treatment at any time if I do not comply with treatment guidelines

16) I understand it is my responsibility to maintain active health insurance coverage, so that I do not have difficulty receiving my VIVITROL injections.

17) I understand that a positive urine drug screen for alcohol and/or opiates, such as Heroin, Methadone, Suboxone®, may result in discontinuation of Vivitrol® Therapy, because these drugs may be lethal if taken while on Vivitrol.

18) I agree to allow ECCF to run a confidential Criminal Offence Record Investigation (CORI) periodically after my release from incarceration. I understand that the purpose of this is to collect data on the efficacy of the VIVITROL Pre-Release Pilot Program.

19) I agree to sign a Release of Information for: A contact person; and the community health clinic offering follow-up treatment, so that ECCF may inquire of my status after release.

20) I agree that violating any of these conditions is grounds for dismissal from participation in the VIVITROL Pre-Release Pilot Program.

21) To the best of my knowledge I do not have any outstanding charges for which I may be re-incarcerated.

22) I understand that once the medication is injected it is not possible to remove it from the body. The medication will be in my system for around 30 days.

23) I understand that there is a risk of a severe reaction at the site of the injection. This may include redness, tenderness, blisters, pain, swelling, bruising, and itching, and can cause tissue death that may require surgical intervention. I understand that I need to seek medical attention if any of these issues occur and worsen over time.

24) Receiving a disciplinary report and a move to segregation may disqualify me from the Vivitrol program.

25) I understand that if I am re-incarcerated, I may not receive another Vivitrol injection.

26) Vivitrol may increase feelings of depression, and can, in rare cases, cause suicidal thoughts. I need to inform family members to be aware of this and inform my physician immediately if I experience severe depression or suicidal thoughts.

27) I understand that if I later stop or miss a dose of this medication, my tolerance to opioid agents will be lower and it is possible to overdose and die on much lower doses of opioid than previously used.

28) I understand that this medication blocks the effects of opioid medications and I will not experience pain relief from these agents if injured and this medication is in my system.

29) I understand that it is important that I inform all medical personnel that I am on this medication and will wear my Vivitrol rubber safety bracelet in case of an emergency.

WARNING: I UNDERSTAND THAT WHILE ON THIS MEDICATION I AM STILL AT RISK OF ACCIDENTAL OPIOID OVERDOSE. WHILE THE MEDICATION DOES BLOCK THE EFFECT OF OPIOIDS, IT CAN BE OVERCOME BY HIGH DOSES AND THIS CAN LEAD TO OVERDOSE AND DEATH.

IF I ATTEMPT TO SELF-ADMINISTER LARGE DOSES OF ALCOHOL, HEROIN OR ANY OTHER NARCOTIC WHILE ON VIVITROL®, I MAY DIE OR SUSTAIN SERIOUS INJURY, INCLUDING COMA.

_____ _____
Patient's Signature Date

I, the undersigned, have defined and fully explained the above information to this individual.

_____ _____
Medical Staff Signature Date

Adapted from NephCare's Long Active Naltrexone (Vivitrol) Consent 10/2017
Adapted from Barnstable County Correctional Facility Vivitrol program 2/2017

Volunteers of America®
Massachusetts

Peter Raskin
Chairman

Thomas L. Bierbaum
Chief Executive Officer

Attachment 4: Letters to the SSAs

June 21, 2018

Joan Mikula, Commissioner
Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Ms. Mikula:

Volunteers of America Massachusetts is applying for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services for persons with an opioid use disorder (OUD) seeking or receiving MAT.

Attached you will find a copy of our SF-424 and a one-page summary of the project that includes: 1) a description of the population to be served; 2) a summary of the services to be provided; and 3) a description of the coordination planned with appropriate state or local health agencies.

If your agency wishes to comment on the proposal, your comments should be sent to SAMHSA by September 7, 2018 via USPS to:

Christopher Craft, Acting Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Room 17E06, 5600 Fishers Lane
Rockville, MD 20857
ATTN: SSA – Funding Announcement No. TI-18-009

Please send an additional copy of your comments to VOAMA. VOAMA will notify the SSA within 30 days of receipt of an award.

Sincerely,

Tom Bierbaum, President and CEO
Volunteers of America Massachusetts

Administrative Offices
441 Centre Street • Jamaica Plain, MA 02130 • Tel: 617.522.8086 • Fax: 617.522.4533
www.voamass.org

Volunteers of America
Massachusetts

Peter Raskin
Chairman

Thomas L. Bierbaum
Chief Executive Officer

June 21, 2018

Allison F. Bauer, J.D., Director
Bureau of Substance Abuse Services
Massachusetts Department of Public Health
250 Washington Street, 3rd Floor
Boston, MA 02108-4609

Dear Ms. Bauer:

Volunteers of America Massachusetts is applying for the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion: Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services for persons with an opioid use disorder (OUD) seeking or receiving MAT.

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Rockville, MD 20857
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Please send an additional copy of your comments to VOAMA. VOAMA will notify the SSA within 30 days of receipt of an award.

Sincerely,

Tom Bierbaum, President and CEO
Volunteers of America Massachusetts

Administrative Offices
441 Centre Street • Jamaica Plain, MA 02130 • Tel: 617.522.8086 • Fax: 617.522.4533
www.voamass.org

Internal Revenue Service

Department of the Treasury
P. O. Box 2508
Cincinnati, OH 45201

Date: December 17, 2004

VOLUNTEERS OF AMERICA OF MASSACHUSETTS INC
441 CENTRE ST
JAMAICA PLAIN MA 02130-1831 416

Person to Contact:
John Crawford 31-08343
Customer Service Representative
Toll Free Telephone Number:
8:00 a.m. to 6:30 p.m. EST
877-829-5500
Fax Number:
513-263-3756
Federal Identification Number:
04-6004304
Group Exemption Number:
1736

Dear Sir or Madam:

This is in response to your request of December 17, 2004, regarding your organization's tax-exempt status.

Your organization is exempt under section 501(c)(3) of the Code because it is included in a group ruling issued to Volunteers of America, Inc, located in Alexandria, Virginia.

Our records indicate that contributions to your organization are deductible under section 170 of the Code, and that you are qualified to receive tax deductible bequests, devises, transfers or gifts under section 2055, 2106 or 2522 of the Internal Revenue Code.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely,

Janna K. Skufca

Janna K. Skufca, Director, TE/GE
Customer Account Services

Note: VOAMA has applied for its FY2019 indirect cost renewal and is awaiting a response. It expects its rate will remain the same.

NEGOTIATED AGREEMENT
NON-PROFIT INSTITUTIONS

INSTITUTION:
Volunteers of America of Massachusetts, Inc.
441 Centre Street
Jamaica Plain, MA 02130

DATE: March 29, 2017

File Ref: This replaces the negotiated agreement dated September 16, 2016

SUBJECT: The indirect cost rate(s) contained herein is for use upon grants and contracts with the Federal Government subject to the conditions contained in Section II.

SECTION I: RATES

Indirect Costs

	Effective Period				Applicable
Type	From	To	*Rate	Locations	To
Final	7/01/2010	6/30/2011	33.91%	All	All Programs
Final	7/01/2011	6/30/2012	33.50%	All	All Programs
Final	7/01/2012	6/30/2013	37.77%	All	All Programs
Final	7/01/2013	6/30/2014	34.68%	All	All Programs
Final	7/01/2014	6/30/2015	39.12%	All	All Programs
Final	7/01/2015	6/30/2016	50.24%	All	All Programs
Provisional	**7/01/2016**	**6/30/2018**	**50.24%**	**All**	**All Programs**

***Base:** Total direct salaries and wages excluding fringe benefits.

Treatment of Fringe Benefits: Fringe benefits applicable to direct salaries and wages are treated as direct costs

SECTION II: GENERAL

LIMITATIONS: Use of the rate(s) contained in this agreement is subject to any statutory or administrative limitations and is applicable to a given grant or contract only to the extent that funds are available. Acceptance of the rate(s) agreed to herein is predicated on the conditions: (1) that no costs other than those incurred by the grantee/contractor were included in its indirect costs pool as finally accepted and that such costs are legal obligations of the grantee/contractor and allowable under the governing cost principles; (2) that the same costs that have been treated as indirect costs are not claimed as direct costs; (3) that similar types of costs have been accorded consistent accounting treatment; and (4) that the information provided by the grantee/contractor which was used as a basis for acceptance of the rate(s) agreed to herein is not subsequently found to be materially incomplete or inaccurate.

ACCOUNTING CHANGES: The rate(s) contained in this agreement are based on the accounting system in effect at the time the proposal was prepared and the agreement was negotiated. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this rate(s) require the prior approval of the office responsible for negotiating the rate(s) on behalf of the Government. Such changes include but are not limited to changes in the charging of a particular type of costs from indirect to direct. Failure to obtain such approval may result in subsequent cost disallowance.

REIMBURSEMENT: Indirect cost reimbursement on all awards will be determined based upon the indirect cost rates established for the fiscal period in which the applicable direct expenditures are incurred.

NOTIFICATION TO FEDERAL AGENCIES: Copies of this document may be provided to other Federal offices as a means of notifying them of the agreement contained herein.

SPECIAL REMARKS: Federal programs currently reimbursing indirect costs to this Department/Agency by means other than the rate(s) cited in this agreement should be credited for such costs and the applicable rate cited herein applies to the appropriate base to identify the proper amount of indirect costs allocated to the program.

OTHER: Participant support costs are direct costs for items such as stipends or subsistence allowance, travel allowances, and registration fees paid to or on behalf of participants or trainees (but not employees) in connection with meetings, conferences, symposia, or training projects. In addition, costs related to contractors of Non-Profit Organizations who are acting in the capacity of a "Conference Trainer/Instructor/Presenter/Facilitator" are also considered participant support costs. These costs are generally excluded from the distribution base. This exclusion applies to the entirety of any subcontracts for the lodging and travel of conference participants or trainees (but not employees).

U.S. DEPARTMENT OF JUSTICE
Office of Justice Programs

PELITA BALAKIT Digitally signed by PELITA BALAKIT Date: 2017.04.21 16:47:05 -04'00'

Signature: Pelita Balakit, Staff Accountant
Grant Financial Management
Office of the Chief Financial Officer

Date:

Volunteers of America of Massachusetts, Inc.

Signature:

Thomas Bierbaum
CEO / President

Name and Title:

4/12/17

Date:

Negotiated by: Pelita Balakit 202-305-2106

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
4040-0013

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

*Name: n/a

*Street 1: n/a Street 2:

*City: n/a State: Zip:

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

n/a

7. * Federal Program Name/Description:

Substance Abuse and Mental Health Services Projects of Regional and National Significance

CFDA Number, *if applicable:* 93.243

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: *First Name: n/a Middle Name:

*Last Name: n/a Suffix:

*Street 1: n/a Street 2:

*City: n/a State: Zip:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: *First Name: n/a Middle Name:

*Last Name: n/a Suffix:

*Street 1: n/a Street 2:

*City: n/a State: Zip:

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** Prefix: *First Name: n/a Middle Name:

*Last Name: n/a Suffix:

Title: **Telephone No.:** **Date:** Completed on submission to Grants.gov

Federal Use Only:

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Standard Form - LLL (Rev. 7-97)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

C.A. No. 18-cv-11972

GEOFFREY PESCE,

Plaintiff,

v.

KEVIN F. COPPINGER, in his official capacity as Essex County Sheriff, AARON EASTMAN, in his official capacity as Superintendent of the Essex County House of Corrections - Middleton,

Defendants

AFFIDAVIT OF DONALD C. KERN

I, Donald C. Kern, M.D., MPH, CCHP, hereby swear and depose the following:

1. I am a doctor of primary care internal medicine and public health and general preventive medicine with almost 25 years' experience in the correctional health care field in both jail and prison settings.

2. My *curriculum vitae* is attached as Exhibit A.

3. I am currently employed as Corporate Medical Director of a correctional health care company called Quality Correctional Health Care ("QCHC") based in Birmingham, Alabama. I am also past president of the American College of Correctional Physicians. As documented by the Centers for Medicare and Medicaid Services on its website, I have not received any consulting fees from any pharmaceutical company in the past five years.

4. I am familiar with the medication known as Vivitrol (Naltrexone), which is an FDA approved drug for treating both alcohol dependence and opiate dependence, including addiction to opioids such as heroin.

5. QCHC is contracted to perform medical services at jails primarily in Alabama, Tennessee, and Mississippi. In previous employment I have been involved in correctional settings across the United States including Massachusetts where I have an active medical license.

6. Currently QCHC has a contract with a county jail in Alabama which received a grant to work with a community agency to provide a non-opioid MAT addiction treatment program using Vivitrol.

7. In my experience in using Vivitrol for addiction treatment in the correctional setting, Vivitrol has been effective in allowing patients to transition back to community care for continued treatment of their opioid use disorder, while avoiding risk of diversion of medication within the correctional setting.

8. I have reviewed the affidavits of Deanna Kiser, RN, and Jason Faro. The programs they describe for monitored opiate detoxification and for medically assisted treatment using Vivitrol (Naltrexone) use standard and clinically appropriate assessment tools and medications for treating possible symptoms of opiate detoxification. Initial detoxification is important for a medically assisted treatment program employing Vivitrol. Patients who have opiates in their system, whether from use prior to jail intake or from access to diverted opiates during incarceration, who then receive Vivitrol may experience abrupt withdrawal symptoms that may be severe.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 19 DAY OF OCTOBER, 2018.

Donald C. Kern

CERTIFICATE OF SERVICE

I certify that on this day I caused a true copy of the above document to be served upon the attorney of record for all parties via CM/ECF

Robert Frederickson III (BBO 670111)
Michael Pickett (BBO 698618)
GOODWIN PROCTER LLP
100 Northern Avenue
Boston, Massachusetts 02210
Tel.: 617.570.1000
Fax.: 617.523.1231
RFrederickson@goodwinlaw.com

Ira Levy *(Pro hac vice* pending)
Alexandra Valenti *(Pro hac vice* pending)
Jenny Zhang (BBO 689838)
GOODWIN PROCTER LLP
The New York Times Building
620 Eight Avenue
New York, NY 10018

Date: October 16, 2018

/s/Stephen C. Pfaff
Stephen C. Pfaff

EXHIBIT A

8/2017

CURRICULUM VITAE

Donald C. Kern, MD, MPH, CCHP

Work Address:
Quality Correctional Health Care
Suite A
200 Narrows Parkway
Birmingham, AL 35242

Home Address:
2974 Rhodes Cir S
Birmingham, AL 35205

TEL: (205) 437-1512 (205) 623-6929

e-mail: donald.kern@qchcweb.net kern@massmed.org

Education history:

9/66 – 6/69	Westfield High School, Westfield, New Jersey
9/69 – 6/73	BA, Mathematics and Economics, Haverford College, Haverford, Pennsylvania
9/73 – 6/77	MD, Tufts University School of Medicine, Boston, Massachusetts
7/77 – 6/80	Residency, Internal Medicine, Creighton University, Omaha, Nebraska
7/80 – 6/82	MPH, Epidemiology and Biostatistics Section (Research Concentration) Boston University School of Public Health
7/80 – 6/82	Fellowship, General Internal Medicine, Boston University School of Medicine
7/82 – 6/84	Fellowship, Geriatric Medicine, Edith Nourse Rogers Memorial Veterans Administration Hospital, Bedford, Massachusetts

Work history:

7/82 – 8/95	Staff Physician, Edith Nourse Rogers Memorial Veterans Administration Hospital, Bedford, Massachusetts
8/95 – 9/96	Medical Director, MCI-Shirley
8/95 – 9/96	Medical Director, MCI-Lancaster

9/96 – 8/97	Medical Director, MCI-Concord
8/97 – 11/03	Medical Director, MCI-Old Colony Correctional Center
11/03 – 6/04	Medical Director; MCI-Cedar Junction
11/03 – 6/04	Associate Program Medical Director, Program in Health Care and Criminal Justice, Commonwealth Medicine, UMASS Medical School
7/04 – 7/05	Medical Director, Correctional Health Services, Health Care Access & Improvement, Department of Health and Mental Hygiene, The City of New York
7/05 – 3/06	Special Consultant, Correctional Health Services, Health Care Access & Improvement, Department of Health and Mental Hygiene, The City of New York
4/06 – 10/08	Consultant in Correctional Health
10/08 – 9/13	Chief Medical Officer, NaphCare, Inc.
10/13 – 4/14	UM Medical Director, Wexford Health Sources, Inc.
4/14 –	Corporate Medical Director, Quality Correctional Health Care

Other offices and appointments:

