Understanding the State of Opioid Use Disorder in the RCORP-ETC Region

2018-2019

RURAL COMMUNITIES
OPIOID RESPONSE
PROGRAM FOR
EAST TENNESSEE
CONSORTIUM

RCORP-
ETC

INTRODUCTION

Between 1992 and 2016, prescription medication overdose deaths in Tennessee increased 377% (from 342 to 1,631 deaths).[1] In 2016, Tennessee was the third highest prescriber of opioids in the United States.[2] Alarmingly, while the number of opioid prescriptions filled is decreasing over time, the overall numbers of hospitalizations and opioid-related deaths are increasing.

Opioid use disorder (OUD) has been ravaging the state of Tennessee, and rural Appalachia is particularly vulnerable. Rural Appalachia's long history of poor economic opportunities, unemployment, inadequate transportation, remote medical services, addiction, and limited treatment services have exacerbated OUD in the region. **The Rural Communities Opioid Response Program for East Tennessee Consortium (RCORP-ETC) is co-led by the University of Tennessee, Knoxville (UT) and community members representing 10 rural Tennessee counties**, including Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Morgan, Roane, Scott, and Union. Home to more than 360,000 people,[3] **the RCORP-ET region's socio-demographic characteristics exasperate residents' risk of OUD and associated health challenges, including HIV, Hepatitis A, B, and C viruses, and Neonatal Abstinence Syndrome (NAS).**[4]

The goals of the RCORP-ET consortium are to decrease the occurrence of OUD and overdose deaths in the ten-county region. To reach these goals, the consortium will coordinate OUD prevention, treatment, and recovery services based on a regional analysis of opioid use, available OUD-related resources, and gaps in OUD-related programs and services. **This report represents the first step to understanding the state of OUD in the RCORP-ETC region.** Future projects based on this report and associated data collection will include a strategic plan, workforce plan, sustainability plan, and strategies to disseminate programs to the consortium and ten-county region.

Because OUD stigma is a barrier to healthcare, the consortium will develop and implement educational programs for primary care providers and local community members. These programs will include scientific information on addiction and recovery success stories, both of which are shown to decrease stigma.[5] Community members will also be trained in naloxone (antagonist) use to prevent opioid-related overdoses.

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Cherokee Health Systems
Childcare Resource & Referral Network
Chota Community Health Services
East Tennessee Quality Growth
Knoxville Area Project Access
LeConte Medical Center
Metro Drug Coalition
Morgan County Correctional Complex
Morgan County General Sessions
Morgan County Residential Recovery Court
Mountain People's Health Council
Oak Ridge National Laboratory
Positively Living
Region II EMS Directors Association
Regional Forensic Center
Rescue 180 Coalition
Roane County Anti-Drug Coalition
Rural Medical Services, Inc.
Sheriff of Grainger County
Sheriff of Hamblen County
Sheriff of Scott County
STAND - Scott County
Tennessee Associations for Children's Early Education
Tennessee Bureau of Investigation
Tennessee Commission on Children and Youth
Tennessee Department of Children's Services East Region
Tennessee Department of Correction - Rehabilitative Services of Probation & Parole, Dept. of Corrections
Tennessee Department of Health – East Tennessee Regional Health Office
Tennessee Department of Health – State Office of Rural Health
Tennessee Department of Human Services – 4th Judicial District Child Support Office
Tennessee Department of Human Services –4th Judicial District Circuit Court
Tennessee Department of Human Services – 8th Judicial District Drug Court and Community Health of East Tennessee
Tennessee Poison Center
Tennessee Primary Care Association (all FQHCs)
Tennessee Valley Coalition for the Homeless
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University of Tennessee Extension Office
University of Tennessee Medical Center – Obstetrics & Gynecology
Whitney Moore (parent of children with NAS)

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METHODOLOGY

Since November 2018, the Analysis Working Group of the RCORP-ETC held monthly meetings to coordinate data collection and analyses. Existing data were first gathered, organized, and summarized. Examples of these data include the Tennessee Department of Health Drug Overdose Dashboard, Behavioral Risk Factor Surveillance System, and the Robert Wood Johnson Foundation's County Health Rankings repository. Two primary data collection efforts were then initiated: 1) Community Strengths and Themes Assessment (CSTA; detailed community members' perspectives on community priorities, quality of life, and assets) and 2) Local Public Health System Assessment (LPHSA; detailed assessment of the region's active organizations and services that promote health, with an emphasis on OUD prevention, treatment, and recovery).

Upon assembling and summarizing the data, the Analysis Working Group reviewed all data for accuracy and interpretation. The overall analysis will allow the consortium to identify opportunities and gaps in OUD prevention, treatment (including MAT), and recovery, including workforce, services, and access to care within the RCORP-ET region. Thus, this report provides a foundation for the Strategic Plan.

RCORP-ETC Analysis Working Group Members

Co-Facilitators	Danielle Sims Knoxville Area Project Access	Laurie L. Meschke UTK Department of Public Health
Membership	Sandy Webber 8th Judicial District Katlyn Clark BHG Recovery Jamie Dean BHG Recovery	Debra Shultz Rescue 180 Keith Shultz Rescue 180 Erica Wilson East Tennessee Regional Health Office Kim Raia East TN Quality Growth and University, of TN County Technical Assistance Service
Graduate Student Support	Zeruiah Buchanan UTK Department of Public Health Tamarra Spalding UTK Department of Public Health	R. Catherine Buddin UTK Department of Public Health Ashlyn Schwartz UTK Department of Child and Family Studies

IDENTIFIED OPPORTUNITIES AND STRATEGIES

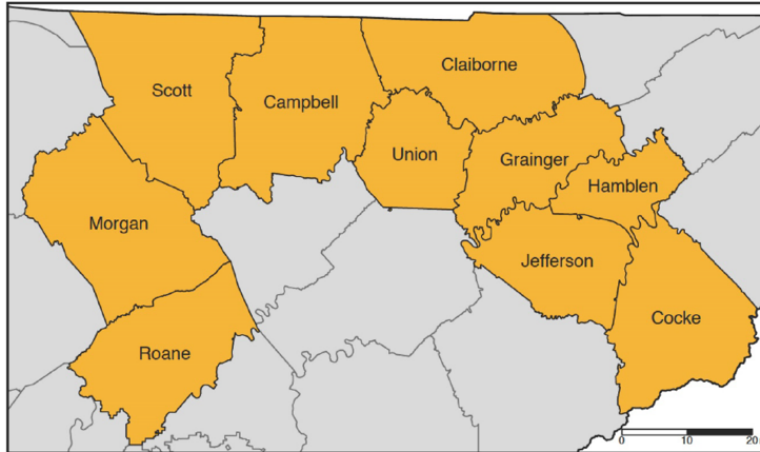
The existing data and the data that were collected for this report revealed opportunities for the RCORP-ETC and the greater community, to decrease the risk of OUD and it many consequences. The opportunities were found at the individual, relationship, and community level.

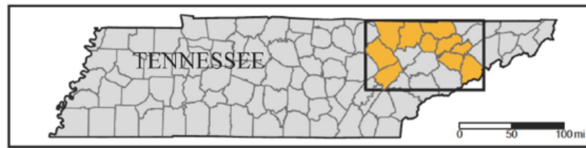
Level	Opportunity	Identified Strategy Examples
Individual	Employment	Job skills training (e.g., punctuality, resume writing, leadership, customer service) GED training Federal Bonding program participation Work opportunity tax credit participation
	Mental health	Increased access to psychological services
	Reduce physical and emotional abuse	Parenting education
	Health insurance	Assistance for Medicaid enrollment
	Reduce transmission of blood borne pathogens	Harm reduction services Medically assisted treatment services
Relationship	Reduce physical and emotional abuse	Access to couples' therapy Anger management training
	Social support	Increase access to recovery support groups
Community	Reduce stigma	Increase community knowledge of addiction; Sharing of success stories
	Treatment efficacy	Enhance research-based practices
	Collaboration of service providers	Point agency to vet and update recommended OUD resource list Quality improvement practices Increase data sharing Capitalize on community leadership for trainings
	Reduce OUD overdose deaths	Increase community access to Naloxone

DEMOGRAPHICS

Where

East Tennessee RCORP-Planning Region

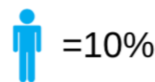


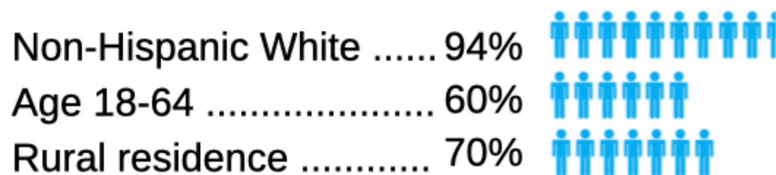


The RCORP-ET region includes 10 counties in East Tennessee: Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Morgan, Roane, Scott, and Union

