Health District
OF NORTHERN LARIMER COUNTY

2/21/2020

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB20-1017: SUBSTANCE USE DISORDER TREATMENT IN CRIMINAL JUSTICE SYSTEM

Concerning treatment of individuals with substance use disorders who come into contact with the criminal justice system, and, in connection therewith, making an appropriation.

Details

Bill Sponsors:	House – *Herod (D) and Kennedy (D)* Senate – *Donovan (D) and Priola (R),* Pettersen (D)
Committee:	House Public Health Care & Human Services House Appropriations
Bill History:	1/8/2020- Introduced 2/12/2020- House Public Health Care & Human Services Refer Amended to Appropriations
Next Action:	Hearing in House Appropriations
Fiscal Note:	2/10/2020[1]

Bill Summary

The bill addresses a variety of issues related to the general topic of substance use disorder (SUD) treatment in the criminal justice system. The bill:

- Requires the Department of Corrections (DOC), jails, and Department of Human Services (DHS) facilities to make at least one opioid agonist available to a person in custody with an opioid use disorder
- Allows for controlled substance disposal and referral to treatment at "safe stations"
- DOC and jails required to ensure continuity of care, based on defined levels of treatment
- If a person who is the subject of a petition to seal criminal records has entered into or successfully completed a licensed SUD treatment program, the court is required to favorably consider the factor in determining whether to issue the order to seal

Issue Summary

Medication-Assisted Treatment (MAT)

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines MAT as medications utilized with counseling and behavioral therapies to treat substance use disorders and to prevent opioid overdose.[2] Currently, there are three classes of medications that that have been approved by the Food and Drug Administration (FDA) to treat opioid use disorders: methadone, buprenorphine, and naltrexone.[3] Methadone is an opioid agonist that reduces the symptoms of opioid withdrawal while blocking the euphoric effects of most opioids, including heroin.[1] Methadone is required to be administered daily in an office setting for the first few years of maintenance treatment. Federal rules require methadone to be prescribed and dispensed by a certified Opioid Treatment Program (OTP). Buprenorphine is an opioid partial agonist that can reduce the effects of withdrawal but it produces effects such as euphoria or respiratory depression.[1] Since buprenorphine has these effects it is often produced in combination with naloxone to reduce the

[1] The fiscal note is based off the bill as introduced, not as it was amended by the House Public Health Care & Human Services Committee. The sections 'Bill Summary' and 'This Legislation' are both based off of the bill as amended in that committee.

[2] Substance Abuse and Mental Health Services Administration (2015). *Medication and Counseling Treatment.* Retrieved from https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

[3] California Health Care Foundation (Sept. 2017). *Why Health Plans Should Go to the "MAT" in the Fight Against Opioid Addiction.* Retrieved from https://www.chcf.org/wp-content/uploads/2017/12/PDF-Why-Health-Plans-Should-Go-to-the-MAT.pdf

potential for misuse.[1] With naltrexone, an opioid antagonist, the medication blocks both the euphoric and sedative effects of opioids; additionally, a patient must to abstain from opioids for 7-10 days before beginning the medication.[1] Injectable naltrexone must be administered in a health care setting by a licensed provider, which includes pharmacists. The following table[4] demonstrates the regulations and effectiveness for the three FDA-approved medications.[2]

Naltrexone can also be utilized to treat alcohol use disorders (AUD). Studies have shown the effectiveness of naltrexone in decreasing cravings and improving outcomes.[5,6]

Table 1. Medications Used in Addiction Treatment

	WHERE IT CAN BE PROVIDED	FDA INDICATIONS	EFFECTIVENESS*	ADMINISTRATION
Methadone	**OUD.** Licensed opioid treatment programs. **Pain.** Any Drug Enforcement Agency (DEA)-licensed prescriber.	OUD and pain management	74% to 80%[12]	**OUD.** Daily pill, liquid, and wafer forms; injectable form in hospitalized patients unable to take oral medications **Pain.** Pill and injectable forms
Buprenorphine and buprenorphine/naloxone	Prescribed by community physicians and dispensed by pharmacies; available in some opioid treatment programs. Physicians receive federal waivers after eight hours of training; nurse practitioners and physician assistants require 24 hours. Patient panels are capped at 30, 100, and 275 per provider (depending on experience and setting).[13-15] Any DEA-licensed provider can prescribe buprenorphine for pain.	OUD and pain management (depending on formulation and dose)	60% to 90%[16]	**OUD.** Daily sublingual, buccal, film, and tablet, or six-month intradermal device **Pain.** Injectable, transdermal, and buccal film
Naltrexone	No restrictions.	Opioid and alcohol use disorders	**OUD.** 10% to 21%[17]	Daily pill or monthly injectable
Naloxone (used only for overdose reversal, not addiction treatment)	Any setting: prescribed or dispensed by a clinician, furnished by a pharmacy without a prescription (legal in several states), dispensed by lay staff in community settings (by standing order), or carried by law enforcement or other first responders.	To reverse respiratory suppression in suspected opioid overdose	May require high doses for extremely high-potency illicit drug use (e.g., fentanyl and carfentanyl)	Intranasal spray, or intravenous, intramuscular, or subcutaneous injectable

