



FINAL REPORT

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

State of Indiana
Fall 2016

December 5, 2016

The Honorable Michael R. Pence
Governor of Indiana
Indiana Statehouse
200 W. Washington Street, Room 206
Indianapolis, IN 46204-2797

Dear Governor Pence,

Thank you for the opportunity to serve as Co-Chairs of the state of Indiana Governor's Task Force on Drug Enforcement, Treatment, and Prevention to identify solutions to the growing drug crisis faced by Hoosiers. We commend you for shining a spotlight on this extremely important issue and for the decision to bring together a diverse group of subject matter experts to obtain input from individuals affected by the drug problem.

Pursuant to Executive Order 15-09, the Task Force conducted a series of regional meetings to hear from individuals, families, community and government leaders, treatment providers, medical professionals, and law enforcement officials affected by substance use disorders. This final report is the culmination of the Task Force's work, which includes 19 actionable recommendations for your administration to consider, all of which have already been implemented or are in the process of being implemented.

Substance use disorder is a complex issue and the challenge in Indiana is great, requiring a comprehensive and integrated approach to enforcement, treatment, and prevention. As such, the need for interagency cooperation and stakeholder collaboration is critical. While this challenge is likely to endure, we trust that your legacy will unite us as we move forward to improve the lives of all Hoosiers affected by this problem.

Respectfully,



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Co-Chair of the Governor's Task Force on Drug Enforcement, Treatment, and Prevention



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TABLE OF CONTENTS

I.	Acronyms and Abbreviations	— 5
II.	Executive Summary	— 6
III.	Background	— 7
IV.	Governor’s Task Force	— 11
V.	Substance Use Disorder Enforcement	— 12
	a.	Background — 12
	b.	Indiana’s Response — 13
		i. Criminal Code Restructuring — 13
		ii. Enhanced Penalties for Persons Dealing Drugs — 14
		iii. Problem-Solving Courts — 15
		iv. Indiana Problem-Solving Courts — 16
		v. Children in Need of Services — 17
		vi. Indiana State Police Statewide Drug Interdiction Initiative — 18
		vii. Regional Therapeutic Communities — 18
		viii. Recovery Works — 21
	c.	Enforcement Best Practices Identified by the Task Force — 21
		i. County Drug Courts — 21
		ii. Juvenile Detention Alternative Initiative — 21
		iii. Allen County Criminal Justice Projects & Initiatives — 22
		iv. Grant County Evidence-based Decision Making — 23
		v. Porter County Partnerships & Initiatives — 24
		vi. Anonymous Crime Reporting Hotlines — 24
VI.	Substance Use Disorder Treatment	— 25
	a.	Background — 25
	b.	Indiana’s Response — 25
		i. Coverage for Vulnerable Populations — 25
		ii. Delivery System — 26
		iii. Indiana Neuro-Diagnostic Institute and Advanced Treatment Center — 27
		iv. Medication Assisted Treatment — 27
		v. Workforce Development — 29
		vi. Involuntary Civil Commitment — 30
	c.	Treatment Best Practices Identified by the Task Force — 31
		i. Medicaid §1115 Demonstration Waivers — 31
		ii. Indiana Addiction Hotline — 31
		iii. Indiana Parenting Institute — 32
		iv. Indiana Department of Correction Vivitrol Pilot Program — 32
		v. Eskenazi Health Midtown — 33
		vi. Education for Pharmacists — 33
		vii. Recovery-Oriented Systems of Care Model — 33
		viii. Prescription Guidelines — 33

TABLE OF CONTENTS (continued)

VII. Substance Use Disorder Prevention	— 36
a. Background	— 36
b. Indiana’s Response	— 36
i. Neonatal Abstinence Syndrome	— 36
ii. Prescription Drug Monitoring	— 38
iii. Naloxone Access (Fatality Prevention Strategy)	— 40
iv. Local Coordinating Councils	— 44
c. Prevention Best Practices Identified by the Task Force	— 45
i. Marion County First Responders	— 45
ii. Youth Prevention Programs	— 45
VIII. Next Steps	— 48
IX. Acknowledgements	— 49
Appendix A: Full List of Task Force Recommendations	— 50
Appendix B: Executive Order	— 52
Appendix C: Task Force Member Biographies	— 54
Appendix D: Task Force Meeting Schedule	— 58
Appendix E: 2013 – 2016 Legislation	— 59
Appendix F: ISDH INSPECT Recommendations	— 73
Appendix G: Agency Efforts to Increase Awareness of Aaron’s Law	— 75

I. ACRONYMS & ABBREVIATIONS

AAC: Adult Addictions Clinic

ACAP: Allen County Adult Probation

ACCC: Allen County Community Corrections

ACDS: Allen Criminal Division Services

CARA: Comprehensive Addiction and Recovery Act of 2016

CDC: Centers for Disease Control and Prevention

CHINS: Child in Need of Services

CLIFF: Clean Lifestyle Is Freedom Forever

CMHI: Children's Mental Health Initiative

CSA: Controlled Substances Act

DATA 2000: Drug Addiction Treatment Act of 2000

DMHA: Indiana Division of Mental Health and Addiction

EBDM: Evidence-based Decision Making

ECHO: Extension for Community Healthcare Outcomes

EMS: Emergency Medical Services

FDA: Food and Drug Administration

FSSA: Family and Social Services Administration

HCADC: Hendricks County Adult Drug Court

HIP: Healthy Indiana Plan

ICDA: Indiana Commission to Combat Drug Abuse

ICJI: Indiana Criminal Justice Institute

IDCS: Indiana Department of Child Services

IDOC: Indiana Department of Correction

IEMS: Indianapolis Emergency Medical Services

IJC: Indiana Judicial Center

IMD: Institution for Mental Disease

IMPd: Indianapolis Metropolitan Police Department

INSPECT: Indiana Scheduled Prescription Electronic Collection and Tracking

IOT: Intensive Outpatient Treatment

ISDH: Indiana State Department of Health

LCC: Local Coordinating Council

MAT: Medication-assisted Treatment

NAS: Neonatal Abstinence Syndrome

NDCS: National Drug Control Strategy

NGA: National Governors Association

NTP: Narcotics Treatment Program

OTP: Opioid Treatment Program

PDMP: Prescription Drug Monitoring Program

PI: Purposeful Incarceration

PLA: Indiana Professional Licensing Agency

PMP: Prescription Drug Monitoring

SAMHSA: Substance Abuse and Mental Health Services Administration

SUD: Substance Use Disorder

VCJDC: Vanderburgh County Juvenile Drug Court

II. EXECUTIVE SUMMARY

Following the national trend, Indiana is experiencing an unprecedented crisis of substance use disorders (SUD),ⁱ with 9.19% of adults reporting illicit drug use in the past month and 4.34% of adults reporting nonmedical use (i.e., use by individuals who were not prescribed the drug or a use that does not comply with the prescription) of pain relievers in the past year, consistent with increasing national rates of 9.84% and 4.0%, respectively.¹ Further, nearly six times as many Hoosiers died from drug overdose in 2014 as did in 2000 (twice the national rate), making Indiana residents more likely to die from a drug overdose than an automobile accident. As in many other states, evidence indicates that a sharp increase in nonmedical use of prescription opioid pain medications is a key driver. As these medications have similar chemical properties as heroin, and the latter is often cheaper and easier to obtain, many prescription opioid abusers have also begun using heroin, resulting in further abuse, overdose deaths, and an increase in the incidence of HIV infections associated with needle sharing.

The state has made considerable efforts to combat this crisis in recent years. For example, recognizing that SUD is a driver of incarceration rates, the state successfully made a statutory change to divert addicted, non-violent offenders to community services. In addition, Governor Pence's successful negotiation of the Healthy Indiana Plan (HIP 2.0) waiver is providing expanded coverage to nearly 400,000 previously uninsured Hoosiers. Moreover, implementation of evidence-based prevention measures including, but not limited to, overdose reversal drug access and prescription monitoring have saved lives and reduced the number of people who develop opioid disorders. Despite these efforts, a recent HIV epidemic in rural Southeastern Indiana has shed new light on the state's drug crisis. In 2015, communities in and around Scott County reported an extraordinarily high number of people with new HIV diagnoses. Where only five individuals had been diagnosed with HIV in the entire county over the preceding 10 years, as of November 28, 2016, there have been 210 individuals diagnosed with HIV since the beginning of 2015.

On September 1, 2015, Governor Mike Pence issued

Executive Order 15-09, establishing the Governor's Task Force on Drug Enforcement, Treatment, and Prevention ("Task Force") to identify best practices and make informed recommendations to the administration.² The multi-disciplinary Task Force was designed to assess statewide resources and available programs; "encourage collaboration among agencies[;] and identify local models that may be extended to other areas of the State."³ Through a series of regional public meetings, the Task Force heard public testimony from a variety of stakeholders, including individuals directly affected by SUD, local and state government officials, clinical providers, law enforcement officials, and community leaders. In addition, the Task Force assessed Indiana's capacity to respond to the crisis and reviewed both state and national best practices in the area of SUD enforcement, treatment, and prevention. A full list of recommendations made by the Task Force can be found in Appendix A.

The findings within this report demonstrate the complexity of the disease of addiction and the challenges faced by the state that require a comprehensive and integrated approach to enforcement, treatment, and prevention. Prior to publication of this report, the Indiana General Assembly passed, and Governor Pence signed into law, Senate Enrolled Act 271, which established the Indiana Commission to Combat Drug Abuse (ICCD). The ICCDA will be responsible for coordinating SUD prevention, treatment, and enforcement throughout the state beginning in 2017, transitioning from and building on the work accomplished by the Task Force.

The Commission's efforts will require focused, ongoing attention to evaluate the impact of the Task Force's recommendations, and to continually monitor and implement new solutions to address the issue of SUD across the state. Some of the recommendations outlined in this report will take time to implement, and their success will require that the Commission continue to move forward with a comprehensive and integrated approach, founded on interagency cooperation and stakeholder collaboration.

ⁱ"The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home." Substance Abuse and Mental Health Services Administration. (2015, Oct. 27). *Substance Use Disorders*. Retrieved October 20, 2016, from <http://www.samhsa.gov/disorders/substance-use>.

