



2023 State of the States

Legislative Roadmap for Reducing Overdose Deaths and Increasing Access to Treatment

November 2023

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INTRODUCTION

The provisional drug overdose death data from the Centers for Disease Control and Prevention (CDC) estimates that over 110,000 overdose deaths occurred in the 12-month period ending in December 2022.¹ Illicit synthetic drugs like fentanyl and methamphetamine, often in combination with other drugs, including cocaine, heroin, and xylazine, caused the majority of these overdose deaths. The data show that fatal drug overdoses in the U.S. leveled out in 2022 after a sharp increase from 2019 to 2021. The biggest percentage increase in overdose deaths in 2022 occurred in Washington and Wyoming, where deaths were up 22 percent as compared to 2021. South Dakota had the biggest percentage decrease in overdose deaths in 2022, where deaths decreased 18 percent from 102 to 84 deaths.

A comprehensive review of the evidence suggests that there are several strategies that can assist state leaders and other stakeholders in preventing overdoses, often by increasing access to treatment. This *2023 State of the States: Legislative Roadmap for Reducing Overdose Deaths and Increasing Access to Treatment* (the *Roadmap*) guides state leaders on the most effective approaches to addressing the opioid and other drug epidemic by identifying 10 evidence-based policy approaches to reduce overdoses. The *Roadmap* can also be used to monitor states' adoption and implementation of the 10 strategies.

Ten Policy Strategies to Reduce Overdoses and Increase Access to Treatment

Each of the 10 strategies outlined in the *Roadmap* points to a specific type of policy that states can implement to reduce overdose deaths and increase access to substance use treatment. The 10 strategies are identified below.

TEN STRATEGIES TO REDUCE OVERDOSES AND INCREASE ACCESS TO TREATMENT

- 1 Syringe Services Programs**

Support access to syringe services programs by adopting laws that implicitly or explicitly authorize them.
- 2 Fentanyl Test Strips**

Support the expanded use of fentanyl test strips by adopting laws to exclude the possession of fentanyl test strips from drug paraphernalia penalties.
- 3 Drug Checking Equipment**

Support the expanded use of drug checking equipment that tests for substances other than fentanyl by adopting laws to exclude the possession of such drug checking equipment from drug paraphernalia penalties.

- 4 Medication for Addiction Treatment in Correctional Settings**

Expand access to medication for addiction treatment (MAT) in custodial settings by requiring state or local correctional facilities to provide MAT through statewide law or state policy.
- 5 Withdrawal Management Services in Correctional Settings**

Require that state and local correctional facilities provide medically managed withdrawal management services through statewide law or state policy.
- 6 School Response to Drug-related Incidents**

Remove laws that require a drug-related incident at school to be reported to law enforcement and implement evidence-based policy approaches that establish a consistent and positive response to drug-related incidents across public schools.
- 7 Naloxone in Schools**

Require all public high schools (at a minimum) in the state to store naloxone on site for responding to overdoses at school or school-sponsored events.
- 8 Substance Use Treatment in the Emergency Department**

Require in-hospital or satellite emergency facilities treating individuals for substance use disorder (SUD) or an overdose to establish specific discharge protocols for such patients, including referrals to outside SUD treatment providers or initiation of medication for addiction treatment for those individuals, where appropriate.
- 9 Substance Use During Pregnancy and Family Care Plans**

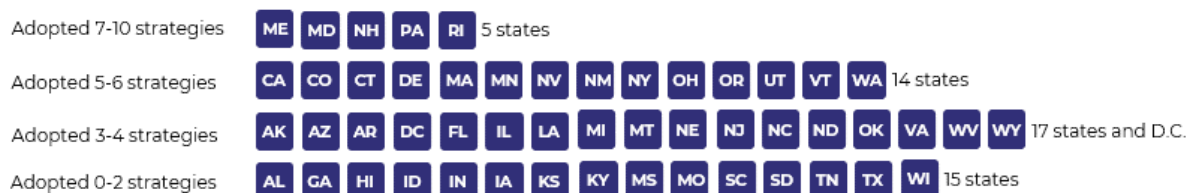
Assist pregnant or postpartum individuals with substance use disorder in seeking help by having specific laws/regulations designed to help families with substance-exposed infants and not automatically considering substance use during pregnancy or giving birth to a substance-exposed infant to be child abuse or neglect, by itself.
- 10 Overdose Fatality Review Teams**

Adopt statewide laws expressly authorizing an overdose fatality review team to obtain certain disclosure-protected information from state and local entities.

Five States Have Adopted At Least Seven of the Ten Strategies

Five states – Maine, Maryland, New Hampshire, Pennsylvania, and Rhode Island – have adopted at least seven of the above-mentioned strategies. Of these five states, Maryland is the only state to have adopted all 10 strategies.

Number of Adopted Strategies by State

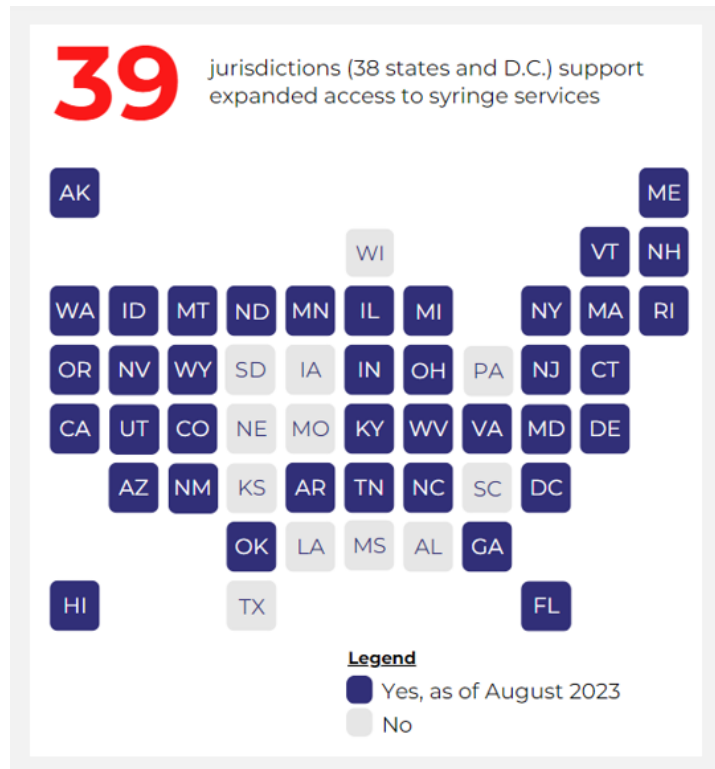


Fourteen states have adopted five to six strategies, 17 states and D.C. have adopted three to four strategies, and 15 states have adopted zero to two strategies.

The remainder of this report will examine the adoption of each of the 10 strategies.

STRATEGY 1: SUPPORT EXPANDED ACCESS TO SYRINGE SERVICES PROGRAMS

Syringe services programs (SSPs), a form of harm reduction, provide a wide range of services, including but not limited to, the provision of new, unused hypodermic needles/syringes, and other injection drug use supplies, such as cookers, tourniquets, alcohol wipes, and sharps waste disposal containers, to people who inject drugs (PWID). The goal of SSPs is to prevent the spread of HIV, viral hepatitis, and other diseases among PWID.² Many SSPs also provide a range of other services, including linkages to substance use disorder (SUD) treatment and recovery services, emergency opioid antagonists, HIV/ hepatitis C (HCV) testing, wound care, education on safer-use practices, and other support services.^{3,4}



As of August 2023, 39 states and D.C. support access to SSPs with jurisdiction-wide laws that explicitly or implicitly authorize them.

WHY ARE SYRINGE SERVICES PROGRAMS IMPORTANT?

People who inject drugs face increased risk of bloodborne disease and infection

Among PWID, 48 percent of those aged 18 to 24 and 44 percent aged 25 to 29 share needles/syringes.⁵ Sharing needles/syringes or other drug injection equipment increases the risk of HIV transmission. Not surprisingly, PWID accounted for 7 percent of new HIV infections in 2020 in the United States.⁶ Moreover, sharing injection equipment and reusing needles/syringes increases the risk of transmitting HCV and hepatitis B (HBV) among PWID—diseases that can cause complications to HIV-positive individuals.⁷

People who inject drugs may experience difficulties obtaining new needles/syringes

Current legal barriers, costs, and discretionary practices by store owners or employees make purchasing new needles/syringes in pharmacies difficult.⁸ Without laws in place mandating nonprescription sales of these items, PWID may be denied access—meaning that obtaining new needles/syringes outside SSPs may be extremely difficult, especially in rural or remote areas.⁹

People who inject drugs experience unique barriers to healthcare access

Research suggests that PWID may delay or avoid medical care due to the stigma they encounter in the general healthcare system and the stigma attached to certain forms of treatment, such as methadone.¹⁰ One study found that the most frequently reported barrier to healthcare access among a study group of people who use drugs (PWUD) was “judgment from clinicians.”¹¹ Integrating health care into spaces where PWID feel “safe,” such as SSPs, may empower individuals to access a higher level of care and seek ongoing treatment.¹² In addition, approximately 21 percent of PWID with HIV have no health insurance,¹³ making community-based SSPs that provide or link to health care a crucial access point for this population.

Syringe services programs are both effective and cost-effective

Research supports SSPs as cost-effective interventions in preventing HIV.¹⁴ For example, a 2016 evaluation of an SSP in the District of Columbia showed a 70 percent decrease in new HIV cases among PWID and a total of 120 HIV cases averted in two years.¹⁵ In addition, a 2019 study suggests that, through legalized needle/syringe exchanges, the city of Baltimore would see a predicted savings of \$43.4 million annually and \$434.3 million over 10 years, with an annual return on investment of \$32 million.^{16,17}

WHAT IMPACT DO SYRINGE SERVICES PROGRAMS HAVE?

Syringe services programs are associated with decreases in risk behaviors

Several studies conclude that SSPs are associated with reductions in injection risk behaviors, such as reusing or sharing injection drug use equipment.¹⁸ One study, for example, looking at a one-for-one syringe exchange program, found that increased syringe exchange coverage corresponded to a 58 percent reduction in sharing injection equipment and a 21 percent reduction in reusing needles/syringes.¹⁹