1979 – 1981	Member, Council on Continuing Physician Education, American Medical Association
1980 – 1984	Delegate from Massachusetts to the American Medical Association-Resident Physician Section
1982 –1995	Assistant Professor, Boston University School of Medicine
1983 –1995	Assistant Professor, Boston University School of Public Health
1984 – 1991	Member, Quality Assurance Board, Edith Nourse Rogers Memorial Veterans Administration Hospital, Bedford, Massachusetts (Chairman, 1984-1989)
1990 –1997	Delegate, Massachusetts Medical Society House of Delegates
1991 – 1997	Member, Committee on Legislation, Massachusetts Medical Society
1999 – 2005	Physician Surveyor, National Commission on Correctional Health Care
2002 – 2007	Member, Budget Committee, Society of Correctional Physicians
2004 – 2008	Member, Board of Directors, National Commission on Correctional Health Care
2005 –	Senior Physician Surveyor, National Commission on Correctional Health Care
2009 –	Adjunct Professor, Department of Health Care Organization and Policy, School of Public Health, University of Alabama at Birmingham
2012 – 2013	Track Manager, Medical and Mental Health, American Jail Association 2013 Annual Training Conference

Professional Societies:

- Massachusetts Medical Society
- Massachusetts Public Health Association
- American College of Correctional Physicians
- American College of Physicians
- American College of Preventive Medicine

Certificates and Licenses:

- Diplomate, National Board of Medical Examiners
- Diplomate in Internal Medicine, American Board of Internal Medicine
- Diplomate in Public Health and General Preventive Medicine, American Board of Preventive Medicine
- Certificate of Added Qualifications in Geriatric Medicine, American Board of Internal Medicine
- Certificate in Geriatrics, Veterans Administration
- Certified Correctional Health Professional, National Commission on Correctional Health Care
- Medical License, Commonwealth of Massachusetts
- Medical License, State of New Jersey
- Medical License, State of New York
- Medical License, State of Nevada
- Medical License, State of Ohio
- Medical License, Commonwealth of Pennsylvania
- Medical License, State of Iowa
- Medical License, State of Maryland
- Medical License, State of Georgia
- Medical License, State of Texas
- Medical License, State of Florida
- Medical License, State of Alabama
- Medical License, Commonwealth of Virginia
- Medical License, State of Tennessee
- Medical License, State of Mississippi
- Medical License, State of South Carolina

Honors:

1988 - Honorary Advisor, Beijing Medical University
1988 - Fellow, American College of Physicians
1988 - Fellow, American College of Preventive Medicine

1989 - Fellow, American Geriatrics Society

Elective Offices

1986 -	Member, Board of Health, Town of Sudbury, MA (Chairman, 3/88-3/89, 3/91-3/92, 3/93-3/95, 3/97-3/98, 3/00-3/01; 3/03-3/04)
2003 – 2007	Treasurer, Society of Correctional Physicians
2005 – 2006	Member, Executive Committee, Board of Directors, National Commission on Correctional Health Care
2007 – 2009	President-Elect, Society of Correctional Physicians
2009 – 2011	President, Society of Correctional Physicians
2011 – 2013	Immediate Past President, Society of Correctional Physicians

Corrections Related Presentations:

- Invited speaker, 20th Annual Conference on Correctional Health Care, National Commission on Correctional Health Care, 1996
- Invited speaker, 23rd Annual Conference on Correctional Health Care, National Commission on Correctional Health Care, 1999
- Invited speaker, 24th Annual Conference on Correctional Health Care, National Commission on Correctional Health Care, 2000
- Invited speaker, 6th Semi-Annual Conference: Clinical Update in Correctional Health Care, National Commission on Correctional Health Care, 2001
- Visiting Scholar, Department of Sociology, Rosemont College, Rosemont, PA, 2001
- Invited speaker, "A Systemwide Approach to Managing Chronically Ill Patients in Correctional Health Care", Academy of Correctional Health Professionals, March 2007
- Invited speaker, "A Systemwide Approach to Managing Chronically Ill Patients in Correctional Health Care", Academy of Correctional Health Professionals, August 2007
- Invited speaker, "Is Howard Still Relevant After 230 Years?", 31st Annual Conference on Correctional Health Care, National Commission on Correctional Health Care, 2007
- Invited speaker, "Should Correctional Physicians Participate in Lethal Injection?", 2nd Annual Academic and Health Policy Conference on Correctional Health, 2008
- Invited participant, "Correctional Health and Healthcare: Identifying and

Prioritizing Data Needs", Bureau of Justice Statistics and National Center for Health Statistics, 28-29 June 2010

- Invited speaker, "Sweet Schizophrenic or Daffy Diabetic: Mental Health Meets Medicine", Updates in Correctional Health Care, National Commission on Correctional Health Care, 2011
- Invited speaker, "Hot Topics in Medicine and Mental Health", 30th Annual Training Conference, American Jail Association, 2011
- Invited speaker, "Health Information Technology", 30th Annual Training Conference, American Jail Association, 2011
- Invited speaker, "When Docs Meet Locks", Medical Director Boot Camp, National Commission on Correctional Health Care and Society of Correctional Physicians, 2011
- Invited speaker, "Medical Is from Mars, Psych is from Venus – Improving Communication and Getting What the Patient Needs", Correctional Mental Health Seeking Solutions, National Commission on Correctional Health Care, 2011
- Invited speaker, "Prevention 2011", National Conference on Correctional Health Care, National Commission on Correctional Health Care, 2011
- Invited speaker, "Correctional Health Care: Law and Ethics Update", American Jail Association 31st Annual Training Conference & Jail Expo, 2012
- Invited speaker, "Welcome to Jail – Jack Bauer Meets Intake Health Assessment", American Jail Association 31st Annual Training Conference & Jail Expo, 2012
- Invited speaker, "Utilization Management", Medical Director Boot Camp, National Commission on Correctional Health Care and Society of Correctional Physicians, 2012
- Invited participant, "Medical Ethics and Practice Challenges of Hunger Strikes in US and Military Prisons", Committee on Human Rights of the National Academies, Institute of Medicine, 2013
- Invited speaker, "Health Law and Ethics", 32nd Annual Training Conference, American Jail Association, 2013
- Invited speaker, "Health Care in the Correctional Culture IV: Working with Custody", Correctional Health Care Leadership Institutes for Physicians and Health Administrators, National Commission on Correctional Health Care, 2013
- Invited speaker, "Creating an Integrated Care Model for Behavioral Health", Correctional Mental Health Care, National Commission on Correctional Health Care, 2013
- Invited speaker, "Correctional Health Care Law and Ethics Update", 33rd Annual Training Conference and Jail Expo, American Jail Association, 2014
- Invited speaker, "Ebony and Ivory: An Integrated Model for Medical and

Behavioral Health", Spring Conference on Correctional Health Care, National Commission on Correctional Health Care, 2014
- Invited speaker, "Developing Rational and Defensible Staffing Plans", Correctional Health Care Leadership Institutes, National Commission on Correctional Health Care, 2014
- Invited speaker, "Correctional Health Care Law and Ethics Update", 34th Annual Training Conference and Jail Expo, 2015
- Invited speaker, "Sick Call: Managing Difficult Patient's Expectations", Spring Conference on Correctional Health Care, National Commission on Correctional Health Care, 2015
- Invited speaker, "John Howard and the History of Correctional Health Care", Correctional Health Care Leadership Institutes, National Commission on Correctional Health Care, 2015
- Invited speaker, "Utilization Management as Continuing Quality Improvement", Correctional Health Care Leadership Institutes, National Commission on Correctional Health Care, 2015
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Publication, Peer Review Journals:

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- Kern DC, Zheng T, Developing Chinese MUMPS for a Beijing Hospital. Proceedings of the MUMPS User's Group, June 1988.

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- Booth BM, Ludke RL, Wakefield DS, Kern DC, DuMond CE. Relationship Between Inappropriate Admissions and Days of Care: Implications for Utilization Management. Hosp. Health Serv. Admin., 1991, 36(3):421-437.
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- Parrino TA and Kern DC. The Alumni Survey as an Instrument for Program Evaluation in Internal Medicine. J Gen Intern Med 9(2):92-95, 1994.
- Markson LJ, Kern DC, Annas GH, Glantz LH. Physician Assessment of Patient Competence. J Am Geriatr Soc 42(10):1074-80, 1994
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Invited Papers:

- Kern DC, Ludke RL, Wakefield DS, and Booth B, Issues in Studying Appropriateness of Hospitalization in the Veterans Administration. American Medical Review Research Center Second Annual Research

Symposium: "Quality Outcome Measurement and Evaluation".
- Kern D, Health Information Technology and Corrections: Proceed with Caution. Correctional Health Care Report 10(5):69-70,77-78, 2009.
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- Kern, D, and Courtney, K, "Medical Is From Mars, Psych Is From Venus: Improving Communication and Getting What the Patient Needs". Correctional Health Care Report 12(6):81-82,92-94, 2011.
- Kern, D, "Weighty Problems for Correctional Institutions". Correctional Health Care Report 12(6):83-84,95-96, 2011.

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- Fabiszewski K, Shapiro R, and Kern DC, Medical Care in Advanced Alzheimer's Disease, in Volicer, L, ed., Clinical Management of Alzheimer's Disease. ASPEN, 1988.

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- Markson L, Fanale J, Steel K, Kern D, and Annas G, "Making Advance Directives Part of Standard Care: A Pilot Study." Presented at the Annual Meeting of the American Geriatrics Society, Chicago, May 1991.
- Kern, DC, Markson, L, "Developing and Implementing Advance Directive Procedures for Patients with Decision-Making Capacity" Presented at the 119th Annual Meeting of the American Public Health Association, Atlanta, November 1991.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

C.A. No. 18-cv-11972

GEOFFREY PESCE,

Plaintiff,

v.

KEVIN F. COPPINGER, in his official capacity as Essex County Sheriff, AARON EASTMAN, in his official capacity as Superintendent of the Essex County House of Corrections - Middleton,

Defendants

AFFIDAVIT OF WILLIAM GERKE, JR.

I, William Gerke, Jr., 20 Manning Avenue, Middleton, MA 01940, on oath depose and states as follows:

1. I have served as Special Sheriff for the Essex County Sheriff's Department ("ECSD") since January 2017;

2. During the summer of 2018, the Essex County Sheriff's Department applied for and received a grant in the amount of $1,575,010.00 from the Department of Health and Human Services Substance Abuse and Mental Health Services for "Targeted Capacity Expansion: Medication Assisted Treatment-Prescription Drug and Opioid Addiction." This is a three-year grant, from September 30, 2018 through September 29, 2021. *Exhibit I—ECSD Grant.*

3. The grant is a collaborative initiative (Essex Medication Assisted Treatment – "EMAT") undertaken by and between the ECSD and Volunteers of America Massachusetts to address the growing need to expand and enhance medication assisted treatment and other recovery supports for incarcerated individuals with an opioid use disorder. The MAT population

of focus is incarcerated individuals (detox/diversion, pretrial, sentenced) drawn from all three ECSD correctional facilities: Middleton House of Correction, Essex County Pre-Release and Re-entry Center and Women in Transition.

4. The Sheriff's Department and Volunteers of America will utilize grant funds in conjunction with members of the Essex County Mental Health and Justice Task Force, who will play an integral role in the oversight and implementation of services under the grants.

5. Specific MAT services include: (1) education of inmates on available MAT services; (2) medical assessment and treatment; (3) administration of one Vivitrol shot at the Middleton House of Correction at the time of release from custody; (4) transportation to a partnering inpatient or outpatient substance provider for follow-up Vivitrol shots; and (5) continued follow-up and case management for a six month period to foster program retention and long-term recovery.

6. The facts recited herein are based upon my personal knowledge.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 18th DAY OF OCTOBER, 2018.

William Gerke, Jr.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

C.A. No. 18-cv-11972

GEOFFREY PESCE,
Plaintiff,

v.

KEVIN F. COPPINGER, in his official capacity as Essex County Sheriff, AARON EASTMAN, in his official capacity as Superintendent of the Essex County House of Corrections - Middleton,
Defendants

AFFIDAVIT OF DEANNA KISER, R.N.

I, Deanna Kiser, 20 Manning Avenue, Middleton, MA 01949, on oath depose and state as follows:

1. I am a registered nurse and also presently serve as Director of Jail Operations for NaphCare, Inc. for services provided to the Essex County Sheriff's Department ("ECSD");
2. NaphCare is a contracted inmate health/patient service provider for the Sheriff's Department, among others;
3. Among other things, NaphCare provides medical and mental health services for individuals admitted to the custody of the ECSD who have substance abuse and chronic health issues;
4. When individuals are admitted to custody, NaphCare administers to individuals an Initial Receiving Screening and Mental Health Screening. If the information received in the Initial Screening is positive for a history of drug and/or alcohol use, or if recent drug and/or alcohol use is reported, a clinical detox screening is initiated to obtain additional information about an individual's drug and/or alcohol history. Based on the information from the screening, a detox protocol may be initiated for administration at the ECSD's Medical Housing Unit (MHU) and Detox Unit;
5. Based on the results of the Comprehensive Screening, a Clinical Opioid Withdrawal Scale (COWS), and/or a Clinical Institute Withdrawal Assessment (CIWA) (for alcohol)

and/or CIWA-B (for benzodiazepine) may be initiated. These are standard assessment tests which are routinely used to evaluate the nature and extent of an individual's withdrawal needs;

6. Based upon subjective and objective information obtained and observed during the assessments, prn medications may be administered based upon the medical needs of an individual. These may include Ibuprofen for pain, Bentyl for stomach cramps, Imodium for diarrhea, Zofran for nausea, and Maalox for indigestion, and Clonidine for anxiety and/or elevated blood pressure and other opiate withdrawal symptoms;
7. Detox protocols in the MHU and Detox Unit generally are in place for approximately three (3) to seven (7) days, depending on an individual's symptoms. During that time period, individuals on the detox protocol are monitored by medical personnel on a 24 hour basis. Individuals are evaluated via the COWS assessment to monitor their progress toward withdrawal;
8. When medically assisted withdrawal has been successfully completed, an advanced care provider (M.D., N.A. or N.P.) evaluates the individual and an order may be provided clearing that person to return to a housing unit. If symptoms persist, an individual may continue to receive medications on an as-needed basis;
9. Medication-assisted withdrawal services are provided routinely on a daily basis. From July 1, 2008 to October 18, 2018, approximately 13,641 individuals have been screened and safely and successfully withdrawn as medically necessary. There have been no deaths associated with the withdrawal process during NaphCare's contractual term with Essex County;
10. At the time of discharge from custody, individuals may be administered a shot of Vivitrol, a non-opioid medication aimed at preventing substance abuse relapse;
11. The facts recited herein are based upon my personal knowledge.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 19th DAY OF October, 2018.

Deanna Kiser, R.N.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

C.A. NO. 18-cv-11972

GEOFFREY PESCE,

Plaintiff

v.

KEVIN F. COPPINGER, et. al.,

Defendants

AFFIDAVIT OF JASON FARO

I, Jason Faro, 20 Manning Avenue, Middleton, MA 01949, on oath depose and state as follows:

1. I am the Director of Classification, Programs/Reentry of the Essex County Sheriff's Department at Middleton, Massachusetts, having been appointed to that position in January, 2018. Prior to that, since February, 2005, I served as Assistant Director of Programs. I have attached a copy of my resume hereto as Exhibit A.

2. One of the primary goals of the Essex County Sheriff's Department is to provide individuals in its custody with treatment and programming services to address problematic behavior, including addiction and substance abuse, so that when individuals are released from custody and return to their families and communities, they have the skills and services in place so that they do not re-offend, thereby reducing recidivism.

3. The Department has had in place classification practices and treatment and program strategies for more than a decade for individuals who have been sentenced to incarceration in an effort to rehabilitate them and reduce recidivism. These efforts commence

upon a sentenced individual's admittance into the Essex County Correctional Facility in Middleton.

4. At the outset of their admittance to the Middleton Facility, all sentenced individuals are assigned, and meet with a reintegration coordinator for purposes of conducting an initial classification. During the initial classification, several factors specific to the individual detainee are examined, including an assessment of the individual's addiction, mental health, employment and education history.

5. Based upon the totality of information obtained during the initial classification process, a classification plan is developed for each individual.

6. An individual's classification plan can include recommendations for core institutional programming options. One such option is assignment to the Department's 80 Lower Housing Unit in its Treatment and Recovery for Addictions in Corrections ("TRAC") program.

7. The TRAC program services eighty (80) individuals housed in a dormitory setting, and is designed as a four (4) month program focused around the disease of addiction, recovery strategies and positive behavior rehabilitation. However, TRAC is available for individuals who are serving sentences of less than four (4) months. The program includes individual and group counselling, introduction of the 12-step process and peer-led recovery groups. An evidence-based curriculum is used to assist individuals to move from a life of addiction to a life in recovery. Specific recovery-centered curriculum topics are introduced to participants on a weekly basis. Programming in the TRAC program was designed, and is administered in coordination with AdCare Criminal Justice Services, a contracted inmate treatment services provider.

8. An individual's classification plan may also include recommendations for

supplemental institutional programming, usually occurring in the Department's Programs Building. Supplemental programming can include Life Skills, Parenting, Education, Computer Literacy, Chaplaincy and Library Services.