*Retention in treatment at 12 months with significant reduction or elimination of illicit drug use.

A recent study indicated that only treatment with buprenorphine or methadone, in comparison with opioid antagonist therapy, inpatient treatment, or intensive outpatient treatment, was associated with a reduced risk of overdose and serious opioid-related morbidity.[7] Evidence has demonstrated the effectiveness of MAT, yet only 10 percent of those that seek this treatment can access it in the United States.[2] The barriers can range from a shortage of buprenorphine prescribers, to restrictive health plans, to stigma.

[4] Note that the acronym OUD included in the figure stands for opioid use disorder.
[5] Anton, R.F. (May 3, 2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. *JAMA. 295*(17). Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/16670409
[6] Helstrom, A.W. (Sept. 2016). Reductions in Alcohol Craving Following Naltrexone Treatment for Heavy Drinking, *Alcohol and Alcoholism 51*(5). Retrieved from https://academic.oup.com/alcalc/article/51/5/562/1740449
[7] Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Netw Open.* 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032

Medication-Assisted Treatment (MAT) in State Prisons and County Jails

An estimated 65 percent of incarcerated individuals in the United States have a substance use disorder.[8] Inmates that have been recently[9] released are 129 times more likely to die from drug overdose than the general population.[10] A recent study in Rhode Island has implied that there is a reduction in fatal drug overdoses when criminal justice facilities implement a MAT program.[11] Rhode Island offers all prisoners with an opioid use disorder to be inducted or continued on a selection of methadone, buprenorphine, and extended release naltrexone (i.e. Vivitrol®). The contractor who provides the medication is a community provider, making linkage to care more effective.

There have been a variety of lawsuits throughout the country regarding SUD treatment in correctional facilities. One lawsuit in Maine, brought by the American Civil Liberties Union (ACLU), regarding the continuation of MAT medication while in a correctional facility.[12] Both a lower court and a federal appeals court found that the county jail must provide the woman with MAT for her SUD while she served a 40-day sentence.

Medicaid Coverage of and Health Care for Confined Individuals

Federal law does not prohibit individuals from being enrolled in Medicaid while incarcerated but it prohibits states from using federal matching funds for health care services for adult and juvenile inmates of public institutions, except when the inmate is admitted to an off-site hospital or other qualifying facility for at least 24 hours.[13,14] The Centers for Medicare and Medicaid Services (CMS) provided guidance in 2015 to clarify when an individual is considered an inmate of a public institution, the following table illustrates that guidance.[15]

Federal matching funds are available for individuals:	Federal matching funds are NOT available for individuals living in:
On parole, probation, or released to the community pending trial	State/federal prisons, local jails, or detention facilities
Living in a halfway house where individuals can exercise personal freedom	Federal residential reentry centers
Voluntarily living in a public institution	Residential mental health & SUD treatment facilities for incarcerated individuals
On home confinement	Hospitals or nursing facilities that exclusively serve incarcerated individuals

Most states, including Colorado, suspend rather than terminate Medicaid benefits during periods of incarceration. This allows for coverage to reactivated more quickly than if the individual has to reenroll for

[8] MACPAC (July 2018). *Medicaid and the Criminal Justice System.* Retrieved from https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf

[9] Within 2 weeks of release

[10] Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from Prison — A High Risk of Death for Former Inmates. *New England Journal of Medicine,356*(2), 157-165. doi:10.1056/nejmsa064115

[11] Green, T.C., Clarke, J., Brinkley-Rubinstein L, et al. (2018) Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. *JAMA Psychiatry, 75*(4):405–407. doi:10.1001/jamapsychiatry.2017.4614