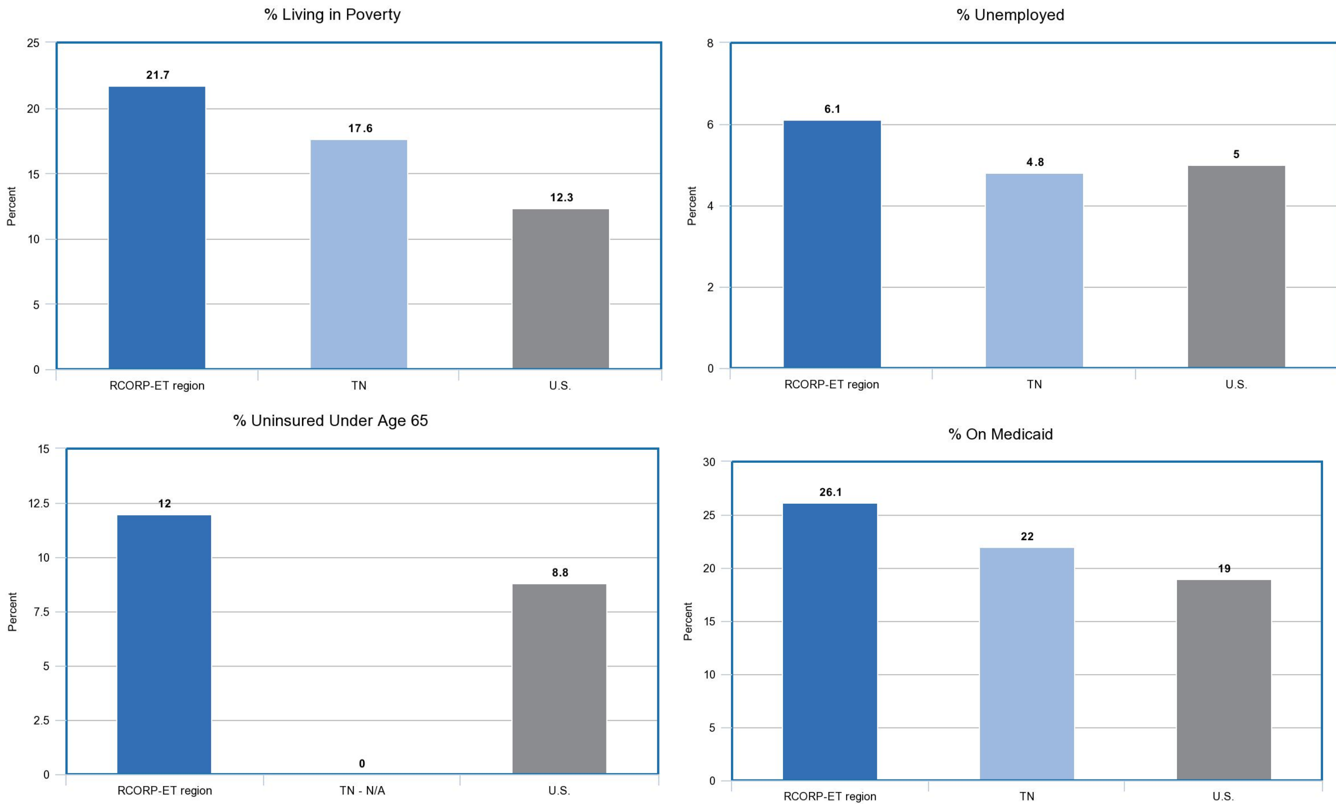
Who

Residents of this region are mostly Non-Hispanic white, aged 18-64, and living in rural areas.



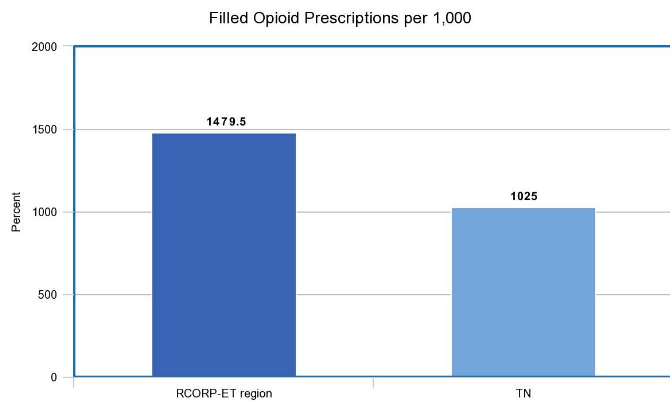


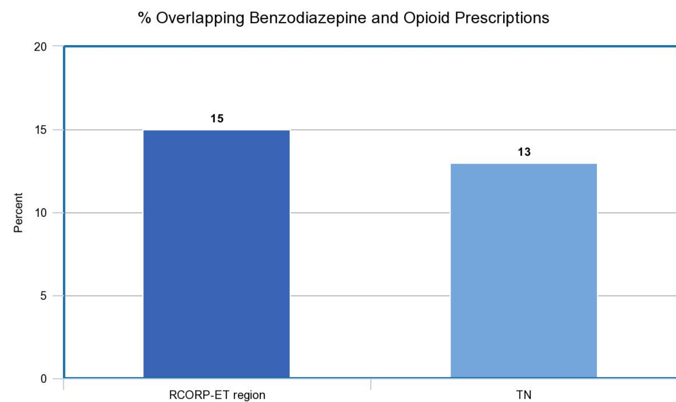
Compared to Tennessee and the U.S. in general, a greater percent of people in the RCORP-ET region experience poverty and unemployment. They are also more likely to be uninsured or enrolled in Medicaid compared to the state and the nation. See Table 1 for more details.



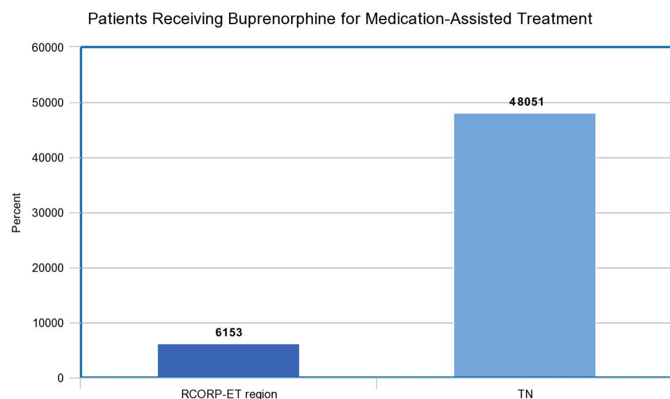
The RCORP-ETC region averaged 1.2 opioid prescriptions per resident, one of the highest rates in the nation.

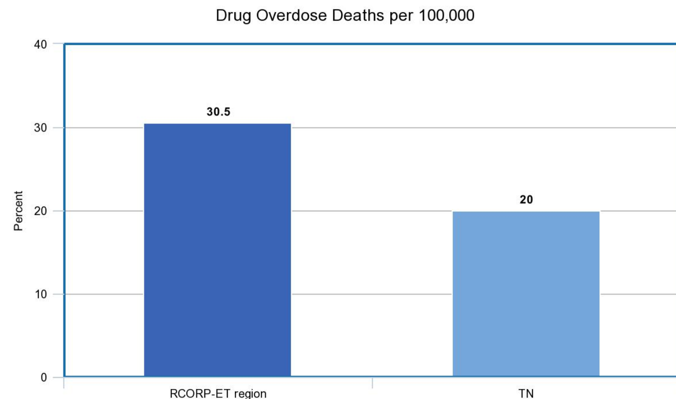
The 10 RCORP-ETC counties experience some of the highest rates of opioid use, overdose, and death from opioid use in the state of Tennessee. See Table 2 for more details.

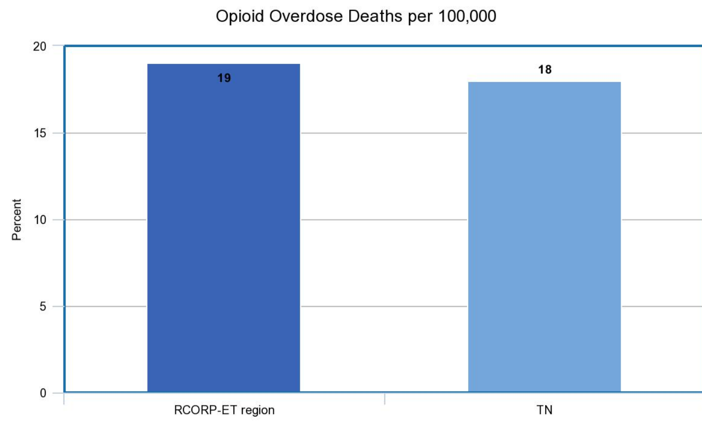


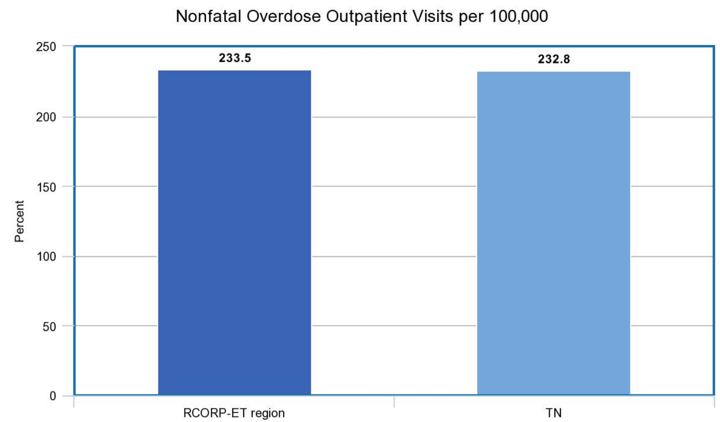


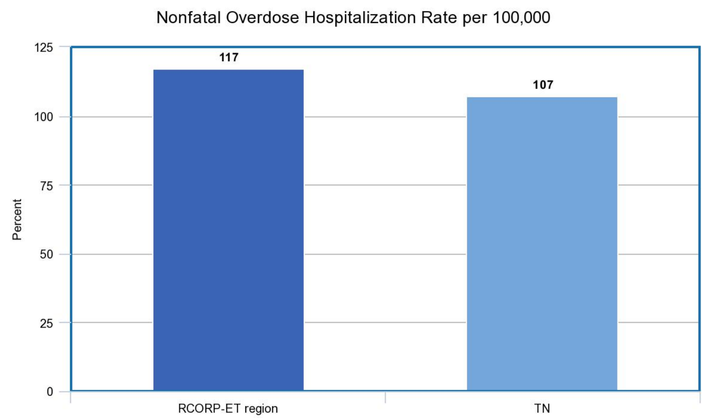
In 2017, benzodiazepines were present in 35% of all opioid overdose deaths.