Syringe services programs are associated with reduced incidents of infection

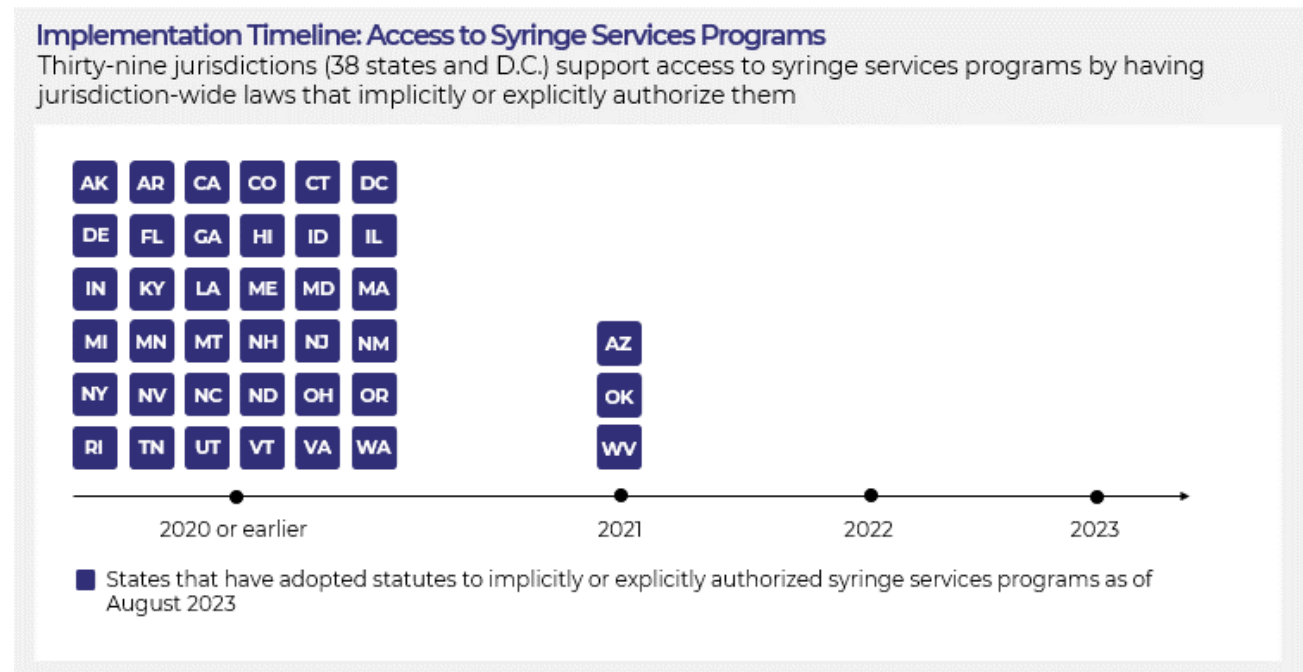
Decades of research highlights the efficacy of SSPs in preventing infectious disease,²⁰ with the impact of these programs on reducing HIV transmission rates especially well documented.²¹ Although there is a need for continued evaluation, early analyses of SSPs show reductions in HBV and HCV incidence as high as 80 percent and reductions in HIV incidence between 33 and 70 percent.^{22,23}

Syringe services programs create opportunities for integrated treatment and linkages to various health and social services

New SSP participants are up to five times more likely to enter into drug treatment, suggesting the utility of these programs for both linkages to care and onsite provision of services.²⁴ A statistical model of SSPs providing on-site buprenorphine treatment predicted that providing such services would avert 20.8 percent of fatal opioid overdoses and result in an 8.6 percent higher treatment initiation rate.²⁵ Furthermore, providing buprenorphine treatment at an SSP is cost-effective.²⁶ Research also highlights the efficacy and cost-effectiveness of providing early-intervention wound care and soft-tissue infection services at SSPs, addressing another critical health risk among PWID.^{27,28}

WHAT PROGRESS HAVE STATES MADE IN THE LAST THREE YEARS TO EXPAND ACCESS TO SYRINGE SERVICES PROGRAMS?

Since 2021, three states, Arizona, Oklahoma, and West Virginia, have enacted statutes authorizing SSPs. The remaining 36 states and D.C. adopted statutes in 2020 or earlier.



IMPLEMENTATION RESOURCES

LAPPA's *Model Syringe Services Program Act* authorizes the establishment of comprehensive SSPs, which are associated with a decrease in bloodborne infectious disease diagnoses and the number of needlestick injuries to first responders and others.

Click here to read the full [Model Syringe Services Program Act](#)

A webinar recording about harm reduction from LAPPA's 2023 Virtual Knowledge Lab series can be found [here](#).

STRATEGY 2: DO NOT SUBJECT FENTANYL TEST STRIPS TO DRUG PARAPHERNALIA PENALTIES

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STRATEGY 3: DO NOT SUBJECT DRUG CHECKING EQUIPMENT THAT TESTS FOR DRUGS OTHER THAN FENTANYL TO DRUG PARAPHERNALIA PENALTIES

Increasing concerns over fentanyl-related overdoses, as well as overdoses caused by other unknown adulterants within substances, alerted many policymakers to the concept of “drug checking.” Drug checking is the process of identifying, analyzing, or detecting the composition of drugs or adulterants within a sampled substance.²⁹

Perhaps the best-known type of drug checking equipment (DCE) are fentanyl test strips (FTS), which disclose the presence or absence of fentanyl in a tested substance. Although FTS are the most publicized type of DCE, they constitute only a subset of such equipment. DCE varies widely in terms of technological complexity, the drug(s) being tested for, and the types of results provided to the user. Simple testing methods include FTS and other rapid drug test strips, liquid reagent tests, and thin-layer chromatography kits.³⁰

Generally, these testing methods provide qualitative information about the presence of a particular drug/substance or lack thereof. However, these methods do not reveal the presence of substances beyond the scope of the test, nor do they provide quantitative information about drug potency. More complex and advanced DCE provides added information about the composition of drugs and other adulterants within a tested substance, as well as drug potency. Advanced DCE includes Fourier-transform infrared spectroscopy, gas chromatography/mass spectrometry, high-performance liquid chromatography, and nuclear magnetic resonance techniques.^{31,32}

As of September 2023, 30 jurisdictions (29 states and D.C.) support access to DCE that tests for substances other than fentanyl by not subjecting such DCE to drug



paraphernalia penalties. Forty-six jurisdictions (45 states and D.C.) support access to FTS via jurisdiction-wide laws that do not subject the possession or use of FTS to drug paraphernalia penalties.

WHY ARE DRUG CHECKING AND FENTANYL TEST STRIPS IMPORTANT?

Fentanyl test strips are accurate, easy to use, and low cost

FTS are simple to use for harm reduction service workers or PWUD. Results are available in a few minutes and are highly accurate.³³ An individual FTS costs approximately one dollar.³⁴ Low cost, ease of use, and utility both in and out of healthcare settings make FTS a useful tool—especially given the reluctance of some PWUD to engage with harm reduction services at distribution

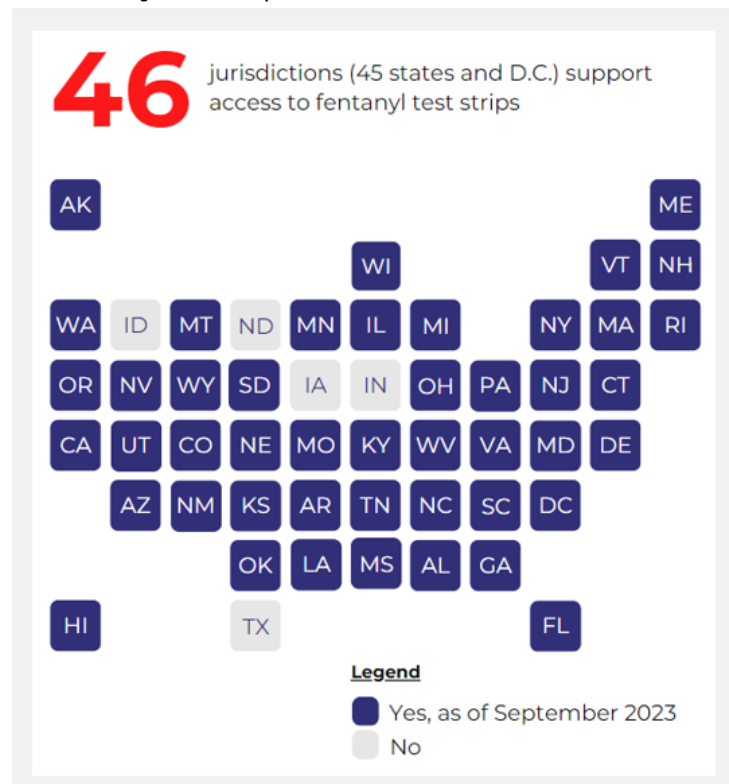
sites due to a fear of legal repercussions or stigma.³⁵ In light of these benefits, the CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly announced in 2021 that federal funds may be used to purchase FTS.³⁶

Using fentanyl test strips is associated with safer or reduced drug use

Several studies demonstrate the effectiveness of FTS in promoting actual behavioral change through safer or reduced drug use.^{37,38,39} In one study, 43 percent of individuals reported safer drug use behavior following the use of FTS, with behavior change being five times more likely after receipt of a fentanyl-positive test result.⁴⁰ A 2020 study showed similar results, with 26.5 percent of individuals receiving a positive FTS result abstaining from using the drug and 30.1 percent using a lower dose.⁴¹ Other examples of behavior changes include disposing of the fentanyl-positive drug, using it with other people around, having naloxone on hand, and taking a small (“tester”) dose of the drug to observe potency.⁴²

Comprehensive drug checking involves testing for drugs beyond fentanyl

Although overdoses due to fentanyl exposure garner a great amount of attention, many other drugs of concern exist. Recent U.S. statistics showing increases in methamphetamine, xylazine, and polysubstance-involved overdose deaths demonstrate this fact.^{43,44,45} A drug checking strategy limited to fentanyl or fentanyl analogs is incomplete. It is impossible to know what the drugs of concern will be in



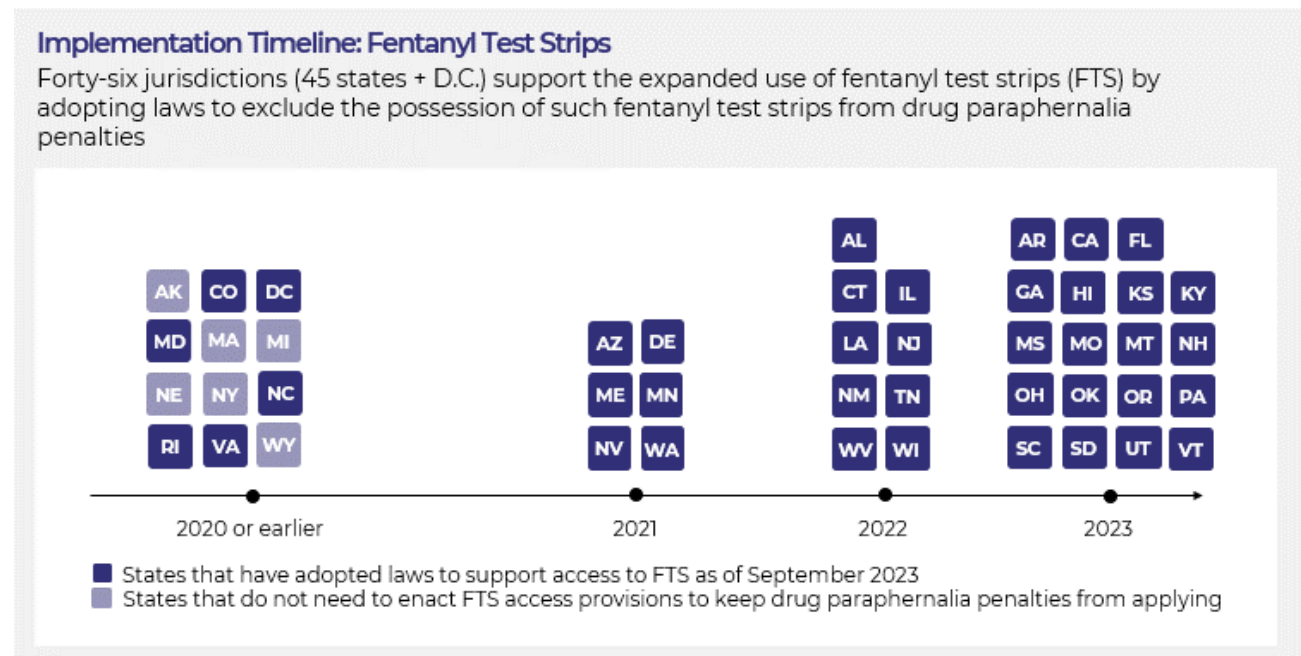
future years, and policymakers do not know which types of DCE will prove most useful going forward. Accordingly, a comprehensive drug checking initiative should involve testing for multiple drugs, not just fentanyl, and involve more technology than rapid testing strips.