[12] American Civil Liberties Union (May 1, 2019). *Federal appeals court upholds ruling that jail must provide Maine women with medication aissted treatment for substance use disorder.* Retrieved from https://www.aclumaine.org/en/press-releases/federal-appeals-court-upholds-ruling-jail-must-provide-maine-woman-medication

[13] 42 USC § 1393d(a)(29)(A)

[14] The Pew Charitable Trusts (Aug. 2, 2016). *How and When Medicaid Covers People Under Correctional Supervision: New federal guidelines clarify and revise long-standing policies.* Retrieved from https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision

[15] Medicaid and CHIP Payment and Access Commission [MACPAC] (July 2018). *Medicaid and the Criminal Justice System.* Retrieved from https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf

the program. In the past, Colorado officials have speculated that 80 to 90 percent of state prison inmates were likely eligible for Medicaid. [16]

Of the 17,977 offenders incarcerated in Colorado prisons as of the end of 2015, auditors found 43 percent had a psychiatric diagnosis and 74 percent needed substance use disorder treatment.[17] These proportions may have changed since the report that found these numbers was published, as SB17-207 was passed by the Colorado General Assembly in 2017 and prohibited individuals being held on an emergency 72-hour mental health hold from being detained or housed in a jail.[18]

Jail Based Behavioral Health Services (JBBS) Program

The JBBS program became operational in October 2011 with the goal of providing appropriate behavioral health services to those individuals in jails and supporting the continuity of care after release from custody.[19] In 2018, 45 of the 64 counties in Colorado participated in the program.[20] The goals of the program include: screening all inmates, identifying veterans and active duty military inmates, providing culturally competent and appropriate treatment services for individuals with SUDs and those inmates with co-occurring mental health conditions, and providing community transition case management services. The protocols and procedures to meet this goals vary by county. The funds are also allowed to be used to support the purchase of medications and psychiatric prescription services. Throughout the program's operation, 21,423 inmates were screened, of which 69 percent were positive for a SUD.[21]

In Larimer, the jail has partnered with SummitStone Health Partners to provide JBBS services. In state fiscal year 2016-2017 the jail provided assessment for 318 individuals, provided SUD individual treatment to 27, and tracked the transition of 390 people.[22] By 12 months after release the 108 individuals were still being tracked and 13.89 percent of those were not in treatment.[22] In April 2019, the Larimer County jail decided to offer and allow for continuation of MAT and the provision of naloxone. At time of publication, since April 2019, the Larimer County jail has provided MAT and naloxone to over 300 individuals.

Law-Enforcement-Assisted Diversion (LEAD) Pilot Program

The LEAD program is a pre-booking diversion program, at the discretion of the police officers, which aims for law enforcement officers to have the appropriate knowledge and tools to re-route individuals with low-level drug and prostitution offenses from the criminal justice system to case managers and referral to needed services (i.e. housing, medical care, mental health care, SUD treatment, and others). Currently, Alamosa, Denver County, Longmont, and Pueblo County receive up to $575,000 per year from the state[23] to pilot the LEAD program.[24] The pilot program currently is funded from April 1, 2018 through June 30, 2020. The goals of the pilot program are to: increase public safety, decrease recidivism, reduce justice system costs, decrease individual-level harm for participants, increase access to services and create systems change. The LEAD National Support Bureau has found that the program increases the likelihood that participants obtain

[16] MACPAC (July 2018). *Medicaid and the Criminal Justice System.* Retrieved from https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf

[17] Colorado Office of the State Auditor (Nov. 2016). *Department of Corrections: Behavioral Health Programs.* Retrieved from http://leg.colorado.gov/sites/default/files/documents/audits/1556p_behavioral_health_programs.pdf

[18] SB17-207: Strengthen Colorado Behavioral Health Crisis System. *Retrieved from https://leg.colorado.gov/bills/sb17-207*

[19] Colorado Department of Human Services [CDHS](2018). *Jail Based Behavioral Health Services.* Retrieved from https://www.colorado.gov/pacific/cdhs/jail-based-behavioral-health-services

[20] Colorado Office of Behavioral Health [OBH], CDHS (July 20, 2018). *Initial Evaluation of Colorado Jail Based Behavioral Health Services.* Retrieved from https://drive.google.com/file/d/1TFK0LZmM_f10Uyao2QppRdoaNGu4llc5/view?pli=1

[21] OBH, CDHS (July 20, 2018). *Initial Evaluation of Colorado Jail Based Behavioral Health Services.* Retrieved from https://drive.google.com/file/d/1TFK0LZmM_f10Uyao2QppRdoaNGu4llc5/view?pli=1

