LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

# MODEL ACCESS TO MEDICATION FOR ADDICTION TREATMENT IN CORRECTIONAL SETTINGS ACT

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Return to Table of Contents

# MODEL ACCESS TO MEDICATION FOR ADDICTION TREATMENT IN CORRECTIONAL SETTINGS ACT

## *TABLE OF CONTENTS*



Return to Table of Contents

## SECTION I. TITLE.

This Act may be cited as the "Model Access to Medication for Addiction Treatment[1] in Correctional Settings Act," "Model Act," or "the Act."

## SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.

(a) The Legislature finds that the continuing overdose crisis has had a devastating impact on [INSERT STATE NAME].[2] Further, the Legislature finds that correctional settings (*e.g.*, jails or prisons) are key points of intervention for addressing substance use disorders and preventing overdose and death.[3]

(b) Further, individuals with untreated addiction disorders who return to opioid use upon release have an increased risk of suffering a fatal drug overdose in the period following their release as compared to the general population.[4]

(c) Medication for addiction treatment works by controlling withdrawal symptoms and both the physiological and psychological cravings that lead to drug use. These medications stabilize brain chemistry, restore disrupted metabolic functions, and act to relieve physiological cravings while blocking the euphoric effects of opioid use.

(d) Further, there is strong evidence that use of medication for addiction treatment for opioid use disorder is an extremely cost-effective intervention, especially for in-custody populations.[5] In addition, comprehensive drug treatment programs that include medication as part of treatment are associated with a reduced recidivism rate, lower post-

[1] *See* Section II's commentary for a better understanding of the term "medication for addiction treatment."

[2] This Act contains certain bracketed words and phrases (e.g., "[insert state name]"). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

[3] Researchers found that 58 percent of state prisoners and 63 percent of sentenced jail inmates met the criteria for drug dependence or abuse, compared to approximately five percent of the general population age 18 or older. Bronson, J. and Stroop, J. *"Drug use, Dependence, and Abuse among State Prisoners and Jail Inmates,"* 2007-2009. Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, NCJ 250546 (June 2017).

[4] Calcaterra, S., Blatchford, P., Friedmann, P. & Binswanger, I. (2011), Psychostimulant-related deaths among former inmates. *Journal of Addiction Med,* November 2, 2011. Binswanger *et al*. (2012). Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors. *Addiction Science & Clinical Practice*, 7:3 http://www.ascpjournal.org/content/7/1/3; Binswanger *et al*. (2016). Clinical risk factors for death after release from prison in Washington State: a nested case-control study. *Addiction.* 2016 Mar;111(3):499-510. Available online at: https://www.ncbi.nlm.nih.gov/pubmed/26476210.

[5] Substance Abuse and Mental Health Services Administration "*Medication Assisted Treatment for Substance Use Disorders*." Informational Bulletin. July 2014.

Return to Table of Contents

release mortality rates and a higher likelihood of gainful employment.[6]

(e) Therefore, it is the intent of the Legislature through this Act to:

(1) Promote the use of all FDA-approved treatment options, including medication for addiction treatment for opioid use disorder, in correctional settings;

(2) To ensure that all incarcerated people with a substance use disorder be provided access to medication for addiction treatment while incarcerated; and

(3) To ensure that, upon release from a correction setting, individuals receiving medication for addiction treatment be provided with a connection for continued care, including a prescription, and the necessary contacts and tools to continue their treatment.

## Commentary

This Act provides state legislators, policymakers, and persons in the corrections and treatment professions with a detailed, comprehensive, evidence-based framework to better respond to substance use disorders in custody settings and decrease overdose related morbidity and mortality.

As with any chronic medical condition, science and evidence inform the way approaches, this is the same with addiction treatment. Best-practices surrounding and concerning treating substance use are fluid and ever-evolving, as is the language used to describe it. Thus, while the Model Act uses the term "medication for addiction treatment" or "MAT," there are other common terms for this type of treatment including "medication-assisted treatment," "medication-based treatment," or "medications for opioid use disorder."

Currently, medication for addiction treatment in correctional settings *primarily* encompasses treatment for persons with opioid use disorder. However, this may change. Legislative provisions in this Act use the term "substance use disorder" as opposed to "opioid use disorder." This is intentional. This Model Act is a living document and is meant to be malleable and easy to adapt without the need for extensive legislative revision.

The language of the Act does not require correctional settings to meet federal requirements to create an opioid treatment program ("OTP"). An OTP is a treatment program federally accredited and certified by the Substance Abuse and Mental Health Services Administration ("SAMHSA") via approved accrediting bodies (such as the National Commission

[6] Volkow, N. D., Koob, G. F., & McLellan, A. T. (2018). "*Neurobiologic advances from the brain disease model of addiction*." *New England Journal of Medicine*, 374(4), 363-371.

Return to Table of Contents

on Correctional Health Care) to provide supervised assessment and medication for addiction treatment for individuals who have an opioid use disorder diagnosis.[7]

This Act instead provides a template to establish and implement medication for addiction treatment programs in correctional settings, while recognizing the unique needs and characteristics of each community and each correctional setting. Programs in some states and counties may choose to contract with community providers and external OTPs to deliver treatment services in custodial settings, while others may be managed entirely by correctional medical and program staff.