Drug checking programs promote outreach and engagement

Drug checking programs successfully facilitate outreach to PWUD.⁴⁶ Through FTS distribution, community partners provide information and linkages to treatment services. Although there is a lack of research examining long-term recovery engagement outcomes associated with FTS programming, stakeholder attitudes surrounding the use of FTS programs for service referrals are positive.^{47,48,49}

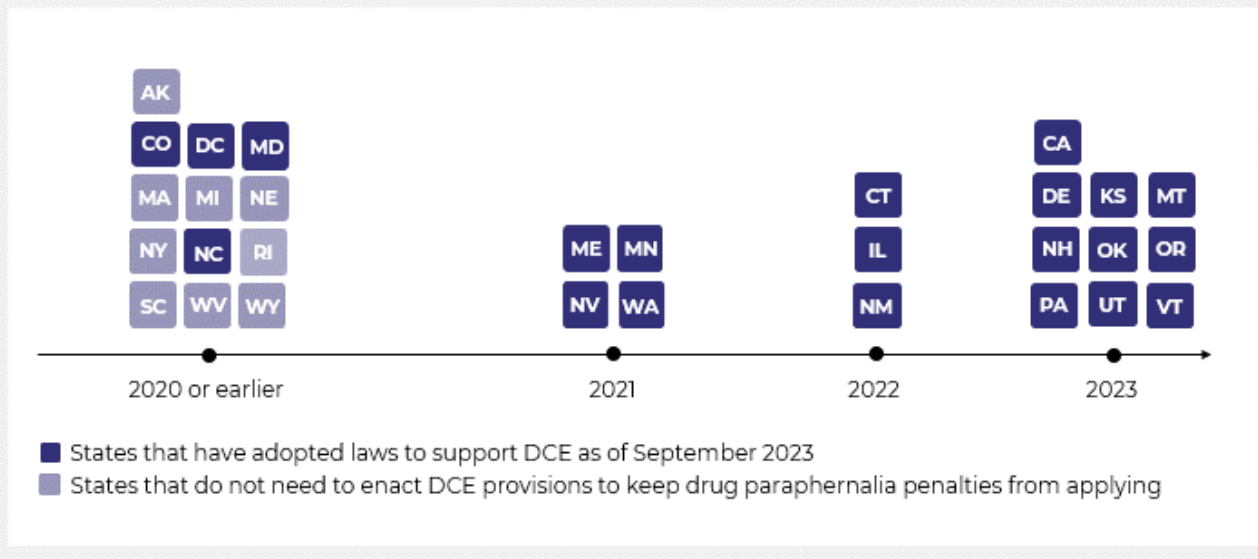
WHAT KIND OF PROGRESS HAVE STATES MADE IN THE LAST THREE YEARS TO ENSURE THAT DRUG CHECKING EQUIPMENT, INCLUDING FENTANYL TEST STRIPS, ARE NOT SUBJECT TO DRUG PARAPHERNALIA VIOLATIONS?

Thirty-four states have adopted legislation since 2021 that addresses how drug paraphernalia laws apply to all DCE or a subset of DCE. In 15 states, this new legislation only applies to FTS. In the other 19 states, the new laws pertain to both FTS and DCE that check for at least one substance other than fentanyl. Some of the legislative activity may reflect states' proactive approaches to ensuring legal clarity. For example, six states with laws adopted in the past five years already had existing drug paraphernalia statutes that likely allowed for the legal use of all DCE, including FTS. (These six states are New Hampshire, Oregon, Rhode Island, South Carolina, Vermont, and West Virginia.)



Implementation Timeline: Drug Checking Equipment

Thirty jurisdictions (29 states + D.C.) support access to drug checking equipment (DCE) that tests for substances other than fentanyl by not subjecting such DCE to drug paraphernalia penalties



IMPLEMENTATION RESOURCES

LAPPA's *Model Fentanyl Test Strip and Other Drug Checking Equipment Act* guides states in introducing legislation to authorize the use and possession of all DCE, including FTS. Click here to read the full text of the [Model Fentanyl Test Strip and Other Drug Checking Equipment Act](#).

A webinar recording about harm reduction from LAPPA's 2023 Virtual Knowledge Lab series can be found [here](#).

STRATEGY 4: REQUIRE ACCESS TO MEDICATION FOR ADDICTION TREATMENT IN STATE OR LOCAL CORRECTIONAL SETTINGS

Medication for addiction treatment (MAT) is a critical component of evidence-based treatment for opioid use disorder (OUD).⁵⁰ Medications that treat OUD stabilize brain chemistry, restore disrupted metabolic functions, and act to relieve physiological cravings while blocking the euphoric effects of opioid use.⁵¹ Currently, there are three forms of MAT approved by the U.S.

Food and Drug Administration (FDA): buprenorphine, naltrexone, and methadone.⁵²

As of September 2023, 16 states have requirements to implement MAT in all, or nearly all, state or local correctional settings.

WHY IS MEDICATION FOR ADDICTION TREATMENT IMPORTANT IN CORRECTIONAL SETTINGS?

Individuals newly released from a correctional setting are at a high risk for overdose

A large body of research shows that individuals are at an elevated risk for overdose and overdose-related mortality both immediately upon reentering the community from a correctional setting (*i.e.*, within the first two weeks) and during a longer reentry period (*e.g.*, up to two years).^{53,54} In fact, drug overdose is the leading cause of death following release from prisons or jails,⁵⁵ with released individuals being 56 to 129 times more likely to die of an overdose compared to the general population, depending on the length of time since release, according to some estimates.^{56,57,58}

Adulteration of illicit drugs increases overdose risk in correctional settings

With fentanyl and other adulterants (*e.g.*, xylazine) infiltrating many drugs in the illegal drug supply in the U.S., the risk of overdose is significantly higher for all individuals, including those incarcerated. Fentanyl is easily smuggled into correctional settings, and only a minuscule amount can cause an overdose.⁵⁹ Moreover, as individuals in jails and prisons usually have reduced drug tolerance levels due to decreased opioid use during incarceration, highly potent substances can easily cause an overdose.⁶⁰ Although current reporting standards for correctional



settings make it difficult to estimate corrections-based fentanyl overdoses, research suggests that overdose events in correctional settings are increasing.⁶¹

Rates of substance use disorder, particularly opioid use disorder, are high among incarcerated populations

The most recent national data indicate that 58 percent of individuals in state prisons and 63 percent of individuals in jails meet the criteria for “drug dependence or abuse,” as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).⁶² In comparison, only about five percent of the general population meet the criteria. Moreover, about 15 percent of the incarcerated population has OUD.^{63,64} Research also suggests that involvement in the criminal justice system correlates with an increased severity of OUD.⁶⁵

There is a significant, unmet need for medication for addiction treatment in correctional settings

The availability of MAT in American correctional settings is limited.^{66,67} As of 2019, only 19 percent of local jails reported initiating MAT for incarcerated people identified as having OUD.⁶⁸ Another study found that slightly less than one-third of individuals screened as having OUD received any form of medication to treat their disease while in jail.⁶⁹ Such statistics, however, are based on individuals screened for OUD and may not fully represent unmet needs, as only about six in 10 local jails conduct substance use screening at intake.⁷⁰ Even where facilities report MAT availability, some restrict MAT use to special populations (*e.g.*, pregnant individuals) or specific times (*e.g.*, at release).⁷¹ Other correctional settings provide MAT only if the individual was receiving it before entry, or they may restrict the type of MAT available.⁷²

Access to all three medications for addiction treatment is preferred for individuals with opioid use disorder

National medical organizations and federal guidance recommend giving patients access to all three FDA-approved forms of MAT.^{73,74} However, this is not the practice in many correctional settings. One study of state prison systems found that 36 percent offered naltrexone, 15 percent offered buprenorphine, nine percent offered methadone, and seven percent offered all three.⁷⁵ For correctional settings that provide access only to naltrexone, research indicates that naltrexone is not as effective in preventing long-term relapse as either methadone or buprenorphine.^{76,77} For example, one study suggests that while naltrexone increases the median time to relapse in justice-involved populations as compared to treatment without medication, there was no difference in relapse rates for the two populations after one year.⁷⁸

Limited access to medication for addiction treatment in correctional settings exacerbates racial inequities

In recent years, Black communities have been disproportionately impacted by overdose deaths,⁷⁹ with rates of overdose death among Black men rising by over 200

percent in the past five years, as compared to a 69 percent increase among white men.⁸⁰ Black individuals with OUD are also less likely to start on MAT for a variety of reasons, including racial differences in interactions with health, human services, and criminal justice systems that are undergirded by structural racism.⁸¹ Moreover, Black people are disproportionately incarcerated in state prisons and local jails,⁸² and time spent in correctional settings further decreases the likelihood of MAT initiation.⁸³ As disparities widen in both rates of OUD and access to MAT, the availability of these potentially life-saving medicines within jails and prisons is critical.⁸⁴

WHAT IMPACT DOES THE PROVISION OF MEDICATION FOR ADDICTION TREATMENT IN CORRECTIONAL SETTINGS HAVE?

Providing medication for addiction treatment in correctional settings reduces overdose deaths

Research indicates that providing MAT during incarceration reduces post-release overdose deaths.⁸⁵ One recent study found that providing MAT in jails decreased overdose mortality upon reentry by 80 percent.⁸⁶ This impact remained even in high-risk environments. For example, another study showed that providing MAT to incarcerated people is associated with decreased post-release mortality despite a worsening fentanyl crisis within the jurisdiction.⁸⁷ Additional research indicates that if all incarcerated individuals with a clinical need for MAT received it, 668 lives per 10,000 incarcerated people would be saved.⁸⁸ Researchers predict that this impact would increase to over 1,600 lives saved per 10,000 people if the medications were provided both during incarceration and after release.⁸⁹

Providing medication for addiction treatment in correctional settings reduces recidivism and improves treatment outcomes

The risk of recidivism is lower among adults who are offered MAT during incarceration.⁹⁰ A recent study found that adults formerly held in jail and who had access to buprenorphine were less likely to recidivate (48.2 percent recidivism rate) compared to individuals released from a comparable facility not offering MAT (62.5 percent recidivism rate).⁹¹ In addition, individuals receiving MAT during incarceration are less likely to relapse after reentry.^{92,93} Research demonstrates that continuing methadone treatment while incarcerated increases the likelihood of treatment engagement after release.⁹⁴

Access to medication for addiction treatment may disrupt illicit drug trading in correctional settings

A common concern about providing MAT in correctional settings is that the medications will be diverted and used by incarcerated individuals for non-prescribed use.⁹⁵ Research indicates, however, that not only are diversion events relatively uncommon (as few as six diversion events per 4,000 prescribed doses in one study) and preventable, but also that formal MAT programs may function to disrupt illicit drug trades.^{96,97} Reports from one state prison system indicate that following the initiation of MAT, rates of drug smuggling within the prison system decreased.⁹⁸

