New England Regional Judicial Opioid Initiative

Policy and Network Overview

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WAYNE STATE
School of Social Work
Center for Behavioral Health and Justice

National Center for State Courts

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INTRODUCTION

The Overdose Epidemic

There have been more than a half million drug overdose deaths in the United States since 1999, with over 70,000 drug overdose deaths in 2017 alone (1). While the majority of these deaths are associated with opioids, the role of opioids has varied dramatically across three time periods over the course of the epidemic, each resulting in increasing death rates (2). The first wave began in the 1990s and was characterized by prescription opioid-related deaths (3,4). Reduced availability of these prescription medications contributed to the second wave of the epidemic, which began in 2010 and was driven by increasing heroin use and a corresponding increase in illicit opioid deaths (3,5,6). The third wave started in 2013 and has been driven by illicit fentanyl, a synthetic opioid that is up to 100 times more potent than morphine (7,8).

The Regional Judicial Opioid Initiative

In April 2019, six Northeastern states—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont—established the New England Regional Judicial Opioid Initiative (NE RJOI), a multi-state collaborative aimed at developing regional solutions to the overdose epidemic from a court perspective, while strengthening collaboration among stakeholders. Participants include chief justices, state courts, state criminal justice agencies, supervision agencies, state public health agencies, legislators, treatment providers, medical experts, and child welfare representatives.

The National Center for State Courts (NCSC) provides project management for the collaborative initiative. To address data and research needs of the NE RJOI, a data action partner, Dr. Brad Ray and the Center for Behavioral Health and Justice (CBHJ) at Wayne State University, were tasked with informing decision-making around potential public health strategies (9). For this first report to the NE RJOI, the CBHJ has conducted a policy and network analysis of the states involved in this initiative. This report outlines specific policy areas that are tailored around the overdose epidemic and provides an overview of differences among the NE RJOI states in key areas identified by stakeholders and the research team. Further, using survey data from NE RJOI stakeholders, researchers established a baseline social network analysis (SNA) of the NE RJOI. Subsequent analysis and reporting will aim to understand whether collaboration and social interactions within and between the NE RJOI states have changed over time. Lastly, CBHJ worked with NCSC and NE RJOI leadership to solicit information on updates or future directions for the Prescription Drug Abuse Policy System (PDAPS) policy areas outlined in this report.

Methodology and Data

In October 2019, the CBHJ, in partnership with the NSCS, conducted a survey of the NE RJOI stakeholders across the six states. The aim of the survey was to identify NE RJOI stakeholders, their professional networks related to the overdose crisis, and future research priorities for CBHJ. In particular, respondents were asked about their professional experience, data and information sharing, and individuals with whom they collaborate. Questions were presented in both open and closed-ended formats. Data collection was discontinued in November 2019 and was analyzed using an SNA to better understand the ways in which individuals interact, the flows of data and information sharing, and key players in the network. Results of the SNA reveal several network structures at the federal, state, and individual level, and will be illustrated as network maps.

The electronic survey was distributed using Qualtrics™ to all NE RJOI stakeholders identified by the NCSC, for a total of 64 individuals across the six states. In total, 84% of stakeholders began the survey. Some of the responses included significant missing data (n= 8), which were excluded

from analysis. Adjusting for these missing data, the final sample size was 46 individuals, nearly three-fourths of the total NE RJOI membership. Of individuals who completed the survey, the average survey duration was seven minutes. Overall, the survey yielded a total response rate of 72%. By state, response rates range from 25% (Maine) to 100% (Vermont). Table 1 describes the number of completed surveys and the response rate for each state.

Table 1: Survey Response Rates by NE RJOI States

NE RJOI States	Completed Surveys	Total NE RJOI Stakeholders	Response Rate
Connecticut	4	7	57%
Maine	1*	4	25%
Massachusetts	16	25	64%
New Hampshire	9	11	82%
Rhode Island	7	8	88%
Vermont	9	9	100%
Total	**46**	**64**	**72%**

** Maine representatives submitted one final consolidated survey response consisting of multiple responses and feedback*

To guide the policy analysis of the Prescription Drug Abuse Policy System (PDAPS) data, the survey also inquired about the NE RJOI stakeholders' preferences on policy topics. Survey respondents were asked to rank the top state-level policy areas for which they believe CBHJ should focus their analysis efforts, with answer choices corresponding to the PDAPS policy areas. Using a weighted ranking system, medications for opioid use disorder (MOUD)[1] in correctional settings was the highest ranked policy area. Other high-ranking areas of interest included Good Samaritan overdose laws and naloxone access and distribution. Further, while not ranked among the top three policies by the stakeholders, the recent attention on drug-induced homicide laws prompted the CBHJ to include this among the policy areas analyzed. Additionally, the survey helped to identify future research priorities for the CBHJ, particularly incarceration effects on Medicaid status, insurance coverage of MOUD, and interstate MOUD treatment challenges.

[1] Please note that MOUD (medications for opioid use disorder) and MAT (medication assisted therapy) are considered interchangeable; however, there is a growing movement to use MOUD that is backed by research suggesting it results in less explicit bias; see Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. *Drug and alcohol dependence*, 189, 131-138.

THE PRESCRIPTION DRUG ABUSE POLICY SYSTEM

PDAPS, funded by the National Institute on Drug Abuse (NIDA), is a database that tracks legal data and policy information regarding major public health issues related to the drug overdose epidemic. There are seven major topics that PDAPS collects information on: (1) criminal justice, (2) expanded access to naloxone, (3) Good Samaritan 911 immunity, (4) medical marijuana, (5) prescription opioid-related controls, (6) prescription drug monitoring programs, and (7) other drug-related topics. Each one of these topics contains subcategories which can be seen in Table 2. Each state, including the District of Columbia, is represented along with the information on each state's specific statute, regulation, or law (if applicable) and language, and the timeframes in which they are in effect.

Table 2: Overview of the Prescription Drug Abuse Policy System Topics

Topic	Specific Law or Policy	Brief Description of Law or Policy
Criminal Justice	Drug induced homicide	Laws that authorize the prosecution of drug-related deaths as criminal deaths
	Incarceration effects on Medicaid status	Effect that incarceration (prison or jail) has on Medicaid enrollment status among Medicaid-eligible individuals
	Involuntary commitment for substance use	Laws which authorize the involuntary arrest, detention, and/or treatment of an individual for substance use disorder
	Medicaid coverage of MOUD	Regulations, statues, and preferred drug lists for Medicaid's coverage of MOUD
	MOUD in state correctional facilities	Laws and policies on MOUD treatment for opioid use disorder (OUD) in state correctional facilities and forms of MOUD provided
Naloxone	Naloxone overdose prevention laws	Laws regarding the prescribing and lay person administration of naloxone
Good Samaritan Laws	Good Samaritan overdose prevention	States that have Good Samaritan Laws and how much protection the laws can provide for a person reporting an overdose
Medical Marijuana	Medical marijuana laws and rules	Addresses state laws and regulations on marijuana's production, transport, sale, quality, and consumption
Prescription Opioid-Related Controls	Direct dispensing of controlled substances	Laws regarding medical professionals authorized to prescribe controlled substances and limitations placed on dispensing
	Prescribing guidelines for acute and emergency care	Recommendations for acute and emergency care opioid prescribing and penalties for failing to comply with prescribing guidelines
	Pain management clinic laws	Addresses state laws that regulate pain management clinics, clinic owners, and the prescribers that are employed at the clinics
Prescription Drug Monitoring Programs (PDMP)	Access and registration	Addresses who is allowed to have access to a PDMP
	Administration	Addresses who is responsible for the administration of PDMPs
	Implementation dates	Dates of key functions (enacted, in operation, and user access)
	Reporting and authorized use	Laws that govern how PDMPs report data and the authorized use of PDMPs
Other Drug-Related Topics	Drugged driving laws	Policies on whether or not driving is prohibited with any specific amount of a controlled substance in a driver's system
	MOUD with methadone laws	Federal and state laws regarding the requirements of receiving MOUD with methadone
	Recreational marijuana laws	Explores recreational marijuana laws and identifies which state agency regulates recreational marijuana

While there are numerous policies, regulations, and laws that can be further expanded upon with the PDAPS, the NE RJOI survey results helped to identify four key areas which are of interest to NE RJOI stakeholders: drug-induced homicide laws, MOUD in correctional facilities, Good

Samaritan laws, and naloxone overdose prevention laws.[2] Table 3 provides a broad overview of these four policy areas across each of the NE RJOI states to illustrate areas of overlap as well as where there may be opportunities for policy change. This report delves into each of these areas further by providing a description of the policy, national trends, differences across the NE RJOI states, and research on the potential impact of these policies for the overdose epidemic

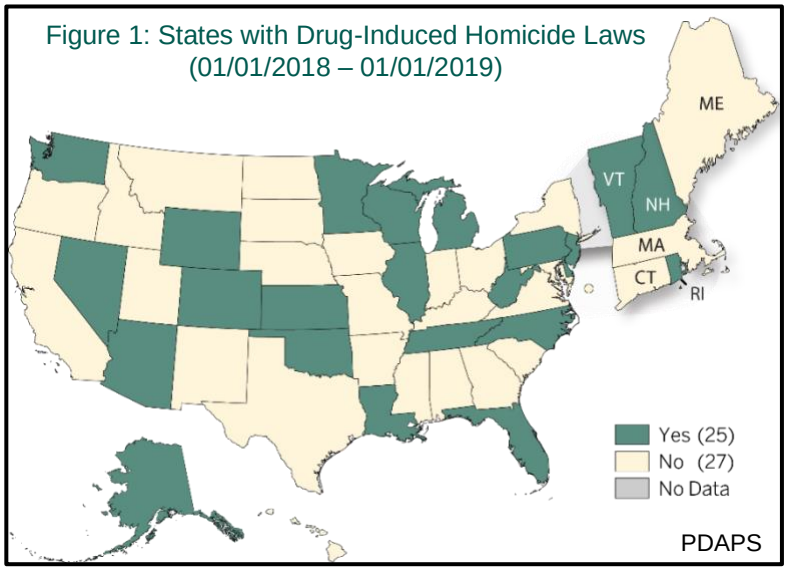
Table 3: Overview of Key PDAPS Topics by NE RJOI States[3]