III. BACKGROUND

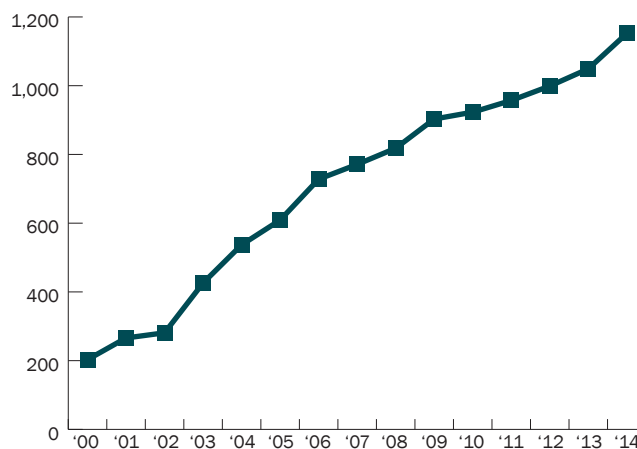
Substance use disorders (SUDs)ⁱⁱ are of great consequence in the United States. In addition to the widely recognized negative health outcomes (i.e., HIV/AIDS, hepatitis, lung disease, and premature death), the consequences of an SUD extend beyond the individual to his/her family, community, and society as a whole.⁷ For example, SUD is identified as a contributing factor in approximately two-thirds of child maltreatment cases; one in three drivers killed in a collision tests positive for drugs; and approximately 60% of criminal offenders test positive for drugs upon arrest.⁸ In addition, the economic impact is considerable, with costs incurred by criminal activity, lost productivity, and increased health care needs together estimated at over \$190 billion annually.⁹

Despite these noted consequences, along with national, state, and local efforts to reduce drug use, in a 2014 survey, one in 10 Americans reported using drugs in the past 30 days, and over three million reported initiating drug use in the past year.¹⁰ Perhaps most concerning, of this group of first-time users, the number reporting nonmedical use (i.e., use by individuals who were not prescribed the drug or a use that does not comply with the prescription) of prescription medications now exceeds those reporting marijuana use (32% and 29%, respectively), illustrating a shift to prescription drugs as a new “gateway drug.”¹¹ And, while the increase in drug use has been relatively modest since 2002 (2% increase), the number of overdose deaths has increased nearly threefold since 2000 (i.e., 17,415 to 47,055), demonstrating a dramatic increase in the risk of death from SUD.¹²

In the state of Indiana, 9.19% of adults report illicit drug use in the past month and 4.34% of adults report nonmedical use of pain relievers in the past year, consistent with increasing national rates of 9.84% and 4.0%, respectively.¹³ Further, the state has experienced a consistent increase in total overdose deaths (i.e., heroin, prescription opioids, benzodiazepines, psychostimulants, and other unspecified narcotics and drugs).¹⁴ As illustrated by Figure 1, nearly six times as many Hoosiers died from drug overdose in 2014 as did in 2000.¹⁵

Further, while the national overdose rate has nearly tripled during this same period, the rate in Indiana has increased

FIGURE 1: Total Overdose Deaths, Indiana, 2000-2014¹⁶



at nearly twice the national rate.¹⁷ Indiana residents are currently more likely to die from a drug overdose than an automobile accident.¹⁸ Evidence indicates increased heroin and prescription opioid overdoses are driving this increase, and the following section describes how the connection between these two drugs is a contributing factor.

A. THE BIOLOGY OF ADDICTION

It can be extremely difficult to understand how or why people become addicted to drugs, alcohol, or substances. Addiction is a chronic brain disease that causes persistent changes in the brain's structure and function, reducing an individual's control over intense impulses.¹⁹ These changes in the brain result in compulsive efforts to seek out one's drug of choice despite the harmful consequences.²⁰ At the height of addiction, many people with opioid use disorder simply cannot help themselves.²¹ Narcotic drugs in particular contain chemicals that engage the brain's “communication system” and disrupt the manner in which nerve cells send, receive, and process information.²² Specifically, narcotics stimulate the release of the brain's natural “chemical messengers,” or neurotransmitters, that affect pleasure or reward sensors in the brain.²³ Other drugs, such as methamphetamine, also cause the brain to release abnormally large amounts of naturally produced neurotransmitters and create intense feelings of pleasure.²⁴ As a person continues to abuse these drugs, the brain adapts by diminishing the neurotransmitters' impact, thereby

ii. “The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.” Substance Abuse and Mental Health Services Administration. (2015, Oct. 27). *Substance Use Disorders*. Retrieved October 20, 2016, from <http://www.samhsa.gov/disorders/substance-use>.

reducing one's ability to enjoy not only the drug, but other life events as well.²⁵ This decreased effect compels further abuse; however, larger amounts of the drug are required to achieve the same high (i.e., drug tolerance).²⁶

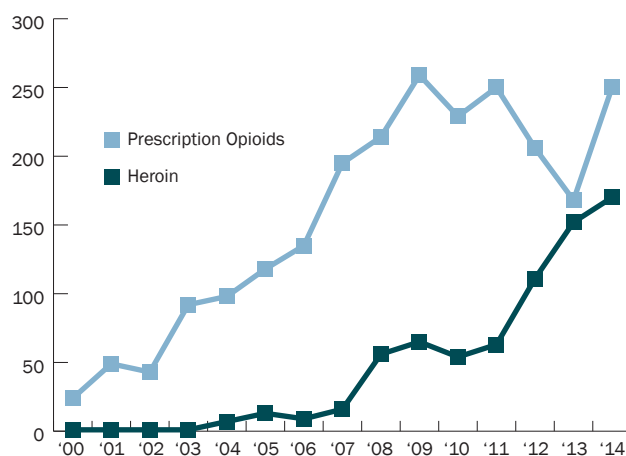
B. PRESCRIPTION OPIOIDS AND HEROIN ABUSE

Americans use prescription medications at a higher rate than any other nation, representing only 5% of the world's population yet consuming 75% of the world's prescription drugs.²⁷ While these consumption figures are alarming in their own right, perhaps more alarming is the country's consumption of opioid prescriptions. In 2016, the United States Department of Health and Human Services reported that on an average day, over 650,000 opioid prescriptions are dispensed in the United States and nearly 4,000 people initiate nonmedical use or diversion of a prescription opioid.²⁸ Diversion of prescription drugs is now the second highest form of illicit drug use in the United States, second only to marijuana.²⁹ Further, treatment demand for prescription opioids in the United States has been rising at a rate far exceeding heroin-related treatment demand.³⁰ Indiana in particular reported the ninth highest rate of opioid prescriptions per capita in the United States in 2012 and the fifth highest rate of diversion in the country.³¹ In 2013, the number of opioid prescriptions dispensed for Medicare beneficiaries was higher than the national average in 80% of Indiana counties, and the number of opioid prescriptions for Indiana Medicare beneficiaries exceeded the total county general population in 12 counties.³² These figures are likely to be considerably higher when including opioid prescriptions paid for by private insurance and Medicaid.

Though individuals often assume prescription pain medications are safer than illicit drugs, they may result in severe adverse health effects (i.e., addiction, overdose, and death), particularly when taken for reasons or in ways or amounts not intended by the prescriber, or when taken for nonmedical use.³³ There is a growing body of research to suggest that patients who become addicted to prescription opioids are increasingly turning to heroin use because it is cheaper and easier to obtain.³⁴ To illustrate this point, four out of every five new heroin users report starting out abusing prescription pain medications and, in 2014, 94% of those in opioid addiction treatment reported having switched to heroin because prescription opioids were "far more expensive and harder to obtain [than heroin]."³⁵ The connection between opioid prescriptions and heroin is further demonstrated in Figure 2,ⁱⁱⁱ showing the number of prescription opioid overdose deaths increased tenfold

between 2000 and 2014, while the number of heroin overdose deaths increased by nearly 25 times during the same relative period.³⁶

FIGURE 2: Heroin v. Prescription Opioid Overdose Deaths, Indiana, 2000-2014³⁷



The increase in the demand for heroin has led to the use of highly toxic heroin adulterants such as fentanyl and Carfentanil in certain markets, which often result in overdose and death.³⁸ Most recently, in August 2016, there were more than 78 overdoses and two deaths reported in Cincinnati, Ohio, during a two-day period.³⁹ During this same timeframe, at least 15 overdoses, one of them fatal, were observed in neighboring Indiana counties, some 90 miles away.⁴⁰ Though not immediately clear whether overdoses in the two states were connected to the same supply of adulterated heroin, officials in Ohio have since reported drug seizures linked to some combination of heroin, fentanyl, and Carfentanil, while officials in Indiana have reported additional overdoses from Carfentanil-laced heroin that came from Cincinnati.⁴¹

Prescription opioid addiction has led to an increase in drug-related crime ranging from prescription forgeries, the most common origin of diverted opioid pain medications, to pharmacy robberies.⁴² In Indiana, there were 175 completed pharmacy robberies in 2015 (predominantly oxycodone and hydrocodone), resulting in a loss of over \$500,000 in legal sales.⁴³ This figure represents more pharmacy robberies than the entire state of California, which has six times the population of Indiana.⁴⁴ Of the total pharmacy robberies in Indiana, three quarters occurred in Marion County alone, with 17 pharmacies robbed three times, three pharmacies robbed four times, and four pharmacies robbed five times.⁴⁵ As a result, many pharmacies have taken measures to improve security, such as armed guards and keeping opioid medications in time-release safes.⁴⁶

ⁱⁱⁱ Note, there were fewer than five heroin overdose deaths reported from 1999 through 2003.

C. METHAMPHETAMINE ABUSE

Although heroin and prescription opioid use currently are the most immediate substance use-related threat to Indiana, methamphetamine use remains an extremely important public health concern. Methamphetamine is a highly addictive stimulant that can be produced using common household ingredients.⁴⁷ Although most of the methamphetamine used in urban areas comes from large-scale production in areas such as Mexico and California, some of the methamphetamine used in Indiana is manufactured locally in crude laboratories (i.e., “meth-labs”) built in home kitchens, garages, and other small areas, often including “rolling” labs concealed in motor vehicles.⁴⁸ The production of methamphetamine creates highly combustible compounds that can cause fires and explosions, presenting a severe health risk to all in the vicinity, including children living in a home used for methamphetamine production. Between 2003 and 2013, the number of children involved in meth-lab incidents increased by nearly fourfold (from 125 to 458).⁴⁹ The health risk from meth-lab incidents extends to law enforcement and other first responders as well, with over 100 Indiana law enforcement officers suffering injuries over the past 15 years.⁵⁰

As pseudoephedrine, a chemical precursor in the manufacture of methamphetamine, is found in many over-the-counter nasal and sinus medications, there have been a series of federal and state-level regulatory restrictions placed on its sale in recent years.⁵¹ At the federal level, the “Combat Methamphetamine Epidemic Act of 2005” was enacted to ban over-the-counter sales of cold medicines containing pseudoephedrine and require daily sales limits, 30-day purchase limits, sales logbooks, verification of customer identification, employee training, and self-certification of regulated sellers.⁵² Prior to passage of these safeguards, in 2014, Indiana reported the highest number of meth-lab seizures in the country (1,471), over 400 more seizures than the next highest state.⁵³ In 2016, the Indiana General Assembly passed, and Governor Pence signed into law, two specific pieces of legislation to further regulate access to pseudoephedrine. First, House Enrolled Act 1157 requires Indiana retailers to record pseudoephedrine purchases in the State’s electronic National Precursor Log Exchange to prevent excessive purchasing.⁵⁴ Second, Senate Enrolled Act 80 allows a pharmacist to deny the sale of ephedrine or pseudoephedrine on the basis of the pharmacist’s professional judgment, and provides the pharmacist with civil immunity for making such a denial.⁵⁵

D. INDIANA HIV EPIDEMIC

In spring 2015, a unique form of SUD became the catalyst

for a public health crisis in rural southeastern Indiana, primarily in and around Scott County. Where only five individuals had been diagnosed with HIV in the entire county over the preceding 10 years, 135 cases were diagnosed between late January and mid-April, and almost all of these individuals were co-infected with hepatitis C virus (HCV).⁵⁶ The majority of cases were linked to syringe-sharing partners injecting oxycodone, a prescription opioid.⁵⁷ Specifically, of those diagnosed, 108 (80.0%) reported injection drug use (IDU), four (3.0%) reported no IDU, and 23 (17.0%) had not been interviewed to determine IDU status.⁵⁸ Among those reporting IDU, all reported dissolving and injecting tablets of oxycodone as his/her drug of choice, though some reported having injected other drugs, including methamphetamine and heroin.⁵⁹ Only 10 (7.4%) female patients were identified as commercial sex workers.⁶⁰ As of November 28, 2016, the Indiana State Department of Health reported a total of 210 individuals testing positive for HIV in Scott County.⁶¹