Finally, there are a number of excellent resources that were integral to the creation of this model act, particularly The National Council for Behavioral Health and Vital Strategies, "Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and implementation Toolkit [8] and the National Sheriff's Association's "Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field." [9]

## SECTION III. DEFINITIONS.

For purposes of this Act, unless the context clearly indicates otherwise, the words and phrases listed below have the meanings given to them in this section:

(a) Assessment. — "Assessment" means the use of an evidence-based, standardized evaluation and collateral data collection process(es) to determine the presence of substance use disorder ("SUD") and whether medication for addiction treatment is medically necessary;

(b) Buprenorphine. — "Buprenorphine" means a partial opioid agonist that is approved by the FDA for the treatment of opioid use disorder ("OUD");

(c) Community-based provider. — "Community-based provider" means an entity that primarily provides treatment services in the community rather than in an institution or isolated setting to persons with SUD and/or mental health conditions and may include

[7] Opioid treatment programs are required to have current valid accreditation status, SAMHSA certification, and Drug Enforcement Administration (DEA) registration before they can administer or dispense opioid drugs for the treatment of opioid addiction.

[8] Keith Brown *et al*., "Medication-Assisted Treatment (MAT) For Opioid Use Disorder in Jails and Prisons", thenationalcouncil.org/, 2020, https://www.thenationalcouncil.org/medication-assisted-treatment-for-opioid-use-disorder-in-jails-and-prisons/.

[9] *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, And Resources for The Field*, National Sheriff's Association, 2018), https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.

Return to Table of Contents

off-site OTPs;[10]

(d) Correctional setting. — "Correctional setting" means a jail, prison, adult or juvenile detention center, or other environment in which a person is confined by a state or local entity;

(e) Evidence-based. — "Evidence-based" means evidence-based medicine that is conscientious, explicit, and judicious in the use of current best evidence in making decisions about the care of individual patients;[11]

(f) Health care practitioner. — "Health care practitioner" means a person licensed by the professional licensing board of the state to provide health care to individuals;

(g) Medication for addiction treatment. — "Medication for addiction treatment" or "MAT" means:

(1) A drug approved by the FDA for the treatment of substance use disorder, including opioid use disorder, and/or alcohol use disorder; or

(2) The use of such a drug, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of SUD and any concomitant conditions associated with it;[12]

(h) Methadone. — "Methadone" means a full opioid agonist approved by the FDA for the treatment of OUD;

(i) Naloxone. — "Naloxone" means an opioid antagonist used for the complete or partial reversal of an opioid overdose;

(j) Naltrexone. — "Naltrexone" means an opioid antagonist that blocks opioid receptors in the brain and is used as a treatment for SUD;

(k) Opioid use disorder. — "Opioid use disorder" or "OUD" means a pattern of opioid use leading to clinically significant impairment or distress, as manifested by symptoms

[10] The definition of "community-based provider" as defined in subsection (c) of Section III is adapted from Medicaid's definition of community-based provider. "Home & Community Based Services. Medicaid". Medicaid.Gov, 2020, https://www.medicaid.gov/medicaid/hcbs/index.html.

[11] Dotson, W. David. *Evidence-Based Practice: What It Is And Why It Matters*. Office Of Public Health Genomics, Center For Surveillance, Epidemiology, And Laboratory Services, 2020, https://www.cdc.gov/genomics/about/file/print/Evidence-Based_Practice_508.pdf. Accessed 2 Sept 2020.

[12] As noted above, best-practices surrounding and concerning treating substance use are fluid and ever-evolving, as is the language used to describe it. Thus, while the Model Act uses the term "medication for addiction treatment," or "MAT," there are other terms for this type of treatment including "medication-assisted treatment," "medication-based treatment," or "medications for opioid use disorder."

Return to Table of Contents

identified in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association or its successor;

(l) Peer support workers. — "Peer support workers" means individuals who have been successful in their recovery process and who help others through shared understanding, respect, and mutual empowerment, and who help people become and stay engaged in the recovery process and reduce the likelihood of relapse;[13]

(m) Program participant. — "Program participant" means an incarcerated person with SUD or drug or alcohol dependence for whom medication for addiction treatment is clinically indicated and who elects to participate in such treatment;

(n) Qualified provider. — "Qualified provider" means a person who has met the necessary requirements to administer, dispense, or prescribe medication for addiction treatment;

(o) Recovery. — "Recovery" means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential;

(p) Screening. — "Screening" means an evidence-based strategy used to:

(1) Identify conditions or risk markers for SUD;

(2) Determine whether an individual needs treatment for SUD;

(3) Assess the extent of the individual's treatment needs; and

(4) Ensure that the individual receives access to the recommended treatment;

(q) Substance use disorder. — "Substance use disorder" means a pattern of use of alcohol or other drugs leading to clinical or functional impairment, in accordance with the definition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association, or any in any subsequent editions;

(r) Telemedicine. — "Telemedicine" means the delivery of health care services through interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment; and

(s) Withdrawal management. — "Withdrawal management" refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of "detoxing" or ceasing or reducing use of an opioid, alcohol, or other drug.

[13] "Who are Peer Workers" SAMHSA, available at https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers (last accessed on June 18, 2020).

