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APPLYING THE EVIDENCE

LEGAL AND POLICY APPROACHES TO ADDRESS OPIOID USE DISORDER IN THE CRIMINAL JUSTICE AND CHILD WELFARE SETTINGS

O'NEILL INSTITUTE
FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW

About this Report

This report is a product of the Addiction & Public Policy Initiative of the O'Neill Institute for National and Global Health Law at Georgetown Law Center and was developed through grant support from Arnold Ventures. The essential vision for the O'Neill Institute rests upon the proposition that the law has been, and will remain, a fundamental tool for solving critical health problems in our local, national, and global communities. The Addiction and Public Policy Initiative works to advance a public health approach to substance use disorders and the opioid epidemic through policies, practices, and regulations that promote evidence based treatment and recovery.

Authors

Regina LaBelle, JD
Shelly Weizman, JD

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INTRODUCTION

APPROXIMATELY 130 PEOPLE IN THE UNITED STATES DIE EVERY DAY FROM OPIOID-RELATED DRUG OVERDOSES, accounting for 47,000 deaths in 2017.[1] Increased national and international attention to this crisis has led to an influx of resources and policy solutions in recent years; however, the problem is much larger than opioids. Addiction is not a new phenomenon and does not occur in a vacuum, but instead occurs at the intersection of public health, criminal justice and social services. Solutions must reflect this reality.

This report focuses on access to treatment in the criminal justice and child welfare settings for several reasons.

FIRST, these systems, rather than the health care system, have traditionally been involved in the response to addiction and its related consequences, particularly for members of marginalized communities. People recently released from correctional facilities and postpartum women are two groups that are at a significantly higher risk for overdose death than the general population.[2] Ensuring access to evidence-based treatment and medication in corrections, courts and child welfare systems is one immediate measure that will save lives.

SECOND, solutions must recognize that there are enormous racial and economic disparities in access to care for substance use disorders. People with greater social and economic capital often have greater access to treatment and other needed resources to support recovery, whereas those who are less resourced are more likely to be impacted by the criminalization and punishment of addiction. Implementing strategic reforms in the criminal justice and child welfare systems presents a crucial opportunity to address these disparities and connect people to life-saving care, which will in turn contribute to lower recidivism and promote healthier and safer communities.

In our current system, jails, prisons, courts and child welfare are often the intervention points for people with substance use disorders. A public health approach to addiction would create a system where people have barrier-free access to a range of services and supports that promote well-being for individuals, families and communities to deflect people from entering the criminal justice and child welfare systems. As we work to transform our systems of care, we must simultaneously improve access to treatment for the people most at risk for overdose to save lives and improve health outcomes for people with substance use disorders and their families.

This report provides recommendations for actions that state and local leaders can take immediately to increase evidence-based practices, decrease arbitrary determinations, and prevent overdose deaths. The report also provides concrete steps that will, in the long-term, help dismantle a siloed system of unequal access and disparities and move towards an integrated system that promotes restorative justice, where people and families are treated with dignity, and where addiction is treated as a health and wellness matter rather than one of moral failing or criminality.

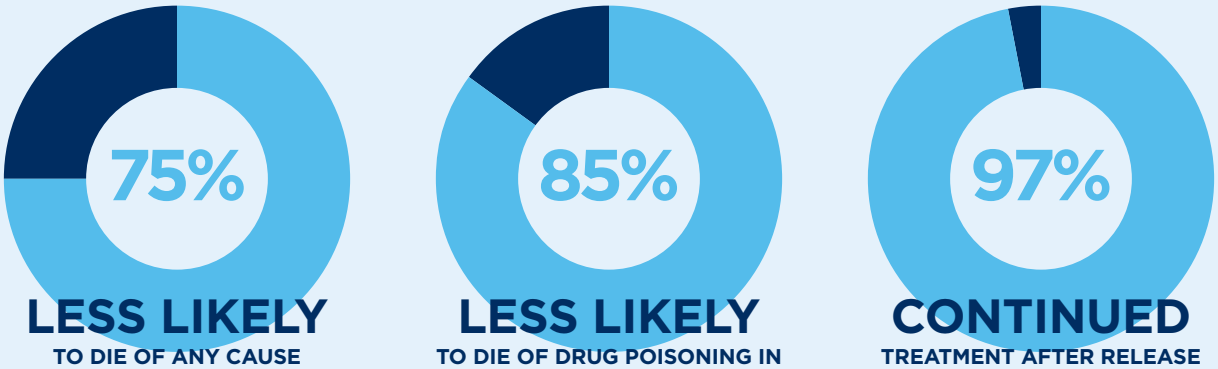
SECTION 1
SAVING LIVES: INCREASING ACCESS TO MEDICATIONS FOR OPIOID USE DISORDER IN U.S. JAILS AND PRISONS

People leaving jails and prisons are one of the groups most at risk for opioid overdose. Incarcerated persons who are released to the community are between 10 and 40 times more likely to die of an opioid overdose than the general American population—especially within a few weeks after release.[3]

However, few correctional institutions have adopted evidence-based strategies to address opioid use disorder (OUD) and few ensure access to methadone, buprenorphine, and naltrexone, the three medications approved by the U.S. Food and Drug Administration (FDA) and the recognized standard of care for treating OUD.[4] In this report, these medications will be referred to as "medications for opioid use disorder", or M-OUD.[5]

There is overwhelming national and international support for the use of M-OUD in jails and prisons as a critical tool to combat overdose deaths. The World Health Organization, the U.S.

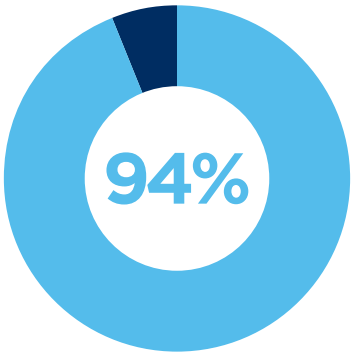
UPON RELEASE FROM INCARCERATION, PEOPLE WHO RECEIVED MEDICATIONS FOR OPIOID USE DISORDER WHILE INCARCERATED



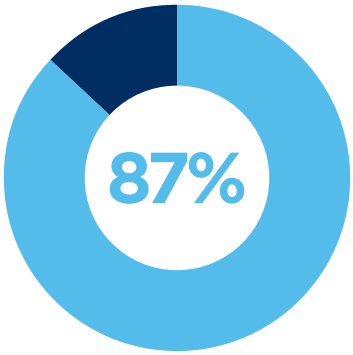
SOURCE: Shabbar I. Ranapurwala et al., Opioid Overdose Mortality Among Former North Carolina Inmates.

SOURCE: Nickolas Zaller, Initiation of Buprenorphine During Incarceration and Retention in Treatment Upon Release; Verner S. Westerberg, et al., Community-Based Methadone Maintenance in a Large Detention Center is Associated with Decreases in Inmate Recidivism.

MORTALITY RATES FOR PEOPLE WHO RECEIVED MEDICATIONS FOR OPIOID USE DISORDER WHILE INCARCERATED



LOWER
RECEIVED M-OUD IN THE FIRST 4 WEEKS OF INCARCERATION



LOWER
RECEIVED M-OUD AT ANY TIME DURING INCARCERATION

SOURCE:
Larney, et al., Opioid Substitution Therapy as a Strategy to Reduce Deaths in Prison: Retrospective Cohort Study.

Substance Abuse and Mental Health Service Administration (SAMHSA), the American Society of Addiction Medicine[6], the National Sheriffs Association[7], the National Commission on Correctional Health Care[8], the President's Commission on Combating Drug Addiction and the Opioid Crisis[9] and myriad professional associations, government agencies, and representatives of the law enforcement community promote the use of M-OUD in corrections.

A large study of individuals with OUD released from prison found that individuals treated during incarceration with M-OUD were 75% less likely to die of any cause and 85% less likely to die of drug poisoning in the first month after release.[10] Research has shown that M-OUD prior to release from incarceration may also increase engagement and retention in community-based treatment—one study found that over 97% of people receiving methadone during incarceration continued treatment after release.[11] This study found that people with OUD who are allowed to continue methadone treatment during incarceration are less likely to be re-arrested than those who are detoxified in jail.[12] The use of M-OUD during incarceration is also associated with better treatment retention, reductions in the spread of infectious diseases, such as HCV and HIV, and lower rates of criminal behavior.[13]

Despite these outcomes, philosophical opposition to M-OUD, fears about diversion, lack of financial resources, limited community-based treatment to connect people with upon discharge, and barriers in prescribing, all contribute to a lack of access to M-OUD in correctional facilities.[14]

In some cases, correctional facilities have policies in place specifically prohibiting use of M-OUD. These policies are based on fears of misuse or on a belief that these medications are swapping one addiction for another.[15] The use of medication for OUD is generally viewed unfavorably even among medical staff at U.S. correctional facilities, with methadone often only being provided, if at all, to pregnant women. A 2003 survey of U.S. state and federal prison medical directors found that only 30% believed that methadone was beneficial to incarcerated persons dependent on opiates, with 35% reporting that methadone was not beneficial and 35% reporting uncertainty or not responding to the question.[16]

This approach, however, is being challenged by evidence that using medication to treat OUD reduces overdose deaths, particularly when provided in correctional facilities. A 2017 study of correctional facilities in England found that treatment with buprenorphine or methadone was associated with an 80 to 85% reduction in post-release drug-related mortality and a reduced likelihood of in-custody deaths

by overdose or suicide.[17] A 2014 study from Australia also found that the availability of M-OUD reduced the likelihood death in prison: compared to people with OUD not receiving medication, the hazard of an unnatural death including overdose deaths, suicide, and other preventable mortality for incarcerated persons receiving in M-OUD was 94% lower in the first four weeks of incarceration and 87% lower for any period of incarceration.[18]

The U.S. is seeing similarly promising results.

In a randomized, controlled trial conducted in the Rhode Island correctional system, incarcerated people who were permitted to continue taking their prescribed methadone were seven times more likely to continue treatment after release than those who were forcibly withdrawn from their medication.[19] Another study of M-OUD in Rhode Island's correctional system showed a 61% decrease in post-incarceration deaths a year following implementation.[20] This decrease contributed to an overall 12% reduction in overdose deaths in Rhode Island's general population.[21] This dramatic reduction in overdose deaths—and significant impact on statewide mortality—is spurring change.

A growing number of states have enacted legislation authorizing, funding, or requiring access to M-OUD in the criminal justice system.

Litigation in states like Massachusetts, Maine and Washington are contributing to a growing area of law related to the legal right to M-OUD while incarcerated.

States and local governments are using new federal dollars like the State Opioid Response (SOR) grant to implement pilot programs. Foundations such as Arnold Ventures and Bloomberg Philanthropies are also funding pilot programs across the country.

The federal government and a number of trade organizations have developed informational materials, best practice guides, and learning collaboratives to assist communities to begin providing access to M-OUD in jails and prisons.[22]

In every successful model, a champion has led the charge—an elected official, Sheriff, judge, county commissioner, or any other person in a position to make policy changes. As the opioid crisis touches more and more lives, and as people in influential positions are personally touched by this crisis or see the impact in their communities, perceptions have begun to shift.

The acceleration of efforts to expand access to medication "behind the walls" of jails and prisons will advance the principle that the constitutional and human rights to health and justice include the right to treatment. These efforts will also help to address the pervasive and deadly stigma against people who use or who have used drugs that has contributed to the criminalization of drug use and mass incarceration in the United States, particularly in low-income communities and communities of color. Most importantly, providing all three forms of M-OUD in the correctional system is an action states and local government can immediately take to dramatically reduce overdose deaths, illicit drug use, communicable disease, and crime.

"I didn't believe in it. But we were convinced to try it. In the first three months we saw a reduction in diversion and recidivism. And it was saving lives. It's a no-brainer."

SHERIFF CRAIG APPLE
ALBANY COUNTY, NEW YORK

KEY PRINCIPLES TO ADVANCE ACCESS TO EVIDENCE-BASED TREATMENT IN CORRECTIONS AND REENTRY

A mandate can be a strong tool for reform. State executives and legislative bodies should consider the following principles when developing legislation, executive orders or programs related to OUD treatment in correctional settings.

1. **CORRECTIONAL FACILITIES SHOULD PROVIDE ALL THREE FORMS OF FDA-APPROVED MEDICATION TO TREAT M-OUD.**

M-OUD is the standard of care for treating OUD. A State can explicitly recognize this in statute and require access to methadone, buprenorphine, and naltrexone for all incarcerated persons with OUD. The statute can permit the mandate to be phased in over a period of time; however, the state should require voluntary transfer of incarcerated persons with OUD from correctional facilities that do not yet provide M-OUD to facilities that do provide it, and permit funding and reimbursement structure to support this. Exceptions can be made based on practicality and based on the standard of care; for example, statutory language can permit flexibility for correctional facilities where there are no opioid treatment programs providing methadone accessible in the area. Statues can also note that M-OUD is the standard of care for treating people with OUD who are pregnant. A statute should also account for access to future FDA-approved medications to treat OUD as well as all other Substance Use Disorders.

2. **CORRECTIONAL FACILITIES SHOULD HAVE EVIDENCE-BASED WITHDRAWAL MANAGEMENT PROTOCOLS FOR ALCOHOL USE DISORDER AND SUBSTANCE USE DISORDER.**

3. **THE STATE SHOULD DEVELOP AND FUND EDUCATIONAL PROGRAMMING AND TECHNICAL ASSISTANCE RELATED TO EVIDENCE-BASED TREATMENT FOR SUD AND OUD IN CORRECTIONAL SETTINGS.**

The addition of M-OUD will be a change in culture and practice for many correctional settings. Education, support, and technical assistance are critical components for the success of a program. Policies can also ensure that information about M-OUD is readily available to persons entering an incarcerated setting, persons in custody, public defenders, medical and corrections staff, health care providers involved in the criminal justice system, among others. The state should also fund data collection and technology to support measurement of outcomes.

4. **THE STATE MUST ALLOCATE FUNDING SUFFICIENT TO SUPPORT PROGRAMMING AND MEDICATIONS FOR ALL INCARCERATED PERSONS WITH OUD.**

This point cannot be overstated. In order to properly implement a new program, jails and prisons will need strong and sustained fiscal support as well as an understanding that resources may need to be reallocated. An unfunded mandate is likely to fail. A strategic approach to sustainable funding for this programming is key. The state should also develop and fund a mechanism for collaboration among key stakeholders, including the state, local government, treatment providers and criminal justice. Models and sources for funding are discussed in detail in this Report.

5. **CORRECTIONAL FACILITIES SHOULD MAKE EVIDENCE-BASED ASSESSMENTS OF ALL INCARCERATED PERSONS FOR SUD, DEVELOP INDIVIDUAL TREATMENT PLANS, AND ENSURE ACCESS TO M-OUD OR WITHDRAWAL MANAGEMENT SERVICES FREE OF CHARGE AND WITHOUT DELAY FOR QUALIFIED PERSONS.**

Using evidence-based screening and assessments to diagnose and choose appropriate treatment, all correctional facilities should conduct an assessment of the mental health and substance use status of each individual who is incarcerated or entering a correctional facility, as soon as practicable but not to exceed 24 hours following incarceration. Following assessment, M-OUD or withdrawal management services should immediately be made available to persons with OUD. M-OUD should not be unreasonably withheld.

Decisions regarding type, dosage, or duration of treatment must be decided by a qualified health care professional licensed, certified, or otherwise authorized by the state. M-OUD and withdrawal management services must be voluntary. Each correctional facility should develop and implement policies for obtaining written consent of participants, and the state should provide a template to assist in this endeavor. Exceptions for consent to treat should be permitted for emergency provision of withdrawal management medications for health and safety.

Correctional facilities should develop an individualized treatment plan for each incarcerated person with SUD. Correctional facilities should not have a blanket policy prohibiting M-OUD or psychiatric medication and should not have a blanket policy that removes all persons from psychiatric or addiction treatment medications upon incarceration. Correctional facilities should develop policies and procedures for dispensing M-OUD, provide access to counseling and peer recovery specialists, and develop a mechanism for collaboration between clinical and justice staff to ensure safety and to decrease diversion.

Participation in M-OUD treatment should not be withheld from a qualifying person and any person should be able to enter M-OUD treatment at any time during incarceration. All should be allowed to continue M-OUD if they are already prescribed medication upon incarceration. No person should be removed from the M-OUD program for having received a disciplinary infraction, including for illicit substance use, either before or during the program. Data and clinical standards of care should inform policies and procedures related to addiction and mental health care in correctional facilities.

