LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

MODEL WITHDRAWAL MANAGEMENT PROTOCOL IN CORRECTIONAL SETTINGS ACT

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SECTION I. SHORT TITLE.

This Act may be cited as the "Model Withdrawal Management Protocol in Correctional Settings Act," "Model Act," or "the Act."

SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.

(a) The Legislature finds that:

(1) Adverse outcomes and deaths related to acute intoxication and drug use upon entering correctional settings and during incarceration have significantly impacted [State];[1]

(2) Correctional settings are key points of intervention for addressing mental health disorders, substance use disorders (SUD), and preventing related injury and death;

(3) Newly incarcerated individuals who use alcohol and/or drugs often require medical intervention to mitigate the effects of withdrawal symptoms and prevent death, suicide, and injury while in custody. As of 2019, the nearly 3,200 jails in the United States housed 734,500 people.[2] The most recent data available show that nearly two-thirds (63 percent) of sentenced individuals in jails met the criteria for drug dependence or "abuse."[3] A survey conducted by the Bureau of Justice Assistance, U.S. Department of Justice, found that just 19 percent of people serving sentences in jails who met the diagnostic criteria for "substance abuse or dependence" received any type of drug treatment while incarcerated;[4]

(4) A 2019 report from the Bureau of Justice Statistics, U.S. Department of Justice found that:

(A) Drug and alcohol intoxication deaths in custody more than quadrupled from 2000 to 2018, from 37 to 178 deaths per 100,000 individuals in custody;

(B) Suicide remained the leading cause of death in local jails in 2018, accounting

[1] This Act contains certain bracketed words and phrases (*e.g.*, "[insert state name]" or [Oversight Agency"]). Brackets indicate instances where state lawmakers will need to insert state-specific terminology or facts.
[2] U.S. DEP'T OF JUST., OFF. OF JUST. PROGRAMS, BUREAU OF JUST. STAT., JAIL INMATES IN 2019 (2021), https://bjs.ojp.gov/content/pub/pdf/ji19.pdf.
[3] U.S. DEP'T OF JUST., OFF. OF JUST. PROGRAMS, BUREAU OF JUST. STAT., DRUG USE, DEPENDENCE, AND ABUSE AMONG STATE PRISONERS AND JAIL INMATES, 2007-2009 1 (2020), https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf.
[4] *Id*.

for almost 30 percent of jail deaths; and

(C) From 2000 to 2018, individuals in custody who died of drug or alcohol intoxication had served a median of one day in jail prior to death.[5]

(5) Untreated withdrawal in custody exacerbates the risk of suicide, particularly for individuals with underlying mental health conditions. Not surprisingly, mental health disorders are prevalent among individuals in custody. A 2017 Bureau of Justice Statistics report found that 44 percent of people in jails had a prior mental health disorder diagnosis by a professional.[6] Moreover, nearly 50 percent of incarcerated people with mental health disorders also have a history of non-medical drug use;[7] and

(6) Comprehensive clinical and administrative protocols addressing withdrawal in custody are necessary to ensure compliance with federal and state civil rights laws, including the Americans with Disabilities Act,[8] the Eighth Amendment as applied to the states under the due process clause of the Fourteenth Amendment,[9] the Civil Rights Act of 1871[10] (hereinafter "the Civil Rights Act" or "42 U.S.C. § 1983"), and [relevant state civil rights laws].

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

(1) Establish and implement evidence-based clinical and administrative protocols for ensuring safe, medically-managed withdrawal from benzodiazepines, alcohol, opioids, stimulants including methamphetamines, and [any other specific substance added to this list by the legislature], and/or induction or continuation of medications for the treatment of substance use disorders for all individuals in custody where clinically indicated;

(2) Ensure that, upon entry into a correctional setting, individuals who are receiving

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[5] E. Ann Carson, *Mortality in Local Jails 2000-2019- Statistical Tables*, 1-3, BUREAU OF JUST. STAT. (2021), https://www.bjs.gov/content/pub/pdf/mlj0018st.pdf.

[6] JENNIFER BRONSON, PH.D. & MARCUS BERZOFSKY, DR. P.H., BUREAU OF JUST. STAT., INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS AND JAIL INMATES, 2011-12, 3, (2017), https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

[7] Tala Al-Rousan et al., *Inside the Nation's Largest Mental Health Institution: A Prevalence Study in a State Prison System,* 17 BMC PUB. HEALTH 342 (2017), https://doi.org/10.1186/s12889-017-4257-0.