NE RJOI States	Drug-Induced Homicide Laws	MOUD in Correctional Facilities	Good Samaritan Laws	Naloxone Overdose Prevention Laws
Connecticut	No	No	Yes	Yes
Maine	No	No	Yes	Yes
Massachusetts	No	No	Yes	Yes
New Hampshire	Yes	No	Yes	Yes
Rhode Island	Yes	Yes	Yes	Yes
Vermont	Yes	No	Yes	Yes

Drug-Induced Homicide Laws

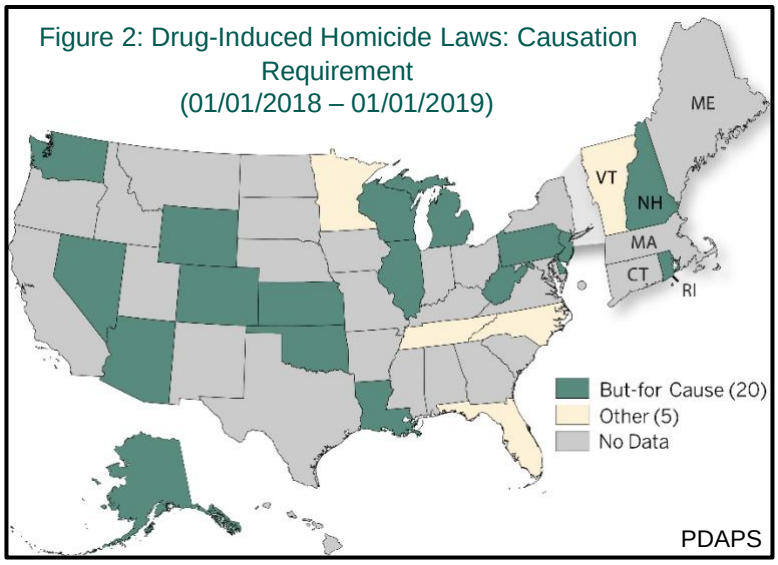
Drug-induced homicide laws are those that authorize the prosecution of drug-related deaths as criminal deaths. These statutes work to establish criminal liability for individuals who make or provide controlled substances to an individual who dies as a result of using said substance. Thus, those who provided the controlled substance are charged with murder. Drug-induced homicide laws vary between states in how a person is sentenced, how they are classified, and what types of processes need to occur before a person is sentenced under the law. In the United States, nearly half (49%) of all states have drug-induced homicide laws (Figure 1). Out of the six NE RJOI states, only three have drug-

Figure 1: States with Drug-Induced Homicide Laws (01/01/2018 – 01/01/2019)



[2] Appendix A provides a brief overview of differences in the remaining PDAPS topics across the NE RJOI states.
[3] The PDAPS data reports legislative policies which are in effect across various time frames. Years in which the laws are in effect will be shown within each figure title.

Figure 2: Drug-Induced Homicide Laws: Causation Requirement
(01/01/2018 – 01/01/2019)

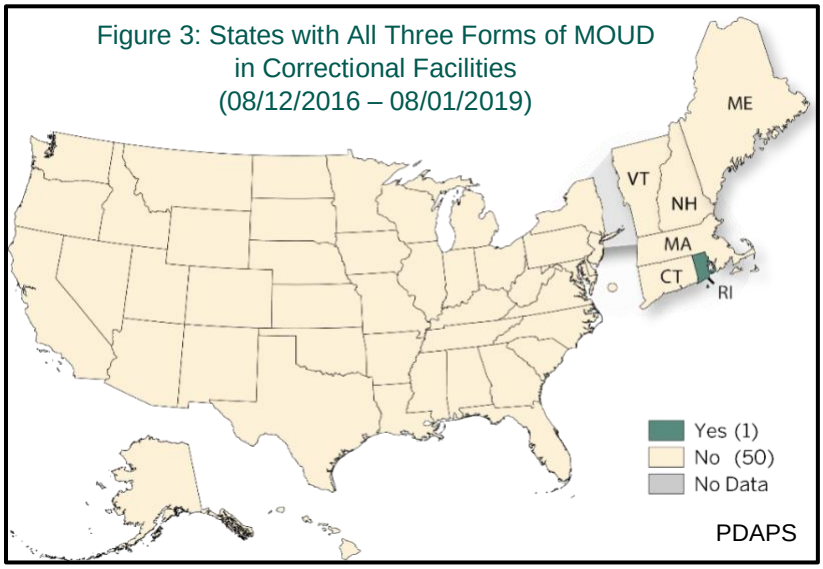


induced homicide laws; New Hampshire, Rhode Island, and Vermont. Rhode Island is one of the earliest states to enact a specific drug-induced homicide law in the year 1981, compared to Vermont and New Hampshire, which enacted these laws in 2003 and 2006, respectively (10). There are differences in these laws across states. One of the most significant examples is how the drug-induced homicide charge is classified. The three NE RJOI states that have a drug-induced homicide law each classify the charge as *Delivery or Distribution Resulting in Death,* compared to other states that may classify it as either a *Murder* or a *Homicide*. There are also differences in sentencing periods between the NE RJOI states. Out of the NE RJOI states, only New Hampshire does not have a mandatory sentencing period if convicted of breaking this law. Vermont has a minimum period of 13-24 months and Rhode Island has a strict sentence of Life in Prison. Each of these three states also stipulate Life in Prison as their maximum sentencing period. In line with the rest of the states in the US, there are also no mitigating factors that could influence sentencing; only Colorado has such factors. Vermont also differs between New Hampshire and Rhode Island regarding causation requirements: Vermont is one of five states that is "proximate" or "contributed to" for causation requirements under their drug-induced homicide statute; all the other states are "but-for" cause (Figure 2).

MOUD in Correctional Facilities

The gold standard medical treatment for substance use disorder (SUD) involving opioids is medications for opioid use disorder (MOUD), which provides pharmacological treatment of addiction supported by behavioral therapy. The three medications approved for the treatment of opioid use disorder (OUD) in the United States include methadone (an opioid agonist), buprenorphine/Suboxone® (a partial agonist), and naltrexone/Vivitrol® (an opioid antagonist). Methadone and buprenorphine are long-acting opioid medications that prevent withdrawal and decrease opioid cravings, drug seeking, and drug use. Naltrexone is a non-opioid medication that blocks the effect of opioids in the body. Ample research has shown that those who receive MOUD have

Figure 3: States with All Three Forms of MOUD in Correctional Facilities
(08/12/2016 – 08/01/2019)

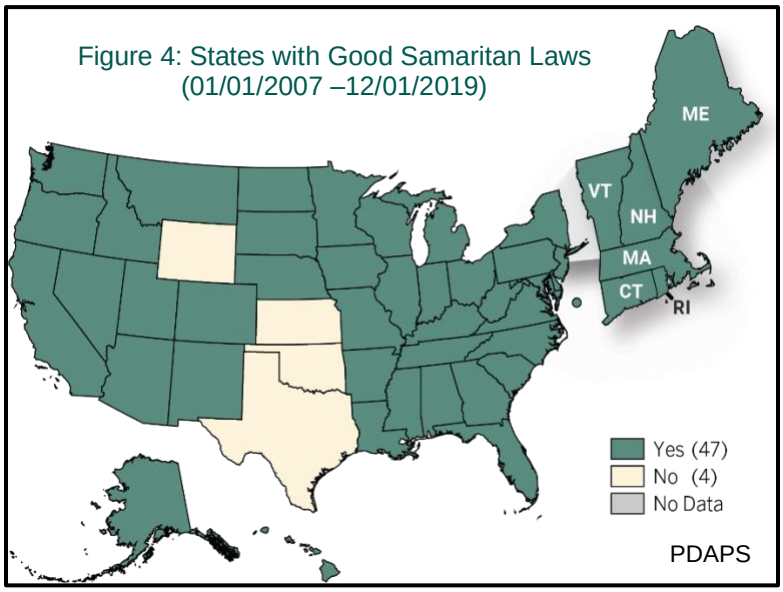


longer periods of abstinence, reduced risk of overdose and death, and are less likely to become infected with HIV and Hepatitis C (11–16).

Each state varies greatly between which forms of MOUD they provide in their state correctional facilities. Only one state currently provides all three forms of MOUD: Rhode Island (Figure 3). In 2016, the Rhode Island Department of Correction's (RIDOC) MOUD program was created, and as of the year 2019, this program has resulted in dramatic reductions in overdose deaths across the state. Their MOUD program was able to screen, identify, and treat individuals who had an OUD in a criminal justice setting and link them to medication and supportive services following release from incarceration (17).

Good Samaritan Laws

Figure 4: States with Good Samaritan Laws (01/01/2007 –12/01/2019)

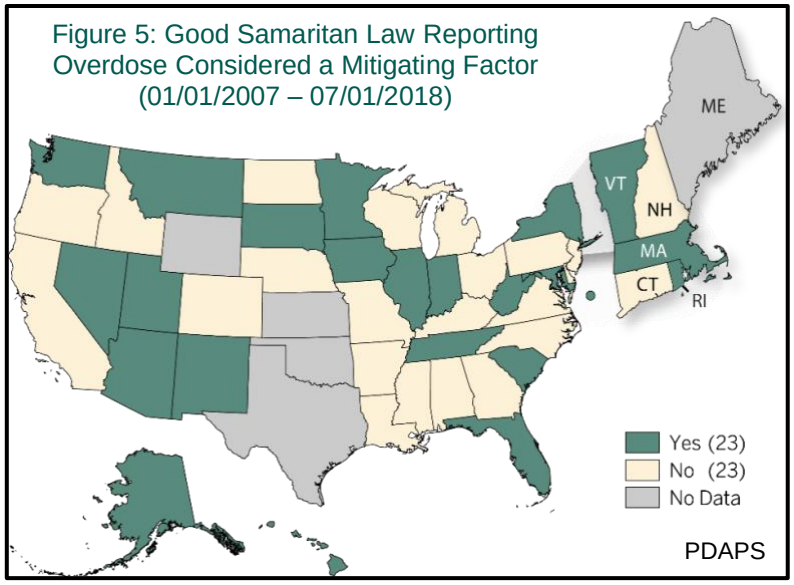


Good Samaritan laws are statutes that were created to provide immunities or other legal protections for people who call for help in the event of an accident (and in many states, an overdose). Indeed, Good Samaritan laws related to drug overdose state that those who call 911 at the scene of an overdose are immune from some civil and criminal liabilities (18). Good Samaritan laws were created due to the concern that individuals who witness an overdose may not call for medical help for fear of being arrested due to the illegal drugs involved. There are many differences between state laws on how much protection these laws can provide for a person reporting an overdose. Despite the perceived benefits of Good Samaritan laws, they are not always utilized among people who use drugs or other lay responders.