6. **CORRECTIONAL FACILITIES SHOULD DEVELOP REENTRY STRATEGIES FOR INCARCERATED PERSONS WHO HAVE PARTICIPATED IN M-OUD AND SUD TREATMENT TO ASSIST WITH CONNECTIONS TO CARE.**

Correctional facilities should develop a reentry plan for each person prior to release from incarceration. A reentry plan should include continuity of care and an affirmative connection to a community-based treatment provider. For people receiving M-OUD, a reentry plan shall include connection to a prescriber. For persons receiving buprenorphine while incarcerated, correctional facilities must arrange for medication upon release to ease transitional periods as long as feasibly possible in consultation with the person's physician. Correctional facilities should develop policies to commence M-OUD prior to release. Procedures must ensure that released individuals who relapse while on parole are not punished but instead receive SUD support.

7. **EACH CORRECTIONAL FACILITY SHOULD PROVIDE ANNUAL REPORTS TO COUNTY EXECUTIVE, STATE LEGISLATURE AND THE GOVERNOR OUTLINING PRESCRIBED DATA POINTS AND OUTCOMES, SUCH AS THE NUMBER OF PEOPLE ASSESSED FOR SUD AND RATES OF RECIDIVISM.**

8. **IN THE LONG TERM, COMMUNITIES MUST ADOPT A SYSTEMS APPROACH TO PROMOTE ALTERNATIVES TO INCARCERATION THAT INCLUDES ALL COMPONENTS OF THE JUSTICE SYSTEM FROM POLICE TO PROBATION, PAROLE, COURTS, AND CORRECTIONS. THE FOCUS SHOULD BE ON REDUCING THE SIZE OF THE JUSTICE SYSTEM WHERE ONLY THE HIGHEST RISK PEOPLE BECOME JUSTICE INVOLVED.**

CURRENT LANDSCAPE AND TRENDS: MEDICATIONS FOR OUD IN JAILS, PRISONS AND REENTRY

CORRECTIONAL FACILITIES HAVE BEEN SLOW to offer M-OUD despite positive outcomes from several long-standing programs, such as in the Rikers Island jail complex in **New York City** which has provided methadone to incarcerated persons with OUD since 1987. As of 2009, 55% of U.S. prison systems offered methadone treatment; however, more than 50% did so only for pregnant women or for chronic pain management.[23] Only 14% offered buprenorphine treatment for any incarcerated persons at all.[24]

Leadership from state governors has shown to be critically important to the success of a coordinated statewide system. **Rhode Island** initiated statewide coordinated programs that include access to all three forms of medication in the states' correctional facilities. In **Vermont**, a 2018 law requires all three forms of medication to be made available when "medically necessary."[25] **Delaware** announced plans to make buprenorphine, naltrexone, and methadone available to incarcerated persons identified as having an opioid addiction in its correctional facilities. This program first started at Sussex Correctional Institution and will expand as soon as possible to all four of its level five state prisons.[26]

"From 2005 to 2015 I was in and out of the system. Most of the time I was a client at the clinic getting methadone, but when I would get incarcerated they just didn't offer it. It wasn't available to anyone. I went cold turkey. I was at a high dose. I was also on benzos. I had seizures, I knocked my front teeth out. Outside the walls, I experienced a lot of success when I addressed my mental health issues as well as my addiction, I took care of my family, I was good to myself. Whenever one of those things would lag behind the other, I would eventually go back to using, go to jail, go cold turkey, it was a cycle. I'm so thankful that nobody has to go through that anymore. A year and a half ago, there was nobody to stand next to someone while they were going through this. Now, we have medication in the jail and a peer program. I run a group. We talk about things like credit repair, banking, second chance housing, how to go through process of re-ordering psych meds. My other job is coaching high school wrestling. I get to work with people on both sides, and maybe help prevent one group from becoming part of the other."

PATRICK WAYNE ROBLES
PEER ADVOCATE, CENTER FOR COMMUNITY MEDICAL SERVICES, ARIZONA

In Delaware, over 25% of overdose-related deaths in the state were from individuals who had been incarcerated, and 75% of those who died of an overdose did so within one year of being released from prison. Delaware has announced plans to make buprenorphine, naltrexone, and methadone available to incarcerated persons identified as having an opioid addiction in its correctional facilities. [27]

In the majority of states, however, a phased approach to M-OUD in correctional settings appears to be the trend. Some states are accelerating their efforts as a result of, or under the threat of, legislation and litigation. Individual county jails are launching programs using funding and support from a combination of state and local government sources, private foundations, and with new federal grants that target the opioid epidemic.

In the wake of several lawsuits and a change in gubernatorial leadership, **Maine** lifted a ban on M-OUD in prisons by Executive Order from Gov. Mills on February 6, 2019 and has committed funding and technical assistance resources to expand M-OUD into all of the state's jails and prisons by the end of 2019.[28]

Maine Executive Order 2 commits funding to "Encourage every county jail to have MAT services available for persons incarcerated who are suffering from a substance use disorder, and help such individuals released from jails to continue to receive support services" and "Assist the Department of Corrections pilot program to provide MAT to inmates, focusing first on those patients with a release date within four years, and helping individuals released from the Department to continue to receive like support services"[29]

In **New York**, proposed legislation to ensure access to M-OUD in all of the jails and prisons failed to pass the state legislature in 2019. Despite this, the state has launched an effort to encourage and support local county jails that want to offer medication to people with opioid use disorder. The state provides jails with funding, technical assistance and connections to local treatment providers. In addition, New York State recently expanded medication programming into its state prison system. By September 2019, six state prisons will be providing methadone to people who enter the prison already on methadone and who have a sentence of less than two years. This is a critical shift because, prior to this policy, people incarcerated in a county jail that provided methadone, such as Rikers Island in New York City, were forced to withdraw or taper prior to being transferred to prison. Now, people will be able to continue receiving methadone following the transfer to a state prison. As of August 2019, 42 jails in New York State are offering long-acting injectable naltrexone and 10-15 are offering methadone and/or buprenorphine, with more being added every month.

In **California**, the state used a combination of federal and philanthropic funding to establish county teams and learning collaboratives that committed to providing at least two of the three forms of M-OUD in correctional settings, drug courts, and child welfare systems in the county. As of August 2019, 29 teams covered 80% of California's incarcerated population, including in rural and frontier areas and the largest urban areas like Los Angeles.

In **Arizona**, the five jails in Maricopa County began phasing in methadone following SAMHSA's 2015 mandate requiring drug courts to provide M-OUD and in the wake of a lawsuit addressing conditions in the jails that jeopardize health and safety. A phased approach began by coordinating medications for drug court clients, pregnant women, and in units where people were serving sanctions and remands. Now, M-OUD is provided for anyone going into the jail who is already receiving it, and for those who ask to be inducted. The county funds the program, which supports 70 people with M-OUD on any given day. M-OUD is also offered in the

> "Just because you are incarcerated, doesn't mean that a medication that is helping you stabilize your life should be taken away. We wouldn't do that with another medication."
>
> **MICHAEL WHITE**
> COMMUNITY MEDICAL SERVICES, OPIOID TREATMENT PROGRAM (OTP) PROVIDING SERVICES AND TECHNICAL ASSISTANCE TO CORRECTIONAL FACILITIES ACROSS THE COUNTRY

state's reentry centers which house persons who have violated probation or parole.

Connecticut, **Colorado**, **Maryland**, **Massachusetts**, **North Dakota**, **New Jersey**, **Pennsylvania** and several other states are following this phased approach.

A number of jails, prisons and pilot programs across the country offer long-acting injectable naltrexone, but not methadone or buprenorphine, or offer methadone and buprenorphine for a short time. Some correctional facilities in **Alaska**[30], for example, offer naltrexone to people pre-release and methadone "bridging" for up to 30 days for short-term stays. Some facilities limit access to M-OUD to people already receiving it when they are incarcerated. Other facilities only offer it pre-release: people with OUD must go into withdrawal when entering the facility, but are induced with M-OUD before they are released.

Private companies contracted to deliver correctional health services in jails are beginning to support M-OUD programs in jails across the country, including in **Alabama**, **Ohio**, **Massachusetts**, **New Jersey**, **Oregon**, **Georgia**, **Florida**, **Louisiana**, **Nevada**, and **Washington**.[31]

Although efforts in most states have begun with pilot projects that included a few county jails or limited use of M-OUD, the trend is accelerating toward statewide coordinated systems that include the best practice of offering all three forms medication in all jails and prisons to all those who require it for the treatment of OUD.

STRATEGIES TO ADVANCE ACCESS TO MEDICATION FOR OUD IN CORRECTIONS

SUSTAINED REFORM OF A SYSTEM often requires a combination of incentives and mandates to inspire change. Legislation, litigation and financial incentives have all served as motivation for reform in the area of access to evidence-based practices for OUD. In addition, champions in government, law enforcement, medicine, philanthropy and advocacy have played a critical role in initiating a grassroots shift to evidence-based care in communities across the country.

LITIGATION

An increasing number of legal cases are establishing the principle that people with OUD who are incarcerated have a legal right to treatment using medications like methadone and buprenorphine. Legal claims are based on the Americans with Disabilities Act (ADA) (for claims against state and local governments), the Eighth Amendment prohibition on cruel and unusual punishment, the Rehabilitation Act and the Administrative Procedures Act.

"In this Court counsel for the State recognized that narcotic addiction is an illness.... We would forget the teaching of the Eight Amendment if we allowed sickness to be made a crime and permitted sick people to be punished for being sick. This age of enlightenment cannot tolerate such barbarous action."—Supreme Court of the United States in *Robinson v. California*[32]

Legal Tools

1. Preliminary Injunctions

A preliminary injunction is a tool to force or prohibit certain actions. To be awarded a preliminary injunction, a plaintiff must establish that he or she is likely to succeed on the merits of his or her claims, that he or she is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his or her favor, and that an injunction is in the public interest.[33]

In the **Massachusetts** case of *Pesce v. Coppinger*, the Plaintiff, Mr. Pesce, sought an injunction requiring the Essex County Sheriff to provide him with access to his physician-prescribed methadone treatment while incarcerated.[34] Similarly, in the Maine case of *Smith v. Aroostook County*, the Plaintiff, Brenda Smith, sought an injunction requiring Aroostook County and its Sheriff to provide her with access to her physician-prescribed buprenorphine treatment while incarcerated.[35] In both cases, the courts found that the plaintiffs were likely to succeed on the merits of their claims of discrimination under the ADA and ordered a preliminary injunction requiring the defendants to provide the plaintiffs with M-OUD while incarcerated.[36]

A blanket policy in a jail that denies access to medically necessary medication for the treatment of an incarcerated person's opioid use disorder, without an individualized reason for that denial, is likely to be disability discrimination under the ADA.

The court in the *Pesce* case also based its decision on a likelihood of success on the merits of Mr. Pesce's claim that denying him access to methadone while incarcerated was cruel and unusual punishment in violation of the Eighth Amendment.[37] Both courts found that denial of M-OUD would cause irreparable harm to these individual plaintiffs, that the balance of equities weighed in favor of the plaintiffs, and that the public interest would be served by allowing these individuals to access M-OUD.

2. Settlement Agreements in Individual Cases

Another **Maine** case involving Aroostook County, *Smith v. Fitzpatrick*, was settled while the *Smith v. Aroostook County* case was pending.[38] In that case, the plaintiff, Zachary Smith (unrelated to Brenda Smith), faced imminent incarceration either in the Aroostook County Jail or at a facility in the Maine Department of Corrections.[39] He had been prescribed buprenorphine for his OUD and alleged that both the Aroostook County Jail and the Maine Department of Corrections had policies prohibiting the use of M-OUD. Mr. Smith brought an action under the ADA and the Eighth Amendment seeking injunctive relief. The case settled with the Maine Department of Corrections agreeing to provide Mr. Smith with buprenorphine during his incarceration. Maine now has plans to expand M-OUD into all jails and prisons by the end of 2019.

The first case brought against the Federal Bureau of Prisons (BOP) regarding access to M-OUD in a federal correctional facility in **Massachusetts**, *DiPierro v Hurwitz*, also settled.[40] In that case, the plaintiff Ms. DiPierro[41] had been prescribed methadone to treat her OUD. She was facing incarceration in a facility operated by the BOP, which she alleged had a policy prohibiting non-pregnant men and women who were incarcerated from using methadone for OUD. Ms. DiPierro alleged violations of the Eighth Amendment, the Rehabilitation Act, and the Administrative Procedures Act, and sought declaratory and injunctive relief to require the

Defendants to provide her with access to her physician-prescribed methadone treatment for her OUD throughout her upcoming incarceration at a BOP facility. She also filed a motion for a temporary restraining order and a preliminary injunction. In settling the case, the Defendants agreed to dispense and administer methadone treatment to Ms. DiPierro throughout the period of her incarceration.

A second case brought against BOP in Federal District court in **Kansas** settled in September 2019.[42] The Plaintiff, Leaman Crews, alleged that officials at Leavenworth Federal Penitentiary failed to provide him with prescribed buprenorphine to treat his OUD and instead were providing him with codeine and Tylenol.[43] As part of the settlement, officials agreed to begin providing him buprenorphine.

3. Class Actions

In **Washington** state, a class action suit was brought against Whatcom County and the Whatcom County Sheriff's Office, alleging that the county's failure to provide M-OUD to people who are in the county jail was discrimination on the basis of disability in violation of the ADA.[44] The lawsuit sought both declarative and injunctive relief requiring the defendants to provide access to M-OUD to the named plaintiffs and a class of persons with OUD who are incarcerated and who will be incarcerated in the future in the jail.

Prior to formal adjudication, the parties entered into a settlement agreement.[45] The settlement included an agreement that Whatcom County Jail will implement written policies that included the following: optional medication assisted withdrawal program; continued "non-methadone" M-OUD, including Suboxone (a combination of buprenorphine and naloxone), Subutex (buprenorphine), or Vivitrol (naltrexone), for those already prescribed these medications; for individuals on methadone, permit transition from methadone to "non-methadone" M-OUD; reasonable attempts for alternative arrangements to keep an individual on methadone if he or she does not wish to transition to a different medication; and induction of Suboxone, Subutex, or Vivitrol for their incarcerated population who are deemed medically qualified and want to engage in treatment. The agreement included provisions permitting transition from methadone to other medications because there are no opioid treatment programs offering methadone in the area. The settlement agreement also included training for personnel and education for people who are incarcerated about M-OUD, provision of county financial resources and sufficient staffing standards, data collection, reentry support, and behavioral health programming.

Causes of Action

1. Americans with Disabilities Act (ADA)

The ADA ensures that people with disabilities have the same rights and opportunities as everyone else. This includes people with addiction to alcohol and people in recovery from opioid and other substance use disorders. While the ADA generally excludes from protection individuals who are actively using illicit substances, when the discrimination is based on that use, that exclusion does not apply to discrimination in receipt of health care, including in jails and prisons. In both the *Pesce* and *Smith* cases, the parties agreed that the plaintiffs were qualified individuals under the ADA.

Title II of the ADA focuses on access to services, programs, and activities in public entities such as public education, corrections and the courts. Under Title II of the ADA "no qualified individual with a disability shall by reason of such disability be excluded from participation or be denied the benefits of the services, programs, or activities of a public entity, or be subject to discrimination by any such entity."[47]

A PERSON HAS A DISABILITY UNDER THE ADA IF THE PERSON HAS:

1. A physical or mental impairment that substantially limits one or more major life activities, e.g. someone with bi-polar disorder, diabetes or addiction to alcohol; or
2. A history of an impairment that substantially limited one or more major life activities, e.g. someone who has a history of cancer; or someone in recovery from illegal use of drugs; or
3. Been regarded as having such an impairment, e.g. someone who has a family member who has HIV, so is assumed to have HIV as well and face discrimination as a result, or someone who is perceived to have a disability and is treated negatively based on the assumption of disability.[46]

In both *Pesce* and *Smith*, the court found that the plaintiffs were likely to succeed in their ADA claims. Both courts recognized that, where a health care service or program is denied in a jail, disagreement with reasoned medical judgment is not sufficient to state a disability discrimination claim. A decision must be based on the person's individual medical needs.[48] Medical decisions that rest on stereotypes about people with disabilities rather than "an individualized inquiry into the patient's condition" may be considered discriminatory.[49] In both cases, the defendants' determination to deny M-OUD was based on a blanket ban on these medications, rather than on a consideration of the specific medical needs of the plaintiffs. Both courts noted the grave danger and risk of death to the plaintiffs if these medications were denied. A blanket policy banning M-OUD in the jail and denying it to these plaintiffs was likely to be discrimination because it was either arbitrary or capricious as to imply that it was a pretext for some discriminatory motive, or discriminatory on its face.