[8] Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12101-12213 (2018).

[9] *See* U.S. CONST. amend. VIII; U.S. CONST. amend. XIV § 1.

[10] The Civil Rights Act of 1871, 42 U.S.C. § 1983 (1996).

FDA-approved medication(s) for a substance use disorder, psychiatric condition(s), and/or medical condition(s) in the community are provided continued care and timely access to prescribed medications while detained, and upon reentry, consistent with the correctional setting's policies and procedures related to medication verification;

(3) Ensure that all correctional and health staff receive initial and ongoing training and education as determined by [Oversight Agency] on the signs, symptoms, and treatment protocols related to withdrawal, substance use disorders, and related medical and mental health conditions;

(4) Conduct ongoing evaluation of practices and quality control as determined by [Oversight Agency] related to withdrawal management and treatment in correctional settings;

(5) Ensure that accurate and comprehensive medical records are maintained;

(6) Prioritize funding for correctional health services in state, county, prison, and jail budgets; and

(7) Proactively implement a systems approach to risk mitigation and reform in correctional settings.

Commentary

This Act provides state legislators, policymakers, and those in the correctional and health care professions with a detailed, comprehensive, evidence-based framework to better respond to withdrawal symptoms and related mental health crises of individuals in custody and decrease their mortality while in correctional settings. This Act is intended to apply to both local jails and state prisons; however, it may be adapted to apply only to jails.

Data shows that the issue of safe withdrawal in custody is pervasive. For example, the Westmoreland County Prison in Pennsylvania reported that, in September 2020, 87 percent of its newly incarcerated individuals "needed to detox" upon arrival.[11] In 2015, 24,000 people in Ohio jails experienced withdrawal.[12]

This Act requires correctional settings to establish and implement administrative and clinical protocols when detaining individuals at risk of withdrawal, while recognizing the unique

[11] WESTMORELAND COUNTY PRISON BOARD MEETING MINUTES (Oct. 26, 2020), https://www.co.westmoreland.pa.us/Archive.aspx?ADID=3058.

[12] Rachel Disell, *Ohio Jails Accept Role as States Busiest Opioid Detox Centers*, CLEVELAND.COM (Oct. 1, 2017), https://www.cleveland.com/metro/2017/10/ohio_jails_accept_role_as_states_busiest_opioid_detox_centers.htmlht.

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needs and characteristics of each state, community, and correctional setting. This Act also requires the induction or continuation of medications for substance use disorders for all individuals in custody where clinically indicated. This Act requires that the protocols for managing a person experiencing withdrawal be commensurate with the accepted standards of care provided to individuals receiving services in the community and include narcotic and palliative remedies, if medically appropriate. The protocols should also incorporate a comprehensive response to related mental health conditions and suicide prevention, including behavioral support and treatment.

This Act requires evidence-based treatment of substance use disorders, including the use of FDA-approved medications to treat both opioid use and alcohol use disorders. Comprehensive drug treatment programs that include medication as part of treatment are associated with a reduced recidivism rate, reduced costs, lower post-release mortality rates, and a higher likelihood of gainful employment.[13]

The scope of the ongoing training, education, evaluation, and quality control referenced in this section, and throughout this model law, should be specified in state regulations, consistent with best practices. The drafters and reviewers of this model act believe that each state or local government entity is in the best position to determine the specific parameters for training, education, evaluation, and quality control and that this level of detail is more appropriate for regulation or state policy.

The "[Oversight Agency]" referenced in this section and subsequently in this model law means the government unit or entity at the state or local level responsible for regulating, monitoring, or otherwise providing oversight of operations or health care within correctional settings. It can include the state or county health department, department of corrections, department of mental health, the state substance abuse treatment authority or other agency, or any combination thereof. The relevant oversight agency was intentionally left open as it may vary among states.

The drafters found resources from the National Commission on Correctional Health Care (NCCHC), U.S. Substance Abuse and Mental Health Services Administration, U.S. Department of Justice, and the American Psychological Association integral to the creation of this model act.

[13] Nora D. Volkow *et al.*, *Neurobiologic Advances From the Brain Disease Model of Addiction*, 374 NEW ENGLAND J. OF MED. 363-371 (2016).