Most NE RJOI states have a Good Samaritan law (Figure 4); only four states in the US do not have these laws. With respect to differences in the Good Samaritan laws between states, many of the protections these laws can provide depend on the involvement of a controlled substance or drug paraphernalia. Almost all US states protect an individual from prosecution if help is called. Other states may provide additional protections, such as against arrest or being charged with a crime. However, when looking at protections offered in the case that an individual is on parole or probation, only around half the states provide protection in such instance; including Massachusetts, Maine, Rhode Island, and Vermont. Focusing on the NE RJOI states that have a Good Samaritan law, as previously mentioned, protections can vary based on whether it is a controlled possession charge or drug paraphernalia charge. For controlled substances, there is a combination of protections from arrest, charge, and prosecution that vary greatly between all five

jurisdictions; however, only Connecticut provides protections against all three. When there is drug paraphernalia involved, Connecticut, Maine, and Rhode Island provide protections against prosecution; Massachusetts, New Hampshire, and Vermont do not offer this protection. There is also variation in states that provide protection when reporting an overdose as a mitigating factor in sentencing. Exactly half of the US states (50%) allow this protection, including Massachusetts, Rhode Island, and Vermont (Figure 5). For those crimes that mitigation is allowed, the variation is great between states, with most only allowing controlled substance offenses. However, Vermont not only mitigates controlled substance offenses, but also alcohol-related offenses as well as other offenses that are beyond controlled substances and alcohol-related violations.

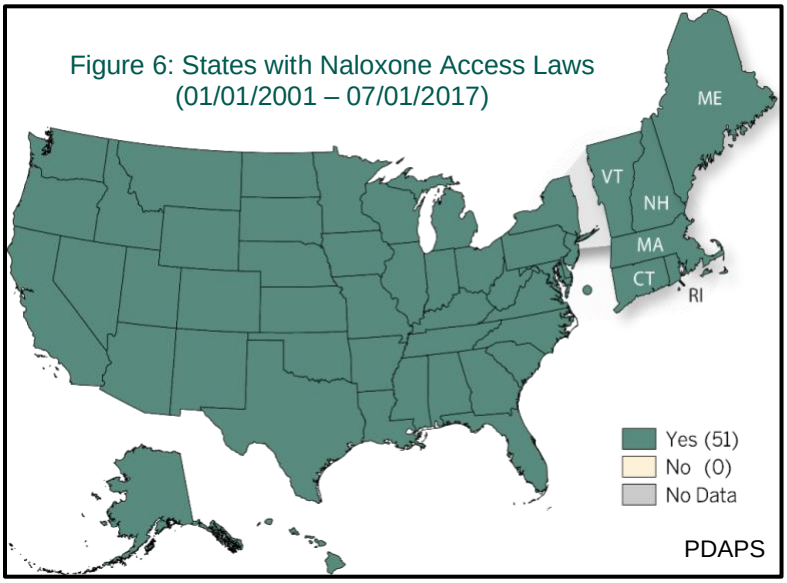
Figure 5: Good Samaritan Law Reporting Overdose Considered a Mitigating Factor (01/01/2007 – 07/01/2018)



Naloxone Overdose Prevention Laws

Naloxone (or commonly referred to as Narcan™) is an opioid antagonist that works by displacing bound opioid receptors in the brain and reversing the effects of an opioid overdose (19). This drug is safe and can work within minutes to negate the effects of opioids. Naloxone is not a controlled substance and does not produce any effects on individuals if taken in the absence of opioids (20).

Figure 6: States with Naloxone Access Laws (01/01/2001 – 07/01/2017)



There are many different state laws regarding the prescribing, dispensing, and lay person administration of naloxone, and PDAPS provides information on the differences between state laws, such as which ones provide civil or criminal immunity to healthcare providers or lay responders who administer naloxone. Figure 6 shows that every US state currently has a law(s) that address access to naloxone. However, there are some significant differences between states regarding what types of legal protections these laws provide for prescribers, dispensers, and lay persons. Figure 7 shows which states provide immunity from criminal prosecution to prescribers and dispensers for prescribing, dispensing, or distributing naloxone to a lay person. The vast majority of states provide protections for both dispensers and prescribers, including four of the six NE RJOI states; Massachusetts and Rhode Island do not provide any

Figure 7: Provide Immunities for Prescribers and Dispensers from Criminal Prosecution (01/01/2001 – 07/01/2017)

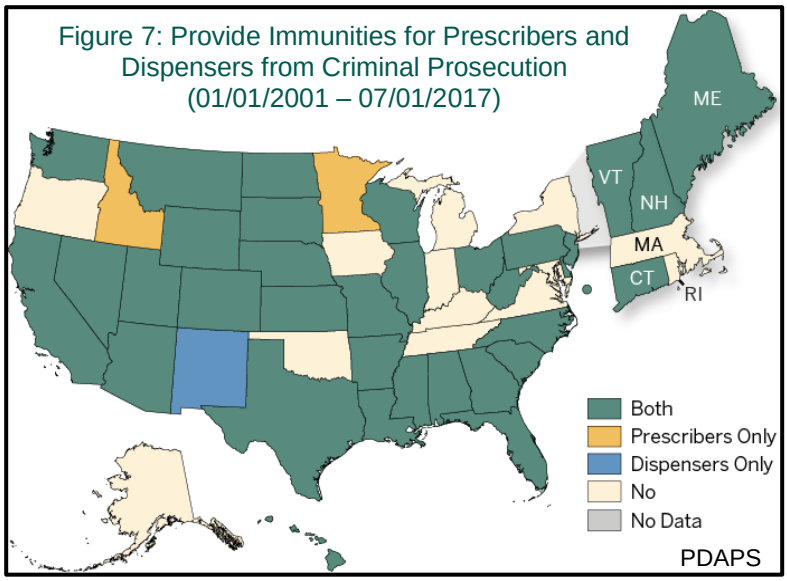


Figure 8: States that Provide Immunities for Lay Responders Administering Naloxone (01/01/2001 – 07/01/2017)

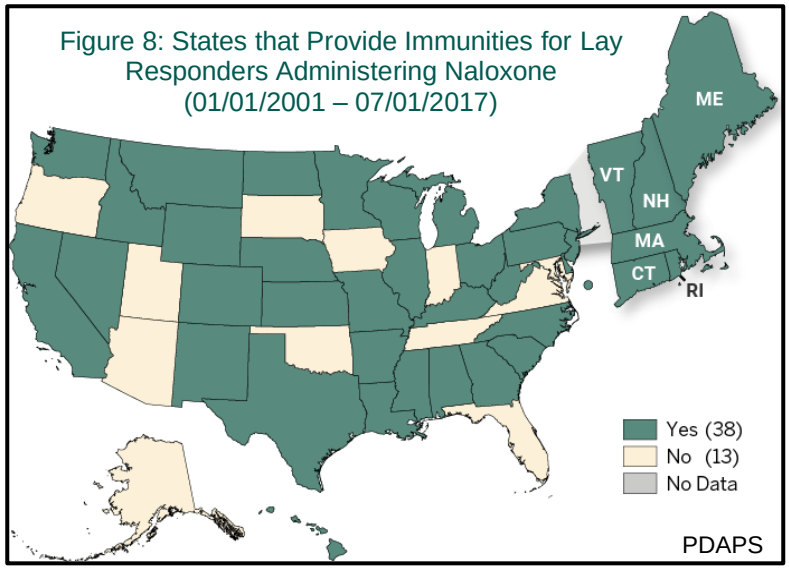
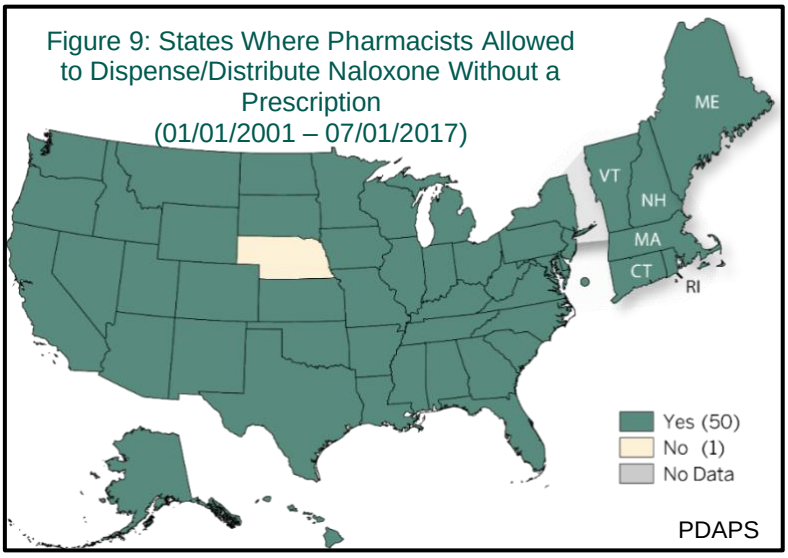


Figure 9: States Where Pharmacists Allowed to Dispense/Distribute Naloxone Without a Prescription (01/01/2001 – 07/01/2017)



immunities for these groups. (Figure 7). However, looking at laws that provide protections for lay responders from criminal liability if they administer naloxone, all the NE RJOI states provide these protections; with a similar distribution of immunity laws for prescribers and dispensers and lay responders across all the other states (Figures 7 and 8).