The courts also noted that concerns over security may be legitimate non-discriminatory grounds for limiting access to a jail program. However, specific security concerns related to the individual's proposed medication intake must be articulated.[50] In *Pesce*, the defendants did not explain why the Middleton jail could not "safely and securely administer prescription methadone in liquid form to Mr. Pesce under the supervision of medical staff, especially given that this is a common practice in institutions across the United States and in two facilities in Massachusetts" where Middleton jail is located. Similarly, in the *Smith* case, the court found that Ms. Smith's request for an accommodation under the ADA would not be unreasonable, because, not only had the jail previously provided the same accommodation to a pregnant woman without issue, the defendants also acknowledged that the requested exemption could be granted in a way that would obviate any security concerns.[51]

Because individual medical determinations and individualized security considerations were not made or sufficiently articulated in either case, both courts found that the plaintiffs were likely to succeed in their ADA claims.

2. Eighth Amendment

The Eighth Amendment prohibits cruel and unusual punishment. The seminal Supreme Court case of *Estelle v. Gamble* established that the Eight Amendment requires prisons to provide adequate medical treatment to incarcerated individuals.[52] To prove a violation of the Eighth Amendment's

prohibition against cruel and unusual punishment, a plaintiff must show that the jail or prison's policy or actions would equate to (1) deliberate indifference of (2) serious medical needs.

The court in *Pesce* found that Mr. Pesce was likely to prevail on the merits of his Eighth Amendment claim. The court found that Mr. Pesce was reasonably likely to show that he has a serious medical need because the treatment he would be denied is the only adequate treatment that has worked for his OUD.

The court also found that Mr. Pesce was likely to successfully show deliberate indifference because Middleton jail's blanket policy ensured that he would be denied methadone treatment despite his physician's recommendation and contrary to the opinions of health care professionals. As a result, Mr. Pesce was at "great risk" for overdose and death.

"Allegations that prison officials denied or delayed recommended treatment by medical professionals may be sufficient to satisfy the deliberate indifference standard."[53]

These cases mirror similar litigation in movements to advance the rights of people with psychiatric disabilities in institutions and corrections, access to treatment for people with HIV and AIDS, and access to harm reduction services such as syringe exchange.

This issue is ripe for litigation in many states and counties. A claim could be brought by any individual with an OUD that is or will be incarcerated or as a class action on behalf of all similarly situated individuals. People who were incarcerated and released can also bring a claim for damages. The trend has been for courts to find that blanket denial of M-OUD is sufficient to state a claim of disability discrimination in violation of the ADA as well as cruel and unusual punishment in violation of the Eighth Amendment, and that generalized concerns about safety and diversion are insufficient.

LEGISLATION

Legislation is a strong tool for reform. A number of states have legislative mandates related to M-OUD in corrections.

Vermont's law requires "Medication Assisted Treatment" (MAT) to be offered at or facilitated by correctional facilities as a medically necessary component of treatment for incarcerated individuals diagnosed with OUD.[54] Vermont defines MAT as the use of FDA-approved medications in combination with counseling and behavioral therapies. The law requires screening for substance use disorder within 24 hours of admission. Incarcerated persons who were receiving MAT prior to incarceration are entitled to continue treatment, unless it is not "medically necessary" in the clinical judgment of a licensed physician, physician's assistant, or advanced practice registered nurse.[55] Incarcerated persons screening positive for OUD may also elect to initiate MAT. The law requires a reentry plan for incarcerated persons and commencement of MAT prior to release if the person screens positive for an OUD, MAT is medically necessary, and the person elects to commence MAT.

In 2019, **Maryland** passed a law requiring county jails to offer M-OUD.[56] Maryland's law establishes a phased-in approach for M-OUD programs in county jails and connections to care upon reentry. Four Maryland counties—Montgomery, Prince George's, St. Mary's and Howard—must implement the program by January 1, 2020. Six additional counties will follow by October 1, 2021. The law is silent on access to M-OUD in the state's prisons. This becomes an issue where local jails provide M-OUD but people are forced to withdraw from these medications upon entering a state prison without an M-OUD program.

Colorado also passed a law in 2019 requiring jails that receive funding from state behavioral health services to develop a plan for access to medications by January 1, 2020.[57] **Colorado's** law requires state prisons to continue providing medications upon transfer from a local jail, if the individual was receiving medication at the jail.

Massachusetts law requires the Department of Correction to offer buprenorphine and methadone at seven state prisons as part of a pilot program. The legislature allocated $2.2 Million for the program in 2018.[58] **New Jersey** announced an $8 million investment in 2019 to provide M-OUD in county jails; prisons and some jails in the state already provide medications for OUD.[59]

FUNDING

Current Fiscal Landscape

Funding is a critical tool for reform. Most states are not mandating jails and prisons to provide M-OUD to people who are incarcerated; however, a number of states are funding specific programs to incentivize jails and prisons to provide this treatment.

Many states are using federal dollars to support the launch of new or expanded M-OUD programs. This includes funding authorized under the federal SUPPORT for Patients and Communities Act and earmarked for programs to combat the opioid epidemic, such as the State Opioid Response (SOR) grant, as well as funding through the Bureau of Justice Assistance at the U.S. Department of Justice, the Comprehensive Opioid Abuse Program (COAP) and the Residential Substance Abuse Treatment (RSAT) for State Prisoners Program.

In addition, private foundations and trade organizations are providing financial resources and technical expertise to a lunch programs across the country.

Some states and counties are incorporating addiction treatment and M-OUD into the correctional health budgets. In some states, criminal justice agencies may participate in group purchasing organizations in order to negotiate more affordable rates for medications on their formulary.[60]

These investments not only support clinical best practice, but advance sound fiscal policy. Analysis of crime costs in **California** estimated that treating criminal justice-involved persons with methadone or buprenorphine, as opposed to detoxification alone, resulted in a cost savings of nearly $18,000 per person over six months.[61] A California law allowing qualified drug offenders to enter treatment instead of jail or prison saved the state close to $100 million in its first year.[62]

Starting an M-OUD program in a jail can be low cost. Methadone and buprenorphine are inexpensive. **Rhode Island**, for example, pays approximately $4.00 for each buprenorphine pill and $8.00 for buprenorphine film provided in the correctional system. Methadone is a generic drug, and costs far less than buprenorphine.

Funding is needed, however, for staff in the jail or prison to perform good assessments to identify people who need treatment, to provide counseling and treatment, and to ensure access to medication following release from incarceration. Ideally, there would also be funding to train staff, collect data, and measure outcomes.

Some states have committed funding to facilitate the shift to evidence-based treatment. **Rhode Island** invests $2 million annually into their program, which includes screening, medication and therapy.[63] **Massachusetts** invested $2.2 million to launch pilot projects in the state's prisons.

FUNDING STRUCTURE AND OUTCOMES: ALBANY COUNTY CORRECTIONS AND REHABILITATION SERVICES CENTER

Under the leadership of Sheriff Craig Apple, and with the support and technical assistance from the New York State Office of Alcoholism and Substance Abuse Services and the Katal Center for Health, Equity, and Justice, Albany County Correctional Facility began providing all three medications to treat OUD in January 2019. Setting up an M-OUD program cost $15,555. The operational costs to serve 110 participants for the first 6 months were $30,202.

Following program implementation, the recidivism rate for the jail declined so dramatically that the Sheriff is now decommissioning 100 jail cells and will be turning them into voluntary transitional housing with treatment and employment supports available.

IMPLEMENTATION COSTS

ITEM	COST
15 M-OUD Meetings	$4,530.00
9 M-OUD Discharge Meetings	$2,718.00
Phone conferences with pharmacy partners	$ 386.00
Phone conferences with State partners	$ 785.00
Policy Development	$2,056.00
DEA X Waiver Training (staff time)	$3,080.00
Staff M-OUD Training (staff time)	$2,050.00
Set up and Initial Implementation Total	$15,555

*Based on hourly rate of $302.00 for attendees

PROGRAM COSTS

ITEM	COST
Medication (110 participants)	$12,855.00
Drug Kits	$ 1,100.00
Physician's Assistant / Nurse Consultations	$ 6,490.00
Nurses daily medication administration	$ 3, 102.00
CASAC M-OUD Consultation	$ 2,455.00
Script dissemination for those released to programs	$ 1,937.00
Phase 2 Sentenced Individuals Chart and Booking Review	$2,263.00
Total M-OUD Program Costs for 110 people	$30,202.00

In 2019, a number of states included new budget funding for medications to treat OUD for their incarcerated population. **Connecticut** appropriated $8 million for such a program in its two year budget. **Ohio** included funding to reimburse counties for OUD medication treatment program costs in county jails.[64] **Oklahoma** provided $500,000 for a pilot program to provide medication to individuals with OUD in county jails.[65] The **New Jersey** Department of Corrections has invested almost $10 million over the past two years to expand M-OUD treatment in jails.[66] This builds on New Jersey's existing initiatives which have established M-OUD in the state prison system.

Medication for OUD in New Jersey jails has led to a 60% decline in overdoses among those who have been incarcerated.[67]

New York's budget included $3.75 million in funding to support addiction treatment programs in county jails. Critically, a measure to require medication in the state's jails and prisons failed to pass in New York because there was no funding appropriated in the budget, and it would have been an unfunded mandate. New York instead is using a combination of federal State Opioid Response (SOR) funds and state moneys to help local county jails and a number of state prisons begin programs providing M-OUD and other treatment services. **California** is also leveraging Federal SOR grant dollars as well as funding from private foundations and the State.

Funding from private foundations in collaboration with government partners has been a critical component of reform in this area. Arnold Ventures is collaborating with the U.S. Department of Justice, Bureau of Justice Assistance (BJA) to fund an initiative to expand M-OUD in 16 county jails nationwide.[68] The program includes support in developing treatment guidelines, managing administration of the medications, and educating jail staff about addiction. Each county is developing a plan with local health care officials to ensure people can access treatment after they are released. Technical assistance is being provided by Health Management Associates. The Friends Institute and the National Institute on Drug Abuse (NIDA) will evaluate outcomes. BJA will be funding a phase 2 to implement the plans. Bloomberg Philanthropies is investing $50 million to support state and local responses to the opioid crisis, including in projects to expand access to M-OUD in jails and prisons.[69] Bloomberg is working in partnership with Vital Strategies, the Pew Charitable Trusts, Johns Hopkins University and the Centers for Disease Control and Prevention through the CDC Foundation in this effort.

Fiscal Sustainability

In order to reduce the number of opioid deaths, government must include evidence-based treatment in jails and prisons as a key component of a comprehensive opioid strategy. This will require evaluating pilots and new policies related to M-OUD in criminal justice settings and identifying ways scale up and financially sustain those with positive outcomes.

Federal grants, one-time appropriations and support from private foundations can support new strategies and practices, but these models must be programmatically and fiscally sustainable to be successful long-term. Government must weave successful programming into the fabric of the criminal justice and health care systems. Investments in evidence-based treatment and medication in corrections will support long-term recovery and contribute to better health outcomes for people and communities. It will also result in potential cost savings from reduced recidivism, reduced use of social services such as shelters and the child welfare system, and increases in positive social outcomes such as employment.

States are exploring the use of Medicaid dollars in innovative ways to pay for treatment behind the walls. **New York** is in the process of applying for a federal Medicaid waiver which will allow the use of federal Medicaid dollars for 30 days pre-release. This can support transitions, connections to care and treatment, and access to medication. **California** is leveraging its 1115 Medicaid waiver as a basis for re-entry programming and to educate jail, prison, and parole officials about the M-OUD and SUD benefits and delivery system available to the justice-involved population. **New Mexico** handles Medicaid redeterminations for people while they are in prison to prevent them from experiencing a gap in coverage upon release.

States should leverage involvement of managed care organizations where practicable and explore using innovations such as Value Based Payment models and expanded access to telemedicine to support these efforts.

States that have not expanded Medicaid have special considerations and should explore maximizing Medicaid dollars to the greatest degree possible. For example, suspending Medicaid rather than terminating it when a person is incarcerated is a more efficient way to get people back on coverage as soon as possible after leaving a correctional facility.

The Federal government should explore providing flexibility regarding the current prohibitions on the use of Medicaid dollars to pay for most services while a person is incarcerated or prior to sentencing. For example, the Federal government should lift the ban on mobile methadone to enable community-based opioid treatment programs to more easily transport the medication to correctional settings. In Atlantic City, **New Jersey**, for example, a mobile methadone program which was launched before the federal ban on such programs and, therefore, permitted, serves both the community and the jail. The program was already funded to serve the community with $335,000 in state dollars. Using mobile methadone to serve people in jail is an innovative way to reduce the costs of transportation and security involved with M-OUD.

MAKING THE CASE USING OUTCOME MEASURES

States and local government entities that have secured funding for these services have shown through data and outcome measures that investing in these services saves money. They have identified grant funding, invested in a pilot program, and used the data collected to show a return on investment and make the case for an expanded program.

Creating a data evaluation framework to collect information on outcomes has been a key component of sustained funding because it helps support the business case for continued investment and to get buy-in from stakeholders such as the public. Camden County, **New Jersey**, which provides all three forms of M-OUD in their jail, began with a public awareness campaign to build community support and followed up with data to explain and demonstrate that the money spent on the front end was a return on investment to reduce recidivism and save lives on the back end.

Grant dollars can be used to fund specific positions to drive outcomes and build business case, such as jail in-reach, care navigation, forensic peers that offer hot handoffs, and data measurement. Collier County, **Florida** funded three positions to track data in county treatment courts.

Many correctional facilities do not currently have procedures for identifying the full picture of their needs for the provision of treatment in their facilities. One place to begin is to benchmark the current situation with a few basic data points, such as rate of recidivism, to tell the story. After that, a facility can begin to collect data through an updated intake process.

The federal government and private foundations are also supporting data collection efforts. Through new federal legislation, NIDA has invested $30 million to evaluate outcomes related to treatment for OUD in criminal justice settings, including the impact of access to medication. The project, called the Justice Community Opioid Innovation Network (JCOIN), supports data collection and outcome measures in a co-op of 10 studies.

In the 16-county project funded by the BJA and Arnold Ventures, Friends Research Institute will be coordinating data collection and outcome measures in order to support scaling programs nationally. Arnold Ventures is also supporting several rigorous studies on M-OUD in the correctional systems in **Maryland**, **North Carolina**, **New York**, **Rhode Island**, and **New Mexico**, and will release results in 2019 and 2020.

In addition to reporting outcomes on the effectiveness of their interventions, researchers, treatment providers, and corrections officials should also consider reporting outcomes on the unique challenges they faced and how they overcame them to serve as a guide for subsequent corrections-treatment partnerships.[70]

"Although research, treatment, and corrections agencies personnel may have different priorities and agenda, they can agree that heroin addiction and its adverse consequences are serious problems that can be reduced with careful planning and collaboration."[71]

PUTTING POLICY INTO PRACTICE

METHADONE AND BUPRENORPHINE are highly regulated medications, with federal approval required to provide either to treat addiction.

MODELS FOR MEDICATION DELIVERY

Methadone must be dispensed by a federally approved Opioid Treatment Program (OTP).

A correctional facility can apply to become an OTP. Riker's Island in **New York City**, for example, has had an on-site OTP since 1987 where participants receive methadone and buprenorphine while incarcerated with connections to care upon return to the community. In Maricopa County, **Arizona**[72], four OTPs on site at county jails offer continuity methadone treatment for patients who were already enrolled in a methadone program in the community, prior to arrest. The jail in Cook County, **Illinois**, provides all three forms of M-OUD at an on-site OTP, as does **Rhode Island** and the **Connecticut** Department of Corrections.

A correctional facility can also partner with an OTP in the community to provide methadone. Community Medical Services, a community-based OTP providing services in 20 states, has partnerships with jails and prisons in 17 correctional facilities across the country to support M-OUD and services to incarcerated persons with OUD.[73] In Southern **Arizona**, for example, Community Medical Services (CMS) transports methadone to two re-entry facilities. The medication is held in P.O. Box-style lock boxes on site. Persons incarcerated at the facility who are prescribed methadone access the lock boxes daily under the supervision of correctional officers. Medication adjustments are done via telehealth weekly. In Atlantic City, **New Jersey**, a mobile methadone van brings the medication and services to the jail.

To treat OUD with buprenorphine, a prescriber must obtain a Drug Enforcement Administration (DEA) waiver called an "X Waiver". While Federal law now allows Advanced Practice Nurses[74] and Physician's Assistants to prescribe buprenorphine, practice laws in

several states prevent this. In 2019, states like **Louisiana**[75] and **Utah**[76] revised their laws to expand the number of practitioners who can provide buprenorphine. The training course for obtaining an X Waiver is eight hours for physicians and 24 hours for other prescribers. In the first year, a prescriber can prescribe for 30 patients, and 100 patients in each year thereafter. If a physician is board certified in addiction medicine, they can prescribe for 275 patients. A "qualified treatment program" can prescribe for 100 patients right away and 275 after a year. Correctional settings can become a qualified treatment program. Buprenorphine can be prescribed by a wavered prescriber at the correctional facility or in collaboration with a prescriber in the community.