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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:[14]

(a) Assessment.— "Assessment" means the use of an evidence-based, standardized evaluation and collateral data collection process(es) to determine the presence of one or more substance use disorders;

(b) 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 individuals with SUDs and/or mental health conditions and may include an off-site opioid treatment program;[15]

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

(d) Correctional staff.— "Correctional staff" means any member of the staff in a correctional setting responsible for the custody, safety, security, and supervision of individuals in custody;

(e) Evidence-based.— "Evidence-based" means a practice that is conscientious, explicit, and judicious in the use of current best evidence in making decisions about the care of individual patients;[16]

(f) Health-trained personnel.— "Health-trained personnel" means correctional staff who are trained in or providing aspects of health care, including medical personnel employed by the correctional facility, staff employed by a third-party correctional health vendor, and other personnel providing medical or health services approved by the physician servicing the correctional setting;[17]

(g) Individual in custody.— "Individual in custody" means any individual that is detained or

[14] Where a definition is based on, or directly pulled from, language from an enacted statute, proposed legislation, or other research material, the footnote referenced at the end of the definition provides that source.
[15] The definition of "community-based provider" as defined in subsection (c) of Section III is adapted from Medicaid's definition of community-based provider. MEDICAID.GOV, HOME & COMMUNITY BASED SERVICES (2020), https://www.medicaid.gov/medicaid/hcbs/index.html.
[16] W. David Dotson, Ph.D., *Evidence-Based Practice: What It Is and Why It Matters*, CDC.gov (2020), https://www.cdc.gov/genomics/about/file/print/Evidence-Based_Practice_508.pdf (last visited Sept. 2, 2020).
[17] *Id.*

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incarcerated in a correctional setting;

(h) Jail.— "Jail" refers to a city- or county-run correctional facility that houses individuals serving sentences of generally less than one year, as well as individuals awaiting trial;[18]

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

(1) A drug approved by the U.S. Food and Drug Administration (FDA) for the treatment of substance use disorders; 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 SUDs and any concomitant conditions associated with it;[19]

(j) Mental health disorder.— "Mental health disorder" means a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning;[20]

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

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

(m) 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 identified in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association or any subsequent editions;

(n) Recovery-oriented care.— "Recovery-oriented care" means care and treatment provided

[18] *Opioid Use Disorder Treatment in Jails and Prisons: Medication Provided to Incarcerated Populations Saves Lives*, THE PEW CHARITABLE TRUSTS (Apr. 23, 2020), https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/opioid-use-disorder-treatment-in-jails-and-prisons (last visited on January 20, 2021).

[19] 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."

[20] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION (DSM-5) 20 (2013).

in support of individuals' recovery;

(o) Requests for care.— "Requests for care" refers to the ability of an individual in custody to seek access to medical care from correctional staff for themselves or another individual in custody based on an established referral system that triages requests for care according to emergent and urgent needs;

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

(1) Identify conditions or risk markers for SUD;

(2) Determine whether an individual needs further assessment for SUD; and

(3) Identify and meet urgent physical and mental health needs.

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

(r) Trauma-informed care.— "Trauma-informed care" incorporates three key elements:

(1) Realizing the prevalence of trauma;

(2) Recognizing how trauma affects all individuals involved with a program, organization, or system, including its own workforce; and

(3) Responding by putting this knowledge into practice.[21]

(s) Vicarious trauma.— "Vicarious trauma" means an occupational challenge for individuals working in the fields of victim services, law enforcement, emergency medical services, fire services, and other allied professions due to their continuous exposure to victims of trauma and violence;

(t) Withdrawal assessment.— "Withdrawal assessment" refers to the use of evidence-based clinical protocols that include subjective and objective symptom collection and evaluation such as Clinical Opiate Withdrawal Scale (COWS) and Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWAS) to ascertain the extent of the individual's treatment needs and to ensure that the individual receives access to the recommended treatment; and

[21] Center for Substance Abuse Treatment (US), *Trauma-Informed Care in Behavioral Health Services*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN. (2014), https://pubmed.ncbi.nlm.nih.gov/24901203/.

(u) Withdrawal management.— "Withdrawal management" refers to the medical and mental health care of individuals who are experiencing withdrawal symptoms as a result of detoxification or the cessation or reduction of the use of drugs, including but not limited to benzodiazepines, alcohol, opioids, stimulants including methamphetamines, and [any other specific substance added to this list by the legislature].

Commentary

The Model Act's drafters are aware that individual states may have currently-in-force statutory or regulatory definitions for some of the terms contained in this section and that lawmakers may want to default to that language. Nevertheless, this Act contains definitions designed to articulate the intended scope of each term as it relates to withdrawal management, and the drafters recommend that the definitions set forth in the Model Act not be changed, as any changes may affect some of the provisions in the Act.

