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Options for Addressing the Demand Side of the Opioid Epidemic

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Summary

The State of Utah is facing what has been referred to as the most devastating drug epidemic in our nation's history. Its effects are hitting our state especially hard, leading to a loss of six Utahns every single week from opioid overdose. Over the past decade, the Utah Legislature has sought, and will continue to seek, innovative yet proven solutions to address what has truly become the greatest health crisis in a generation.

Opioid outreach efforts are taking place in two categories: (1) supply and (2) demand. Though as a state we have already taken significant steps to address the problem, opioid overdose deaths have continued to increase and the Legislature may want to take additional steps.

Recommendations

1. Deflection of those with substance use disorder (SUD) prior to arrest or contact with the justice system.
2. Funding for family residential treatment programs on an ongoing basis to keep families together and improve outcomes for children.
3. Increasing protection of children in utero and opportunities for follow-up care after birth.
4. Regular audits of all treatment programs receiving state money.

Background

1. **Deflection for those with substance use disorder (SUD) prior to arrest or contact with the justice system.** Utah's justice reform, or Justice Reinvestment Initiative (JRI), [HB 348](#) (2015), provides for greater use of diversion into treatment for those charged with low-level drug offenses. For many struggling with addiction, treatment is complicated by mounting fines and a criminal record, which make it much more difficult to move forward without state assistance and relapse. Deflection reroutes individuals, in very narrow circumstances, with substance use disorder (SUD) prior to arrest or contact with the justice system (see Appendix).
 - a. According to treatment providers, one of the biggest obstacles to employment and self-reliance after the completion of treatment by way of the justice system is the

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problems associated with trying to obtain employment with a criminal record and related fines. Providing more opportunities for treatment *prior* to arrest can have a positive impact on outcomes throughout the community.

- b. Police could serve as a point of contact for individuals seeking help. Substance users can voluntarily contact the police, outreach efforts could be employed or screening could take place upon arrest and charges held in abeyance during the treatment period. Through voluntary contact and outreach efforts, treatment is offered without fear of arrest, and the police provide a referral and transportation to treatment facilities.
 - i. Gloucester, Massachusetts Police Department's [Angel program](#) has been in place since 2015. The town saw a 31% reduction in drug-related crime after the program was instituted. This model has since been [adopted](#) by 260 police departments in 30 states. In a preliminary analysis of 200 participants:
 1. 70% completed treatment and follow-up services, compared to Utah's 2017 average for successful treatment completion of [43.8%](#).
 2. Those who completed experienced a relapse rate of 40%, compared to the average rate of [47%](#) within the first year.
 - ii. [A Way Out](#) in Lake County, Illinois has a fast-track process for those seeking SUD treatment. Anyone can simply walk into any participating police department and ask for help through the program.
 1. Approximately [70%](#) of participants have exceeded the goal for residential retention.
 - iii. [STEER](#) in Montgomery County, Maryland provides police officers with a screening tool to determine eligibility for deflection. Charges can be held in abeyance while the individual is engaged in treatment services.
 1. Too new to evaluate the results.
2. **Funding for family residential treatment programs on an ongoing basis to keep families together and improve outcomes for children.** “... [treatment](#) that supports the family as a unit has proven to be effective for maintaining maternal drug abstinence and child well-being.” According to Diane Moore, Utah Director of the Division of Child and Family Services (DCFS), research indicates that the lowest rates of trauma and best long-term outcome for children occur when efforts are able to create safety for children in their own home without the use of foster care (see Appendix).
 - a. Success rates for these family residential treatment programs are high. Not only do the children benefit from being with a parent, but parents benefit from the relationship as well. The Social Research Institute at the University of Utah is currently in the process of analyzing outcomes for children in SUD residential

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treatment, but no numbers are available at this time. We do know that DCFS's overall [reunification rate](#) for those who left foster care last year was 40%, while the family residential program at Odyssey House has seen:

- i. 85% of families permanently reunited, with the juvenile court awarding permanent custody to the parent and terminating DCFS involvement;
 - ii. 87% parental abstinence from drugs and alcohol one year post treatment;
 - iii. 80% employment among parents one year post discharge versus 0% upon admission;
 - iv. Average monthly income of \$2,800 one year post treatment versus \$300 at admission and
 - v. 0% homeless one year out versus 42% upon admission.
- b. SUD family programs allow diversion for parents who meet very specific criteria, in a residential treatment setting. Families stay together or are reunified while parents, as well as their children, receive counseling and training that will enable them to better function when back on their own as a family. The average family in these programs consists of one parent and 1.7 children.
- i. The current cost, in addition to already accessed funding, is about \$1.3 million per year to serve 40+ families at any given time, in residential treatment lasting 4-6 months.
- c. Treatment providers report that all, or nearly all, program participants are Medicaid-eligible. The Department of Health could be directed to bundle Medicaid reimbursement rates for family programs.
- i. As of November 2017, the Centers for Medicare and Medicaid Services [approved Utah's waiver request](#) to receive reimbursement for short-term residential SUD treatment. The Utah Department of Health has chosen to apply a bundled daily service rate of \$125 to newly-eligible facilities only, which serve the single adult population and none of which serve families. Unlike facilities that serve single adults, family programs have long been supported by Medicaid dollars so have all been set up for a 16-bed maximum capacity. The Department of Health has chosen to keep the reimbursement process the same (per-service) for these smaller facilities as it was prior to the waiver that allowed payment for 17+ bed facilities.
 - ii. Children's healthcare is also paid by Medicaid on a per-service basis and could be bundled (although reimbursements for children under 30 months of age are [very limited](#)).
 1. According to treatment providers, some states already bundle Medicaid payments for children in family residential treatment facilities.

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- d. All additional costs of taking care of children in these settings have previously been paid with one-time state General Fund money, offering no promise of continuity or consistency.
 - i. FY 2019: \$884,900 one-time General Fund
 1. [Original request](#) was for \$1,664,100 ongoing General Fund
 - ii. FY 2016-18: Temporary Assistance for Needy Families (TANF), Salt Lake County, and federal Substance Abuse and Mental Health Services Administration (SAMHSA)
 - iii. As a result of the recently passed Family First Prevention Services Act (2018), Title IV-E federal funds previously directed to foster care can now be used for family residential substance abuse programs at match rates of 50% (for those never removed from the home) and 70% (for those removed and in state custody while in the program). This is the first time federal dollars have been able to be used without removal of the child from the home.
 1. For FY 2019, IV-E Foster Care funds are estimated at [\\$25.7 million](#), or about 14% of the [DCFS budget](#).
 - a. Funding is based on the [eligibility](#) of children in care.
 2. The Division of Child and Family Services (DCFS) is currently working to find solutions to draw down these funds for *prevention* of entry into foster care, which was authorized by the Act with the requirement that only high level, evidence based programs be used. The match rate under these circumstances is 50%. Once DCFS has met all of the requirements to begin drawing down these funds, which could take a number of years, they should:
 - a. direct existing funds toward family treatment programs for that population and/or
 - b. add additional match dollars to expand the use of IV-E funds.
 3. As a part of the Act, DCFS can receive a 70% match rate for children removed from the home and in DCFS custody while in a family residential treatment program starting October 1, 2018. In these reunification cases, there is no requirement for evidence based practices and the state receives a higher match rate than what is available when trying to prevent DCFS custody and foster care placement. In response to this portion of the law, DCFS should serve this population by:
 - a. directing existing funds toward family treatment programs for these children and/or