The Scott County HIV epidemic was met with swift response from state officials. On March 26, 2015, Governor Pence declared a public health emergency in Scott County, ordering the state to coordinate a multi-agency response and provide additional resources and tools to address the outbreak.⁶² Specifically, the declaration allowed state agencies to provide free, rapid HIV and HCV testing, as well as referrals to medical care and HIV Care Coordination services; establish an incident command center in Scott County to coordinate HIV and SUD treatment; launch a medical clinic to assist with individual care; provide resources and support to help individuals sign up for Healthy Indiana Plan (HIP 2.0) to gain access to SUD treatment and other needs as determined; and create and implement a public education awareness campaign focused on SUD treatment, safe sex, needle disposal, and HIV testing and treatment.⁶³ Recent survey results indicate a decline in the sharing of needles (18% to 2%) and other injection equipment such as spoons and filters (24% to 5%).⁶⁴

In addition to direct services and public awareness, the declaration authorized Scott County officials to take actions necessary to contain the epidemic, including a targeted needle exchange program, which at the time Governor Pence issued his Executive Order was not permitted in Indiana.⁶⁵ In May of 2015, the Indiana General Assembly also passed, and Governor Pence signed into law, Senate Enrolled Act 461, which authorizes the State Health Commissioner to declare a public health emergency; sets forth conditions in which a local health department, a municipality, a county, or a nonprofit organization may operate a syringe exchange program; and expires the authorization of such a program on July 1, 2019.⁶⁶ The bill also provides exceptions to

certain criminal laws concerning the funding, possession, and distribution of needles and syringes; however, no federal or state funds are made available to support the development, implementation, or evaluation of syringe access programs.⁶⁷

Preliminary research indicates that injection behaviors have changed over time for those using the Scott County needle exchange program.⁶⁸ Specifically, needle sharing among participants declined 85% between the first and most recent visits, with the frequency of reusing the same syringe also declining significantly.⁶⁹ Further, the number of syringes returned and distributed both increased significantly.⁷⁰ Despite these favorable indicators, participants also reported injecting drugs more often between their first and latest trips to the exchange, with the median injection frequency rising from five to nine times per day.^{71*}

Though originally set to expire on May 24, 2016, the Scott County needle exchange program has been extended through May 24, 2017.⁷²

The law enforcement community has also realized considerable success pursuing suspected persons dealing drugs in Scott County. For example, in early February 2016, federal, local, and state authorities served several search warrants and took 10 people into custody in connection with a large-scale criminal organization targeting Scott County and flooding the area with methamphetamine and prescription pain medications.⁷³ This coordinated, multi-agency effort also resulted in confiscation of over \$35,000, 12 guns, and one pound of meth and other prescription drugs.⁷⁴ As the operation had ties to a local car business, it was also raided and all of the vehicles were seized.⁷⁵ The individuals indicted were accused of a variety of charges from dealing prescription pills and other illegal drugs to supplying narcotics, which could result in sentences from 10 years to life in prison.⁷⁶ Warrants were also served concurrently in Detroit and Louisville in connection with the investigation, which started in June 2015, when officials began working together to find the source of drugs

linked to the HIV outbreak.⁷⁷

The Scott County epidemic also highlights the complexity of SUDs and reveals an alarming incidence of prescription opioid abuse in Indiana's rural communities. This is not surprising given research suggesting the embracing social structures and large elderly populations often associated with rural communities—factors thought to help protect the community from inner-city problems like SUD—may have made these communities more susceptible to prescription opioid abuse.⁷⁸ Specifically, individuals living in rural areas report being more closely related to members of their social network than individuals in urban areas, and are more likely to engage with geographically close family members.⁷⁹ Further, many rural residences include one or more elderly adults, a group with higher rates of chronic pain and more likely to use prescription pain medications.⁸⁰ As a result, prescription opioids are often present in rural homes and readily accessible to extended family members, correlating to existing research indicating that most prescription pain medications used are obtained from family members and friends.⁸¹

It is important to understand that many of the underlying factors contributing to the HIV outbreak in Scott County continue to exist throughout Indiana. For example, the social factors leading individuals to seek drugs, including unemployment, stress, depression, and peer pressure, are not isolated to Southern Indiana. Further, prescription medications are readily available in many communities. Finally, as discussed later in this report, current SUD treatment services in Indiana are often insufficient to meet the growing need. The Centers for Disease Control and Prevention analyzed these (and other) factors to identify counties across the United States at highest risk of an HIV outbreak.⁸² Although the final study is forthcoming, preliminary reports include a number of counties in southeastern Indiana.⁸³

* See updated information on the next page in letter from the CDC.



Public Health Service
DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Disease Control and Prevention (CDC)

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August 23, 2017

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Dear Director McClelland,

CDC is grateful for the work of this Commission and for its leadership in reducing injurious opioid use in Indiana. We want to ensure the Commission has the best available data to inform its recommendations and actions. To that end, CDC wishes to clarify certain preliminary results of a study we conducted of the syringe services program (SSP) in Scott County; specifically the finding that persons using the SSP increased their median daily number of injections from five to nine as this program was getting started. In the Commission's Task Force Final Report published in the fall of 2016, these results were unfortunately mischaracterized as evidence that the SSP had led to increased drug use.¹ This conclusion is erroneous as described below. CDC respectfully asks the Commission to consider revising this error in the Task Force's 2016 report and adding this letter to the official record to ensure correct characterization of these data when they are referenced in the report.

The study in question was designed to assess the impact on injection behaviors of a first-of-its-kind emergency SSP established in Scott County during the 2015 HIV and hepatitis C outbreak in that county. This study and another, which occurred very early in the outbreak investigation, were conducted jointly by Scott County Health Department, the Indiana State Department of Health, Indiana University, and the U.S. Centers for Disease Control and Prevention. In the first study, scientists measured self-reported changes in injection behavior among 148 persons who injected drugs (PWID) before and after they enrolled in the SSP. In the second study, scientists conducted qualitative in-depth interviews with 56 PWID in Scott County to provide context for the changes measured in the first study and to better understand how the drug of choice in this community, OPANA® ER, was being used.

The first study found strong evidence that after joining the SSP, access to sterile injection equipment significantly decreased unsafe injection behaviors that could transmit HIV and hepatitis C. The second study showed that in this context, drug use among PWID who joined the SSP remained essentially stable. Five of 56 people interviewed had reduced or discontinued drug use, and only one person reported increased drug use due to tolerance and increasing need.

1. Final Report, Governor's Task Force on Drug Enforcement, Treatment, and Prevention, State of Indiana, Fall 2016
http://www.in.gov/gtfdetp/files/Governors_Drug_Task_Force_Final_Report.pdf, page 10

CDC and our colleagues also learned that the number of times PWID in Scott County injected themselves was extremely high, on average 10-15 times per day, and in one extreme example up to 35 times per day. This high injection frequency was caused in large part by a chemical added by OPANA® ER's manufacturer to deter misuse of the drug through snorting or injection. The presence of this chemical deterrent made it difficult to dissolve OPANA® ER tablets. To dissolve tablets in a cooker to create a solution for injection, PWID often needed to add more than 100 cc of water, a volume that exceeded the capacity of the 100 cc syringes used most often in this community and in the U.S. To inject this entire drug-containing solution required administering more than one injection per each injection episode. Further, the process for dissolving OPANA® ER tablets left behind a visible residue in the cooker, which many PWID believed contained leftover drug. This residue prompted PWID to add more water to dissolve the residue, creating an additional dose that was then injected. Thus at each injection episode, PWID were injecting themselves 1-4 times. This is a very atypical practice. Other injected drugs, such as heroin, can be administered with a single injection. Due to OPANA® ER's short duration of action when injected (half-life 3-4 hours), PWID also had to inject frequently to prevent experiencing withdrawal symptoms, further adding to the total daily number of injections to which PWID were exposed.²

As CDC and our colleagues began to synthesize the data from these two studies, we recognized a paradox. Namely, during the first few months after the SSP was activated (and as described at a major international meeting of infectious disease experts in October 2015³ and cited in the Task Force's 2016 report) clients reported that their number of daily injections increased from five to nine. Yet our in-depth interviews indicated that drug use among PWID had remained stable during this time.

We now recognize that the data about number of injections in fact substantially underestimated PWID's true injection frequency. We have learned that this underestimation resulted from misunderstandings among both SSP staff and clients. At the SSP's outset, staff did not initially know (and would not have been expected to know based on available evidence at the time) that more than one injection took place each time a PWID injected OPANA® ER. They asked PWID how many times a day they injected in order to calculate the appropriate number of needles/syringes to dispense. As the SSP program matured, staff began to recognize that PWID were injecting multiple times at each injection episode. As a result, SSP staff improved their assessment of clients' needle/syringe needs by counting not just injection episodes but also number of injections per episode. SSP clients did not realize that sterile equipment was necessary for every injection, not just each time they used drugs; indeed, enrolling in the SSP may have been the first time many clients assessed their actual usage.

With time and experience, SSP staff helped clients understand that to achieve truly safe injection 100% of the time, clients needed to report a number of injections equal to the total number times they injected themselves with a needle each day. The increase in injection frequency from five to nine times per day that we observed during the first weeks the SSP's operation reflects this collective learning curve.

As stated on page 10 of the Task Force's 2016 report, "Despite these favorable indicators, participants also reported injecting drugs more often between their first and latest trips to the exchange,

2. The well-intentioned action by the manufacturer to deter abuse of OPANA® ER inadvertently increased public health risk and fueled the rapid spread of HIV in Scott County. As a result, the Food and Drug Administration recommended OPANA® ER be removed from the U.S. market and the manufacturer has complied

3. See: <https://idsa.confex.com/idsa/2015/webprogram/Session7425.html>. Also listed as reference #73 in the Task Force's Final Reports

with the median injection frequency rising from five to nine times per day.” This conclusion is incorrect. Rather, the apparent increase is most consistent with improved assessment of SSP clients’ injection frequency in an environment where we were learning that the true injection frequency was unprecedentedly high. PWID reported that their drug use remained stable, consistent with the well-established fact that SSPs do not increase drug use.^{4,5,6} As highlighted in the 2016 report from the U.S. Surgeon General, “Evaluation studies have clearly shown that needle/syringe exchange programs are effective in reducing HIV transmission and do not increase rates of community drug use.” We do not believe these data on injection frequency when considered in their full context are evidence to the contrary.

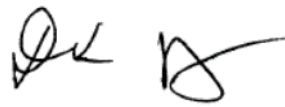
CDC hopes that this letter clarifies our finding that as the SSP in Scott County began operation, the apparent increase in injection frequency used to determine clients’ needle/syringe needs in no way indicated increased drug use among PWID accessing the program.

CDC welcomes any questions that you, the Commission, or its Task Force have regarding these studies. The findings have been compiled into a number of scientific papers that are in process of undergoing peer-reviewed publication.