The term "whole-patient," as used in the definition of medications for addiction treatment in subsection (i), refers to the federal requirements regarding the provision of counseling in association with certain medications.[22]

The term "substance use disorder" is an umbrella term that encapsulates misuse of all substances, including alcohol.

SECTION IV. WITHDRAWAL MANAGEMENT.

(a) In general.— Every correctional setting located within [State] shall establish and follow a comprehensive withdrawal management protocol for initial and ongoing screening, assessment, and medical management of withdrawal from benzodiazepines, alcohol, opioids, stimulants including methamphetamines, and [any other specific substance added to this list by the legislature] for all individuals in custody.

(b) Elements of protocol.— Each withdrawal management protocol developed pursuant to subsection (a) shall:

(1) Include specific procedures applicable to individuals entering custody and procedures applicable at any time throughout custody;

(2) Be established in consultation with medical professionals including, but not limited to, doctors, nurse practitioners, qualified addiction specialists, and obstetricians;

[22] 42 C.F.R. § 8.12(f) (2020); *see also* Substance Abuse & Mental Health Serv. Admin., *Medication and Counseling Treatment*, SAMHSA.GOV (last updated Aug. 19, 2020), https://www.samhsa.gov/medication-assisted-treatment/treatment#counseling-behavioral-therapies.

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(3) Be in writing and contain defined procedures; and

(4) Be reviewed and updated no less than on an annual basis, to reflect promising practices and the latest research.

(c) Protocol.— The withdrawal management protocol shall include each of the following:

(1) Medical clearance.— Immediate referral for care and medical clearance for individuals who are unconscious, semi-conscious, bleeding, mentally unstable, severely intoxicated, exhibiting symptoms of withdrawal from one or more substances, or otherwise urgently in need of medical attention.

(2) Receiving screening.— A receiving or intake screening conducted as soon as possible upon acceptance into custody to identify and meet urgent physical and mental health needs that includes:

(A) Evidence-based screening for substance use disorder and mental health conditions;

(B) Procedures for identifying and verifying each individual's current medications, including medications for addiction treatment and medications for the treatment of mental health and other medical conditions; and

(C) Where appropriate, a urinalysis conducted by qualified health-trained personnel.

(3) Withdrawal assessment.— A withdrawal assessment conducted as soon as possible.

(4) Withdrawal management.— Appropriate withdrawal management for individuals in custody who are intoxicated or undergoing withdrawal, including, but not limited to:

(A) Monitoring by qualified health care professionals using validated instruments and approved protocols as clinically indicated until symptoms have resolved;

(B) Housing in a safe, on-site location that allows for effective monitoring;

(C) Incorporation of protocol specific to pregnant and postpartum individuals which includes collaboration with a treatment provider that offers specialized services for pregnant and postpartum individuals;

(D) Incorporation of protocol related to suicide and self-harm; and

(E) Use of medication where clinically appropriate, including medications for addiction treatment.

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(5) Requests for care.—- A referral system for addressing requests for care by individuals in custody to triage emergent or urgent needs for themselves or other individuals in custody, including needs related to intoxication or withdrawal. Correctional setting staff shall inform all individuals in custody of protocol for requests for care at intake.

(6) Timely response.— Procedure for the submission of oral or written health care requests by individuals in custody to health-trained personnel on a daily basis, as well as a requirement for a timely response when withdrawal symptoms are observed or reported by correctional staff or health-trained personnel, other individuals in custody, or the person experiencing withdrawal; and

(7) Records.— Procedures for maintaining accurate and thorough medical records.

(d) Conducting withdrawal management.— Withdrawal management provided pursuant to paragraph (c)(4), including regular and ongoing monitoring of withdrawal symptoms, shall be conducted by health-trained personnel under the direction of medical personnel. The withdrawal management protocol provided by this section shall include criteria for referral and transfer to a higher level of care consistent with established standards of care if such higher level of care is indicated and not available in the correctional setting.

(e) Minimum required care.— Individuals in custody who are intoxicated or undergoing withdrawal shall be appropriately managed and treated using the same standard of care provided to individuals receiving care in the community. The correctional setting shall assess and appropriately treat individuals in custody, including pregnant individuals, with FDA-approved medications for addiction treatment where clinically indicated.