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- the Division of Substance Abuse and Mental Health (DSAMH) or another entity.
- a. Eighteen states [require physicians](#) to report pregnant women to child protective services (CPS) if they suspect abuse through exposure.
 - b. If notification were made to DCFS in Utah, it would require a change in the definition of “child” in order to cover an unborn child, and could trigger an investigation that could possibly be a disincentive to seeking medical services or reporting a potential problem.
4. Changing the definition of “child” to allow CPS to open an investigation prior to birth might still be worth investigating further.
- a. Vermont allows for a CPS investigation to be opened one month prior to the birth of the child, according to information from DCFS.
5. The state could require physicians to test for drugs when they suspect that a baby is being exposed in utero.
- a. Iowa, Kentucky, Missouri and Oklahoma require doctors to [perform testing](#) when they suspect abuse.
6. A hotline could be established, whereby community members could report suspicions of SUD in pregnant women. As mentioned above, this would probably be most effective as a public health response rather than through DCFS.
- a. Services could be extended on a voluntary basis, as a support and resource to help in creating a plan for the mother and child prior to delivery.
- ii. Outreach or introduction of services in the hospital, when a baby is born addicted or exposed. Hospitals could be directed to either test every child or to test based on consistent, predetermined criteria.
1. Currently, different hospitals respond differently to concerns of drug or alcohol exposure of an infant. Some hospitals test routinely, some do only upon suspicion of use. Once a hospital, after birth, has determined that a child was exposed in utero, either by testing or by the admission of the mother, they *must* call DCFS and report. CPS then performs an assessment to establish the validity of the allegation.
- iii. Coordinated follow-up visits, in the doctor’s office or in-home through a home visiting program.

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1. Currently, children diagnosed with NAS or Fetal Alcohol Syndrome (FAS) automatically qualify for the Baby Watch program, which includes support and services in the home.
2. If DCFS becomes involved in the hospital, coordination with other agencies and treatment services should be a part of the overall strategy.
 - a. According to DCFS, there is no automatic sharing of information between them and the Department of Health regarding services being offered to a particular family or individual. The Legislature could possibly look at options for increasing transparency and data sharing without violating privacy laws.
4. **Regular audits of all treatment programs receiving state money**, by an outside auditing entity, to assess actual rates of success. New and reauthorized money could then be dedicated to programs proven most effective.
 - a. Every year, state money is sought out for new treatment programs. Funds are tight, demand continues to balloon and rates of success are variable. [UCA Section 62A-15-103](#) requires programs to meet certain standards and DSAMH to evaluate their effectiveness and consider their impact, but an outside audit can offer additional valuable perspective, insight and transparency, while ensuring a high level of accuracy and confidence in the results. In order to make best use of the limited funds we have, it is important to determine as clearly as possible where those funds ought to be spent through a thorough analysis done by those not administering the programs themselves. Representative Brad Daw is planning to introduce legislation.

Appendix

Recommendation #1. **Deflection of those with substance use disorder (SUD) prior to arrest or contact with the justice system:**

- In the Angel program, individuals are ineligible for participation if:
 - They have three or more drug convictions;
 - There is an outstanding warrant for their arrest;
 - The officer believes the individual poses a threat to staffers;
 - The individual is a minor and doesn't have guardian consent; or
 - They exhibit signs of withdrawal or other medical condition (sent to hospital).
- Gloucester Police Department Angel program led to the creation of the Police Assisted Addiction and Recovery Initiative (PAARI) to work with enforcement agencies across the country to expand program initiatives.

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- Florida HB 5001 (2016) appropriates funds for naltrexone to treat alcohol or opioid related addiction for individuals with a high likelihood of criminal justice involvement.

Recommendation #2. **Funding for family residential treatment programs on an ongoing basis to keep families together and improve outcomes for children:**

- [Research](#) on the impact of removing children from the home and the ensuing trauma.
- Parents diverted from the criminal justice system.
 - Average cost to incarcerate a woman in Utah is \$40,000/year with state-only funds.
 - According to treatment providers, approximately 70% of these families are engaged in Family Dependency Drug Court, and 95% have court involvement.
- Children diverted from foster care/DCFS custody.
 - Average cost of a child in DCFS custody is \$30,000/year
 - According to treatment providers, the vast majority of these children would be in the foster care system and likely permanently removed from their parents otherwise.
 - According to treatment providers, most of these children struggle with their own mental health and developmental problems as a result of their parents' substance abuse and these concerns are addressed as well through family treatment.

