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MODEL ACCESS TO MEDICATION FOR ADDICTION TREATMENT IN CORRECTIONAL SETTINGS ACT

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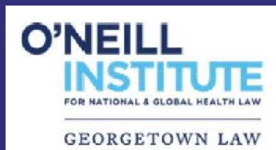

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SECTION I. TITLE.

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) Legislative findings. —The [legislature][2] finds that:

(1) In 2023, an estimated 46 million Americans age 18 or older had a substance use disorder, including [x] individuals in [state].[3]

(2) The most current data from the Bureau of Justice Statistics, U.S. Department of Justice, indicate that 58 percent of state prisoners and 63 percent of sentenced individuals in jails met the criteria for "drug dependence" or "abuse."[4] In comparison, around five percent of the general population age 18 or older met the criteria for "drug dependence" or "abuse."[5]

(3) Medication for addiction treatment works by controlling withdrawal symptoms and both the physiological and psychological cravings that lead to substance use.[6] These medications stabilize brain chemistry, restore disrupted metabolic functions, and act to relieve physiological cravings while blocking the euphoric effects of the substance used.[7]

(4) Research shows that medication for addiction treatment can successfully treat substance use disorders and help sustain recovery.[8] Specifically, medication for addiction treatment has been shown to improve patient survival, increase retention

[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.*, "[legislature]"). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

[3] *Results from the 2023 National Survey on Drug Use and Health: Detailed Tables*, U.S. DEP'T OF HEALTH & HUM. SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., Table 5.1A (2024), https://www.samhsa.gov/data/sites/default/files/reports/rpt47100/NSDUHDetailedTabs2023/NSDUHDetailedTabs2023/2023-nsduh-detailed-tables-sect5pe.htm.

[4] JENNIFER BRONSON, ET AL., DRUG USE, DEPENDENCE, AND ABUSE AMONG STATE PRISONERS AND JAIL INMATES, 2007-2009 1 (2020), https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf.

[5] *Id.*

[6] *Medications for Substance Use Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. (Apr. 11, 2024), https://www.samhsa.gov/medications-substance-use-disorders.

[7] *Id.*

[8] *Id.*

in treatment, decrease criminal activity among individuals with substance use disorders, increase a patient's ability to gain and maintain employment, and improve birth outcomes among pregnant individuals who have substance use disorders.[9]

(5) Researchers have found that individuals who receive medication for addiction treatment while incarcerated are more likely to continue using medication for addiction treatment following their release.[10] The continuation of medication for addiction treatment post release reduces an individual's risk of overdose during reentry.[11]

(b) Purpose. —The purpose of this Act is to:

(1) Promote the use of all U.S. Food and Drug Administration-approved medication for addiction treatment options in correctional settings;

(2) Ensure that all incarcerated individuals with a substance use disorder are provided access to medication for addiction treatment while incarcerated, are treated as individual patients, and have individualized treatment plans reflecting their clinical needs and not a one-size-fits-all approach; and

(3) Ensure that, upon release from a correctional setting, individuals receiving medication for addiction treatment are provided with a connection in the community for continued care, including a prescription for the medication for addiction treatment and the necessary contacts and tools to continue their treatment.

Commentary

According to the most recent National Survey on Drug Use and Health, an estimated 46 million Americans aged 18 or older had a substance use disorder in 2023.[12] As stated in the legislative findings, individuals involved in the criminal justice system are disproportionately at risk for substance use disorder (SUD) and of dying from an overdose as compared to the general population. Because of the high rates of SUD among incarcerated individuals, correctional settings have the ability to serve as points of access for evidence-based treatment, specifically

[9] *Id.*
[10] Noa Krawczyk, et al., *Transitions Of Care Between Jail-based Medications For Opioid Use Disorder and Ongoing Treatment in the Community: A Retrospective Cohort Study*, 261 DRUG AND ALCOHOL DEPENDENCE 111377 (Aug. 2024), https://doi.org/10.1016/j.drugalcdep.2024.111377.
[11] *Id.*
[12] *2023 National Survey on Drug Use and Health, supra* note 3.

medication for addiction treatment (MAT). Research shows that MAT can successfully treat SUD and help sustain recovery. The Model Act uses the term "medication for addiction treatment" but other commonly used terms include "medication-assisted treatment" and "medication-based treatment." Additionally, individuals and entities sometimes use the more specific terms of "medication for opioid use disorder" or "medication for alcohol use disorder." Currently, MAT only exists for opioid use disorder (OUD) and alcohol use disorder.[13] However, medications for other substance use disorders are currently in development. Much of the discussion in the commentary sections of this Act surrounds MAT for OUD, which includes methadone,[14] buprenorphine,[15] and naltrexone,[16] however, the drafters of the Model Act use the broad term, "substance use disorder," in the statutory language when discussing MAT to allow for the future development and U.S. Food and Drug Administration (FDA) approval of MAT for substances other than opioids and alcohol. Using such broad language helps to avoid the need for subsequent legislation to adjust to new forms of MAT.

According to the BJS, jail deaths involving drug or alcohol intoxication quadrupled between 2000 and 2019.[17] About 40 percent of deaths in jails occur within the first seven days, with a median time served of just one day for deaths in custody related to drug or alcohol intoxication.[18] Additionally, during the first two weeks after release from a correctional setting, formerly incarcerated individuals with SUD have an elevated risk of experiencing a fatal overdose.[19] A study of individuals released from the Washington State Department of Corrections found that within the first two weeks after release, formerly incarcerated individuals are 129 times more likely to experience a fatal overdose than the general population.[20] Additionally, a study of formerly incarcerated individuals in North Carolina showed that the risk

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[13] *See Medications for Substance Use Disorders*, *supra* note 6.

[14] Methadone is an FDA-approved long-acting full opioid agonist and a Schedule II controlled substance. Methadone can only be dispensed through an opioid treatment program. *See Methadone*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated Mar. 29, 2024), https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/methadone.

[15] Buprenorphine is an FDA-approved partial opioid agonist and a Schedule III controlled substance. This medication can be prescribed or dispensed in physician offices. Buprenorphine may be prescribed as a buprenorphine/naloxone combination medication. *See Buprenorphine*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated Mar. 28, 2024), https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/buprenorphine.

[16] Naltrexone is an FDA-approved opioid antagonist that can be prescribed and administered by any healthcare practitioner licensed to prescribe medications. *See Naltrexone*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated Mar. 29, 2024), https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone.

[17] E. ANN CARSON, MORTALITY IN LOCAL JAILS, 2000–2019 – STATISTICAL TABLES 2 (2021), https://bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf.

[18] *Id.* at 3-4.

[19] *See* Daniel M. Hartung, et al., *Fatal and Non-Fatal Opioid Overdose Risk Following Release from Prison: A Retrospective Cohort Study Using Linked Administrative Data*, 147 J. OF SUBSTANCE USE AND TREATMENT 208971 (Apr. 2023), https://doi.org/10.1016/j.josat.2023.208971.

[20] *See* Ingrid A. Binswanger, et al., *Release from Prison — A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 161 (Feb. 2007), https://doi.org/10.1056/NEJMsa064115.

of death by heroin overdose at two weeks post-release was 74 times higher than that of the general population.[21]

Racial disparities in incarceration further exacerbate health disparities for Black individuals, Indigenous individuals, and other people of color during incarceration and upon reentry into their communities. According to the Centers for Disease Control and Prevention (CDC), overdose death rates increased 44 percent for Black individuals and 39 percent for American Indian and Alaska Native individuals between 2019 and 2022; in comparison the overdose death rate for white individuals increased 22 percent during the same period.[22] Furthermore, the Substance Abuse and Mental Health Services Administration (SAMHSA) reports that Black and Hispanic or Latino individuals who need treatment for SUD only receive treatment 18.6 percent and 17.6 percent of the time, respectively, in comparison to 23.5 percent of white individuals.[23] Similar exacerbated health disparities are exhibited in the sexual and gender minority population due to their disproportionate representation in correctional systems. The National Institute on Drug Abuse reports that the sexual and gender minority population has higher rates of SUD than individuals who identify as heterosexual and cisgender and are more likely to enter treatment with more severe SUD.[24]

Providing MAT in correctional settings is critical to reducing the risk of complications associated with withdrawal and overdose both during incarceration and upon reentry. When the Rhode Island Department of Corrections expanded access to MAT statewide, it reduced post-correctional overdose death rates by 60.5 percent in the first year.[25] In addition to minimizing the risk of overdose and other adverse complications and placing individuals on the path toward recovery, the National Sheriffs' Association and the National Commission on Correctional Health Care cite additional benefits of providing MAT in correctional settings, including reducing recidivism among individuals with SUD, increasing the safety and security of a correctional facility, and reducing costs, including costs associated with health care spending.[26]

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[21] Shabbar I. Ranapurwala, et al., *Opioid Overdose Mortality Among Former North Carolina Inmates: 2000–2015*, 108 AM. J. PUBLIC HEALTH 1207, 1210 (Sept. 2018), https://doi.org/10.2105/AJPH.2018.304514.