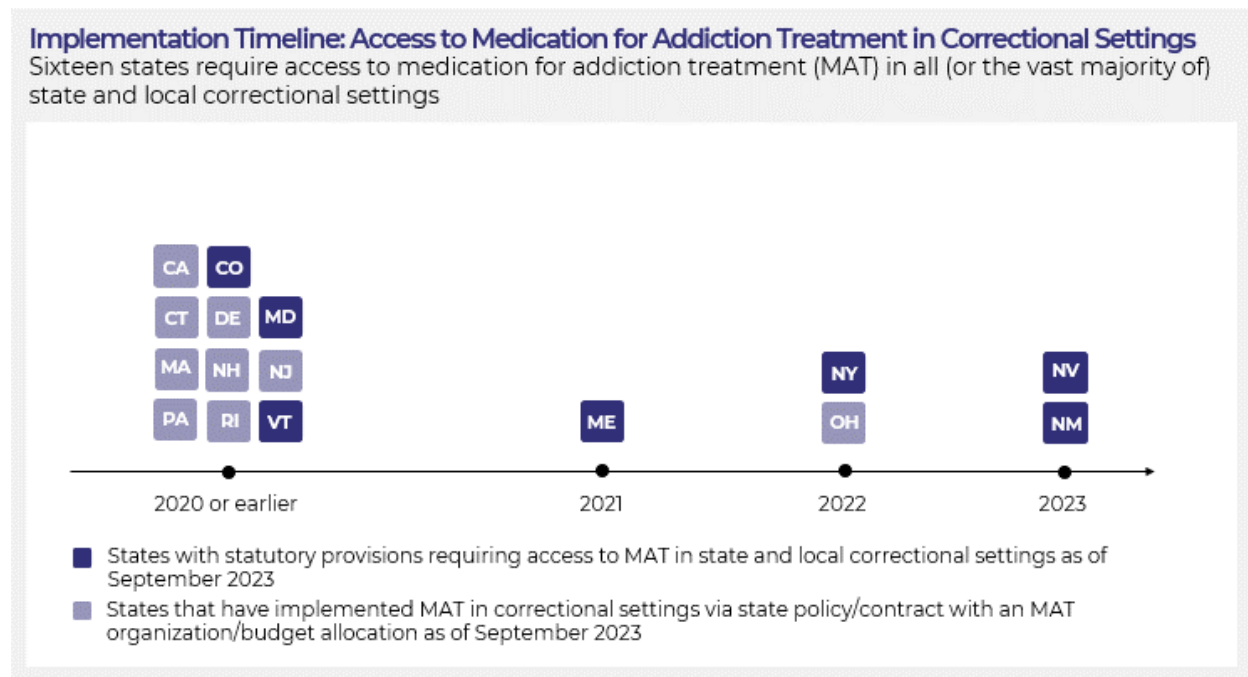
Providing medication for addiction treatment in correctional settings is cost-effective

A large body of research demonstrates that MAT is both “cost-effective and cost-beneficial.”⁹⁹ For example, studies show that the use of buprenorphine and methadone is more cost-effective than treatment approaches without medication.¹⁰⁰ Although providing any of the three medications reduces healthcare utilization costs,¹⁰¹ offering all three types of MAT maximizes cost benefits, as naltrexone-only approaches appear to be more expensive and less effective.

WHAT PROGRESS HAVE STATES MADE IN THE LAST THREE YEARS TO ENSURE THAT INDIVIDUALS INCARCERATED IN CORRECTIONAL SETTINGS HAVE ACCESS TO MEDICATION FOR ADDICTION TREATMENT?

Only seven of the 16 states with MAT requirements have statutory provisions, while the remaining nine states adopted state policy and/or allocated funding to support the implementation of MAT in correctional settings. A planning period of 12-18 months is common when implementing MAT in correctional settings. As a result, the dates below may not reflect the date when all (or most) facilities provided MAT.

Finally, some states, like Colorado and Maine, have incrementally adopted policies to address MAT in jails and prisons. For example, in 2019, Colorado required county jails that receive Jail Based Behavioral Health Services (JBBS) funding to have an MAT policy in place on or before January 1, 2020. In 2020, Colorado authorized and strongly urged MAT for individuals with OUD in the custody of the department of corrections, local jails, multijurisdictional jails, municipal jails, and the department of human services. Finally, in 2023, Colorado passed a statute requiring jails to provide MAT by July 2023.



IMPLEMENTATION RESOURCES

LAPPA's *Model Access to Medication for Addiction Treatment in Correctional Settings Act*, written in collaboration with the O'Neill Institute for National and Global Health Law at the Georgetown University Law Center, sets forth a comprehensive, evidence-based framework for ensuring that all incarcerated individuals with an SUD be provided access to FDA-approved MAT in state and local correctional settings.

Click here to read the full [**Model Access to Medication for Addiction Treatment in Correctional Settings Act**](#).

A webinar recording about overdose prevention and treatment in corrections settings from LAPPA's 2023 Virtual Knowledge Lab series can be found [**here**](#).

STRATEGY 5: REQUIRE STATE AND LOCAL CORRECTIONAL SETTINGS TO PROVIDE WITHDRAWAL MANAGEMENT SERVICES

Withdrawal management protocols outline a comprehensive approach to the treatment, monitoring, and long-term recovery plan for individuals in a correctional setting¹⁰² who experience withdrawal from drugs or alcohol. Best practice guidelines for withdrawal management recommend that, for individuals in custody who are intoxicated or undergoing withdrawal, correctional settings should: (1) allow qualified healthcare professionals to monitor those individuals within a safe housing environment; (2) incorporate specialized treatment for pregnant and postpartum individuals; (3) create defined protocols to prevent suicide and self-harm during and after cessation of substances; and (4) initiate or continue clinically appropriate medications, including MAT such as buprenorphine and methadone.¹⁰³



In addition to medical management, proper protocols specify screening, assessment, and continued-care procedures.¹⁰⁴ Without withdrawal management protocols, an inmate's withdrawal from drugs and alcohol can be fatal. Even if the individual avoids death, withdrawal can cause severe dehydration, vomiting, electrolyte imbalance, blood pressure and cardiac problems, seizures, and psychiatric issues (including increased suicidal tendencies).¹⁰⁵ Although this issue is present in both jails and prisons, it is particularly important for jails, which house a population that shuffles between in-custody and release.

As of June 2023, nine states have statutory requirements to provide medically managed withdrawal management services in state and/or local correctional settings via either statewide law or protocol/policy.

WHY ARE WITHDRAWAL MANAGEMENT PROTOCOLS IN CORRECTIONAL SETTINGS IMPORTANT?

Justice-involved individuals have elevated risk factors for dangerous withdrawal outcomes

Research indicates that individuals with co-occurring substance use and mental health disorders make up 15 percent of people arrested annually.¹⁰⁶ This population is at an elevated risk of severe withdrawal symptoms and complications.¹⁰⁷ Moreover, individuals with co-occurring disorders are at a higher risk of suicide.¹⁰⁸ This is a significant concern, as untreated withdrawal symptoms can increase suicide risk,¹⁰⁹ and suicide is the leading cause of death in jails.¹¹⁰ Physical comorbidities also increase the risk of death from withdrawal.¹¹¹ Incarcerated individuals have higher rates of chronic health issues than the general population but are less likely to have received treatment for these comorbidities. This places this group at an elevated risk for adverse withdrawal outcomes.^{112,113}

There is a significant unmet need for comprehensive withdrawal protocols in jails

While national estimates of the percentage of individuals entering jails in withdrawal are unavailable, data from specific jurisdictions indicate a high need for services. In the period from 2000 to 2019, mortality in jails due to drug or alcohol intoxication increased by 397 percent.¹¹⁴ Currently, drugs and alcohol are the third-leading cause of death in U.S. jails.¹¹⁵ The extent to which withdrawal specifically contributes to jail-based mortality is unknown, however, as withdrawal-specific deaths are likely underreported.¹¹⁶ Nationally, for individuals who die of drug or alcohol intoxication in jails, the median length of time between initial incarceration and death is one day.¹¹⁷ This indicates a critical need for screening and timely delivery of treatment and services.

Withdrawing from substance use without medication, when an indicated need exists, increases future overdose risk

In the absence of MAT, withdrawal from substances such as opioids places individuals at a higher risk of subsequent overdose death.¹¹⁸ This is because detoxification lowers an individual's tolerance to substances but does not treat the underlying chronic disorder.¹¹⁹ Withdrawal without appropriate medical monitoring and subsequent initiation of MAT contributes to high rates of relapse and overdose deaths following release from incarceration.¹²⁰ Unfortunately, specialized treatment for withdrawal is uncommon, with less than one percent of people in state correctional settings placed in a detoxification unit during their incarceration.¹²¹

Forced withdrawal from medication for addiction treatment can worsen long- and short-term outcomes

In addition to mandating that new arrivals withdraw from illicit substances, some jails require individuals to cease MAT and any prescription opioids used to manage

pain.¹²² Aside from the risk of returning to use illicit substances and a subsequent overdose, research also suggests that incarcerated individuals who undergo forced MAT withdrawal later experience an aversion to such treatment after release due to the severity of withdrawal symptoms.¹²³ Forced withdrawal from MAT in jails may, therefore, act as a barrier to future treatment initiation.

Many correctional settings lack adequate care for pregnant individuals with substance use disorder

Rapid discontinuation of opioids can be especially dangerous for pregnant individuals, with associated outcomes including premature labor, fetal distress, and miscarriage.¹²⁴ As of 2023, however, the majority of states lack laws that cover the treatment of pregnant individuals with SUD or the provision of MAT to this population.¹²⁵ In a national survey of U.S. jails, 60 percent of facilities reported maintaining such individuals on MAT initiated in the community prior to entry, while 32 percent reported initiating pregnant individuals on medication once incarcerated.¹²⁶

WHAT IMPACT DO WITHDRAWAL MANAGEMENT PROTOCOLS HAVE?

Establishing proper protocols reduces liability for deaths in custody and promotes a non-stigmatizing staff culture that prioritizes inmate safety

Recent research found that, between 2015 and 2020, civil litigation involving deaths in custody resulted in over \$292 million awarded to plaintiffs.¹²⁷ Frequent contributing factors in these awards involved a correctional setting's failure to screen and properly supervise or monitor an incarcerated individual with a history of substance use, mental illness, or suicidal thoughts. By providing clear protocols and training for all correctional staff, individuals at risk for overdose, withdrawal, or other medical issues may be better identified before these issues reach a critical point.¹²⁸ Moreover, training and education on SUD and withdrawal help reduce stigma and promote a culture of objective and evidence-based practice within jails and prisons.¹²⁹ Additionally, clarifying staff roles through protocols—including defining situations in which healthcare professionals should be involved—can improve the appropriate delivery of services.¹³⁰

Adopting standardized reporting procedures enables improved assessment and quality improvement

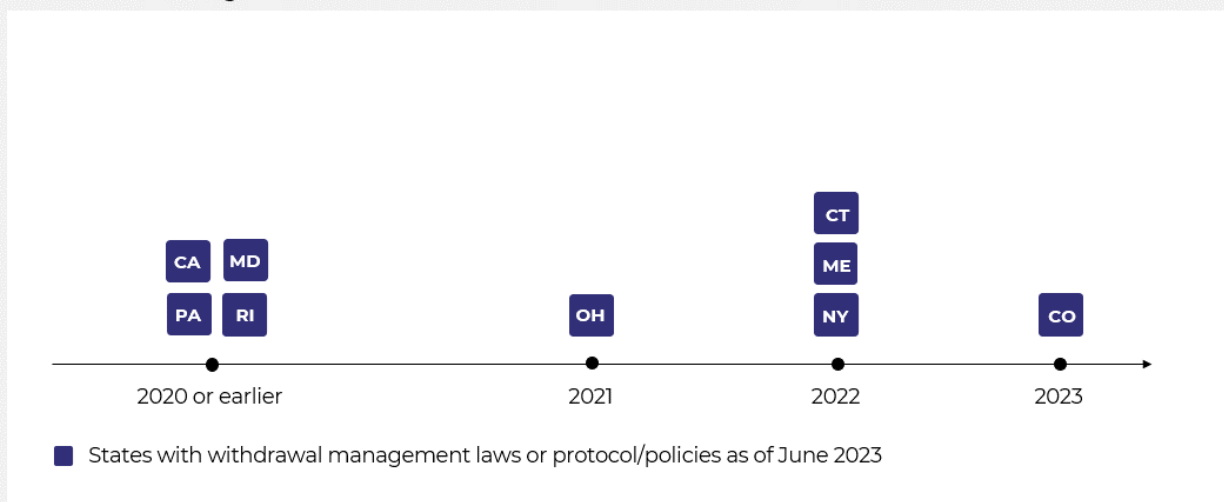
Withdrawal-related deaths in custody are often categorized as “illness” or “other,” with the cause of death being attributed to symptoms without specifying withdrawal as an underlying cause.¹³¹ Withdrawal management protocols for correctional settings that include standardized reporting requirements can increase those facilities' ability to effectively direct funding and improve procedures.