Sincerely,



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4. U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016

5. Wodak A, Cooney A. Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. *Substance use & misuse* 2006;**41**:777-813.

6. Groseclose SL, Weinstein B, Jones TS, Valleroy LA, Fehrs LJ, Kassler WJ. Impact of increased legal access to needles and syringes on practices of injecting-drug users and police officers-Connecticut, 1992-1993. *JAIDS Journal of Acquired Immune Deficiency Syndromes* 1995;**10**:82-89.

IV. GOVERNOR'S TASK FORCE

On September 1, 2015, Governor Mike Pence issued Executive Order 15-09 (See Appendix B), establishing the Governor's Task Force on Drug Enforcement, Treatment, and Prevention ("Task Force") to serve as an advisory body reporting directly to the Office of the Governor.⁸⁴ This multi-disciplinary group was comprised of the following:⁸⁵

- Representative of the Governor's Office
- Commissioner of Indiana State Department of Health
- Commissioner of Indiana Department of Correction
- Director of Indiana Department of Child Services
- Superintendent of Indiana State Police
- Secretary of Indiana Family and Social Services Administration
- Chief Medical Consultant of Indiana State Department of Health
- One representative from the Indiana Prosecuting Attorneys Council
- One representative from the Indiana Supreme Court
- One physician with expertise in treatment and addiction
- One representative of the Indiana Sheriffs' Association
- One judge recommended by the Chief Justice of the Indiana Supreme Court
- One representative of the Indiana Association of Chiefs of Police
- One representative of the emergency medical services community
- One representative of faith-based and community outreach
- One representative from the Indiana Minority Health Coalition
- One representative from the insurance industry
- Four members of the Indiana General Assembly

Specific members appointed by and serving at the pleasure of the Governor are noted on Page 2 of this report and member biographies are provided in Appendix C.

The purpose of the Task Force was to "identify solutions to Indiana's drug problem that consider the many factors and stakeholders involved in combating drug abuse, including the areas of law enforcement, prevention, and treatment."⁸⁶ The Task Force was also designed to assess resources and programs available statewide, "encourage collaboration among agencies, and identify local models that may be extended to other areas of the State."⁸⁷ In order to accomplish its mission, the Task Force was directed to:

- (1) evaluate existing drug abuse resources and existing drug abuse commissions across the state;
- (2) identify effective strategies so federal, state, and local law enforcement can partner together to combat drug abuse;
- (3) analyze available resources for treatment and identify best practices for treating drug addiction; and
- (4) identify programs and policies that are effective in preventing drug abuse, including early youth intervention programs.⁸⁸

The Governor's Executive Order also directed the Task Force to hold regional meetings across the state (See Appendix D) beginning fall 2015, to hear from local government leaders, SUD treatment providers, medical professionals, law enforcement, community leaders, and others affected by SUD.⁸⁹ A total of 12 meetings were held around the state, many of which included opportunities for public testimony.

V. SUBSTANCE USE DISORDER ENFORCEMENT

Traditional law enforcement efforts have been, and will continue to be, a vital component of any drug policy; however, incarceration alone does not adequately address, treat, or prevent the complex realities of drug addiction and its mental health, public health, and public safety consequences. While drug enforcement strategies must continue to address serious drug-related crime and violence, proponents of comprehensive modern drug policy recognize the need for enforcement methods that are commensurate with an individual's criminal actions.

A. BACKGROUND

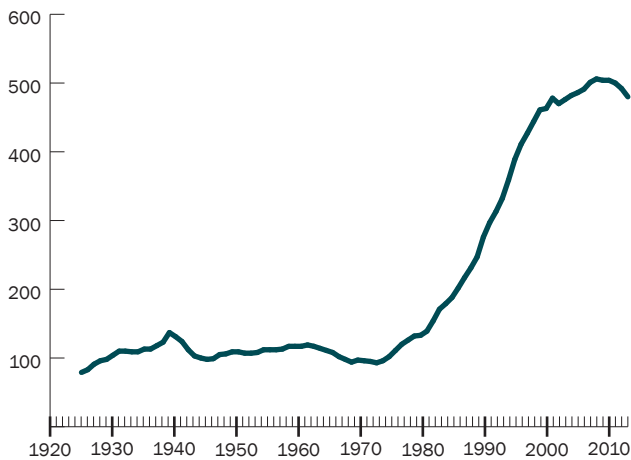
Data from the Bureau of Justice Statistics suggests that between 1925 and 1972, the combined state and federal imprisonment rate, excluding jails, fluctuated around 110 per 100,000 population.⁹⁰ Following this near 50-year period of relative stability, the rate grew rapidly and continuously, increasing annually by six to eight percent through the year 2000.⁹¹ While slowing somewhat over the next decade, by 2012 the rate was 471 per 100,000—over four times the historical average.⁹² Adding jails, the rate totaled 707 per 100,000 in 2012.⁹³ In terms of absolute numbers, U.S. penal

population growth has been extraordinary, increasing by more than 1.9 million people since 1972, to a total of 2.23 million in 2012.⁹⁵

Among the main and proximate drivers of the growth in the imprisonment rate over the past 40 years has been an increase in adjudicating drug crimes.⁹⁶ In the early 1970s, the U.S. government began increasing drug enforcement and enhanced international interdiction efforts.⁹⁷ This led to the enactment of the Controlled Substances Act (CSA), which placed the control of select plants, drugs, and chemical substances under federal jurisdiction.⁹⁸ The CSA established the statutory framework for federal regulation of production, possession, and distribution of controlled substances; however, each state has its own statutory framework for drug enforcement and the majority of drug crimes are dealt with at the state level.^{iv}

Following enactment of the CSA, the drug arrest rate grew sharply, particularly over the course of the 1980s, when the arrest rate for possession and use offenses^v increased nearly 90%.⁹⁹ Note, in Indiana, illegal drug use itself is not a crime; only possession and delivery are crimes. Following a brief two-year decline in the early 1990s, the drug arrest rate continued to grow, peaking in 2006 at 162% above the 1980 level.¹⁰⁰ In 2009, 1.6 million arrests were reported for drug related crimes.¹⁰¹ This increase, coupled with state and federal laws establishing greater structure in sentencing through specified guidelines for each offense, mandatory-sentencing laws, and repeat offender laws (i.e., “three strikes” laws), led to significant increases in incarceration rates. As of 2014, 50% (95,800) of sentenced offenders in federal prison were serving time for drug offenses, representing half of all male offenders and more than half of all female offenders.¹⁰² Further, nearly 16% of all state offenders in 2014 were convicted of drug violations (208,000 offenders), including 24% of all females in state prison (22,000 offenders) and 15% of all males in state prison (186,000 offenders).¹⁰³

FIGURE 3: Federal Incarceration Rate (per 100,000 resident population)⁹⁴



^{iv} To put this in perspective, in 2012, the U.S. Drug Enforcement Administration arrested 30,476 suspects for federal drug offenses while state and local law enforcement arrested 1,328,457—these figures include over 38,000 Hoosiers. Congressional Research Service. (2014). *Drug Enforcement in the United States: History, Policy, and Trends*. Washington, DC; Indiana Prevention Resource Center at Indiana University Bloomington. (2016). *Alcohol and Drug Related Arrest Data*. Retrieved May 13, 2016, from [www.drugs.indiana.edu](http://www.drugs.indiana.edu/main/GIS_table.php?page_group=21&tablename=Intro2.2): http://www.drugs.indiana.edu/main/GIS_table.php?page_group=21&tablename=Intro2.2

^v While drug law violations related to possession or sales account for the most common type of offense, drugs and crime are directly and highly correlated, and serious drug use can amplify and perpetuate preexisting criminal activity. As a result, drugs are often directly implicated in other crimes (e.g., theft or prostitution) or offenses related to a lifestyle that predisposes the drug user to engage in illegal activity (e.g., through association with other offenders or illicit markets). Moreover, “[i]ndividuals who use illicit drugs are more likely to commit crimes, and it is common for many offenses, including violent crimes, to be committed by individuals who had used drugs prior to committing the crime, or who were using at the time of the offense.” National Institute on Drug Abuse. (2014). *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (NIH Publication No. 11-5316).

The increase in imprisonment of drug offenders has helped drive the explosive overall growth in United States corrections expenditures, which in 2010 totaled more than \$80 billion as compared to \$17 billion in 1980.¹⁰⁴ The majority of these expenditures have historically occurred at the state level and continue to do so, with more than 57% of direct outlays for corrections coming from state governments, compared to 10% from the federal government and nearly 33% from local governments.¹⁰⁵ This growth in corrections expenditures has driven a parallel surge in taxpayer spending. From 1980 to 2013, federal prison spending increased 595%, from \$970 million to more than \$6.7 billion in inflation-adjusted dollars and, as a result, taxpayers spent almost as much on federal prisons in 2013 as they paid to fund the entire United States Justice Department in 1980, after adjusting for inflation.¹⁰⁶

The state of Indiana has seen an increase in its penal population over the past 40 years, increasing by approximately 22,000 people since 1972, to a total of 28,067 in 2012.¹⁰⁷ During calendar year 2016, the number of adult offenders serving prison time in Indiana for committing drug dealing Felony Classes A, B, C, and D, Levels 1-6 (including methamphetamine, cocaine or narcotics, marijuana, or Schedule I, II, III, or IV) was 1,400.¹⁰⁸ The number of adult offenders serving time for drug possession offenses, including marijuana, controlled substances, drug paraphernalia, syringes, and precursors, was 749.¹⁰⁹ As of July 1, 2016, 29.1% of all adult offenders incarcerated with DOC had a drug-related offense.¹¹⁰ The number of juvenile drug offenders in the Indiana Department of Correction (IDOC) system during calendar year 2016 serving time for drug dealing was 2, possession was 96, and alcohol offenses was 23, for a total of 121, bringing the total of all drug offenders to 2,270 or close to 30% of all offenders.¹¹¹ The IDOC budget has been about 5.5% of the total state appropriated budget over the last five years, and

expenditures have remained somewhat steady over that same time period, increasing less than 6% since fiscal year 2012.¹¹²

B. INDIANA'S RESPONSE

Consistent with National Drug Control Strategy, Indiana has sought to integrate evidence-based interventions across the continuum from arrest, jail, and pre-trial to sentencing, incarceration, and release, with the objective of specifically targeting offenders' needs and criminal behaviors. The following section outlines several key initiatives reviewed by the Task Force.^{vi}

i. Criminal Code Restructuring

In 2013, the Indiana General Assembly passed, and Governor Pence signed into law, House Enrolled Act 1006 ("HEA 1006"), restructuring the state's criminal code for the first time in over 25 years.¹¹³ The purpose of HEA 1006, among other things, was to promote the use of evidence-based best practices for rehabilitation of offenders in community settings (i.e., residential, outpatient, or day reporting); divert non-violent offenders away from prisons, thereby keeping limited prison space available for more violent offenders; give judges maximum discretion to impose sentences based on a consideration of all the circumstances related to the offense; and to maintain proportionality of penalties across the criminal code, with like sentences for like crimes.¹¹⁴ As part of this effort, the criminal sentencing structure was considerably revised, including the elimination of mandatory minimum sentencing for certain drug offenses (i.e., dealing Schedule I drugs, dealing drugs to a minor, and dealing drugs with 1,000 feet of a drug free zone), even with a prior felony conviction.¹¹⁵

Tables 2 and 3 provide a comparison of pre- and

TABLE 2: PRE- AND POST-HEA 1006 SENTENCING STRUCTURES¹¹⁶

CLASS	PRE-2014 SENTENCE (ADVISORY)	LEVEL	POST-2014 SENTENCE (ADVISORY)
A	20-50 Years (30 Years)	1	20-40 Years (30 Years)
-	-	2	10-30 Years (17.5 Years)
B	6-20 Years (10 Years)	3	3-16 Years (9 Years)
-	-	4	2-12 Years (6 Years)
C	2-8 Years (4 Years)	5	1-6 Years (3 Years)
D	0.5-3 Years (1.5 Years)	6	0.5-2.5 Years (1 Year)

^{vi} A comprehensive listing of recent state legislation is included as Appendix E. In total, nearly 30 criminal justice reform and drug control laws have been passed in Indiana since 2013, representing a comprehensive approach to modern drug enforcement, treatment, and prevention in the state.