9. As individuals prepare to wrap up their sentences and return to their families, homes and communities, reintegration and clinical staff provide reentry services directed toward connecting individuals with community-based supports and services to continue their rehabilitation. A naltrexone-based medically assisted treatment ("MAT") option utilizing the injectable medication Vivitrol is available, with proper medical screening and education provided. Twenty-four (24) hours prior to release, individuals receive their first dose of Vivitrol, and Department staff coordinate subsequent doses with community providers. A continuum of care between correctional and community-based linkages for addiction and recovery services can be facilitated through the Intensive Outpatient Program ("IOP") and/or Structured Outpatient Addiction Program ("SOAP"). Long-term residential and sober housing placements can be secured prior to release. Department of Mental Health ("DMH") access can also be arranged by reintegration staff. Meeting locations for AA and NA meetings in the communities are also made available.

10. I have attached a summary of institutional and reentry programming provided by the Department as Exhibit B.

11. The Department utilizes similar treatment and programming strategies with individuals seeking alternative sentencing/diversion options in its Detoxification Units (both Male and Female). The Detox Units are a pre-trial tool available to judges, probation officers, the District Attorney's Offices, defense attorneys and police officers that can serve as an alternative to incarceration.

12. The Detox Units comprise a 28-day treatment program whereby 42 males and 42 females can receive medication to assist with withdrawal symptoms, along with treatment, programming, emotional and spiritual support aimed at assisting individuals' recovery and rehabilitation.

13. The programming services provided in the Detox Units are based upon the same curriculum delivered by the Department and AdCare in its TRAC program.

14. At the successful completion of the 28-day detox, individuals have in place a treatment plan whereby they may be eligible at Court for multiple alternatives to incarceration, such as long-term treatment center admittance, admittance to sober housing, placement within community-based IOP services, medically-assisted treatment with Vivitrol, day reporting with the Office of Community Corrections, and home confinement/work release with drug testing.

15. Vivitrol is a prescribed, non-opioid medication used to treat alcohol and opioid dependence. Along with other forms of supportive rehabilitation services, such as education, counselling and effective aftercare, this approach has historically provided successful outcomes for sustained recovery and rehabilitation, leading to a reduction in recidivism.

16. In collaboration with the community-based Police Assisted Addiction and Recovery Initiative ("PAARI"), recovery coaches are utilized to provide peer recovery support services to assist individuals in achieving sustained recovery, to address barriers to successful recovery by serving as role models and advocates and to connect individuals with recovery-oriented self-help and pro-social assets within their local communities that will assist their rehabilitation and reduce recidivism.

17. I have attached a Detoxification Unit Guide to summarize this program as Exhibit C.

18. The Detox program has received considerable public recognition, praise and support within local communities. By way of example, I have attached various news articles evidencing same attached hereto as Exhibit D.

19. The facts recited herein are based upon my personal knowledge.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 19 DAY OF OCTOBER, 2018.

Jason Faro

EXHIBIT A

Jason William Faro
246 Pleasant Street
North Andover, MA 01845
Cell: (978) 886-3094
Work: (978) 750-1900 ext. 3519

EXPERIENCE

09/14 - Present **Adjunct Professor School of Criminology** *Merrimack College*
Graduate and Undergraduate Program *North Andover, MA*

- Course of instruction: Introduction to Criminology, Incarceration, Prison Incarceration and Treatment

09/16 - Present **Adjunct Professor** *North Shore Community College*
Criminal Justice Division Danvers, MA

- Course of instruction: Principles of Corrections.

09/08 – 05/13 **Adjunct Professor** *Northern Essex Community College*
Criminal Justice Division *Lawrence, MA*

- Course of Instruction: Modern Policing, Introduction to Corrections.

01/18 – Present **Director of Classifications** *Essex County Sheriff's Department*
Programs/Reentry *Middleton, MA*
Assistant Superintendent IV

- Management of offender treatment, education, reentry, chaplaincy and contracted program services within institution. Responsible for strategic planning for agency programming and treatment services as they relate to addiction, mental health and reentry.
- Management of institutional classifications system and associated reentry initiatives.
- Manage all collaboration regarding institutional treatment of offenders with probation, parole, specialty courts, Department of Education, Mass Sheriff's Association, Department of Public Health, Veteran's Administration and community-based treatment providers.
- Sustain communication with probation and parole as to determine inmate needs and best practice initiatives for offender reentry into community.
- Developed reentry linkages and partnerships for facility population, pre-trial and sentenced.
- Consultation in grant development for department and partnering agencies.
- Development of institutional policy relative to offender programming, treatment and reentry initiatives and services.

02/05 – 01/18 **Asst. Director of Programs** *Essex County Sheriff's Department*
Middleton, MA

- Managed programs areas that involve institutional programming: Residential Substance Abuse Treatment program, Alternatives to Violence Program, Education, Chaplaincy unit, Institutional Library.
- Principal within education unit, oversight of adult education services, HiSET (formerly GED), Title 1, special education and participating colleges.
- Department lecturer for all visiting high schools, colleges/universities, special dignitaries and government agencies.
- Sustain communication with probation and parole as to determine inmate needs and best practice initiatives for offender reentry into community.

- Manage contracts with Program and Treatment providers (Adcare Criminal Justice Services)
- Developed Medically Assisted Treatment Program for institution

01/04 – 02/05 **Deputy Director of Office of Community Corrections** *Essex County Sheriff's Department, Lynn, MA*

- Managed day-to-day operations of program security as well as participant compliance to mandated conditions and reporting of any violations to supervising agency (i.e. parole, probation, sheriff's department).
- Coordinated randomized drug testing of all referred offenders.
- Developed work release program for probation and sheriff's department participants.
- Provided technical as well as operational support for electronic monitoring program.
- Provided regular updates and correspondence to participating courts within county regarding offender compliance as well as referrals.

11/01 – 01/04 **Director of Electronic Monitoring** *Essex County Sheriff's Department, Lawrence, MA*

- Supervised electronic monitoring (EM) staff involving participant compliance to mandated conditions, progressive discipline as well as compliance with program documentation/reporting.
- Developed work release program within EM unit.
- Revised entire program policy and operational procedures.
- Provided staff with training on EM technology.
- Acted as primary liaison with participating residential programs on matters involving security, treatment, financing and EM technology.
- Managed all billing, inventory control and correspondence with EM provider (Behavioral Innovations Inc.)
- Revised all program documents and databases on Microsoft Word and Access.

12/00 – 11/01 **Correctional Counselor** *Essex County Sheriff's Department, Middleton, MA*

- Provided direct clinical services to clients with substance abuse and co-occurring disorders.
- Completed all required Department of Public Health documentation and reports.
- Facilitated treatment groups as well as individual counseling.
- Developed several groups regarding substance abuse issues and recovery.
- Provided supervision of program population as to ensure compliance to program and security requirements.
- Developed clinical assessments and treatment plans.
- Directed aftercare services for program population.

02/98 – 12/00 **Correctional Officer/Deputy Sheriff** *Essex County Sheriff's Department, Middleton, MA*

- Provided direct supervision of inmate population.
- Reporting of and documenting of all matters involving the care, custody and control of inmate population.

05/95 – 08/97 **U.S. Border Patrol Agent** *United States Dept. of Immigration and Naturalization, Laredo, TX*

- Enforcement of immigration laws as well as laws pertaining to the Controlled Substance Act.
- Conducted investigations involving the trafficking of both drugs and undocumented persons.
- Detailed report writing of investigations, arrests and seizures.

- Regular interaction and collaboration with community as well as other law enforcement agencies (County Sheriff's Office, Texas State Police, US Customs, Drug Enforcement Agency)

EDUCATION/TRAINING

September 2003 — ***Master of Science***
Springfield College
Springfield, Massachusetts
Program: Human Services/Criminal Justice
G.P.A. 3.89/4.00

December 1999 — ***Substance Abuse Counseling Certification***
Northern Essex Community College
Haverhill, Massachusetts
Program: Drug and Alcohol Counseling
G.P.A. 4.00/4.00

May 1994 — ***Bachelor of Science***
Salem State College
Salem, Massachusetts
Program: Criminal Justice/Political Science
G.P.A. 3.74/4.00

TRAINING

February 1998 — ***Essex County Sheriff's Department Basic Training Academy***
Middleton, Massachusetts
10-week training program inclusive of all facets of law enforcement and correctional policy and procedure.
Class Secretary
Graduated 2nd out of 28 officers.

September 1995 — ***Federal Law Enforcement Training Academy***
Artesia, New Mexico
21-week program inclusive of all facets of law enforcement involving fire arms proficiency, driving, defensive tactics, immigration law, and criminal law. Recipient of Physical Fitness Award for Basic Training Class 284. Class guide on.

Memberships

North shore Community College School of Criminal Justice: Advisory Board Member

EXHIBIT B

Sample: Sentenced Population Institutional and Reentry Programming Options

All sentenced inmates are met with an assigned reintegration coordinator within 48 hours. During this initial classification process several areas are examined.

- Offender sentencing and release date
- Examination of charges
- Inquiry of open cases/warrants
- Screen for Lower Security Placement (ECPRC)
- Submission of speedy trial to respective courts (if necessary)
- Inmate assessment:

1. Addiction History
2. Mental Health History
3. Employment History
4. Education History
5. Insurance status

Based on totality of inmate information a classifications plan is developed that is inclusive of:

Housing assignment

Core Institutional programming recommendations (see description)

Supplemental Institutional programming recommendations [redacted]

Availability and coordination of Reentry options [redacted]

Core Institutional Programming Descriptions:

80 Lower Housing Unit: Treatment and Recovery for Addictions in Corrections (TRAC)
Treatment and Recovery for Addictions in Corrections (TRAC) has emerged from the Accountability Model developed by Dr. Valle. It is a 4-month program focused around the disease of addiction, recovery strategies, and positive behavior change. The program includes individual and group counseling, the introduction of the 12-step process, and peer led recovery groups. An evidenced based curriculum from Hazelden titled "Living in Balance" is used to assist inmates to move from a life of addiction to a life in recovery. Each week a specific topic from the curriculum is delivered to the population. The curriculum rotation is followed below. **Curriculum Rotation:** Week 1: Alcohol & Benzos

Week 2:	Opioids
Week 3:	Tobacco, Synthetics, Cannabis
Week 4:	Stimulants, Cocaine, Methamphetamine
Week 5:	Blood Borne pathogens
Week 6:	Grief & Loss, Life changing events
Week 7:	Anger, resentment, Forgiveness
Week 8:	Relationships and Co-dependency
Week 9:	Depression, Anxiety, Stress
Week 10:	Stages of Change
Week 11:	Addiction and the Family
Week 12:	Gambling & other addictions
Week 13:	Decision Making and Goal setting
Week 14:	Timelines & Change Plans
Week 15:	Relapse Prevention
Week 16:	Spirituality, Health & Wellness

60 Bed Housing Unit: Alternatives to Violence Program (ATV)

The Alternatives to Violence (ATV) Program operates out of the 60 Bed housing unit at the Essex County Sheriff's Department's House of Corrections in Middleton, Massachusetts. Treatment, programming, and reentry services are delivered by Adcare Criminal Justice Services.

The ATV Program unit houses 120 male inmates, all of whom have the opportunity to engage in daily activities that support rehabilitation from offender thinking and behavioral patterns, as well as address common underlying issues of trauma, addiction, abuse and lack of education. The core program is split into two tracks: A Cognitive Skills Training track and a Domestic/ Anger Management track. Both tracks are in a group format and use Cognitive Behavioral Therapy and Dialectical Behavioral Therapy techniques and offer certificates for 35 hours of classroom time (12 weeks which meet 3 times per week). The groups meet off the unit in the Programs building, providing an adult-learning classroom environment. Facilitators are expected to utilize a trauma-informed model of care when working with the inmate participants and best practices in delivering curriculum and services.

The Cognitive Skills Training track seeks to build skills learning about following topics and taking part in complementary activities:

- Values Identification
- Emotional Literacy and Identification
- Identification of Positive, Negative, and Neutral Thinking
- Thinking Errors
- Fixed vs. Growth Mindset
- Mindfulness
- Decision Making
- Strategies for Promoting Change and Dealing with Roadblocks
- Empathy Skills Building
- Role Play and Games

The Domestic/ Anger Management track seeks to build skills learning about following topics and taking part in complementary activities:

- The Stages of Change

- The Cycle of Abuse and Violence
- Hierarchy of Needs
- Development of Behaviors and Habits/ Thought Cycle and Self Talk
- High Risk Thoughts and Behaviors/ Thought Stopping
- Boundaries
- Jealousy, Anger, and Criticism
- Healthy Relationships
- Communication Skills
- Drug and Alcohol Abuse/ The Influence of Addiction on Relationships

Both ATV Program tracks currently use evidence-based curricula from The Change Companies. Group facilitators utilize the following workbooks: Thinking Errors, Responsible Thinking, Values for Responsible Living, Managing My Life, Personal Growth, Relapse Prevention, and Change Plan. Groups are discussion based and use complementary activities such as small group discussion, peer instruction, role play, games, mindfulness activities, and art therapy exercises.

Supplemental Institutional Programming Descriptions:

(Courses are delivered in Programs Building)

Life Skills:

- Self-reflection is the focus in this class. Each student will develop a better understanding of their own values and behaviors. This course teaches ways to focus on positive behaviors to deal with the challenges faced in everyday life. Inner values, coping skills, problem solving, and conflict resolution are some of the many topics discussed.

Parenting:

- The Parenting Program is designed to assist incarcerated men build a healthy parent-child relationship. Through psycho-educational exercises participants will:

  Increase their knowledge about children and parenting
  Learn effective problem-solving skills
  Develop a deeper understanding of how one's own life experiences can Affect parenting
  Become a positive role model and develop personal skills involving; Patience, values, goal setting, boundaries, positive discipline, and Expectations.

Education:

- HiSet: Instruction allows students to obtain their HiSet. Students are initially assessed on existing educational levels and needs. Three levels of instruction exist based on student assessment: Adult basic Education for our lower level learners, Pre HiSet and HiSet for our higher-level learners. Students are regularly assessed as to move to higher levels of instruction. Students are offered with onsite testing to obtain High School Equivalency Credential.
- Title I: Program provides financial assistance to educational programs for youth in State-operated institutions and to support school districts' programs involving collaboration with locally operated state agencies.
- Special Education: Department of Elementary and Secondary Education (ESE) provides special education services to eligible students with disabilities up to 22 years who are incarcerated in thirteen of the Commonwealth's County Houses of Correction, operated under the jurisdiction of a sheriff.
- Merrimack College, College Credit Program: Program allows students to participate in college level courses and to obtain transferable college credits upon successful completion. Program is offered by Merrimack College and faculty.
- English for Speakers of Other Languages (ESOL) is a three-level developmental program for adults with limited or non-existent English language skills. The program has five strands: listening, speaking, reading, writing and number skills. The major goal of the program is to mainstream non-English speakers into academic or vocational programs and enhance their language skills for re-entry to the community and workplace.

Computer Literacy:

- Program is designed for students who wish to gain a basic understanding of personal computer applications and operations. Programming involves instruction with Microsoft Word, Power Point, Access, Excel, Key Boarding and Graphic design.

Chaplaincy services:

- Chaplaincy services are available to all inmates within the institution. Programming involves traditional access to religious services and interfaith groups. Individual counseling opportunities are also available through this unit.

Library services:

- Inmate population is offered one hour per day Monday – Friday to access the institutional library. During this time, inmates are allowed to check out selected readings and conduct research involving legal matters.

Available Reentry Services

Reentry services involve coordination between client and assigned reintegration staff. Services may also be accessed through clinical staff within assigned program units.

Medically Assisted Treatment (MAT):

- Inmates within the facility have the option to access a naltrexone-based MAT option for their release. Clients will be screened by medical staff and educated on this MAT option. 24 hours prior to release they will receive their first dose. Subsequent doses are coordinated with an outside provider.

Intensive Outpatient Programming (IOP) and Structured Outpatient Addiction Programs:

- Inmates who are returning home and wish to have a continuum of care can access programming through an IOP or SOAP program. Services traditionally offer addiction services and or co-occurring disorder supports.

Long Term Residential (LTR) and Sober Housing:

- Essex County Sheriff's Department has several options that allow clients to secure placement within a LTR and sober housing option prior to release. Participating Sober Houses are MA Alliance for Sober Housing (MASH) certified.

Veteran's Services:

- Veterans services through the Department of Veteran's Affairs are available during incarceration and post incarceration.

Department of Mental Health (DMH):

- DMH access is available through reintegration staff.

Mass Health Application:

- Reintegration staff are certified application counselors and are equipped to submit applications for Mass Health.

Young Adult Services:

- Community based services for populations 18-24 are available to this populations. Services typically include continued access into education, employment, mentoring and life skills. Partnering agencies include: ROCA, UTEC, Straight Ahead Ministries and Lawrence Youth Team.

Alcoholics and Narcotics Anonymous:

- Meeting locations within client respective community is made available to those interested.