[22] OBH, CDHS (Dec. 2017). *Jail Based Behavioral Health Services Annual Report: Fiscal Year 2017.* Retrieved from https://drive.google.com/file/d/1OCoj-8UUX9XMzgFBcijtXugOL-rGEpOu/view

[23] From the Marijuana Tax Cash Fund

[24] OBH, CDHS (Jan. 2020). *Law Enforcement Assisted Diversion (LEAD).* Retrieved from https://drive.google.com/file/d/1h04sgDqCdERtSrnpUamqtLs8EheA0wiy/view

housing, employment, and income.[25] Additionally, program participants were 58 percent less likely to be arrested after enrollment in comparison to those who went through the criminal justice system in a "usual" manner.

Co-Responder Program

The co-responder model partners behavioral health specialists with law enforcement officers to respond to behavioral health-related calls. The teams work to de-escalate the situation and divert individuals to crisis services and assessments instead of arrest and criminal justice involvement. There are generally two approaches to the program, either an officer with a behavioral health specialist ride together in the same vehicle for an entire shift or the behavioral health specialist is called to the scene and the call is handled with an officer.[26] The goals of the program are to prevent unnecessary incarceration or hospitalization, provide alternative care in the least restructure environment, prevent duplication of services, and facilitate the return of law enforcement to patrol. Currently, 35 local governments in Colorado receive funds from the state[27] to operate the program.[28] Estes Park, Fort Collins, Loveland, and Larimer County are participating in the program.

This Legislation

Opioid Treatment While in Custody

The bill requires correctional facilities under the authority of the Department of Corrections (DOC) and private contract prisons, local jails, multijurisdictional jails, and municipal jails to make at least one opioid agonist available to a person with an opioid use disorder (OUD) who is in custody. The facility is to diagnose and begin procuring the medication as soon as practicable, but no later than three days after the person is taken into custody. The treatment is to be maintained throughout the duration of the person's incarceration, as medically necessary. The medications must be available throughout the duration of the person's incarceration. They may be transitioned from an opioid agonist to an opioid antagonist if a medical professional determines that it is medically appropriate. Additionally, Department of Human Services (DHS) facilities must provide the same medication and follow the same procedures as outlined above for the duration of a person's commitment or placement at the facility. The bill defines "opioid agonist" as a full or partial agonist that is FDA-approved for OUD. Additionally, the bill defines "opioid antagonist" as naltrexone or any similarly acting drug that is not a controlled substance and is FDA-approved for OUD.

Safe Station

The bill defines a "safe station" as any municipal police station, county sheriff's office, or fire station. An individual may turn in any controlled substance and request assistance in accessing SUD treatment at a safe station. Personnel at the safe station are to utilize current protocols and procedures for disposing of the controlled substance. A person that turns in the controlled substance is not subject to arrest or prosecution for possession. Safe station personnel are to make reasonable efforts to determine if the person needs immediate medical attention and if necessary, facilitate transportation to an appropriate medical facility. If immediate medical attention is not required, personnel are to provide the person with information about the behavioral health crisis response system, help identify available treatment options and, if practicable, transport the person to the most appropriate facility for SUD treatment. The information about the behavioral health crisis hotline must be developed by OBH and provided to the safe stations for its distribution.

[25] LEAD National Support Bureau (n.d.) *Evaluations.* Retrieved from https://www.leadbureau.org/evaluations
[26] OBH, CDHS (Dec. 2018). *Co-Responder Programs.* Retrieved from https://drive.google.com/file/d/1X6sGTS18Zv4bjEKlcjWA_8DAwFTN_H3v/view
[27] From the Marijuana Tax Cash Fund, Mental Health Block Grant, State General Fund
[28] OBH,CDHS (Jan. 2020). *Co-Responder Programs.* Retrieved from https://drive.google.com/file/d/1X6sGTS18Zv4bjEKlcjWA_8DAwFTN_H3v/view

Continuity of Care

The bill requires continuity of care be provided to individuals receiving MAT for SUD while incarcerated in a jail or prison, based on defined levels of treatment.