TABLE 3: PRE- AND POST-HEA 1006 PENALTIES FOR POSSESSION OF METHAMPHETAMINE, COCAINE, OR A NARCOTIC DRUG¹¹⁷

PRE-2014 AMOUNT	CLASS	POST-2014 AMOUNT	LEVEL
>3 grams on school bus or 1,000 feet of drug-free zone	A	>28 grams	3
<3 grams on school bus or 1,000 feet of drug-free zone	B	10-28 grams	4
>3 grams or also in possession of firearm	C	5-10 grams	5
<3 grams	D	<5 grams	6

post-HEA 1006 sentencing structures and a comparison of pre- and post-HEA 1006 penalties for possession of methamphetamine, cocaine, or narcotic drugs.^{vii} Post-2014 amounts in Table 2 do not take into account potential enhancing circumstances.

As noted above, HEA 1006 provides for diversion of non-violent offenders to services in the community. Pursuant to Indiana Code, “forensic diversion programs” are designed to provide adults who have been charged with a non-violent offense and who have an addictive disorder, an opportunity to receive community treatment and other services in lieu of, or in addition to, incarceration.¹¹⁸ Predictions based on the criminal code changes in HEA 1006 vary.

Regardless of the exact figures, HEA 1006 has placed greater responsibility on local communities, several of which have begun to cite the reduction in dealer penalties as a challenge to proper drug enforcement.¹¹⁹ For example,

an offender may have little incentive to opt into a diversion program when facing a short sentence, particularly when such a program is strictly enforced and the offender is not prepared to address his or her behavior or addiction.¹²⁰ Despite the challenges, several initiatives are being implemented throughout the state to support communities in their efforts.

ii. Enhanced Penalties for Persons Dealing Drugs

A little more than a year after HEA 1006 took effect, the Task Force recommended that Governor Pence pursue legislation to enhance sentences for aggravated drug dealers.¹²¹ Governor Pence chose to include this legislative proposal as part of his 2016 legislative agenda. Upon announcing it would be included on his agenda, Governor Pence stated, “We need to crack down on drug dealers who are peddling these poisons and preying on Hoosiers gripped by addiction. This most recent recommendation from the

TASK FORCE RECOMMENDATION & STATUS UPDATE

On December 8, 2015, the Task Force adopted a recommendation to support legislation to enhance penalties for persons dealing drugs convicted of serious and aggravated offenses. In the intervening months between adopting the recommendation and publication of this report, House Enrolled Act 1235 (HEA 1235) was included on Governor Pence’s legislative agenda, introduced in the Indiana General Assembly, passed, and signed into law on March 21, 2016.¹²² HEA 1235 creates a mandatory ten-year minimum sentence for individuals with a prior unrelated felony conviction (in any jurisdiction) for dealing in a controlled substance that is not marijuana, including an attempt or conspiracy to commit the offense; and who is convicted of a Level 2 felony for dealing in heroin or methamphetamine under Indiana law.¹²³ At a signing ceremony, Governor Pence noted that “any strategy to address drug abuse must start with enforcement. We need to make it clear that Indiana will not tolerate the actions of criminals, and I’m pleased to sign into law HEA 1235 to increase penalties on drug dealers.”¹²⁴ In addition, Senate Enrolled Act 290 (SEA 290) was introduced in the Indiana General Assembly, passed, and signed into law on March 21, 2016.¹²⁵ SEA 290 provides that a person may be convicted of dealing in cocaine or a narcotic drug (a Level 5 felony) without additional evidence, if the amount of the drug involved is at least 28 grams (formerly required evidence in addition to the weight of the drug that the person intended to manufacture, finance the manufacture of, deliver, or finance the delivery of the drug).¹²⁶

^{vii} Note, cocaine and most narcotics are Schedule II drugs; however, heroin is a Schedule I drug, even though it is a narcotic.

Task Force is another step forward in enacting policy that will allow us do just that.”¹²⁷ The legislation as passed created a mandatory minimum sentence of 10 years for individuals with a prior unrelated felony conviction (in any jurisdiction) for dealing in a controlled substance that is not marijuana, including an attempt or conspiracy to commit the offense; and who is convicted of a Level 2 felony for dealing in heroin or methamphetamine under Indiana law.¹²⁸

iii. Problem-Solving Courts

Over the past several decades, courts, in concert with government and community partners, have developed innovative programs to deal with offenders’ problems that were not, or could not, be adequately addressed in traditional courts.¹²⁹ Referred to as “problem-solving courts,” these specialized courts “seek to broaden the focus of legal proceedings, from simply adjudicating facts and legal issues to changing the future behavior of litigants and ensuring the well-being of communities.”¹³⁰ Though most problem-solving courts are relatively new, early research demonstrates a positive impact on the lives of offenders and victims, and, in some instances, cost-savings related to incarceration.¹³¹ Basic characteristics of problem-solving courts include a focus on outcomes (e.g., reducing recidivism or creating safer communities); system change (i.e., reforming how governments respond to problems); increased judicial involvement and non-traditional roles for court personnel; collaboration among courts and external entities (e.g., developing partnerships with behavioral providers); and early identification/screening to identify offenders who would benefit from the program.¹³²

The most common type of problem-solving courts are “drug courts.” Founded in Miami/Dade County, Florida, in 1989, drug courts are specialized court docket programs targeting criminal offenders with drug dependency problems and incorporating services and treatment programs as an alternative to incarceration.¹³³ The original drug court programs targeted adults and were “grounded in the notion that demand for illicit drugs and the related involvement in crime that led to the revolving door of the criminal justice system ‘could be reduced through an effective and flexible program of court-supervised drug treatment.’”¹³⁴ Drug courts are specifically designed to guide drug-addicted offenders into treatment that will not only reduce dependence and improve quality of life, but also benefit society through reduced crime, reduced costs associated with incarceration and crime, and increased public safety.¹³⁵ While drug courts may charge offenders administrative fees and fees for time spent in the program, such fees may be waived on an individual basis as determined by the

court.¹³⁶ In addition, participants are generally responsible for paying for any medical treatment they receive.

Typical drug court models allow for eligible individuals to be sent to drug court in lieu of traditional justice system case processing.¹³⁷ The drug court then requires that participants remain in court-mandated treatment for at least one year, while supervising them closely.¹³⁸ During their time in the program, participants are provided with intensive treatment and other services to establish and maintain sobriety; held accountable by the drug court judge; regularly and randomly tested for drug use; required to appear in court frequently for progress reviews; and rewarded or sanctioned as appropriate.¹³⁹ Drug court judges are supported by a team, typically consisting of a drug court coordinator, addiction treatment providers, prosecutors, public defenders, law enforcement officers, and parole and probation officers who work together to provide services to the offender.¹⁴⁰ Eligibility for drug court varies by jurisdiction, as does the specific drug court model (i.e., adult drug court v. family drug court).¹⁴¹ Most drug courts do not consider violent offenders.¹⁴² Finally, adult drug courts usually consider both drug and “drug-driven” offenses, and where offenses do involve victims, consent of the victim and payment of restitution is typically mandatory.¹⁴³

While target population, program design, and service resources vary, modern drug courts are generally based on a comprehensive “Ten Key Component” model formalized by the National Association of Drug Court Professionals and the U.S. Department of Justice’s Office of Justice Programs.¹⁴⁴ To receive federal drug court funding, programs must adhere to these 10 components:¹⁴⁵

1. Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants’ due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participants’ compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.¹⁴⁶

As of December 2014, over 3,000 drug courts operate in the United States.¹⁴⁷ While the proliferation of drug courts is arguably demonstrative of their effectiveness, exhaustive scientific research further supports their adoption. For example, a series of meta-analyses supports the observation that adult drug courts “significantly reduce crime, typically measured by fewer rearrests for new offenses and technical violations.”¹⁴⁸ Further, recidivism rates for drug court participants are generally reported as 8-26% less than other justice system responses, with the best programs “reducing crime by as much as 45% over other dispositions.”¹⁴⁹ With respect to costs, a recent cost-related meta-analysis reported that drug courts produced, on average, \$2.21 in direct benefits to the criminal justice system for every \$1.00 invested, with an even higher return (\$3.36) for programs targeting more serious, higher-risk offenders.¹⁵⁰

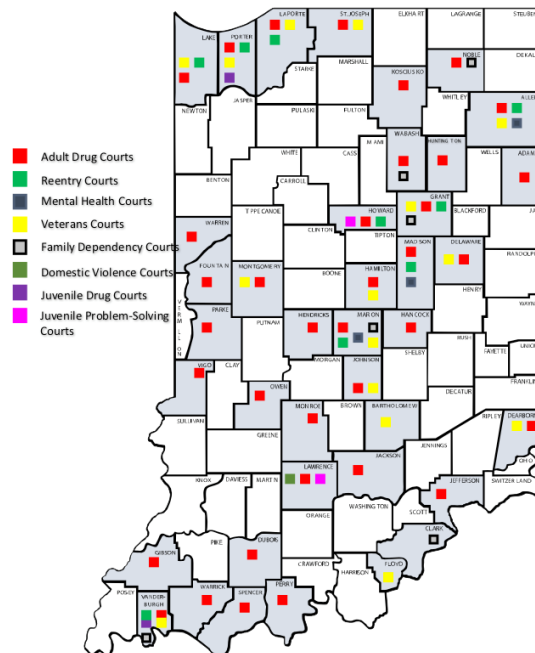
The success of drug courts has led to a new generation of problem-solving courts designed to address a range of social issues including truancy, mental illness, domestic violence, child support, community, and homelessness.¹⁵¹ In addition, the drug court model itself has evolved to include a range of other specialized drug courts including, but not limited to, family dependency treatment courts and veteran treatment courts.¹⁵² Family dependency treatment courts focus on child abuse or neglect cases where parental SUD is a contributing factor, and seek to aid parents or guardians in regaining control of their lives to enhance the possibility of family reunification.¹⁵³ Given the high rate of substance use and mental health disorders common among veterans (i.e., traumatic brain injury or post-traumatic stress disorder), veteran treatment courts exist as a hybrid drug/mental health court directly coordinating with Departments of Veterans Affairs (federal and state), the Veterans Benefits Administration, volunteer mentors, and organizations that support veterans and their families.¹⁵⁴ All problem-solving court and drug court models follow the National Association of Drug Court Professionals Ten Key Components.¹⁵⁵

iv. Indiana Problem-Solving Courts

Though Indiana began providing court-established alcohol and drug services in the mid-1970s, the state’s first official drug courts were not established until 1996, in Gary City Court and Vigo County.¹⁵⁶ Following a dramatic increase in the number of state drug courts, in 2002, the Indiana General Assembly enacted specific drug court legislation and, by 2003, drug court rules were adopted to provide a framework for certification of drug courts operating under state statute.¹⁵⁷ In 2010, Public Law 108 was passed creating the statutory framework for Indiana Judicial Center (IJC) certification of additional problem-solving courts^{viii} including community courts to address specific neighborhood or local criminal problems, domestic violence courts, family dependency drug courts, mental health courts, and veteran courts.