WHAT PROGRESS HAVE STATES MADE IN THE LAST THREE YEARS TO ENSURE THAT CORRECTIONAL SETTINGS HAVE WITHDRAWAL MANAGEMENT PROTOCOLS?

Five of the nine states with statewide laws, protocols, or policies to support the implementation of withdrawal management protocols in correctional settings adopted the law or policy after 2020, with Colorado being the most recent state to pass legislation.

Implementation Timeline: Withdrawal Management in Correctional Settings

Nine states have laws, protocols, or policies that require withdrawal management protocols in correctional settings



IMPLEMENTATION RESOURCES

LAPPA's *Model Withdrawal Management Protocol in Correctional Settings Act* requires evidence-based treatment of SUD, including the use of FDA-approved medications; requires correctional settings to establish and implement administrative and clinical protocols when detaining individuals at risk of withdrawal; and provides state legislators, policymakers, and those in the correctional and health care professions with a comprehensive framework to better respond to withdrawal symptoms and related mental health crises of individuals in custody to decrease their mortality while in correctional settings.

Click here to read the full [Model Withdrawal Management Protocol in Correctional Settings Act](#).

A webinar recording about overdose prevention and treatment in corrections settings from LAPPA's 2023 Virtual Knowledge Lab series can be found [here](#).

STRATEGY 6: A DRUG-RELATED INCIDENT THAT OCCURS AT SCHOOL SHOULD NOT NECESSARILY BE REPORTED TO LAW ENFORCEMENT

SAMHSA suggests that “schools are the ideal setting to prevent, identify, treat, and support substance use and mental illness concerns.”¹³² However, many current responses to substance use and drug-related incidents in schools result in undesired, inequitable, and discriminatory outcomes.¹³³ While alternative discipline and therapeutic solutions are successful in some school settings, there are no requirements that districts apply evidence-based practices—or universally report on these practices. This results in wide disparities in disciplinary outcomes and what commentators call the “school-to-prison pipeline.” An evidence-based policy approach, including “an accurate collection and analysis of data to improve oversight and accountability,”¹³⁴ can establish a consistent and positive response to drug-related incidents across public schools.



The laws of 22 jurisdictions (21 states and D.C.) do not require a drug-related incident at school to be reported to law enforcement. Eliminating automatic law enforcement reports encourages evidence-based policy approaches that establish a consistent and positive response to drug-related incidents across public schools.

WHY ARE EVIDENCE-BASED SCHOOL DRUG RESPONSE POLICIES IMPORTANT?

Rates of substance use and substance use disorder in school-age children are concerning

According to results from the 2021 Youth Risk Behavior Survey, 22 percent of students in grades 9-12 were offered, sold, or given an illegal drug on school property in the preceding 12 months.¹³⁵ Recent efforts do not appear to be successful in decreasing substance use by children. From 2015 to 2019, the percentage of youth ages 12 to 17 experiencing a SUD in the prior year increased slightly, from an estimated 3.4 percent to 3.6 percent.¹³⁶

Without clear, evidence-based policies, students often face criminal penalties for minor behavioral issues, including drug possession and use

Currently, statutes or regulations in 29 states require that all drug offenses in school settings be reported to law enforcement,¹³⁷ which results in contact with the justice system for an issue that is likely resolvable at the school and family level. Moreover, in districts with an in-school law enforcement presence (e.g., school resource officers (SROs)), the lines between school-based and law enforcement responses to student behaviors are often unclear, and minor misbehaviors are often criminalized.¹³⁸ In a recent study, one out of three SROs surveyed reported that the school does not specify the disciplinary situations in which they are authorized to intervene.¹³⁹ Even in situations without an in-school police presence or automatic referrals to law enforcement, school policies that promote punitive and exclusionary responses to drug-related incidents push students toward negative socioeconomic outcomes.

Exclusionary discipline in schools for drug-related issues remains common

Exclusionary discipline refers to removing a student from the school without providing services (e.g., out-of-school suspensions and expulsions).¹⁴⁰ Such practices remain common in the U.S., partly due to zero-tolerance policies and mandatory punishments.¹⁴¹ During the 2021-2022 school year, 62 percent of all public schools had some form of zero-tolerance policy. Of these schools, 85 percent reported that the zero-tolerance policy encompassed the possession of illegal drugs.¹⁴²

Common disciplinary practices in schools are ineffective and can result in long-term harm

Research highlights the harm caused by exclusionary discipline. Students who have been expelled or suspended have lower educational attainment¹⁴³ and are more likely to (1) have contact with the juvenile justice and the criminal justice systems, (2) be charged with a crime as an adult, and (3) need Supplemental Nutrition Assistance Program (SNAP) benefits.^{144,145} Approximately 30 percent of racial disparities in young adult criminal justice outcomes, SNAP receipt, and college completion flow from inequalities in exposure to school discipline.¹⁴⁶

In the absence of comprehensive policies, school responses to drug-related incidents are often discriminatory.

Studies have found that compared to white students, Black students are more than twice as likely to be suspended for the same incident,¹⁴⁷ receive longer suspensions,¹⁴⁸ and experience disciplinary action overall.¹⁴⁹ For example, during the 2015-2016 school year, researchers determined that nationally, students lost instruction due to exclusionary discipline at 23 days lost per 100 students enrolled. However, white students lost instruction at a rate of 14 days lost per 100 white students enrolled, while Black students lost instruction at a rate of 66 days lost per 100 Black students enrolled.¹⁵⁰

Existing education intervention frameworks, such as Positive Behavioral Interventions and Supports and Multi-tiered Systems of Support, are promising in improving behavioral outcomes and reducing substance use in children and adolescents.¹⁵¹ However, research suggests that secondary schools with primarily Black students are significantly more likely to have zero-tolerance policies than predominantly white schools (82 percent and 68 percent, respectively) and are also less likely to utilize alternative behavioral approaches such as social-emotional learning programs.¹⁵²

WHAT IMPACT DO EVIDENCE-BASED DRUG-RESPONSE POLICIES HAVE?

Evidence-based policies can allow funding to shift away from ineffective approaches

An established, evidence-based policy for drug-related incidents allows school districts to redirect funds into more effective programs and support. Currently, approximately 14 million school students attend a school with a police presence but without a counselor, nurse, psychologist, or social worker.¹⁵³ A recent study of state grants that fund SROs shows that SROs do not reduce serious incidents or other infractions such as possession or use of drugs.¹⁵⁴ Additionally, the evidence suggests that SROs may be associated with increased student offenses reported to law enforcement.¹⁵⁵ A funding shift towards behavioral supports may include funding for school counselor positions, which can improve protective factors for students at risk of substance use,¹⁵⁶ or restorative justice coordinator positions.¹⁵⁷

Evidence-based policies can set clear priorities

Policies are crucial to reconceptualizing and redefining goals. An established school policy for drug-related incidents demonstrates a shift from punitive discipline toward student retention goals and the delivery of therapeutic support and interventions at the interpersonal, family, and community levels.

Evidence-based policies can establish data collection and monitoring practices specific to drug-related discipline

A key component of evidence-based policy is data collection and analysis, which allows stakeholders to monitor program delivery and outcomes.¹⁵⁸ Policies that include standardized reporting requirements will provide a better understanding of drug use and abuse in schools, which will, in turn, afford researchers and practitioners more opportunities to identify how to help students who struggle with drug use and abuse to succeed in school.¹⁵⁹ Better data reporting can also highlight areas where disparities exist—a crucial step in improving equity outcomes.

Evidence-based school disciplinary policies likely reduce costs

One study found that school dropouts directly associated with disciplinary practices cost Texas between \$750 million and \$1.35 billion over the lifetime of each cohort of students.¹⁶⁰ Moreover, “grade retentions” (*i.e.*, requiring students to repeat grades) associated with disciplinary practices cost Texas an estimated \$76 million annually.

Policies that ensure effective, non-exclusionary discipline practices can reduce instances of grade retention and drop-outs and, therefore, costs.

IMPLEMENTATION RESOURCES

LAPPA's *Model School Response to Drugs and Drug-related Incidents Act* guides states in establishing a consistent and positive response for public schools to best support students who have drug or drug-related incidents on school premises or at school-related functions.

Click here to read the full text of the [**Model School Response to Drugs and Drug-related Incidents Act**](#).

A webinar recording about school response to drugs and drug-related incidents from LAPPA's 2023 Knowledge Lab series can be found [**here**](#).

STRATEGY 7: REQUIRE ALL PUBLIC HIGH SCHOOLS TO STORE NALOXONE ON SITE FOR RESPONDING TO OVERDOSES AT SCHOOL AND AT SCHOOL-SPONSORED EVENTS

Guidance from national professional organizations and a growing body of research supports schools keeping naloxone on hand as part of their comprehensive school emergency and response plans.¹⁶¹ Components of such response plans may consist of (1) proactive engagement and prevention training to school staff; (2) follow-up support, with an emphasis on vicarious trauma; (3) school-wide education on overdose response and prevention; and (4) protocols for reporting and documenting overdoses and naloxone administration.¹⁶²

Moreover, school systems making naloxone available on site should include guidelines regarding when and how naloxone will be administered and provide staff training before implementation.

As of September 2023, eight states have laws requiring all public high schools in the state to maintain naloxone on site for responding to overdoses at school or school-sponsored events.



WHY IS PROVIDING ACCESS TO NALOXONE IN SCHOOLS IMPORTANT?

The rate of youth drug overdose is increasing, and fentanyl and other synthetic opioids put youth at an elevated overdose risk

Overdose mortality rates among adolescents (ages 14-18) increased by 94 percent between 2019 and 2020 and 20 percent between 2020 to 2021.¹⁶³ In 2021, there were 1,146 deaths among adolescents—a rate of 5.49 per 100,000 individuals.¹⁶⁴ Furthermore, in 2021, 77.1 percent of adolescent overdose deaths involved fentanyl.¹⁶⁵ A recent report using 2021 data found that 1.9 percent of all youths aged 12 to 17 reported using opioids in the past year.¹⁶⁶ In addition to fentanyl exposure among the segment of youth using opioids, research shows there is a rise in fentanyl contamination in stimulants, benzodiazepines, and other substances.^{167,168} The fentanyl adulteration of drugs other than opioids means that more than the 1.9 percent of youth noted above may be at risk of overdose. Indeed, 14.1 percent of

youth report using any illicit drug in the past year while 21.3 percent of youth report any lifetime use.¹⁶⁹

Other characteristics of youth put them at a heightened overdose risk

In addition to the rising fentanyl crisis, youth risk factors for overdose include “optimistic bias,” meaning that youth perceive less risk of fentanyl’s lethality due to beliefs in their invincibility.¹⁷⁰ Youth also are more likely to engage in risk-taking behaviors and have generally shorter drug-use histories. As a result, they may have less ability to gauge risk, are less likely to know what they are consuming, and have a lower tolerance—all factors that increase the risk of overdose.¹⁷¹ In terms of environmental risk factors, researchers note that the COVID-19 pandemic worsened many adolescents’ mental health and potentially compounded risk factors, with many young people experiencing stressors in their home lives.¹⁷²

Youth who use substances face barriers to accessing and carrying naloxone

Experts highlight a need for increased youth access to naloxone.¹⁷³ Although most types of health insurance do not include age restrictions for naloxone coverage, youth access remains low.¹⁷⁴ This may be attributed to several factors, including stigma regarding providing it to youth or incorrect assumptions by pharmacists regarding minimum age requirements for naloxone purchase.^{175,176} Health providers, often pediatricians, may also be less likely to educate youth on overdose prevention or prescribe naloxone. In a survey of pediatric residents, 82 percent reported frequent exposure to patients using opioids and at risk of overdose; however, only 42 percent discussed overdose prevention with such patients.¹⁷⁷ Additionally, while 71 percent of residents in pediatrics knew of naloxone as a prevention measure, only 10 percent ever prescribed it.¹⁷⁸ Due to youths’ barriers to obtaining naloxone, making the medication available inside schools is important.