Throughout the past few years, additional focus has been made by state legislatures to expand naloxone access through clinician-prescribing as well as pharmacy-based naloxone dispensing (21). Pharmacists and pharmacies alike play a significant role in the overdose epidemic. With more than 90% of Americans living within 5 miles of a community pharmacy, a large percentage of individuals have the ability to access naloxone, whether it be during an opioid prescription pick-up or over the counter (22,23). All US states, except for Nebraska, allow pharmacists to dispense or distribute naloxone without a prescription (Figure 9).

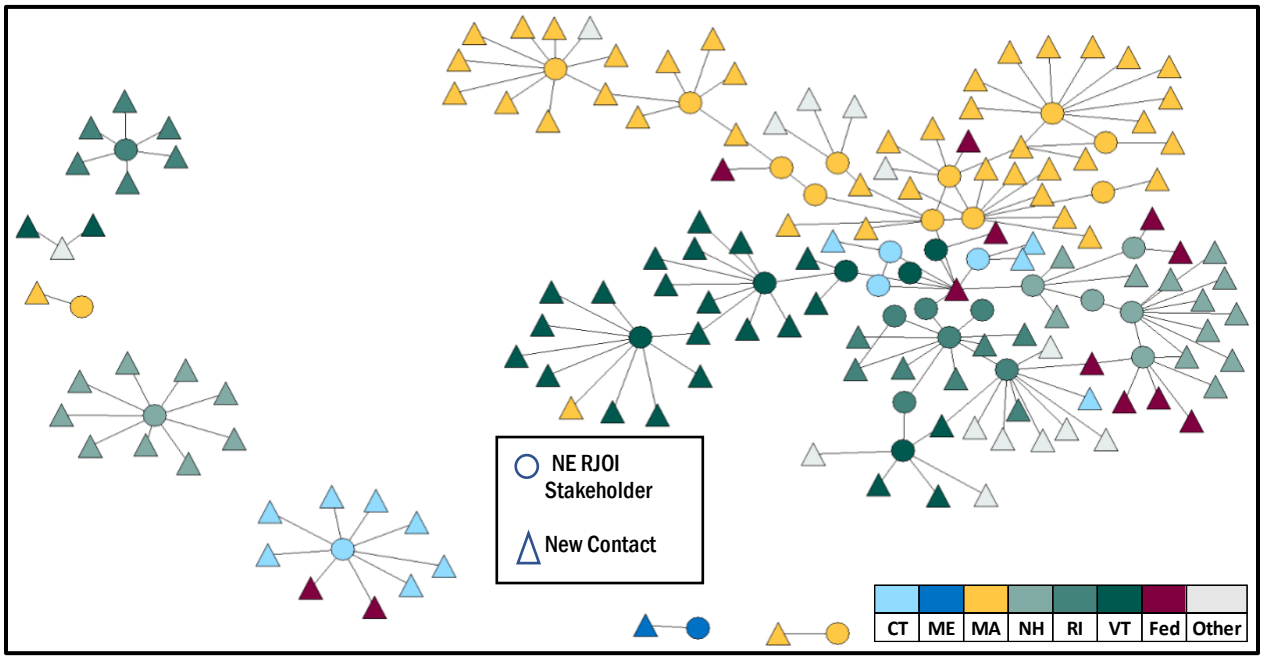
BASELINE SOCIAL NETWORK ANALYSIS

The ability to convene stakeholders with diverse professional backgrounds is central to the success of the NE RJOI. To evaluate the impact of the NE RJOI over time, the CBHJ used social network analysis (SNA) to understand the nature and quality of collaboration among NE stakeholders. A social network is a collection of structural relationships between entities, including individuals, groups, organizations, and even countries. Each social network contains nodes, or entities within the network, with unique traits. These nodes are connected by relationships, or ties. SNA focuses on the importance of social relationships—and the structures that contain them—in explaining observed behaviors and shaping attitudes and beliefs. Further, SNA views networks as dynamic; over time, relationships among actors change in response to both internal and external factors and pressures. In short, SNA is a methodology that allows the visual representation and analysis of social relationships within a network, making it an appropriate tool to assess NE RJOI.

In the survey, respondents were asked to identify up to 10 individuals with whom they worked with the most in the past year *as it relates to the overdose epidemic*, including individuals both inside and outside their organization. After identifying these individuals, survey respondents were also asked to indicate the frequency of interactions (i.e., weekly, monthly, or yearly) and the venues in which these interactions occurred, including formal and informal meetings, collaboration on grants or programs, and sharing data or information. Based on captured survey data, the research team identified several networks and subgroups among the NE RJOI participants. In particular, this survey helps identify the network "baseline," where follow-up analyses will identify how the NE RJOI network changes over time.

Figure 13 illustrates the total NE RJOI network, with each node representing one individual. While there are 46 NE RJOI stakeholders (who provided complete survey data) included in the network map, there are

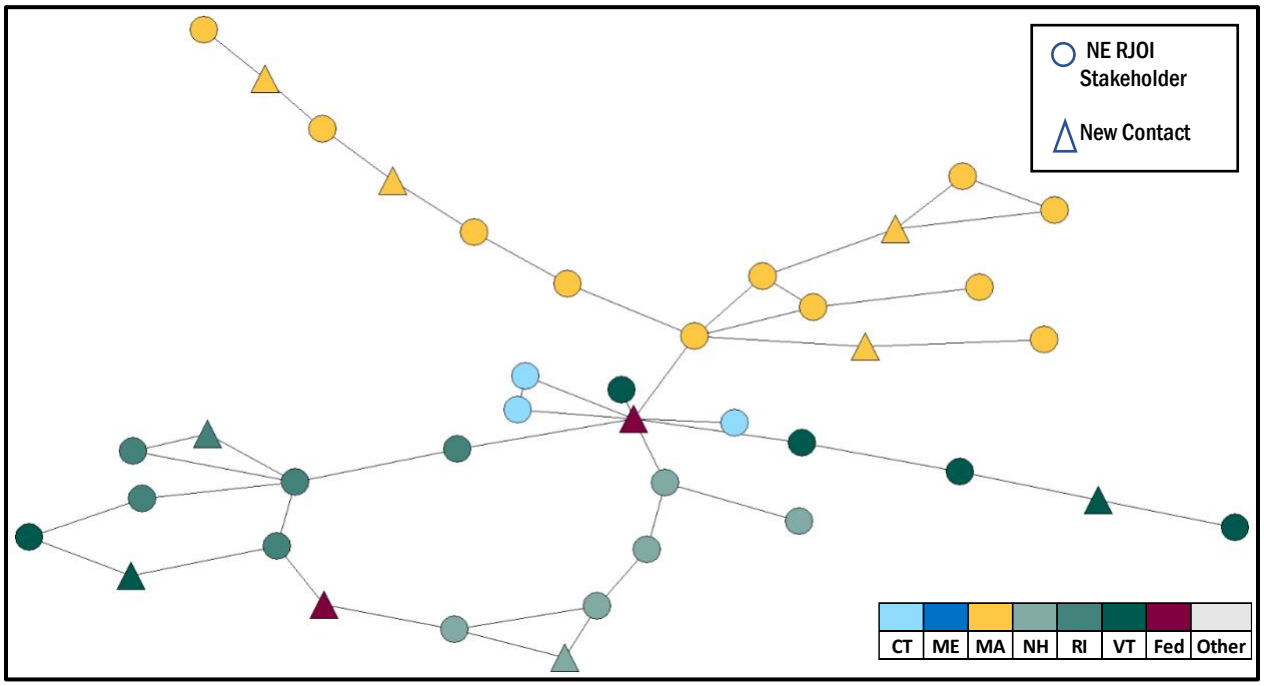
Figure 13: NE RJOI Network Map



a total of 175 individuals that comprise the broader New England network of individuals working on opioid-related issues. The additional 130 individuals (depicted with a triangle) were identified as "individuals with whom [NE RJOI members] worked the most in the past year *as it relates to the overdose epidemic*, including individuals both inside and outside [their] organization." In total, there are 348 social relationships among these individuals with an average of 2 relationships per individual depicted.

There are several key individuals that together connect the NE RJOI states. Figure 14 isolates individuals who are prominent, or "key players," within the network; that is, they collaborate with at least two other individuals. Again, the shape of each node corresponds with whether that individual is a NE RJOI stakeholder (circle) or a new contact captured from the survey (triangle). The color of each node corresponds to the state with which they are employed, as illustrated in the legend. Nearly all states are represented among the key players, though connections are similarly segmented by state, and the key player in the middle represents the NCSC external facilitator for the initiative (Kris Bryant).

Figure 14: NE RJOI Network Map, Key Players



STATE UPDATES

In January 2020, the CBHJ worked with NCSC and NE RJOI leadership to solicit information on updates or future directions for the PDAPS policy areas outlined in this report. In doing so, we hoped to gain more up-to-date information in order to identify trends in policy areas. For example, while three NE RJOI states (Vermont, New Hampshire, and Rhode Island) have drug-induced homicide laws, we learned that in Maine, the Attorney General has the authority to charge individuals with murder or manslaughter in cases where an individual supplied the drug that caused the death of another person. In Connecticut, a drug-induced homicide bill was introduced during the 2019 legislative session; however, it did not advance to become a law. In terms of naloxone, we learned that Massachusetts had passed a law to provide legal immunity to prescribers and dispensers who administer, distribute, or dispense naloxone to lay persons, which should remove the barriers of obtaining this life saving medication. Similarly, in Rhode Island, a prescription for naloxone is not needed at any pharmacy; and since 2017, prescriptions filled for Schedule II, III, IV, and V controlled substances also include naloxone. Further, in Rhode Island, Medicaid covers the cost of naloxone, and all private insurance providers are required to provide naloxone at a free or low-cost price. In Maine, efforts were made to assure that all recovery residences keep naloxone on hand within the facility which will help to reduce overdoses in these settings; moreover, Maine's only law enforcement training program now trains all cadets in naloxone administration, and the Maine Judicial Branch recently mandated that all Judicial Marshals carry naloxone while on duty. Additionally, all of the NE RJOI states have implemented expansive naloxone distribution programs for lay responders. There were also efforts to expand Good Samaritan laws in Maine to individuals who seek help at the scene of an overdose from prosecution and probation violation. As such, all NE RJOI states have an overdose-related Good Samaritan law; and in Rhode Island, as of 2016, the Attorney General is required to submit an annual report detailing instances where an individual was provided legal immunity as a result of this law.