As of May 17, 2016, there were 76 certified problem-solving courts in Indiana, including 37 adult drug courts, four juvenile drug courts, nine reentry courts, three mental health courts, six family dependency drug courts, 16 veteran treatment courts, and one domestic violence court (See Figure 4).¹⁵⁸ There are also 12 to 15 problem-solving courts in the planning stage, largely focused on veterans treatment.¹⁵⁹ During State Fiscal Year 2014-2015, the IJC assisted the Indiana Supreme Court and the Division of State Court Administration in administering a grant program that provided a total of approximately \$315,000 to 44 certified problem-solving courts.¹⁶⁰

FIGURE 4: Indiana Problem-Solving Courts¹⁶¹



viii. Prior to this legislation, state law only permitted two types of certified courts to address specific problems faced by defendants: drug courts and reentry courts.

In 2006, an independent research organization performed process, outcome, and cost studies of five adult drug courts in Indiana, all established between 1996 and 2001, and targeting nonviolent, non-dealing, drug-related/substance abusing offenders.¹⁶² Qualitative data indicated that each assessed drug court had a strong foundation in the National Association of Drug Court Professionals Ten Key Components, with the majority of teams comprised of partners from different treatment, judicial, and community agencies.¹⁶³ In all five courts, participants had access to a wide array of treatment and ancillary services.¹⁶⁴ Quantitative data suggested that despite differences in demographics, as well as drug court characteristics and practices, all programs experienced a participant graduation rate above the national average, with cost-savings to local agencies and the state—combined savings projected to total over \$7 million.¹⁶⁵ Further, all five courts demonstrated reduced recidivism (up to 50%), increased treatment completion rates above the national average, and produced a return on investment up to \$5.37 for every \$1.00 spent.¹⁶⁶

Despite the above findings, advocates cite a number of concerns regarding the long-term success of problem-solving courts in Indiana including a lack of dedicated funding.¹⁶⁷ While many problem-solving courts, particularly drug courts, receive federal grants, these funds are typically intended to cover only start-up costs, ultimately leaving programs dependent upon strained state and local budgets.¹⁶⁸ Moreover, problem-solving courts “are often more vulnerable to funding cuts due to their higher evaluation and treatment expenses compared to traditional adjudication.”¹⁶⁹ In addition to funding constraints, many problem-solving courts across the state are at capacity in terms of judicial time, case management time, and available treatment providers.¹⁷⁰ Taken together, these limitations have resulted in smaller programs, which limit a court’s potential.¹⁷¹ As such, advocates have suggested an

extension of problem-solving court education and training to promote awareness of the programs and their benefits, interagency/disciplinary collaboration, and increased understanding of addiction and recovery, use of medication-assisted treatment, and SUD symptoms.¹⁷² Given an increase in the rates of abuse and neglect associated with SUD,^{ix} these opportunities should emphasize collaboration with state and local health departments, as well as clinical and child welfare service providers.¹⁷³ Finally, advocates also encourage a coordinated approach to research and evaluation of problem-solving courts, while promoting fidelity to evidence-based models.¹⁷⁴

v. Children in Need of Services

An analysis of National Survey on Drug Use and Health data indicates that approximately 8.3 million U.S. children (11.9%) lived with at least one parent who was dependent on or abused alcohol (7.3 million) or an illicit drug (2.1 million) in the past year.¹⁷⁵ While not all of these children will experience maltreatment, they are at an increased risk. Studies indicate some form of substance use in 23% of all child abuse cases, and 19.8% of all neglect cases.¹⁷⁶ Severe and ongoing parental SUD can also result in parent and child separation due to incarceration, long-term treatment, or following an intervention by child protective services (i.e., foster care, traditional foster care, or residential home placement). With respect to the latter, national research indicates that 61% of infants and 41% of older children in out-of-home care are from families with some form of active SUD.¹⁷⁷ These figures are increasing in Indiana where the percentage of children removed from homes due to parental SUD increased from 48% (5,101 children) in State Fiscal Year 2015, to 52.2% (6,223 children) in State Fiscal Year 2016.¹⁷⁸

To address the potential negative impact on children,

TABLE 4: CHILDREN IN INDIANA DEPARTMENT OF CHILD SERVICES CARE¹⁷⁹

TYPE	JUNE 2015	JUNE 2016
Total CHINS	18,621	21,374
In-Home	5,487	6,107
Total Out-of-Home	13,134	15,267
Out of Home - <i>Relative Placement</i>	6,239	7,492
Out of Home - <i>Traditional Foster Care</i>	5,808	6,567
Out of Home - <i>Residential Home Placement</i>	862	952
Out of Home - <i>Other Placement</i>	225	256

^{ix} The IDCS reports that approximately 70% of CHINS cases statewide have some addiction in the family structure.

most states have child protection laws addressing some aspect of parental substance use. As of 2016, 34 states have addressed exposure of children to illegal drug activity (e.g., sale, distribution, and production) in their criminal statutes, and several states have expanded their civil definition of child abuse and neglect to include a caregiver's use of drugs that impair his or her ability to care for the child or expose the child to illegal drug activity.¹⁸⁰ In Indiana, the Department of Child Services (IDCS) may take a "child in need of services" (CHINS) into protective custody if the child is under 18 years of age, experiencing one or more statutorily defined conditions of maltreatment, and the situation is unlikely to be remedied without the coercive intervention of the court.¹⁸¹ Examples of maltreatment include neglect, abuse,^x the child being born with fetal alcohol syndrome or a controlled substance or legend drug in its body, or the child being at risk from the mother's use of alcohol, a controlled substance, or legend drug during pregnancy.¹⁸² Though not specific to substance use issues, Table 4 represents the total number of CHINS children under IDCS supervision statewide as of June of 2015 and June of 2016.

Far too often, children struggling with significant mental health issues or SUDs who have not been maltreated end up in the child welfare system, simply because of a family's difficulty accessing services.¹⁸³ The most common situation occurs when a family is unable to afford services and the child commits a delinquent act.¹⁸⁴ When this occurs, the judicial system may defer to the family's wishes, in which case the family is forced to decide between allowing the child to become a ward of the state, pressing charges, or taking the child home and continuing to struggle with the child's problems.¹⁸⁵

vi. Indiana State Police Statewide Drug Interdiction Initiative

In 2013, the Indiana State Police (ISP) began a statewide drug initiative designed to "move from a distant relationship on the roadways to a direct relationship in the communities," and to take a "holistic look at the needs of the state at large as it pertains to trafficking and abuse of heroin, methamphetamine, and prescription opioids as gateways to other criminal activity."¹⁸⁶ These efforts strategically

move ISP to an "All Crimes Drug Interdiction' mission with a focus on communities that lack the required resources to combat [such] issues" (drug interdiction is generally defined as a "continuum of events focused on interrupting illegal drugs smuggled by air, sea, or land").¹⁸⁷ Specific efforts have included training troopers to look beyond initial violations during traffic stops to determine whether there is criminal activity involved; increasing the number of specialized drug investigators in the ISP Drug Enforcement Section; and conducting high-intensity directed criminal patrols driven by data and local surveys to identify areas of focus.¹⁸⁸ To date, 600 field enforcement troopers have received All Crimes Drug Interdiction training, additional Drug Enforcement Section undercover detectives have been recruited, and ISP has invested in additional vehicles and equipment to support the Drug Enforcement Section interdiction unit.¹⁸⁹ Finally, the ISP Criminal Intelligence Section is using a compressive approach to support patrol operations with intelligence-based policing, investigative support, and case follow through to ensure that troopers and detectives are cooperatively investigating every case with a drug nexus.¹⁹⁰ The first high intensity criminal patrol pursuant to the initiative ("Project Blue Light") took place August 19-20, 2016, in cooperation with the Ohio State Highway Patrol along the I-70 corridor.¹⁹¹ The ISP reports that in 2015, troopers pulled 82 pounds of heroin, 105 pounds of methamphetamine, 136 pounds of cocaine, and 1,164 pounds of marijuana off the streets.¹⁹²

vii. Regional Therapeutic Communities

Emerging in the late 1950s, therapeutic communities are a common form of long-term residential treatment for individuals suffering from SUDs.¹⁹³ Therapeutic communities are recovery-oriented,^{xi} focusing on the whole person and overall lifestyle changes, not simply abstinence from drug use.¹⁹⁴ Participants are encouraged to examine personal behaviors and engage in "right living," emphasizing honesty, personal responsibility, hard work, and a willingness to learn.¹⁹⁵ This approach further acknowledges the chronic, relapsing nature of SUDs and views such lapses as opportunities for learning.¹⁹⁶ Recovery is, therefore, seen as a gradual, ongoing process of cognitive change through clinical interventions, and it is expected to take time for participants to advance through the stages of

^x The statutory definition of abuse includes evidence that illegal manufacture of a drug or controlled substance is occurring on the property where a child resides.

^{xi} This orientation is substantively different from an acute-care treatment model, which focuses on interrupting drug use and helping the patient attain abstinence during treatment rather than addressing overall lifestyle changes. *Research Report Series: Therapeutic Communities (NIH Publication Number 15-4877)*. Retrieved May 19, 2016, from [www.drugabuse.gov: https://www.drugabuse.gov/sites/default/files/therapeuticcomm_rrs_0723.pdf](http://www.drugabuse.gov/sites/default/files/therapeuticcomm_rrs_0723.pdf).