Return to Table of Contents

## Commentary

The use of the term "correctional setting" as defined in subsection (d) is intended to encompass a plethora of settings wherein a person who is incarcerated or detained might receive medical treatment for a substance use disorder without using terms likely to have already-established meanings under state law.

"Correctional setting" includes prisons, jails or other settings where the person might be incarcerated either before, during, or after arrest or trial.

As of August 2020, medications approved by the FDA for the treatment of SUD include buprenorphine (typically in combination with naloxone), naltrexone, and methadone.

The term "whole-patient" as used in the definition of medication for addiction treatment in subsection (h) refers to the federal requirements regarding the provision of counseling in association with certain medications.[14]

## SECTION IV. MEDICATION FOR ADDICTION TREATMENT PROGRAM IN CORRECTIONAL SETTINGS.

(a) In general.— The [Commissioner of the Department of Health][15], in conjunction with the [Commissioner of the Department of Corrections], the state director for alcohol and drug treatment, and any other state agency as appropriate, shall establish a medication for addiction treatment program to be administered in correctional settings in the state. Pursuant to this Act, the program shall include:

(1) Access to all forms of medication for addiction treatment for the duration of a program participant's incarceration; and

(2) Initial and ongoing training and technical assistance for correctional setting staff, including health care practitioners, in each facility.

(b) Local correctional settings.— Pursuant to this section, the [Commissioner of the Department of Health] in consultation with local governmental units, county sheriffs, local departments of health, corrections and other governmental entities, shall implement medication for

[14] 42 C.F.R. § 8.12(f) (2020); *see also,* "Medication and Counseling Treatment". *Samhsa.Gov*, 2020, https://www.samhsa.gov/medication-assisted-treatment/treatment#counseling-behavioral-therapies, *see also Medication National Practice Guideline For The Treatment Of Opioid Use Disorder: 2020 Focused Update.*. American Society of Addiction Medicine, 2019, pp. 48-50, https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2.

[15] The state may want to determine the agency or department best equipped to oversee the program

addiction treatment program in jails.

(c) Services.— The services to be provided by the programs established in subsections (a) and (b) of this section shall be in accordance with accepted medical standards and plans developed by participating local governmental units, in collaboration with county sheriffs, considering local needs and available resources. These plans must be approved by the commissioner(s).

(d) Minimum required services. — Services provided in this section shall include, but not are not limited to, the following:

(1) Benzodiazepine, stimulant, heroin, alcohol, and opioid withdrawal management;

(2) Access to all forms of medication for addiction treatment to ensure that each program participant receives the particular form found to be the most effective at treating and meeting their individual needs;

(3) Group and individual counseling and clinical support;

(4) Peer support services;

(5) Reentry planning; and

(6) Reentry and transitional support.

(e) Exemption.— Upon application of a correctional setting that is unable to meet the requirement that program participants have access to all forms of medication for addiction treatment, the commissioner may grant a limited exemption if the commissioner determines that:

(1) There are no providers within a reasonable distance of the correctional setting that have received the required accreditation, certification, or waiver; and

(2) No alternative arrangement for storage and delivery of medications is feasible.

(f) Services referral. — Correctional settings may choose to enter into an agreement with another correctional facility to provide medication for addiction treatment services pursuant to the requirement that the commissioner and any other relevant parties shall periodically review such agreement.

(g) Pre-existing programs.— Any medication for addiction treatment program that is operative at the time this Act becomes effective that meets or exceeds the standards set forth in this section shall be deemed to have met the requirements of this section. Such programs shall certify annually in writing to the commissioner that they have met or exceeded the standards

set forth herein.

(h) **Optional** [Local correctional settings.— Pursuant to this section, each local government unit, in consultation with the state's behavioral health agency, shall implement medication for addiction treatment in jails.]

### Commentary

Subsection (b) of Section IV provides a legislative framework for the implementation of medication for addiction treatment language when the state itself oversees local correctional settings, such as jails. Optional subsection (h) provides alternative language for implementation of Section IV in states where local jails are largely autonomous from oversight by the state's department of corrections or a similar department or agency.

## SECTION V. PROGRAM REQUIREMENTS.

(a) In General. — Correctional settings shall provide program participants in each medication for addiction treatment program with access to medications for the treatment of SUD.

(b) Participation. — The decision to participate in a medication for addiction treatment program shall be made by the program participant. The decision as to which available federally approved medication is administered, dispensed, or prescribed shall be between the qualified provider and the program participant.

(c) Assessment. — Immediately upon an individual's arrival at the correctional setting, upon request, at any time during incarceration, or if medically or clinically indicated, qualified staff at the correctional facility shall conduct an assessment using a designated evidence-based tool to evaluate the individual for an SUD. The assessment should be standardized across correctional settings within the State and should be based on the criteria for diagnosing SUD as set out in the Diagnostic and Statistical Manual of Mental Disorders ("DSM-V") or its successor.

(d) Qualified Providers. — Each correctional setting shall have staffing agreements with a sufficient number of qualified providers or health care practitioners authorized by law to administer each medication for addiction treatment to ensure access to their medications by program participants, unless the facility has received an exemption pursuant to Section IV.

(e) Program procedure. — following the assessment provided for in subsection (c) of this section, an individual assessed as having an SUD, for which an available federally approved

medication, exists shall be offered placement in the medication for addiction treatment program.