Any prescriber can administer naltrexone because it is not a controlled substance.

SUPPORT THROUGH EDUCATION, TRAINING, AND LEARNING COMMUNITIES

SUCCESSFUL PROGRAM IMPLEMENTATION requires education, training, technical assistance, and support. A number of projects are utilizing an organized learning collaborative to promote clinical best practices and strategies for collaboration.

In June 2019, the National Governors Association and the American Correctional Association (ACA) hosted a number of multi-state workshops with funding from the federal Centers for Disease Control and Prevention (CDC) for state leaders from corrections, public health, Medicaid and reentry to discuss how to improve access to M-OUD services inside correctional settings, foster care, and reentry and to identify potential models for implementation.[77] Representatives from **Indiana**, **Iowa**, **Kentucky**, **Louisiana**, **North Carolina**, **Ohio**, **Tennessee**, **Virginia** and **West Virginia** participated in the workshops and state officials from **Arizona**, **Colorado**, **Delaware**, **North Dakota**, **Pennsylvania**, **Rhode Island**, **Vermont** and **Washington** served as faculty experts.

Similarly, the 16-county initiative funded by the U.S. Department of Justice's Bureau of Justice Assistance and Arnold Ventures has convened the teams from each of the 16 counties to meeting in person and in an online community throughout the duration of the project.

In **California**, teams from 29 counties (covering 81% of the population) are working to expand access to medication in jails and drug courts and to assure that treatment is accessible upon release. The County Touchpoints project, launched in August 2019, provides training and technical assistance to leaders, managers, and line staff in key positions of interface with the justice-involved population in a Learning Collaborative model across the state. A key piece of this initiative is to identify leaders and get their commitment to support managers and line staff as well as to develop workbooks, issue briefs, and targeted training for each group of stakeholders.

As part of the initiative to introduce M-OUD in state prisons, **New Jersey** instituted an intensive three-day education program for correctional officers conducted by Rutgers University. The program included training on the science behind addiction, M-OUD, and stereotypes and myths.

Funding to support learning collaboratives, training and education, especially in the case of a legislative mandate, is critical for implementation.

INTERNATIONAL COMPARATIVE ANALYSIS

THE UNITED STATES MUST RESPOND POSITIVELY to the overwhelming evidence supporting the use of M-OUD to combat overdose deaths both within jails and prisons and upon release back into the community. While some jurisdictions are making strides, much more is required across all of the United States to protect one of the most at-risk groups for opioid overdose. The federal government, states, counties, and nongovernmental organization or individuals with lived experience, have a number of tools—including litigation, legislative and statutory reform, and funding—that can be used to address this significant problem.

As this country moves forward with improving access to M-OUD in jails and prisons, it is useful to reflect on the successes and challenges experienced internationally. In Canada, for example, M-OUD has been available in certain prisons across the country since 1999, with initiation and continuation available in 43 federal prisons.[80] Provincial and territorial prisons do not, however, consistently provide M-OUD and advocates continue to push for improvements in the provision of medication to people with OUD incarcerated across Canada.

On the other side of the Atlantic, most European countries provide M-OUD and related services to people who have been sentenced as well as those in pre-trial detention.[81] However, even in countries that provide M-OUD in prisons, there remain certain limitations. In countries like Bulgaria, Croatia, and Romania, only people who have been sentenced have access to these services. Other countries such as Netherlands, Latvia, and the Czech Republic only provide medication access to individuals that began treatment prior to incarceration.

While lessons can be learned from every model, there remains work to be done to address the risk of opioid overdose faced by people all around the world.

SECTION TWO
BEST PRACTICES: ENSURING ACCESS TO MEDICATION FOR OPIOID USE DISORDER IN TREATMENT COURTS

Treatment courts, also known as drug courts, are specialized court docket programs for criminal defendants, juveniles, and parents with pending child welfare cases who have "alcohol and other drug dependency problems."[82]

Treatment courts grew out of an attempt to mitigate the effects of rigorous prosecutions and sentencing policies that are very expensive and largely ineffective in reversing the cycle of drug use and crime.[83] In developing these courts, it was recognized that the prison system is especially costly and inefficient to solve substance use challenges in the United States.[84] Treatment courts bring together judges, prosecutors, defense attorneys, treatment providers, and court staff in a collaborative effort to address defendants' substance use disorders (SUD). There are now over 3,000 treatment courts nationwide.

In 2012, nearly half of treatment courts did not use or permit medications in their programs.[85]

In the wake of a nationwide explosion of opioid overdose deaths and evidence that people with opioid use disorder (OUD) experience significantly better outcomes when receiving "medications for opioid use disorder" (M-OUD), including methadone, buprenorphine, and naltrexone, the federal government and trade organizations such as the National Association of Drug Court Professionals (NADCP) have worked to promote and incentivize access to M-OUD in treatment courts. Federal funding for treatment courts through the Bureau of Justice Assistance and SAMHSA require courts to permit M-OUD. In 2010, NADCP issued a unanimous resolution directing treatment courts to "learn the facts" about M-OUD and obtain expert consultation from trained addiction psychiatrists or addiction physicians.

> "If adequate treatment is available, candidates are not disqualified from participation in the Drug Court because of co-occurring mental health or medical conditions or because they have been legally prescribed psychotropic or addiction medication."
>
> **NADCP'S BEST PRACTICE STANDARDS**

There has also been judicial leadership on these issues. Chief Judge Janet DiFiore of the New York Supreme Court is championing an expansion of Opioid Intervention Courts (OICs) across the state. OICs prioritize treatment over criminal prosecution by ensuring that defendants are connected to M-OUD within 24 hours of arrest, followed up by 90 days of intensive daily court monitoring.[86] Nationally, the judiciary is recognizing that addiction can impact people involved in all areas of the court system, not just for the small percentage of people diverted to treatment courts. The National Judicial Opioid Task Force, in collaboration with the National Association of State Courts, developed guidelines and recommendations on how the judiciary can positively impact the opioid crisis in courts at every level, with access to M-OUD as a central focus.[87]

As a result of these efforts, treatment courts and states are incorporating M-OUD as a necessary tool for the treatment of people with OUD participating in treatment court programs. Twenty out of 25 states (80%) responding to a national survey indicated that they adopted the NADCP Best Practice Standards, which promote M-OUD, for purposes of credentialing, funding, or training new and existing treatment courts in their jurisdictions. A number of states have codified NADCP's standards and competencies directly into law and/or policy.

Despite this progress, significant challenges remain with implementing best practices in treatment courts:

1. **Stigma and misunderstanding of M-OUD remain in many systems**

   In some jurisdictions, an individual judge or member of the treatment court team may favor one form of treatment over another, which may not be the best clinical approach for an individual drug court participant. Clinical decision making may be done by a court, probation officer, or other member of a treatment team, rather than a clinician. In other jurisdictions, there may be a lack of support for evidence-based treatment or medication from government partners. For example, a court may permit M-OUD, but the probation department or jail in the area might not. In other cases, training and education about the science of addiction and best practices simply may not be a priority; as a result, untrained staff make decisions based on limited understanding.

2. **Racial, ethnic, and gender disparities exist in many treatment courts, reflecting and exacerbating systemic injustices.[88]**

   To address this, American University and the Bureau of Justice Assistance developed the Racial and Ethnic Disparities (RED) Program Assessment Tool to help treatment court professionals identify and examine areas where racial and ethnic disparities may exist in their court programs.[89]

3. **Access to treatment and medication, particularly in rural areas, remains a central concern.**

   In many areas throughout the country, there are no opioid treatment programs to dispense methadone and few prescribers authorized to prescribe buprenorphine: almost 50% of counties lack a publicly available M-OUD provider; for rural counties, over 70% do not have a publicly available provider.[90]

KEY PRINCIPLES TO ADVANCE ACCESS TO MEDICATION FOR OPIOID USE DISORDER IN TREATMENT COURTS

Courts, communities, and states can increase access to M-OUD by incorporating the following principles into law and/or policy:

REQUIRE COURTS TO PROVIDE AFFIRMATIVE ACCESS TO M-OUD

Courts should facilitate access to all three FDA-approved medications and help participants connect to access where available. Courts should ensure equal access for people with mental health conditions in policy and practice. Clinical standards should drive decisions and policy, not individual philosophical beliefs or ease of administration.

This legislation should apply to all courts, including treatment/problem-solving courts, and should be supported by state and local funding. A court should not impose limitations on medication prescribed to the defendant by a health care provider for mental health or related conditions. The treatment court program should be required to maintain a network of SUD treatment programs representing a continuum of graduated substance use treatment options commensurate with the needs of defendants, including programs that offer M-OUD. No guilty plea should be required when: (a) the people and the court consent to the entry of such an order without a plea of guilty; or (b) based on a finding of exceptional circumstances, the court determines that a plea of guilty shall not be required. Exceptional circumstances exist when, regardless of the ultimate disposition of the case, the entry of a plea of guilty is likely to result in severe collateral consequences.

MODEL LANGUAGE FOR LEGISLATION:

"A court, including drug court, treatment court, family court and problem-solving court, may not prohibit a defendant from participating in and receiving FDA-approved medication to treat his or her addiction, including for alcohol use disorder and opioid use disorder, under the care of a clinician licensed in this State to prescribe such medication. Drug court participants may not be required to refrain from using medication assisted treatment as a term or condition of successful completion of the drug court program."

PROGRAMS SHOULD NOT PRECLUDE PARTICIPATION FOR PEOPLE CONVICTED OR ACCUSED OF A FELONY

The primary eligibility criteria for treatment court should be the defendant's clinical needs rather than the crime charged.

TRAUMA-INFORMED APPROACH SHOULD GOVERN

The approach must be solution-focused and trauma informed. Jail time should not be used as a sanction, particularly if a jail does not offer M-OUD.

Courts should adopt an affirmative obligation to help people access M-OUD where available. Courts should be cognizant of their use of language in materials and promote non-stigmatizing language. Drug court handbooks and court participation agreements around the country vary widely in their description of addiction and SUD and some do not reflect best practices for treatment. For example, one handbook explicitly states that courts will not pay for M-OUD even though no insurance covers the cost of medication in that state. Other handbooks prohibit all pain medications, benzodiazepines, and/or certain psychiatric medications as well as medications that interfere with drug testing.

Policies, materials, and language should problem-solve and affirmatively assist people to connect with evidence-based treatment and medication, including through the use of court's budgets, rather than perpetuating stigmatizing attitudes about the use of M-OUD. Courts with a blanket policy barring entire categories of medication risk litigation. Clinical decisions are best left to clinicians.

A CENTRAL BODY IN EACH STATE SHOULD CERTIFY TREATMENT COURTS ACCORDING TO EVIDENCE-BASED STANDARDS.

The central body should have authority to certify treatment courts and a variety of tools to advance and incentivize the adoption of evidence-based practices, including funding.

TREATMENT COURTS ARE ONE TOOL IN A HOLISTIC SYSTEM OF DIVERSION AND DEFLECTION.

Treatment courts are one tool for assisting justice-involved people with a SUD. Communities should invest in a range of interventions that support access to addiction treatment and harm reduction services over incarceration. The selection criteria for treatment courts participants should be re-examined so individuals selected for treatment courts are only those who are most in need of a more intensive supervision process driven by clinical best practices, while others are diverted out of the criminal justice system entirely wherever possible.

FIGURE 1: Treatment Courts Distance to M-OUD Providers (km)

Drug Courts: Distance to M-OUD providers (km): ≤14.6 14.7-41.3 41.4-81.7 81.8-190.7 190.8+

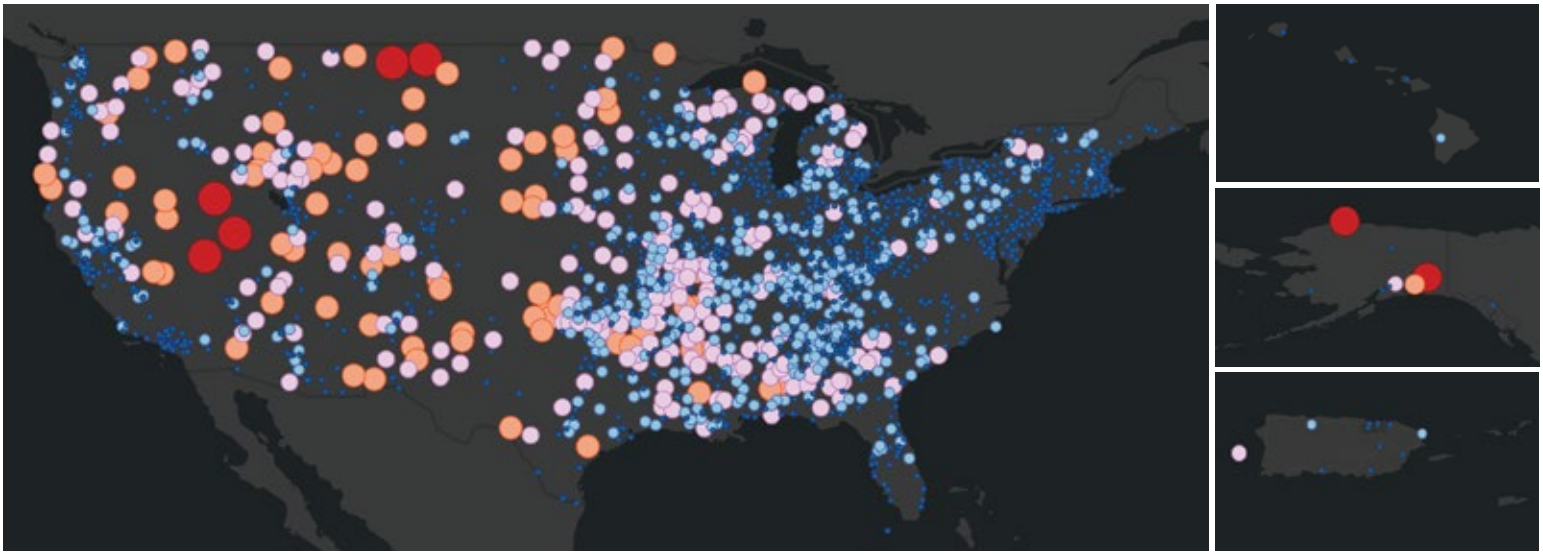
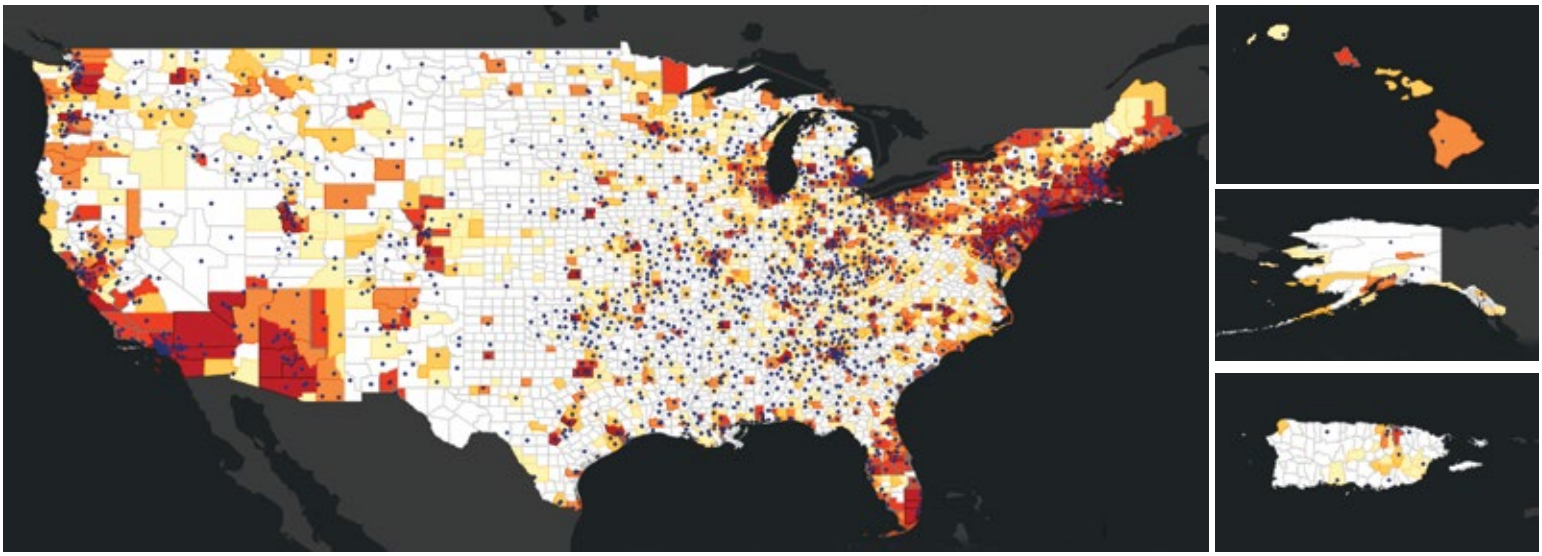


FIGURE 2: Number of M-OUD Providers by County

Number of M-OUD Providers by County: 0 1 2 3-4 5-9 10+ | Drug Courts



Maps developed for this Report by American Institutes for Research (AIR).