^{xii} More than half all persons incarcerated in the United States meet the criteria for an SUD, approximately five times higher than the general population. National Institute on Drug Abuse. (2015, July). *Research Report Series: Therapeutic Communities (NIH Publication Number 15-4877)*. Retrieved May 19, 2016, from [www.drugabuse.gov: https://www.drugabuse.gov/sites/default/files/therapeuticcomm_rrs_0723.pdf](http://www.drugabuse.gov/sites/default/files/therapeuticcomm_rrs_0723.pdf).

treatment.¹⁹⁷ As participants progress through the stages of recovery, they assume greater responsibilities within the therapeutic community, with the ultimate goal of leaving not only drug-free, but also employed, in school, or in training.¹⁹⁸ Today the therapeutic community approach has been adopted in over 65 countries.¹⁹⁹

Therapeutic communities have been adapted over time to address the treatment needs of different populations. During the 1990s, as the proportion of criminal offenders with SUDs rose,^{xii} correctional institutions began incorporating in-prison therapeutic communities with the goal of reducing both drug use and recidivism.²⁰⁰ In addition, a growing number of community-based therapeutic community programs have begun providing aftercare for offenders upon release.²⁰¹ In addition to recovery-oriented therapy, in-prison therapeutic community treatment includes discharge planning to assist participants in identifying and accessing community services upon release (i.e., housing, training, and treatment) and generally facilitating re-entry into the community.²⁰² Studies show that in-prison therapeutic communities reduce recidivism and can be a cost-effective way to decrease substance use and improve public safety, with the most positive outcomes seen when offenders “participate in community-based therapeutic community treatment when transitioning from incarceration and continue care after discharge to prevent relapse and return to the social connections and environments formerly linked to drug abuse and crime.”²⁰³

PERSONAL TESTIMONY ▼

Cynthia shared with the Task Force her son’s journey as an addict and the support she found in order to assist with his recovery. Cynthia’s son, a heroin addict, has overdosed at least nine times and spent time in rehabilitation, jail, and now prison. He recently participated in an Indiana Department of Corrections Therapeutic Community and is awaiting a court date for reconsideration of his sentence. For many years, Cynthia believed it took willpower for her son to change but, through participation in a support program called Parents of Addicted Loved-ones (PAL), she realized that she was co-dependent and enabling her son’s behavior. Originally founded in Arizona, the PAL model recognizes addiction as a “family disease” and is designed to address the uniqueness of the parent/child relationship. PAL provides education on issues such as addiction, recovery, and co-dependence. PAL also uses stories to help parents better understand the feelings of anger, guilt, fear, loss, and denial, they are experiencing. Cynthia is now the facilitator of a PAL group in Avon, Indiana, which has been active for over three years. She encouraged the Task Force to consider the support that families of addicted individuals need, noting that “if we’re still doing the same thing once they come out of recovery, it’s not going to help them in the long-term.”

TASK FORCE RECOMMENDATION & STATUS UPDATE

On November 19, 2015, the Task Force adopted a recommendation to direct the Indiana Department of Corrections to work with Starke and other northwest Indiana counties to pilot and adopt the Regional Therapeutic Communities program, which provides more treatment options for local officials in addressing addiction. As described above, the Purposeful Incarceration program permits review for modification of an offender’s sentence of up to five years upon completion of TC treatment. Under the recommended local TC program, IDOC offenders will receive the same treatment closer to home, as opposed to being housed in a traditional prison setting, with the ultimate goal of improving family structure and dynamics and decreasing criminal behavior in local communities through recovery.²⁰⁴

In the intervening months between adopting the recommendation and publication of this report, Starke County Jail, a new facility, was identified as the first local site given the area’s high rate of methamphetamine lab seizures, and the Starke County Sheriff’s willingness to designate TC “pods” (individual self-contained housing units) separate from the general population utilizing specially trained staff.²⁰⁵ On February 5, 2016 the Indiana Department of Corrections (IDOC), in partnership with officials at the Starke County Jail, launched the state’s first non-prison-based therapeutic community (TC) for IDOC offenders.²⁰⁶ The program began with the transfer of six individuals from Indiana’s Westfield Correctional Facility to help set up and serve in leadership roles, and 43 inmates have been admitted since opening.²⁰⁷ As of August 29, 2016, six participants had completed the program, four of whom received a sentence modification, and the program’s current retention rate is 93%.²⁰⁸

^{xii} More than half all persons incarcerated in the United States meet the criteria for an SUD, approximately five times higher than the general population. National Institute on Drug Abuse. (2015, July). Research Report Series: Therapeutic Communities (NIH Publication Number 15-4877). Retrieved May 19, 2016, from www.drugabuse.gov/sites/default/files/therapeuticcomm_rrs_0723.pdf.

In 2009, the IDOC began a cooperative project with Indiana Court Systems called Purposeful Incarceration (PI), which allows judges to sentence chemically addicted offenders and document that they will “consider a sentence modification” should the offender successfully complete an IDOC therapeutic community.²⁰⁹ The Department currently maintains over 1,700 therapeutic community beds in nine facilities, providing intensive SUD treatment.²¹⁰ The IDOC has two different types of therapeutic communities—a general unit that serves offenders with significant abuse of any substance, and a Clean Lifestyle Is Freedom Forever (CLIFF) unit that serves offenders with significant impairment as a result of methamphetamine abuse—both of which have the same structure and core components; however, CLIFF units also utilize a curriculum specially designed to treat stimulant abusers.²¹¹

The core IDOC therapeutic community program is a minimum of eight months in duration, is competency based (i.e., participants work on one competency at a

time, which is likely a small component of a larger learning goal), and rewards successful completion with up to a six-month time credit on a participant’s sentence.²¹² As in a traditional model, IDOC therapeutic communities hold participants highly accountable, allowing them to earn privileges and responsibilities in the community as they progress in their recovery.²¹³ Participants are segregated from the general prison population, and following the intensive treatment phase, continue to participate in the therapeutic community to work on relapse prevention issues and re-entry planning.²¹⁴ Initial program outcomes suggest a reduction in recidivism and significantly fewer in-prison conduct violations among therapeutic community participants as compared to general population units.²¹⁵ In addition, the PI program has helped foster a close working relationship between the IDOC therapeutic communities and the Indiana Judicial System; currently 17 counties have participated in PI and judges have referred over 70 offenders.²¹⁶

TASK FORCE RECOMMENDATION & STATUS UPDATE

On January 29, 2016, the Task Force adopted a recommendation to direct the Indiana Criminal Justice Institute and the Indiana Division of Mental Health and Addiction to identify a county criminal justice entity and implement a therapeutic substance use disorder treatment program for offenders awaiting adjudication and for those serving sentences while in jail.

In the intervening months between adopting the recommendation and publication of this report, the Indiana Criminal Justice Institute and the Indiana Division of Mental Health and Addiction solicited input from stakeholders in jails throughout the state and identified several best practices for jail-based addiction services:

1. A commitment from the sheriff and jail commander to allow time and space for services is vital. These services impact the jail’s routine, schedule, staffing resources, budgets, and partnerships. Sheriffs and commanders who are supportive of jail services are key to their implementation.
2. Jail services need to be a part of a larger service delivery system outside of the jail. Persons can start their recovery in jail while some continue their recovery that began in the community. A solid hand-off to a community provider is important to ensure continuity of services and to demonstrate the overall system commitment to providing services.
3. Partnerships with community providers, probation, and community corrections help ensure that services started in one part of the system can continue.
4. Programs must have a sound foundation that describes the goals and parameters of the program. Using licensed addiction providers improves program development, delivery, and continuity.
5. Support for community providers is vital to providing local jail services. Bringing partners together to plan, implement, and evaluate is essential to success.
6. Programs that view addiction services as part of overall health services will be better suited to meet the needs of offenders.

Further, the Indiana Criminal Justice Institute and the Division of Mental Health and Addiction report that Recovery Works initiated jail reentry services in November 2016. Recovery Works referrals from jails are occurring as persons prepare to leave jail and enter community services. Several counties are coordinating with their local providers to ensure services that start in the jail are continued as needed in the community.

viii. Recovery Works

In 2015, the Indiana General Assembly passed, and Governor Pence signed into law, an amendment to HEA 1006 establishing the Forensic Treatment Services Grant Program through the Indiana Division of Mental Health and Addiction (DMHA).²¹⁷ The program, now known as “Recovery Works,” is designed to provide vouchers to healthcare professionals offering specialized services to uninsured individuals struggling with mental illness or substance addiction, who may otherwise face incarceration.²¹⁸ In its first year, Recovery Works provided \$10 million in grant funds, with an additional \$20 million during its second year.²¹⁹

Forensic psychology generally refers to “[t]he application of clinical specialties to legal institutions and people who come into contact with the law,” emphasizing the application of clinical skills such as assessment, treatment, and evaluation to forensic settings such as jails, prisons, or other specialty facilities.²²⁰ Recovery Works specifically focuses on pre-incarceration diversion services and post-incarceration re-entry services, with the goal of diverting low-level offenders from incarceration to community services, and to reduce recidivism.²²¹ Individuals are referred to the program by a treatment provider, a criminal justice provider (e.g., IDOC, Community Corrections, etc.), or the individual’s attorney.

Once determined eligible for the program, Recovery Works participants receive services from certified community mental health centers, addiction treatment services providers, private mental health institutes, or opioid treatment programs that have applied and received authorization from DMHA to provide services to participants.²²² Designated service providers include certain behavioral health professionals and licensed professionals (e.g., psychiatrist, physician, and psychologist).²²³ Covered services include, but are not limited to, alcohol and drug screening, case management, housing assistance, inpatient detoxification, intensive outpatient treatment, medication-assisted treatment, medication for treatment of mental health/SUD, counseling (i.e., individual, family, and group), and transportation.²²⁴

C. ENFORCEMENT BEST PRACTICES IDENTIFIED BY THE TASK FORCE

A number of SUD enforcement, treatment, and prevention best practices are being implemented across the state. The following section outlines several opportunities related to enforcement that may serve as models for other communities.

i. County Drug Courts

The Vanderburgh County Juvenile Drug Court (VCJDC), located in southwestern Indiana, began operations in 2002 and is one of only four juvenile drug courts in the state.²²⁵ A variety of local agencies and providers partner in the program (e.g., school corporation, Office of Family and Children, and local treatment providers), with the main team consisting of the magistrate, a probation officer, a deputy prosecutor, and a public defender.²²⁶ The VCJDC targets juvenile offenders with SUD problems, many of whom have a history of criminal activity, and provides treatment, education, intensive case management, and court supervision to assist youth offenders in overcoming the challenges of SUD.²²⁷ The program consists of four phases, each varying in length and intensity based on the participant’s sobriety and progress; frequency of contact decreases for each advancement in phase.²²⁸ Non-compliant participant behavior may result in sanctions that can lengthen the time spent in a given phase, though the average time participants spend in the program is seven months.²²⁹ Additional information about VCJDC is available at: <http://www.vanderburghgov.org/index.aspx?page=527>.

The Hendricks County Adult Drug Court (HCADC), located in Central Indiana, began operations in 2011.²³⁰ The HCADC uses a multi-disciplinary team-based approach to provide intensive supervision to high-risk and high-need adult offenders through a five phase program.²³¹ Eligible offenders are enrolled for a minimum of 24-months post-conviction (i.e., plea or probation violation) and are subject to random drug testing at least twice weekly, as well as graduated incentives and sanctions to support their recovery.²³² As of 2015, HCADC has graduated 28 participants from the program; five were re-arrested, two passed away (one of an overdose), and 10 continue to be in active recovery and stay in contact with the program.²³³ The program reports only three relapses; however, each is back in a recovery program.²³⁴ Additional information about the HDAC is available at <http://www.co.hendricks.in.us/departments/division.php?structureid=67>.

ii. Juvenile Detention Alternative Initiative

In 2006, Indiana was one of the first states to implement the Juvenile Detention Alternative Initiative as an alternative to incarceration for juvenile drug offenders. The Initiative is a public-private partnership with the Annie E. Casey Foundation, with the goal of promoting positive youth development by eliminating unnecessary or inappropriate confinement.²³⁵ This goal is achieved by moving low-risk youth from secure detention into community-based alternative programs.²³⁶ To date, the Initiative has expanded to include 32 Indiana counties as host sites, and 69% of Indiana youth ages 10-17 live in a county implementing the

Initiative.²³⁷ The results are impressive and include lower recidivism rates, fewer minors being incarcerated, and an estimated \$15 million savings reported from IDOC.²³⁸ By 2012, participating counties experienced a reduction in detention admissions by an average of 45%, and a reduction in the average daily detention populations of 41%.²³⁹

iii. Allen County Criminal Justice Projects & Initiatives

Allen County, the state's third most populous county, is combating the drug crisis through both statutory and non-statutory problem-solving courts and by aligning projects and initiatives across three separate agencies in its criminal justice system—Allen County Community Corrections, Allen County Adult Probation, and Allen County Criminal Division Services.²⁴⁰ This interagency collaboration allows for joint-negotiation of service contracts, cost savings, and uniform case planning, in addition to fostering the development of new treatment programs, problem-solving court workgroups, community assessment screening teams, and training to enhance evidence-based practices.²⁴¹ As a result, Allen County is better positioned to bridge the gap between the criminal justice system and private providers to meet the needs of high risk offenders.