EXHIBIT C

Essex County Sheriff Department's Detoxification Unit Guide

Kevin F. Coppinger, Sheriff

Essex County Sheriff's Department

Essex County Correctional Facility Detox Unit

Essex County Sheriff's Department

Referral Process

- ☆ All referrals are generated through the courts
  - Judges
  - Probation
  - Defense Attorneys
  - District Attorney
  - Police
- ☆ An ECSD staff member will be available to discuss potential referrals.

Reasons for Detox Unit

- ☆ Growth in pre-trial population and a lack of community detoxification beds are causing severe overcrowding in jails.
- ☆ Upon completion of the 28-day treatment, individuals may be able to dispose of their cases by utilizing other pre-trial tools as an alternative to incarceration.

Who is Eligible?

- ☆ Violation of Probation cases (i.e. dirty screens for opiates, other drugs and/or alcohol)
- ☆ Anyone presenting clear signs of addiction
- ☆ Probationers, who seem interested and/or invested in wanting help at no cost to them
- ☆ Crimes of violence and serious felony charges eliminate individuals from consideration.

Essex County Sheriff's Department

Individualized Care

- Medical
  - After medical assessment, individuals may receive medication to assist with withdrawal symptoms.
- Psychological
- Emotional
- Spiritual
- Personal hygiene
  - Limited canteen available to purchase personal products
- Accountability
- Respect for others and the rehabilitation process

Unit Essentials

- Bedding:
  - 42 hospital style detoxification beds; conducive to rehabilitation
- Laundry
  - Services available daily
- Dietary Supplements: Aramark
  - Three meals per day
  - Juice, fruit and light snacks available on unit
- Recreation: on unit
  - Elliptical
  - Two stationary bikes

On-Unit Care

- ☆ Medical: NaphCare
  - Fully equipped medical suite
  - 24-hour medically trained personnel
- ☆ Psychological: AdCare
  - Individual counseling
  - Dual collaboration treatment plan created with Probation
  - On-staff treatment clinician
- ☆ Spiritual
  - Access to all religious services available at ECCF

Return to Court

- After completion of 28 day detox:
  - ☆Transportation provided by ECSD to the court
  - ☆Individual treatment plan shared with Probation via email and hand-delivered to assist Judge, Assistant DA and court officials

Detoxification Unit Tracks

- Track I: Offenders that are NOT returned to incarceration at the ECSD, but are released with court-ordered conditions such as:
- Long-term treatment center admittance;
- Medically-assisted Treatment
- Level 2, 3 & 4 mandated Office of Community Corrections (OCC) day reporting
- Community Service and drug testing
- GPS Home confinement/work release and drug testing.

Detoxification Unit Tracks (cont.)

- ☆Track II: Returned to custody.
- ☆ECPRC
  - Mandatory drug testing
  - GPS supervision
  - Individual aftercare treatment plan until case is adjudicated.
- ☆Pre-trial status (TRAC program)

Medically-Assisted Treatment

- Vivitrol – prescribed, injectable medication used to treat alcohol and opioid dependence
- Additional tool to supplement other forms of recovery treatment to provide better outcomes for sustained recovery
- Available to Pre-trial and Sentenced population upon release
- Requires education, counseling, medical clearance and scheduling of after-care follow-up appointment

Essex County Sheriff's Department

ECSD & PAARI Recovery Coach Program

- One male and one female recovery coach assigned to ECSD Male and Female Detox Units – 10-20 hours/week
- Provide peer recovery support services to inmates to assist them in achieving sustained recovery
- Work collaboratively with ECSD Detox team and inmates to develop comprehensive treatment plan
- Address barriers to successful recovery and serve as a role model and advocate for Unit inmates

Essex County Sheriff's Department

ECSD & PAARI Recovery Coach Program

- ✯ Conduct group meetings and meet one-on-one with individual inmates as assigned to encourage attendance and participation in recovery-oriented, self-help and pro-social groups
- ✯ In consultation with the ECSD Detox team, accompany inmates to court in order to provide support prior to and after court proceeding
- ✯ Benefits – links to recovery assets "beyond the walls"
  - Continuum of Community-based Recovery Care
  - Saving Lives & Families
  - Reducing Recidivism & Safer Communities

Essex County Sheriff's Department

ECSD Detox Contacts

☆Middleton Facility (978)-750-1900

Asst. Supt. Jim Petrosino ext. 3500/ c: 978-994-7718

Program Director Jason Faro ext. 3519

Assistant Program Director Darya Maslova ext. 3333

Community Relations Coordinator Gary M. Barrett. ext.4302


ESSEX COUNTY
SHERIFF'S HEADQUARTERS
Kevin F. Coppinger, Sheriff

EXHIBIT D

SHERIFF SETTLES INTO HIS NEW OFFICE

BY DAILY ITEM STAFF | March 21, 2017

ITEM PHOTO BY OWEN O'ROURKE
Essex County Sheriff Kevin Coppinger talks about this first three months in office.

By GAYLA CAWLEY

MIDDLETON — Former Lynn Police Chief Kevin Coppinger, settling into his new job as Essex County sheriff after being sworn in in January, is focusing on the budget and reducing the recidivism rate among inmates at the Essex County Correctional Facility.

The biggest issue right now is the budget, Coppinger said. The department has a projected $19 million deficit through June 30, the end of the current fiscal year. Out of the 14 sheriff's departments in the state, he said Essex County is one of the four that have been traditionally underfunded and lives off supplemental budgets through the legislature.

Coppinger said his goal is to get the budget stabilized and fully funded as of July 1 each year. He said the budget cycle for FY18 is ongoing, but right now, the struggle is to come up with the $19 million to get through the rest of the fiscal year.

The sheriff said one of the reasons he ran, after 34 years as a cop, was because he wanted to see some change. He's a third-generation police officer, who started off with the Lynnfield Police Department, before transferring to Lynn.

Coppinger said he often saw the same individuals arrested and brought back. He said it was a revolving wheel, and called the department's 47 percent recidivism rate last year outrageous. He wants to see some changes, and plans on a program audit to look at all of the different programs in the department. The goal is to improve the programs for the inmates to address that cycle.

"When the inmates come in, the goal is when they are released, they're released in better shape than when they came in," Coppinger said. "Again, the long-term goal is that they don't recidivate. So, somebody commits a crime, they get sentenced here — the average sentence is nine months. We want to make sure (when) they leave the door, they don't come back."

http://www.itemlive.com/news/a-candid-look-at-life-on-the-streets/

One of the department's highlights, Coppinger said, is the detox program, which works closely with the courts, particularly the drug courts. There is a program for men and women, which includes 42 beds in each unit and 28-day programs. Other programs include anger management, GED for their high school equivalencies and work releases, he added.

The work program for inmates is through the pre-release center in Lawrence, better known as the farm. Coppinger said it's getting to the point in the season where the sheriff's department will do a lot more community service work, so inmate work crews will be sent to the municipalities and nonprofits if they want something done.

Coppinger said it also helps the department to send inmates to be released back into the communities to the pre-release center.

"They don't just sit in a cell for nine months and then we open up the doors and they go home," he said. "We put them through programs. They leave here and they go to Lawrence. They're hopefully a work release. They come back at night. Some of them are on bracelets. Some of them are in our custody full-time. And then, you slowly get them acclimated to go back into community life. It's a multi-faceted set of goals we have."

Coppinger said the facilities for inmates in the department also operate on a risk-based system. For instance, those involved in the work release are not violent or career criminals, but low-risk inmates who may be serving time for motor vehicle violations or child support issues. With the detox programs, drug dealers would not be allowed in, but those charged with drug possession would.

He said there are also segregation cells for the hardcore criminals. Gang members have to be separated from each other. The key is classification, Coppinger said, and when the inmate comes in the door, the goal is to gather as much information on them as possible to get them into the right buildings and programs. In Middleton, where the sheriff's office is located, there are 11 buildings for the jail.

A women's facility is in Salisbury. Most women go to Framingham, including all those convicted of violent crimes, Coppinger said. There are 24 beds in Salisbury, he said, and when women can be held there for other, more minor offenses, they are.

The department also oversees offices of community correction in Lynn, Lawrence and Salisbury, Coppinger said.

Keeping inmates busy with programs keeps them productive, Coppinger said. By sending more productive members back into the community, he said it might lighten the load on law enforcement. There could be fewer calls to police, and they could better address other issues that need their attention. Reform is not a new philosophy, he said, but he and his staff are just bringing a new perspective.

"I just think I bring a little bit different perspective based on my law enforcement background," Coppinger said. "I know what the root causes of crime are. I watched them for 30 odd years. You see what drives a lot of folks to crime. Hopefully, between these initiatives and working with the cities and towns and even in prevention mechanisms, we can make a dent. We're certainly not going to completely eradicate crime. If we can knock down that recidivism rate, it's all the better."

Gayla Cawley can be reached at gcawley@itemlive.com. Follow her on Twitter @GaylaCawley.

Rick Jeffery

From: William Raynard
Sent: Friday, October 19, 2018 10:42 AM
To: Rick Jeffery
Subject: Fox News August 14, 2017 Detox Program

https://www.boston25news.com/news/a-head-start-on-recovery-behind-bars/581967391

Unique jail program helps reunite local mom with son

Updated: Aug 14, 2017 - 1:38 PM

Unique jail program helps reunite local mom with son
A unique program offers pre-trial inmates access to addiction services.

Boston 25 News first reported on this program last summer. We wanted to know if the program was working so we've tracked the progress of one participant since she left jail one year ago.

Boston 25 met Kristen Bell last July in the Middletown Jail.

Content Continues Below
"If you would have asked me where I'd be in a year, I would have sold myself short," said Bell.

Bell was one of the first inmates in the Essex County Pre-trial Detox Unit for Women. It's a 28-day program that gives inmates dealing with addiction a head start on recovery. The women awaiting trial receiving around-the-clock counseling and access to resources to help them transition outside of jail walls.

>>ORIGINAL STORY: Jail detox program gives female heroin addicts a head start to recovery

Jacqueline Smart was referred to the pre-trial detox unit in July of 2016.

"Being arrested saved my life. I was homeless, living in my car. I was using because I didn't want to be alive anymore," said Smart.

It was her first time behind bars.

"This program helped turn everything around," said Smart.

Now a free woman, Smart returned for the one-year anniversary of the unit to thank the people who helped turn her life around.

Kevin Coppinger inherited the program when he took over as Essex County Sheriff in January.

"This is very, very unique. There is no other program like this," said Coppinger.

In fact, it's the only program in the country that provides addiction treatment for women in jail that are awaiting trial.

Sheriff Frank Cousins started the program for women after seeing success with the male pre-trial detox unity, which opened six months earlier. Coppinger says the majority of people in Essex County Jail are dealing with some kind of substance abuse program. He says the detox units are an investment.

"We get these folks for 28 days, if we can succeed in getting them on the right path to treatment and rehabilitation, it will help us reduce cost," said Coppinger.

The investment has paid off for Smart and Bell, who became friends in the detox unit.

"Her and I still talk to this day. We're both still clean," said Smart.

Bell is now reunited with her son Aiden after a year-long battle to stay sober. They live in a transitional house with other families that share the same struggle. She's looking for a steady job and a permanent place to live, which are not easy tasks for someone with a criminal record. Bell knows how far she's come, but knows that her war to conquer addiction is far from over.

"I still have a thousand battles. I wake up every day and know my battle is not over," said Bell.

Over 400 women have gone through the 28-day detox since it opened last summer, with 80 percent successfully completing the program.

Sheriff Coppinger says there has been a lot of interest in the success of the program from other counties around the state.

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Kevin F. Coppinger
Sheriff

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FOR IMMEDIATE RELEASE
June 21,2018

William Raynard
Public Information Officer
978-774-3281

ESSEX COUNTY SHERIFF'S DEPARTMENT TO BE AWARDED P.A.A.R.I. LAW ENFORCEMENT LEADERSHIP AWARD

The Essex County Sheriff's Department will be presented the Law Enforcement Leadership Award on June 27th at 6 PM at the Gloucester House, 63 Rogers St., Gloucester. The Police Assisted Addiction Recovery Initiative (P.A.A.R.I.) will be hosting the third annual celebration, which will recognize the leadership and advocacy by law enforcement, government and advocacy groups who continually work to end the current opioid addiction crisis.

Sheriff Kevin Coppinger, Community Relations Coordinator Gary Barrett and the entire Detox Unit team will be recognized for their innovative approaches to treatment and re-entry. The 42 bed male and 42 bed female detox units are located within the House of Correction in Middleton.

P.A.A.R.I encourages opioid users to seek recovery, helps distribute life saving opioid blocking drugs to prevent and treat overdoses, connects addicts with treatment programs and facilities and provides resources to Essex Sheriff's Department to fight the opioid addiction epidemic.

"The Essex County Sheriff's Department is honored to receive the P.A.A.R.I. Leadership Award. The Detox Units are part of our Department's commitment to reduce recidivism by working with agencies like P.A.A.R.I. to prepare people in recovery for a more productive and responsible role in their home communities," said Sheriff Coppinger.

The Sheriff's Department Detox Unit utilizes the PAARI recovery coaches who provide support services to participants for 10-20 hours per week both during and after a participant's release. This allows the program to extend beyond the walls back into the communities with coordinated services to address barriers to successful recovery.

####

William Raynard

From: William Raynard
Sent: Saturday, September 08, 2018 8:56 AM
To: Kevin Coppinger; Dennis Newman; Barbara Maher; William Gerke; Monica Harris; Gary Barrett; Jay Faro; Darya Maslova
Subject: Essex County Sheriff's Department receives AmeriCorps grant

http://beverly.wickedlocal.com/news/20180908/essex-county-sheriffs-department-receives-americorps-grant

Essex County Sheriff's Department receives AmeriCorps grant

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Our Picks

Sheriff Kevin F. Coppinger announced that the Essex County Sheriff's Department (ECSD) is once again partnering with the Police Assisted Addiction and Recovery Initiative (PAARI) and will be receiving a 2018-19 AmeriCorps grant from PAARI to retain two part-time recovery coaches as part of the ECSD's detox team in the male and female detox units.

This groundbreaking statewide program, which launched last year, combines the power of service with the power of the recovery community and the power of law enforcement-based referral programs, placing AmeriCorps members in host police department sites across Massachusetts. The ECSD is the only Sheriff's Department in Massachusetts participating in the AmeriCorps PAARI grant program.

PAARI AmeriCorps members build the capacity of law enforcement programs and assist those suffering from substance use disorders by connecting them to treatment and recovery services that divert them from the criminal justice system. The ECSD is one of 73 law enforcement partners selected to receive an AmeriCorps grant from PAARI to bring on AmeriCorps members to prevent overdose deaths and provide vital resources to community members with substance use disorders.

"By integrating PAARI recovery coaches into our detox team, we try to make it easier for individuals battling addiction in the critical stage as they transition into their home communities," said Sheriff Coppinger. "The recovery coaches enable us to reach beyond our walls and connect our Detox participants to vitally important community-based resources to better

their chances for a sustained recovery. The department is happy to work with the PAARI AmeriCorps program for a second year."

PAARI received a three-year grant from the Massachusetts Service Alliance and the Corporation for National and Community Service to launch this first-of-its-kind program that places AmeriCorps members into service at host police department sites across Massachusetts, assisting with local police-led addiction and recovery programs to combat the growing opioid epidemic.

"PAARI's mission is to provide resources to help law enforcement agencies combat the opioid epidemic and this innovative program will add significant capacity to our law enforcement partners and utilize service as a solution to address critical community needs," said PAARI executive director Allie Hunter McDade. "We are thrilled that the Essex County Sheriff's Department is continuing as a partner for the second year of this groundbreaking program."

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WICKED LOCAL MIDDLETON
Includes content from the Tri-Town Transcript

Middleton detox program spotlighted at police summit

Dec 12, 2017 at 3:28 PM
Dec 12, 2017 at 3:28 PM

Essex County Sheriff Kevin Coppinger addressed over 200 law enforcement leaders and addiction treatment specialists as part of the first Police Assisted Addiction and Recovery Initiative Summit held at the Boston University School of Public Health on Dec. 5.

Representatives from 27 states across the nation gathered to share ideas on best practices in preventing overdose deaths and providing access to addiction treatment and recovery services.

Coppinger noted that the current opiate epidemic affects thousands of people in all walks of life and that in 2016, over 65,000 deaths were attributed to drug overdoses nationally.

"The majority of our inmates have addiction issues and upon release, without proper planning in place, they are 58 times at greater risk to overdose than those not previously incarcerated," said Coppinger. "Working with the courts, the district attorneys, defense attorneys, probation and police, our innovative detox program at the Middleton Jail has provided meaningful options for inmates and now with the assistance of PAARI and the Recovery Coach initiative, we are ready to take our program to the next level to help combat this horrible epidemic."

Coppinger described the Detox Unit as a 28-day program available for both men and women in separate housing units. There are 42 available beds in each unit. Treatment services and health care needs are provided by outside experts in those fields and upon successful completion of the program participants are returned to the courts with an individual plan for re-entry back into the community.