SOURCES: Esri, HERE, Garmin, FAO, NOAA, USGS, © OpenStreet Map contributors and the GIS User Community. Data Source: http://findtreatment.samhsa.gov and National Association of Drug Court Professionals.

Figure 1 illustrates the distance between treatment courts and M-OUD providers across the country. **Figure 2** maps out the number of M-OUD providers by county in relation to the location of treatment courts.

These maps provide relevant data: (1) there are many parts of the country with little or no M-OUD and many areas without treatment courts, (2) the distances between treatment courts and M-OUD providers are generally greatest in central United States, and (3) even where the distances are not as great, they are often significant enough to hinder access to opioid treatment programs for those going through treatment courts.

As communities explore solutions to addiction and overdose, strategic and targeted approaches to increasing access to treatment and medication are key.

STRATEGIES TO ADVANCE ACCESS TO MEDICATION FOR OUD IN TREATMENT COURTS

A COMBINATION OF TOOLS CAN BE APPLIED to advance access to M-OUD in treatment courts. Depending on the unique conditions in each jurisdiction, these tools can include legislative mandates, litigation, funding that incentivizes M-OUD, technical assistance and education for courts, treatment court certification, advocacy, and leadership from the judiciary and other change makers.

LEGISLATION

Although most state legislation authorizing treatment courts does not address access to M-OUD, a number of states—**Illinois**, **Missouri**, **New Jersey**, **New York**, and **Washington**—have statutes affirmatively prohibiting courts from requiring a defendant to refrain from using M-OUD as a condition of a participation in, or completion of, a treatment court program.

- **Illinois**: Specifies that a court may not prohibit a defendant from participating in and receiving M-OUD and prohibits a court from requiring a defendant to refrain from using M-OUD as a condition of completion of a drug court program.[91]
- **Missouri**: Specifies that a family court, drug court, or veteran's court shall not prohibit a participant from participating in and receiving M-OUD; that a court participant shall not be required to refrain from using M-OUD as a term or condition of successful completion of the court program; and that a participant shall not be in violation of the terms or conditions of the court on the basis of participation in M-OUD under the care of a physician.[92]

"I think it's important for people to have M-OUD while they are in jail and in drug court because it helps people stay stable in an unstable situation. It's one tool they can use to help them along in their whole process to get them to a happier point in their life. I was on Suboxone while I was in jail and in drug court. It helped me especially when I was in jail because it was the first time I was in jail and I was going through withdrawals on top of it, and it helped make a terrible situation a little better, so I wasn't sick and in jail at the same time. In drug court it helped because it was an anchor for me. It was a tool I knew I had that I could utilize to get through the process and maintain my recovery while I went thorough drug court. Now, I am not on Suboxone any more, I got to the point where I am able to maintain my recovery with the help of my support system and coping skills, but if I didn't have access to it when I did I wouldn't have made it to this point."

T.K. RABII — PEER ADVOCATE

- **New Jersey**: Permits successful completion of special probation drug court program notwithstanding the use of M-OUD.[93]
- **New York**: Prohibits removing a defendant from a judicial diversion program because of participation in prescribed drug treatment under the care of a licensed or certified physician.[94]
- **Washington**: Requires a person lawfully possessing or using lawfully prescribed medication for the treatment of opioid use disorder to be treated the same in judicial and administrative proceedings as a person lawfully possessing or using other lawfully prescribed medications.[95]

Other states have adopted legislation that authorizes pilots related to M-OUD access in treatment courts. A **California** law requires the corrections department to establish a three-year pilot program to provide a medically-assisted SUD treatment model for the treatment of incarcerated persons.[96] **Michigan** has an M-OUD reentry pilot program that connects people with opioid and alcohol addiction to services pre- and post-release from prison.[97]

While M-OUD is permitted in treatment courts guidelines and policy documents in most states, even those without an explicit statutory requirement, the application of those policies is at the discretion of individual courts. A study by the California Health Foundation, for example, found that only some courts in **California** are successfully including M-OUD as a treatment option for their clients, but that many courts have not yet done so.[98]

In some cases, M-OUD funding and policy is limited to, or specifically favors, naltrexone, rather than all three FDA-approved medications to treat OUD. **Florida**, for example, appropriated funds for naltrexone only to treat alcohol or opioid related addiction for individuals who are in court-ordered community-based treatment or involved in the criminal justice system.[99] In **Ohio**, a recent report found that while all forms of M-OUD are permitted, 89% of M-OUD utilized in drug court system is naltrexone. Ohio is also home to a specialty court called "Vivitrol Drug Court" which doubles as a naloxone clinic for individuals in recovery who need to come into court for probation check-ins or other routine visits.[100] **Pennsylvania** law directs the Corrections Department to establish a "non-narcotic medication-assisted substance abuse treatment" grant program, referring to naltrexone, the only "non-narcotic of the three FDA-approved medications."[101] **Tennessee** appropriated $750,000 for an opioid addiction treatment pilot program to provide opioid relapse and/or alcohol addiction dependence treatment, including "non-narcotic medication-assisted treatment" to adults who are participating in, or eligible for participation in a drug court treatment program.[102] **Virginia**

CASE STUDY

KENTUCKY

In 2013, Kentucky courts changed a policy that prohibited treatment court participants from utilizing M-OUD. This shift came on the heels of (1) a change in federal treatment court grant rules prohibit exclusion from treatment court for use of prescribed M-OUD to M-OUD; (2) a federal court case brought under the Americans with Disabilities Act against Kentucky to compel the courts to permit a Johnson County nurse with opioid use disorder to take prescribed medications to treat her addiction while under court supervision; and (3) a series of articles in the Huffington Post on the topic.[103]

appropriated funds to create drug court pilot programs in Norfolk and Henrico counties to test the effectiveness of "non-narcotic, non-addictive, long-acting, injectable prescription treatment" regimens.[104] In **West Virginia's** addiction treatment pilot program, treatment providers connected with treatment court must provide access to "non-narcotic, long-acting antagonist therapy" included in the pilot program's medication-assisted treatment.[105]

Providing funding for naltrexone only is problematic because it results in legislative leadership or a court making a clinical decision that should be in the purview of a health care provider.

FUNDING

In many states, funding is used to drive access to M-OUD in treatment courts. **Louisiana**, for example, used SAMHSA funds to support an M-OUD program in treatment courts.[106] In **Michigan**, 19 courts were awarded grants to provide M-OUD for participants.[107] **Missouri** appropriates funds for treatment programs focused on M-OUD and requires the Drug Courts Coordinating Commission to enter into agreements with the drug courts, Driving While Impaired (DWI) courts, veteran's courts and other treatment courts in order to fund M-OUD programs.[108] **Ohio** appropriated $5 million for a pilot program to provide addiction treatment, including M-OUD, to people with OUD, alcohol use disorder, or both, and allows the pilot program to use medication.[109] **Wisconsin** appropriated funding for a "treatment alternatives and diversion" grant program and required funds be used for local diversion programs that allow participants to use medication.[110] **New York** used State Targeted Response (STR) funds to connect people in Buffalo's opioid treatment court with buprenorphine using a mobile van.

CERTIFICATION

Some states have a centralized certification program for treatment courts, which can be used as a tool for requiring M-OUD. In **New Mexico**, for example, there are separate certification programs for adult drug courts and DWI courts, respectively.[111] These programs include in-depth surveys in order to ensure that each New Mexico treatment court is operating efficiently and appropriately. **Indiana** has a similar system.[112] **Utah** provides treatment courts with a certification checklist, including requirements such as proper disclosure of eligibility and exclusion practices, confirmation that the court employees do not apply subjective criteria or personal impressions to determine participants' suitability for the program, and fixed terms for the presiding judge.[113] In **Ohio**, treatment courts are required to submit an application, undergo a site visit, and submit specific program materials as part of the certification process.[114] Similar treatment court certification systems operate by county, such as Mendocino County[115] in **California** and Reno County in **Kansas**.[116]

EDUCATION, TRAINING AND TECHNICAL ASSISTANCE

Education, training and technical assistance are key components to successful treatment courts. NADCP provides two volumes of best practices as guidance to treatment courts nationwide.[117] Organizations such as the Center for Court Innovation also provide guidance and information to courts, including those that want to develop different models of specialized treatment courts, such as the Opioid Treatment Courts launched in **New York**.[118] Likewise, the National Drug Court Resource Center, a program funded by the federal government and administered by American University in Washington, D.C., equips treatment court practitioners with access to a myriad of drug court resources including recent evidence-based findings, training and technical assistance, publications, webinars, and listservs.[119]

DEVELOPING NEW MODELS FOR TREATMENT COURT

New models for specialty courts that work with OUD treatment continue to emerge. For example, Buffalo, **New York** has an Opioid Intervention Court, a judicially supervised Triage Program where participants are linked with M-OUD and, if needed, mental health services within hours of their arrest.[120] SAMHSA has also produced recommendations for trauma-informed judicial practices, such as proper communication techniques, procedural improvements, and environmental changes.[121] A **Wisconsin** court applies this model for adults and juveniles who have a history of trauma.[122] Other courts, such as Colorado's Recovery Court, use longer-term programming in order to divert individuals in from the carceral system and help them recovery from OUD and SUD.[123]

SYSTEMS APPROACH TO DIVERSION AND DEFLECTION

Treatment courts are one model that serves as an alternative to incarceration, however, communities across the country are launching deflection programs, pre-arrest and pre-incarceration models, and programmatic initiatives that divert people out of the criminal justice system entirely.[124]

Promising models include:

- **Law Enforcement Assisted Diversion (LEAD):** Pre-booking diversion model developed with the community that allows law enforcement officers to re-direct people who would otherwise be charged with low-level offenses to community-based services instead of jail and prosecution.[125] Technical assistance and guidance are available to support implementation of this model.[126]

- **Police Assisted Addiction Recovery Initiative (PAARI):** Provides support and resources to help law enforcement create non-arrest pathways to recovery.[127] The model may be different in each community, but will generally involve (1) self-referral for treatment by presenting at a local police station or asking law enforcement for help with no criminal repercussions, and (2) follow-up by police and/or community-based organization offering services following an overdose or other incident where law enforcement were called.

- **Stop, Triage, Educate, Engage, Rehabilitate (STEER) program:** Risk-need triage model that incorporates both prevention and intervention approaches by using a case manager who rides with the officers, goes to district stations, follows up with individuals referred to the program in the community, and meets and motivates the person to rapidly engage with and stay in treatment.[128] If eligible criminal charges are present, the charges can be held in abeyance if the individual voluntarily accepts a STEER intervention referral.

- **Staten Island HOPE:** Pre-arraignment diversion program designed to redirect low-level drug offenders to community-based health services instead of jail and prosecution.[129] The focus of the program is to reduce overdoses and to improve health outcomes by exposing those in need to treatment options and resources, including harm reduction services, naloxone training and distribution from a peer mentor. The program also aims to improve public safety by reducing criminal activity. Detention Diversion Advocacy Program in San Francisco, California and the Pretrial Services Agency for the District of Columbia operate in similar ways to dismiss defendant's cases and work with clients outside the correctional system. These models and others present opportunities to improve outcomes for individuals with OUD and move away from an approach that criminalizes, rather than treats, addiction.

SECTION THREE
ADDICTION AND CHILD WELFARE POLICY: HEALTHIER OUTCOMES FOR FAMILIES

As part of a comprehensive approach to addressing OUD and its collateral consequences, there is a need for evidence-based approaches to treatment in the context of the child welfare system. This includes trauma-informed approaches, including family-centered treatment, and access to the three FDA-approved "medications for opioid use disorder" (M-OUD): methadone, buprenorphine, and naltrexone.

The number of pregnant women with opioid use disorder (OUD) who presented to hospital labor/delivery departments quadrupled between 1999 and 2014.[130] Between 2012 and 2016, the number of children in foster care nationally rose 10%.[131] Child welfare experts believe that parental substance use has been a driving cause of the increase in placements.[132] In the hardest-hit states, including Georgia, Minnesota, Indiana, and Montana, foster care populations rose by more than 50% between 2012 and 2016.[133] As a result of this phenomenon, communities are implementing a range of responses. Removal of a child from their parent's home puts the child at risk for adverse outcomes, including substance use disorder.[134]

New program models focused on integrated services and supports show promising outcomes. For example, in the Sobriety Treatment and Recovery Team (START) model, researchers found that clients with a history of opioid use who received a year of M-OUD-based treatment increased the odds of retaining custody of their children by 120% compared with those who were not prescribed M-OUD. Mothers recovering from OUD are more likely to succeed in family reunification when comprehensive services that are matched to their individual, specific needs are provided and when recovery management and other social and family supports are integrated into the treatment plan.[135]

However, many barriers and challenges exist in the systems serving families. For mothers in recovery from addiction, finding support can be difficult, and caseworkers, courts, and other providers often misunderstand how treatment works and lack guidelines on how to incorporate it into child welfare practice.[136] Despite the success of M-OUD as a treatment modality, parents enrolled in such programs often face serious limits on treatment availability.[137] This can be due to a misunderstanding of M-OUD and limited interaction between child welfare agencies and health care providers.[138] The silos between health care and family services impede treatment and cause unnecessary family separation.[139] Better coordination among all the systems serving families would increase the likelihood of a parent accessing evidence-based treatment and would also promote family reunification.

Pregnant women and parents with OUD often face stigma and adverse consequences, even when seeking and receiving treatment. Pregnant women who use substances, especially women of color and women in lower socioeconomic brackets, are subject to increased surveillance and may face arrest, prosecution, conviction and/or child removal.[140] Some state legislatures have passed or introduced legislation that may exacerbate poor outcomes for families experiencing SUD. For example, **North Carolina** House Bill 918, introduced in 2019, would speed up the time to terminate parental rights to as little as nine months for children born with illicit drugs in their system and would diminish the role of the biological family when deciding permanent placement.[141] In **Tennessee**, the legislature introduced a "Fetal Assault" bill in 2019 to authorize arrest and incarceration of women who use illicit drugs during pregnancy.[142] A similar **Tennessee** law, passed in 2014 and sunset in 2016, was associated with an array of negative outcomes for mothers and babies: out of state births rose, and prenatal care decreased.[143] Although the 2019 measures did not all pass, they demonstrate that there is a limited understanding of what states can do to effectively address this problem.

Recognized practices to support pregnant and postpartum women with OUD include: universal screening for substance use during pregnancy; provision of M-OUD and behavioral counseling during pregnancy and the postpartum period; anticipation and management of Neonatal Abstinence Syndrome (NAS) for infants prenatally exposed to substances; and multidisciplinary, long-term follow-up care for mothers and infants to improve outcomes."[144] Models that support collaboration and coordination among providers and systems serving families are key to achieving successful outcomes.

KEY PRINCIPLES AND STRATEGIES: COMMUNITIES MUST RE-IMAGINE THE SYSTEM SERVING FAMILIES

The key to reform is a culture shift that moves from a crisis-driven system that prioritizes enforcement and compliance to an approach that uses a public health model and puts families at the center. Misaligned incentives, rigid and siloed systems, and missed opportunities all drive systemic barriers and poor outcomes for families. Policy and funding must be made with families in mind and as part of strategic planning, and should be trauma-informed.

SYSTEMS MUST BE COORDINATED, FLEXIBLE AND TRAUMA-INFORMED WITH A FOCUS ON DIGNITY.

Systems that treat, rather than punish, addiction, begin with an understanding of addiction at every level. Systems must be nimble and adaptable, and they must give people in every service setting the opportunity to respond effectively.