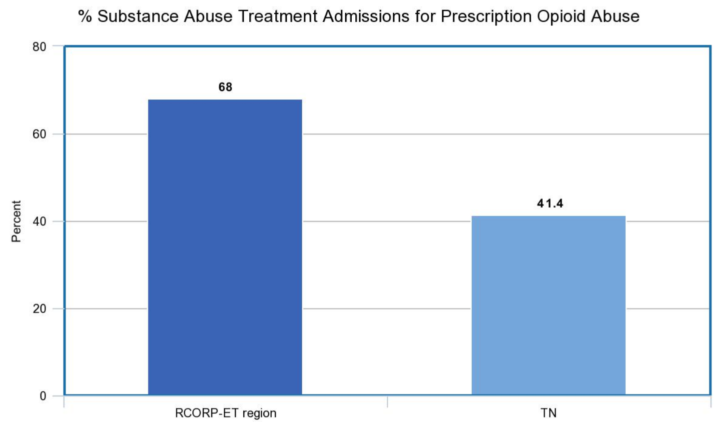






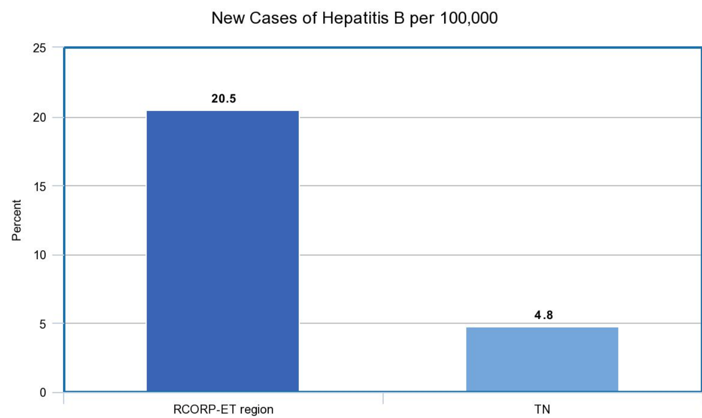


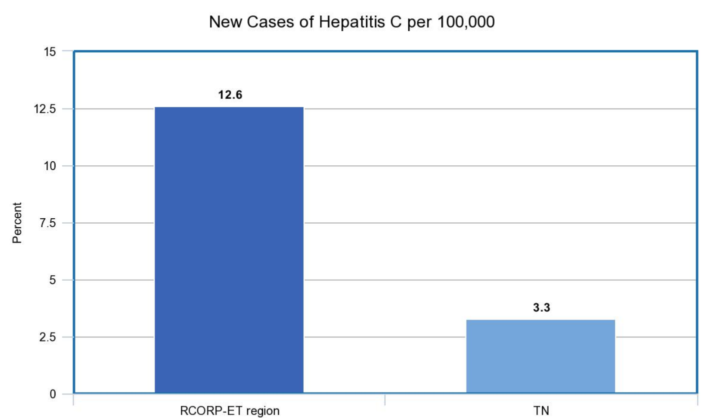


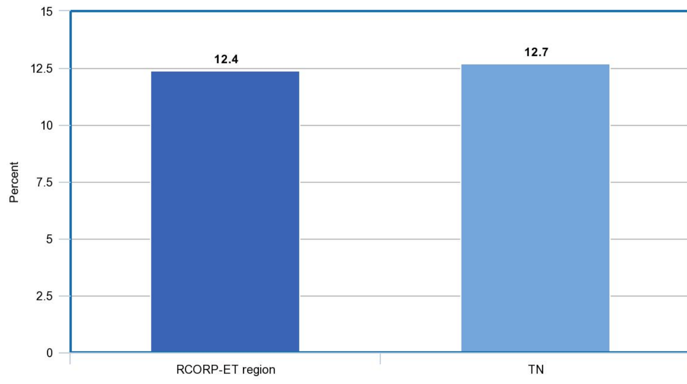


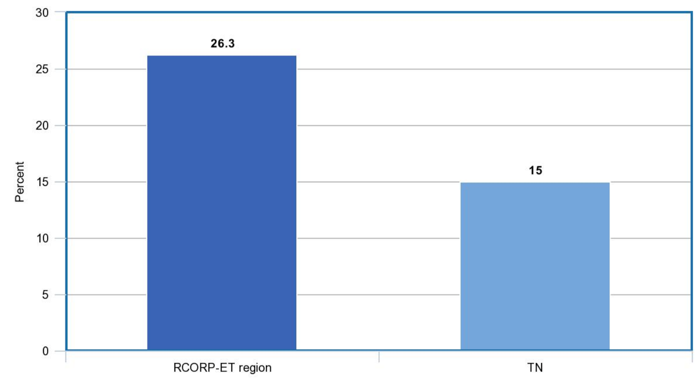
OPIOID USE-RELATED HEALTH ISSUES

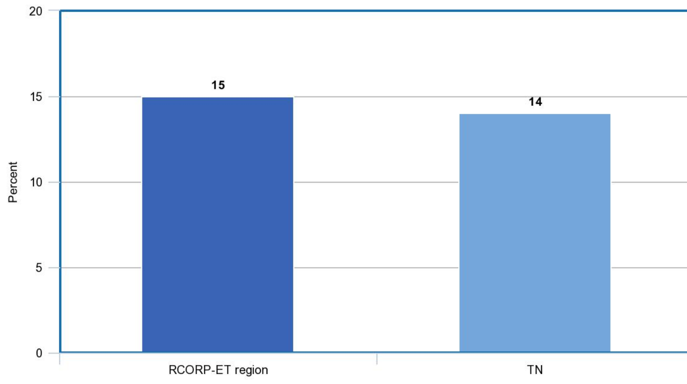
The RCORP-ETC region suffers from poorer mental and physical health outcomes, including increased risky behaviors and sexual risk-taking, oftentimes related to prescription and illicit opioid use. See Table 3 for more details.

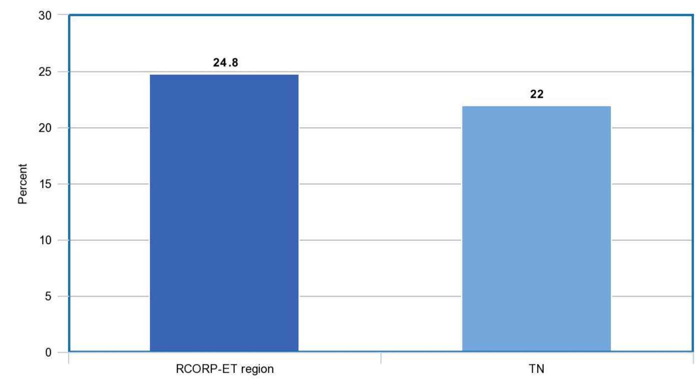





% Diagnosed with Diabetes
15
12.5
10
7.5
5
2.5
0
Percent
12.4
12.7
RCORP-ET region
TN


Motor Vehicle Crash Deaths per 100,000
30
25
20
15
10
5
0
Percent
26.3
15
RCORP-ET region
TN


% Adults Reporting 14+ Days Poor Mental Health Monthly
20
15
10
5
0
Percent
15
14
RCORP-ET region
TN


% Adult Smokers
30
25
20
15
10
5
0
Percent
24.8
22
RCORP-ET region
TN

OPIOID-RELATED PROGRAMS AND SERVICES

The RCORP-ETC region includes a number of OUD-related programs and services; however, the area also depends on urban-based providers located in Knox County. See Tables 4 and 10 for more details.

By the numbers:

	RCORP-ETC Region	East TN Region	TN
Number of beds available in substance abuse adult halfway houses	0	43	474
Number of beds available in alcohol and drug abuse adult residential treatment facilities	0	231	1,305
SA addiction recovery program sites	1	3	N/A
SA prevention sites (ages 12-25)	22	26	147
SA prevention coalitions	6	7	N/A

Despite existing OUD programs and services, several gaps in services related to prevention, treatment, and recovery from OUD remain within the target rural area. Within east Tennessee, there are 43 beds available at substance abuse halfway houses and 231 beds available at drug abuse residential treatment sites; however, these facilities are located in metropolitan areas of east Tennessee; the rural RCORP-ETC counties have no substance abuse beds.[6] East Tennessee hospitals report that detox patients frequently occupy psychiatric beds.[7] The RCORP-ETC region has only one methadone clinic; the vast majority are located primarily in urban areas.[8] A 2016 SAMHSA report identified that all RCORP-ETC counties (except Union) had at least one area that was underserved by medication-assisted treatment (MAT) facilities.[9]

By the numbers:

	RCORP-ETC Region	TN
Health Professional Shortage Areas	52	351
Mental Health Providers	1-90 (12.5 average)	8,963
Buprenorphine Treatment Providers	0-7 (2.5 average)	657
Ryan White HIV/AIDS Providers	0	45

OPIOID-RELATED WORKFORCE

Compared to Tennessee and the United States, the RCORP-ETC region faces dire disparities in mental healthcare. A total of 186 mental health providers work across the RCORP-ETC region. Here, the ratio of residents to mental health providers varies from 710:1 in Hamblen County to 21550:1 in Morgan County—the highest demand ratio in Tennessee. The region also suffers from a lack of primary care physicians. In 2016, 151 physicians served the RCORP-ETC region, with a median ratio of 2,430 residents to every one primary care provider. Alarmingly, this is almost twice that of the state ratio of providers (1380:1). Of the 151 physicians, 29 (19.2%) have a Drug Enforcement Administration waiver to prescribe buprenorphine. However, 5 of the 10 countries have 0 or 1 provider. See Table 5 for more detail.