"Now that we have the Recovery Coaches in place, the link between our program and successful reintegration back into the community is greatly enhanced," Coppinger said. This allows the program to extend beyond the facility walls. PAARI and the Essex County Sheriff's Office Detox Team conduct group meetings, attend participant's court appearances and work together to

address barriers to successful recovery. The coaches will serve as liaisons between the individuals and available services throughout the county, working with a variety of resources to try and stem the tide of recidivism.

Coppinger believes that this kind of coordinated partnership, with extended community follow-up, will have a significant effect on a participant's success after completion of the detox program.

While proud to share the details about Essex County's program, Coppinger also stated: "I was also glad to hear about what strategies are having success in other states. And I look forward to sharing that information with local police and fire chiefs, mayors, school superintendents, and leaders of organizations across Essex County with whom I work collaboratively with to find and implement effective solutions. We cannot ignore this problem."

TAUNTON DAILY GAZETTE

Essex County Sheriff's Department receives AmeriCorps grant

Posted Sep 8, 2018 at 12:28 AM
Updated Sep 8, 2018 at 12:28 AM

Sheriff Kevin F. Coppinger announced that the Essex County Sheriff's Department (ECSD) is once again partnering with the Police Assisted Addiction and Recovery Initiative (PAARI) and will be receiving a 2018-19 AmeriCorps grant from PAARI to retain two part-time recovery coaches as part of the ECSD's detox team in the male and female detox units.

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UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

C.A. NO. 18-cv-11972

GEOFFREY PESCE,

Plaintiff

v.

KEVIN F. COPPINGER, et. al.,

Defendants

AFFIDAVIT OF AARON EASTMAN

I, Aaron Eastman, 20 Manning Avenue, Middleton, MA 01949, on oath depose and state as follows:

1. I am the Superintendent of the Essex County Correctional Facility at Middleton, Massachusetts, having been appointed to that position in December, 2017. Prior to that, I served as the Director of Security at the Middleton facility between 2012 and 2015, as well as the Superintendent of the Essex County Pre-release and Re-entry Center located in Lawrence, MA between 2015 and 2017;

2. I am familiar with the policies, procedures and practices of the Essex County Sheriff's Department with respect to among other things, the Department's overall mission, the classification of sentenced inmates upon intake into the Essex County Correctional Facility, Middleton, MA, as well as the integration of inmates into institutional and community-based programming services available to address problematic inmate behaviors, including substance abuse and addiction, as well as the safeguards in place to provide for the overall safety and security of the institution, its inmate population, its staff, vendors, volunteers, visitors and the

public at large.

3. As set forth in its Department Philosophy and Goals, 103 ECSD 910.00, a copy of which is attached hereto as Exhibit A:

> [e]mployees of the Essex County Sheriff's Department are committed to a fully integrated criminal system, which ensures public safety. Each facility provides an environment, which offers opportunities for positive behavior change, optimizes community reparation and works collaboratively with the community and other agencies in pursuit of its mission. See 103 ECSD 910.06.

4. In upholding and carrying out this mission, the Department is mindful that a majority of the individuals incarcerated at its facilities are those dealing with addiction and substance abuse issues who have engaged in criminal activity often as a result of drug-related offenses or crimes committed to perpetuate their drug-seeking behavior.

5. Mindful of its population and the issues they face, one of the Department's primary objectives for years has been to:

> [c]ollaborate with NaphCare [its medical provider], AdCare [its clinical and programs provider], other law enforcement agencies and community partners to formulate a plan to aggressively combat opioid abuse and overdose. Working groups will meet regularly to put together a process which begins during incarceration and follows inmates into the community, utilizing Court mandated post release supervision and community partners to assist opioid users with their recovery. See Exhibit A, 103 ECSD 910.08, 1.

6. In implementing and carrying out these objectives with respect to successfully rehabilitating those individuals suffering with addiction and substance abuse issues, the Department's general philosophy has been and continues to be, one of medically assisted treatment ("MAT") from the moment they enter the facility to the time they are released to the community. In short, the Department provides individuals with the opportunity to immediately and safely withdraw from opiates upon their incarceration, followed by a comprehensive

treatment plan inclusive of substance abuse treatment, education, programing, re-entry services and after-care treatment upon release to the community, and in some cases the utilization of Vivitrol at the end of incarceration. In so doing, individuals have the opportunity to return to the community living a drug-free life without being dependent on addictive medications.

7. The Department contracts with a private medical provider, NaphCare, Inc., to provide medical care and treatment to individuals incarcerated at the Department. NaphCare has served as the Department's medical provider since 2008.

8. NaphCare has in place protocols for treating inmates who enter the facility either utilizing or addicted to opioids, including methadone. NaphCare also has protocols for treating inmates experiencing the symptoms of withdrawal from opiates and opiate addiction. Medically assisted withdrawal ("MAW") of those individuals entering the facility in these circumstances is done under the care and supervision of NaphCare medical staff.

9. To the best of my knowledge, during the timeframe for which NaphCare has served as the Department's medical provider, we have never had a single in-custody death from an inmate experiencing withdrawal from drugs in accordance with these protocols which have proven to be both safe and effective.

10. In fact, the Department has received and is currently accredited by both the American Correctional Association ("ACA") and National Commission on Correctional Health Care ("NCCHC"), NCCHC dealing specifically with the provision of medical care by the Department. Both accreditations come after a comprehensive audit and review of both the medical facility as well as the medical provider's protocols and treatment regimens, inclusive of its protocols for treating inmates experiencing symptoms of withdrawal from opiates and opiate addiction.

11. Once successfully withdrawn from the opioid and cleared by NaphCare, individuals are provided with wide-ranging, comprehensive programming, treatment, counseling, educational, re-entry and after-care service options all with respect to substance abuse issues in an attempt to modify and/or change their criminal behavior, with the ultimate goal of reducing recidivism. These programming options have been implemented and function under the direction of the Department's Director of Classification, Programs/Reentry.

12. In order to create an environment where individuals can safely withdraw from the opioid, remain clean and then fully participate in the programming and treatment referenced above, the Department's philosophy and commitment is to maintain a drug-free environment. This is done not only for the individual in recovery, but for the overall safety and security of the institution, its population, staff, vendors, volunteers, visitors and the public at large. As such, opioids like suboxone and methadone, and all other forms of illegal drugs, are expressly prohibited from all facilities and are considered contraband as they are widely known to be coveted within populations of incarcerated individuals for their intoxicating effect.

13. In order to maintain a drug-free environment, the Department has gone to great lengths to keep opioids like suboxone and methadone and other forms of illegal drugs out of its facilities, including amongst other measures, implementing a comprehensive Search Policy, attached hereto as Exhibit B, utilization of a Body Scanner upon admission to the Middleton facility, X-ray equipment, drug-detecting K-9's, cell searches, screening of mail, use of informants, as well as substance abuse testing in the form of widespread urine screens. Moreover, individuals in possession of these drugs have been and continue to be subject to internal discipline and in some cases, criminal prosecution.

14. Nevertheless and despite vigilant efforts to the contrary, it remains a fact that

illegal drugs and opioids of this nature have and continue to enter facilities and prisons across the Commonwealth, including the Essex County Sheriff's Department. Cases in which I am either aware or advised that:

- drugs have been detected hidden inside the detainee's body cavity upon their initial admission to the facility;
- drugs have been detected hidden inside the detainee's body cavity upon their return from an outside court appearance and/or medical visit;
- drugs have been detected sewn into clothing;
- drugs have attempted to be smuggled in dentures;
- drugs have been attempted to be smuggled into the facility through visits;
- drugs have been detected on, or diluted in, adhesive strips of envelopes, letters and postage entering the facility in the mail;
- drugs have been detected in cells following a cell search; and
- even with respect to medications legally prescribed and administered by the medical provider within the jail, inmates have attempted to hoard the medication through what is known as "cheeking" and other means, hiding the medication either for later personal use, or to disseminate to other detainees.

15. The admission, presence and availability of such opioids and other drugs entering the facility poses a very real risk to the safety and security of the institution, its detainees, staff, vendors, visitors, volunteers and public at large. By way of example but not limited thereto, the Department has had numerous cases in which it has discovered:

- Detainees have utilized such drugs for recreational use and intoxicating effects inside the jail, which in some cases has led to overdose, and even fatality;

- Correctional staff have come in contact with such drugs during routine searches which in some cases has led them to overdose, requiring immediate medical attention, care and treatment;
- Detainees in possession of the drugs have attempted to traffic the drug within the facility and otherwise use said drugs as a form of currency;
- Detainees have been discovered attempting to strong-arm fellow detainees to smuggle, obtain and/or sell drugs inside the facility, in some cases intimidating, threatening and/or utilizing violent behavior in an attempt to coerce same. In other instances, the Department has discovered that detainees have placed money in an individual's canteen account in exchange for receiving drugs inside the facility;
- In some instances, staff have been assaulted while conducting cell searches by inmates attempting to conceal the drugs in their cell;
- On numerous occasions, both my staff and I have been advised directly by detainees attempting to successfully rehabilitate from substance abuse that the presence of these drugs within the facility and on their unit creates tension on the unit, and directly interferes with and/or disrupts their treatment in an otherwise drug-free environment;
- the Department has a significant health and safety concern about a detainee receiving prescribed opioid medication through MAT then potentially utilizing and ingesting other opioids and illegal drugs otherwise smuggled into the facility as referenced above, such as fentanyl and K2, potentially causing a serious risk to the individual.

16. I am aware that in the event he is not provided his methadone treatment at the Department, Mr. Pesce has requested that he be transported to an outside facility, specifically Lahey Clinic in Danvers, MA.

17. The transport of a detainee outside of the secure correctional facility for medical reasons poses one of the greatest security concerns and risks faced by the Department and its staff and as such, only occurs when absolutely medically necessary as determined by the medical provider. During any such transport, correctional staff are at their most vulnerable in providing for the safety and security of the inmates under their care, custody and control. It is during these times that correctional staff are faced with the greatest risk of escape or third party intervention. As such, inmates in need of medical care at an outside facility are not advised of the time, date, transport or even the name and location of the medical facility, until immediately prior to transport for safety, security and precautionary measures. With respect to Mr. Pesce, the Department would be transporting him to a known destination, on a designated route, at a specific date and time known to Mr. Pesce, to an unsecure medical facility, contrary to its normal protocols.

18. In addition to the safety and security risks posed by such a medical transport remains the very same concerns articulated in paragraphs fourteen (14) and fifteen (15) above with respect to opioids, medications and other drugs being smuggled back into the facility, and the consequences with respect thereto. As noted above and despite best efforts to the contrary, inmates transported outside of the facility for medical reasons have been known to attempt to smuggle drugs and/or medications back into the facility for either personal use or dissemination. Moreover, this may not even be of the detainee's volition as detainees have been known to attempt to strong-arm fellow detainees to obtain drugs and/or medications and smuggle them into

the facility.

19. Upon information and belief, there is currently no House of Correction in Massachusetts which provides methadone to its male detainee population.

20. The facts recited herein are based upon my personal knowledge.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 18 DAY OF OCTOBER, 2018.

Aaron Eastman

EXHIBIT A

Essex County Sheriff's Department

ESSEX COUNTY HOUSE OF CORRECTION

Title:	103 ECSD 910.00 Department Philosophy and Goals		
Original Issue: 2017-12-13	Last Revised: Revised Date	Revision Number: 1	Issuing Authority: Choose an Authority
Category: 02 - Personnel Rules	Next Review Date: 6 Months	Distribution: ALL	Effective Date:
References: CMR			

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910.01 Purpose

The purpose of 103 ECSD 910.00 is to delineate the mission of the department within the context of the total correctional system to include the philosophy and goals of the department. This policy shall provide a system of communication and establish the current structure of authority, responsibility and accountability within the department.

910.02 Cancellation

103 ECSD 910.00 cancels all previous rules and regulations, policy statements, bulletins, directives, orders and notices regarding the department's goals and mission.

910.03 Applicability

This policy is applicable to all employees within the Essex County Sheriff's Department.

910.04 Access to Regulations

This policy shall be maintained within the Essex County Sheriff's Department central policy file and accessible to all staff.

910.05 Department Policy

It is the philosophy of the Essex County Sheriff's Department to promote public safety by imprisoning criminal offenders while maintaining a commitment to crime prevention in the community. Essex County Sheriff's Department seeks to operate clean, safe, and humane facilities, with an appropriate range of services, which recognize the individual needs of the offenders.

910.06 Department Mission

Employees of the Essex County Sheriff's Department are committed to a fully integrated criminal justice system, which ensures public safety. Each facility provides an environment, which offers opportunities for positive behavioral change, optimizes community reparation and works collaboratively with the community and other agencies in pursuit of its mission. (CMR 910.01)

This mission is achieved through the following initiatives:

1) To protect the public by safely and humanely incarcerating criminal offenders at the appropriate security level consistent with public safety;
2) To provide inmate work, education, and programming opportunities;
3) To establish sound policies and procedures;
4) To inform and educate the public consistent with established policy;
5) To provide a professional and rewarding work environment for staff;
6) To develop innovative and cost effective alternatives to incarceration that enhances the efficiency of the department.

910.07 Department Long Range Goals

The department has established long-range goals, which include, but are not limited to: (CMR 910.01)

1) Continue development of initiatives to address ongoing overcrowding problems;
2) Expand work opportunities and programs for the inmate population with particular attention paid to the development of programs that provide a vehicle for inmates to give something back to the community;
3) Expand the department's partnerships with other criminal justice organizations and state agencies;
4) Continue to identify funds and implement emerging technological advances;
5) Pursue and maintain ACA accreditation;
6) Improve the internal management and planning systems to foster team work and responsiveness among all employees;
7) Develop and implement an initiative to enhance and strengthen relations with the community;

8) Conduct an evaluation of the training program for the purpose of enhancing program delivery.

Leadership: Promote a "person-Centered" leadership philosophy within all ranks of Middleton supervision. Ranking staff from sergeants to upper management will develop subordinate personnel through mentoring, succession planning and the promotion of continuing education and training. Training and management staff will jointly develop and promote supervisory training which will meet the diverse needs of the Middleton leadership team.

910.08 Facility Objectives for 2015 (CMR 910.02)

Essex County Correctional Facility

1. Collaborate with Naphcare, AdCare, other law enforcement agencies and community partners to formulate a plan to aggressively combat opioid abuse and overdose. Working groups will meet regularly to put together a process which begins during incarceration and follows inmates into the community, utilizing Court mandated post release supervision and community partners to assist opioid users with their recovery.

2. Work with System Analyst to prepare for the new Inmate Records Management System. Current systems are being looked at to maximize the capability of each system and bridge the systems together to eliminate duplication of data.

3. Coordinate construction projects in order to maintain proper security throughout the facility. Current roofing/HVAC projects will overlap with the Commonwealth Energy Project here at the ECCF creating the need to accurately schedule the work to contain construction sites to a minimum portion of the facility at a time.

4. The pre-trial population in Essex County is documented to be the highest in the Commonwealth. Classification will work with the Courts and the District Attorney's Office in order to identify pre-trial inmates that are appropriate for pre-trial diversion programs or home placement with supervision by the (3) Offices of Community Corrections.

5. Compete for grants involving re-entry in order to expand the services that are provided to sentenced inmates that are being released into the community. With resources being as limited as they are, it is important that we supplement our budget with grant money to enhance the re-entry process to help our inmates succeed in their communities.

Essex County Pre-Release Center

1) Complete the upgrade to the current video camera surveillance system at the CAC. The current camera system has been invaluable to prevent security issues from going unresolved. Enhancing and expanding the system will continue to aide security investigations in their daily operations.

2) Provide Re-Entry Coordinators the time and resources to expand our current work release opportunities for inmates. With the number of inmates on electronic monitor at sober

houses increasing, the need for employment increases. Re-Entry Coordinators can assist work release by going into the community with offenders and seek jobs relevant to their skills.

3) Increase the assistance the center provides to cities and town throughout the county by utilizing our community service to its fullest.

4) In April 2014, begin the replacement of the existing vinyl windows and screen throughout the institution. Also included will be a new heating system and solar hot water system.

5) Start the MDOC inmate step down initiative.

6) Modernize the kitchen/inmate dining area.

Wit Goals

1. Continue to provide and expand community service opportunities in the surrounding areas. This not only allows for positive community relations, but it also gives the female the sense of accomplishment and the idea of giving back to the community.

2. Work with the Training Department at the Middleton facility in order to implement a Female Offender training curriculum. The power point presentation that was created by WIT staff focuses on topics ranging from mental health and medical issues, to communication, to manipulation and the setting of boundaries.

3. Collaborate with agencies such as the Department of Mental Health, Department of Revenue, and the Department of Children and Families. Encourage those agencies to make on-site visits to the WIT residents.

4. Create more innovative training and/or employment opportunities with other state agencies and local business for the offenders to access, both while they are incarcerated and for post release.

5. Maintain the high standards of security and programming in order to ensure the WIT facility continues to achieve ACA accreditation.

910.09 Staff Meetings

A Superintendent to whom all employees are responsible manages each facility. The Sheriff, Superintendent and Team Leaders shall conduct staff meetings at least monthly with their staff complement to discuss issues relating to the operation of units/divisions under their control.