The policy area with the most activity was that of expanding MOUD in correctional facilities. Clearly, the NE RJOI states understand the importance of providing these medications to those in criminal justice settings as all states have now made strides to expand access to MOUD in jails and prisons. For example, Massachusetts has successfully implemented all three forms of MOUD within eight county Houses of Correction and two state correctional facilities; MOUD is available in all Maine State Department of Correction Facilities, but the state is now working to implement MOUD in 10 of the 15 county jails, with the remaining jails set to implement MOUD during 2020; and in 2018, Vermont enacted Act 176 stating that inmates who enter a correctional facility while prescribed to MOUD must be provided with continued medication while incarcerated. Further, Act 176 in Vermont states that if an inmate screens positive as having OUD, they will be given the option to start MOUD within prison, specifically buprenorphine or methadone (24). New Hampshire has implemented MOUD within the state prison as well as within several of the 10 county jails, while methadone is available in six of Connecticut's 20 Department of Correction Facilities. As states make efforts to expand treatment into the correctional settings, it is important to remember that simply offering one form of MOUD is not sufficient as all individuals respond to medications differently. Rhode Island currently offers all three forms of MOUD in correctional settings, and this MOUD is provided by an outside vendor that has several service providers throughout the state. Those released from incarceration are still considered patients of the outside vendor, thus they have immediate access to MOUD upon release. As recommended by the National Sheriff's Association, correctional facilities should strive to screen inmates for OUD, provide all three forms of MOUD for those already prescribed and induce new clients, provide a continuum of care with a community provider, and provide naloxone post release (25).

CONCLUSIONS AND RECOMMENDATIONS

The NE RJOI represents a multi-state collaborative aimed at identifying regional solutions to the overdose epidemic and recent research supports this approach by suggesting that there are in fact multiple epidemics that vary by geographic region in the United States. For example, in southern states, overdose deaths were linked to prescription opioids, and in many rural states, this has declined since 2013 (in places like Kentucky, Ohio, Indiana and West Virginia we can see distinct waves in rippling patterns). Heroin took root in the western and Midwestern states, especially in urban areas near major interstates associated with drug trafficking (heroin-related deaths followed a major corridor linking El Paso to Denver); and in the northeast, this study finds an epidemic linked to synthetic opioids such as fentanyl, sold in street markets (26). The NE RJOI should consider these regional differences when looking for potential solutions.

In surveying the NE RJOI, our aim was to assess the organizational strength of the initiative but also to determine specific policy areas of interest among this organization. Policy can have a tremendous impact on the overdose epidemic. It is important to remember that this epidemic is made up of *accidental* drug overdose deaths, and state policy decisions can make a significant difference in preventing accidental deaths. Indeed, similar to how state-mandated gun control or seat belt laws have reduced accidental deaths, state-level policies have been shown to reduce preventable drug overdose deaths. For example, state-level mandatory prescribing monitoring programs or state-level opioid prescribing policies have been associated with decreased prescription opioid overdose death rates in states where these laws have been enacted (27). Based on the survey results and current evidence base, we examined four policies in the PDAPS data: Drug-Induced Homicide Laws, MOUD in Correctional Facilities, Good Samaritan Laws, and Naloxone Overdose Prevention Laws.

Despite increasing popularity of drug-induced homicide laws, research does not support their effectiveness in reducing overdose deaths. Indeed, much research suggests that increased incarceration is not an effective solution to the overdose epidemic; rather, the opposite is true. Increased incarceration is associated with higher rates of drug use and recidivism among drug offenders (28–31). While local prosecutors may perceive drug-induced homicide laws as a means to go after major drug dealing operations, they in fact often result in cases against minor players with SUD. To the extent possible, we recommend that NE RJOI states not enact these policies and aim to roll them back where possible, such as in Vermont, New Hampshire, and Rhode Island. Additionally, drug-induced homicide laws can undermine good policy, namely Good Samaritan laws that are intended to legally protect those who call for emergency. According to a report by the Drug Policy Alliance, the potential impact of drug-induced homicide laws include increased fear, increased racial disparities in the criminal justice system, and reduced access to needed treatment services (10). Indeed, 911 is often not called at the scene of an overdose, often due to fear of police involvement among people who use drugs, sometimes even when a state has a Good Samaritan law (32–36). A prospective cohort study in which individuals (n=351) were trained in naloxone administration and overdose response found that those who were knowledgeable of the state's Good Samaritan law were three times more likely to call 911 at the scene of an overdose (37). Currently, all NE RJOI states have introduced life-saving Good Samaritan legislation intended to encourage bystanders to call 911 at the scene of an overdose, and we recommend that the NE RJOI aim to identify opportunities to educate their communities about these laws as this appears critical to their utilization.

Naloxone is one of the most important tools in the overdose epidemic and, it is important to highlight the consistency in policies providing access to naloxone across the NE RJOI states. In

recent years, all NE RJOI states have expanded access to naloxone among lay responders, and we encourage the NE RJOI stakeholders to consider additional opportunities for distributing this life-saving substance to those at high risk of overdose (e.g., not only through harm reduction and community outreach efforts but also among persons exiting correctional settings). Equally important is assuring that effective treatment is available for individuals following a nonfatal overdose and for OUD as no treatment has proven more effective than MOUD. As illustrated in our analysis of the PDAPS' data, these medications are incredibly under-utilized in criminal justice and correctional settings. According to a report by the National Sheriffs' Association and the National Commission on Correctional Health Care, as of January 2018, 20 states did not offer any form of MOUD for inmates in state correctional facilities, other than for pregnant women (25). Further, of the thousands of local and county jails across the country, less than 200 in the US provide MOUD to inmates (25). The cost of implementation, stigma regarding the use of MOUD, and lack of education regarding MOUD effectiveness may contribute to limited use of MOUD in correctional settings (38,39). Implementing MOUD in correctional facilities is challenging. There are many laws and policies that are provide barriers to allowing the use of MOUD in jails and prisons, such as state laws regarding prescribing practices.

Federal efforts through the State Opioid Response (SOR) and State Target Response Technical Assistance (STR-TA) have assisted in expanding other forms of MOUD; specifically, buprenorphine. As more individuals with OUD become engaged with these medications, they may experience arrests related to relapse, as a result of barriers to treatment and MOUD access. When this occurs, these individuals enter correctional facilities where these medications must be available for continued treatment and care. Recent lawsuits, including those within the NE RJOI states, have continually found that facilities not compliant with MOUD care and treatment violate the American Disabilities Act as well as the Eighth Amendment of the US Constitution (40–42). However, many of the NE RJOI states have greatly improved access to MOUD within their correctional facilities. The NE RJOI is fortunate to have Rhode Island as part of their regional initiative. In 2016, operating as a unified corrections system, Rhode Island implemented MOUD in every jail and prison and experienced a 60.5% decrease in post-release overdose fatalities (17,25). If other NE RJOI states follow Rhode Island, it could not only result in dramatic reductions in overdose deaths but also reduce recidivism and drug-use behavior (43–48). With these potential reductions, the impact at a regional level would also lead to decreases in the national rates.

Baseline Social Network Analysis

In this report we have also provided a baseline description on the nature of the NE RJOI social network. Unsurprisingly, this analysis revealed that the NE RJOI is in the early stages of development and our goal is to monitor the network over time to evaluate the effectiveness of the external facilitation. In total, only 3 percent of total possible relationships are present in the network, where the network will likely become denser over time. Importantly, the current NE RJOI network is largely siloed by state. That is, individuals most often collaborate with others who work in their same state. This too is not surprising, but over time we will assess whether collaborations have developed but also patterns in these collaborations and their impact on the initiative's outcomes. A collaborative approach to tackling the overdose epidemic is essential to understanding challenges faced by other communities or agencies. Further, a multi-agency perspective of the overdose epidemic and its contributing factors is critical in generating innovative strategies to fight the epidemic while also sustaining future partnerships (49). To this end, we recommend the NE RJOI continue identifying and engaging across states to share information but also seek collaborations with new prospective stakeholders. Moreover, we recommend continuing to partner with federal stakeholders both for sustainability but also so the NE RJOI stakeholders can use their collective knowledge and voice to effect change at this level,

as federal changes in drug policies are necessary to achieve sustained improvements in overdose deaths and the treatment of SUD.