- *Level 1 Stabilization:* person in custody less than 30 days, receiving MAT, monitored by medical personnel, and assessed for other medical or mental health needs. Upon release the person shall receive information regarding treatment options in the community.
- *Level 2 Treatment:* person in custody more than 30 days, stabilized on MAT, receiving medical or mental health follow-up treatment as needed, receiving counseling and support. While in custody the person will be followed by a case manager to identify treatment needs. Once a release date is established, the person is to receive re-entry services. If the person is bonded or released, the staff will attempt to identify and reinstate the person's Medicaid, identify treatment services, and schedule appointments, as time permits. At a minimum, the person shall receive information regarding treatment options in the community.
- *Level 3 Re-Entry Services:* person is within 60 days of release, has completed level 1 & 2, has been maintained on MAT, and received counseling and SUD treatment while in custody. Before release, the staff must ensure that the person's Medicaid is reinstated (if eligible), ensure treatment services are readily available, schedule appointments with the person's behavioral health provider or licensed provider, provide post release resources, and address transportation needs.

The executive director of the DOC, in consultation with the Office of Behavioral Health (OBH), the Office of Economic Security in DHS, HCPF, DOLA, and local service providers, is to develop resources for inmates post-release that provide information to help prepare inmates for release and successful reintegration. The resources must reflect the needs of diverse and underserved populations and communities.

Sealing of Criminal Records

The bill requires courts to favorably consider the entrance into or successful completion of a licensed SUD treatment program by an individual that is petitioning to seal their records.

Diversion Programs

OBH may contract with cities and counties to create, maintain, or expand criminal justice diversion programs. The goal of such a program should be to connect law enforcement officers with behavioral health providers to assist individuals in need of intervention of to divert individuals from the criminal justice system. By November 1, 2021, and every November 1 after, DHS is to include an update regarding the funding and implementation of diversion program in its SMART Act hearing.[29] The State Board of Human Services may promulgate rules to implement this section.

Appropriation

The bill requires that for the 2020-2021 state fiscal year, $1.15 million is to be appropriated to DHS to be used by OBH. The appropriation is from the General Fund.

Reasons to Support

Increasing the entities that provide MAT through the criminal justice system may help reduce the costs, to both the state and local governments, of re-arrests and re-incarceration as well as the societal, human, and health care costs associated with SUDs. MAT is an evidence based practice that can help individuals with an opioid use disorder or alcohol use disorder. This bill helps solidify MAT as a standard of care for incarcerated populations and requires DOC to implement broadly which will help Larimer County jail clients transition successfully from jail to prison and vice versa.

[29] Enacted in 2010 and extensively revised in 2013, Colorado's SMART Government Act includes requirements for state departments to create publicly-available annual strategic/performance plans and present them to the General Assembly.

The creation, maintenance, and expansion of diversion programs may be beneficial in Larimer County with the construction of the new behavioral health facility.

Supporters

- Alkermes
- American Civil Liberties Union of Colorado (ACLU)
- Colorado Behavioral Healthcare Council (CBHC)
- Colorado Coalition for the Homeless
- Colorado Criminal Defense Bar
- Colorado Criminal Justice Reform Coalition
- Colorado Medical Society
- Colorado Psychiatric Society
- Colorado Society of Osteopathic Medicine
- Mental Health Colorado
- National Alliance on Mental Illness
- Tribe Recovery Homes

Reasons to Oppose

Factors that may limit the willingness or ability to incorporate the provision of MAT into correctional facilities and DHS facilities may include a preference for drug-free treatment, limited knowledge of the benefits of MAT, security concerns, regulations prohibiting use of certain MAT by certain agencies, the lack and cost of qualified medical staff, and the time and adjustments needed for implementation. The creation of safe stations may not be an ideal solution for Larimer County until the new facility is up and running as there really would not currently be anywhere to take or refer most individuals to for same day service. Additionally, many other communities would not be able to provide a referral to a program or facility that would be able to provide same day services. Correctional facility staff may not have time or resources to ensure that an individual's Medicaid is reinstated.

Opponents

- Adams County
- Colorado Municipal League
- County Sheriffs of Colorado
- Special District Association of Colorado

Other Considerations

The bill solely addresses opioid use disorder treatment while in custody of the DOC, jails, or DHS. It is important to note that naltrexone can also be used to treat alcohol use disorder. The language could be updated from opioid use disorder to substance use disorder to encompass the use of naltrexone for alcohol use disorder.

Many communities do not and/or will not have the county/city budgets to support MAT programs by themselves. Some may point to grant funding as an opportunity to supplement; however, the vast majority of grant and foundation funding will not pay for the actual medications.

In the continuity of care section of the bill it is not clear what the difference is between receiving MAT and being stabilized on MAT.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of

date printed. For more information about this analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.