(f) Medical Evaluation. — Potential program participants shall be provided access to a qualified provider or health care practitioner for the following purposes:

(1) To perform a medical examination to determine if the potential program participant is a candidate for any or all medications to treat for substance use disorder;

(2) To explain the risks and benefits of medication for addiction treatment;

(3) To administer and oversee the induction phase of initiating treatment with medication, if applicable; and

(4) To monitor the patient's response.

(g) Placement.— Participation in the medication for addiction treatment program shall not be mandatory nor shall program participation be denied to any individual who is assessed as having a substance use disorder and who wishes to participate.

(h) Commencement.— Incarcerated persons may elect to undergo assessment and, if clinically indicated, commence participation in the medication for addiction treatment program at any time during the course of the person's incarceration, including immediately prior to their release.

(i) Denial.— No person shall be denied participation in or dismissed from the medication for addiction treatment program on the basis of a positive drug screen. No person shall be removed from or denied participation in the medication for addiction treatment program due to administrative segregation or as a result of having received any disciplinary infraction, including those not related to drug use.

(j) Fee.— Program participants shall not be charged a fee for participation in the program or for their medication.

(k) Continuation of treatment.— A person using medication for addiction treatment prior to such person's confinement in a correctional setting shall be eligible, upon verification and request by such person, to continue such treatment in the medication for addiction treatment program, consistent with the individual's choice and the clinical recommendations of the individual's qualified provider.

(l) Discontinuance.— A program participant may elect to discontinue medication for addiction treatment. In such cases, discontinuation shall adhere to a medically appropriate tapering

protocol.

(m) Program components. — The medication for addiction treatment program created pursuant to this Act shall provide an individualized treatment plan for each program participant developed in conjunction with the program participant and a qualified provider or health care practitioner. Each plan shall provide medication(s) and an appropriate level of counseling and recovery support.

(n) Policies and procedures. — Each correctional setting shall implement program policies and procedures that address the following:

(1) Administration of medication to program participants;

(2) Communication and coordination between medical staff and correctional staff;

(3) Communication and coordination between jail, medical staff, and third-party providers, if applicable;

(4) Maintenance of medication inventory consistent with state and federal laws, where applicable;

(5) Mechanism for medication administration, dosing, and delivery, developed in collaboration between correctional and medical staff;

(6) Challenges by potential program participants to determinations related to participation in the medication for addiction treatment program;

(7) Agreements with community-based providers to facilitate re-reentry and access to treatment post-release;

(8) Implementation of best practices for reducing diversion of medication for addiction treatment; and

(9) The use of telemedicine, where applicable.

## Commentary

Informed consent and patient choice are key components of successful medication for addiction treatment and, consequently, are included in the treatment and assessment provisions of this Act. The American Medical Association's stance on this subject is to urge respect for the incarcerated person and their autonomy and to strive to obtain informed consent from incarcerated patients to the fullest extent possible.[16] Further, federal law requires that treatment

[16] Annalise Norling, "AMA Code of Medical Ethics' Opinions Related to Health Care for Incarcerated People", Journal of Ethics | American Medical Association, 2017, https://journalofethics.ama-assn.org/article/ama-code-medical-ethics-opinions-related-health-care-incarcerated-people/2017-09.

Return to Table of Contents

be voluntary and that each patient give informed, written consent to that treatment. [17] Finally, it is important that program participants feel that they can discuss decisions made related to medication for addiction treatment.18

One of the goals of this section is to curb or limit dangerous drug withdrawal. Drug withdrawal, particularly when there is concurrent alcohol use, may cause fatalities if not monitored properly. If not adequately monitored, complications associated with opioid withdrawal may be underestimated, especially for older individuals and those with other medical conditions.[19] Because correctional settings process more opioid and other drug withdrawals than other institutions, it is crucial that withdrawal is managed through appropriate medical supervision.[20]

Pregnant women should receive special assessment and treatment for substance use disorder. Data reveals that from 2000 to 2009, the use of opioids during pregnancy increased from 1.19 to 5.63 per 1,000 hospital births.[21] Abrupt discontinuation of opioids at any time can be dangerous. This is particularly true of use during pregnancy which can result in premature labor, fetal distress, and miscarriage.[22] Each pregnant women identified as having a substance use disorder in a correctional setting should receive an immediate assessment and should be offered medication to prevent the onset of withdrawal symptoms. Pregnant women should also receive long-term medication for addiction treatment as soon as practicable and throughout the pregnancy and the postpartum period and/or until release and linkage with a community provider to ensure continuity of care.

## SECTION VI. TRAINING AND EDUCATION.

(a) In general. — The [Department of Corrections], in conjunction with the [Department of Health] and the state drug and alcohol authority and/or appropriate jurisdictional health authority, shall provide or ensure, as applicable, ongoing training for staff in correctional settings regarding medication for addiction treatment.

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[17] "[A] program physician shall ensure that each patient voluntarily chooses maintenance treatment and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient, and that each patient provides informed written consent to treatment." (42 CFR § 8.12(e)(1)).

[18] AMA Code of Medical Ethics' Opinions Related to Health Care for Incarcerated People", Journal of Ethics | American Medical Association, 2017.

[19] Dark S., Farrell M., "*Yes, people can die from opiate withdrawal*," *Addiction* 11. no. 2 (Jan. 2017): 199-200, available at https://onlinelibrary.wiley.com/doi/full/10.1111/add.13512.