[22] *Overdose death rates increased significantly for Black, American Indian/Alaska Native people in 2020*, CENTERS FOR DISEASE CONTROL AND PREVENTION, (July 18, 2022), https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html.

[23] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., U.S. DEPT. OF HEALTH & HUMAN SERV., RACIAL/ETHNIC DIFFERENCES IN SUBSTANCE USE, SUBSTANCE USE DISORDERS, AND SUBSTANCE USE TREATMENT UTILIZATION AMONG PEOPLE AGED 12 OR OLDER (2015-2019) 53 (2021), https://www.samhsa.gov/data/sites/default/files/reports/rpt35326/2021NSDUHSUChartbook.pdf.

[24] *LGBTQI+ People and Substance Use*, NATIONAL INSTITUTE ON DRUG ABUSE, (May 2024), https://nida.nih.gov/research-topics/lgbtqi-people-and-substance-use.

[25] Traci C. Green, et al., *Post-incarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 75 JAMA PSYCHIATRY 405 (Apr. 2018), https://doi.org/10.1001/jamapsychiatry.2017.4614.

[26] NAT'L SHERIFFS' ASS'N AND NAT'L COMM'N ON CORR. HEALTH CARE, JAIL-BASED MEDICATION-ASSISTED TREATMENT: PROMISING PRACTICES, GUIDELINES, AND RESOURCES FOR THE FIELD 5 (2018), https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.

In addition, the American Correctional Association,[27] the American Society for Addiction Medicine,[28] and the National Governors Association[29] have issued policy briefs and official statements supporting the adoption of MAT programs in correctional settings.

Despite the growing body of evidence supporting the use of MAT programs in correctional settings, very few jails and prisons in the U.S. offer MAT. A 2023 survey of MAT for OUD in U.S. jails, conducted by the Justice Community Opioid Innovation Network (JCOIN), found that only 30.5 percent of jails provide buprenorphine, only 20.2 percent provide methadone, and only 23.5 percent provide naltrexone.[30] The JCOIN study also found that, of the jails that offer MAT, 72.6 percent only make it available to individuals who are already receiving MAT prior to entering the facility.[31] Only 28.4 percent initiate MAT for individuals who were not receiving MAT prior to entry.[32] In 2021, 53 percent of Residential Substance Abuse Treatment (RSAT)[33] funded state prisons provided MAT.[34] Ideally, when clinically indicated and desired by the individual, all correctional settings should both continue and initiate MAT for all individuals with an SUD upon entry. The Office of National Drug Control Policy, Executive Office of the President has established the goal of increasing the number of state prisons and local jails offering MAT by 50 percent by 2025.[35]

The failure of a correctional institution to provide MAT may result in legal liability. In 2022, the Civil Rights Division of the DOJ issued a guidance document outlining the Americans

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[27] AMERICAN CORRECTIONAL ASSOCIATION AND AMERICAN SOCIETY OF ADDICTION MEDICINE, JOINT PUBLIC CORRECTIONAL POLICY ON THE TREATMENT OF OPIOID USE DISORDERS FOR JUSTICE INVOLVED INDIVIDUALS (Jan. 2018). https://www.asam.org/docs/default-source/public-policy-statements/2018-joint-public-correctional-policy-on-the-treatment-of-opioid-use-disorders-for-justice-involved-individuals.pdf?sfvrsn=26de41c2_2.

[28] AMERICAN SOCIETY OF ADDICTION MEDICINE, PUBLIC POLICY STATEMENT ON TREATMENT OF OPIOID USE DISORDER IN CORRECTIONAL SETTINGS (July 2020). https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/2020-statement-on-treatment-of-oud-in-correctional-settings.pdf?sfvrsn=ff156c2_0.

[29] KELLY MURPHY, ET AL., NAT'L GOVERNORS ASS'N, FINDING SOLUTIONS TO THE PRESCRIPTION OPIOID AND HEROIN CRISIS: A ROAD MAP FOR STATES 24 (July 2016). https://www.nga.org/wp-content/uploads/2019/08/1607NGAOpioidRoadMap.pdf.

[30] JENNIFER LOGAN, ET AL. O'NEILL INSTITUTE FOR NATIONAL AND GLOBAL HEALTH LAW AT GEORGETOWN UNIVERSITY LAW CENTER, MEDICATIONS FOR OPIOID USE DISORDER IN U.S. JAILS AND PRISONS: STATUS UPDATE 2 (Mar. 2024) https://oneill.law.georgetown.edu/wp-content/uploads/2024/03/ONL_QT_MOUD_Status_Update_P3-.pdf.

[31] *Id.*

[32] *Id.*

[33] "The Residential Substance Abuse Treatment (RSAT) Program is a formula grant program that enhances the capabilities of state, local, and tribal governments to provide residential substance use disorder (SUD) treatment to adult and juvenile populations during detention or incarceration, initiate or continue evidence-based SUD treatment in jails, prepare individuals for reintegration into the community, and assist them and their communities throughout the reentry process by delivering community-based treatment and other recovery aftercare services." *Residential Substance Abuse Treatment for State Prisoners (RSAT) Program*, BUREAU OF JUSTICE ASSISTANCE, last modified Nov. 21, 2023, https://bja.ojp.gov/program/rsat/overview.

[34] OFFICE OF NATIONAL DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, NATIONAL DRUG CONTROL STRATEGY PERFORMANCE REVIEW SYSTEM REPORT 37 (Mar. 2023).

[35] *Id.* at 35.

with Disabilities Act (ADA) protections for individuals in SUD treatment or recovery.[36] Title II of the ADA prohibits correctional settings from discriminating against a qualified individual with a disability on the basis of that disability.[37] The guidance document explicitly states that a blanket policy prohibiting the use of MAT in a correctional setting would violate the ADA.[38] In addition to violating the ADA, the failure to provide MAT to individuals in correctional settings can lead to constitutional violations, as there is a right to medical care under the Eighth Amendment of the U.S. Constitution for individuals in prison and under the Fourteenth Amendment of the U.S. Constitution for pretrial detainees. Courts have consistently ruled that the denial of MAT in correctional settings violates the constitutional right to adequate medical care.[39] Recent litigation brought forth by individuals in correctional settings who have been denied MAT has resulted in multiple settlements and rulings that have expanded access to MAT.[40] In November 2023, Allegheny County, Pennsylvania, reached an agreement with the U.S. Attorney's Office for the Western District of Pennsylvania to offer all forms of FDA-approved MAT to any individuals booked into the county jail for whom such treatment is medically appropriate.[41] As part of the agreement, Allegheny County agreed to pay $10,000 to an individual allegedly denied access to methadone while incarcerated at the county jail. In December 2023, the Big Sandy Regional Jail Authority (Big Sandy) in Kentucky reached an agreement with the U.S. Attorney's Office for the Eastern District of Kentucky to provide all forms of FDA-approved MAT to those who need it, including individuals who did not have a prescription for such treatment prior to incarceration.[42] The agreement stemmed from a complaint brought forth by a medical provider who claimed that his patient had been denied buprenorphine while incarcerated at Big Sandy.[43]

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[36] C.R. DIVISION, U.S. DEP'T OF JUST., THE AMERICANS WITH DISABILITIES ACT AND THE OPIOID CRISIS: COMBATING DISCRIMINATION AGAINST PEOPLE IN TREATMENT OR RECOVERY (Apr. 2022), https://archive.ada.gov/opioid_guidance.pdf.