> Tennessee ranks 43rd in the nation with only 138.2 mental health providers per 100,000 people; this is 30% less than the U.S. rate of 218 per 100,000 people.

Areas of Concern/Disparities

Lack of available beds in substance abuse treatment and recovery facilities
Limited access to mental health providers
Limited buprenorphine treatment providers

Assets

Regional density of substance abuse prevention coalitions
Regional density of substance abuse prevention sites for persons (ages 12-25)

LITERATURE REVIEW

In the past 20 years, the United States has seen an increase in the number of individuals with opioid use disorder (OUD) and related deaths. [10] The risk of OUD is affected by both risk and protective factors. Risk factors increase the risk of OUD, while protective factors lower the risk of OUD by buffering the impact of a risk factor.[11] Prevention and treatment efforts try to reduce the risk factors and build up protective factors. Research has identified several OUD risk factors, but we know little about protective factors.

A number of OUD risk factors are demographic characteristics. People who are non-Hispanic white have at greater risk for OUD than non-Hispanic blacks and Hispanics. People without a high school diploma are at greater risk of OUD than those with a college degree or more. People who are disabled are more likely to have OUD than people who are employed full-time. Adults with Medicaid or no insurance coverage have greater risk of OUD diagnoses than those with only private insurance. Persons diagnosed with alcohol, marijuana, cocaine, hallucinogen, heroin, stimulant, or sedative use disorders are more likely to also have OUD than people without the corresponding disorders.[10] Additionally, early drug use, as young as age 13, increases the risk of later development of drug abuse.[12] Starting at age 13, with each year that drug use initiation is delayed, there is a 4-5% less chance of lifetime drug abuse or dependence.[10] Most alarmingly, people with family members with a substance abuse concern are 8 times more likely to abuse substances; this is the greatest risk factor overall.[13]

Relationship characteristics can also affect the risk of OUD. For persons in treatment for OUD or cocaine use disorder, marriage has been related to a lower initial levels of heroin use and a significant decrease in heroin use across a 35-week period, whereas separated adults increased their heroin use during this time. Single and cohabitating people also decreased their heroin use, but not as much as the married people. When looking at the interaction between marriage and having a close personal relationship with their significant other, people who were married and reported a close personal relationship with their spouse have a reduced risk of cocaine and heroin use across 35 weeks, compared to those who are single or cohabiting in a close personal relationship or married but not in a close personal relationship.[14] Both victims and perpetrators of intimate partner violence (IPV) have an increased risk of OUD.[15] The strongest relationship-related risk is adverse childhood experiences (ACEs). Each additional ACE results in a 2- to 4- fold increased risk of drug initiation from adolescence into adulthood.[16]

For protective factors, having a college degree or more and being enrolled in a private health insurance program reduced the risk of OUD. In general, having a strong social support system also served as protective factors. Youth who have a good relationship with a teacher and/or involved parents, were less likely to have OUD.[14]

COMMUNITY STRENGTHS AND THEMES ASSESSMENT

The community strengths and themes assessment survey was designed to better understand the 10-county region's challenges and strengths related to opioid use disorder (OUD). We invited all persons who were 18 years or older who live, work, or play in the 10-county region to answer the survey. The survey was available from January 27 to February 8, 2019; 710 people responded, either on-line (n=652) or in a paper form (n=58). See Table 6 for more detail.

Participant Characteristics

People living in all 10 counties participated in the survey (9-88 residents by county. Most participants were female and ages 40-54. Further, most participants had a bachelor or master's degree and were employed full-time.

OUD Experience and Stigma

Of the respondents, 10% reported experiencing OUD now or in the past. Over half of the respondents had someone close to them with OUD.

The 8-item stigma scale was adapted from a general substance abuse stigma scale.[17] The summed response scores ranged from 8-40; a higher score indicated greater perceived levels of community stigma related to OUD. For the 507 people who answered all 8 questions, the average stigma score was 29.3, ranging from 14-40. Perceived community OUD stigma did not differ by county. We found no difference in mean stigma scores between people who reported having someone close to them who was addicted to opioids and those who did not. However, people with personal OUD experience (n=68) reported a significantly higher mean level of stigma (Mean=30.6) compared to people without OUD experience (n=427; Mean=29.0; $p<.05$).

Strengths and Challenges

After reviewing the current research, we identified 24 community challenges and 19 community strengths related to OUD. Participants were asked to select the three that they thought were most important. Over 100 people selected seven of the challenges (see Table xx). Not enough treatment and recovery services was by far the gravest concern, and was selected by 247 people. Of participants, over 100 people also chose: 1) *High cost of OUD treatment*; (2) *mental illness*; (3) *unemployment*; (4) *lack of support groups to prevent OUD relapse*; (5) *poor treatment outcomes*; and (6) *lack of knowledge of treatment and recovery resources*;

Six community strengths were also selected by over 100 people. These included: (1) *support for people with OUD;* (2) *law enforcement;* (3) *support to prevent OUD relapse*, (4) *community services work together or collaborate*; (5) *plenty of treatment and recovery centers*; and (6) *access to routine healthcare*. The differences of opinion between the strengths and challenges is apparent. For example, 247 people view *not enough treatment and recovery services* as a challenge but 106 selected *plenty of treatment and recovery services* as a strength; 58 selected these services as both a strength and a challenge. Similarly, 115 identified lack of support groups to prevent OUD relapse as a challenge but 118 selected the presence of these support groups as a community strength; 24 people selected *support groups* as both a strength and a challenge. See Table 7 for more detail.

Summary of Priority Areas

RCORP-ETC region identified the following priorities to decrease the incidence and prevalence OUD and OUD overdose deaths in the RCORP-ETC region, based on collected data.

Prevention

-Reduce unemployment
-Enhance mental health
-Decrease physical and emotional abuse
-Increase community knowledge of addiction

Treatment

-Increase high quality effective treatment facilities
-Increase community and service providers' knowledge of treatment and recovery resources

Recovery

-Increase access to support groups

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

A local public health system assessment helps people understand the number and breadth of organizations that protect and contribute to the community's health. This particular assessment focused on services related to opioid use disorder. The RCORP-ETC members shared their views about the strengths and challenges faced by the greater local public health system. They also shared ways to work better with other groups of people. This information will help identify and plan programs or policies to better promote the community's health.

Based on the job titles and organizations of RCORP-ETC members, each was placed in one of six discussion groups: (1) Education, (2) Law enforcement, (3) Innovative approaches, (4) Access to health services, (5) Competent workforce, and (6) Support for individual and community health efforts.[18] A University of Tennessee-Knoxville (UTK) faculty member or graduate student guided each discussion group. Each group was asked four or five questions. The discussions were recorded so that the shared information could be more accurately summarized. UTK faculty and students wrote down the main ideas shared for each question. The answers were then put together by themes or what they had in common.

Inform, educate, and empower people about health issues

All of the participants in this discussion group were involved in educational activities. The audiences include youth, incarcerated adults, community leaders, and policymakers. Collaborations occurred across the county and between various systems including health councils, schools, and organized coalitions. Adverse childhood events or ACEs are increasingly emphasized in educational events related to addiction. Advocacy efforts oftentimes utilize social media (e.g., Facebook, Twitter, Instagram, and Snapchat) and email. Other message delivery modes identified were billboards, public service announcements, local TV and radio stations, and public forums

Enforce laws and regulations that protect health and ensure safety

The consortium members who participated in this discussion group had expertise on child and family services, which guided their responses. Incarceration, unemployment, and active OUD were identified as common challenges faced by families. OUD is often hidden by families who are aware of the associated stigma and fear that disclosure may lead to intervention by the Department of Child Services (DCS). Families seldom have the concept of a safety net provided by social services and typically do not ask for help.

It was not uncommon for organizational policies to vary both within and between counties. This flexibility allowed professionals to be more creative in their support of children and families. Given this adaptability, monitoring the policies was accomplished through multiple reviews of the case managers' actions and peer consultation. The timeframe of 90 days to "fix" the issue of a client was regularly enforced, but the "fix" varied greatly between cases.

Implementing policy changes within the represented organizations varied from easy to complicated. An example of challenging policy changes included defining terms (e.g., child abuse) and attempts to standardize protocol. The participants did not view OUD as increasing their caseload, but that it did complicate their mandate.