All staff should be encouraged to participate in the process of problem solving and strategy development, and in the development of policies and procedures.

Each Superintendent shall determine the frequency of staff meetings at various levels of responsibility and the persons, identified by job titles, who should attend. Staff meetings should be held at least monthly and shall be documented. (CMR 910.07)

Each Superintendent, acting in the capacity as the facility's chief administrator, shall meet with the facility's division heads on a weekly basis.

The Division heads shall conduct staff meetings with their staff at least monthly. All staff meetings shall be documented.

Communications between staff members and inmates is essential to the efficient operation of the facility. Individual employees will make every attempt to respond to inmate inquiries and/or direct the inmate to a staff member who should have the information requested.

Inmates shall receive Orientation at each facility upon arrival. A statement signed and dated by the offender and staff documents orientation completion and receipt of an inmate handbook.

910.10 Organizational Structure

The Department shall develop an organizational chart, which accurately reflects the structure of authority, responsibility and accountability within the facility. Such organizational chart shall be reviewed at least annually and updated as needed by the Superintendent or designee. (CMR 910.03)

910.11 Facility Policy and Procedure Manual (CMR 910.04)

Each facility shall maintain a Policy and Procedure manual to include: policies, procedures, rules and regulations, post orders, and plans that are appropriate to the function of the facility. These manuals shall be available to employees, and an orientation shall be conducted to familiarize employees with the documents that concern their respective jobs.

All statements contained in the policy and procedure manual shall comply with department policy, applicable State Law, jurisdictional authority regulations and the American Correctional Association standards. The manual shall include, but not be limited to written policies and procedures in the general topic areas of:

a. management and training
b. business and fiscal management
c. personnel, labor relations and training
d. security management
e. safety and emergency management
f. facility maintenance, sanitation and hygiene
g. facilities planning and capital management
h. inmate programs, services and classification
i. inmate rights
j. rules and discipline
k. medical and health care
l. food services

The Sheriff and Superintendents shall review all policies and procedures at least annually from the effective date. During this annual review each policy and procedure shall be reviewed to ensure that:

a. It is consistent with ACA standards,
b. It is consistent with any jurisdictional authority's regulations,
c. It is practicable for implementation,
d. It is current, operationally sound and consistent with the philosophy and goals of the Department.

The compliance unit shall maintain the original copies of all Department policies for a minimum of five years.

New or revised policies and procedures are disseminated to designated staff, volunteers, and when appropriate, to inmates prior to their going into effect. This expeditious dissemination shall increase the effectiveness of the facility's communication system.

All policies, procedures and operating manuals are current, operationally sound, and reflect existing policy. As necessary, program changes are implemented in response to reviews.

910.12 Review Date

This policy shall be reviewed at least annually from the effective date.

910.13 Severability Clause

If any article, section, subsection, sentence, clause or phrase of 103 ECSD 910.00 is for any reason held to be unconstitutional, contrary to statute, in excess of the authority of the Sheriff or otherwise inoperative, such decision shall not affect the validity of any other article, section, subsection, sentence, clause, or phrase of these regulations.

EXHIBIT B

Essex County Sheriff's Department

ESSEX COUNTY HOUSE OF CORRECTION

Title:	103 ECSD 214.00 Search Policy		
Original Issue: 2018-07-24	Last Revised: Revised Date	Revision Number: 1	Issuing Authority: Choose an Authority
Category: 02 - Personnel Rules	Next Review Date: 6 Months	Distribution: ALL	Effective Date: Eff. Date
References: CMR			

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214.01 Purpose

The purpose of this policy is to establish guidelines for searching person(s) and areas within all ECSD facilities. Searches are conducted to detect and prevent the introduction of contraband, recover missing or stolen property, to prevent escapes and other disturbances. (924.06(1))

214.02 Cancellation

This policy cancels all previous policy statements, bulletins, directives, orders, notices, rules and regulations regarding searches.

214.03 Applicability

This policy shall be applicable to all inmates committed, transferred or remanded to any holding facility staffed by the Essex County Sheriff's Department.

214.04 Access to Regulations

103 ECSD 214.00 shall be maintained within the Essex County Sheriff's Department central policy file and shall be accessible to all employees of the Essex County Sheriff's Department. Upon request, redacted copies will be made available to inmates.

214.05 Superintendent's Search Plan

The Superintendent or designee may order the search of any person entering or confined in a facility, in or on state property, including parking areas, in order to ensure the security and safety of the facility, its inmates, employees and visitors.

Staff, inmates and visitors shall be notified in writing (e.g., handbooks, posting, etc.) of the general policies at each facility regarding searches and items considered to be contraband.

214.06 Facility Search Plan

Each facility shall develop a search plan, which will include frequent unannounced searches of inmates, inmate quarters and every other area of the facility as often as necessary to ensure the safety and security of the facility. The search plan shall state the following reasons for conducting searches within the facility:

A. To prevent introduction of weapons and other dangerous contraband into the facility.

B. To detect the manufacture of weapons, escape devices, etc. to prevent against escape or other disturbances.

C. To discover and suppress trafficking between inmates as well as between employees and inmates, inmates and visitors, and inmates and vendors.

D. To discourage theft and trafficking in the facilities.

E. To prevent malicious waste or destruction of state property.

F. To discover hazards to health and safety that may go unnoticed during a more routine inspection.

G. To recover missing or stolen property.

H. To discover suicide and homicide attempts or potential suicide and homicide attempts by detecting excess items such as shoelaces, metal, plastic bags, extra sheets, medications etc., within the an inmate's cell/room. When searching an inmate's cell/room his mental status should be considered.

I. To provide alternative search procedures for visitors/staff entering the facility with automatic implantable cardioverter defibrillator and/or pacemakers.

J. To establish guidelines for crime scene/evidence preservation and storage

All cells/bed areas shall be searched at a minimum of once per month. All non-housing/common areas that have routine access by inmates shall be searched at a minimum of once per month, i.e., Library, gym, work areas etc.

All non-housing areas that are not routinely accessible to inmates shall be searched at a minimum of once per quarter.

Post assignments shall be identified that require the searching of inmates, visitors, and staff. The plan shall also cite the strategic advantages and purpose for such post assignment duties, including the type of search technique generally employed.

The facility shall maintain a tracking system that provides a ready means of ensuring that no particular area of the facility is either ignored or over saturated with searches.

A tracking system shall identify each area of the entire facility and identify staff responsible for searching each area. OMS shall be used to document the date, time, cell number/room or area of the facility, the person conducting the search, remarks, inmate's name and number, contraband found.

The Assistant Superintendent of Security is responsible to ensure all areas of the facility are searched at least once per month. The searches of the facility shall be the responsibility of all three shifts.

The searching of visiting areas (i.e., bathrooms, chairs, etc.) shall be conducted before and after visiting hours by the visiting room officers and documented in OMS under the appropriate tab.

Post orders identify requirements of searching of inmates, visitors and staff. Searches shall be conducted, but not limited to, the following post positions:

A. During all inmate movement periods, officers may be required to perform random pat searches. At this time, officers shall ensure that all inmates are wearing their identification wristbands.

B. Officers may be assigned to perform random pat searches of inmates entering or departing the dining hall from all meal periods. Random pat search number shall be assigned by the Shift Commander during roll call.

C. Officers assigned to the Lobby shall be required to search all packages.

D. Officers assigned to the visitor pedestrian trap shall be required to search visitors via walk through metal detector, fluoroscope, pat search, and/or search of the day.

E. Inmates entering/leaving the upper yoke area or maintenance shall be subject to a metal detector search and random pat searches performed by the officer or maintenance personnel.

F. Officers assigned to the gym, rec. yard, programs building shall perform random pat searches of inmates and packages (i.e. books etc.) entering and leaving these areas.

G. Kitchen Officers are required to perform pat searches and random strip searches of all inmate workers leaving these areas.

H. Restrictive Housing Unit (RHU)/Medical Housing Unit (MHU)/Intake areas are required to perform pat/strip searches of all inmates entering and exiting.

To ensure that all areas of the facility are searched at least once per month, OMS will be utilized and the Shift Commanders of all three shifts shall be responsible to ensure that the searches are entered into the OMS in the appropriate common area search.

Alternate Search Procedures

Alternate search procedures have been developed regarding the use of hand-held and walk through metal detectors in order to safeguard against the risk posed to individuals with automatic implantable cardioverter defibrillator and/or pacemakers.

Upon notification from an individual that he/she has an automatic implantable cardioverter defibrillator and/or pacemaker, the trap officer will perform the following duties:

A. Explain to the individual that an alternative search procedure shall be implemented with their consent.

B. Any individual having an automatic implantable cardioverter defibrillator and/or pacemaker shall be thoroughly pat searched. Prior to the search, the individual must give consent to the search, which is to be recorded in the search log.

C. Any individual refusing an alternate search shall be denied entrance into the facility for that day. The Shift Commander shall be notified and an incident report shall be filed prior to the end of the shift.

At a minimum, the following sign shall be posted permanently in the visitor lobby area where such searches are commonly done;

"Use of hand-held and walk-through metal detectors may interfere with the operation of an automatic implantable cardioverter defibrillator and/or pacemaker. Notify staff if you have such a device and an alternative search procedure will be used."

214.07 Strip Searches - Male

Strip searches should be employed, when necessary, for the close scrutiny of an inmate's person in determining if that inmate is carrying an item(s) considered to be contraband. Strip searches shall be

employed for routine security checks or when there is a specific suspicious incident that would indicate that an inmate is perhaps carrying contraband. Safe Keeps, non-arraigned detainees and police holds are not subject to strip search unless there is reasonable suspicion.

Specific situations in which strip searches may be employed, include but are not limited to: (924.06(3a-h))

A. entrance or exit from a secure perimeter and area
B. before and after court or medical trips
C. after the detection of an alleged disciplinary infraction
D. when custodial staff have reason to believe a person may possess contraband
E. after an escape or attempted escape
F. placement in restrictive housing from general population
G. prior to or following a visit (this facility is a non-contact visit facility with the exception of attorney visits)
H. return from temporary release.

The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches except in exigent circumstances and only by a qualified medical personnel, and only when authorized by the Sheriff or his designee.

The facility shall not search or physically examine a transgender/intersex inmate for the sole purpose of determining the inmate's genital status.

Strip searches of individual inmates should be conducted in relative privacy, by one security personnel with a second security staff member present, except in an emergency as determined by the Sheriff/Facility Administrator or designee, overseeing the process and while rendering as much dignity to the situation as possible. Strip searches by members of the opposite sex shall not be permitted.

Procedure: **Strip Search**

The Shift Supervisor whenever possible assigns two staff members to conduct the strip search. One staff member is responsible for giving verbal commands while the other staff member examines the removed clothing for contraband.

1. Prior to conducting a strip search, staff must wear protective gloves.

2. Staff does not place their hands on an inmate during a strip search unless an emergency situation arises. Staff is continuously visually inspecting the inmate during this process.

3. Staff makes no comments other than direct orders to the inmate regarding the strip search and remains objective.

4. Staff remains a safe distance (three to four feet) away from the inmate during a strip search.

5. Staff informs the inmate to wait for instructions and not to remove any clothing or reveal any body part until asked. Staff controls the pace of the strip search.

6. When near a wall, staff instructs the inmate to stand approximately 3 feet away from the wall, with her feet placed shoulder width apart.
7. Staff instructs the inmate not to make any sudden gestures or movements during the strip search and not to move until directed to do so by staff.
8. Staff asks the inmate if he has any contraband on his person and if he does to hand it to the staff and the inmate does so.
9. Staff instructs the inmate to remove articles of clothing and to hand them back to them.
10. Staff manually checks each article of clothing searching for contraband by feeling, scrunching and twisting the fabric.
11. Staff visually observes all personal jewelry on an inmate. When the inmate has a religious medallion or wedding ring, it must meet ECCF standards for allowed jewelry. All other jewelry must be removed and handed to the Officer.
12. When the inmate has a medical bandage or cast, staff inspects it to the best of their ability for contraband. If necessary, staff sends the inmate to medical for further inspection of the area.
13. Staff asks the inmate if he has a prosthetic piece. If he does, staff inspects the prosthetic piece, including wheelchairs, crutches, glass eyes, etc., to the best of their ability to check for contraband. If necessary, staff sends the inmate to medical for further inspection.
14. Staff instructs the inmate to remove any items in his hair, if applicable.
15. Staff instructs the inmate to lean forward and run his fingers through his hair.
16. Staff instructs the inmate to turn his head from side to side to expose the ears. Staff instructs the inmate to fold the top portion of his ear down to enable staff to see behind the ear.
17. Staff asks the inmate if he wears dentures. If so, staff instructs the inmate to remove the denture for inspection.
18. Staff instructs the inmate to open his mouth and to move the tongue back and forth to allow staff to visibly inspect inside the mouth.
19. Staff instructs the inmate to tilt his head back to be able to observe in the inmate's nostrils.
20. Staff instructs the inmate to lift both arms and visibly inspects under arms.
21. Staff instructs the inmate to lift his breasts for visual inspection. When the inmate has a large midsection, he is asked to lift his stomach for visual inspection.
22. Staff instructs the inmate to turn around, facing away from the Officer, lift up each foot and wiggle his toes.

23. Staff then instructs the inmate to bend forward at the waist, spread his buttocks apart with his own hands, and cough.

24. Staff conducting the strip search notifies the Shift Supervisor if there is evidence of inmate injury, cuts, bruises, recent needle marks, scars, tattoos or any contraband at the conclusion of the search.

25. If staff observes any possible contraband item protruding from a body cavity during the course of a strip search, staff instructs the inmate to remove the contraband.

26. Staff holds out a plastic evidence bag and instructs the inmate to remove the contraband, when the inmate is willing to do so and can, and place it in the bag.

27. Staff will secure the evidence in the bag and forward it to Security Investigations.

28. Staff carefully handles the contraband, taking all necessary health precautions, and processes it according to procedures for the handling of contraband.

29. When the inmate refuses to, or cannot remove the contraband, staff permits the inmate to dress, but does not allow the inmate to use the toilet and/or bathroom facilities and never leaves the inmate unattended.

30. While monitoring the inmate, staff notifies the Shift Supervisor of the circumstance.

31. The Shift Supervisor makes arrangements to have the inmate moved into a single cell.

32. The Shift Supervisor reports to the area to move the inmate to a single cell and place the inmate on a continuous eye-ball observation watch for possible possession of contraband.

33. The Shift Supervisor directs staff to place the inmate in restraints and move him to a single cell, for continuous observation.

34. The OIC directs the unit Officer to temporarily shut off the water to this cell during this contraband watch.

35. Staff will have him remove all his clothing and he will be given a paper johnny. The officer will then remove all the clothing from the cell. The officer will then exit the cell and secure the door.

36. The Shift Commander assigns an Officer to sit on the continuous one on one eyeball watch.

37. The Officer documents the watch on the Fifteen-Minute Wellness and Continuous Observation Watch form.

38. When the inmate removes the contraband or uses the lavatory, the Officer on the continuous watch immediately notifies the OIC Unit Officer.

39. The Unit Officer calls the Shift Supervisor by telephone and/or radio informing him that the inmate has removed or extracted the contraband.

40. The Shift Supervisor sends staff with a sealable contraband bag to visually search the inmate's cell, to include the lavatory for contraband.
41. Staff places the contraband in a sealable contraband bag when found and immediately turns the evidence over to the Shift Supervisor. In the event that the contraband is found during non-business hours, the evidence bag will be placed in the evidence locker located in the Shift Supervisor
42. The Shift Supervisor makes the decision to take the inmate off the contraband watch.

There will be no intrusive body cavity searches; manual or instrumental, for security reasons unless all of the following have occurred: (924.06(4a-c))

A. Probable cause has been determined through reasonable belief that the inmate is carrying contraband or other prohibited material.
B. The Superintendent has given authorization.
C. Search warrant obtained

NOTE: And then only by medically trained personnel. (924.06(4))

The following procedure for fecal search is to eliminate or minimize the employee's exposure to all body substances. The following equipment shall be available to conduct fecal searches:

A. Disposable latex gloves
B. Disposable resistant surface barrier
C. Plastic or wooden utensil
D. Puncture proof fluid resistant container with biohazard label.
E. Red plastic bag for garbage
F. Antimicrobial soap
G. High-level disinfectant for cleaning work surface.

Cover work surface with protective padding. Glove or double glove if preferred, using the utensils cut or mash excreta as needed. If evidence is found, place it in a fluid resistant container with biohazard label. When done, roll up protective padding with all contents inside and dispose infectious waste. Remove gloves and wash hands with an antimicrobial soap. Spray the surface with a high-level disinfectant, wipe it down and spray again to leave a residue on the surface.