Naloxone can be safely administered in school settings

According to the CDC, naloxone can safely be administered to people of all ages, including children.¹⁷⁹ Estimates of efficacy in reversing an overdose after naloxone administration by a layperson range from 75 to 100 percent.¹⁸⁰ Therefore, teachers, school nurses, and other school staff can be trained to administer the medication successfully. Moreover, naloxone does not affect individuals who do not have opioids in their system.¹⁸¹ As a result, naloxone is a low-risk intervention that can be used in school settings.

WHAT IMPACT DOES KEEPING NALOXONE IN SCHOOLS HAVE?

Placing naloxone in schools increases marginalized populations’ access to it

Racial barriers reduce access to SUD care. For example, Black youth are 49 percent less likely to receive MAT as compared to white youth.¹⁸² With such statistics, there is an increased risk that a Black student will have an untreated SUD as compared to a white student. Given this increased risk, providing access to naloxone in schools is crucial. The differences in naloxone access between rural and urban locations are

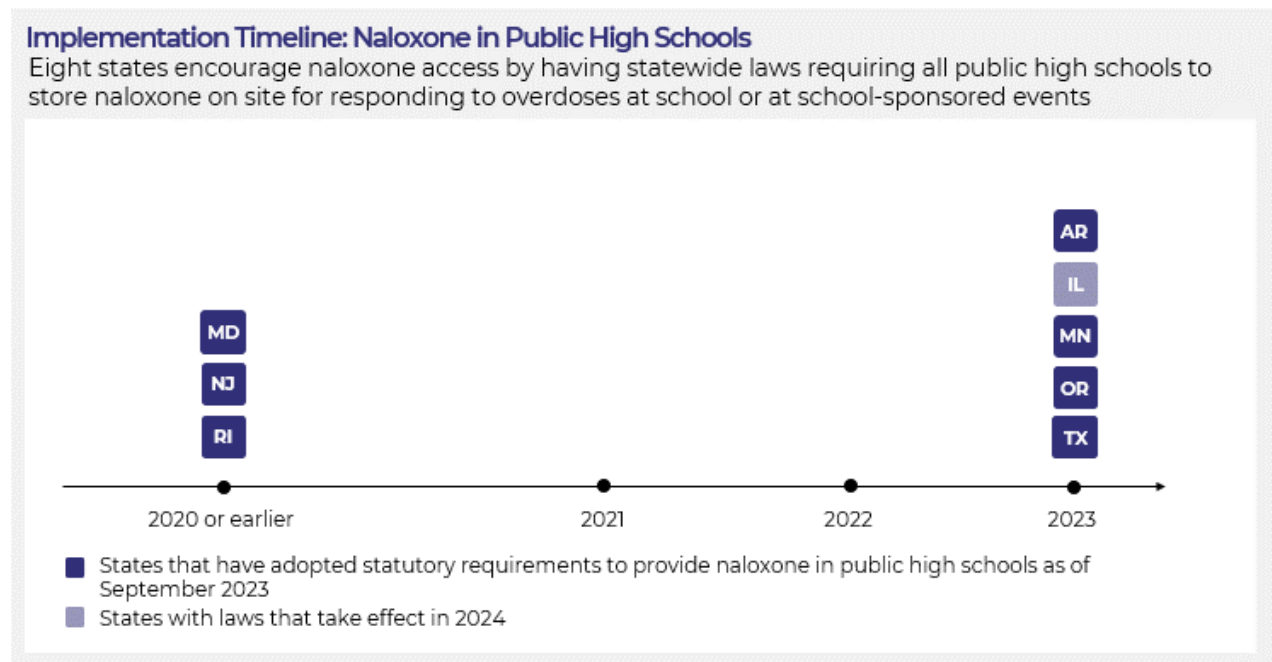
also a concern, as studies indicate that prescriptions for the medication differ 25-fold between some rural and urban regions.¹⁸³ Schools can be a valuable site at which to provide a method of harm reduction to students with less access to SUD care outside of school.

Placing naloxone in schools is a relatively low-cost way to save lives

Between July 2019 and December 2021, there were over 1,800 overdose deaths of individuals aged 10-19 in the 32 U.S. jurisdictions (31 states and the District of Columbia) with available trend data.¹⁸⁴ A handful of those occurred on school grounds. For example, in Rhode Island, where all K-12 schools, public or private, must provide and maintain naloxone in each school facility, the department of health reported nine naloxone administrations in educational settings to students aged 10 to 18 over the past four years.¹⁸⁵ Compared to state and local school budgets, the cost to outfit each school with adequate naloxone, even at the over-the-counter cost of about \$45, is quite modest. Some states, like Colorado, can utilize the naloxone bulk purchase funds available to schools, first responders, and harm reduction programs to provide low or no-cost naloxone.¹⁸⁶ Accordingly, placing naloxone in K-12 or 6-12 schools can be a relatively low-cost way to save lives.

WHAT PROGRESS HAVE STATES MADE IN THE LAST THREE YEARS TO REQUIRE ALL PUBLIC HIGH SCHOOLS TO KEEP NALOXONE ON SITE FOR RESPONDING TO OVERDOSES AT SCHOOL AT SCHOOL-SPONSORED EVENTS?

Of the eight states that have statutes requiring public high schools to keep naloxone on site, five states adopted their statute in 2023. Illinois' statute takes effect in 2024.



STRATEGY 8: INCREASE ACCESS TO SUBSTANCE USE TREATMENT IN EMERGENCY DEPARTMENT SETTINGS

Emergency departments, both hospital-based and freestanding structures, are critical access points for preventing drug and alcohol-related deaths. Individuals with SUD and other comorbidities (*e.g.*, poverty and homelessness) often seek care in emergency departments.¹⁸⁷

Emergency departments also routinely admit patients with substance use-related emergencies. Historically, however, emergency departments initiated few, if any, interventions for SUD before discharging these patients. Such emergency department-initiated interventions for SUD aim to provide better patient care by providing: (1) screening, brief intervention, and referral to treatment (SBIRT) models; (2) emergency department-initiated MAT; (3) risk education; (4) harm reduction (*e.g.*, naloxone distribution); and/or (5) specialized patient navigator programs.

Individuals with SUD are about five to seven times more likely to be hospitalized than the general population.¹⁸⁸ Substance use-related hospital visits are rising nationally, with opioid-related inpatient stays increasing by approximately 64 percent from 2005 to 2014 and the rate of opioid-related emergency department visits doubling during that same time frame.¹⁸⁹ In the overall hospitalized population, approximately 15 percent of patients have an active SUD.^{190,191}

As of November 2023, seven states have laws that require in-hospital or satellite emergency facilities treating individuals for SUD or an overdose to establish specific discharge protocols for such patients, including referrals to outside SUD treatment providers, and MAT for those individuals, where appropriate.



WHY ARE EMERGENCY DEPARTMENT-INITIATED INTERVENTIONS FOR SUBSTANCE USE DISORDER IMPORTANT?

Emergency departments rarely provide in-patient or post-hospitalization follow-up treatment for substance use disorder

In a national survey of emergency department physicians, just five percent of respondents reported that their emergency department provided MAT.¹⁹² Moreover, 57 percent of surveyed physicians believed that “detox” and “rehab” treatment is rarely or never accessible for emergency department patients with indicated need.¹⁹³

Emergency department-initiated services are feasible and acceptable among patients and providers

Studies demonstrate the effectiveness of emergency department-based interventions that include distributing naloxone,^{194,195} SBIRT,¹⁹⁶ harm reduction education, and treatment referrals.¹⁹⁷ Research also supports emergency department initiation of MAT.¹⁹⁸ Initiating MAT at the emergency department is a crucial intervention area, as only about one in four people with an indicated need for MAT actually receive it there.¹⁹⁹ Providing MAT is accepted by emergency department providers, with hospital-based clinicians reporting favorable attitudes towards MAT and a high motivation to treat OUD in hospital settings.²⁰⁰

Hospitals are a critical point of intervention for substance use-impacted populations

An estimated 5.5 to 7.2 percent of patients hospitalized with substance use-related emergencies die within one year of discharge from the emergency department.^{201,202} Outcomes are similar among patients with SUD who are hospitalized in general (*i.e.*, not specifically due to overdose), with one study showing that 7.8 percent of hospitalized patients with OUD died within 12 months of discharge.²⁰³ Individuals with SUD are at higher risk of secondary infections and related health issues such as endocarditis, HCV, HIV, and soft-tissue injuries—issues that may require hospitalization.²⁰⁴ Accordingly, such emergency care visits are a crucial time to engage patients in treatment and services for underlying SUDs.²⁰⁵

Emergency departments present an opportunity for treatment engagement with uninsured and publicly insured individuals who use drugs

Individuals who use drugs are more likely to be uninsured than the general population,²⁰⁶ and being uninsured increases the likelihood of overdose-related mortality.²⁰⁷ Although uninsured individuals are a high-risk overdose group, research finds that counties with more uninsured residents are less likely to have Medicaid-accepted substance use treatment facilities.²⁰⁸ In addition to barriers in accessing MAT,²⁰⁹ accessibility of harm reduction measures is limited among this population. For example, a recent study found that, historically, naloxone was cost-prohibitive for purchase by individuals without insurance.²¹⁰ The initial market price for over-the-counter naloxone seems unlikely to help dramatically. Research suggests that low-

threshold MAT prescribing in settings such as emergency departments can improve engagement with marginalized groups, including uninsured populations.²¹¹

WHAT IMPACT DO EMERGENCY DEPARTMENT-INITIATED INTERVENTIONS HAVE?