[37] 42 U.S.C.A. § 12132 (Westlaw through Pub. L. No. 118-66).

[38] *Id.* at 2.

[39] *See Pesce v. Coppinger*, 355 F. Supp. 3d 35 (D. Mass. 2018) (holding that failure to provide MAT likely violates the ADA and Eighth Amendment); *P.G. v. Jefferson Cnty*., No. 5:21-CV-388, 2021 WL 4059409 (N.D.N.Y. Sept. 7, 2021) (holding that failure to provide MAT likely violates the ADA and Eighth Amendment); and M.C. v. Jefferson Cnty., No. 6:22-CV-190, 2022 WL 1541462 (N.D.N.Y. May 16, 2022) (notably the first class action against a jail to find denial of MAT likely to amount to ADA and constitutional violations).

[40] *See* SHELLY WEIZMAN, ET AL., O'NEILL INSTITUTION FOR NATIONAL AND GLOBAL HEALTH LAW AT GEORGETOWN LAW CENTER, NATIONAL SNAPSHOT: ACCESS TO MEDICATIONS FOR OPIOID USE DISORDER IN U.S. JAILS AND PRISONS (2021), https://oneill.law.georgetown.edu/wp-content/uploads/2021/07/National-Snapshot-Access-to-Medications-for-Opioid-Use-Disorder-in-U.S.-Jails-and-Prisons.pdf; *See also* AMERICAN CIVIL LIBERTIES UNION, OVER-JAILED AND UN-TREATED: HOW THE FAILURE TO PROVIDE TREATMENT FOR SUBSTANCE USE IN PRISONS AND JAILS FUELS THE OVERDOSE EPIDEMIC 14 (2021), https://www.aclu.org/publications/report-over-jailed-and-un-treated.

[41] *Allegheny County Jail*, C.R. DIVISION, U.S. DEP'T OF JUST., (last updated Jan. 16, 2024), https://www.justice.gov/crt/case/allegheny-county-jail.

[42] *U.S. Attorney's Office Announces Agreement to Ensure Access to Medications for Opioid Use Disorder at Big Sandy Regional Detention Center*, U.S. ATT'Y OFF. E. DIST. KY., (last updated Feb. 14, 2024), https://www.justice.gov/usao-edky/pr/us-attorneys-office-announces-agreement-ensure-access-medications-opioid-use-disorder.

[43] *Id.*

Although much implementation of MAT in correctional settings has been driven by litigation and settlements, there are some states that have taken legislative or executive action to encourage or mandate correctional facilities to provide access to MAT. As of September 2023, only 16 states have requirements to implement MAT in all, or nearly all, state or local correctional settings.[44] Only seven (Colorado, Maine, Maryland, Nevada, New Mexico, New York, and Vermont)[45] of the 16 states with MAT requirements have statutory provisions, while the remaining nine states (California, Connecticut, Delaware, Massachusetts, New Hampshire, New Jersey, Ohio, Pennsylvania, and Rhode Island) adopted state policy and/or allocated funding to support the implementation of MAT in correctional settings.[46]

The purpose of this Model Act is to provide a framework for states to provide all incarcerated individuals that suffer from SUD access to all FDA-approved forms of MAT during the length of their incarceration. This Act also seeks to close the gaps in care that occur during the reentry period to ensure that individuals leaving incarceration have continued access to MAT.

SECTION III. DEFINITIONS.

[States may already have definitions in place for some or all of the following terms. In such case, states may use the existing definitions in place of those listed below.]

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:[47]

(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 and whether medication for addiction treatment is medically necessary;

(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 substance use disorder and/or mental health conditions and may include off-site opioid treatment programs;[48]

[44] 2023 STATE OF THE STATES, LEGIS. ANALYSIS & PUB. POL'Y ASS'N, 16 (Nov. 2023), https://legislativeanalysis.org/wp-content/uploads/2023/12/2023-State-of-the-States.pdf.
[45] COLO. REV. STAT. ANN. § 17-26-104.9 (West 2024); ME. REV. STAT. ANN. tit. 34-A, § 1208-B (West 2024); MD. CODE ANN., CORR. SERVS. § 9-603 (West 2024); NEV. REV. STAT. ANN. § 209.4247 (West 2024); N.M. STAT. ANN. § 24-1-5.11 (West 2024); N.Y. CORRECT. LAW § 626 (McKinney 2024); N.Y. MENTAL HYG. LAW § 19.18-c (West 2024); and VT. STAT. ANN. tit. 28, § 801b (West 2024).
[46] *See* WEIZMAN, ET AL., *supra* note 40.
[47] Where a definition is based on, adapted from, or taken verbatim from language from an enacted statute, proposed legislation, or other research material, the footnote referenced at the end of the definition provides that source.
[48] The definition based on *Home & Community Based Services*, MEDICAID.GOV (last accessed Sept. 10, 2024), https://www.medicaid.gov/medicaid/home-community-based-services/index.html.

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

(d) Diversion. — “Diversion” means the transfer of a legally prescribed controlled substance, including medication for addiction treatment, from the individual for whom it was prescribed to another person for illicit use.[49]

(e) Evidence-based. — “Evidence-based” means an approach to medicine that emphasizes the practical application of the findings of the best available current research.[50]

(f) Healthcare practitioner. — “Health care practitioner” means an individual who is licensed or otherwise authorized by the state to administer, dispense, or prescribe medication for addiction treatment.[51]

(g) Medication for addiction treatment. — “Medication for addiction treatment” means drugs approved by the U.S. Food and Drug Administration for the treatment of substance use disorder;[52]

(h) Opioid treatment program. — “Opioid treatment program” means a substance use disorder treatment program that is certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by an independent SAMHSA-approved accrediting body and is regulated by 42 C.F.R. Part 8 [and state law or regulation governing opioid treatment programs, if applicable].[53]

(i) Overdose reversal medication. — “Overdose reversal medication” means a medication

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[49] Definition based on U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE SURGEON GENERAL, FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH 4-22 (Nov. 2016), https://www.hhs.gov/sites/default/files/facing-addiction-in-america-surgeon-generals-report.pdf.

[50] Livia Puljak, *The Difference Between Evidence-based Medicine, Evidence-based (Clinical) Practice, and Evidence-based Health Care*, 142 J. OF CLINICAL EPIDEMIOLOGY 311 (Nov. 2021), https://doi.org/10.1016/j.jclinepi.2021.11.015.

[51] Based on *Definitions*, NATIONAL PRACTITIONER DATA BANK (last visited Jul. 2, 2024), https://www.npdb.hrsa.gov/guidebook/CDefinitions.jsp.

[52] *See Medications for Substance Use Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated Apr. 11, 2024), www.samhsa.gov/medication-assisted-treatment.

[53] *See Certification of Opioid Treatment Programs (OTPs)*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated June 11, 2024), https://www.samhsa.gov/medications-substance-use-disorders/become-accredited-opioid-treatment-program.

approved by the U.S. Food and Drug Administration to reverse an overdose.[54]

(j) Peer support worker. — "Peer support worker" means an individual who provides non-clinical care and assistance that encompasses a range of activities and interactions between people who share similar experiences of navigating substance use disorder in an effort to aid individuals in long-term recovery.[55] Peer support specialists are also known as peer specialists, peer recovery coaches, peer advocates, and peer recovery support specialists.[56]

(k) Program participant. — "Program participant" means an incarcerated individual with substance use disorder for whom medication for addiction treatment is clinically indicated and who elects to participate in such treatment;

(l) 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;[57]

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

(1) Identify conditions or risk markers for substance use disorder;

(2) Determine whether an individual needs treatment for substance use disorder;

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

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

(n) Substance use disorder. — "Substance use disorder" means a pattern of use of drugs leading to clinical or functional impairment, in accordance with the definition in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or in any subsequent editions, and includes, but is not limited to, alcohol use disorder, opioid use disorder, and stimulant use disorder;[58]

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[54] *Opioid Overdose Reversal Medications*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated Mar. 26, 2024), https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/opioid-overdose-reversal-medications.

[55] Taken in part from *Model Expanding Access to Peer Recovery Support Services Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Oct. 2020), https://legislativeanalysis.org/model-expanding-access-to-peer-recovery-support-services-act/.