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APPENDIX

Glossary of Acronyms

CBHJ	Center for Behavioral Health and Justice
MOUD	Medications for Opioid Use Disorder
NCSC	National Center for State Courts
NE RJOI	New England Regional Judicial Opioid Initiative
NIDA	National Institute on Drug Abuse
OUD	Opioid Use Disorder
PDAPS	Prescription Drug Abuse Policy System
PDMP	Prescription Drug Monitoring Program
RIDOC	Rhode Island Department of Correction
SNA	Social Network Analysis
SOR	State Opioid Response
STR-TA	State Target Response Technical Assistance
SUD	Substance Use Disorder

The Prescription Drug Abuse Policy System Questions by New England RJOI States

Criminal Justice All Questions

Topic		Specific Law and Policy	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Drug Induced Homicide Law	1	Does the state have a specific drug induced homicide law?	No	No	No	Yes	Yes	Yes
	2.	How does the statute classify the charge brought against the accused?				Delivery or Distribution Resulting in Death	Delivery or Distribution Resulting in Death	Delivery or Distribution Resulting in Death
	3.	Mandatory minimum sentence?				No	Yes	Yes
	3.1.	What is the mandatory minimum incarceration period? (if applicable)					Life in Prison	13 - 24 Months
	4.	Is there a mandatory maximum sentence?				Yes	Yes	Yes
	4.1.	What is the mandatory maximum incarceration period? (if applicable)				Life in Prison	Life in Prison	229-240 Months
	5.	Are there mitigating factors that influence sentencing for this statute?				No	No	No
	6.	What are the causation requirements in place under the statute?				But-for Cause	But-for Cause	Proximate/ Contributed to
Incarceration Effects on Medicaid Status	1.	Effect on an individual's Medicaid status upon confinement in jail?	Yes	Yes	Yes	Yes	Yes	Yes
	1.1.	Does the state terminate Medicaid upon incarceration?	Yes	Yes	No	Yes	No	No
	1.2.	Does the state suspend Medicaid upon incarceration?	No	No	Yes	No	Yes	Yes
	1.2.1.	What is the maximum period for which Medicaid can be suspended?			Full term of incarceration		Full term of incarceration	Full term of incarceration
	2.	Effect on an individual's Medicaid status upon confinement in prison?	Yes	Yes	Yes	Yes	Yes	Yes

	2.1.	Does the state terminate Medicaid upon incarceration?	Yes	Yes	No	Yes	No	No
	2.2.	Does the state suspend Medicaid upon incarceration?	No	No	Yes	No	Yes	Yes
	2.2.1	What is the maximum period for which Medicaid can be suspended?			Full term of incarceration		Full term of incarceration	Full term of incarceration
Involuntary Commitment for Substance Use	1	Is substance use disorder grounds for involuntary commitment?	Yes	Yes	Yes	No	No	Yes
	1.1.	Does statute explicitly authorize the civil commitment of substance users?	Yes	No	Yes			No
	1.2.	Is the statute a general mental health commitment law, using broad language to include substance use?	No	No	No			No
	1.3.	Is statute a mental health commitment law with a definition of mental illness that includes substance use?	No	Yes	No			Yes
	2	Is involuntary commitment permitted where an individual is deemed to be a danger?	Yes	Yes	Yes			Yes
	2.1.	What type of danger is grounds for involuntary commitment?	Danger to self, Danger to others	Danger to self, Danger to others	Danger to self			Danger to self, Danger to others
	2.2.	Are additional grounds required for involuntary commitment?	No	No	No			Yes
	2.2.1.	What additional grounds may be required?						Gravely Disabled
	2.3.	Are there grounds other than danger that permit involuntary commitment?	Yes	Yes	Yes			No
	2.3.1.	What other grounds are permitted?	Capacity to seek treatment, Needs Treatment, Gravely disabled	Gravely disabled	Gravely disabled			

	3.	What is the maximum duration of an initial involuntary commitment?	180 Days	120 Days	90 Days			90 Days
	4.	Who can initiate involuntary commitment?	Family, Medical Professional, Designated staff at a treatment facility, Any interested person	Designated staff at a treatment facility	Family, Law Enforcement, Medical Professional, Government Official			Friend, Family, Law Enforcement, Medical Professional, Mental Health Professional, Designated staff at a treatment facility, Any interested person
	5.	Is judicial review of the involuntary commitment required?	Yes	Yes	Yes			Yes
	6.	Is a clinical assessment required to involuntarily commit a patient due to substance use disorder?	Yes	Yes	Yes			Yes
	6.1.	Is the clinical assessment binding on commitment decision due to substance use disorder?	No	No	No			No
	7.	What type of health care professionals can perform an assessment?	MD	MD, PA, NP, Psychologist, Psychiatric RN	MD, Counselor/ Social Worker, Psychologist			MD, Psychiatrist
	8.	Does the individual have a right to counsel at the commitment hearing?	Yes	Yes	Yes			Yes
	9.	Does an extension to an existing involuntary commitment require a court order?	Yes	Yes	No			Yes
	10.	Which of the following rights must be provided to a patient who has been committed due to substance use disorder?	Right to make a phone call, Right to have visitors	Right to have visitors	None			Right to make a phone call, Right to have visitors

	11.	What treatments can be performed without patient consent?	Not specified in law	Receive medication, Restrained, Secluded	Not specified in law			Receive medication, Restrained
	12.	Is there a recommitment process?	Yes	Yes	Yes			Yes
	12.1.	Does it require external review?	Yes	Yes	No			Yes
Medicaid Coverage of Medication Assisted Treatment	1.	Does the State Medicaid program cover MOUD?	Yes	Yes	Yes	Yes	Yes	Yes
	1.1.	Which MOUD medication types are covered by the State's Medicaid program?	Buprenorphine, Naltrexone	Buprenorphine, Naltrexone	Buprenorphine, Naltrexone	Buprenorphine	Buprenorphine, Naltrexone	Buprenorphine, Naltrexone
	2.	What MOUD drugs are included on the preferred drug list?	• Suboxone (Buprenorphine and Naloxone) (film or tablet) • Subutex (Buprenorphine) (tablet) • Vivitrol (Naltrexone) (extended-release)	• Suboxone (Buprenorphine and Naloxone) (film or tablet) • Vivitrol (Naltrexone) (extended-release)	• Suboxone (Buprenorphine and Naloxone) (film or tablet)	• Suboxone (Buprenorphine and Naloxone) (film or tablet) • Subutex (Buprenorphine) (tablet)	• Suboxone (Buprenorphine and Naloxone) (film or tablet) • Subutex (Buprenorphine) (tablet)	• Suboxone (Buprenorphine and Naloxone) (film or tablet) • Vivitrol (Naltrexone) (extended-release)
	3.	What MOUD drugs are included on the non-preferred drug list?	• Suboxone (Buprenorphine and Naloxone) film or tablet	• Bunavail (Buprenorphine and Naloxone) film • Probuphine (Buprenorphine) implant • Sublocade (Buprenorphine extended-release) injection • Subutex (Buprenorphine) tablet • Zubsolv (Buprenorphine	• Bunavail (Buprenorphine and Naloxone) film • Probuphine (Buprenorphine) implant • Sublocade (Buprenorphine extended-release) injection • Suboxone (Buprenorphine and Naloxone) film or tablet • Zubsolv (Buprenorphine	• Bunavail (Buprenorphine and Naloxone) film • Zubsolv (Buprenorphine and Naloxone) tablets	• Bunavail (Buprenorphine and Naloxone) film • Cassipa (Buprenorphine and Naloxone) film • Probuphine (Buprenorphine) implant • Sublocade (Buprenorphine extended-release) injection • Suboxone (Buprenorphine	• Bunavail (Buprenorphine and Naloxone) film • Cassipa (Buprenorphine and Naloxone) film • Probuphine (Buprenorphine) implant • Sublocade (Buprenorphine extended-release) injection

			and Naloxone) tablets	and Naloxone) tablets • Vivitrol (Naltrexone for extended-release) injection		and Naloxone) film or tablet • Zubsolv (Buprenorphine and Naloxone) tablets • Vivitrol (Naltrexone for extended-release) injection	• Suboxone (Buprenorphine and Naloxone) film or tablet • Zubsolv (Buprenorphine and Naloxone) tablets
MOUD in State Correctional Facilities	1. Does the state offer all three FDA-approved medications for MOUD to all state inmates?	No	No	No	No	Yes	No

Naloxone Overdose Prevention Laws All Questions

Topic	Specific Law and Policy	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Naloxone Overdose Prevention Laws	1. Does the jurisdiction have a naloxone access law?	Yes	Yes	Yes	Yes	Yes	Yes
	2. Do prescribers have immunity from criminal prosecution for prescribing, dispensing or distributing naloxone to a layperson?	Yes	Yes	No	Yes	No	Yes
	2.1. Is participation in a naloxone administration program required as a condition of immunity?	No	No		No		No
	2.2. Are prescribers required to act with reasonable care?	No	Yes		Yes		No
	3. Do prescribers have immunity from civil liability for prescribing, dispensing or distributing naloxone to a layperson?	Yes	Yes	No	Yes	No	Yes
	3.1. Is participation in a naloxone administration program required as a condition of immunity?	No	No		No		No
	3.2. Are prescribers required to act with reasonable care?	No	Yes		Yes		No

	4.	Do prescribers have immunity from professional sanctions for prescribing, dispensing, or distributing naloxone to a layperson?	Yes	Yes	No	Yes	Yes	No
	5.	Do dispensers have immunity from criminal prosecution for prescribing, dispensing or distributing naloxone to a layperson?	Yes	Yes	No	Yes	No	Yes
	5.1.	Is participation in a naloxone program required as a condition of immunity?	No	No		No		No
	5.2.	Are dispensers required to act with reasonable care?	No	Yes		Yes		No
	6.	Do dispensers have immunity from civil liability for prescribing, dispensing or distributing naloxone to a layperson?	Yes	Yes	No	Yes	No	Yes
	6.1.	Is participation in a naloxone program required as a condition of immunity?	No	No		No		No
	6.2.	Are dispensers required to act with reasonable care?	No	Yes		Yes		No
	7.	Do dispensers have immunity from professional sanctions for prescribing, dispensing, or distributing naloxone to a layperson?	Yes	Yes	No	Yes	Yes	No
	8.	Are prescriptions of naloxone authorized to third parties?	Yes	Yes	Yes	Yes	Yes	Yes
	8.1.	Is naloxone program participation required for a third-party prescription?	No	No	No	No	No	No
	8.2.	Are prescribers required to act with reasonable care?	No	Yes	No	Yes	No	No
	9.	Are pharmacists allowed to dispense or distribute naloxone without a patient-specific	Yes	Yes	Yes	Yes	Yes	Yes

		prescription from another medical professional?						
	9.1.	How are pharmacists allowed to dispense or distribute naloxone without a patient-specific prescription from another medical professional?	Pharmacist prescriptive authority	Standing order, Protocol order, Naloxone-specific collaborative practice agreement	Standing order	Standing order	Standing order	Standing order, Protocol order
	10.	Is a layperson immune from criminal liability when administering naloxone?	Yes	Yes	Yes	Yes	Yes	Yes
	10.1.	Is participation in a naloxone administration program required as a condition of immunity?	No	No	No	No	No	No
	10.2.	Are laypeople required to act with reasonable care?	Yes	Yes	No	Yes	Yes	No
	11.	Is a layperson immune from civil liability when administering naloxone?	Yes	Yes	Yes	Yes	Yes	Yes
	11.1.	Is participation in a naloxone administration program required as a condition of immunity?	No	No	No	No	No	No
	11.2.	Are laypeople required to act with reasonable care?	Yes	Yes	No	Yes	Yes	No
	12.	Does the law remove criminal liability for possession of naloxone without a prescription?	No	No	Yes	No	Yes	Yes
	12.1.	Is participation in a naloxone administration program required as a condition of immunity?			No		No	No
	12.2.	Is acting with reasonable care required as a condition of immunity?			No		No	No