[20] *Id*. citing Fiscella K., Pless N., Meldrum S., Fiscella P. "*Alcohol and opiate withdrawal in US Jails*." *Am J Public Health* 2004; 94: 1522–4. It is also important to note that a participant does not have to be fully in withdrawal to join the program and in fact may medications like methadone to help manage opioid withdrawal. *See* "Guidelines for The Psychosocially Assisted Pharmacological Treatment of Opioid Dependence.". No. Annex 12, 2009. *National Center for Biotechnology Information*, doi: Prescribing Guidelines. Accessed 3 Aug 2020.

[21] Lipari R., Smith K., "Women of Childbearing Age and Opioids," *Center for Behavioral Health Statistics and Quality Report* (last accessed November 12, 2019). (https://www.samhsa.gov/data/sites/default/files/report_2724/ShortReport-2724.html).

[22] *Id*.

(b) Correctional staff. — Prior to implementation of a medication for addiction treatment program and on an ongoing basis for new and existing staff, all staff at a correctional setting shall receive regular training on topics related to medication for addiction treatment in correctional settings, including but not limited to:

(1) The use of FDA-approved medications to reverse an opioid overdose;

(2) The medication for addiction treatment program;

(3) Substance use disorder, including opioid use disorder, and the standard of care for treating substance use disorder, as well as the risks associated with discontinued use of opioids, including morbidity and mortality;

(4) Screening, assessment, and treatment protocols for substance use disorders, including alcohol use disorder, and methods to identify individuals at risk of developing a substance use disorder; and

(5) Promising practices and the correctional setting's specific policy for addressing diversion of medication used in medication for addiction treatment, including implementation of communication protocols and procedures that involve both health care and correctional security staff.

(c) Education. — The [Department of Health], in conjunction with other appropriate state and local agencies, shall disseminate information on medication for addiction treatment for SUD to the public. This shall include:

(1) Targeted information to groups most impacted by and at risk of overdose and marginalized communities; and

Widely disseminated information on who is impacted by substance use and opioid use disorder, what medication for addiction treatment consists of, the potential benefits of medication for addiction treatment, and other educational information.

## Commentary

Stigma about individuals who suffer from a substance use disorder is driven by stereotypes about their perceived moral failings or dangerousness. While the public is beginning to recognize that a substance use disorder is a chronic medical condition, the use of medication to manage or treat a substance use disorder is still is perceived by many as wrong or simply replacing one drug for another. This perception exists despite evidence that medication for

Return to Table of Contents

addiction treatment reduces morbidity, increases treatment retention, and improves the well-being of individuals who struggle with substance use disorder.[23]

Unfortunately, the prevalence of negative beliefs surrounding medication for addiction treatment also extends to those who work within correctional settings.[24] For patients with a substance use disorder, "critical treatment decisions often occur in the law enforcement and judicial systems rather than in medical settings."[25] This is why staff engagement prior to the implementation of medication for addiction treatment program is crucial.[26]

## SECTION VII. REENTRY AND TREATMENT.

(a) In general. — The medication for addiction treatment program shall include plans for a reentry strategy for program participants that begins upon admission into the program and can be initiated quickly.

(b) Reentry. — Pursuant to subsection (a) of this section, upon admission of a program participant to the medication for addiction treatment program, the correctional setting shall develop a plan of reentry that:

(1) Includes information regarding post-incarceration access to medication for addiction treatment and supportive therapy in the geographic region in which the person will reside upon release that can offer continuity of care without interruption of treatment;

(2) Provides the program participant with a copy of his or her prescription upon release, as applicable, and any other documentation necessary for continuity of care, and is called into a pharmacy of the participant's choosing;

(3) Requires the participant be given a supply of any necessary medication, where applicable and permissible under state and federal laws and regulations, to continue their treatment regimen;

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[23] Mancher M., Leshher AL., *Medications for Opioid Use Disorder Save Lives,* National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder (Washington, DC: National Academies Press) 2019.

[24] *Id.*

[25] "A survey of prison medical directors across the United States revealed that many were not familiar with the medical and social benefits of providing medications for OUD—particularly buprenorphine—in correctional facilities] *Id.* citing to McKenzie, M., Nunn, A., Zaller, N. D., Bazazi, A. R., & Rich, J. D. (2009). *Overcoming obstacles to implementing methadone maintenance therapy for prisoners: implications for policy and practice*. Journal of opioid management, 5(4), 219–227. https://doi.org/10.5055/jom.2009.0024 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2936228/).

[26] Ross MacDonald, MD, *MAT in CJ Settings: Foundations of Staff Buy-in.*" Presentation at Medications for Opioid Use Disorder (MOUD) in Corrections conference, Providence, Rhode Islands (January 2020).

(4) Includes referrals and affirmative linkages to care:

(A) To an available opioid treatment program (OTP), qualified provider, or health care practitioner in the participant's geographic area that can administer, dispense, or prescribe medication for addiction treatment to the participant upon release;

(B) To supportive therapy as clinically indicated; and

(C) To peer support, pursuant to subsection (c) of this section;

(5) Provides a scheduled appointment with a community-based OTP, qualified provider, or health care practitioner who is able to accept the program participant as a patient;

(6) Provides the participant with assistance in obtaining health insurance;

(7) Provides information on available housing, employment, and transportation resources and any other information that will assist the participant in continued recovery once released; and

(8) Provides program participants with naloxone and education on its use.