[56] *Value of Peers*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf.

[57] Working Definition of Recovery, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (2012), https://store.samhsa.gov/sites/default/files/d7/priv/pep12- recdef.pdf.

[58] Taken in part from *Model Expanded Access to Emergency Opioid Antagonists Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Sept. 2021), https://legislativeanalysis.org/model-expanded-access-to-emergency-opioid-antagonists-act/.

(o) Telemedicine. — "Telemedicine" means the delivery of health care services, including diagnosis, consultation, treatment, and prescribing, through the use of interactive remote conferencing technology, such as audio, video, or other electronic media; and

(p) Withdrawal management. — "Withdrawal management" refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence.[59]

Commentary

The terms defined in this section may already be defined under state law, and states are free to use those definitions in lieu of the definitions provided in this section. However, the definitions included in this section may have been revised to better fit the needs and circumstances of this Act.

SECTION IV. CREATION OF A MEDICATION FOR ADDICTION TREATMENT PROGRAM IN CORRECTIONAL SETTINGS.

(a) In general.— The [Commissioner of the Department of Health],[60] 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 all correctional facilities in the state. Pursuant to this Act, the program shall include:

  (1) Access to all forms of U.S. Food and Drug Administration-approved medication for addiction treatment for the duration of a program participant's incarceration;

  (2) Individual treatment plans for each program participant; and

  (3) Initial and ongoing training and technical assistance related to medication for addiction treatment for correctional facility staff, including healthcare practitioners, in each institution.

(b) Local correctional settings.— Pursuant to this section, the [Commissioner of the Department of Health] in consultation with local governmental units, county sheriffs,

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[59] Based in part on WORLD HEALTH ORGANIZATION, CLINICAL GUIDELINES FOR WITHDRAWAL MANAGEMENT AND TREATMENT OF DRUG DEPENDENCE IN CLOSED SETTINGS 31 (2009), https://www.ncbi.nlm.nih.gov/books/NBK310652/. *See also Model Withdrawal Management Protocol in Correctional Settings Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (June 2021), https://legislativeanalysis.org/model-withdrawal-management-protocol-in-correctional-settings-act/.

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

local departments of health, corrections and other governmental entities, shall implement medication for addiction treatment programs 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 by a medication for addiction treatment program in a correctional institution shall include, but are not limited to, the following:

(1) Initial and periodic physical and behavioral health assessment services;
(2) Withdrawal management;
(3) Access to all forms of U.S. Food and Drug Administration-approved medication for addiction treatment;
(4) Group and individual substance use disorder counseling and clinical support;
(5) Infectious disease screening and prevention education;
(6) Specific services, including reproductive health services, for pregnant and postpartum program participants;
(7) Peer support services; and
(8) Reentry planning and support.

(e) Exemption.— Upon application of a correctional facility that is unable to meet the requirement that program participants have access to all U.S. Food and Drug Administration-approved forms of medication for addiction treatment, the commissioner may grant a limited exemption if the commissioner determines that there are not any community opioid treatment programs within [x] miles of the facility and that a facility is unable to properly store and maintain medications in accordance to federal and state law within its existing space.

(f) Services referral. — Correctional institutions may choose to enter into an agreement with another correctional institution 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) Outside providers. — Correctional settings choosing to contract with a community overdose treatment program shall establish a memorandum of understanding and review the agreement annually.

(h) 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.

(i) Coordination between local and state facilities.— Local correctional institutions shall coordinate with state correctional institutions to ensure continuity of care and reduce the risk of adverse events and treatment failures, especially surrounding the transfer of an individual from local to state custody.

(j) **Optional** [Local correctional facilities. — 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

One of the key components of this Model Act is the requirement that correctional facilities provide program participants with all FDA-approved forms of MAT. In terms of medication for OUD, this means offering program participants methadone, buprenorphine, and naltrexone. Having all forms of FDA-approved MAT available empowers program participants to work with their healthcare practitioner to choose a medication that will work best for their specific needs. Additionally, individuals who enter a correctional facility already on MAT will experience a smoother transition if they are able to continue using the same form of MAT during their time in the facility. Furthermore, individuals will have an easier time transitioning back into their communities during reentry if the same forms of MAT available in a correctional facility are also available in the community.

The Model Act does not specifically set forth how a correctional institution should implement its MAT program in order to provide facilities with the flexibility to choose a program model that best suits their needs. For example, small correctional settings with limited clinical capacity may find it more feasible to partner with an outside MAT provider. Alternatively, correctional settings with large populations of individuals with SUD may find it more economical to provide MAT services in-house. Providing all FDA-approved forms of MAT for OUD can be complex due to each form of medication being regulated differently, but the federal government has taken steps in recent years to reduce the regulatory burden associated

with these medications to increase accessibility. Section 1262 of the Consolidated Appropriations Act of 2023 removed the federal requirement for healthcare practitioners to apply for a special waiver, known as the Drug Addiction and Treatment Act (DATA)-2000 Waiver or the X-Waiver, prior to prescribing buprenorphine for the treatment of OUD.[61] Now any healthcare practitioner with a U.S. Drug Enforcement Administration (DEA) registration number that includes Schedule III authority can prescribe buprenorphine.[62] Additionally, the law removed the limit on the number of patients to whom a healthcare practitioner could prescribe buprenorphine.[63]

Correctional institutions have three program model options that will enable them to provide all FDA-approved forms of MAT. The first option is to contract with a community opioid treatment program (OTP), which provides MAT for OUD and is certified by SAMHSA and accredited by an independent SAMHSA-approved accrediting body.[64] In addition to successfully completing the certification and accreditation process, OTPs must meet other requirements outlined in 42 C.F.R. Part 8.[65] Partnering with a community OTP is an ideal option for smaller correctional settings that do not have the clinical staff or physical space to operate an in-house MAT program. Depending on the population of the correctional setting and logistics, program participants can be transported to a community OTP by the correctional facility, or the community OTP can provide MAT services at the correctional setting via a mobile medication unit.[66] A community OTP can also use telehealth to provide counseling and other assessment and treatment services to program participants.[67]

The second option is for a correctional facility itself to become certified and accredited as an OTP. Correctional facilities that wish to become an OTP must be able to meet all of the requirements set forth in 42 C.F.R. Part 8. Under federal law, OTPs must be able to provide counseling, along with medical, vocational, educational, or other assessment and treatment services.[68] SAMHSA believes that regardless of what form of MAT is provided, it is more effective when counseling and other services are available to provide the patient with a "whole-person approach."[69] Federal law also requires OTPs to provide counseling on preventing exposure to, and the transmission of, human immunodeficiency virus, viral hepatitis, and sexually transmitted infections and to either directly provide services and treatments, or actively provide links to treatment, to patients who have received positive test results for these conditions.[70] Additionally, specific services, including reproductive health services, for pregnant

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[61] Consolidated Appropriations Act of 2023, Pub. L. No. 117-328, § 1262, 136 Stat. 4459, 5681 (2022).
[62] *Waiver Elimination (MAT Act)*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated May 29, 2024), https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act.
[63] *Id.*
[64] *Certification of Opioid Treatment Programs (OTPs)*, supra note 53.
[65] *Id.*
[66] *See Id.*
[67] *See* Medications for the Treatment of Opioid Use Disorder, 89 Fed. Reg. 7,528 (Feb. 2, 2024).
[68] Federal Opioid Use Disorder Treatment Standards, 42 C.F.R. §8.12 (2024).
[69] *Medications, Counseling, and Related Conditions*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, (last updated Mar. 28, 2024), https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions#counseling-and-behavioral-therapies.
[70] 42 C.F.R. §8.12 (2024)

and postpartum program participants must be provided and documented either by the OTP or by referral to appropriate healthcare practitioners. The drafters set forth the minimum required services in subsection (d) to reflect the requirements delineated in 42 C.F.R. Part 8 to assist correctional facilities in becoming OTPs should they choose to do so. Correctional institutions should also be aware that methadone, as a Schedule II drug, has certain requirements for registration, storage, inventory, and records under the Controlled Substances Act (CSA).[71] These facilities should make sure to check with state regulators about other rules related to methadone.