Early identification is critical and can start to be accomplished through universal assessment and referral. In the child welfare context, however, generic screening and referral methods may have limited effectiveness because parents misreport for fear of losing benefits or custody. Trained professionals and peer support specialists are critical components to develop a more responsive system. In **Kentucky**, for example, trained professionals are embedded in social service offices to work full time with public assistance staff and child welfare workers to assess and refer individuals to high quality M-OUD. The assessment involves using motivational interviewing to engage people across a range of challenges, including legal issues, intimate partner violence, and housing. In **New Hampshire**, the First Step program "embeds licensed alcohol and drug counselors (LADCs) in select child welfare program district offices across the state [to] train [Department of Children, Youth, and Families] and juvenile justice staff on substance misuse issues and screening techniques, and provide consultation to help

staff better facilitate family access to SUD treatment and community-based services and supports."[145]

Access to treatment with medication, intensive case management, recovery coaching and other tools are elements of a successful system. Hope Homes Recovery Services in **Georgia**, for example, offers residences and treatment services specifically tailored to mothers of minor children and offers referral source collaboration, parent and family support, and life skills development.[146] **Virginia**, **Kentucky**, and other states employ peer support specialists in long-term recovery from OUD who are trained to provide emotional support while helping parents navigate treatment, connect them with other community services and supports, and provide parenting education and training. **New Jersey** developed the Maternal Wraparound Program (M-WRAP), jointly funded by state child welfare and substance use treatment agencies, which provides intensive case management, home visits, and recovery coaching to pregnant and post-partum women with SUD.[147]

Barriers to services exist in many communities, particularly in rural areas. The Family First Prevention Services Act, passed in 2018, is a strong tool to foster and fund interagency collaboration, including among child welfare agencies, state agencies overseeing addiction treatment, the courts, the Medicaid program, and others.[148] Systems should implement models that support collaboration and capacity building, such the Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative Learning Community (OMNI LC), a learning collaborative supported by the Centers for Disease Control (CDC) and the Association of State and Territorial Health Officials (ASTHO). OMNI LC supports multidisciplinary teams in 12 states[149] to develop strategies and action plans in targeted focus areas to address the needs of pregnant and postpartum women with OUD and infants prenatally exposed to substances, including: 1) access to and coordination of quality services; 2) provider awareness and training; 3) data, monitoring, and evaluation; 4) financing and coverage; and 5) ethical, legal, and social considerations.[150]

Working upstream to prevent and identify addiction and collateral consequences often requires a significant and sustained investment of fiscal and human resources up front but to avoids more costly consequences downstream.

CHILD WELFARE LAWS SHOULD NOT PENALIZE USE OF M-OUD.

State abuse and neglect laws cover a wide range of behavior which may harm or threaten the health of a child. Federal law requires a Plan of Safe Care (POSC) for any infant affected by neonatal abstinence syndrome (NAS), a condition that may present due to withdrawal from opioids at the time of birth.[151] This can include legally prescribed substances and medications used for the treatment of OUD: methadone and buprenorphine. Some states require mandatory reporting of NAS to state officials,[152] and some require that all notifications of substance-affected infants are investigated, regardless of the circumstances.[153]

SAMHSA has issued guidance and technical assistance to states to implement a comprehensive approach to POSC development and highlights cross-systems efforts.[154] **Delaware**, for example, requires that healthcare providers involved in the delivery or care of infants determined to be affected by substance exposure notify the child welfare division of such infants and requires a "coordinated, service-integrated response by various agencies in this state's health and child welfare systems to work together to ensure the safety and well-being of [identified] infants … by developing, implementing, and monitoring a Plan of Safe Care."[155] M-OUD providers lead the development and monitoring of prenatal POSC for pregnant women in treatment. **New York** developed a POSC template and flowchart to determine which newborns are appropriate for a report to the statewide central registry for

CASE STUDY

FAMILY TREATMENT COURT IN TOMPKINS COUNTY, NEW YORK

Increasingly, systems serving families are recognizing that a trauma-informed, solution-focused approach is key for positive outcomes. The Family Treatment Court in Tompkins County, New York (Ithaca), for example, checks Adverse Childhood Experiences (ACEs) scores and has virtually eliminated sanctions. Instead, the court institutes a milestone-based approach that embraces evidence-based practices, such as Strengthening Families, connections with public health nurses trained in SafeCare, child and parent psychotherapy, and connecting parents with M-OUD in low-barrier clinics in the area. Children and Family Futures provides intensive training and technical assistance on these strategies, paid for first through a grant from the Doris Duke Foundation and now through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. This has created a culture shift towards a trauma-informed approach, not only in the court, but in the local Department of Social Services (DSS), which administers the child welfare system. The entire community is now becoming trained in these practices with staff from the court and local DSS becoming trainers.

"The 'us versus them' mentality has to shift. We are seeing success now that we've gotten away from re-traumatizing people like we were in the weekly court appearances where you get called up to the podium. We are doing better with engaging. We are embracing peer support and are now hosting monthly sober event for families to create an atmosphere where families can feel normal. We aren't even tracking clean dates any more, the focus is on actions and behaviors. It's not really about the numbers in the end, it's about finding a more human way to support families."—Judge John Rowley, Tompkins County Family Treatment Court.

The experience in Tompkins County also highlights barriers to treatment and sustained recovery for mothers and fathers, particularly in rural areas. A lack of transportation options and limited treatment resources persist despite strong partnerships with community-based organizations. A new program model called REACH offers one solution: a low-barrier space where, on a part-time basis, buprenorphine prescribers from the area assess patients and offer the medication. However, there are still not enough prescribers to meet the need, there is limited housing and inpatient capacity, especially programs that keep mother and child together. There are no programs that keep the father and child together. State and federal resources should be targeted to address gaps in the continuum of care and support.

POSC development led by child protective services, versus those newborns who will have the POSC developed by hospital staff and community partners.[156]

In some states, however, reporting a child with NAS, even due to use of M-OUD, may result in a mother being arrested or in child removal.[157] In **Alabama**, 479 women were arrested under the state's "chemical endangerment" law for the use of both illicit and prescribed drugs.[158] This law was amended in 2015 to allow exemptions for prescriptions. Nonetheless, this law and the impact of similar laws and policies may have a chilling effect on the willingness of pregnant women who use substances to be forthcoming with providers and seek help and support or disclose that they are receiving treatment for OUD.[159]

NAS has at times been interpreted as a *per se* reason for child removal, even where the law is silent on the issue. For example, in **New Jersey**, although there is no law which directly addresses M-OUD in the context of abuse or neglect, a mother prescribed methadone faced losing custody after her baby was born with NAS. The Division of Youth and Family Services filed an abuse and neglect complaint against the mother, Yvonne, to determine whether a *per se* finding of abuse or neglect can be sustained based solely on a newborn's methadone withdrawal following a mother's participation in a treatment program prescribed by a licensed physician.[160] The state Supreme Court found that the statute in question[161] "does not suggest that a finding of abuse or neglect can be premised solely on a harm caused to a child without consideration of the reasonableness of the parent's conduct."[162] The court opined that a parent may cause injury to a child to protect that child from greater harm.[164] Under those circumstances, the court determined that the mother acted with reasonableness, not gross negligence or recklessness.[164]

The mandated arrest or removal of a child where a parent is taking M-OUD often creates a paradox: a parent may either recover from her addiction using evidence-based medication, or she may maintain custody of her child, but she can't do both. Pregnant women risk seeking a reasonable course of action, such as taking methadone in order to avoid withdrawal and miscarriage, and then being punished for that decision. States which do not specify that abuse and neglect does not include M-OUD remove clinical decision-making from clinicians. States should consider providing specific direction in statute or policy related to child removal when a mother is prescribed M-OUD.

Pregnant women are also often subject to similar treatment. For example, in **Wisconsin**, a state court has "exclusive original jurisdiction over an unborn child alleged to be in need of protection or services which can be ordered by the court whose expectant mother habitually lacks self-control in the use of… controlled substances or controlled substance analogs, exhibited to a severe degree, to the extent that there is a substantial risk that the physical health of the unborn child."[165] In these situations, the court is also able to exercise jurisdiction over the expectant mother. The effect of this law appears in a 2013 case in which a pregnant woman confided in her doctor that she had previously struggled with an addiction to prescription painkillers but had used Suboxone and was in recovery.[166] Despite a drug test which affirmed her claim, healthcare providers reported the woman to the Department of Human Services, and she was taken from her home and presented in shackles before a court.[167] While the woman was denied a lawyer, a legal guardian was appointed to represent her fetus.[168] The pregnant woman was forced back onto Suboxone and sent to an inpatient drug treatment program for 90 days against her will. She lost her job as a result, just weeks before she would give birth to her baby.[169]

In 2017, the US Department of Justice made it clear that the ADA extends certain protections for qualified parents with OUD receiving M-OUD; specifically, a court generally cannot deny a parent visitation with her child by reason of the parent's past history of opioid use disorder or current use of M-OUD, nor can a court impose a blanket rule requiring parents to stop participating in M-OUD in order to gain custody of their children.[170]

State law should reflect that M-OUD is the standard of care for the treatment of OUD. State abuse and neglect laws should not have a blanket policy that triggers an investigation, child removal, or arrest for the use of prescribed M-OUD by a pregnant person or parent. Individualized examinations on a case by case basis should be required.

M-OUD alone should not be considered abuse or neglect. **West Virginia** law prohibits the termination of parental rights solely because the parent receives OUD treatment medications.[171] While this is a positive first step, a parents' use of prescribed M-OUD alone should not be a reason for denying custody, visitation or any other parental rights. **Arizona**

provides a carve-out under the definition of neglect for infants who are born exposed to drugs as a result of medical treatment administered to the mother.[172]

These laws must also be accompanied by education and adequate resources to support healthier families, as well as strategies for community collaboration.

STREAMLINE FUNDING SOURCES.

Federal legislation and funding can support and incentivize states' efforts to improve access to evidence-based and family-based care. There are a number of funding sources available to states that provide support for new programs, additional training for staff, preventative services, treatment and other expenses.

The 2018 SUPPORT for Patients and Communities Act (SUPPORT Act) includes provisions that are intended to increase access to evidence-based treatment and follow-up care, particularly for pregnant women, children, people in rural areas, and people in recovery.[173]

The Family First Prevention Services Act provides guidance and funding to states with the goal of reducing foster care entries and keeping families together.[174] This Act seeks to change the way Title IV-E funds, which provide for the maintenance and administrative costs of foster care,[175] can be spent by states. States, territories, and tribes with an approved Title IV-E plan now have the option to use these funds for prevention services that would allow candidates for foster care to stay with their parents or relatives. Half of the costs will be covered by the federal program, while the other half is covered by the state.[176] Other long-standing federal sources for maternal and child health and development include Title V, Maternal and Child Health State Block Grants, Individuals with Disabilities Education Act, Child Abuse Prevention and Treatment Act (CAPTA), Centers for Medicare and Medicaid Innovation's MOMS and InCK demonstration projects.

CASE STUDY

ARIZONA

Arizona changed the definition of "neglect" to exclude drug exposure that was the result of a medical treatment administered to the mother or the newborn infant by a health professional. [Rev. Stat. § 8-201(2), (24)]. This was followed by a large effort to educate the community. The shift occurred after a woman, a combat veteran who had been in methadone treatment for a year, was separated from her newborn after delivery. In order to build upon this change with a culture shift, the community used a collective impact model to collaborate with all the possible partners in the system, including government, residential treatment, OB/GYNs, and pre-natal services to develop a new approach. The local Opioid Treatment Program, Community Medical Services, began providing parenting classes before the baby is born (instead of after) and delivers a binder to the child welfare worker with information about all the courses and programming the new parent has engaged in. This allows the provider to be a strong and organized advocate for the parent. The community also began advocating for a "pre-dependency" hearing to get ahead of an investigation and allow predictability upon delivery, particularly because determinations must be made within 48 hours after delivery. A new "nesting-inn" program is slated to be launched in Phoenix in November where new mothers can receive services along with their babies in a residential setting.

Medicaid expansion, which includes reimbursement for SUD and treatment medications, is a critical funding source.[177] The wider use of Medicaid funding for treatment and related staffing is necessary to support inpatient treatment programs that specifically serve families as well as treatment and harm reduction services in the community. Access to M-OUD among Medicaid patients is far higher on average in Medicaid expansion states than non-expansion states, particularly for pregnant women.[178] Systems serving families should maximize innovative approaches to treatment, such as school-based health services and telemedicine.

Funding opportunities provided by agencies in the Department of Health and Human Services, particularly SAMHSA and the Health Resources and Services Administration (HRSA), include efforts to increase the availability of treatment and M-OUD.[179] States should ensure this funding is maximized and targeted to those at highest risk of overdose, as well as used to support the transformation of systems serving families.

These federal funding streams are often hard to navigate and difficult to coordinate. Funding should be mapped and streamlined to be easily accessible and coordinated for states and communities.

LEVERAGE TECHNOLOGY AND DATA.

Systems should consider how to develop meaningful administrative oversight mechanisms that use data in a targeted way. Legacy federal requirements for certain data systems coupled with layers of state reporting requirements contribute to an uncoordinated data landscape. Many communities lack understanding of the prevalence of SUD in the child welfare system, what interventions are being used, and whether those interventions are successful. Data is a strong tool for measuring outcomes and targeting scarce resources to families with highest need and risk. Systems must be modernized so the people engaged in the system can get access to information in an automated way with the goal of keeping children at home and ensuring access to services.

PRIORITIZE TRAINING AND WORKFORCE DEVELOPMENT FOR THE CHILD WELFARE WORKFORCE.

Prioritizing workforce development, education and formalized training are key components to a successful system. High turnover is a particular challenge in child welfare. Training in best practices and M-OUD must include all people in human services, not just clinicians. The child welfare workforce and people with lived experience should be engaged and involved in training and education efforts. Systems should look at ways to address vicarious trauma and maximize the use of technology to create efficiencies.

LAUNCH AND SUSTAIN ALTERNATIVE MODELS USING EVIDENCE-BASED PROGRAMMING.

While the challenges and barriers to care in the child welfare system are great, they are not impossible to overcome. Evidence-based programming and innovative approaches are beginning to gain momentum across the country and are shifting the culture of child welfare towards a system that fosters collaboration and encourages the preservation of families. A number of programs have emerged to support a families' ability to access treatment while maintaining custody of their children. These programs focus on addressing barriers to care and encourage an individualized, collaborative, and trauma-informed approach to care.

Strengthening Families utilizes evidence-based techniques to support families, limit foster

care entries, and provide needed care to both parents and children. The framework includes five key focal points: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. The program, currently in more than 30 states, employs this model by working with families, programs, and communities that may be in need of updated, research-informed guidance.[180]

Sobriety Treatment and Recovery Teams (START): The **Kentucky** START program "integrates child welfare and SUD services for families with the goal of keeping children at home whenever it is safe and possible."[181] This evidence-based child welfare intervention seeks to ensure rapid access to OUD treatment.[182] START also provides direct services to children, such as screenings and home visits.[183] The **Ohio** START program, which the Kentucky program is based on, also focuses on keeping children at home. In order to ensure quality treatment, Ohio's program is reviewed by the Ohio State University's College of Social Work and the Voinovich School of Leadership and Public Affairs at Ohio University.[184]

SafeCare: SafeCare is an evidence-based parenting program for families with children aged 0 to 5 with the mission of ensuring that all parents can provide a nurturing, safe, and healthy home environment for their children. This program provides training and support for systems and agencies around the world to adopt researched, evidence-based practices and deliver better care to families. The SafeCare model is divided into four key modules: health, home safety, parent/child interactions, and parent/infant interactions.

Maternal Opiate Medical Supports Plus (MOMS+): MOMS+ works closely with pregnant women who have OUD in order to ensure that they are getting the appropriate treatment and the right supports. MOMS+ integrates a number of agencies and organizations and tailors its services to each individual client and provide a plan of coordinated care for mothers and families.[185] MOMS+ utilizes a mentor-partner model and leverages existing service delivery and payment models like maternity medical homes for pregnant women with OUD and bundled payments for NAS care.

Family Treatment Drug Courts (FTDCs): FTCDs, alternatively known as dependency drug courts or family drug courts, use a multidisciplinary, collaborative approach to serve families that require SUD treatment and who are involved with the child welfare system.[186] Well-functioning FTDCs bring together SUD treatment, child welfare services, mental health, and social services agencies in a non-adversarial approach. These courts seek to provide safe environments for children, intensive judicial monitoring, and interventions to treat parents' SUD and other co-occurring risk factors. The Family Preservation Court in **Louisiana**, is a specialty court established to address the safety and well-being of children in the dependency system by providing parents access to drug and alcohol treatment, judicial monitoring of their sobriety and individualized services to support the entire family. Simply using the name of the court to focus on family preservation helps to target the court's mission: preserving families. Safe Baby Courts focus on the mental and physical health of infants and toddlers in the child welfare system. The Zero to Three Safe Babies Court Team, a national program which works with courts, connects babies and their families with the support and services they need to promote healthy child development, while at the same time working with judges to make a family's experience with the court system as efficient as possible. **Tennessee** currently has seven safe baby courts, which focus exclusively on children ages birth to four and utilize the Safe Babies Court Team's model for supporting families and focusing, above all else, on child development. **Florida** adopted the same model for their early childhood courts.

These program models and efforts by government, providers, advocates and others illustrate the continued need for targeted practices and cross-sector collaboration in the systems serving families.

VISION FOR THE FUTURE

Many people with SUD, including the large majority of women entering addiction treatment, present significant symptoms of trauma.[187] Often the systems that engage people with SUD, including criminal justice, courts, and the child welfare systems, re-traumatize them, hinder their recovery, and contribute to a cycle of injustice, poverty and death. To truly address addiction and the current epidemic of overdoses, as well as prevent a new generation from entering this cycle, improving health and treating people with compassion and dignity must drive policies.