(f) Continuity of care.— Subject to the provisions of subsection (g), individuals in custody who are admitted to a correctional setting while under the medical care of a licensed physician, a licensed physician's assistant, a licensed advanced practice registered nurse, or a licensed nurse practitioner, and who are taking medication at the time of admission pursuant to a valid prescription, including medication for pain, benzodiazepines, buprenorphine, methadone, or other medication prescribed in the course of treatment for substance use disorders or mental health conditions, shall be entitled to continue that medication and to be provided that medication by the correctional setting without delay.

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(g) Procedure to discontinue continuity of care.— If a physician employed by, or servicing, the correctional setting determines that the continuity of care provided by subsection (f) is medically problematic, the correctional setting must take the following steps:

(1) If the individual in custody has a prescribing physician, the physician employed by, or servicing, the correctional setting must inform the prescribing physician and collaborate with the individual's physician on the individual's treatment plan for reentry;

(2) Taper medication in a timely and clinically appropriate manner using evidence-based practices, and, where appropriate, provide alternate medication;

(3) Ensure that the individual in custody is seen by a mental health professional or other treatment provider within 24 hours of the decision to discontinue the continuity of care;

(4) Require that the physician employed by, or servicing, the correctional setting who makes the clinical judgment to discontinue a medication enters the reason for the discontinuance into the individual in custody's medical record, specifically stating the reason for the discontinuance; and

(5) Provide the individual in custody, both orally and in writing, with a specific explanation of the decision to discontinue the medication.

(h) Denial of medication.— A correctional setting may not deny an individual in custody clinically-indicated treatment or medication on the basis of a positive drug screen, administrative segregation, or as a result of having received any disciplinary infraction, including those not related to drug use. Health-trained personnel shall not participate in disciplinary action and shall not be compelled to provide clinical information solely for the purposes of discipline.

(i) Reentry.— The correctional setting must provide individuals in custody with a reentry plan upon release that ensures that the individual is directly connected to a provider in the community to continue medication as well as to peer support within the geographic area where they will reside upon release.

(j) Continuous quality improvement.— Each correctional setting shall implement a continuous quality improvement program, including ongoing evaluation of practices,

review of data, and quality control, as specified by [Oversight Agency].

(k) Annual review.— Clinical protocols for intoxication and withdrawal shall be reviewed and approved annually by the correctional setting's responsible physician and shall be consistent with nationally-accepted treatment guidelines.

(l) Exemption.— Upon an application of a correctional setting that is unable to meet the requirements outlined in this section related to the administration of medications for addiction treatment, the [Oversight Agency] may grant a limited exemption if the commissioner determines that there are no facilities or providers within a reasonable distance of the correctional setting that have received the required accreditation, certification, or waiver.

Commentary

The goal of this Act is to curb or limit dangerous, unmanaged withdrawal symptoms inside of a correctional setting. Withdrawal from a substance may be fatal if not appropriately monitored. Further, complications associated with opioid withdrawal may be underestimated, especially for older individuals and those with other medical conditions.[23] Additionally, the use of administrative segregation by correctional facilities poses dangerous risks to individuals in custody experiencing withdrawal symptoms. Administrative segregation, or solitary confinement, is the placement of an individual in custody in a cell away from others as a form of internal discipline, to protect the individual from others, or to prevent the individual from "causing trouble."[24] Using administrative segregation to manage the medical needs of individuals in custody undergoing withdrawal or mental health crises can increase the risk of severe medical and behavioral health consequences, including death by suicide.[25]

This section's protocols follow the best practices outlined in the National Commission on Correctional Health Care's *2018 Standards for Health Services in Jails,* which includes practices pertaining to supervised withdrawal in jails.[26] NCCHC standards advise that health services and monitoring of individuals in custody be provided by licensed or certified health care professionals and not cell mates.[27] Use of cell mates to monitor withdrawal is a regular occurrence where evidence-based protocols do not exist and is not accepted clinical practice.

[23] Shane Darke, Sarah Larney & Michael Farrell, *Yes, People Can Die From Opiate Withdrawal*, 112 ADDICTION 199-200 (Feb. 2017), https://onlinelibrary.wiley.com/doi/full/10.1111/add.13512.
[24] *Solitary Confinement*, Cornell Law School, (last visited June 9, 2021), https://www.law.cornell.edu/wex/solitary_confinement.
[25] Susan Pollitt & Luke Woollard, *Barriers to Access and Inadequate Levels of Care in North Carolina Jails*, 80 N.C. MED. J. 345–346 (Nov.-Dec. 2019), https://doi.org/10.18043/ncm.80.6.345.
[26] NAT'L COMM'N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN JAILS (2018).
[27] NAT'L COMM'N ON CORR. HEALTH CARE, JAIL-BASED MEDICATION-ASSISTED TREATMENT, 22 (2018).