The final program option is for a correctional institution to utilize the DEA's hospital/clinic designation. To register with the DEA as a hospital/clinic, the institution must complete DEA form 224, which asks for information such as the address of the institution and the DEA license of the provider supervising the clinic.[72] DEA Form 224 defines a hospital/clinic as:

> A physical location at which any combination of inpatient, outpatient, or emergency medical services are provided, based upon authority granted by the State in which it is located. This includes any school which provides medical services to human patients in the process of teaching medicine. This definition does not include individual practitioners, incorporated or otherwise, licensed to practice medicine in a State.[73]

Thus, a correctional facility will need to meet state licensing requirements for hospitals/clinics, in order to obtain DEA hospital/clinic registration.[74] Additionally, such institutions must ensure that they can comply with the CSA. Some correctional facilities may already be registered with the DEA as a hospital/clinic.

Under SAMHSA's April 2024 rule changes to 42 C.F.R. Part 8, correctional facilities registered with the DEA as a hospital/clinic are now expressly authorized to provide methadone as a treatment for OUD to specific individuals in their care.[75] This change allows correctional institutions to initiate methadone treatment for specified program participants without having to be certified as an OTP. A correctional facility that is registered as a hospital/clinic may only dispense methadone as a secondary treatment when the individual in the facility seeks "treatment of medical conditions other than OUD."[76] Plainly stated, a correctional institution can only dispense methadone to an individual if he or she has a diagnosis in addition to OUD. Current

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[71] Physical security controls for non-practitioners; narcotic treatment programs and compounders for narcotic treatment programs; mobile narcotic treatment programs; storage areas, 21 C.F.R. § 1301.72 (2024); Inventory Requirements, 21 C.F.R. § 1304.11 (2024); Maintenance of Records and Inventories, 21 C.F.R. § 1304.04 (2024).
[72] Kelly S. Ramsey, *Brief FAQ on Methadone Use to Treat Opioid Use Disorder (OUD) in Carceral Settings Using the Hospital/Clinic Designation*, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH (last modified Mar. 27. 2024), https://opioidprinciples.jhsph.edu/wp-content/uploads/2024/03/FAQ-Methadone-in-Carceral-Settings.pdf.
[73] *Application for Registration Under Controlled Substances Act of 1970*, DEPARTMENT OF JUSTICE, DRUG ENFORCEMENT AGENCY (last accessed Aug. 15, 2024), https://apps.deadiversion.usdoj.gov/webforms2/spring/main?execution=e1s1.
[74] Ramsey, *supra* note 72.
[75] Opioid Treatment Program Certification, 42 C.F.R. § 8.11(h)(3) (2024).
[76] *Id.*

SAMHSA and DEA regulations do not specify the primary diagnoses that enable a correctional facility registered as a hospital/clinic to offer methadone as a secondary treatment, which gives a healthcare practitioner discretion in determining when to initiate or continue methadone treatment.[77] In theory, any primary diagnosis other than OUD would likely suffice.[78] To dispense methadone with a primary diagnosis instead of a secondary diagnosis a correctional institution must become an OTP.

Correctional facilities should also be aware of the DEA's 72-hour rule or the "three day rule," which allows a healthcare practitioner to dispense up to three days of doses to a person with OUD from a stock supply of methadone or buprenorphine at the facility.[79] While this rule tends to be used mostly in hospital emergency departments, it also applies in correctional settings.[80] The three day rule "allows for uninterrupted treatment with methadone or buprenorphine when an individual is released from a [correctional facility], particularly when done on a weekend."[81] This is particularly helpful for individuals being treated with methadone, as methadone cannot be dispensed by a pharmacy for the treatment of OUD like buprenorphine can.[82] Using the three day rule allows an individual to leave a correctional setting without a gap in medication access, giving the individual a few days to connect with a community OTP.[83] Correctional facilities should check with their state regulatory authority to determine if there are additional state laws or regulations governing the three-day rule.[84]

Regardless of which program model a correctional setting chooses, the facility should provide withdrawal management services to all who need it, including individuals who decline to participate in the MAT program. Individuals entering a correctional facility who are cut off from using certain substances are likely to experience withdrawal symptoms, particularly if the individual is a long-time user of the substance.[85] The failure to identify and manage withdrawal symptoms can result in serious health complications and even death.[86] A proper withdrawal management program should reflect legal and regulatory requirements and include evidence-based responses to individuals at risk for or experiencing withdrawal and thresholds for when individuals need to be transferred to an external medical facility for care.[87] For more information on establishing a withdrawal management protocol, correctional facilities should refer to the

[77] *Methadone Treatment: Recent Revision to Regulation Covering Facilities Treating Individuals for a Primary Diagnosis Other Than Opioid Use Disorder*, LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION (June 2024), https://legislativeanalysis.org/methadone-treatment-recent-revision-to-regulation-covering-facilities-treating-individuals-for-a-primary-diagnosis-other-than-opioid-use-disorder/.
[78] *Id.*
[79] Administering or Dispensing of Narcotic Drugs, 21 C.F.R. § 1306.07(b) (2024).
[80] Ramsey, *supra* note 72.
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] BUREAU OF JUSTICE ASSISTANCE, U.S. DEPARTMENT OF JUSTICE, GUIDELINES FOR MANAGING SUBSTANCE WITHDRAWAL IN JAILS 1 (June 2023), https://bja.ojp.gov/doc/wmg-flyer.pdf.
[86] *Id.*
[87] *Id.*

Bureau of Justice Assistance's Guidelines for Managing Substance Withdrawal in Jails and LAPPA's Model Withdrawal Management Protocol in Correctional Settings Act.

Subsection (b) 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. MEDICATION FOR ADDICTION TREATMENT PROGRAM REQUIREMENTS.

(a) Assessment. — Immediately upon an individual's arrival at the correctional facility, qualified staff shall conduct an assessment using a designated evidence-based tool[88] to evaluate the individual for a substance use disorder. The assessment should be standardized across correctional institutions within the state and should be based on the criteria for diagnosing substance use disorder as set out in the Diagnostic and Statistical Manual of Mental Disorders ("DSM-V") or its successor.

(b) Program procedure. — Following the assessment provided for in subsection (a) of this section, an individual assessed as having a substance use disorder, for which an available U.S. Food and Drug Administration-approved medication exists, shall be offered placement in the medication for addiction treatment program.

(c) Medical evaluation. — Upon referral to the medication for addiction treatment program, potential program participants shall receive a medical evaluation from a healthcare practitioner to determine if he or she is a candidate for medication for addiction treatment. During this medical evaluation, the healthcare practitioner shall discuss with the potential program participant the risks and benefits of medication for addiction treatment, the types of medications available, and a proposed treatment plan.

(d) Program participation.— Participation in the medication for addiction treatment program shall not be mandatory, and the decision to participate in the program shall be made

[88] The National Institute on Drug Abuse has a list of evidence-based screening and assessment tools that can be used with adolescence and adults to determine their specific substance(s) use and risk level. *See Screening and Assessment Tools Chart*, NATIONAL INSTITUTE ON DRUG ABUSE (last updated Jan. 6, 2023), https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools.

solely by the individual. Individuals choosing to opt out of the program shall not receive any adverse action and shall continue to receive other medical care and services as necessary. Program participation shall not be denied to any individual who is assessed as having a substance use disorder for which medication for addiction treatment is medically appropriate and who wishes to participate in the program.

(e) Choice of medication.— The type of medication for addiction treatment a program participant receives shall be determined solely by the program participant and his or her healthcare practitioner within the facility. Individuals previously on medication for addiction treatment prior to incarceration shall receive the same medication previously prescribed to him or her by a community healthcare practitioner, unless another form of medication is clinically indicated.

(f) Commencement.— An individual 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 individual's incarceration, including immediately prior to their release.

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

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

(i) Discontinuance.— A program participant may elect to discontinue medication for addiction treatment at any time during his or her incarceration. In such cases, discontinuation shall adhere to a medically appropriate tapering protocol.

(j) 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 his or her healthcare practitioner.

(k) Behavioral therapy.— A correctional facility shall continuously offer individualized and

group behavioral therapies, such as counseling, to program participants but shall not condition participation in such services as a requirement for receiving medication for addiction treatment.