Good Samaritan 911 Immunity All Questions

Topic		Specific Law and Policy	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Good Samaritan Overdose Prevention Laws	1.	Does the jurisdiction have a drug overdose Good Samaritan Law?	Yes	Yes	Yes	Yes	Yes	Yes
	2.	What protection does the law provide from controlled substance possession?	Arrest, Charge, Prosecution	Arrest, Charge, Prosecution	Charge, Prosecution	Arrest, Prosecution	Charge, Prosecution	Arrest, Prosecution
	3.	What protection, if any, does the law provide from drug paraphernalia laws?	Arrest, Charge, Prosecution	Arrest, Charge, Prosecution	None	None	Charge, Prosecution	None
	4.	Does the law provide protection from probation or parole violations?	No	Yes	Yes	No	Yes	Yes
	4.1.	What protection does the law provide from probation or parole violations?		Protections from arrest or prosecution	Protections from sanctions for violation of probation/ parole		Protection from charge or prosecution	Protections from sanctions for violation of probation/ parole
	5.	Is reporting an overdose considered a mitigating factor in sentencing?	No	Yes	Yes	No	Yes	Yes
	5.1.	For what types of crimes is mitigation permitted?		Controlled substances	Controlled substances		Controlled substances	Controlled substances, Alcohol-related, Other controlled substances and alcohol-related violations

Prescription Opioid-Related Controls All Questions

Topic		Specific Law and Policy	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Direct Dispensing of Controlled	1.	Are Physicians expressly granted the authority to directly dispense controlled substances to patients?	Yes	Yes	Yes	No	Yes	Yes

Substances Laws	1.1.	Are there restrictions on how large of a supply a physician may dispense?	No	No	Yes		No	No
	1.2.	Are there any restrictions on charging for directly dispensed drugs?	No	No	No		No	No
	1.2.1.	How are physicians restricted from charging for drugs?						
	1.3.	Are physicians limited to only dispensing to their own patients?	No	Yes	No		No	No
	1.4.	Are physicians required to provide information to the patient about the availability of drugs elsewhere?	No	No	No		No	No
	1.5.	Are physicians permitted to delegate dispensing to other employees?	Yes	Yes	No		Yes	Yes
	1.5.1.	To whom may a physician delegate direct dispensing?	RN, PA	PA			PA	PA
	1.6.	Are physicians required to register with a state agency or professional board prior to direct dispensing?	Yes	No	Yes		Yes	Yes
	1.6.1.	What board is the physician required to register with?	Department of Consumer Protection		Department of Public Health		Board of Pharmacy	Medical Board
	2.	Are Nurse Practitioners authorized to directly dispense controlled substances?	Yes	Yes	Yes	Yes	Yes	Yes
	2.1.	Are nurse practitioners limited to only dispensing manufacturer samples?	Yes	No	No	No	No	No
	2.2.	Are nurse practitioners required to participate in a written agreement with a physician in order to directly dispense?	No	No	Yes	No	No	No
	2.3.	Are nurse practitioners required to register for direct dispensing?	No	No	Yes	No	Yes	Yes

	3.	Are Physician Assistants authorized to directly dispense controlled substances?	Yes	Yes	Yes	Yes	Yes	Yes
	3.1.	Are Physician Assistants limited to dispensing medications to the extent the supervising physician authorizes?	Yes	Yes	Yes	Yes	Yes	Yes
	4	Are practitioners regulated differently based on the geographic location of their office?	No	No	No	No	No	No
	4.1.	Which office locations are regulated differently?						
	4.2.	How are these offices regulated differently?						
Opioid Prescribing Guidelines for Acute and Emergency Care	1	Has the jurisdiction adopted opioid prescribing guidelines for acute or emergency care?	Yes	Yes	Yes	Yes	Yes	Yes
	1.1.	Through what mechanism were the opioid guidelines adopted?	Statute, Medical board guidelines	Statute, Regulation, Medical board guidelines	Statute	Regulation	Regulation, State department guidelines	Regulation
	2	Has the jurisdiction adopted opioid prescribing guidelines for treating acute pain?	Yes	Yes	Yes	Yes	Yes	Yes
	2.1.	Is there a mandatory penalty for failure to comply with the acute pain guidelines?	No	Yes	No	No	No	No
	2.2.	Can a physician's license be revoked for failing to comply with the acute pain guidelines?	No	No	No	No	No	No
	2.3.	Do the acute pain guidelines recommend or require a prescribing limit?	Recommend	Require	Require	Not addressed	Require	Require except in cases of extenuating circumstances
	2.3.1.	What is the supply limit for prescribing opioid medication for acute pain?	7 days' supply	7 days' supply	7 days' supply		Other	7 days' supply

	2.4.	Do the acute pain guidelines recommend or require that physicians use the lowest effective dose?	Not addressed	Not addressed	Not addressed	Recommend	Not addressed	Recommend
	2.5.	Do the acute pain guidelines require reviewing the state prescription drug monitoring program database for a patient's prescribing history?	No	No	No	Yes	Yes	Yes
	3.	Has the jurisdiction adopted separate emergency department opioid prescribing guidelines for treating pain?	No	No	No	Yes	Yes	No
	3.1.	Is there a mandatory penalty for failure to comply with the emergency department guidelines?				No	No	
	3.2.	Can a physician's license be revoked for failing to comply with the emergency department guidelines?				No	No	
	3.3.	Do the emergency department guidelines require or recommend a prescribing limit?				Require	Require	
	3.3.1.	What is the supply limit for prescribing opioid medication for emergency departments?				7 days' supply	3 days' supply	
	3.4.	Do the emergency department guidelines direct emergency providers to not refill prescriptions?				No	Yes	
	3.5.	Do the emergency department guidelines recommend or require that physicians use the lowest effective dose?				Require	Not addressed	
	3.6.	Do the emergency department guidelines require reviewing the state prescription drug monitoring program database?				Yes	Yes	

Pain Management Clinic Laws	1.	Is there a pain management clinic law?	No Data Available
	2.	What criteria does the jurisdiction use to determine if a practice is subject to the pain management clinic law?	
	3.	Does the jurisdiction require certification for all pain management clinics?	
	3.1.	For how long is the certification valid?	
	3.2.	Are registration fees explicitly required in the law?	
	4.	Does the jurisdiction have requirements for pain management clinic owners?	
	4.1.	Is at least one owner required to be a physician?	
	4.2.	What are the owner requirements?	
	5.	Does the jurisdiction explicitly require the pain clinic to have a medical director?	
	5.1.	Does the law require that a medical director be physically present at the pain clinic site?	
	6.	Does the law have requirements for pain clinic physicians?	
	6.1.	What are the requirements for pain clinic physicians?	
	7.	Does the pain management clinic law provide prescription limitations that must be followed by pain clinic physicians?	
	7.1.	Does the pain management clinic law limit the supply of medication that physicians can prescribe?	
	7.1.1.	What is the maximum supply of medication that physicians can	

		prescribe to a pain management clinic patient?	
	7.2.	Does the pain management clinic law limit the supply of medication that physicians can dispense?	
	7.2.1	What is the maximum supply of medication that physicians can dispense to a pain management clinic patient?	
	8	Does the law explicitly restrict which healthcare practitioners can dispense opioids?	
	8.1.	Which professionals are explicitly authorized to dispense opioids in pain management clinics?	
	8.1.1.	Are these professionals required to have any specific controlled substance training?	
	9.	Is a healthcare practitioner required to perform a physical examination before initiating chronic pain treatment?	
	10.	Does the law require pain management clinics to conduct drug testing?	
	11.	Does the law make reference to discussing alternatives to opioid treatment with the pain management clinic patient?	
	12.	Are pain clinic physicians required to be registered with the PDMP?	
	13.	Are pain clinic physicians required to check the PDMP prior to prescribing opioids?	
	14.	Does the law restrict the method of payment to receive pain management services?	
	15.	Does the law require clinic sites to keep patient records?	

	15.1.	For how many years is the clinic required to retain patient records?	
	16.	Does the law explicitly allow inspections of facilities to ensure compliance?	
	17.	Does the pain clinic law provide explicit penalties for noncompliance?	
	17.1	What are the types of penalties for noncompliance?	