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NCCHC standards further guide that, while non-life-threatening symptoms can be treated in convalescent or outpatient settings, severe withdrawal symptoms must be managed in hospitals, and medical supervision must be available at all times using valid withdrawal assessment instruments (*e.g.,* COWS, the Objective Opiate Withdrawal Scale, and the CIWAS, Revised).[28] Additionally, each correctional facility should provide evidence-based care during confinement. Risk of overdose, suicide, and death can be significantly reduced by continuing medications to treat substance use disorder and mental health conditions for those who previously started treatment or by initiating medications in custody, where appropriate.[29]

NCCHC also recommends standards related to health care requests and services, including the opportunity for individuals in custody to submit oral and written health care requests at least daily and prompt response and evaluation provided in a clinically-appropriate time frame.[30] NCCHC advises that this practice can be satisfied in multiple ways, including walking into the clinic in the correctional setting and making an appointment, writing requests on slips that are dropped into a locked box and picked up by health staff, telephoning a nurse in the clinic, or using sign-up sheets in the dining or housing area.[31] In addition, each correctional setting should have written policies and procedures, training, and a quality improvement process to implement these requirements and ensure compliance.

NCCHC standards advise that a qualified opioid treatment program be contacted when a pregnant individual, with opioid use disorder or undergoing treatment for opioid use disorder, is taken into custody; specifically, a treatment provider that offers specialized services for pregnant and postpartum individuals.[32] Correctional settings should maintain an ongoing contractual relationship with an opioid treatment program or OB-GYN buprenorphine prescriber to rapidly provide evidence-based and appropriate medical care for pregnant patients who are incarcerated and withdrawing from opioids. The provider must assess and appropriately treat the pregnant patient with FDA-approved medications for addiction treatment (other opioid pain relievers such as acetaminophen with codeine or hydrocodone are not acceptable).[33] Abrupt discontinuation of opioids can be dangerous for anyone, but this is particularly true of use during pregnancy, as studies show it may result in premature labor, fetal distress, and miscarriage.[34] Also, in order to ensure continuity of care, pregnant patients should receive long-term MAT as soon as practicable after intake and throughout the pregnancy and the postpartum period until release and linkage with a community-based provider.

The exemption described in sub-section (l) is intended to apply only to the provisions of this subsection requiring induction and continuation of MAT. This is added based on the recognition that all forms of MAT may not be available within a reasonable distance from every correctional setting in the state and, therefore, an individual correctional setting may require a

[28] *Id.*
[29] *Id.*
[30] NAT'L COMM'N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN JAILS (2018), 100-101.
[31] *Id.*
[32] NAT'L COMM'N ON CORR. HEALTH CARE, JAIL-BASED MEDICATION-ASSISTED TREATMENT (2018).
[33] *Id.*
[34] *Id.*

narrow exemption. The "[Oversight Agency]" referenced in this provision means the government unit or entity at the state or local level responsible for regulating, monitoring, or otherwise providing oversight of operations or health care within correctional settings. It can include the state or county health department, department of corrections, department of mental health, the state substance abuse treatment authority or other agency, or any combination thereof. The relevant oversight agency was intentionally left open as it may vary among states.

SECTION V. TRAINING AND EDUCATION.

(a) In general.— Each correctional setting shall ensure ongoing training as determined by [Oversight Agency] for all correctional staff and health-trained personnel on administrative and clinical protocols, as applicable, for withdrawal from benzodiazepines, alcohol, opioids, stimulants including methamphetamines, and [any other specific substance added to this list by the legislature]. The training program shall be established or approved by [Oversight Agency] in cooperation with each setting's administrator and medical director.

(b) All staff.— Correctional staff and health-trained personnel within each correctional setting shall receive initial and ongoing training that includes, but is not limited to:

  (1) Education on substance use disorder and the standard of care for treating substance use disorder, as well as the risks associated with the discontinued use of substances, including morbidity and mortality;

  (2) Instruction on administering naloxone;

  (3) Principles of evidence-based, trauma-informed care and recovery-oriented care; and

  (4) Knowledge and skills necessary to address and prevent vicarious trauma.