(l) Medication maintenance.— Program participants shall receive their medication for addiction treatment at therapeutic levels for as long as it is beneficial to the individuals, which may be while in the facility or in the community.

(m) Pregnant and postpartum program participants.— A correctional setting shall have a special medication for addiction treatment program protocol for pregnant and postpartum program participants.

(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 the institution's correctional staff and medical staff and third-party providers, if applicable;
(4) Maintenance of medication inventory, storage, and recordkeeping 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) Protocols for drug screening;
(7) Challenges by potential program participants to determinations related to participation in the medication for addiction treatment program;
(8) Agreements with community-based providers to facilitate reentry and access to treatment post-release;
(9) Implementation of best practices for reducing diversion of medication for addiction treatment; and
(10) The use of telemedicine, where applicable.

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Commentary

Informed consent and patient choice are key components of successful MAT programs, including those that serve incarcerated individuals. It is the position of the American Medical Association that physicians strive to obtain informed consent from incarcerated patients to the best of their ability and respect their autonomy.[89] Potential program participants should always be provided the choice of whether to engage in MAT and educated on the risks and benefits associated with such treatment.[90] Federal regulations governing OTPs require healthcare practitioners to ensure that: (1) each patient has voluntarily chosen MAT treatment; (2) all relevant facts concerning MAT have been clearly and adequately explained to the patient; and (3) each patient has provided informed consent to treatment.[91]

This Model Act implements the principles of the Missouri Department of Mental Health's "Medication First" approach.[92] The Medication First approach is similar to the "Housing First" approach to ending chronic homelessness.[93] In both the Housing First and Medication First approaches, "the lack of mandatory prerequisites provides individuals rapid access to what they need first (*i.e.* housing or stabilizing medications)."[94] These two approaches are based on the tenets of: (1) rapid access; (2) stability/perpetual access; (3) consumer choice in service participation; and (4) lack of punitive structure or ongoing requirements.[95] The medication first framework follows four key principles:

(1) Clients receive pharmacotherapy as quickly as possible, prior to lengthy assessments or treatment planning sessions;
(2) Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
(3) Individualized psychosocial services are offered but not required as a condition of pharmacotherapy; and
(4) Pharmacotherapy is discontinued only if it appears to be worsening the client's condition.[96]

The Medication First approach does not mean "Medication Only."[97] The approach implies that MAT programs should provide program participants with wrap-around services,

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[89] Annalise Norling, *The AMA Code of Medical Ethics' Opinions Related to Health Care for Incarcerated People*, 19 AM. MED. ASS'N J. OF ETHICS 911 (Sept. 2017), https://journalofethics.ama-assn.org/sites/joedb/files/2018-05/coet1-1709.pdf.
[90] SHANNON MACE, ET AL., MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER IN JAILS AND PRISONS: A PLANNING AN IMPLEMENTATION TOOLKIT, 14 (2023), https://www.thenationalcouncil.org/resources/medication-assisted-treatment-mat-for-opioid-use-disorder-in-jails-and-prisons-a-planning-and-implementation-toolkit/.
[91] 42 C.F.R. § 8.12(e)(1).
[92] Rachel P. Winograd, et al., *The Case for a Medication First Approach to the Treatment of Opioid Use Disorder*, 45 AM. J. OF DRUG & ALCOHOL ABUSE 333, 334 (2019), https://doi.org/10.1080/00952990.2019.1605372.
[93] *Id.*
[94] *Id.* at 335.
[95] *Id.*
[96] *Id.*
[97] *Id.*

such as behavioral therapy in addition to their MAT but should never prohibit an individual from receiving MAT for refusing to participate in those additional services.[98] The Medication First philosophy regarding voluntary psychosocial services is a key aspect of what sets this approach apart from traditional treatment approaches which typically only offered MAT to patients in conjunction with mandatory behavioral therapy.[99] Note that federal regulations require OTPs to provide "adequate substance use disorder counseling and psychoeducation to each patient as clinically necessary and mutually agreed-upon, including harm reduction education and recovery-oriented counseling."[100] However, the regulations state that a patient's refusal of counseling should not prevent him or her from receiving MAT.[101] All behavioral therapies offered by a correctional facility's MAT program should be voluntary and patient centered with an emphasis on the issues that are of the greatest concern to the individual.[102]

While MAT should be offered to all individuals with SUD, correctional facilities that house pregnant and postpartum individuals should develop special MAT policies and protocols for this population. The abrupt discontinuation of drugs during pregnancy can result in premature labor, fetal distress, and miscarriage.[103] To avoid obstetrical complications, the American College of Obstetricians and Gynecologists and the American Society for Addiction Medicine recommend treating pregnant individuals with SUD with MAT.[104] MAT use during pregnancy has been shown to improve prenatal care, reduce illicit drug use, and minimize the risk of fetal withdrawal.[105] If an eligible pregnant program participant declines MAT or if MAT is not clinically appropriate for such individual, then the correctional facility should provide the individual with medically supervised withdrawal under the care of a healthcare practitioner.[106] Postpartum individuals should continue receiving MAT and should not be forced to discontinue their medication after giving birth.[107]

Diversion of medications is a common concern among correctional facilities operating an MAT program. The implementation of a diversion control plan can help a correctional institution reduce diversion events. Note that federal regulations require that OTPs have a diversion control

[98] *Id.*
[99] *Id.*
[100] 42 C.F.R. § 8.12(f)(5)(i) (2024).
[101] *Id.*
[102] MACE, ET AL., *supra* note 90, at 42
[103] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS 1 (2016), https://store.samhsa.gov/sites/default/files/sma16-4978.pdf.
[104] *Id.* at 2.
[105] Id. at 3.
[106] AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, OPIOID USE AND OPIOID USE DISORDER IN PREGNANCY 7-8 (Aug. 2017), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy.
[107] BUREAU OF JUSTICE ASSISTANCE, GUIDELINES FOR MANAGING SUBSTANCE WITHDRAWAL IN JAILS 52 (June 2023), https://www.cossup.org/Topics/CourtsCorrections/JailResources/Guidelines.

plan in place.[108] A diversion control plan is defined as "a set of documented procedures that reduce the possibility that controlled medications will be transferred or otherwise shared with others to whom the medication was not prescribed or dispensed."[109] A correctional facility's diversion control plan may include guidance on medication formulation, dispensing and ingestion practices, medication storage, and the protocol for responding to a diversion incident.[110] In correctional facilities, MAT diversion tends to occur as a means for individuals to self-treat symptoms of withdrawal or help others who are not enrolled in the MAT program.[111] Studies show that correctional facilities with MAT programs that offer MAT to all who need it, as opposed to those that offer MAT to only certain populations, experience less medication diversion.[112] By increasing legitimate access to MAT and reducing the number of individuals with unmet SUD treatment needs, a correctional facility lessens the demand for contraband MAT and reduces the illicit market value of these medications within the facility.[113] MAT programs in correctional facilities have also been shown to make facilities safer by reducing the sale and possession of diverted or contraband substances and decreasing the number of conflicts among residents.[114]

When diversion of MAT does occur, correctional staff and healthcare practitioners should examine the context and circumstances surrounding the diversion event and the behavioral motivations of the individuals involved in order to formulate a plan to avoid future diversion.[115] For example, a program participant may be experiencing peer pressure or bullying from a non-program participant who wants him or her to share the MAT.[116] A potential solution in this case may be separating the two individuals or housing program participants in a separate unit, if feasible. Alternatively, a program participant could be diverting his or her MAT to another individual who he or she believes is going through withdrawal. A solution in this case would be to medically evaluate the individual receiving the diverted MAT to determine if he or she is a candidate for the MAT program, or if he or she is already a program participant, whether the individual needs an adjustment to his or her dosage. Program participants that are identified as diverting MAT should not be immediately discharged from the MAT program.[117] Punitive "no tolerance" approaches to MAT diversion have proven to be unhelpful and can lead to the diverter

[108] 42 C.F.R. § 8.12(c)(2) (2024).
[109] Definitions, 42 C.F.R. § 8.2 (2024).
[110] MACE, ET AL., *supra* note 90, at 39.
[111] Elizabeth A. Evens, et al., *Diversion of Medications to Treat Opioid Use Disorder: Qualitative Findings from Formerly Incarcerated Adults in Massachusetts*, 122 INT'L J. OF DRUG POL'Y 104252, 104255 (2023), https://doi.org/10.1016/j.drugpo.2023.104252.
[112] *Id.* at 104256.
[113] *Id.*
[114] *Id.* at 104257.
[115] Michelle R. Lofwall and Sharon L. Walsh, *A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences from Around the World*, 8 J. ADDICTION MED. 315, 12 (Sept./Oct. 2014), https://doi.org/10.1097/ADM.0000000000000045.
[116] *Id.* at 22.
[117] *Id.* at 12.