Research for new insights and innovative solutions to health problems

Best practices in Public Health requires that research and best evidence be incorporated into program and policy planning. Three consortium members shared their views on how research is incorporated into the efforts to address OUD. Personal interest was identified as a motivating factor for research integration. Data were often collected in-house (e.g., physician practice) but were also collected in collaboration with other organizations. Success in research is assessed through publications, awards, patents, and memberships to scientific committees. The majority of the participants have collaborated with one or more universities. Dissemination was emphasized. In addition to presentations, health literacy, or low literacy level products, have been created to enhance the integration of research in practice.

Link people to needed personal health services

Two groups were able to reflect on the four questions related to healthcare access. Participants noted that data to assess how well vulnerable residents are accessing healthcare are very limited; the importance of sharing data was emphasized, as services are often working in siloes. Understanding healthcare access is further complicated as limited resources may lead to the inappropriate use of local services, e.g., using jails for detoxification. Referrals are also very inconsistent within and between counties. Emergency care data are perhaps the most helpful.

When asked to comment on the assessment of the public health services related to opioid use, policy efficacy was highlighted in relation to reducing access to opioids. These included policies related to pain clinic practices including medical directors, owners, and other regulations. The participants also acknowledged the evaluation of the contraception access program that is occurring via the criminal justice system. In general, quality assessment relied greatly on word of mouth. Ideally, one entity would develop and

maintain a list of quality resources by county. Regarding the respondents' organizations, internal assessments were addressed via by-law adherence and monitoring grant deliverables.

Finally, the consortium members listed a number of current activities to enhance the healthcare access of vulnerable persons. These included: home visitation, services for the incarcerated, community access to naloxone, scheduling appointments and transportation, resume writing, and enforcing accountability. It was noted that despite the primary role of an organization (e.g., medical care), the effort must be more holistic to ensure that vulnerable patients have access to services (e.g., transportation). One participant recommended that OUD be treated like a chronic disease, comparable to diabetes. Once such model is used by the Delancey Street Foundation in San Francisco. However, challenges will still exist. For example, sex offenders are very stigmatized and can only receive OUD treatment in Nashville; a difficult distance.

Assure a competent public health and personal healthcare workforce

Three consortium members contributed to this discussion. The participants shared their experience with performance evaluations. An orientation period can occur prior to part- or full-time position. For the annual reviews, expectations are typically delivered from upper management (e.g., governor) and applied to the reviews conducted by direct supervisors. Employees are also asked to evaluate the organization. Workforce education and training varied widely by organization. National and state leadership, including licensing requirements, can mandate trainings. As an empowerment effort, employees can also identify their training needs. Leadership and customer service were identified as critical training areas. Both tools and coaching are important training strategies. Participants espoused that special emphasis should be given to incarcerated employees to promote success and future employment. In addition to GED testing and job training, transportation is also an important barrier to address. In closing the participants were asked, in relation to OUD, what types of workforce development opportunities are necessary to better promote community health? Baseline skills including punctuality and relationship building; increasing the retention of parole officers could be supportive. Employees should also ensure that they are providing a healthy, positive work environment.

Two programs to incentivize hiring includes the Federal Bonding program (Insurance provision) and the work opportunity tax credit for employees who hire vulnerable people such as veterans, persons with disabilities, or ex-felons. Brain changes associated with OUD were noted as further complicating employment possibilities.

Develop policies and plans that support individual and community health efforts

Participants were not able to identify leadership training relate to OUD. However, the East Tennessee Regional Leadership Association was noted, as the organization taps into the local leadership. The membership could serve as ambassadors for leadership training. Optimally new policies and plans will be guided by existing data. In relation to OUD, relevant information cited included data on overdose deaths, narcan rescues, neonatal abstinence syndrome, blood-borne pathogens (e.g., Hepatitis C), and family services referrals. Tracking the occurrence of educational efforts would also be helpful in identifying gaps in content and audiences. Such monitoring and associated evaluation data can be challenging to access at the county level as much is only available at the state level.

Collaboration between local public health systems and the medical community of East Tennessee was viewed as informal, without policy or regulation, but necessary factor in addressing the OUD. Some viewed OUD-related stigma as challenging the relation between public health and medical services. Finally, local public health systems were discussed as a critical advocacy group to promote policies to decrease OUD. Ideally public health can assist in creating policies to align with and promote a high quality standard to care, particularly since the science of treatment approaches is relatively new. Identified resources toward this end included UTK and East Tennessee Quality Growth, which is associated with the city and county planning committee and focuses on the built environment.

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APPENDICES

Table 1. Demographics
RCORP-ETC region, East TN Region, TN Region 2, TN, and US[1]

Measure	RCORP-ETC region*†	East TN region‡	TN-Region 2§	Tennessee	U.S.
% rural population	21.9-100.0 (70.0)	--	--	33.6	0-100 (59.5)
% uninsured under age 65	11.0-15.0 (12.0)	12	--	--	8.8 (2016)
% on Medicaid	21.0-35.3 (26.1)	--	--	22.0	--
% of population living in poverty	16.5-27.3 (21.7)	--	17.5	17.6	--
% unemployed	5.2-7.6 (6.1)	--	--	4.8	1.7-23.5 (5.0)
% White, non-Hispanic	81.8-97.5 (94.0)	--	--	78.8	2.8-98.0 (84.0)
% African American, non-Hispanic	.3-4.0 (1.6)	--	--	16.8	0-85.2 (2.2)
% Hispanic	.8-11.5 (1.7)	--	--	5.2	.5-96.3 (4.1)
% below 18 years	19.6-24.5 (21.0)	--	20.4	22.6	0-40.8 (22.3)
% pop ages 18-64	59.0-64.0 (60.0)	--	59.3	61.9	--
% 65 older	15.6-21.2 (18.5)	--	17.2	15.7	4.6-56.3 (18.1)
% high school graduates	74.0-97.0 (90.0)	--	--	88.0	30.0-100.0 (88.0)
% Some college	31.9-49.3 (38.0)	--	--	59.0	16.0-94.0 (57.0)
% Diagnosed with diabetes	11.5-13.8 (12.4)	--	--	12.7	3.0-21.0 (11.0)
Average life expectancy at birth (years)[2]	72.1-74.91 (73.4)	74.5	74.6	76.4[3]	78.7[4]
* Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Morgan, Roane, Scott, and Union counties, Tennessee; † Min-Max (median); ‡ RCORP-ETC region plus Anderson, Blount, Loudon, Monroe, and Sevier counties, Tennessee; § East Tennessee region plus Knox County, Tennessee.					

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Table 2. Opioid Use Related Health Issues
RCORP-ETC region, East TN Region, TN Region 2, TN, and US

Measure	RCORP-ETC region*†	East TN region‡	TN-Region 2§	Tennessee	U.S.
Filled opioid prescriptions filled rate per 1,000 persons (2017)[5]	1,223-1,795 (1,479.5)	1,281	--	1,025	--
# Drug overdose deaths (2016)[6]	4-26 (8)	240	240	22	3-87 (18)
Drug overdose mortality rate per 100,000 (2014-2016)	11.0-45.0 (30.5)			20	--
# Opioid overdose deaths (2016)	1-21 (4.5)	149	296	1,186	--
Opioid overdose death rate per 100,000 (2016)[7]	19	20	--	18	--
# Heroin overdose deaths	0-4 (.5)	21	38	260	--
Heroin overdose death rate per 100,000[8]	--	3	--	4	--
# Nonfatal overdose hospitalization	19-77 (36.5)	924	1,371	7,092	--
Nonfatal overdose hospitalization rate	40-179 (117.0)	122	--	107	--
# of nonfatal opioid overdoses (2015)	26-118 (74.5)	1,636	2,597	13,034	--
Nonfatal opioid overdose rate per 100,000 (2015)	49-342 (204.0)	216	--	213	--
% of SA treatment admissions with prescription opioids as substance of abuse (2016)[9][10]	58.5-88.9 (68.0)	--	69.2	41.4	--
* Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Morgan, Roane, Scott, and Union counties, Tennessee; † Min-Max (median); ‡ RCORP-ETC region plus Anderson, Blount, Loudon, Monroe, and Sevier counties, Tennessee; § East Tennessee region plus Knox County, Tennessee.					

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[10] State of Tennessee, Department of Mental Health and Substance Abuse Services. "2017 Tennessee Behavioral Health County and Region Services Data Book." September 2017.

Table 3. Opioid Comorbidities
RCORP-ETC region, East TN Region, TN Region 2, TN, and US

Measure	RCORP-ETC region*†	East TN region‡	TN-Region 2§	Tennessee	U.S.
Motor vehicle crash deaths	15.8-32.3 (26.3)	--	--	15	3-77 (17)
HIV prevalence rate per 100000 (13 years or older; 2015)	22.0-136.8 (62.3)	--	--	297	10-2,590 (122)
Acute HBV incidence rate per 100,000 (2014-2016)[11]	20.5	14.4	11.4	4.8	1.0
Acute HCV incidence rate per 100,000 (2014-2016)[12]	12.6	10.6	8.8	3.3	0.8
Average number of poor mental health days	4.6-5.1 (4.9)	--	--		--
% Adults reporting 14 or more days of poor mental health per month	13.2-16.0 (15.0)	--	--	14	8-22 (12.0)
% Adult smokers	21.3-27.2 (24.8)	--	--	22.0	7-43 (17.0)
% of persons living in poverty who enrolled in Behavioral Health Safety Net (2016)	1.1-6.1 (4.0)	--	--	3.9	--
Rate per 1,000 of TDMHSAS-funded crisis services face-to-face assessments, 18 or older	3.5-20.9 (11.1)	--	10.5	12.3	--
* Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Morgan, Roane, Scott, and Union counties, Tennessee; † Min-Max (median); ‡ RCORP-ETC region plus Anderson, Blount, Loudon, Monroe, and Sevier counties, Tennessee; § East Tennessee region plus Knox County, Tennessee.					