(c) Correctional staff.— All correctional staff shall receive initial and ongoing training, as determined by [Oversight Agency], on the following:

  (1) Signs and symptoms associated with withdrawal from benzodiazepines, alcohol, opioids, stimulants including methamphetamines, and [any other specific substance added to this list by the legislature], including related mental health symptoms; and

  (2) Protocols and procedures for communicating concerns related to withdrawal to appropriate or designated health-trained personnel.

(d) Health-trained personnel.— All health-trained personnel at a correctional setting shall receive initial and ongoing training, as determined by [Oversight Agency] on the

following:

(1) Nationally accepted clinical protocols and emerging promising practices for addressing withdrawal from benzodiazepines, alcohol, opioids, stimulants including methamphetamines, [any other specific substance added to this list by the legislature], and related mental health conditions;

(2) Substance-specific screening, assessment, and treatment protocols for all substance use disorders and mental health disorders, and methods to identify individuals at risk; and

(3) Communication protocols and procedures that involve both health-trained personnel and correctional staff.

Commentary

Requiring staff to be trained in harm reduction and best practices for addressing substance use disorder, while including trauma-informed care and recovery-oriented care (*e.g.*, methadone advocate training, Medication-Assisted Recovery Service (MARS) training,[35] Mental Health First Aid[36]), can help address the stigma surrounding substance use, create conditions for objective and evidence-based care, and change the culture of the correctional setting for the safety of all.[37] Additionally, staff-centered engagement in dialogue around vicarious trauma will empower the staff members to be more engaged in their work and in addressing the needs of individuals in custody.[38]

NCCHC standards advise that health care personnel serve the health needs of their patients without bias or judgment on the merit of providing care to individuals in custody.[39] Maintaining ethical boundaries and professional attitudes can be difficult in correctional settings, but orientation and continuing education focused on ethical conflicts can help maintain ethical perspectives.[40]

The scope of the ongoing training and education referenced in this section should be specified in state regulations or agency policies, consistent with best practices. The drafters and reviewers of this model law believe that each state or local government entity is in the best position to the determine, develop, review, or approve the specific parameters for training and education and that this level of detail is more appropriate for regulation or agency policy. The "[Oversight Agency]" referenced in this provision means the government unit or entity at the

[35] MEDICATION-ASSISTED RECOVERY SERVICES, http://marsproject.org/.
[36] MENTAL HEALTH FIRST AID, https://www.mentalhealthfirstaid.org/about/.
[37] Center for Substance Abuse Treatment (US), *supra* note 24.
[38] INT'L SOC'Y FOR TRAUMATIC STRESS STUD., VICARIOUS TRAUMA TOOLKIT (2021), https://istss.org/clinical-resources/treating-trauma/vicarious-trauma-toolkit.
[39] NAT'L COMM'N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN JAILS, (2018).
[40] *Id.*

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state or local level responsible for regulating, monitoring, or otherwise providing oversight of operations or health care within correctional settings. It can include the state or county health department, department of corrections, department of mental health, the state substance abuse treatment authority or other agency, or any combination thereof. The relevant oversight agency was intentionally left open as it may vary among states.

SECTION VI. CONFIDENTIALITY.

All individuals and entities operating pursuant to this Act shall adhere to:

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

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

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

Commentary

Confidentiality requirements are found under federal statute, federal regulation, and other state laws outside of this Act. However, this section highlights the importance of patient privacy in the context of substance use disorder, as it is a sensitive matter and an area that is difficult to navigate.

Often, there may be multiple care providers and entities that require access to an individual's 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 those involved in the treatment of individuals in custody. In addition, 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 treatment in correctional settings and upon reentry.

SECTION VII. REPORTING.

(a) In general.— The [Oversight Agency] shall, within one year of the effective date of this Act and annually thereafter, deliver a report to the governor and to the state legislative committees on [corrections and healthcare, or similar] addressing data collected on withdrawal management in correctional settings as provided in subsection (c).

(b) Data retrieval process.— Each correctional setting shall report the data elements provided in subsection (c) to [Oversight Agency] by [quarterly, bi-annually, or annually date determined by Oversight Agency]. Each correctional setting shall ensure that the data

elements provided are de-identified.