(c) Peer support services. — If available, the reentry treatment plan shall ensure that a program participant is directly connected to an individual within the geographic area in which they will reside upon release who is authorized by the state to provide peer support services.

(d) Parole and Probation. — Reentry planning should include a collaborative relationship between the program participant's qualified provider or health care practitioner and parole or probation staff, as applicable, including timely sharing of accurate information regarding the program participant's medication for addiction treatment regimen. Additionally, the [Department of Corrections] shall develop procedures to provide any program participant who notifies their probation or parole officer of a relapse/recurrence or who receives a positive drug screen with substance use disorder support in lieu of arrest, incarceration, or revocation of probation or parole.

(e) No violation for medication for addiction treatment. — Once released from the correctional setting, a program participant shall not be subject to a parole or probation violation solely due to the use of or decision to either continue or discontinue the use of medications for addiction treatment.

## Commentary

Individuals are at a substantially increased risk of an overdose death during the first two weeks post-release,[27] and the continued use of methadone and buprenorphine substantially reduces this risk.[28] Thus, subsection (b) of Section VII requires that a program participant be provided continuity of care after release. This may include ensuring that he or she has as a "last dose letter" or a "bridge prescription" that is called into a pharmacy of the participant's choosing as well as a supply of any necessary medication, where applicable and permissible under state and federal laws and regulations, to continue their treatment regimen.

Subsection (c) of Section VII requires that the person leaving custody be connected to a peer support specialist in his or her geographic area if one is available. Peer support can be an important component of recovery from a substance use disorder. The creation and implementation of a peer support program is beyond the purview of this Act; it is worth noting, however, that over 40 states have some form of formalized peer support program and that combining state peer support programs with medication for addiction treatment increases the likelihood of recovery.[29]

An important component of reentry and treatment is insurance. Continuity in providing medication for addiction treatment after a program participant's incarceration has ended is imperative. While tackling the inclusion or revision of state insurance programs or Medicaid may also be beyond the purview of the Model Act a few examples of what states have done to help citizens access Medicaid can be offered.[30] In Arkansas, the state passed law to remove barriers

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[27] Merrall, E. L., Kariminia, A., Binswanger, I. A., Hobbs, M. S., Farrell, M. Marsden, J. Bird, S. M. (2010). *Meta-analysis of drug-related deaths soon after release from prison*. *Addiction*, 105(9) 1545-1554.

[28] Green, T. C., Clarke, J., Brinkley-Rubinstein, L., Marshall, B., Alexander-Scott, N., Boss, R., & Rich, J. D. (2018). *Post incarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system*. *JAMA Psychiatry*, 75(4) 405-407.

[29] Kaufman, L., Kuhn, W., & Stevens Manser, "*Peer Specialist Training and Certification Programs: A National Overview*" Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin (2016), available at http://sites.utexas.edu/mental-health-institute/files/2017/01/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview-2016-Update-1.5.17.pdf.

[30] In general, a substantial number of persons incarcerated in correctional settings are, or will be, on Medicaid. (The Pew Charitable Trusts, "*How and When Medicaid Covers People Under Correctional Supervisions: New Federal Guidelines Clarify and Revise Long-Standing Policies*," (Issue Brief) available at https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision (last accessed December 4, 2019)(citing to Danielle Kaeble *et al*., "Correctional Populations in the United States, 2014," Bureau of Justice Statistics (January 2016), available at http://www.bjs.gov/content/pub/pdf/cpus14.pdf.)) In order to reduce medical costs associated with those who are released without insurance or not receiving Medicaid, it would be productive to suspend, rather than terminate, Medicaid coverage when someone is incarcerated. In fact, the Centers for Medicare & Medicaid Services ("CMS"), a unit of the U.S. Department of Health & Human Services, explicitly encourage states not to terminate coverage for enrolled inmates during their times in correctional settings and instead suggests that states suspend or toll Medicaid coverage until release or until enrollees receive off-site inpatient care. A person who is involved with the criminal justice system can also receive Medicaid benefits but only if he or she meets the state's eligibility criteria for all residents. This group also includes those arrested but released pending trial, parolees, and individuals under home arrest. (*Id.*) This would allow Medicaid services to seamlessly resume or immediately take effect after release from a correctional setting, which would ensure continuity of treatment. Further, Federal law and regulations do not

that would require prior authorization for medication for addiction treatment.[31] This is also true in Delaware,[32] Missouri,[33] Maryland,[34] and Vermont[35] and several other states. Further, in response to the ongoing opioid epidemic and recent changes to federal guidelines, Medicaid programs in California, Colorado, the District of Columbia, Illinois, and New Jersey now cover all formulations of buprenorphine, with no prior authorization requirements.[36]

## SECTION VIII. ADDITIONAL REQUIREMENTS

Any additional guidelines or standards not contemplated within this Act shall be promulgated by regulation and shall be based on the most current recommendations set out by the National Center for Correctional Health Care on medication for addiction treatment in correctional settings.