214.08 Strip Search – Female

Before conducting a strip search you shall get the approval from the Shift Supervisor to conduct the strip search. Strip searches should be employed, when necessary, for the close scrutiny of an inmate's person in determining if that inmate is carrying an item(s) considered to be contraband or in the event of a suspicious incident. Safe Keeps, non-arraigned detainees and police holds are not subject to strip search unless there is reasonable suspicion. Specific situations in which strip searches may be employed, include but are not limited to: before and after court, medical trips; after the detection of an alleged disciplinary infraction; when custodial staff have reason to believe a person may possess contraband; after return from an escape or attempted escape.

Strip searches of individual inmates should be conducted in relative privacy, by one security personnel with a second security staff member present, except in an emergency as determined by the Sheriff/Facility Administrator or designee, overseeing the process and while rendering as much dignity to the situation as possible. Strip searches by members of the opposite sex shall not be permitted.

Strip searches may be initiated, but are not limited, to, following reasons:

A. Alleged disciplinary infraction,

B. Inmate believed to be in possession of contraband,

C. Return after escape or attempted escape,

D. Prior to and following contact visits or when there is reasonable suspicion that contraband has been passed between visitor and inmate,

E. Return from temporary release (furlough, work release, court appearance, etc.),

F. Facility/area shakedowns.

Strip searches should be employed in a private area. A female staff member informs the inmate and the other staff that she will conduct the strip search. At this time there will be no male officers in the area. If a situation arises, where the female officer needs assistance the male officer may enter the cell or area.

The Officer will provide as much privacy during the strip search, unless the inmate becomes non-compliant or combative. In the event the inmate becomes non-compliant or combative, Primary Response will enter the cell, and a K-9 Unit will be within an earshot. Primary Response Officers will assist in regaining control of the inmate, if needed. If the inmate continues to be combative with staff they will be placed in a restraint chair. If the inmate is pregnant, she will be placed in 4-points restraints on her left side, following the approved procedure.

If the inmate is complaint with the female staff member the strip search shall commence. First the female officer will order the inmate to face her and state any sudden movements might be taken as an act of aggression.

The inmate will then be instructed to take off articles of clothing one by one and hand them to the officers. The inmate will be instructed to not throw the articles of clothing at any time. The officer will search each article of clothing, by crushing and squeezing. Once all the clothing is off of the inmate she waits for further instructions, from the officer.

Procedure: <u>Strip Search</u>

The Shift Supervisor whenever possible assigns two female staff members to conduct the strip search. One staff member is responsible for giving verbal commands while the other staff member examines the removed clothing for contraband.

1. Prior to conducting a strip search, staff must wear protective gloves.

2. Staff does not place their hands on an inmate during a strip search unless an emergency situation arises. Staff is continuously visually inspecting the inmate during this process.

3. Staff makes no comments other than direct orders to the inmate regarding the strip search and remains objective.

4. Staff remains a safe distance (three to four feet) away from the inmate during a strip search.

5. Staff informs the inmate to wait for instructions and not to remove any clothing or reveal any body part until asked. Staff controls the pace of the strip search.

6. When near a wall, staff instructs the inmate to stand approximately 3 feet away from the wall, with her feet placed shoulder width apart.

7. Staff instructs the inmate not to make any sudden gestures or movements during the strip search and not to move until directed to do so by staff.

8. Staff asks the inmate if she has any contraband on her person and if she does to hand it to the staff and the inmate does so.

9. Staff instructs the inmate to remove articles of clothing and to hand them back to them.

10. Staff manually checks each article of clothing searching for contraband by feeling, scrunching and twisting the fabric.

11. Staff visually observes all personal jewelry on an inmate. When the inmate has a religious medallion or wedding ring, it must meet ECCF standards for allowed jewelry. All other jewelry must be removed and handed to the Officer.

12. When the inmate has a medical bandage or cast, staff inspects it to the best of their ability for contraband. If necessary, staff sends the inmate to medical for further inspection of the area.

13. Staff asks the inmate if she has a prosthetic piece. If she does, staff inspects the prosthetic piece, including wheelchairs, crutches, glass eyes, etc., to the best of their ability to check for contraband. If necessary, staff sends the inmate to medical for further inspection.

14. Staff instructs the inmate to remove any items in her hair such as barrettes, bobby pins, elastics, hair weaves, extensions, wigs etc. if applicable.

15. Staff instructs the inmate to lean forward and run her fingers through her hair.

16. Staff instructs the inmate to turn her head from side to side to expose the ears. Staff instructs the inmate to fold the top portion of her ear down to enable staff to see behind the ear.

17. Staff asks the inmate if she wears dentures. If so, staff instructs the inmate to remove the denture for inspection.

18. Staff instructs the inmate to open her mouth and to move the tongue back and forth to allow staff to visibly inspect inside the mouth.

19. Staff instructs the inmate to tilt her head back to be able to observe in the inmate's nostrils.

20. Staff instructs the inmate to lift both arms and visibly inspects under arms.

21. Staff instructs the inmate to lift her breasts for visual inspection. When the inmate has a large midsection, she is asked to lift her stomach for visual inspection.

22. Staff instructs the inmate to turn around, facing away from the Officer, lift up each foot and wiggle her toes.

23. Staff instructs the inmate to remove any feminine hygiene products and dispose of them. Staff then instructs the inmate to bend forward at the waist, spread her buttocks apart with her own hands, and cough.

24. Staff conducting the strip search notifies the Shift Supervisor if there is evidence of inmate injury, cuts, bruises, recent needle marks, scars, tattoos or any contraband at the conclusion of the search.

25. If staff observes any possible contraband item protruding from a body cavity during the course of a strip search, staff instructs the inmate to remove the contraband.

26. Staff holds out a plastic evidence bag and instructs the inmate to remove the contraband, when the inmate is willing to do so and can, and place it in the bag.

27. Staff will secure the evidence in the bag and forward it to Security Investigations.

28. Staff carefully handles the contraband, taking all necessary health precautions, and processes it according to procedures for the handling of contraband.

29. When the inmate refuses to, or cannot remove the contraband, staff permits the inmate to dress, but does not allow the inmate to use the toilet and/or bathroom facilities and never leaves the inmate unattended.

30. While monitoring the inmate, staff notifies the Shift Supervisor of the circumstance.

31. The Shift Supervisor makes arrangements to have the inmate moved into a single cell.

32. The Shift Supervisor reports to the area to move the inmate to a single cell and place the inmate on a continuous eye-ball observation watch for possible possession of contraband.

33. The Shift Supervisor directs staff to place the inmate in restraints and move her to a single cell, for continuous observation.

34. The OIC directs the unit Officer to temporarily shut off the water to this cell during this contraband watch.

35. Staff will have her remove all her clothing and she will be given a paper johnny. The officer will then remove all the clothing from the cell. The officer will then exit the cell and secure the door.

36. The Shift Commander assigns an Officer to sit on the continuous one on one eyeball watch.

37. The Officer documents the watch on the Fifteen-Minute Wellness and Continuous Observation Watch form.

38. When the inmate removes the contraband or uses the lavatory, the Officer on the continuous watch immediately notifies the OIC Unit Officer.

39. The Unit Officer calls the Shift Supervisor by telephone and/or radio informing him that the inmate has removed or extracted the contraband.

40. The Shift Supervisor sends staff with a sealable contraband bag to visually search the inmate's cell, to include the lavatory for contraband.

41. Staff places the contraband in a sealable contraband bag when found and immediately turns the evidence over to the Shift Supervisor. In the event that the contraband is found during non-business hours, the evidence bag will be placed in the evidence locker located in the Shift Supervisor

42. The Shift Supervisor makes the decision to take the inmate off the contraband watch.

214.09 Fully Clothed Searches (Pat Searches)

The department shall train security staff in how to conduct cross-gender pat down searches and searches of transgender and intersex inmates in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. (924.06(2))

Fully clothed searches (pat searches) should be employed for the relatively quick scrutiny of an inmate's person. Situations where fully clothed searches may be employed include, but are not limited to: egress and ingress to housing units, work sites, dining areas and recreation areas.

When searching a group of inmates, efforts should be made to keep searched and un-searched inmates separate. Prior to the actual search, the inmate shall be instructed to remove outer garments such as a jacket, hat, gloves, etc. Then with arms extended to the side at a right angle to the inmate's torso and feet apart at least 20 inches, the search should commence.

Approaching the inmate from the rear or front, the custodial staff member shall remove all contents from the inmates pockets, then start at the bottom of the head, using both hands, touch or pat a direct course across the bottom of the arms to the armpits and then proceed to the bottom of the shoulders.

Returning your hands to the original starting position, pat the shoulders and then down the back and sides to the belt line. Search the belt line, all pockets and then up to the top of the chest area.

At the back of the waistline, proceed down the back and sides of the legs to the shoe tops. Check the shoe tips, cuffs and socks and then the front and inside of the legs to the shoe tops. Check the shoe tips, cuffs and socks and then the front and inside of the legs up to the groin area.

Observation should be made of the hair, ears, mouth, as well as any article carried or worn by the inmate.

214.10 Fully Clothed Searches - Female

When conducting a pat down search, it should be conducted be a staff member of the same sex.

Fully clothed searches (pat searches) should be employed for the relativity quick scrutiny of an inmate's person.

When searching a group of inmates, efforts should be made to keep searched and un-searched inmates separate. Prior to the actual search, the inmate shall be instructed to remove outerwear, (jacket, hat, gloves, etc) and any items from pockets. Then with arms extended to the side at a right angle to the inmate's torso and feet apart at least 20 inches, the search should commence.

Approaching the inmate from the back, the custodial staff member shall remove all contents from the inmate's pockets The Officer then informs the inmate to face the officer. Then start at the head, using both hands. If the inmate has hair or it is tied up, have the inmate take her hair down and have her run her fingers through it. Touch or pat across the bottom of the arms to the armpits. Using the back of your hand, go under the right and left breast and proceed toward the middle. When the inmate wearing an undergarment or a bra of any type. The officer will instruct the inmate to pull the bottom of the bra out and shake it to see if there is any contraband.

Returning your hands to the original starting position, pat the shoulders and then down the back and sides to the belt line. Search the belt line, including all pockets.

At the back of the waistline, proceed down the back sides of the legs to the shoe tops. Check the shoe tips, cuffs and socks and then the front and inside of the legs to the groin area.

Be advised, when searching the groin area the custodial staff will use the back of their hand. If the staff member feels an object, they will escort the inmate to a private area and ask the inmate to take the object out. If the inmate does not comply, the Shift Supervisor should be notified.

Procedure:
Pat Search

1. Prior to conducting a pat down search, staff must wear protective gloves.
2. Staff briefly explains the pat search and its purpose to the inmate.
3. Staff instructs the inmate to place her hands out to the side and to remain facing away from the staff.

4. When near a wall, staff instructs the inmate to stand approximately 3 feet away from the wall, with her feet spread shoulder width apart and hands placed on the wall.

5. Staff instructs the inmate not to make any sudden gestures or movements during the pat search and not to move until directed to do so by staff.

6. Staff asks the inmate if she has any contraband on her person and if she does to hand it backwards to the staff and the inmate does so.

7. Staff instructs the inmate to show her hands.

8. Staff instructs the inmate to run her fingers through her hair and to turn her head side to side for visual inspection behind the ears.

9. Staff instructs the inmate to place her hand on the wall.

10. Staff touching the clothing handles the clothing with caution in the event there may be dangerous contraband that may harm the staff.

11. Staff begins by feeling, scrunching and twisting the clothing of the collar area.

12. Staff feels the sleeve and arm area by feeling, scrunching and twisting the fabric for both arms.

13. Staff searches the armpit area by hand.

14. Staff searches the front and back mid- section area of the inmate by feeling, scrunching and twisting the fabric. Paying extra attention to possible contraband, which might be hidden in and under the bra.

15. Female staff feels for contraband under the inmate's breasts by using the back of her hands.

16. Staff works their way to the waistline and between the breasts and feels, scrunches and twists the fabric and seams

17. Staff works down one side of the inmate's leg at a time by feeling, scrunching and twisting the fabric. Staff repeats this process for the other leg.

18. Staff searches the groin area and buttocks with the back or side of her hand.

19. Staff instructs the inmate to move her feet back together and to raise each foot for visual inspection under the shoe. The Staff will order the inmate to take off her shoes, the officer will then inspect the inside of each shoe.

20. Staff instructs the inmate to place her hands back on her head and to turn to face the staff.

21. Staff instructs the inmate to open her mouth and to move her tongue from side to side for visual inspection of the mouth.

22. Staff asks the inmate if she has any dentures or partials. If so, and when necessary, staff instructs the inmate to remove her dentures or partials for visual inspection.

214.11 Housing Area Searches

Daily unit searches shall be completed by each respective shift as are designated by post orders and supervisors. These daily searches shall be documented in the OMS system under the appropriate location drop-down. If the OMS system is not operating, you must document your searches in the paper log book and shall transfer the information from the paper log to the OMS system once it's operating again.

The unit officer on 7x3 and 3x11 shall complete a minimum of two (2) cell searches per shift daily as scheduled by the unit OIC, with the corresponding reports logged and reviewed by the unit OIC.

The 11x7 shift will perform nightly searches of all common areas, to include day room areas, showers, stairways etc. and record areas searched on the appropriate reports and logged for review by the unit OIC.

Cells/bunks in RHU, MHU and FHU (to include observation rooms and "dry tanks") are to be searched prior to and after each use and the results of those searches shall be documented in the unit log and entered into the appropriate area in OMS.

In conducting searches of housing areas as with other types of searches two basic objective are sought: identification of contraband and the detection of future escape attempts. As a result, efforts should be made to be thorough in conducting searches of these areas. Care should be taken not to damage an inmate's property or unnecessarily disarrange the same.

Remove the inmate from the cell or room and conduct a pat search of the inmate. Upon entering the cell secure the cell door in the open position to avoid being accidentally locked in a cell. Before starting your search, look at the items that are about to be searched.

Start the search with the bed and use it as a workbench when finished searching it. Remove the mattress and other bedding and examine above and below the bunk and in any crevices between the bunk and frame and the wall. Look under the bed and check for items suspended from springs or fastened to the bed frame. With the mattress removed, examine the upper side of the bed frame and springs. Examine the bed frame supports to ensure that they have not been partially sawed through for easy removal.

Examine the mattress and pillows by rolling them lengthwise. Check the sides and ends for cuts and tears in the covering. Any indication of re-sewed seams calls for more careful examination, including opening the seams for extensive probing. Pay extra attention to any seams or double thickness of cloth.

Search the desk area next, one shelf at a time, and return all items to their original positions. Examine all surfaces of the desk. Contraband may be taped to the underside of shelves or concealed in shelf ledges, supports, legs, or false sides or backs of the shelves.

Check all clothing (including dirty laundry) piece by piece. Pay special attention to seams, double thickness of material, and pockets.

Open and check every item (letters, books, magazines, toilet articles, and so forth). Check all footwear, including linings, soles, and heels; feel inside shoes all the way to the toe and remove inner soles and any removable arch supports.

Shake talcum powder containers and squeeze toothpaste tubes. Remove small amounts of contents of commonplace items to check for illegal substitutions. Check to see that bars of soap have not been hollowed out.

When so equipped, look in, under, and behind the washbasin, in the drain overflow. Contraband may be suspended in the pipes or hollows on wires or threads, or stuck on with glue or tape.

When so equipped, examine the toilet carefully, inside and out. Check under the base of the toilet, behind the toilet where it connects to the wall and the toilet drain. Examine the toilet paper slot and all rolls of toilet paper to make certain that contraband is not rolled up within the roll.

If there are inmate electronic devices, examine them carefully. Remove backs if applicable, check battery wells, examine cords, and confiscate items which appear to have been altered so the insides can be searched by designated individuals prior to return to the inmate.

Carefully remove any pictures on the wall to see if there are any cuts in the walls. Carefully scrutinize the walls, ceiling and floor for indications of sawing, digging, cutting, defacing or other possible signs of an escape attempt. Remove any loose tiles and check underneath them.

Look for indications that mortar has been removed and replaced with a substitute. If the concrete is of poor quality, it is easy for the inmate to gouge out holes as hiding places for contraband.

Check heat or ventilation duct openings for indications of tampering or concealed contraband. Look for strings, thread, or wire holding something suspended in the duct.

Look around interior window frames and the window ledge. If ledges have a covering of any sort, be sure that nothing is concealed beneath them. Examine window bars/screens for evidence of tampering. Be alert for any wires, strings, or thread fastened to the bars/screens and suspended outside the window.

Carefully examine the cell door and the wall in which it is set. Pay particular attention to the areas above eye level. Examine the cell door-locking device for signs of tampering, and check the area with the door in both the open and closed position.

214.12 Non-Housing, Shop, Program and Activity Area Searches

Common areas of a facility (kitchen, shops and program areas) should be inspected at a minimum of monthly. These inspections shall be reported to the Shift Supervisor and documented in the Shift Supervisor log. (924.06(1)

Visiting areas (including trash, furniture, and toilet areas) should be thoroughly searched before and after visits. Staff should complete trash removal only and documented in the OMS under the appropriate drop-down.

An element of the daily perimeter checks should include searching for items hidden next to or under fences. Areas adjacent to roadways should be carefully searched for items thrown over the fence and documented in the K-9 activity log and OMS Common Area Search Log.