Recommendation #3. **Increasing protection of children in utero and opportunities for follow-up care after birth:**

- Chart of [state laws](#) on reporting substance exposed newborns to CPS (starting on p. 7).
- Kansas and North Dakota allow the mother to be offered services on a voluntary basis (according to DCFS).
- [Alaska](#) connects with mothers at high risk of abusing opioids during pregnancy through Women, Infants, and Children (WIC) with staff trained to screen for substance misuse or abuse.
- Kentucky provides [supplemental grant funding](#) to community substance abuse treatment providers for residential treatment services for pregnant women with evidence-based behavioral health or medically assisted treatment.
- Indiana, through [SB 446](#) (2017), instituted an opioid addiction recovery pilot program for expectant mothers that provides treatment in a residential care facility and home visitation following discharge.

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- From the Utah Department of Health, 8/29/2018:

Figure 1: Number of hospital discharges as a result of complicated pregnancies or births due to a mother's drug dependence, Utah 2002-2014

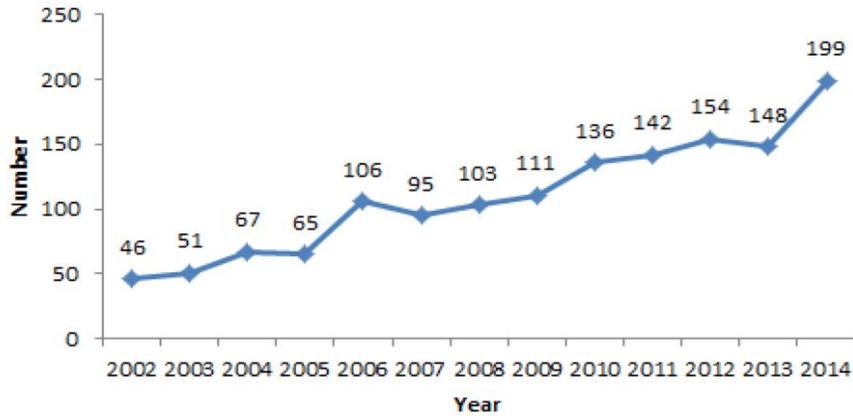
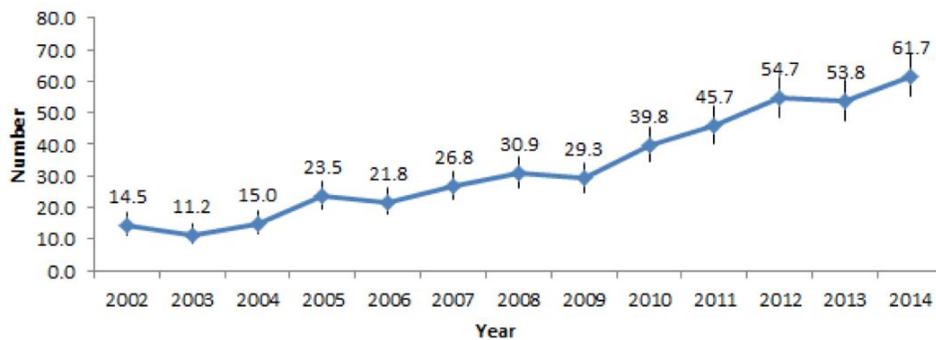


Figure 2: Rate of newborns (birth to 28 days) with NAS (ICD 9 779.5 any diagnosis field) per 10,000 population, Utah 2002-2014



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Figure 3: Number of newborns (birth to 28 days) with NAS (ICD 9 779.5 any diagnosis field), Utah 2002-2014