Emergency department-based intervention improves health outcomes

Emergency department-initiated substance use care combined with follow-up treatment effectively reduces post-discharge substance use.²¹² Research shows that providing buprenorphine-naloxone (*i.e.*, Suboxone) in emergency departments reduces the risk of both future emergency department visits and overdose deaths.^{213,214} These improved outcomes are consistent across care settings, with buprenorphine initiation in rural hospitals, for example, associated with reduced future emergency department visits and hospitalization rates.²¹⁵

Emergency department-initiated programs increase substance use disorder treatment engagement

A 2015 study found that approximately 78 percent of patients continued outpatient SUD treatment after emergency department treatment initiation and follow-up coordination.²¹⁶ Another more recent study found that an emergency department-based patient navigator initiative improved 30-day SUD treatment engagement for individuals with alcohol, opioid, and cocaine-related disorders.²¹⁷ Research similarly supports the positive impact of emergency department-based initiation of buprenorphine and behavioral counseling on treatment engagement following discharge.²¹⁸

Emergency department-initiated programs can decrease stigma-related barriers to care, thereby reducing disparities

Emergency department-based substance use initiatives can be a pathway to reducing medical stigma and bias. A recent study found that implementing a hospital-based harm reduction program was associated with decreased stigma, as reported by the hospital staff.²¹⁹ Another study suggests that peer recovery specialists may promote positive culture change among hospital staff, reducing bias and stigma toward people with SUD.²²⁰ As substance use stigma disproportionately impacts patients of color, this may be useful in targeting racial disparities in SUD outcomes.²²¹

Emergency department-initiated programs reduce costs

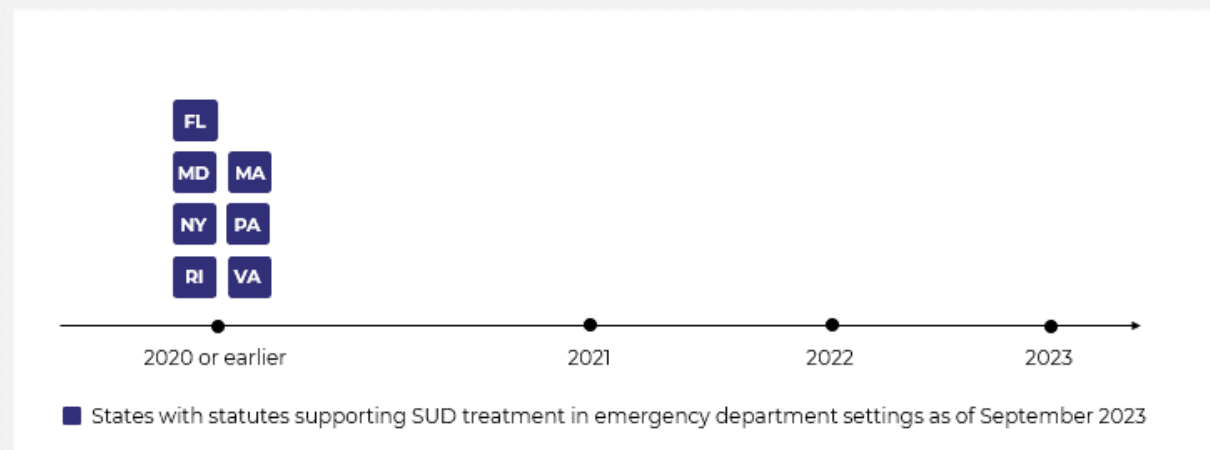
Several studies show the cost benefits of providing emergency department-based care for SUD. For example, one treatment program for people with SUD reduced future emergency department and inpatient hospital visits, generating a cost savings of \$17,780 per patient.²²² Moreover, multiple studies have demonstrated that SBIRT interventions used in emergency departments are cost-effective.^{223,224}

WHAT PROGRESS HAVE STATES MADE IN THE LAST THREE YEARS TO INCREASE ACCESS TO SUBSTANCE USE TREATMENT IN EMERGENCY DEPARTMENT SETTINGS?

The seven states requiring emergency departments to establish specific discharge protocols for patients treated for substance use-related emergencies or initiate MAT for those patients, where clinically appropriate, adopted those laws before 2021.

Implementation Timeline: Substance Use Disorder Treatment in Emergency Department Settings

Seven states require in-hospital or satellite emergency facilities treating individuals for substance use disorders (SUD) or an overdose to establish specific discharge protocols for such patients, including referrals to outside SUD treatment providers or initiation of medication for addiction treatment for those individuals, where appropriate



IMPLEMENTATION RESOURCES

LAPPA's *Model Substance Use Disorder Treatment in Emergency Settings Act*, developed in collaboration with the O'Neill Institute for National and Global Health Law at Georgetown University, addresses the barriers to implementing protocols in emergency medical settings that would ensure evidence-based treatment of patients with substance use-related emergencies. The Act also intends to address barriers to expedited connection to the appropriate level of care following discharge and incorporates best practices and promising innovations from interdisciplinary research analyzing protocols for emergency medical care delivery for the people most at risk of dying after emergency room discharge.

Click here to read the full text of the [Model Substance Use Disorder Treatment in Emergency Settings Act](#).

A webinar recording about treatment in emergency department settings from LAPPA's 2023 Virtual Knowledge Lab series can be found [here](#).

STRATEGY 9: ASSIST PREGNANT OR POSTPARTUM INDIVIDUALS WITH SUBSTANCE USE DISORDER IN SEEKING HELP BY HAVING SPECIFIC LAWS/REGULATIONS DESIGNED TO HELP FAMILIES WITH SUBSTANCE-EXPOSED INFANTS; AND NOT AUTOMATICALLY CONSIDERING SUBSTANCE USE DURING PREGNANCY, OR GIVING BIRTH TO A SUBSTANCE-EXPOSED INFANT, TO BE CHILD ABUSE OR NEGLECT

The federal Child Abuse Prevention and Treatment Act (CAPTA) includes a requirement for states that receive CAPTA funds to have policies and procedures in place mandating that any healthcare professional involved in the care or delivery of an infant “born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder” notify their state or local child welfare agency of that infant’s birth.²²⁵ This notification does not constitute an allegation of child abuse or neglect, and CAPTA does not require the submission of any identifying information with the notification. CAPTA does, however, require a family care plan to be created for each infant for whom a notification is submitted.

Family care plans, also known as plans of safe care, are intended to be a non-punitive, collaborative, interdisciplinary, and responsive approach to ensuring the health and well-being of parents with SUD and newborn infants affected by parental SUD.²²⁶ When child safety is not a concern, family care plans offer a pathway for families to receive services and provide population-level tracking to increase resources to higher-need communities.²²⁷ Family care plans are responsive to the needs of substance-exposed infants and the affected pregnant or postpartum person. Such programs link families to services such as substance use, mental health, or other medical treatment; peer support; and social services (*e.g.*, housing, employment, and educational assistance).²²⁸

In some states, however, reports of substance use during pregnancy follow the same pathway as child abuse and neglect reports—a process that can result in child



removals and foster care placements.^{229,230} Concerns over this practice have led many commentators to call for alternative approaches that are outside of existing child protective services (CPS).²³¹

As of November 2023, eight states assist pregnant or postpartum individuals with substance use disorder in seeking help by having specific laws/regulations designed to help families with substance-exposed infants and not automatically considering substance use during pregnancy or giving birth to a substance-exposed infant to be child abuse or neglect, by itself.

WHY ARE SUPPORTIVE AND NON-PUNITIVE FAMILY CARE PLANS IMPORTANT?

Substance use-related deaths comprise a significant proportion of maternal mortality counts

In 2016, deaths involving opioids accounted for 10 percent of all pregnancy-associated deaths in a study of 22 states.²³² Nationally, the leading causes of pregnancy-related death are behavioral health conditions, including overdose and suicide.²³³ In some states, overdose is a primary driver of increased pregnancy-associated death.^{234,235,236} Postpartum individuals experience heightened risk factors for relapse, such as losing insurance and treatment access, sleep deprivation, stress, and the threat of losing child custody.²³⁷ In addition to vulnerability to relapse and overdose, untreated SUD is linked to a risk of pregnancy-associated suicide.²³⁸

Untreated substance use disorders in pregnancy can pose risks to fetal and infant development

Untreated SUD is linked to premature birth, low birth weight, and other health and developmental problems for the infants to which they subsequently give birth.^{239,240} In some cases of opioid exposure, there may be a risk of long-term negative outcomes for the child, such as behavioral, learning, and mental health issues later in life.²⁴¹

Rates of substance use disorder in pregnancy and Neonatal Abstinence Syndrome have increased in recent years

Between 2010 and 2017, there was an 82 percent increase in incidents of Neonatal Abstinence Syndrome (NAS),²⁴² with the 2017 NAS rate estimated at 7.3 per 1,000 birth hospitalizations.²⁴³ However, NAS rates vary significantly by state, with five states exceeding 20 per 1,000 birth hospitalizations.²⁴⁴ Similarly, during the same period, the number of pregnant people with opioid-related diagnoses at the time of their deliveries increased by 131 percent.²⁴⁵ Recent estimates suggest that OUD impacts 6.5 per 1,000 deliveries.²⁴⁶ Other forms of substance use besides opioids are also a concern, as about a quarter of pregnant people use alcohol and two to five percent use marijuana.^{247,248}

Punitive approaches to substance use during pregnancy are based on—and increase—stigma

Punitive responses to substance use during pregnancy increase stigma, reinforcing the belief that using substances during pregnancy makes a person unfit to be a parent.²⁴⁹ Stigmatizing attitudes may include the idea that treatment does not work or the person is not worthy of treatment.²⁵⁰ Such assumptions about treatment are reflected in the types of services offered. Delivery of MAT is highly effective in improving the health of the pregnant individual and the fetus.²⁵¹ However, only 19 states have created or funded drug treatment programs for pregnant people.²⁵² Stigma as an access barrier is further demonstrated by a recent study which found that when providers believed a patient to be pregnant, they were 17 percent less likely to offer MAT.^{253,254}

Policies that separate families increase health risks for both the postpartum individual and the infant

In 25 states, substance use during pregnancy is classified as child abuse²⁵⁵ and may result in the removal of the child. A large body of research shows that children removed from the home and placed into foster care have significantly worse health and well-being outcomes than children with similar cases who were not removed from the home.²⁵⁶ In some states, individuals who use drugs while pregnant face incarceration.²⁵⁷ However, experts say that incarceration is traumatic and can potentially worsen mental and behavioral health outcomes for the postpartum individual and the child.²⁵⁸ Not only is parental-infant separation highly detrimental to childhood development; health risks for the child are intensified in cases of parental incarceration.²⁵⁹

Punitive approaches to substance use during pregnancy are not effective

According to the American College of Obstetricians and Gynecologists, “criminalization and incarceration for SUD during pregnancy are ineffective as behavioral deterrents and harmful to the health of the pregnant person and their infant.”²⁶⁰ Research supports this conclusion. Punitive policies are associated with high rates of infants born with SUD,²⁶¹ with a recent study showing a 10 to 18 percent increase in NAS following the implementation of punitive policies.²⁶²

Punitive approaches to substance use during pregnancy create significant barriers to care

Stigma and fear of legal repercussions may discourage pregnant individuals from accessing care or disclosing substance use to healthcare providers.^{263,264} Since the most effective approaches to improving birth outcomes for substance-exposed infants begin during pregnancy, it is crucial that pregnant people feel comfortable accessing care without punishment.²⁶⁵ A recent analysis found that in states with more punitive policies (*i.e.*, policies that define substance use during pregnancy as child abuse), pregnant individuals are less likely to be offered MAT and less likely to receive timely or quality care before and after pregnancy.^{266,267}

Current policies exacerbate disparities

Policies that criminalize rather than treat substance use during pregnancy amplify several other intersecting disparities. Black and Indigenous families are generally overrepresented in the child welfare system,²⁶⁸ and Black parents are less likely to be reunified with their children once removed from the home.²⁶⁹ During pregnancy, Black people are more likely than individuals of other races to be tested for drug use. They are more likely to be incarcerated or lose custody of their child immediately after birth for prenatal drug use.²⁷⁰

WHAT IMPACT DO FAMILY CARE PLANS AND PROTECTIONS FOR PREGNANT PEOPLE WITH SUD HAVE?