## Commentary

The intent of Sections VI through VIII is to provide a legislative framework for assessing, screening, and treating persons in state and local correctional settings who may have a substance use disorder. This framework would not be possible without the guidance provided by the National Center for Correctional Health Care ("NCCHC"). As a nationally recognized organization, the NCCHC provides benchmark and voluntary accreditation for health service systems and the governance and administration of these systems in correctional settings.[37] These benchmarks include the screening and assessment of persons for substance use disorder and provide detailed recommendations that are better suited for implementation through regulation because of the changing nature of medication for addiction treatment practices and evolving research on this subject.

require that a state terminate Medicaid enrollment when a person is incarcerated, but the law does prohibit federal payments for that person's health care costs while he or she is in prison or jail (excluding the inpatient exception). (*Id*.) Guidance from CMS in April 2016 clarifies that states must accept applications from people who are incarcerated and enroll or reenroll them if determined eligible. This guidance from the federal government encourages states to suspend enrollment or coverage by using markers or other indicators in the claims processing system that help ensure that claims submitted by states are denied for disallowed services provided to people who are incarcerated.

[31] Ark. Code Ann. § 23-99-1119 (eff. April 12, 2019).

[32] Del. Code Ann. tit. 18, § 3571V (eff. January 13, 2020).

[33] Mo. Ann. Stat. § 191.1165 (eff. August 28, 2019).

[34] Md. Code Ann., Ins. § 15-851 (eff. May 25, 2017).

[35] Vt. Stat. Ann. tit. 18, § 4754 (eff. Jan. 1, 2020).

[36] A. Gupta, E. Weber, "*State Medicaid Programs Should Follow the 'Medicare Model' Remove Prior Authorization Requirements for Buprenorphine and Other Medications to Treat Opioid Use Disorders*," Legal Action Center, P. 2, available at https://lac.org/wp-content/uploads/2019/07/access-to-meds-in-medicaid-eweber-FINAL-070919.pdf.

[37] "About Us" National Commission on Correctional Health Care, accessed March 18, 2020, https://www.ncchc.org/about.

Return to Table of Contents

## SECTION IX. CONFIDENTIALITY.

In general. — All individuals and entities operating pursuant to this Act shall adhere to:

(1) The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191 (Aug. 21, 1996).

(2) Federal confidentiality laws and regulations, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2; and

(3) All state laws and regulations that protect relevant health information. [Insert citations for state law and regulation(s)].

### Commentary

Patient privacy can be a particularly sensitive area to navigate as applied to persons in recovery from a substance use disorder.[38] Often, there may be multiple care providers and entities that require access to a participant's electronic medical records. However, these persons or entities may not be held to the same standard of data protection. This section is designed to protect patient privacy while still making health records accessible to persons involved in the treatment of program participants. Existing state privacy records may have to be evaluated to ensure that these laws are not overly restrictive and do not inhibit necessary and meaningful information sharing that can expedite and enhance medication for addiction treatment in correctional settings.

## SECTION X. REPORTING.

(a) In general. — The [Department of Corrections] and the [Department of Health] shall, within one year of the effective date of this Act and annually thereafter, deliver a report to the governor and the state legislative committees on [public health or equivalent] on data collected from medication for addiction treatment in correctional settings program. enacted or governed pursuant to this Act.

(b) Required elements. — The report required in subsection (a) shall include data collection, and analysis to include:

(1) The impact of the medication for addiction treatment program on participants, including factors such as the rate of opioid overdose mortality upon reentry, before

[38] Hu, L. L., Sparenborg, S., & Tai, B. (2011). *Privacy protection for patients with substance use problems*. *Substance abuse and rehabilitation*, *2*, 227–233, (last accessed January 3, 2020).

Return to Table of Contents

and after correctional medication for addiction treatment program implementation, behavior infraction rates, recidivism rates, HIV and hepatitis C treatment rates, program participation, and program retention among other related relevant factors;

(2) The impact of the medication for addiction treatment program on institutional safety and performance;

(3) Estimated cost savings of implementing withdrawal management and medication for addiction treatment programs.

(4) Any recommendations for additional legislative enactments that may be needed or required to improve or enhance the program as determined to be appropriate by the commissioner;

(c) Additional data. — The following specific data points shall also be included in the report:

(A) Number of incarcerated persons assessed to have a substance use disorder; and

(B) Number of participants in the medication for addiction treatment program and recidivism rates of participants.

(d) Regulations. — The [Department of Corrections] and [Department of Health] pursuant to subsection (b) of this section shall promulgate regulations implementing this Section within one-hundred and twenty (120) days of adoption of the effective date of this Act.

## Commentary

Tracking, monitoring, and evaluating, the efficacy and success of a medication for addiction treatment program is crucial to sustaining effective programs. Some states have coordinated with universities and other institutions of higher learning to conduct the evaluations, as well as to track and conduct research related to medication for addiction treatment programs in correctional settings. For example, in New Jersey, the Department of Corrections and other stakeholders have worked with Rutgers University to create a peer support program, a key component of the state's approach to ensuring that persons leaving prison have support[39]. By partnering with a university, states can expand their research resources and ability to analyze data about the implementation of medication for addiction treatment in their state.

## SECTION XI. FUNDING.

(a) In general. — The Legislature shall appropriate [$ _____] to the [Department of

[39] Patti Verbanas, "Rutgers Provides Hope for Ex-Offenders Navigating Recovery and A Life Beyond Bars", Impact.Rutgers.edu, 2020, https://impact.rutgers.edu/irts.