The vicinity of all visitor traffic points should be searched daily to discover items that are hidden or thrown by visitors that are intended for inmates. Visitor holding areas should be scrutinized carefully.

Areas outside a secure perimeter should be searched for contraband to help stem the flow of contraband into a facility.

Shops, vocational training areas have a wide range of possible contraband hiding places. Vents, block and brick walls, workbenches, machinery, bins, toolboxes, covered openings, elevator shafts, outbuildings, lockers and staff only areas.

Vocational shops, maintenance areas, program and activity areas with which inmates have contact shall be searched at least once per month. Upon completion of searches, staff shall notify the Shift Supervisor to be documented in the Shift Supervisor log.

214.13 Vehicle and Supply Searches

All vehicles and supplies entering and exiting an ECSD facility shall be subject to search. Special provisions shall be made to include the searching of all materials, stores, provisions and equipment delivered to the confines of the ECCF. Use of handheld metal detector is encouraged after a physical and visual search.

In cases where the owner/operator refuses to submit to a search, and the search is without probable cause, the vehicle shall be permitted to leave the property.

All vehicle entrances to facility property shall be clearly marked with signs posted in both English and Spanish, stating that all vehicles entering upon correctional facility property are subject to a search.

For the authorization to search vehicles not owned by the Sheriff's department on facility property, one of the following requirements must be met:

A. The owner/operator of the vehicle to be searched must consent and sign to the provisions according to permission to search waiver.
B. If the search requested, is without probable cause, the owner/operator may refuse the vehicle search and shall be permitted to leave the property.

If the search requested is based upon probable cause, consultation with the District Attorney's office or Attorney General's office is recommended.

If the search requested, is based upon probable cause, the owner/operator of the vehicle to be searched may sign a consent form. If the owner/operator refuses such search, the vehicle shall be seized until such time as the owner/operator allows the search to be conducted.

The use of K-9's and patrol officers to conduct random searches of vehicles in facility parking areas is permitted. These searches are to insure that vehicles are locked and no valuables are left in the open.

In the event, a certified drug K-9 unit reacts to a vehicle, or through the officer observation, provides probable cause, the owner/operator will be requested to submit to a search of his/her vehicle(s).

214.14 Seizure of Contraband/Evidence

When searches result in the seizure of contraband/evidence to be used for the purpose of evidence in either disciplinary proceedings or prosecution the following procedure shall be followed:

1. To maintain chain of custody, the officer who seized the evidence must seal the evidence in an evidence bag with a copy of the incident report.

2. Once the evidence has been tagged the evidence should be turned over to Security Investigations. If the evidence is seized during non-business hours it will be placed in the Security Investigations Evidence locker in the Shift Commanders Office. Each piece of evidence that is placed in the locker must be documented in the log book to maintain the chain of custody. Attach a copy of the report to the piece of evidence that is being submitted. Also, record the appropriate information on the evidence bag before placing it in the locker, such as a name, booking number, time, date, location found and chain of custody. Before placing the evidence into the locker, the Shift Supervisor/Executive Officer shall review the evidence and log to be sure all information is completed correctly. A member of Security Investigations will check the locker on a daily basis, to retrieve any evidence that maybe submitted.

3. Access to the storage cabinet shall be limited to Security Investigations and the Assistant Superintendent. The cabinet has two separate locks on it. Security Investigations maintains one key and the Assistant Superintendent maintains the key to the other lock. These keys shall not be given to any other person or interchanged. This method ensures that two persons are present each time the cabinet is opened.

4. A disciplinary report and/or incident report shall be turned into the Shift Commander prior to the end of your tour of duty by the officer in charge of the search.

5. In cases where arrest has been authorized to affect the search the Sheriff's department arrest procedure shall be followed.

6. All other property which has been seized shall be forwarded to the property department who shall inventory and store such property until such time it is disposed of in accordance with 103 ECSD 202, Inmate Property.

7. Whenever an inmate is discharged or paroled, all items of property that have been seized and stored within the property department shall be returned to the inmate upon resolution proceedings, except where items are illegal or in violation of the rules and regulations of the facility.

214.15 Storage of Contraband/Evidence (924.06(7)

All evidence including common area finds shall be stored in a locked cabinet within a secure room with access to the room being limited. Access to the cabinet shall be limited to the Security Investigations Unit.

Evidence/contraband considered a controlled substance and or associated paraphernalia should be stored in a locked cabinet within a secure room (Security Investigations Office) with access to the room being limited. Access to the safe shall be limited to Security Investigations.

A log shall be maintained on all evidence, including common area finds as well as controlled substances. Each item shall be logged and each entry should include:

- Suspects name
- Date of recovery
- Date placed in safe
- Location of recovery
- Detailed description of evidence
- Case number
- Logging officer's name

A separate in/out log shall be maintained on the controlled substance evidence and is to be stored inside the controlled substance safe. Any evidence that leaves the controlled substance safe for any reason shall be logged in and out.

214.16 Disposal of Evidence/Contraband (924.06(6)

Security Investigations shall be responsible for coordinating the collection, storage and disposal/destruction of evidence.

After acceptance of evidence, it shall be stored in a secure vault, with limited access. Security Investigations shall coordinate destruction dates with the Department of Public Health and the contracted disposal company.

Log notations for evidence disposal and the evidence destruction document shall be kept in a permanent file. Security Investigations will submit a report to the Superintendent or designee upon destruction of evidence regarding items destroyed.

Evidence will be maintained at the Security Investigations Office no longer than six months after all disciplinary or legal requirements have been satisfied. Evidence items not associated with any disciplinary or legal matter shall not be maintained any longer than 6 months if possible.

Evidence that is considered a controlled substance will be transported for disposal with all accompanying documentation. All control substance evidence transported must be accompanied with the required disposal forms filled out as required by the Department of Public Health's drug destruction protocol.

Security Investigations shall be responsible for maintaining documentation on all evidence received and all evidence disposed. Security Investigations will submit a report to the Superintendent or designee upon destruction of evidence. Proper log notations are to be made on evidence disposal and the evidence destruction documents shall be complete and kept in a permanent file.

214.17 Crime Scene Search and Investigation (924.06(7))

When an incident occurs that may possibly result in criminal prosecution, the Superintendent or designee should be notified immediately after the incident has been contained or neutralized. Crime scene procedures shall be developed for instances when it has been determined that criminal prosecution may be warranted in addition to the normal facility discipline process. Crime scene search and investigation should be conducted in such a manner so as to ensure the legal protection of the rights of the inmate(s) and the preservation of evidence for the Commonwealth.

Protection of life supersedes the preservation of the crime scene. If necessary, remove the inmate to medical care or have medical care brought to the inmate.

The Shift Commander shall assign staff member(s) to secure the crime scene, the assigned staff member(s) will be responsible for the following until security investigations arrives:

A. Secure the area. No staff shall enter without the prior approval of the Shift Commander
B. Remove all inmates from the immediate area and keep them segregated from all other inmates.
C. Assign one staff member to identify and list each inmate in the area and all inmates that had access to the area. Inmates shall remain segregated until released by Security Investigations or the Shift Commander. Search all inmates as they are released.
D. Do not allow anyone into the crime scene until Security Investigations arrives. Record date, time and names of all staff that enter the scene, items removed, record a description of the area when arrived on scene.
E. Upon arrival, DO NOT TOUCH OR ALLOW ANYONE TO TOUCH ANY ITEMS, until Security Investigations arrives.
F. Do not release the crime scene until approved by the Superintendent.

Security Investigations shall search the crime scene and be responsible for using protective gloves, conducting a thorough search of the crime scene for possible evidence. Taking any video photography and/or digital photography and gathering and tagging all evidence.

Security Investigations shall be responsible for gathering any intelligence information to include, but not be limited to, inmate correspondence, telephone conversations, six-part folder, visiting cards and from inmate and staff interviews.

When searches result in the seizure of contraband/evidence to be used for the purpose of evidence in either disciplinary proceedings or prosecution, the following shall occur:

A. The officer who seized the evidence must seal the evidence in an evidence bag. The evidence bag must be tagged with the following information: date, time, defendant's name, where and condition evidence was found (in detail), description of evidence, and the name of the officer who took custody of the evidence (if applicable).

B. Once the evidence has been tagged, the evidence should be turned over to Security Investigations to be logged and placed in the designated storage safe. During non-business hours the evidence will be secured in the evidence box located in the Shift Supervisor's. The officer placing the evidence into the evidence locker shall be responsible for entering the

information in the evidence log book to ensure chain of custody. The evidence log book is in the Shift Supervisor's office.

214.18 Review Date

These regulations shall be reviewed annually from the effective date.

214.19 Severability Clause

If any article, section, subsection, sentence, clause or phrase of 103 ECSD 214.00 is for any reason held to be unconstitutional, contrary to statute, in excess of the authority of the Sheriff or otherwise inoperative, such decision shall not affect the validity of any other article, section, subsection, sentence, clause or phrase of this policy.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

C.A. No. 18-cv-11972

GEOFFREY PESCE,

Plaintiff,

v.

KEVIN F. COPPINGER, in his official capacity as Essex County Sheriff, AARON EASTMAN, in his official capacity as Superintendent of the Essex County House of Corrections - Middleton,

Defendants

AFFIDAVIT OF STEPHEN K. VALLE

I, Stephen K. Valle, on oath depose and state as follows:

1. I currently serve as President for AdCare Criminal Justice Services ("AdCare-CJS") and have done so since 1997.

2. AdCare-CJS provides program services to inmates, detainees, and other justice-involved clients in county and state correctional institutions, community corrections centers, drug courts, re-entry programs, and in specialized programs for co-occurring disorders, justice-involved women, and incarcerated parents. All of AdCare-CJS' programs operate within a criminal justice setting.

3. AdCare-CJS programs have been developed and operated under my leadership. I ama licensed psychologist and nationally recognized expert in the field of addiction treatment. I designed the first of its kind correctional program for chronic drunken drivers and other substance abuse offenders at MCI-Longwood. The Longwood model evolved into broader

institutional substance abuse programs for the Massachusetts Department of Correction and I operated these programs with distinction for years.

4. AdCare-CJS has been providing addiction-related programming and ancillary services to the Essex County Sheriff's Department ("ECSD") since ____1999___.

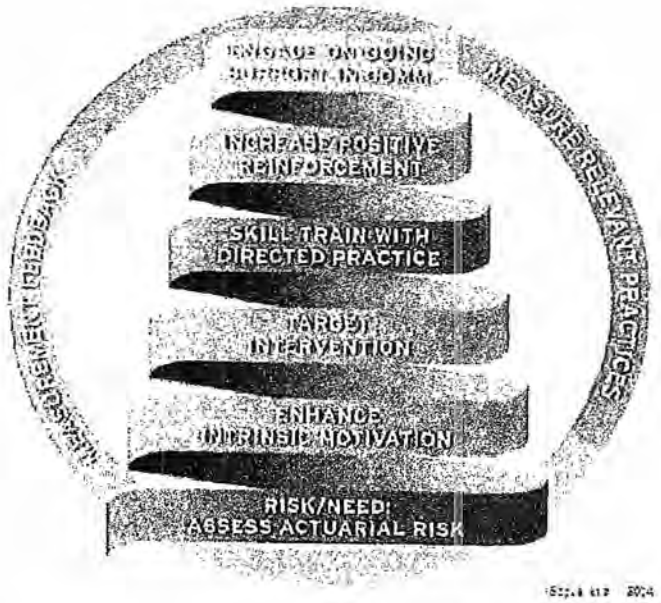
5. AdCare-CJS' programming services at ECSD utilize The Accountability Training Program Model (Valle, 1991), a modified therapeutic community ("TC") approach that is based upon the significant research data supporting the drug-free TC model (visit https://drugabuse.gov/publications/research-reports/therapeutic-communities/what-therapeutic-communitys-approach for an overview).

Accountability Training is a public safety model of treatment that integrates the need to provide services that address individual treatment needs with the mandate to provide the specific type of services that can make a positive impact on public safety by reducing recidivism. The model has been implemented throughout AdCare-CJS programs in numerous correctional settings in Massachusetts as well as other states. The core components of a TC are designed to teach accountability and pro-social behavior by using the community as method. In other words, the individual learns how to live as an accountable member of a community by living in a community that emphasizes personal and interpersonal responsibilities. To enhance the distinct identity of the community, most TCs are set apart from other communities and have their own hierarchy, traditions, rules, and guiding principles. The notion of mutual help has a central role in the therapeutic community model. Peers engage with peers, guided by professional staff members, to maintain a pro-social, recovery-based mileu in which behavior change can occur through social learning. The good of the community takes precedence. According to NIDA, "Participants live drug free together in a residential setting (although sometimes TCs are in prisons or shelters)"(NIDA, 2015. Therapeutic Communities. Retrieved from https://www.drugabuse.gov/publications/research-reports/therapeutic-communities).

6. In 2001, the National Institute of Justice ("NIJ") conducted an outcome evaluation of multiple RSAT programs across the country. One of the programs evaluated was the Barnstable County Male RSAT program, which was developed and staffed by AdCare-CJS in partnership with the Barnstable County Sheriff's Office. The data clearly demonstrated that the program, which implemented the Accountability Training Program, decreased recidivism. A long-term follow-up study was conducted and it further demonstrated that these results held up over time; long term recidivism was less for men who completed the RSAT drug-free program than it was for men who did not. The male RSAT program's results were featured in an edition of the publication American Jails and were presented in professional forums (American Correctional Association, Cape Cod Symposium on Addictive Disorders, UKESAD, etc.) nationally over the subsequent years.

7. In 2010, the Bureau of Justice Assistance ("BJA") established a national RSAT Training and Technical Assistance Center. Based upon individual accomplishments in the field and the proven efficacy of our model, AdCare-CJS principals I and Vice president of Operations Lisa Talbot-Lundrigan were named to its core Faculty. We provide regular and ongoing training and technical assistance to RSAT programs nationally, many of which follow the drug-free, therapeutic community approach, similar to the services provided in the Essex County RSAT Program.

8. In most fields, including the field of offender treatment, there is an evolutionary process that begins with promising practices, progresses through best practice standards, and ultimately ends in evidence-based practices. In the field of correctional treatment, the National Institute of Corrections has published the following evidence-based practices.



Crime and Justice Institute, Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention, (Boston, MA: 2004) available online at http://cjinstitute.org/files/evidencebased.pdf

9. Within the Essex County Sheriff's Department's TRAC program, AdCare-CJS implements a curriculum-driven cognitive-behavioral change program in the context of an integrative, modified therapeutic community that is aligned with these eight principles. The program:

1. implements a standardized actuarial assessment (TCU and LSI-R-SV) that informs individual treatment plans.
2. Uses tools of motivational enhancement and contingency management to enhance motivation. Peers and professional staff alike work with new community members to draw them into program activities and increase their investment in their own behavior change process. This is also an

underlying principal of twelve step and other mutual help fellowships and is an important recovery skill to develop.

3. Targets interventions to those assessed to have the highest risk of recidivate if their criminogenic treatments needs are unmet.

4. Builds the skills necessary for engaging in early recovery through repeated interventions in group and individual settings. This principal is at the heart of the TRAC program activities: cognitive-behavioral groups that illuminate criminal thinking patters, pro-criminal sentiments and thinking errors. In active addiction, substances prevent the individual from engaging in the type of critical thinking necessary for behavior change but in correctional programs that allow for full abstinence, a supportive environment, and a culture that promotes pro-social learning, the inmate can begin to learn to identify maladaptive thinking and behavior patterns.

5. The TRAC program participants earn increased privileges as a way of positive reinforcement to demonstrate that pro-social and pro-recovery choices and behaviors lead to increased freedom and status; just as such behaviors are associated with positive effects in long-term recovery and abstinence.

6. The TRAC program, in collaboration with ECSD prepares the inmate for release by developing comprehensive reentry plans that address the multiple needs most people have upon release from incarceration. Staff members from within the institution facilitate a warm handoff to

community based providers of counseling, MAT, and other social services to engage in ongoing community support.

7. ECSD measures relevant practices by tracking released individuals and by analyzing data to assess trends and areas of strength as well as barriers and opportunities for change.

8. ECSD provides measurement feedback to appropriate correctional administrators and professionals to monitor both inmate and program performance.

10. The drug-free modified therapeutic community model was listed on the National Registry of Evidence Based Practices and is one of the more widely studied and replicated models of correctional program services, particularly in RSAT programs. We implement the model because it is supported by evidence, because it addresses criminal thinking and behavior, because our implementation of the model has been evaluated to decrease recidivism, and because there are resources within the ECSD to sustain a drug-free therapeutic community.

Therapeutic Community Citations:

Welsh, W. (2007). A multisite evaluation of prison-based therapeutic community drug treatment. Criminal Justice and Behavior, 34, 1481-1498.

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SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 19 DAY OF OCT., 2018.

Stephen K Valle

CERTIFICATE OF SERVICE

I certify that on this day I caused a true copy of the above document to be served upon the attorney of record for all parties via CM/ECF

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