"All people have the right to flower, to reveal their full potential as human beings, to fulfill their mission in this world.... That is the meaning of human rights."

DAISAKU IKEDA

ENDNOTES

1 *What is the U.S. Opioid Epidemic?*, U.S. Department of Health and Human Services, https://www.hhs.gov/opioids/about-the-epidemic/index.html; *Medications to Treat Opioid Addiction Are Effective and Save Lives, But Barriers Prevent Broad Access and Use, Says New Report*, The National Academies of Science, Engineering, and Medicine (March 20, 2019), http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=25310.

2 Jon Berg, *Breaking The Cycle: Medication Assisted Treatment (MAT) In The Criminal Justice System*, Substance Abuse and Mental Health Serv. Blog (March 15, 2019), https://blog.samhsa.gov/2019/03/15/breaking-the-cycle-medication-assisted-treatment-mat-in-the-criminal-justice-system; Davida M. Schiff et al., *Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts*, 132(2) Obstetrics & Gynecology 466, 467 (2018).

3 Jon Berg, *Breaking The Cycle: Medication Assisted Treatment (MAT) In The Criminal Justice System*, Substance Abuse and Mental Health Serv. Blog (March 15, 2019), https://blog.samhsa.gov/2019/03/15/breaking-the-cycle-medication-assisted-treatment-mat-in-the-criminal-justice-system.

4 The National Academies of Science, Engineering, and Medicine, Medications for Opioid Use Disorder Save Lives: Conclusions 2 (2019).

5 Medications for the treatment of OUD are also sometimes referred to as Medication Assisted Treatment or MAT.

6 Kype Kampman & Margaret Jarvis, *American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, 9 J. Addict. Med. 1, 8 (2015).

7 National Sheriffs' Association & National Commission on Correctional Health Care, Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field 5 (2018).

8 Nat'l Commission on Correctional Health Care, *Substance Use Disorder Treatment for Adults and Adolescents*, Position Statement (Oct. 23, 2016), https://www.ncchc.org/substance-use-disorder-treatment-for-adults-and-adolescents.

9 The President's Commission on Combating Drug Addiction and the Opioid Crisis, Report 72 (2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

10 Shabbar I. Ranapurwala et al., *Opioid Overdose Mortality Among Former North Carolina Inmates: 2000-2015*, 108(9) Am. J. of Public Health, 1207, 1207-13 (2018).

11 Nickolas Zaller, *Initiation of Buprenorphine During Incarceration and Retention in Treatment Upon Release*, 45(2) J. Substance Abuse Treatment 222, 222 (2013); Verner S. Westerberg, et al., *Community-Based Methadone Maintenance in a Large Detention Center is Associated with Decreases in Inmate Recidivism*, 70 J. Substance Abuse Treatment 1, 1 (2016).

12 Verner S. Westerberg, et al., *Community-Based Methadone Maintenance in a Large Detention Center is Associated with Decreases in Inmate Recidivism*, 70 J. Substance Abuse Treatment 1, 5 (2016).

13 Shabbar I. Ranapurwala et al., *Opioid Overdose Mortality Among Former North Carolina Inmates: 2000-2015, 108(9)* Am. J. of Public Health, 1207, 1207-13 (2018).

14 Substance Abuse and Mental Health Services Administration, Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States 2 (2019).

15 Stephen Magura et al., *Buprenorphine and Methadone Maintenance in Jail and Post-Release: A Randomized Clinical Trial*, 99 Drug & Alcohol Dependence 222, 223 (2009); In a survey of medical staff and case managers at the Connecticut Department of Corrections, the majority of respondents viewed medication as substituting one addiction for another and did not believe that medication programs for inmates should be expanded or that medication reduces criminal behavior. Michelle McKenzie et al., *Overcoming Obstacles to Implementing Methadone Maintenance Therapy for Prisoners: Implications for Policy and Practice*, 5(4) J. Opioid Mgmt. 219, 220 (2009).

16 Josiah D. Rich et al., *Attitudes and Practices Regarding the Use of Methadone in US State and Federal Prisons*, 82(3) J. Of Urb. Health: Bull. of the New York Acad. of Med. 411, 414 (2003).

17 Marsden, et al., *Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death After Release? A National Prospective Observational Study in England*, 112 Addiction 1408-1418 (2017).

18 Larney, et al., *Opioid Substitution Therapy as a Strategy to Reduce Deaths in Prison: Retrospective Cohort Study*, 4 BMJ Open 1, 1 (2014).

19 Josiah D. Rich et al., *Methadone Continuation Versus Forced Withdrawal on Incarceration in a Combined US Prison and Jail: A Randomised, Open-Label Trial*, 386 Lancet 350, 357 (2015).

20 Traci C. Green et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, Research Letter, 75(4) JAMA 405, 405 (2018).

21 Traci C. Green et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, Research Letter, 75(4) JAMA 405, 405-406 (2018).

22 Substance Abuse and Mental Health Services Administration, Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States (2019); National Sheriffs' Association & National Commission on Correctional Health Care, Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field (2018).

23 Amy Nunn et al., *Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems: Results from a Nationwide Survey*, 105 Drug & Alcohol Dependence 83, 83 (2009).

24 Amy Nunn et al., *Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems: Results from a Nationwide Survey*, 105 Drug & Alcohol Dependence 83, 83 (2009).

25 The State's initial roll-out of the program was met with criticism over a slow start and dispute over medical necessity. Jess Aloe, *Opioid addiction: Advocates, legislators frustrated over buprenorphine rollout in prisons*, Burlington Free Press (Oct. 26, 2018), https://www.burlingtonfreepress.com/story/news/2018/10/26/addiction-medication-access-prisons-frustrates-lawmakers-mat-buprenorphine-vermont/1739985002/.

26 Delaware has a unified correctional system. Nick Ciolino, *Medication for Opioid Addiction to Be Expanded in State Prisons*, Delaware Public Media (Jul. 3, 2019), https://www.delawarepublic.org/post/medication-opioid-addiction-be-expanded-state-prisons.

27 *Delaware Prisons to Get Opioid Treatment Program*, Associated Press (Jul. 31, 2019), https://www.apnews.com/9dae62982bca4564b5cadd939cbc26e9.

28 Office of the Governor of Maine, An Order to Implement Immediate Responses to Maine's Opioid Epidemic (2019).

29 Office of the Governor of Maine, An Order to Implement Immediate Responses to Maine's Opioid Epidemic (2019).

30 *Key Performance Indicators: Department of Corrections,* State of Alaska Office of Mgmt & Budget (Sept. 9, 2019), https://omb.alaska.gov/html/performance/program-indicators.html?p=24.

31 Terry DeMio, *Jail using medicine to help inmates addicted to drugs*, Associated Press (June 29, 2019), https://www.apnews.com/c173956e8e3448a0a49071d8f0157106.

32 Robinson v. California, 370 U.S. 660, 667 (1962).

33 Winter v. Natural Resources Defense Council, Inc., 555 U.S. 7, 20 (2008) (citing Munaf v. Geren, 553 U. S. 674, 689-90 (2008) (slip op., at 12); Amoco Production Co. v. Gambell, 480 U. S. 531, 542 (1987); Weinberger v. Romero-Barcelo, 456 U. S. 305, 311–312 (1982).

34 Plaintiff Mr. Pesce has been in active recovery for OUD with the support of daily methadone. Prior to this, Mr. Pesce had overdosed at least six times, lost his job, lost custody of his son, and had become homeless. Methadone has been the only treatment to successfully help Mr. Pesce to stay in active recovery, helping him to maintain employment and contribute financially to his family. Prior to starting methadone, Mr. Pesce was arrested for DUI and put on probation. While still on probation, Mr. Pesce was pulled over and charged with driving on a revoked or suspended license. As a result, he faced jail sentences to be served in the Middleton jail in Essex county for both the original charge of DUI/probation violation and the second charge of driving on a suspended license. At the time, Middleton jail expressly prohibited the use of methadone. Per Mr. Pesce's physician, forcefully withdrawing Mr. Pesce from methadone would increase his chances of relapse, recidivism, and death. Pesce v. Coppinger, 355 F. Supp. 3d 35 (2018).

35 Plaintiff Brenda Smith has been in active recovery since 2009 when she was first prescribed Suboxone, then later transitioned to buprenorphine in 2014 which she still continues to take twice daily. Ms. Smith's M-OUD remains necessary according to her physician. Ms. Smith's decade of active recovery has allowed her to regain custody of her children, secure housing, and obtain employment. In 2014, Ms. Smith was incarcerated where she was forced to withdraw from Suboxone, an experience that led her to experience the worst pain in her life along with suicidal thoughts for the first time. Smith v. Aroostook Cty., 376 F. Supp. 3d 146 (2019).

36 A federal appeals court subsequently upheld the district court ruling in Smith v. Aroostook County, which ordered the Aroostook County Jail to provide Ms. Smith with access to M-OUD for her opioid use disorder during her 40-day jail sentence.

37 In the Smith case, the court declined to address the likelihood of success on Ms. Smith's eighth amendment claim because it found that Ms. Smith's ADA claim was likely to succeed.

38 Smith v. Fitzpatrick, 2019 WL 1387682.

39 Complaint at 1, Smith v. Fitzpatrick, 2019 WL 1387682.

40 Smith v. Fitzpatrick, 2019 WL 1387682 at 2.

41 With the help of her prescription methadone, Ms. DiPierro had been in active recovery for years at the time the case was brought.

42 Sandra E. Garcia, *Kansas Inmate Will Be Allowed Opioid Addiction Drugs*, N.Y. Times (Sept. 11, 2019), https://www.nytimes.com/2019/09/11/us/kansas-aclu-inmate-opioids.html.

43 Sandra E. Garcia, *Kansas Inmate Will Be Allowed Opioid Addiction Drugs*, N.Y. Times (Sept. 11, 2019), https://www.nytimes.com/2019/09/11/us/kansas-aclu-inmate-opioids.html.

44 Plaintiffs alleged that Defendants provide M-OUD to pregnant people with OUD, but deny this treatment to all others. The proposed class excluded pregnant people. Kortlever v. Whatcom County, No. 18-00823 (W.D. Wash. 2019).

45 Settlement Agreement, Kortlever v. Whatcom County, No. 18-00823 (W.D. Wash. 2019).

46 *The ADA, Addiction and Recovery*, ADA National Network, https://adata.org/factsheet/ada-addiction-and-recovery.

47 Americans With Disabilities Act, 42 U.S.C. § 12101 (1194).

48 Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 285 (1st Cir. 2006).

49 Pesce, 355 F. Supp. 3d at 46 (citing *Kinman*, 451 F. 3d at 285 (quoting Lesley v. Chie, 250 F.3d 47, 55 (1st Cir. 2001))).

50 Kogut v. Ashe, 602 F. Supp. 2d 251, 253 (D. Mass. 2009) (denying petitioner's access to a program was not a violation of the ADA given petitioner's record of violence in jail).

51 Smith, 376 F. Supp. 3d at 161-62.

52 Estelle v. Gamble, 429 U.S. 97, 102 (1976). *See also* Wilson v. Seiter, 501 U.S. 294, 296–97 (1991) (applying the requirements of Estelle to state facilities through the Fourteenth Amendment)..

53 Alexander v. Weiner, 841 F. Supp. 2d 486, 493 (D. Mass. 2012).

54 28 V.S.A. § 801(e)(2) (2018).

55 Under the Vermont law, "medically necessary" is defined as "health care services that are appropriate in terms of type, amount, frequency, level, setting, and duration to the individual's diagnosis or condition, are informed by generally accepted medical or scientific evidence, and are consistent with generally accepted practice parameters. Such services shall be informed by the unique needs of each individual and each presenting situation, and shall include a determination that a service is needed to achieve proper growth and development or to prevent the onset or worsening of a health condition." 28 V.S.A. § 801(e)(5)(A) (2018).

56 Md. Code Ann., Corr. Servs. § 9-603.1 (LexisNexis 2017).

57 Colo. Rev. Stat. § 16-11.3-103 (2019).

58 Mass. Gen. Laws ch. 6, § 219 (2018) (stating that "[t]here shall be a commission on community-based behavioral health promotion and prevention located within, but not subject to the control of, the executive office of health and human services.").

59 Lilo H. Stainton, *State Expands Addiction Treatment Programs in County Jails*, NJ Spotlight (Sept 23, 2019), https://www.njspotlight.com/2019/09/19-09-22-state-expands-addiction-treatment-programs-in-county-jails/

60 Substance Abuse and Mental Health Services Administration, Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States 4 (2019).

61 Emanuel Krebs et al., The Costs of Crime During and After Publicly Funded Treatment for Opioid Use Disorders: A Population-Level Study for the State of California, 112(5) Addiction 838, 839 (2017).

62 National Institute on Drug Abuse, *Treating Opioid Addiction in Criminal Justice Settings*, National Institute of Health (Dec. 2017), https://www.drugabuse.gov/publications/treating-opioid-addiction-in-criminal-justice-settings/treating-opioid-addiction-in-criminal-justice-settings#ref.

63 *Rhode Island Prisons Push To Get Inmates The Best Treatment For Opioid Addiction*, NPR (Nov. 19, 2018), https://www.npr.org/sections/health-shots/2018/11/19/668340844/rhode-island-prisons-push-to-get-inmates-the-best-treatment-for-opioid-addiction.

64 2019 Bill Text OH H. B. 166.

65 2019 Bill Text OK S.B. 86.

66 Lilo H. Stainton, *State Expands Addiction Treatment for Prisoners*, NJ Spotlight (Aug. 9, 2018), https://www.njspotlight.com/2018/08/18-08-08-state-expands-addiction-treatment-for-prisoners/.

67 Lilo H. Stainton, *State Expands Addiction Treatment for Prisoners*, NJ Spotlight.com (Aug. 9, 2018), https://www.njspotlight.com/2018/08/18-08-08-state-expands-addiction-treatment-for-prisoners/.

68 The 16 counties are: Camden County, NJ; Chesterfield County, VA; Clackamas County, OR; Collier County, FL; Cook County, IL; Cumberland County, ME; Durham County, NC; Eaton County, MI; Hudson County, NJ; Ingham County, MI; Jefferson County, KY; Lewis and Clark County; MT; Marion County, IN; Orleans Parish, LA; Shelby County, TN; and St. Louis County, MN.

69 Bloomberg Philanthropies is supporting projects in Pennsylvania, Michigan, and several other states.

70 Timothy W. Kinlock et al., *Developing and Implementing a New Prison-Based Buprenorphine Treatment Program*, 42(2) J. Offender Rehabilitation 91, 102 (2010).

71 Timothy W. Kinlock et al., *Developing and Implementing a New Prison-Based Buprenorphine Treatment Program*, 42(2) J. Offender Rehabilitation 91, 102 (2010).

72 *Medication-Assisted Treatment (MAT)*, Maricopa County, https://www.maricopa.gov/1195/Initiatives.

73 CMS currently supports the following: Maricopa County Jail (5 facilities); Arizona Department of Corrections (4 facilities: Alhambra, Perryville, MRC, and PRC); Ward County, North Dakota; Cass County, North Dakota; Mat Su Pretrial, Alaska; Goose Creek, Alaska; Hiland Mountain, Alaska; North Dakota Department of Corrections (CMS helped develop program); Travis County, Texas; Marion County Jail. CMS will begin supporting the following facilities: Wisconsin Department of Corrections, Milwaukee County Jail, Pinal County Jail, Yuma County Jail.

74 There are four types of Advanced Practice Nurses: Nurse Practitioners (NPs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs) and certified nurse midwives (CNMs).

75 2019 La. Acts 910.

76 2019 Bill Text UT H. B. 398.

77 *State Leaders Convene For Strategies On Drug Treatment And Recovery For Justice-Involved Populations*, National Governors Association (June 14, 2019), https://www.nga.org/news/press-releases/state-leaders-convene-for-strategies-on-drug-treatment-and-recovery-for-justice-involved-populations/.

78 Stephen Magura et al., *Buprenorphine and Methadone Maintenance in Jail and Post-Release: A Randomized Clinical Trial*, 99 Drug & Alcohol Dependence 222, 230 (2009); Timothy W. Kinlock et al., *Developing and Implementing a New Prison-Based Buprenorphine Treatment Program*, 42(2) J. Offender Rehabilitation 91, 99 (2010).

79 Substance Abuse and Mental Health Services Administration, Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States 3 (2019).

80 *Regional Overview: North America*, GLOBAL HARM REDUCTION 123 (2018), available at https://www.hri.global/files/2018/12/10/NorthAmerica-harm-reduction.pdf.