Prescription Drug Monitoring Program All Questions

Topic		Specific Law and Policy	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
PDMP Access and Registration	1.	Does this state have legislation authorizing access by professionals to a PDMP system?	Yes	Yes	Yes	Yes	Yes	Yes
	2.	What professionals have access to the PDMP data?	Prescribers, Dispensers, Regulatory Boards	Prescribers, Dispensers, Regulatory Boards, Medical Examiner/ coroner, person designated by prescriber, patient's authorized legal representative, designated vendors, auditors, Executive Directors, DHHS Medicaid Unit	Prescribers, Dispensers, Regulatory Boards	Prescribers, Dispensers, Regulatory Boards, Medical Examiner/ coroner	Prescribers, Dispensers, Regulatory Boards	Prescribers, Dispensers, Regulatory Boards, Medical Examiner/ coroner
	2.1.	Whose PDMP data does the law allow prescribers to access?	Current patients,	Current patients	Current patients	Current patients	Current patients	Current patients

			Prospective patients					
	2.2.	Whose PDMP data does the law allow dispensers to access?	Current patients	Current patients	Current patients	Current patients	Current patients	Current patients
	3.	Does the PDMP allow delegates to access data?	Yes	Yes	Yes	Yes	Yes	Yes
	4.	Does the law allow patients to access their own PDMP data?	No	Yes	Yes	Yes	Yes	Yes
	5.	Does the law allow in-state law enforcement to access PDMP data?	Yes	No	Yes	Yes	Yes	No
	5.1.	For what purpose does the law allow in-state law enforcement to access PDMP data?	There are no restrictions on law enforcement access to PDMP data		Law enforcement has access for active investigations	Law enforcement must be granted access by issuance of warrant/ judicial finding of probable cause	Law enforcement must be granted access by issuance of warrant/ judicial finding of probable cause	
	6.	Does the law explicitly allow out-of-state law enforcement to access PDMP data?	No	No	Yes	No	Yes	No
	6.1.	For what purpose does the law allow out-of-state law enforcement to access PDMP data?			Law enforcement has access for active investigations		Law enforcement must be granted access by issuance of warrant/judicial finding of probable cause	
PDMP Adminis-tration	1.	Does this state have legislation authorizing a PDMP?	Yes	Yes	Yes	Yes	Yes	Yes
	2.	Which state agency or department is responsible for operating the PDMP?	Consumer protection agency	Department of Health/HHS	Department of Health/HHS	Professional licensing authority (e.g., Pharmacy or Medical Board	Department of Health/HHS	Department of Health/HHS

	3.	How does the law provide funding for the PDMP?	No funding provisions included in the law	Grants	No funding provisions included in the law	Charging fees, Grants, Gifts	Grants	Grants
	4.	Does the law require the PDMP to have an advisory/oversight board?	Yes	No	Yes	Yes	No	Yes
	5.	Does the law require evaluation of the PDMP?	Yes	No	Yes	Yes	Yes	Yes
	6.	How long does the law allow PDMP data to be stored by the administrating agency?	Between 2 to 5 years	5 years or more	No timeframe specified	Between 2 to 5 years	5 years or more	5 years or more
	7.	Is the PDMP permitted or required to identify suspicious or statistically outlying prescribing, dispensing or purchasing activity?	No	Yes	Yes	Yes	Yes	Yes
	7.1.	Is the PDMP permitted or required to take any action if it discovers any suspicious or statistically outlying prescribing, dispensing or purchasing activity?		Must report to prescriber or dispenser	Must report to law enforcement, Must report to professional licensing body, Permitted to report to prescriber or dispenser	Must report to professional licensing body, Permitted to report to prescriber or dispenser	Other	Must report to professional licensing body, Permitted to report to prescriber or dispenser
	8.	Does the law exempt PDMP data from open records or FOIA laws?	Yes	Yes	Yes	Yes	Yes	Yes
	9.	Does the law permit or require PDMP to release de-identified data for research or education?	Yes	Yes	Yes	Yes	Yes	Yes
	9.1.	Is release of the data permitted or required?	Permitted	Permitted	Permitted	Permitted	Permitted	Required
PDMP Implemen-tation Dates	1.	Does this state have legislation authorizing a PDMP?	Yes	Yes	Yes	Yes	Yes	Yes
	1.1.	When was the PDMP enabling legislation first enacted?	6/6/2006	6/23/2003	1/1/1992	6/12/2012	1/1/1978	5/31/2006
	1.2.	When did the PDMP become operational?	7/1/2008	7/1/2004	1/1/1994	9/2/2014	1/1/1979	1/1/2009

	1.3.	When did the PDMP first allow authorized users to access the data?		1/1/2005		10/16/2014		4/1/2009
	1.4.	When did the PDMP start receiving prescription data electronically?	7/1/2008	7/1/2004	1/1/1994	9/2/2014	1/1/2006	1/1/2009
PDMP Reporting and Authorized Use	1.	Does the state have legislation authorizing a PDMP?	Yes	Yes	Yes	Yes	Yes	Yes
	2.	Does this state have legislation requiring dispensers to report data to the PDMP?	Yes	Yes	Yes	Yes	Yes	Yes
	2.1.	How often must dispensers report data to the PDMP?	Between 2 and 6 days	By close of the next business day	Every 7 days	Every 7 days	Between 2 and 6 days	Every day
	3.	What drug schedules are required to be reported to the PDMP?	State Schedule II-V	Federal Schedule II-IV	Federal Schedule II-V	Federal Schedule II-IV	State Schedule II-IV	Federal Schedule II-IV
	4.	Does the state require prescribers to check the PDMP before prescribing controlled substances?	Yes	No	Yes	Yes	Yes	Yes
	4.1.	In what circumstance, is a prescriber required to check the PDMP?	Every patient, every time		All chronic pain patients	All chronic pain patients	All chronic pain patients	All chronic pain patients
	5.	Does the state require dispensers to check the PDMP before dispensing controlled substances?	No	No	No	No	No	No
	5.1.	In what circumstance, is a dispenser required to check the PDMP?						
	6.	Is the PDMP allowed to share data with Medicaid/Medicare?	No	Yes	Yes	No	No	Yes
	7.	Is the PDMP allowed to share data with private insurers?	No	No	No	No	No	No
	8.	Does the law permit the PDMP to share data with other state PDMPs?	No	Yes	Yes	Yes	No	Yes

	8.1.	Does the law impose any of the following restrictions on interstate sharing of PDMP data?		Only if other state has PDMP laws consistent with or similar to this state	Receiving state must allow reciprocity with this state, Must have bilateral memorandum of understanding or data sharing agreement, Only if other state has PDMP laws consistent with or similar to this state	Must have bilateral memorandum of understanding or data sharing agreement		Receiving state must allow reciprocity with this state

Other Drug-Related Topics All Questions

Topic		Specific Law and Policy	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Drugged Driving Laws	1.	Does the state have a drugged driving law?	Yes	Yes	Yes	Yes	Yes	Yes
	2.	Does the state prohibit drugged driving using an under the influence standard?	Yes	Yes	Yes	Yes	Yes	Yes
	2.1.	What drugs are prohibited?	Any drug	Any drug	Marijuana, Narcotic drug, Depressant, Stimulant substance	Any drug, Chemical Substance	Any drug, Controlled Substance	Any drug
	2.2.	Does the law allow a person to claim an affirmative defense?	No	No	No	No	No	Yes
	2.2.1.	Under what circumstances may a person claim an affirmative defense?						No intention of placing vehicle in motion
	2.3.	What are the available penalties for a first time drugged driving offense?	Imprisonment, Probation, Fine, License suspension, Enrollment in drug or alcohol	Imprisonment, Fine, License suspension, Enrollment in drug or alcohol treatment	Imprisonment, Probation, Fine, License suspension, Enrollment in drug or alcohol treatment course	Imprisonment, Fine, License suspension, Enrollment in drug or alcohol treatment course	Fine, License suspension, Enrollment in drug or alcohol treatment course	Imprisonment, Fine, License suspension

			treatment course	course, probation				
	3.	Does the state prohibit operating a vehicle with a threshold amount of a drug in a person's body?	No	No	No	No	Yes	No
	3.1.	What drugs are prohibited?					Any controlled substance	
	3.2.	Does the per se drugged driving law exclude marijuana?					No	
	3.2.1.	Through what mechanism does the state exclude marijuana from the per se drugged driving law?						
	3.3.	Does the per se drugged driving law include marijuana?					Yes	
	3.3.1.	What is the threshold amount of marijuana to be charged with an offense?					Any amount	
	3.4.	Does the law allow a person to claim an affirmative defense?					No	
	3.4.1.	Under what circumstances may a person claim an affirmative defense?						
	3.5.	What are the available penalties for a first time drugged driving offense?					Imprisonment, Fine, License suspension, Enrollment in drug or alcohol treatment course	
Medications for opioid use disorder with Methadone Laws	1.	Does the jurisdiction have a law on the dispensing of methadone for the treatment of opioid use disorders?	Yes	Yes	Yes	Yes	Yes	Yes
	2.	Are there laws regulating the operation of opioid treatment programs (OTPs)?	Yes	Yes	Yes	Yes	Yes	Yes

	3.	Is physician evaluation required for new patient admission?	Yes	Yes	Yes	Yes	Yes	Yes
	3.1.	How soon must the physician evaluate the new patient?	1 day	14 days	14 days	14 days	1 day	14 days
	4.	What is the standard minimum length of dependence permissible for new patient admission into an OTP?	1 year	1 year	1 year	1 year	1 year	1 year
	5.	Are counseling services for admitted patients required at OTPs?	Yes	Yes	Yes	Yes	Yes	Yes
	5.1.	Is there a mandatory patient to counselor ratio in the law?	No	Yes	No	No	No	No
	5.1.1.	What is the standard patient to counselor ratio?		35:1				
	6.	Is treatment planning for admitted patients required at OTPs?	Yes	Yes	Yes	Yes	Yes	Yes
	6.1.	Is periodic review of the treatment plan required by law?	Yes	Yes	Yes	Yes	Yes	Yes
	7.	Is random toxicology testing required?	Yes	Yes	Yes	Yes	Yes	Yes
	7.1.	How many random toxicology tests are required per year?	8	12	15	12	8	8
	8.	Can patients receive approval for take-home medication?	Yes	Yes	Yes	Yes	Yes	Yes
	9.	Does the jurisdiction require a central registry of OTP patients?	No	Yes	No	No	No	Yes

WAYNE STATE
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