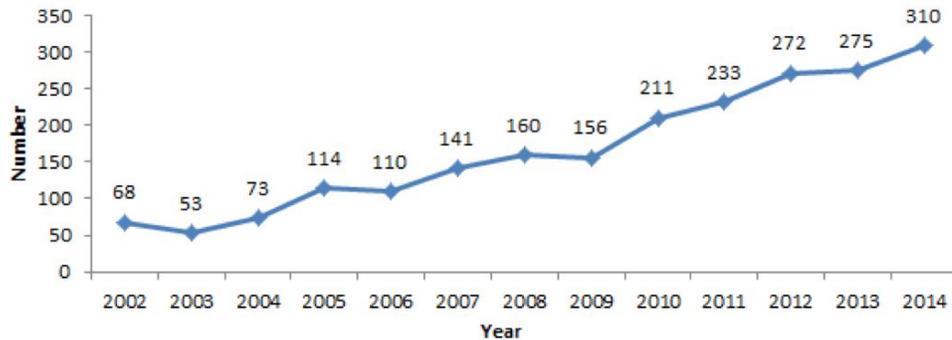
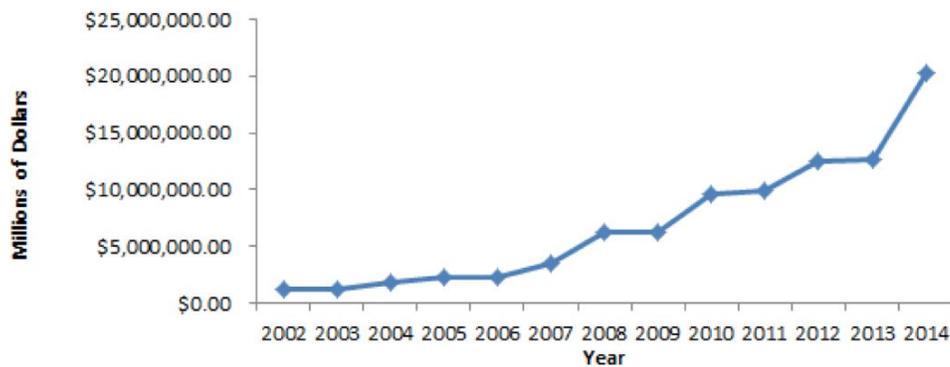


Figure 4: Total charges for newborns (birth to 28 days) with NAS, Utah 2002-2014



From the Division of Child and Family Services, 9/7/2018:

	FY16	FY17	FY18
Total Fetal Exposure and Addiction Cases	678	828	955
Number of Supported Fetal Exposure and Addiction Cases	481	604	676
Outcomes of Supported FE/FA Cases	FY16	FY17	FY18
Voluntary In-Home Services	47	61	51
Court-Ordered In-Home Services	85	93	85
Foster Care	152	191	171
No Ongoing DCFS Services	197	259	369

Other Possible Solutions

1. Pay-for-performance, outcome-based medically assisted treatment (MAT) where a provider could experiment with new and innovative treatments but is only paid by the state if they are successful. Often, MATs are shown to be substantially more effective than traditional treatment alone but are so expensive that they tend to be cost-prohibitive; paying only for success helps mitigate the cost problem and allows for innovation and experimentation. Representative Daw is planning to introduce legislation.
2. Produce more master's level social workers and counselors to be able to handle the influx of newly-insured individuals into the market.
 - a. State schools could be required to open more slots for graduate students in these fields, specifically master of social work and master of science in professional counseling, in order to meet the needs of the community.
 - b. Changes could be made to the treatment delivery model and the use of paraprofessionals to augment professional staff could be promoted and encouraged.
3. Ban the sale of synthetic urine, which is being used to an ever greater degree to thwart drug testing and potentially create risks for the public. At least [18 states](#) have already taken action to ban its sale or use. Representative Eliason is planning to introduce legislation.
4. Testing of children in the vicinity of a drug arrest of a parent.
5. Use of voluntary non-opioid directives to alert practitioners to not prescribe or administer opioids.