[11] State of Tennessee, Department of Mental Health and Substance Abuse Services. "2017 Tennessee Behavioral Health County and Region Services Data Book." September 2017.
[12] State of Tennessee, Department of Mental Health and Substance Abuse Services. "2017 Tennessee Behavioral Health County and Region Services Data Book." September 2017.

Table 4. Opioid-Related Programs and Services
RCORP-ETC region, East TN Region, TN Region 2, TN, and US

Measure	RCORP-ETC region*	East TN region†	TN-Region 2‡	Tennessee	U.S.
Bed capacity at SA adult halfway house sites (5/15/2017)	0	43	146	474	--
Bed capacity of alcohol and drug abuse adult residential rehabilitation treatment sites (5/15/2017)[13]	0	231	279	1,305	--
SA addiction recovery program sites	1	3	6	--	--
SA prevention sites (ages 12-25; 2016)	22	26	36	147	--
SA prevention coalitions	6	7	8	--	--
Drug Takeback Boxes	1-4 (2) §	--	--	--	--
* Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Morgan, Roane, Scott, and Union counties, Tennessee; † RCORP-ETC region plus Anderson, Blount, Loudon, Monroe, and Sevier counties, Tennessee; ‡ East TN region plus Knox County, Tennessee; § Min-Max (median).					

[13] State of Tennessee, Department of Mental Health and Substance Abuse Services. "2017 Tennessee Behavioral Health County and Region Services Data Book." September 2017.

Table 5. Opioid-Related Workforce
RCORP-ETC region, East TN Region, TN Region 2, TN, and US

Measure	RCORP-ETC region*†	East TN region‡	TN-Region 2§	Tennessee	U.S.
Health Professional Shortage Areas[14]	52	73	75	351	17,250
Number of mental health providers[15,16]	1-90 (12.5)	--	--	8,963	597,372
Ratio of mental health providers to population[17]	710:1-21,550:1 (3,326)	--	--	740:1	470:1
Buprenorphine Treatment Practitioners[18]	0-7 (2.5)	--	--	657	29,001
Ryan White HIV/AIDS providers[19]	0	0	4	45	2,074
Number of primary care physicians[20]	3-41 (16.5)	--	--	--	--
Ratio of Primary care physicians to population[21]	1,630:1-10,750:1 (2,430.0:1)	--	--	1,380:1	220:1-46,000:1 (2,040:1)
* Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Morgan, Roane, Scott, and Union counties, Tennessee; † Min-Max (median); ‡ RCORP-ETC region plus Anderson, Blount, Loudon, Monroe, and Sevier counties, Tennessee; § East Tennessee region plus Knox County, Tennessee.					

[14] SAMHSA. "Buprenorphine Treatment Practitioner Locator." Accessed July 13, 2018.
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[18] SAMHSA. "Buprenorphine Treatment Practitioner Locator." Accessed July 13, 2018.
[19] East Tennessee Regional Health Office.
[20] Robert Wood Johnson Foundation. "County Health Rankings." Accessed July 22, 2018.
[21] Ibid.

Table 6. Community Strengths and Themes Survey Participant Characteristics Number (percent)

Characteristic	*Total n=710*	*Campbell n=39*	*Claiborne n=67*	*Cocke n=38*	*Grainger n=14*	*Hamblen n=52*	*Jefferson n=88*	*Morgan n=9*	*Roane n=49*	*Scott n=83*	*Union n=21*	*Other N=46*	*Missing n=204*
Age													
18-25	37 (5.2)	2 (5.1)	13 (19.4)	1 (2.6)	0 (0)	2 (3.8)	3 (3.4)	0 (0)	2 (4.1)	12 (14.5)	2 (9.5)	0 (0)	0 (0)
26-39	155 (21.8)	5 (12.8)	20 (29.9)	15 (39.5)	5 (35.7)	21 (40.4)	18 (20.5)	2 (22.2)	8 (16.3)	34 (41.0)	10 (47.6)	15 (32.6)	2 (1.0)
40-54	178 (25.1)	21 (53.8)	22 (32.8)	8 (21.1)	4 (28.6)	16 (30.8)	29 (33.0)	6 (66.7)	13 (26.5)	30 (36.1)	5 (23.8)	19 (41.3)	5 (2.5)
55-64	105 (14.8)	9 (23.1)	7 (10.4)	13 (34.2)	3 (21.4)	7 (13.5)	29 (33.0)	1 (11.1)	16 (32.7)	6 (7.2)	3 (14.3)	8 (17.4)	3 (1.5)
65 or Over	35 (4.9)	2 (5.1)	4 (6.0)	1 (2.6)	2 (14.3)	5 (9.6)	7 (8.0)	0 (0)	8 (16.3)	1 (1.2)	1 (4.8)	3 (6.5)	1 (.5)
Missing	200 (28.2)	0 (0)	1 (1.5)	0 (0)	0 (0)	1 (1.9)	2 (2.3)	0 (0)	2 (4.1)	0 (0)	0 (0)	1 (2.2)	193 (94.6)
Sex													
Male	85 (12.0)	5 (12.8)	9 (13.4)	10 (26.3)	4 (28.6)	4 (7.7)	13 (14.8)	2 (22.2)	10 (20.4)	12 (14.5)	4 (19.0)	9 (19.6)	3 (1.5)
Female	422 (59.4)	33 (84.6)	57 (85.1)	28 (73.7)	10 (71.4)	10 (71.4)	71 (81.8)	7 (77.8)	37 (75.5)	70 (84.3)	17 (81.0)	36 (78.3)	8 (3.9)
Other	1 (.1)	0 (0)	0 (0)	0 (0)	0 (0)	1 (1.9)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Missing	202 (28.5)	1 (2.6)	1 (1.5)	0 (0)	0 (0)	0 (0)	3 (3.4)	0 (0)	2 (4.1)	1 (1.2)	0 (0)	1 (2.2)	193 (94.6)
Education Level													
Less than high school	8 (1.1)	0 (0)	0 (0)	1 (2.6)	0 (0)	1 (1.9)	2 (2.3)	0 (0)	0 (0)	4 (4.8)	0 (0)	0 (0)	0 (0)
High school graduate	77 (10.8)	5 (12.8)	10 (14.9)	9 (23.7)	1 (7.1)	7 (13.5)	12 (13.6)	0 (0)	4 (8.2)	15 (18.1)	6 (28.6)	5 (10.9)	3 (1.5)
Some college	113 (15.9)	2 (5.1)	22 (32.8)	4 (10.5)	6 (42.9)	15 (28.8)	18 (20.5)	2 (22.2)	12 (24.5)	14 (16.9)	4 (19.0)	12 (26.1)	2 (1.0)
Associate degree	63 (8.9)	2 (5.1)	10 (14.9)	6 (15.8)	3 (21.4)	5 (9.6)	13 (14.8)	6 (66.7)	4 (9.2)	10 (12.0)	2 (9.5)	2 (4.3)	0 (0)
Technical License	46 (6.5)	8 (20.5)	4 (6.0)	3 (7.9)	1 (7.1)	2 (3.8)	9 (10.2)	0 (0)	3 (6.1)	13 (15.7)	0 (0)	3 (6.5)	0 (0)
Bachelor's degree	95 (13.4)	11 (28.2)	11 (16.4)	5 (13.2)	1 (7.1)	7 (13.5)	15 (17.0)	0 (0)	17 (34.7)	11 (13.3)	6 (28.6)	10 (21.7)	1 (.5)
Some graduate school	13 (1.8)	2 (5.1)	0 (0)	1 (2.6)	0 (0)	1 (1.9)	4 (4.5)	0 (0)	0 (0)	1 (1.2)	0 (0)	2 (4.3)	2 (1.0)
Graduate school	97 (13.7)	9 (23.1)	9 (13.4)	9 (23.7)	2 (14.3)	14 (26.9)	13 (14.8)	1 (11.1)	9	15 (18.1)	3 (14.3)	11 (23.9)	2 (1.0)
Missing	198 (27.9)	0 (0)	1 (1.5)	0 (0)	0 (0)	0 (0)	2 (2.3)	0 (0)	0 (0)	0 (0)	0 (0)	1 (2.2)	194 (95.1)
Employment Situation													
Full-time	353 (49.7)	34 (87.4)	44 (65.7)	24 (63.2)	5 (35.7)	33 (63.5)	53 (60.2)	6 (66.7)	33 (67.3)	62 (74.7)	16 (76.2)	37 (80.4)	6 (2.9)
Part-time	52 (7.3)	1 (2.6)	8 (11.9)	6 (15.8)	3 (21.4)	5 (9.6)	8 (9.1)	1 (11.1)	3 (6.1)	7 (8.4)	2 (9.5)	3 (6.5)	1 (.5)
Temporary	3 (.4)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Student	23 (3.2)	0 (0)	6 (9.0)	0 (0)	0 (0)	2 (3.8)	4 (4.5)	0 (0)	0 (0)	0 (0)	1 (4.8)	0 (0)	0 (0)
Retired	49 (6.9)	1 (2.6)	3 (4.5)	3 (7.9)	2 (14.3)	4 (7.7)	12 (13.6)	1 (11.1)	9 (18.4)	2 (2.4)	1 (4.8)	4 (8.7)	2 (1.0)
Not looking for employment	28 (4.0)	3 (7.7)	3 (4.5)	1 (2.6)	0 (0)	2 (3.8)	4 (4.5)	1 (11.1)	1 (2.0)	7 (8.4)	0 (0)	0 (0)	2 (1.0)
Unemployed, looking for employment	33 (4.7)	0 (0)	2 (3.0)	4 (10.5)	4 (28.6)	5 (9.6)	5 (5.7)	0 (0)	2 (4.1)	5 (6.0)	1 (4.8)	0 (0)	0 (0)
Missing	169 (23.8)	0 (0)	1 (1.5)	0 (0)	0 (0)	1 (1.9)	2 (2.3)	0 (0)	1 (2.0)	0 (0)	0 (0)	2 (4.3)	193 (94.6)