Access to treatment, including medication for addiction treatment, improves pregnancy and birth outcomes

In addition to reducing risks of relapse,²⁷¹ MAT improves adherence to prenatal care and addiction treatment programs and reduces the risk of obstetric complications.²⁷² In one study, the implementation of state policies that prioritize treating pregnant people with SUD is associated with modest reductions in low gestational age and low birth weight and increases in prenatal care utilization.²⁷³

Non-punitive policies, including family care plans and specialized notification systems, can redirect individuals to appropriate services

Formal CPS response pathways are often not tailored to the needs of substance-impacted families, and the existing responses can often be ineffective. States can reduce stigmatization and redirect resources by creating separate pathways for families to access care through family care plans. Family care plans, which involves community-based referrals and peer services, may improve trust and engagement with marginalized populations.²⁷⁴ The interdisciplinary nature of family care plans also can create linkages across service providers. This is important, as people with SUD often experience multiple health risks.²⁷⁵

Protective and supportive policies reduce parent-infant separation and promote family unity, which benefits health

Studies emphasize the importance of keeping infants with the birthing parent immediately after birth and through infancy to improve short- and long-term outcomes.²⁷⁶ Maintaining the birthing parent-infant dyad is also a key recommendation in treating NAS.²⁷⁷ Overall, keeping families together offers a crucial protective factor when it is safe to do so.

Using family care plans to integrate services is effective and reduces costs

Pregnancy and parenthood can motivate behavioral change and increase engagement in SUD treatment.²⁷⁸ Research promotes integrated substance use treatment and prenatal care services as an effective strategy to reduce maternal and fetal complications and costs.²⁷⁹ In addition to medical cost savings, the approach

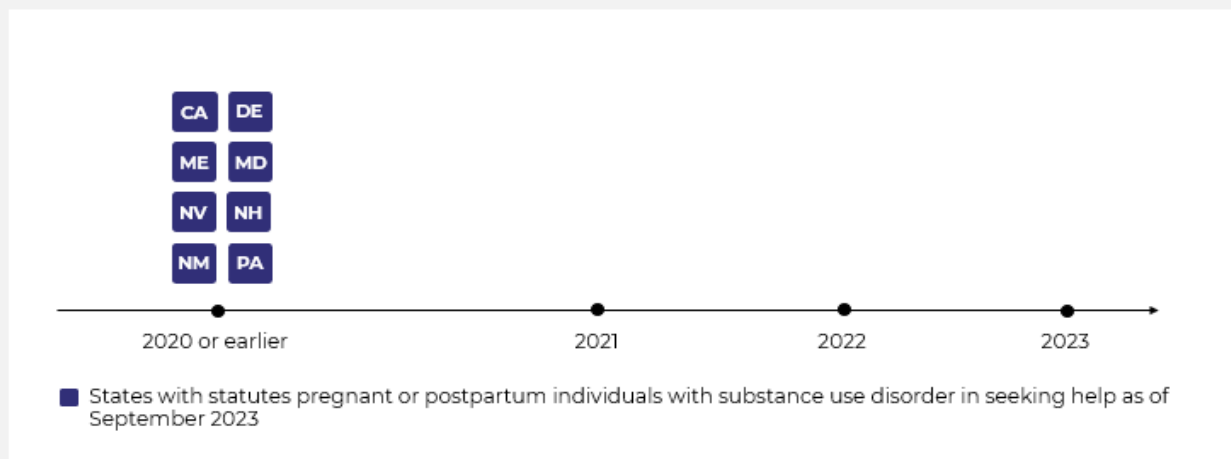
can reduce unnecessary child welfare system utilization costs, including CPS investigations, foster care placements, and court involvement.

WHAT PROGRESS HAVE STATES MADE IN THE LAST THREE YEARS TO SUPPORT PREGNANT OR POSTPARTUM INDIVIDUALS WITH SUBSTANCE USE DISORDER IN SEEKING HELP?

The eight states that assist pregnant or postpartum individuals with substance use disorder in seeking help by having specific laws/regulations designed to help families with substance-exposed infants and not automatically considering substance use during pregnancy or giving birth to a substance-exposed infant to be child abuse or neglect, by itself, adopted those laws before 2021.

Implementation Timeline: Substance Use During Pregnancy and Family Care Plans

Eight states assist pregnant or postpartum individuals with substance use disorder in seeking help by having specific laws/regulations designed to help families with substance-exposed infants and not automatically considering substance use during pregnancy or giving birth to a substance-exposed infant to be child abuse or neglect, by itself.



IMPLEMENTATION RESOURCES

LAPPA's *Model Substance Use During Pregnancy and Family Care Plans Act* provides certain protections to pregnant or postpartum individuals with an SUD so that such individuals are not penalized for receiving medical treatment, including medication(s) to treat the SUD; and establishes that an infant born affected by parental SUD or showing signs of withdrawal is not, by itself, grounds for submitting a report of child abuse or neglect.

Click here to read the full text of the [Model Substance Use During Pregnancy and Family Care Plans Act](#).

A webinar recording about substance use during pregnancy and family care plans from LAPPA's 2023 Knowledge Lab series can be found [here](#).

STRATEGY 10: SUPPORT INFORMATION SHARING WITH OVERDOSE FATALITY REVIEW TEAMS

Overdose fatality reviews (OFRs)—also called OFR teams, boards, panels, committees, or commissions—examine and attempt to understand the circumstances leading to a fatal drug overdose.²⁸⁰ A key component of OFRs is their multidisciplinary nature, bringing together professionals across sectors such as mental and behavioral health, criminal justice, healthcare and emergency services, social services, and public health.²⁸¹ The primary function of OFRs is to compile and analyze data from several sources to conduct case-by-case reviews of fatal overdose deaths.

Due to the relatively recent emergence of OFRs, there is limited systematic research related to this strategy.^{282,283} Despite this, case review models used in other settings, such as child fatality reviews, are effective in improving policy and practice,²⁸⁴ and initial findings from OFRs are

promising.^{285,286} Research suggests that local OFRs produce recommendations more quickly than national agencies and organizations.^{287,288} This is crucial for rapidly responding to changing trends in substance-related mortality.

As of November 2023, 13 states have adopted statutes expressly authorizing an OFR team to obtain certain disclosure-protected information from state and local entities. A fourteenth state, Michigan, has legislation passed by both state houses that awaits enrollment and presentment to the governor.



WHAT ARE OVERDOSE FATALITY REVIEWS AND WHY ARE THEY IMPORTANT?

Information collection is a key challenge for overdose fatality review

To the extent possible, information collected before an OFR case review should include medical records, SUD treatment records, medical examiner reports, criminal justice records, and social services records.²⁸⁹ At the same time, OFRs must abide by the Health Insurance Portability and Accountability Act's Privacy Rule, 42 C.F.R. Part

2, and other federal and state confidentiality laws. Overly restrictive or incorrect interpretations of these laws can impede the case review process.²⁹⁰ Even where OFRs operate on a local level, statewide legislation can be used to specify—and thus authorize—many types of disclosure-protected information that local OFRs can access.

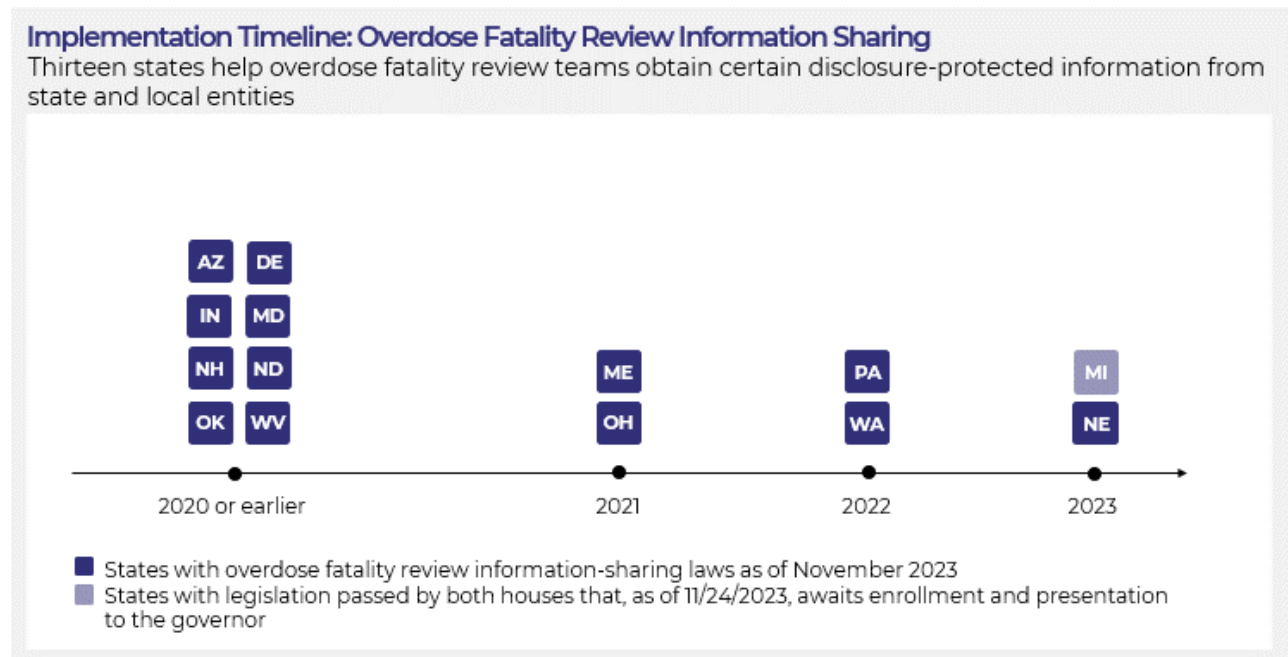
By analyzing information held by multiple agencies and organizations, a local OFR can create a timeline of public health and safety services offered to the decedent, referrals to other providers, service gaps, and missed opportunities. The OFR can also use cross-sector data to assess any social determinants of health that influenced the deceased individual’s behavior and decision-making.²⁹¹

OFrs can improve cross-sector collaboration in communities

As OFRs bring together representatives from key sectors for problem-solving and strategic planning, the review process helps individual OFR team members understand each agency’s role in overdose prevention.²⁹² OFRs increase team members’ knowledge of the resources available across other agencies and organizations, as well as gaps in services and community-level needs and assets.^{293,294} As a result, OFRs increase member agencies’ shared accountability and collective responsibility in preventing future overdose deaths.^{295,296}

WHAT PROGRESS HAVE STATES MADE IN THE LAST THREE YEARS TO SUPPORT INFORMATION SHARING FOR OVERDOSE FATALITY REVIEW TEAMS?

Of the 13 states with statewide laws authorizing an OFR team to obtain certain disclosure-protected information from state and local entities, the laws in eight states took effect in 2020 or before, while five adopted laws since 2021.



IMPLEMENTATION RESOURCES

LAPPA's *Model Overdose Fatality Review (OFR) Teams Act* creates a legislative framework for establishing county-level, multidisciplinary OFRs in individual states. While overdose deaths occur nationally, OFRs established at the local level allow for the identification of challenges unique to a local area. This model act addresses the duties, responsibilities, and composition of OFRs in order for them to properly examine and understand the circumstances leading up to a fatal overdose.

Click here to read the full [**Model Overdose Fatality Review \(OFR\) Teams Act**](#).

A webinar recording about OFRs from LAPPA's 2023 Knowledge Lab series can be found [here](#).

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https://www.cdc.gov/drugoverdose/od2a/pdf/OD2A_EvalProfile_OverdoseFatalityReviews_508.pdf

²⁹³ Ibid.

²⁹⁴ Heinen, & O'Brien. (2020). *Practitioner's guide*.

https://www.cossup.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf

²⁹⁵ Costello, & Cruz. (2020). *Evaluation profile*.

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ABOUT LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

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

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

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