(c) Required elements.— The report required in subsection (a) and data provided in subsection (b) shall include, but shall not be limited to, the following data elements and shall include totals and categorization by demographic descriptors, including but not limited to race, age, and gender:

(1) Information about substance-related deaths and overdoses in custody:

(A) Number of individuals who have died in custody due to intoxication, overdose, withdrawal, or other substance-related incidents;

(B) Number of overdoses in custody;

(C) Number of suicide-related deaths in custody; and

(D) Number of times naloxone was administered in each correctional setting;

(2) Information about withdrawal management and substance use screening, assessment, and treatment of individuals in custody, including but not limited to:

(A) Number of individuals in custody screened for intoxication or withdrawal symptoms at intake;

(B) Number of individuals in custody screened positive for intoxication or withdrawal symptoms at intake;

(C) Number of COWS and CIWAS assessments that are completed accurately and at appropriate time intervals;

(D) Number of individuals in custody with a diagnosed substance use disorder;

(E) Number of individuals in custody actively being treated for a substance use disorder while in custody;

(F) Number of people referred to MAT for continuation and induction by type of MAT;

(G) Number of people referred to MAT;

(H) Description of type and quantity of substance use disorder, mental health, and MAT services provided;

(I) Number of persons connected to ongoing treatment upon reentry; and

(J) Number of persons connected to peer support while in custody and upon reentry;

(3) Costs.— Reasonable assessment of the range of cost savings due to implementing withdrawal management protocols, including cost of lawsuits and settlements due to deaths of individuals in custody and reduced hospital admissions;

(4) Vendors.— Information about vendors including:

(A) Names, addresses, and points of contact for all vendors providing health, mental health, and substance use disorder treatment services in the correctional setting, including, but not limited to, third-party correctional health vendors and community-based providers; and

(B) All costs involved in the delivery of that treatment;

(5) Any recommendations for additional legislative enactments that may be needed or required to improve or enhance protocols; and

(6) Any other data elements required by [Oversight Agency] by rule.

(d) Public availability.— The reports governed by this section shall be public records within the meaning of the [state's freedom of information act] and are open to public inspection, with the exception of any portion of the report that is privileged or protected under [State] or federal law.

Commentary

Tracking, monitoring, and evaluating the efficacy and success of withdrawal management protocols is crucial to saving lives and money. The list of data elements was created by subject matter experts who participated in the development of this model law. These experts believe that data and metrics are critical elements to ensure quality, accountability, and transparency in the implementation of this legislation.

The process and additional detail related to data collection and reporting referenced in this section should be specified in state regulations or agency policies. The drafters and reviewers of this model law believe each state or local government entity is in the best position to the determine, develop, review, or approve the specific parameters and process for data and reporting and that this level of detail is more appropriate for regulation or agency policy. The "[Oversight Agency]" referenced in this provision means the government unit or entity at the state or local level responsible for regulating, monitoring, or otherwise providing oversight of operations or health care within correctional settings. It can include the state or county health department, department of corrections, department of mental health, the state substance abuse treatment authority or other agency, or any combination thereof. The relevant oversight agency was intentionally left open as it may vary among states.

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SECTION VIII. FUNDING.

The Legislature shall appropriate [$ _____] to the [Oversight Agency] for the purpose of funding services provided as part of clinical and administrative withdrawal management protocols in state and local correctional settings.

Commentary

Funding for withdrawal management can come from city and county monies, as well as federal, state, and private grants.

Potential funding sources for withdrawal management in correctional settings include federal funding and opioid settlement funds from litigation against the pharmaceutical industry, including pharmaceutical manufacturers or distributors.[41] Legislation should be considered that requires opioid settlement funds or other new monies be allocated to cover costs associated with establishing comprehensive programming addressing substance use disorder, including withdrawal management protocols, in state, county, and city correctional facilities.

SECTION IX. REGULATIONS.

[Oversight Agency] shall promulgate regulations implementing this Act within [number of days] of the effective date of this Act. Any additional guidelines or standards not contemplated within this Act shall be based on established practices for withdrawal management in correctional settings.

Commentary

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. These benchmarks include screening and assessing persons for substance use disorder and providing detailed recommendations that are better suited for implementation through regulation because of the changing nature of addiction treatment practices and evolving research on this subject.

The "[Oversight Agency]" referenced in this provision means the entity at the state level responsible for promulgating regulations to monitor or otherwise providing oversight of operations or health care within correctional settings. It can include the state health department, department of corrections, department of mental health, the state substance abuse treatment

[41] Katie Zezima, *Ohio Tries an Unusual Tactic Toward Opioid Settlement: Working Together*, WASH. POST, (Feb. 24, 2020, 7:23 p.m. CST), 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.

authority or other agency, or any combination thereof. The relevant oversight agency was intentionally left open as it may vary among states.

SECTION X. 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.

SECTION XI. EFFECTIVE DATE.

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

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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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