Table 7. OUD-Related Characteristics by County
Number (percent) unless otherwise specified

Self-Addiction (past or present)	*Total n=710*	*Campbell n=39*	*Claiborne n=67*	*Cocke n=38*	*Grainger n=14*	*Hamblen n=52*	*Jefferson n=88*	*Morgan n=9*	*Roane n=49*	*Scott n=83*	*Union n=21*	*Other N=46*	*Missing n=204*
Yes	71 (10.0)	4 (10.3)	12 (17.9)	8 (21.1)	2 (14.3)	9 (17.3)	7 (8.0)	0 (0)	3 (6.1)	17 (20.5)	1 (4.8)	7 (15.2)	1 (.5)
No	440 (62.0)	33 (84.6)	55 (82.1)	30 (78.9)	11 (78.6)	42 (80.8)	81 (92.0)	8 (88.9)	46 (93.9)	66 (79.5)	19 (90.5)	39 (84.8)	10 (4.9)
Prefer not to answer	5 (.7)	1 (2.6)	0 (0)	0 (0)	1 (7.1)	1 (1.9)	0 (0)	1 (11.1)	0 (0)	0 (0)	1 (4.8)	0 (0)	0 (0)
Missing	194 (27.3)	1 (2.6)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Someone Close to You Addicted (past or present)	***Total n=710***	***Campbell n=39***	***Claiborne n=67***	***Cocke n=38***	***Grainger n=14***	***Hamblen n=52***	***Jefferson n=88***	***Morgan n=9***	***Roane n=49***	***Scott n=83***	***Union n=21***	***Other N=46***	***Missing n=204***
Yes	382 (53.8)	29 (74.4)	52 (77.6)	30 (78.9)	10 (71.4)	34 (65.4)	63 (71.6)	6 (66.7)	36 (73.5)	62 (74.7)	17 (81.0)	36 (78.3)	7 (3.4)
No	129 (18.2)	8 (20.5)	15 (22.4)	8 (21.1)	3 (21.4)	17 (32.7)	23 (26.1)	3 (33.3)	13 (26.5)	21 (25.3)	4 (19.0)	10 (21.7)	4 (2.0)
Prefer not to answer	5 (.7)	1 (2.6)	0 (0)	0 (0)	1 (7.1)	1 (1.9)	2 (2.3)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Missing	194 (27.3)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	193 (94.6)
Community OUD stigma (8 items)	***Total n=710***	***Campbell n=39***	***Claiborne n=67***	***Cocke n=38***	***Grainger n=14***	***Hamblen n=52***	***Jefferson n=88***	***Morgan n=9***	***Roane n=49***	***Scott n=83***	***Union n=21***	***Other N=46***	***Missing n=204***
Mean (STD) *n*	29.3 (5.0)	28.8 (4.7)	29.1 (4.9)	30.6 (5.0)	30.1 (4.6)	29.0 (5.3)	29.2 (5.3)	30.1 (4.6)	29.0 (5.6)	29.1 (4.6)	27.1 (5.5)	29.8 (4.8)	30.8 (5.1)
n (percent)	507 (71.4)	38 (97.4)	65 (97.0)	38 (100.0)	14 (100.0)	50 (96.1)	82 (93.1)	9 (100.0)	49 (100.0)	83 (100.0)	20 (95.2)	44 (95.7)	15 (7.4)

Table 8. Challenges Related to Opioid Use Disorder n(%)

Check the <u>three</u> most important <u>challenges</u> that increase opioid use disorder (OUD) or opioid addiction in your community.	*Total n=710 (percent)*
not enough treatment and recovery services	247 (34.8)
high cost of treatment for OUD	177 (24.9)
mental illness	146 (20.6)
unemployment	116 (16.3)
lack of support groups to prevent OUD relapse (e.g., NA/AA meetings)	115 (16.2)
poor treatment outcomes	109 (15.4)
lack of knowledge of treatment and recovery resources	101 (14.2)
physical or emotional abuse	96 (13.5)
little community knowledge about addiction	92 (13.0)
location of treatment services	78 (11.0)
lack of social support for people with OUD	73 (10.3)
poor opinion of people with OUD who seek help	71 (10.0)
community isolation	58 (8.2)
community services do not work together or collaborate	52 (7.3)
negative perceptions of OUD treatment	50 (7.0)
need for more law enforcement	44 (6.2)
poor perception of medically assisted treatment (MAT) of OUD	40 (5.6)
lack of confidence in OUD treatment facilities	37 (5.2)
legal challenges	31 (4.4)
community disapproval of OUD	29 (4.1)
personal experience with OUD	28 (3.9)
employer drug screening	17 (2.4)
lack of naloxone (antagonist) training	10 (1.4)
lack of insurance coverage for inpatient treatment	6 (.8)

Table 9. Strengths Stigma Related to Opioid Use Disorder n(%)

Check the <u>three</u> most important <u>strengths</u> that reduce opioid use disorder (OUD) or opioid addition in your community.	***Total n=710 (percent)***
support for people with OUD who seek help	164 (23.1)
law enforcement	131 (18.5)
support groups to prevent OUD relapse (e.g., NA/AA meetings)	118 (16.6)
community services work together or collaborate	117 (16.5)
plenty of treatment and recovery services	106 (14.9)
access to routine healthcare	105 (14.8)
access to drug treatment centers	93 (13.1)
insurance pays for inpatient treatment	90 (12.7)
positive treatment outcomes	88 (12.4)
good mental health promotion	77 (10.8)
knowledge of treatment and recovery resources	75 (10.6)
community knowledge about addiction	72 (10.1)
access to mental health facilities	63 (8.9)
social support for people with OUD	54 (7.6)
location of treatment facilities	52 (7.3)
naloxone (antagonist) training	50 (7.0)
community support for OUD treatment	48 (6.8)
confidence in OUD treatment facilities	12 (1.7)
affordable treatment for OUD	3 (.4)

TABLE 10. OUR RESOURCES IN THE RCORP-ETC REGION

Updated information available at: https://www.tn.gov/behavioral-health/substance-abuse-services/criminal-justice-services.html

Preventative Services

Find more prevention services through the CDC's National Prevention Information Network: https://npin.cdc.gov/

Find more TN Prevention services: https://www.tn.gov/behavioral-health/substance-abuse-services/prevention.html

Call the Tennessee Association of Alcohol, Drug, and other Addiction Services (TAADAS) REDLINE 24/7 addiction treatment and recovery hotline: 1-800-889-9789 https://www.taadas.org/our-programs-and-services/redline

TN Department of Mental Health and Substance Abuse Services (TDMHSAS) Prevention and Treatment Provider Directories can be located at: https://www.tn.gov/behavioral-health/substance-abuse-services/criminal-justice-services/substance-abuse-prevention-treatment-block-grant.html

Category	Name	Website	Address	Email	Phone #	Mission/additional information
Anti-drug coalition	Metro Drug Coalition	https://metrodrug.org	4930 Lyons View Pike, Knoxville, TN 37919	kpershing@metrodrug.org	865-588-5550	Improve the health of the greater Knoxville community by reducing the use of alcohol and drugs through policy, systems and environment change
Anti-drug coalition	Prevention Alliance of TN (PAT)	https://tncoalitions.org/	220 Veterans Parkway, Suite E, Murfreesboro, TN 37128	info@tncoalitions.org		Serves as the collective voice for substance abuse prevention by empowering coalitions, advocating for effective policies and building strategic partnerships.
Anti-drug coalition	Rescue 180 Jefferson County Substance	rescue180.com	2734 Lisa Circle Strawberry Plains, TN, 37871	Rescue180@yahoo.com	865-640-4843	Provides prevention education for Jefferson county and implements evidence based strategic planning using the SPF

	Abuse Coalition	https://www.facebook.com/Rescue180				model, 7 strategies for community change.
Naloxone training	Regional Overdose Prevention Specialists Region 2 ROPS grant	https://www.tn.gov/behavioral-health/substance-abuse-services/prevention/prevention/regional-overdose-prevention-specialists.html Sevier County Cares is provider of the grant to area coalitions.	10 regions across TN Download map of specialists with contact information: https://www.tn.gov/content/dam/tn/mentalhealth/documents/ROPS%20Map%2012_19_18.pdf Supplied Region 2: Sevier, Cocke, Blount, Jefferson, Loudon, Hamblen, Monroe	Nogle@seviercountytn.gov	865 640 2052	Point of contact for training and education and for the distribution of naloxone. This is the grant that supplied Narcan to our first responder and is being resupplied again.
Prescription drug control	Prescription drug take-back boxes	https://www.tn.gov/behavioral-health/substance-abuse-services/prevention/prevention/find-a-prescription-drug-take-back-box.html	Interactive map of boxes: http://tdeconline.tn.gov/rxtakeback/	See interactive map	See interactive map	Provide a place where unused prescription drugs can be safely disposed
Recovery Support groups	Lifeline Peer Project	https://www.tn.gov/behavioral-health/substance-abuse-services/prevention/prevention/lifeline-peer-project.html	10 regions across TN: Map of locations: https://www.tn.gov/content/dam/tn/mentalhealth/documents/Lifeline%20Contacts	Contact information provided in PDF	Contact information provided in PDF	Established to reduce stigma related to the disease of addiction and increase access to substance abuse recovery