81 Health in Prisons: Fact Sheets for 38 European Countries, World Health Organization (2019).

82 *Overview of Drug Courts*, National Institute of Justice (May 14, 2012), https://www.nij.gov/topics/courts/drug-courts/pages/welcome.aspx.

83 James J. Hennessy, *Introduction: Drug Courts in Operation*, 33(4) J. of Offender Rehabilitation, 1, 1 (2008).

84 James J. Hennessy, *Introduction: Drug Courts in Operation*, 33(4) J. of Offender Rehabilitation, 1, 1 (2008).

85 Harlan Matusow et al., *Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes*, 44(5) J. of Substance Abuse Treatment 473, 482 (2013).

86 Janet DiFiore, New York State's Opioid Intervention Court 1 (2017).

87 *National Judicial Opioid Task Force*, National Center for State Courts (Jul. 16, 2019), https://www.ncsc.org/opioidtaskforce.

88 *Introduction*, 1 Journal for Advancing Justice 1, 1 (2018).

89 This tool can be accessed at https://redtool.ndcrc.org/.

90 A total of 1457 counties (46.4%), and 946 of 1328 rural counties (71.2%), lacked a publicly available OUD medication provider in 2017. Haffajee RL et al., *Characteristics of US Counties With High Opioid Overdose Mortality and Low Capacity to Deliver Medications for Opioid Use Disorder*, JAMA Network Open (June 28, 2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2736933.

91 730 Ill. Comp. Stat. 166/25(e) (2016).

92 V.A.M.S. 487.200; V.A.M.S. 478.004.

93 N.J. Stat. Ann. 2C:35-14(f)(7) (West 2015).

94 N.Y. Crim. Pro. Law § 216.05 (McKinney 2015).

95 Wash. Rev. Code § 71.24.587 (2018).

96 2016 Cal. Legis. Serv. Ch. 33 (S.B. 843) (WEST).

97 2016 Mich. Legis. Serv. P.A. 268 (H.B. 5294) (WEST).

98 Policy Brief: Collaborative Courts and Medication-Assisted Treatment in California, California Health Policy Strategies, LLC 1(2018).

99 2016 Fla. Sess. Law Serv. Ch. 2016-66 (H.B. 5001) (WEST).

100 Paige Pfleger, *In This Ohio Courthouse, Addiction Treatment Is Just Down The Hall*, Illinois Public Media (Feb. 11, 2019), https://will.illinois.edu/news/story/in-this-ohio-courthouse-addiction-treatment-is-just-down-the-hall.

101 2016 Pa. Legis. Serv. Act 2016-25 (H.B. 1589) (WEST).

102 2015 Tenn. Legis. Serv. Ch. 427 (H.B. 1374) (WEST).

103 Jason Cherkis, *Kentucky Reforms Drug Court Rules To Let Heroin Addicts Take Prescribed Meds*, The Huffington Post (Apr. 17, 2015), https://www.huffpost.com/entry/heroin-addiction-kentucky_n_7088270.

104 2016 Va. Legis. Serv. Ch. 188 (H.B. 245) (WEST).

105 2015 W. Va. Acts Ch. 62 § 62-15A-2 (a).

106 *Louisiana: Fiscal Year 2018 Discretionary Funds*, Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/grants-awards-by-state/LA/discretionary/2018/details.

107 *Drug Court Legislation*, National Center for State Courts, https://www.ncsc.org/Topics/Court-Management/Leadership-and-Change-Management/Opioids-and-the-Courts/Legislation-categories/Drug-Court-Legislation.aspx.

108 State of Missouri Office of State Courts Administrator, Drug Courts Coordinating Commission Treatment Court Program Status (2018), https://www.courts.mo.gov/file.jsp?id=31408.

109 2013 Ohio Legis. Serv. Ann. File 25 (Am. Sub. H.B. 59) (WEST).

110 2015-2016 Wis. Legis. Serv. Act 388 (2015 A.B. 657) (WEST).

111 *NM Drug Court Certification*, New Mexico Courts: The Judicial Branch of New Mexico, https://pscourts.nmcourts.gov/nm-drug-court-certification.aspx.

112 *Certification and Program Forms*, Indiana Judicial Branch, https://www.in.gov/judiciary/iocs/2365.htm.

113 *Utah Adult Drug Court Certification Checklist*, https://www.utcourts.gov/psc/docs/Utah_Drug_Court_Certification_Checklist.pdf.

114 *Specialized Dockets Certification*, The Supreme Court of Ohio & the Ohio Judicial System, http://www.supremecourt.ohio.gov/JCS/specDockets/certification/default.asp

115 *Mendocino County*, National Drug Court Research Center, https://ndcrc.org/source/mendocino-county/.

116 *Certificates*, National Drug Court Research Center, https://ndcrc.org/topic/certificates/.

117 *Adult Drug Court Best Practice Standards*, National Association of Drug Court Professionals, https://www.nadcp.org/standards/adult-drug-court-best-practice-standards/

118 *About*, Center for Court Innovation, https://www.courtinnovation.org/about.

119 *National Drug Court Resource Center: Project Description*, American University, https://www.american.edu/spa/jpo/initiatives/national-drug-court-resource-center.cfm.

120 Buffalo Opioid Intervention Court, Brochure, https://www.nawj.org/uploads/files/midyear_conference/materials/opioid_crisis/buffalo_opioid_intervention_court_brochure.pdf.

121 *Essential Components of Trauma-Informed Judicial Practice*, Substance Abuse and Mental Health Services Administration, https://www.nasmhpd.org/sites/default/files/DRAFT_Essential_Components_of_Trauma_Informed_Judicial_Practice.pdf.

122 Dee J. Hall, *A Day in Trauma-Informed Court: Parents Work to Regain Custody of Their Kids*, Wisconsin Watch (May 22, 2016), https://www.wisconsinwatch.org/2016/05/a-day-in-trauma-informed-court-parents-work-to-regain-custody-of-their-kids/.

123 Erinn Calahan, *15 Set to Graduate from Recovery Court*, The Colorado Springs Business Journal (Sept. 24, 2019), https://www.csbj.com/2019/09/24/15-set-to-graduate-from-judicial-recovery-court/.

124 *Diversion Program*, Foundation of Hope, https://www.foundationofhope.org/programs/diversion/.

125 *LEAD: Law Enforcement Assisted Diversion*, National Institute of Corrections, https://nicic.gov/lead-law-enforcement-assisted-diversion.

126 *Our Mission*, LEAD National Support Bureau, https://www.leadbureau.org/.

127 *About Us*, PAARI: The Police Assisted Addiction and Recovery Initiative, https://paariusa.org/about-us/.

128 STEER Police Deflection Stop, Triage, Engage, Educate and Rehabilitate (2017), http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/STEER-FactSheet.pdf; https://www.policechiefmagazine.org/deflection-a-powerful-crime-fighting-tool-that-improves-community-relations/.

129 *About Sihope.org*, SIHOPE.ORG, https://sihope.org/learn-more.html.

130 *Number of Women With OUD in Labor/Delivery Quadruples*, American Academy of Family Physicians (Aug. 21, 2018), https://www.aafp.org/news/health-of-the-public/20180821oudlabor-delivery.html.

131 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study 1 (2018).

132 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study 1 (2018).

133 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study 1 (2018).

134 Joseph J. Doyle, *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97(5) The Am. Econ. Rev. 1583, 1599 (2007) (finding that children in foster care are estimated to have a juvenile delinquency rate three times higher than those not in foster care); Cheryl Zlotnick et al., *Life Course Outcomes on Mental and Physical Health: The Impact of Foster Care on Adulthood*, 102(3) Am. J. of Pub. Health 534, 538 (2012) (finding that children in foster care are 1.5 times more likely to experience physical or mental health problems, including substance use disorders); Joseph J. Doyle, *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97(5) The Am. Econ. Rev. 1583, 1601 (2007) (finding that girls in foster care are ten percent more likely to become teen mothers); Matthew J. Lindquist & Torsten Santavirta, *Does Placing Children in Foster Care Increase Their Adult Criminality?*, 31 Labour Economics 72, 82 (2014) (finding that boys placed in foster care as adolescents are estimated to have about a 38% higher rate of adult criminality later in life).

135 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Medication-Assisted Treatment for Opioid Use Disorder in the Child Welfare Context: Challenges and Opportunities 3 (2018).

136 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study 1 (2018).

137 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Medication-Assisted Treatment for Opioid Use Disorder in the Child Welfare Context: Challenges and Opportunities 1 (2018).

138 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Medication-Assisted Treatment for Opioid Use Disorder in the Child Welfare Context: Challenges and Opportunities 1 (2018).

139 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study 1 (2018).

140 Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3(2) Health Just. 1, 1 (2015).

141 Brooke Conrad, *Lawmakers Looking to Ease Adoption Rules for Children Whose Parents are Dealing with Substance Abuse*, Carolina Journal (Sept. 4, 2019), https://www.carolinajournal.com/news-article/lawmakers-looking-to-ease-adoption-rules-for-children-whose-parents-are-dealing-with-substance-abuse/.

142 Tenn. H.B. 1168 (2019).

143 Sheila Burke, *Doctors Applaud End of Tennessee's Fetal Assault Law*, Associated Press News (Apr. 1, 2016), https://apnews.com/08ce8448799148bf852babadc33d1aef; Sung Choi & Douglas Leslie, Address at the AcademyHealth Annual Research Meeting: Implementation of the Tennessee Fetal Assault Law Was Significantly Associated with Higher Rates of Late or No Prenatal Care Among High-Risk Populations (June 4, 2019), available at https://academyhealth.confex.com/academyhealth/2019arm/meetingapp.cgi/Paper/33233.

144 Charlan D. Kroelinger, et al. *State Strategies to Address Opioid Use Disorder Among Pregnant and Postpartum Women and Infants Prenatally Exposed to Substances, Including Infants with Neonatal Abstinence Syndrome*. 68 Morbidity & Mortality Weekly Reporter 777–783 (2019).

145 National Academy for State Health Policy, State Strategies to Meet the Needs of Young Children and Families Affected by the Opioid Crisis 5 (2018), available at https://nashp.org/wp-content/uploads/2018/09/Children-and-Opioid-Epidemic-1.pdf.

146 Hope Homes Recovery Services, http://hopehomesrecovery.org/ (last visited Oct. 1, 2019).

147 National Center on Substance Abuse and Child Welfare, On the Ground: How States Are Addressing Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families (2019), https://ncsacw.samhsa.gov/files/on-the-ground-508.pdf.

148 Family First Prevention Services Act, H. R. Res. 253, 115th Cong. § 123 (2018).

149 OMNI LC supports the following states: Alaska, Florida, Illinois, Kentucky, Nevada, Ohio, Pennsylvania, Rhode Island, Tennessee, Vermont, Washington, West Virginia

150 Charlan D. Kroelinger, et al. *State Strategies to Address Opioid Use Disorder Among Pregnant and Postpartum Women and Infants Prenatally Exposed to Substances, Including Infants with Neonatal Abstinence Syndrome*. 68 Morbidity & Mortality Weekly Reporter 777–783 (2019).

151 Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. § 5101 (2018); Family First Prevention Services Act, H. R. Res. 253, 115th Cong. § 123 (2018).

152 Arizona, Florida, Georgia, Kentucky, Tennessee, and Virginia. Shahla M. Jilani et al., *Evaluation of State-Mandated Reporting of Neonatal Abstinence Syndrome — Six States, 2013–2017*, 68 Morbidity and Mortality Weekly Report 6, 6 (2019).

153 Shahla M. Jilani et al., *Evaluation of State-Mandated Reporting of Neonatal Abstinence Syndrome — Six States, 2013–2017,* 68 Morbidity and Mortality Weekly Report 6, 6 (2019).

154 National Center on Substance Abuse and Child Welfare, On the Ground: How States Are Addressing Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families (2019), https://ncsacw.samhsa.gov/files/on-the-ground-508.pdf.

155 Del. Code Ann. tit. 16, §§ 901B-906B (2018).

156 National Center on Substance Abuse and Child Welfare, On the Ground: How States Are Addressing Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families (2019), https://ncsacw.samhsa.gov/files/on-the-ground-508.pdf.

157 U.S. Gov't Accountability Office, Substance-Affected Infants – Additional Guidance Would Help States Better Implement Protections for Children 14 (2018).

158 Rebecca Seung-Bickley & Randall Marshall, *New Report Shows Alabama's Pregnancy Law Hurts, Not Helps,* ACLU Alabama (May 25, 2017), https://www.aclualabama.org/en/news/new-report-shows-alabamas-pregnancy-laws-hurts-not-helps.

159 U.S. Gov't Accountability Office, Substance-Affected Infants – Additional Guidance Would Help States Better Implement Protections for Children 14 (2018).

160 New Jersey Div. of Child Protection and Permanency v. Y.N., 104 A.3d 244, 244 (2014).

1611 N.J. Stat. Ann. § 9:6-8.21(c)(4)(b) (2018).

162 New Jersey Div. of Child Protection and Permanency v. Y.N., 104 A.3d 244, 253 (2014).

163 New Jersey Div. of Child Protection and Permanency v. Y.N., 104 A.3d 244, 253 (2014).

164 New Jersey Div. of Child Protection and Permanency v. Y.N., 104 A.3d 244, 253 (2014).

165 Wis. Stat. § 48.133 (2018).

166 Beltran v. Strachota, 2014 WL 4924668.

167 Beltran v. Strachota, 2014 WL 4924668.

168 Beltran v. Strachota, 2014 WL 4924668.

169 Beltran v. Strachota, 2014 WL 4924668.

170 U.S. Attorney for the Southern District of N.Y., Comment Letter on Medication-Assisted Treatment and the Americans with Disabilities Act (Oct. 3, 2017) https://lac.org/wp-content/uploads/2018/02/DOJ-SDNY-ltr-to-OCA-10.3.17.pdf.

171 W. Va. Code § 49-4-604(e) (2018).

172 Ariz. Rev. Stat. § 8-201(25)(c).

173 Corey S. Davis, *The SUPPORT for Patients and Communities Act — What Will It Mean for the Opioid-Overdose Crisis?*, 380 New England J. of Med. 3, 3 (2019).

174 Family First Services Prevention Act, 42 U.S.C. § 671 (2018).

175 *Title IV-E Home Page*, New York State, https://ocfs.ny.gov/main/fostercare/titleiv-e/.

176 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Medication-Assisted Treatment for Opioid Use Disorder in the Child Welfare Context: Challenges and Opportunities 7 (2018).

177 Suzanne C. Brundage & Carol Levine, The Ripple Effect: The Impact of the Opioid Epidemic on Children and Families 19 (2019); Joint Principles: Addressing the Opioid Epidemic, American Academy of Family Physicians et al. 2 (2018).

178 Lisa Clemans-Cope et. al., State Variation in Medicaid Prescriptions for Opioid Use Disorder from 2011 to 2018, the urban institute (2019); Bachhuber MA, Mehta PK, Faherty LJ, Saloner B. Medicaid coverage of methadone maintenance and the use of opioid agonist therapy among pregnant women in specialty treatment. Med Care. 2017;55(12):985–990.

179 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, The Relationship between Substance Use Indicators and Child Welfare Caseloads 6 (2018).

180 Strengthening Families Program, https://strengtheningfamiliesprogram.org/.

181 National Academy for State Health Policy, State Strategies to Meet the Needs of Young Children and Families Affected by the Opioid Crisis 4 2018, available at https://nashp.org/wp-content/uploads/2018/09/Children-and-Opioid-Epidemic-1.pdf.

182 National Academy for State Health Policy, State Strategies to Meet the Needs of Young Children and Families Affected by the Opioid Crisis 4 2018, available at https://nashp.org/wp-content/uploads/2018/09/Children-and-Opioid-Epidemic-1.pdf.

183 National Academy for State Health Policy, State Strategies to Meet the Needs of Young Children and Families Affected by the Opioid Crisis 4 2018, available at https://nashp.org/wp-content/uploads/2018/09/Children-and-Opioid-Epidemic-1.pdf.

184 *Ohio START*, Public Children Services Association of Ohio, https://www.pcsao.org/programs/ohio-start.

185 *Maternal Opiate Medical Supports Plus (MOMS+)*, Ohio Perinatal Quality Collaborative, https://www.opqc.net/projects/active-projects/maternal-opiate-medical-supports-plus-moms.

186 Center for Children and Family Futures and National Association of Drug Court Professionals, Family Treatment Court Best Practice Standards supported by Grant #2016-DC-BX-K003 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice (2019), https://www.nadcp.org/wp-content/uploads/2019/09/Family-Treatment-Court-Best-Practice-Standards_Final2.pdf.

187 Douglas L. Polcin et al., *Addressing Trauma Among Women With Serious Addictive Disorders: Treatment Models, Program Factors, And Potential Mediators*, 4(3-4) Journal of Drug Addiction, Education, and Eradication, 221–237 (2008).

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