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returning to use and facing an increased risk of morbidity and mortality while in the facility.[118] Correctional facilities may penalize an individual for diverting MAT, but the punishment should involve only the removal or limitation of non-medical privileges. Drug testing can be used to monitor potential diversion, though it should be used in a therapeutic manner as a tool for promoting recovery and compliance and not for punishment.[119]

Participation in a correctional setting's MAT program should always be regarded as evidence-based medical treatment for a chronic condition and not as a reward or privilege.[120] Like with instances of diversion, program participants should not be removed from the program for testing positive for other drugs, being put in administrative segregation, or other disciplinary infractions. Federal courts have held that SUD and the side effects of withdrawal are "serious medical needs"[121] and that delaying necessary medical treatment for non-medical reasons can be considered deliberate indifference under the Eighth and Fourteenth Amendments of the U.S. Constitution.[122] Additionally, in *Ferguson v. Palm Beach County Sheriff's Department of Corrections*, the court determined that taking an incarcerated individual off MAT as a form of punishment would constitute deliberate indifference.[123] Security staff within a correctional facility should never make any decisions regarding MAT, including the termination of care.[124] The decision to terminate MAT is to be made solely by a program participant and his or her healthcare practitioner. Should a program participant wish to terminate MAT, he or she should be provided with proper tapering of the medication and withdrawal management.

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 correctional facility staff regarding medication for addiction treatment.

(b) Training for all staff. — Prior to the implementation of a medication for addiction treatment program, all correctional facility staff shall receive training and education on the following topics:

(1) Substance use disorder;

[118] *Id.*
[119] MACE, ET AL., *supra* note 90, at 61.
[120] *Id.* at 64.
[121] *See Foelker v. Outagamie Cnty.*, 394 F.3d 510, 512–13 (7th Cir. 2005); *Schiavone v. Luzerne Cnty.*, 2022 WL 3142615, at *3 (M.D. Pa. Aug. 5, 2022); and *Johnson v. Dixon*, 2023 WL 6481252, at *4 (S.D. Fla. 2023).
[122] *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985).
[123] 2023 WL 6142466, at *3-4 (S.D. Fla. 2023).
[124] MACE, ET AL., *supra* note 90.

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(2) Withdrawal and withdrawal management;

(3) The science behind medication for addiction treatment;

(4) The correctional setting's medication for addiction treatment program and program policies and procedures;

(5) Recovery-oriented principles and approaches;

(6) Signs of medication diversion and policies to respond to diversion incidents;

(7) Security issues related to the medication for addiction treatment program; and

(8) The use of U.S. Food and Drug Administration-approved overdose reversal medications.

(c) Training for program staff.— Prior to the implementation of a medication for addiction treatment program, all correctional staff directly involved with the medication for addiction treatment program, including healthcare practitioners, shall receive training and education on the following topics, in addition to the training required in (b):

(1) Screening, assessment, and treatment policies and protocols; and

(2) Federal, state, local, and accreditation bodies' rules and regulations related to storage, administration, disposal, ordering, and recordkeeping of medication for addiction treatment.

(d) New hires.— All correctional facility staff hired after the implementation of the medication for addiction treatment program shall receive the appropriate training for their position during their onboarding period.

(e) Annual training.— All correctional facility staff shall receive training on the medication for addiction treatment program on an annual basis after the program is implemented.

(f) [**Optional** External provider training.— If contracting with a community overdose treatment program to provide medication for addiction treatment services on-site, the correctional institution shall train the community overdose treatment program staff in the following:

(1) The correctional institution's security protocol;

(2) Expectations regarding the conduct of staff and program participants; and

(3) An overview of the correctional facility's systems, including information systems and records management.]

Commentary

For an MAT program to be successful, the operational/security staff must coordinate and communicate with the medical staff often.[125] MAT programs require multidisciplinary teams of staff from both inside and outside of the correctional setting to safely deliver medications and ensure the proper care of program participants.[126] A multidisciplinary approach helps to increase trust, reduce mistakes, increase transparency, and minimize security issues and diversion.[127] Developing this type of environment requires proper training and education of all correctional staff. The designated agencies must train and educate all staff on SUD, the benefits of MAT, the institution's MAT program, and how to identify and address medication diversion.[128] Staff directly involved with the MAT program should receive more extensive training.[129] Furthermore, if a correctional institution is contracting with a community OTP to provide MAT services in-house, then the external OTP staff should receive training on the institution's policies, including its security protocol.[130] Training should occur prior to the implementation of the MAT program and annually thereafter, with all new hires receiving training during the onboarding process.[131]

SECTION VII. REENTRY AND TREATMENT.

(a) In general. — A correctional facility's medication for addiction treatment program shall provide all program participants with an individualized reentry treatment plan within sixty (60) days prior to release.

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

(1) Includes information regarding post-incarceration access to medication for addiction treatment and supportive therapy in the geographic region in which the individual 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 and any other documentation necessary for continuity of care and is called

[125] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, MAT INSIDE CORRECTIONAL FACILITIES: ADDRESSING MEDICATION DIVERSION 2 (Aug. 2019), https://store.samhsa.gov/product/mat-inside-correctional-facilities-addressing-medication-diversion/pep19-mat-corrections.
[126] *Id.*
[127] *Id.*
[128] *Id.* at 4.
[129] MACE, ET AL., *supra* note 90, at 44.
[130] *Id.*
[131] *Id.*

into a pharmacy of the participant's choosing, as applicable;

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

(4) Includes referrals and affirmative linkages to care:

(A) To an available opioid treatment program or healthcare practitioner in the program 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 opioid treatment program 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 an overdose reversal medication 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 healthcare practitioner and parole or probation staff, as applicable, including timely sharing of accurate information regarding the program participant's medication for addiction treatment regimen.

(e) Parole and probation support. — Within one (1) year of the enactment of this act, the [Department of Corrections] shall develop procedures to provide any program participant

who notifies his or her probation or parole officer of a return to use or who receives a positive drug screen with recovery support in lieu of arrest, incarceration, or revocation of probation or parole.

(f) 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 released from a correctional facility are at an increased risk of overdose, particularly during the first two weeks after release.[132] Ensuring that an individual can continue his or her MAT once released can help to reduce the risk of overdose during the reentry period. The Model Act requires correctional facilities to provide all program participants with an individualized reentry treatment plan to allow an individual to continue to receive MAT and supportive services in his or her community upon release. While the details of a program participant's reentry treatment plan will depend on what form of MAT he or she is prescribed, all reentry treatment plans should include referrals to a healthcare practitioner (or an OTP if the individual is prescribed methadone) and linkages to peer support and social services.

States are encouraged to apply for a Medicare reentry Section 1115 demonstration waiver so that they can cover pre-release services for a Medicaid-eligible program participant for up to 90 days prior to the individual's expected release date, if they have not already done so. The submission and approval of a Medicare reentry Section 1115 demonstration waiver by the U.S. Department of Health and Human Services exempts a state from the inmate exclusion policy[133] so that it can provide pre-release services to a Medicaid-eligible incarcerated individual for a set period while the incarcerated individual prepares for reentry into the community. This helps facilitate the incarcerated individual's connection to community-based care providers prior to release, which should reduce gaps in care during the reentry period and support care continuity. For more information on Medicare reentry Section 1115 demonstration waivers please refer to LAPPA's Model Medicaid Reentry Section 1115 Demonstration Waiver Act.

SECTION VIII. CONFIDENTIALITY.

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

(a) The Health Insurance Portability and Accountability Act of 1996;

(b) 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2; and

(c) All state laws and regulations that protect relevant health information. [Insert citations for

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[132] *See* Hartung, et al., *supra* note 19.