			%208-3-18.pdf			
Harm reduction	East Tennessee Harm Reduction Clinic (HRC)	https://www.projectactknox.com/ssp/	900 E. Hill Ave, Ste 285, Knoxville, TN 37915		865-525-1540 ext. 205	
Provider screening training	Substance Abuse Screenings in Tennessee: Screening, Brief Intervention, and Referral to Treatment services (SBIRT-TN)	https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/substance-abuse-screenings-in-tennessee--sbirt-tn-.html	Office of Prevention and Early Intervention Services for the TN Department of Mental Health and Substance Abuse Services	Office of Prevention and Early Intervention Services for the TN Department of Mental Health and Substance Abuse Services	SAMHSA information on SBIRT: https://www.samhsa.gov/sbirt	The service provides universal screening in a primary care setting for risky substance use, coupled with a patient-centered discussion of screening with results between the patient and health care provider.

Treatment and Recovery

Find more TN Treatment and Recovery services: https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery.html

Category	Name	Website	Address	Email	Phone #	Mission/additional information
Recovery Support Services	Addictions Recovery Program (ARP)	Information and list of providers: https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/recovery-support-services.html	TN Department of Mental Health & Substance Abuse Services	Melvin Smith Melvin.smith@tn.gov	615-532-7807	Offers a variety of services to individuals with issues brought on by their substance abuse.

Recovery Support Services	Rescue 180 Aftermath Group	https://www.rescue180.com/	Jefferson County	Rescue180@yahoo.com	865-640-4843 865-640-4842	Helps patients who have received Narcan by first responders reach out to others who have survived an overdose. Group that meets with patient's family and works to get the overdose patient into treatment and recovery.
Detoxification	Medically Monitored Withdrawal Management Services (MMWM)	Information and list of providers: https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/crisis-detoxification.html	TN Department of Mental Health & Substance Abuse Services	Jackie Talley Jackie.talley@tn.gov	615-741-8518	Detox services delivered by medical and nursing professionals. They provide 24 hour medically supervised evaluation and withdrawal management in a facility with inpatient/residential beds.
Detoxification	Medically Managed Inpatient Detox at Pathways	https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/medically-managed-inpatient-detox.html	Pathways 238 Summar Drive Jackson, TN 38301		1-800-587-3854	An organized inpatient substance abuse withdrawal management service. It is delivered by medical and nursing professionals and provides 24-hour, medically-directed observation, evaluation, monitoring, and withdrawal management in an acute care inpatient setting.
Treatment	Adults Substance	https://www.tn.gov/behavioral-health/substanc	TN Department of Mental	Linda McCorkle	615-532-7803	State-funded treatment for adults with an alcohol or drug

	Abuse Treatment	e-abuse-services/treatment---recovery/treatment---recovery/adult-substance-abuse-treatment.html	Health & Substance Abuse Services Services provided in Johnson City, Gray, Knoxville, Oak Ridge, Chattanooga, Nashville, Hohenwald, Franklin, among others Download list of services: https://www.tn.gov/content/dam/tn/mentalhealth/documents/SAPT%20-Treatment%20Agency%20Listing%20for%20directory%202019.doc	Linda.mccorkle@tn.gov Addresses and contact information is provided for each service in downloadable Word Document referenced	Addresses and contact information is provided for each service in downloadable Word Document referenced	dependency, or adults with a co-occurring substance use and a psychiatric diagnosis Treatment is available for c-occurring disorders (more information and providers: https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/co-occurring-disorders.html)
Treatment	Oxford House – Recovery Housing for Adults	https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/oxford-house---recovery-housing-for-adults.html	Oxford Houses can be found in Chattanooga, Clarksville, Jackson, Johnson City, Knoxville, Madison, Memphis, Nashville. See addresses on PDF: http://www.o			Safe, supportive housing options for adults at least 18 years old who are in recovery from alcohol abuse and/or drug abuse

			xfordhouse.org/pdf/tn_directory_listing.pdf			
Treatment	Treatment for Pregnant Women Abusing Substances	Information at: https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/treatment-for-pregnant-women-abusing-substances.html	TN Department of Mental Health & Substance Abuse Services	Linda McCorkle Linda.mccorkle@tn.gov	615-285-4334	Services target adolescents and adults in need of treatment and/or recovery support services including detoxification, outpatient treatment, and HIV outreach.
Treatment and Recovery	Women's Recovery and Treatment	https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/women-s-recovery-and-treatment.html	Services in Johnson City, Gray, Knoxville, Chattanooga, Nashville, Jackson, Memphis: PDF list of services available: https://www.tn.gov/content/dam/tn/mentalhealth/documents/Listing_of_Women_and_Pregnant_Women_(2).pdf	Address and contact phone number found on downloadable PDF referenced	Address and contact phone number found on downloadable PDF referenced	Residential housing for pregnant women, intensive outpatient, case management, trauma-specific interventions and recovery support, parenting skills, child care and transportation are available.
Treatment	Adolescent Substance Use Disorders Services Program	lhttps://www.tn.gov/behavioral-health/substanc	TN Department of Mental Health &	Jackie Talley Jackie.talley@tn.gov	615-741-8518	Treatment is available for adolescents 13-18 years of age who have a primary or secondary

		e-abuse-services/treatment---recovery/treatment---recovery/adolescent-substance-use-disorders-services-program-.html	Substance Abuse Services Providers available in Johnson City, Gray, Knoxville, Chattanooga, Nashville, Manchester, Jackson, Bolivar, Pinson, Memphis Download list of providers with contact information: https://www.tn.gov/content/dam/tn/mentalhealth/documents/Adolescent_Substance_Use_Disorders_Services_Program_Provider_Listing_FY_14-15.docm.	Contact information for providers available in Word Document	Contact information for providers available in Word Document	alcohol or other drug abuse or dependency diagnosis or co-occurring substance use and psychiatric diagnosis. Adolescent Services are available through residential, outpatient, and day treatment for youth in need of substance abuse treatment.
Treatment	Medically Assisted Treatment (MAT)	Information and listings by type of medication: https://www.tn.gov/behavioral-health/substance-abuse-	Locations depend on type of medication offered (buprenorphine,			The use of medications with counseling and behavioral therapies, to provide a "whole-patient" approach to treatment of substance use disorders

		services/treatment---recovery/treatment---recovery/opioid-treatment-programs.html	methadone, naltrexone)			

Criminal justice services

Find out more about TN Department of Mental Health and Substance Abuse Services (TDMHSAS) Office of Criminal Justice's Services: https://www.tn.gov/behavioral-health/substance-abuse-services/criminal-justice-services.html

Category	Name	Website	Address	Email	Phone #	Mission/additional information
Help for People Going to Court	Criminal Justice Behavioral Health Liaison Program	https://www.tn.gov/behavioral-health/substance-abuse-services/criminal-justice-services/help-for-people-going-to-court.html	Throughout TN		865-444-2333, ext. 1522	Available to Individuals with serious mental illness and substance abuse issues who are incarcerated or who are at risk of being incarcerated
Courts	Drug or Recovery Courts	https://www.tn.gov/behavioral-health/substance-abuse-services/criminal-justice-services/recovery-drug-court-programs-in-tn.html	Contact for locations	Ellen Abbott Ellen.l.abbott@tn.gov	615-253-7837	Offer treatment and recovery services in place of a jail sentence for non-violent offenders
Courts	Fourth Judicial Recovery Court Services, Inc.	www.services4recovery.com	Jefferson County PO Box 1246 White Pine, TN 37890	Pwill4jdc@gmail.com	865 674-2857	A and D assessments. Intensive Out patient program, basic DUI program. Transitional housing for females including pregnant females

DUI School	Driving Under the Influence (DUI) School	https://www.tn.gov/behavioral-health/substance-abuse-services/criminal-justice-services/dui-schools-in-tennessee.html	Offered throughout Tennessee Database available (In the 'Licensed Category' dropdown menu, choose Alcohol and Drug DUI School Services', then specify location): https://mh.tn.gov/CTS4/Inquiry.aspx?RPT=TDMHSAS%20License%20Inquiry	Ellen Abbott Ellen.l.abbott@tn.gov	615-253-7837	A licensed DUI School is an early intervention program that provides screening, assessment, and education for individuals convicted of driving under the influence of alcohol and/ or other drugs. The program helps individuals who want to have their driver's license reinstated or are court ordered to participate in a DUI school program.
Supervised Probation Offender Treatment	The Community Treatment Collaborative	https://www.tn.gov/behavioral-health/substance-abuse-services/criminal-justice-services/treatment-for-probation-and-parole-violators.html	Throughout TN	Ellen Abbott Ellen.l.abbott@tn.gov	615-253-7837	A substance abuse treatment service for Tennessee Department of Correction state probation and parole technical violators. Pays for court-ordered alcohol and drug treatment on a residential rehabilitation, halfway house, and outpatient basis