Return to Table of Contents

Corrections] for the purpose of funding services provided as part of medication for addiction treatment in state and local correctional settings and pursuant to this Act and shall appropriate [$ _____] to the [Department of Health] or state substance use authority for the purpose of funding services provided as part of medication for addiction treatment in state and local correctional settings.

(b) Federal funds. — The state will pursue federal funding, matching funds, grants, and foundation funding for the initial start-up and ongoing activities required under this Act, both for funding for state agency activities and local-specific activities related to medication for addiction treatment.

(c) Guidelines and requirements. — Funding shall be made available to support both new and existing medication for addiction treatment programs in a broad spectrum of geographic regions within the state including urban, suburban, and rural communities.

## Commentary

Research indicates that in the long-term, any type of medication for addiction treatment programs in correctional settings saves states money. According to the 2018 Substance Abuse and Mental Health Services Administration TIP 63: Medications for Opioid Use Disorders, "[d]ata indicate that medications for opioid use disorder are cost effective and cost beneficial."[40] Persons with substance use disorder who successfully complete treatment are less likely to relapse and recidivate. Funding medication for addiction treatment is a cost-saving measure.

Medication for addiction treatment in correctional settings also provides additional economic benefits. In New Jersey "[a] striking 91 percent of individuals receiving the MAT [medication assisted therapy] course complete" treatment successfully, compared with only 50 percent who receive other forms of treatment.[41] This is compared to individuals who receive other forms of substance use disorder treatment, where only 50 percent successfully complete treatment.[42]

Section XI provides general language to enable a state legislature to fund the appropriate entities to implement medication for addiction treatment in correctional settings within the state. This is purposeful. The ways that a state could fund and implement medication for addiction treatment are myriad and as the language in Section XI indicates, there are different funding avenues that states can take advantage of to help offset the cost of establishing or expanding medication for addiction treatment programs. Further, states often house their incarcerated

[40] *TIP 63: Medications for Opioid Use Disorder*. SAMHSA, 2020, pp. 1-7, Accessed 23 Nov 2019.
[41] "Drug Treatment in NJ's Jails Helps Break Cycle of Crime and Addiction", North jersey, 2018, https://www.northjersey.com/story/news/2018/08/06/drug-treatment-nj-jails-helps-break-cycle-crime-and-addiction/913078002.
[42] *Id.*

Return to Table of Contents

population in county jails. As a result, states should also increase payments to counties to offset the cost of providing additional medication for addiction treatment for persons in state correctional settings.

There is also federal funding available to combat the opioid crisis. In 2017-2018, the federal government included nearly $11 billion for these type of programs in the federal budget.[43] "These programs span the continuum of care, including prevention, treatment, and recovery."[44] A combination of state and federal funding can significantly increase the monies available for the state opioid response. In Arizona, for example, the state's coordinated response to the opioid crisis included access to several federal grants, increasing Arizona's share of federal expenditures to address the opioid epidemic from $75,873,531 in 2017 to $117,058,843 in 2018.[45] The 54 percent increase translates to a per capita increase from $11 dollars per person to $17 per person.[46] This has had a direct impact on Arizona's ability to respond to the opioid crisis. With the funds from just one of the federal grants, Arizona reported that the state was able to treat 4,447 people for opioid use disorder.[47] Over the same period, over 3,000 people received recovery support services through the federal funding and over 8,000 naloxone kits were purchased.[48]

Finally, a potential funding source for medication for addiction treatment programs are opioid settlement funds. Opioid settlement funds are funds recovered by a state attorney general from litigation against the pharmaceutical industry, including pharmaceutical manufacturers or distributors.[49] Legislation should be considered that requires opioid settlement funds be allocated to cover costs associated with establishing a medication for addiction treatment program in state prison or county jails.

## SECTION XII. RULES AND REGULATIONS.

[Relevant state agencies and officials] shall promulgate such rules and regulations as are necessary to effectuate this Act.

## SECTION XIII. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the remaining provisions of this Act shall not be affected nor diminished.

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[43] *Tracking Federal Funding to Combat the Opioid Crisis*, (repr., Bipartisan Policy Center, 2019), https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf.
[44] *Id.* at 14.
[45] *Id.* at 19.
[46] *Id*.
[47] *Id. at 23.*
[48] *Id*.
[49] Zezima, Katie. "Ohio Tries An Unusual Tactic Toward Opioid Settlement: Working Together". *Washington Post*, 2020, https://www.washingtonpost.com/national/ohio-tries-an-unusual-tactic-toward-opioid-settlement-working-together/2020/02/24/d5923faa-4c48-11ea-9b5c-eac5b16dafaa_story.html. Accessed 2 Sept 2020.

Return to Table of Contents

## SECTION XIV. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of determination of the effect].

Return to Table of Contents

# ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

Based in Washington D.C., and led by and comprised of experienced attorneys, the Legislative Analysis and Public Policy Association is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

LAPPA produces timely model laws and policies that can be used by national, state, and local public health, public safety, and substance use disorder practitioners who want the latest comprehensive information on law and policy as well as up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to fact sheets. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorders, medication-assisted treatment in correctional settings, and the involuntary commitment and guardianship of individuals with alcohol or substance use disorders.


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