[133] 42 U.S.C. 1396d (a)(31)(A).

state law and regulation(s)].

Commentary

Patient privacy can be a particularly sensitive area to navigate as applied to individuals in recovery from SUD.[134] Often, there may be multiple care providers and entities that require access to a participant's electronic medical records. However, these individuals 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 program participants. Existing state privacy laws and regulations may have to be evaluated to ensure that they 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 IX. REPORTING.

(a) Annual report. — Within one (1) year of the effective date of this act and annually thereafter, each correctional facility in the state shall submit a de-identified report containing the information in subsection (c) to the state [Department of Corrections].

(b) Data analysis. — The state [Department of Corrections] shall analyze each annual report submitted pursuant to subsection (a). It shall create a single report continuing an aggregate of the data submitted and shall submit that report to the governor and the [appropriate committees] of the state legislature.

(c) Contents of annual report. — The annual report required in subsection (a) shall include, but not be limited to, the following information:

(1) The number of individuals entering the correctional facility;

(2) The number of individuals screened for substance use disorder;

(3) The number of individuals diagnosed with substance use disorder;

(4) The number of individuals who received withdrawal management services;

(5) The number of individuals who chose to participate in the correctional facility's MAT program;

(6) The demographics of program participants, including age, sex, gender, race, and ethnicity;

(7) The number of pregnant program participants;

[134] *See* Lianne Lian Hu, et al., *Privacy Protection for Patients with Substance Use Problems*, 2 SUBSTANCE ABUSE AND REHABILITATION, 227 (2011) https://doi.org/10.2147/SAR.S27237.

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(8) The number of program participants receiving each type of medication for addiction treatment;

(9) The proportion of program participants who are continuing community treatment versus starting treatment while incarcerated;

(10) The average length of stay of program participants;

(11) The number of program participants that opt to receive counseling services;

(12) The number of program participants who remain on medication for addiction treatment at the time of release;

(13) The number of program participants who continue to receive medication for addiction treatment upon reentry;

(14) The number of program participants who are insured through Medicaid or private insurance at the time of release;

(15) The impact of the medication for addiction treatment program on institutional safety and performance, including the number of diversion events;

(16) The number of fatal and non-fatal overdoses that occurred within the correctional setting;

(17) The number of suicides that occurred within the correctional institution;

(18) The rate of unintentional fatal and non-fatal overdose among program participants recently released into the community;

(19) The rate of recidivism among program participants;

(20) Estimated cost savings of implementing withdrawal management and medication for addiction treatment programs; and

(21) 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;

(d) De-identified data. — All data and metrics contained within the report shall be de-identified.

(e) Public access to reports. — Reports submitted pursuant to this section are not confidential and may be shared with the public.

Commentary

Tracking, monitoring, and evaluating the efficacy and success of a medication for addiction treatment program is crucial to sustaining effective programs. It is important to collect and evaluate data across the continuum of care, including metrics related to screening, treatment, and pre-release planning.[135] Data should also be collected prior to the initiation of the program in order to have a baseline for comparison over time.[136] Program evaluations and data collection can be conducted internally or by a third party, such as a university.[137]

The drafters recommend that a correctional institution evaluate the demographics of program participants in order to identify any disparities in MAT access and outcomes.[138] In addition to demographic information related to age, sex, gender, race, and ethnicity, a correctional facility may consider collecting demographic information on a program participant's housing area/unit, security designation, and pre-trial detainee/post-trial status.[139] Jails may have a particularly difficult time collecting and analyzing data due to the fact that some individuals are housed in a jail for a very short time.[140] For such reason, a jail, when calculating and evaluating metrics, may want to exclude data from individuals who are housed in the facility for less than a certain period of time. For example, a jail might choose only to evaluate MAT program retention among individuals with a minimum length of stay.[141]

Correctional facilities should be aware that collecting and evaluating certain metrics may require data sharing between security staff and medical staff within the correctional setting.[142] In order to share data across departments or systems, it may be necessary to execute a data sharing or use agreement.[143] A correctional facility should also monitor and evaluate the impact of the MAT program on individuals released into the community whenever possible. In order to measure these effects, correctional facilities should collaborate and share data with community stakeholders, such as community OTPs and healthcare practitioners.[144] Any data shared between a correctional institution and an outside stakeholder should comply with all relevant federal and state privacy laws.

SECTION X. FUNDING.

(a) Budget allocation . — Unless otherwise fully funded through another source, the legislature shall appropriate sufficient funds for each fiscal year to the [Department of Corrections] for the purpose of establishing, implementing, operating, and overseeing

[135] MACE, ET AL., *supra* note 90, at 75.
[136] *Id.* at 74.
[137] *Id.*
[138] *Id.* at 75.
[139] *Id.*
[140] *Id.* at 77.
[141] Id. at 78.
[142] *Id.* at 80.
[143] *Id.*
[144] *Id.*

medication for addiction treatment programs in state and local correctional facilities.

(b) Pursuit of funding. — The [Department of Corrections] may pursue all federal funding, matching funds, and foundation or other charitable funding for the initial start-up and ongoing activities required under this Act as allowable under [state] law.

(c) Opioid settlement funds. — Funds available from an opioid-related litigation settlement or damage award may be used to fund the programs required by this Act.

(d) Acceptance of gifts.—The [Department of Corrections] and any public or private agency or organization acting under contract with the department, may accept such gifts, grants, and endowments, from public or private sources, as may be made from time to time, in trust or otherwise, for the use and benefit of the purposes of this Act and expend the same or any income derived from it according to the terms of the gift, grant, or endowment, as allowed by state and federal law.

(e) Guidelines and requirements. — Funding shall be made available to support both new and existing medication for addiction treatment programs.

Commentary

Funding sections in model laws can be complicated, as states fund projects through legislation in a variety of ways, and there is no "one size fits all" approach. However, if the Model Act omits the funding discussion altogether, the legislation could give the appearance of an unfunded mandate.

Research indicates that providing MAT in correctional facilities is cost effective and cost beneficial.[145] Cost benefit analyses of MAT show that it leads to lower health care usage than SUD treatment without medication.[146] In addition to reducing health care spending, MAT programs in correctional facilities can reduce expenditures related to crime in the long run by reducing recidivism,[147] making MAT programs in correctional settings a sound investment for the state.

Potential funding sources for the establishment and ongoing operations of MAT programs in correctional facilities include state general revenue, federal funding, opioid-related litigation settlements and damage awards, and charitable grants. SAMHSA state opioid response (SOR) grants are one example of federal funds that can be used to support the activities of this Act. SOR grants are meant to be used to "address the public health crisis caused by escalating

[145] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, TREATMENT IMPROVEMENT PROTOCOL (TIP) 63 ES-3 (July 2021), https://store.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002.

[146] *Id.* at 1-7

[147] *Id.*

opioid misuse, opioid use disorder, and opioid-related overdose across the nation."[148] States and territories can use SOR funds to: "(1) increase access to U.S. Food and Drug Administration-approved medications for the treatment of opioid use disorder; (2) support the continuum of prevention, harm reduction, treatment, and recovery support services for OUD and other concurrent substance use disorders; and (3) support the continuum of care for stimulant misuse and use disorders, including those involving cocaine and methamphetamine."[149] Other federal funds that can be used to support MAT programs in correctional facilities, include, but are not limited to, SAMHSA MAT expansion grants, SAMHSA state targeted response to the opioid crisis grants, and DOJ RSAT for state prisoners program grants.[150] Furthermore, as stated in the commentary for Section VII, states are encouraged to apply for a Medicare reentry Section 1115 demonstration waiver so that they can cover pre-release services for a Medicaid-eligible program participant for up to 90 days prior to the individual's expected release date.

SECTION XI. RULES AND REGULATIONS.

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

SECTION XII. 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 XIII. 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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[148] *State Opioid Response Grants*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, (last updated May 17, 2024), https://www.samhsa.gov/grants/grant-announcements/ti-24-008.
[149] *Id.*
[150] *See* MACE, ET AL., *supra* note 90, at 87-88.

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The Legislative Analysis and Public Policy Association (LAPPA) 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.

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