Allen County Community Corrections (ACCC) operates a community-based offender supervision program that includes a reentry court and a restoration court.²⁴² The reentry court provides stabilization services to offenders returning to the community in order to assist with successful re-integration. Specifically, the reentry court applies electronic monitoring, field supervision, and case management; and participants are expected to complete relevant treatment, classes and job search activities, and develop goals for positive behavioral change during their time in the program.²⁴³ The reentry court judge provides oversight while community mentors, faith-based mentors, and local employers are encouraged to assist offenders in successfully meeting their goals.²⁴⁴ The restoration court is a problem-solving court serving offenders with co-occurring mental illness and addiction who are statutorily eligible for diversion; offenders sentenced to home detention as a condition of probation; direct placement offenders; offenders released prior to reaching their maximum sentence; and reentry offenders from the Allen Superior Court.²⁴⁵ Offenders are sentenced to participate in the program for one year and receive judicial oversight, case management, and mental health services.²⁴⁶ Electronic monitoring is required for a minimum of six months and may be removed by obtaining employment, attending SUD treatment, managing prescribed medication, and

attending counseling as ordered.²⁴⁷ In November 2013, the restoration court began operating a veteran court program in collaboration with the Allen Superior Drug Court to facilitate receipt of entitlement benefits and address unique priorities specific to veterans.²⁴⁸

Allen Criminal Division Services (ACDS), the supervising division of Allen Superior Court, operates a drug court^{xiii} and an alcohol countermeasures program that provide pretrial services to “improve public safety, reduce alcohol and drug related criminal activity as necessary and deviant behavior, and improve the quality of life of offenders, their family members and the public, by guiding offenders towards overall life improvements.”²⁴⁹ The drug court promotes abstinence, recovery, lasting change, and community safety by targeting criminal offenders charged with alcohol or drug-related offenses and individuals who are identified as having committed other offenses to support their substance use habit.²⁵⁰ In addition to providing assessments, referrals, and supervision through intensive case management and judicial monitoring, the drug court utilizes a system of incentives and sanctions, the magnitude of which is relevant to a participant's risks and needs, as well as proximal and distal behaviors.²⁵¹ The typical period of participation in the drug court is approximately 12 to 18 months, with the intensity of supervision being assessment driven and determined by a participant's progress along with their level of compliance with individual requirements.²⁵² The ACDS alcohol and countermeasures program provides alcohol and drug services to substance use-involved offenders charged with, or convicted of, predominantly misdemeanor offenses who are in need of intervention, education, referral, treatment or rehabilitation for substance use in addition to court supervision.²⁵³ The length of supervision in the program is driven by charge class—C misdemeanor 60-day sentence, B misdemeanor 180-day sentence and A misdemeanor 365-day sentence.²⁵⁴ Pretrial services is responsible for the court-ordered release and supervision of criminal defendants who are out of custody awaiting disposition in their criminal case.²⁵⁵ The program maintains regular in-person contacts with offenders assuring compliance with their conditions of release from custody.²⁵⁶

In addition to the aforementioned statutory problem-solving courts, Allen County Adult Probation (ACAP) also operates a non-statutory program called “HOPE Probation” in an effort to reach high-risk/high-need non-violent offenders who are ineligible for traditional problem-solving courts due to their history or very high risk, evidence-based assessment, to re-offend. Originating in Hawaii in 2004,

^{xiii} As noted previously, the ACDS drug court collaborates with the ACCC restoration court to provide veteran court services.

HOPE Probation (Hawaii's Opportunity Probation with Enforcement) is a one-year, high-intensity supervision program designed for repeat offenders with SUD problems.²⁵⁷ Participants may be directly placed in HOPE Probation at sentencing or through a modified probation order following a violation of regular supervision if the client is in need of more accountability.²⁵⁸ HOPE consists of four 90-day phases, whereby participants report for weekly scheduled appointments, receive increased home visits, and receive random urine screening.²⁵⁹ Failure to report for a scheduled appointment or random urine screen results in immediate court action and a warrant is issued for the participant's arrest.²⁶⁰ The underlying premise of HOPE Probation is that the rules of probation are more readily followed when any violation quickly results in a brief jail sanction (usually two to 15 days depending on the severity of the offense), as offenders who are willing to commit repeated violations of their probation when the consequences are delayed and uncertain under regular supervision are far less likely to risk going to jail even for a single violation.²⁶¹

Allen Criminal Division Services also recently initiated a pretrial pilot project to promote pretrial justice by maximizing risk-based release for defendants while minimizing harm to the community, reasonably assuring community safety, and increasing the likelihood of court appearances.²⁶² The target population for this project includes non-violent felony Level 5 and Level 6 arrestees with prior felony convictions being held on a financial bond.²⁶³ Release decisions are based on, and in accordance with, a participant's risk level rather than his/her ability to post a bond pursuant to a charge-driven bond schedule, which does not account for individual risk.²⁶⁴ An evidence-based pretrial risk assessment is conducted on non-violent Level 5 and Level 6 repeat offenders, and if a defendant is determined to be low to moderate risk, he/she may be conditionally released on his/her own recognizance at the time of initial hearing.²⁶⁵

Despite Allen County's comprehensive and collaborative approach to addressing the drug crisis, stakeholders cite several remaining service gaps related to housing, medication-assisted treatment (MAT), and prisoner reentry.²⁶⁶ With respect to housing, while outpatient treatment services and community-based criminal justice supervision services are available to offenders in Allen County, stable and sober housing is often limited.²⁶⁷ Without residential facilities to support offenders and facilitate continued treatment, offenders cannot be released to community corrections.²⁶⁸ In March 2016 alone, over 90 offenders referred for supervision with ACCC were found ineligible due to unsuitable housing.²⁶⁹ Regarding MAT—

an approach that uses U.S. Food and Drug Administration (FDA)-approved pharmacological intervention (e.g., methadone, buprenorphine, and naltrexone) in combination with behavioral interventions for persons suffering from SUD—Allen County often lacks access to relapse prevention medications and associated services.²⁷⁰ Access to, and clinical supervision of, MAT could allow for release of certain offenders without housing, thereby resolving some of the issues previously identified.²⁷¹ Of note, the Allen County Health Commissioner is currently working to identify private providers and hospitals with outpatient MAT programs in an effort to increase access for justice-involved persons.²⁷² Lastly, concerning prisoner reentry, stakeholders highlight the need for individuals or organizations, analogous to healthcare "Navigators," trained to assist offenders with accessing insurance programs (i.e., HIP 2.0 and Recovery Works) and social services upon release.²⁷³

iv. Grant County Evidence-based Decision Making

Grant County, in North Central Indiana, is a leader in the practice of Evidence-based Decision Making (EBDM), a strategic and deliberate method of applying empirical knowledge and research-supported principles to justice system decisions made at the case, agency, and system level.²⁷⁴ The EBDM initiative was developed in 2008 by the National Institute of Corrections in partnership with the Center for Effective Public Policy, in an effort to reform the criminal justice system using research findings to inform and guide decisions across the justice system and stakeholder collaboration to make communities safer and use tax dollars more efficiently.²⁷⁵ Grant County was one of the first pilot communities for EBDM, and its mission in this initiative is to "[promote] risk and harm reduction by utilizing collaborative decision-making and interventions founded on evidence-based research."²⁷⁶ The goals of the Grant County EBDM initiative include: (1) reducing the use of jail for low risk, nonviolent, pretrial defendants by 10% over three years; (2) meeting (on average) American Bar Association case processing arrest to disposition standards of nine months for felonies and 90 days for misdemeanors; (3) reaching a 70% rate of victim satisfaction with the court process within one year; (4) reducing new offense rearrests for probationers to less than 40% within three years; and (5) improving housing stability, employment, and family functioning for probationers by 25%.²⁷⁷ As a result of EBDM, the drug and reentry courts in Grant County have experienced recidivism reduction compared to control groups.²⁷⁸ In 2015, the EBDM initiative was extended to six additional Indiana counties: Hamilton, Jefferson, Hendricks, Bartholomew, Porter, and Tipton.²⁷⁹ The ICJI sponsors the EBDM Policy Team, led by Justice Stephen H.

David, which focuses on criminal justice policies in these counties.²⁸⁰ The EBDM Team has also applied and has been approved by National Institute of Corrections for technical assistance to fully implement EBDM at the state level.²⁸¹

v. Porter County Partnerships & Initiatives

Porter County in Northwest Indiana has experienced an increase in heroin use and overdoses in recent years, which some say is directly tied to drug trafficking from the Chicago metropolitan area.²⁸² As a result, the Porter County Sheriff's Office has increased its undercover officers, added an officer stationed in Chicago, and established a Heroin Overdose Response Team to investigate overdoses, something not done in most Indiana counties.²⁸³ Stakeholders cite the last of these as particularly effective, as intelligence from investigations is shared with state drug enforcement units and the Lake County High Intensity Drug Trafficking Area, a group of local, state, and federal agencies that collectively work to combat drug-related crimes in the Lake County region.²⁸⁴ As the majority of Porter County's incarcerated population is serving time for SUD-related convictions, the Sheriff's Office has also expanded the County Jail's drug treatment program and skills training offerings, demonstrating a recidivism rate of approximately 50%, which is lower than national rates.²⁸⁵ Finally, the Porter County Sheriff's Office recently developed a drug prevention video featuring stories from offenders with opioid use disorder.²⁸⁶ The video is designed to empower youth in grades five through 12 to make good decisions.²⁸⁷

vi. Anonymous Crime Reporting Hotlines

Several communities across Indiana have implemented anonymous crime reporting hotlines such as Crime Stoppers (e.g., Terre Haute and Muncie) and We-Tip (e.g., Lafayette and Evansville).²⁸⁸ We-Tip has been cited as a successful tool in combating drug use and associated crimes in Southern Indiana which, as noted earlier in Section II, has been hit particularly hard in recent years by methamphetamine use and production, as well as prescription abuse.²⁸⁹ We-Tip, headquartered in California, was founded in 1972 as a 100% anonymous crime reporting resource for citizens who have information regarding a crime but fear reprisal from the criminal they are turning in.²⁹⁰ Informants calling the We-Tip hotline are not recorded or traced, and the hotline does not use caller identification—in fact, it is the hotline's policy that if at any time the informant starts to identify him or herself, the operator must ask the informant to call back to speak with another operator, then disconnect the call.²⁹¹ Once the call is complete, informants are asked if they would like a reward pending the outcome of their call and, if yes, the caller is given a code to call back at a later date to check the status of the reward.²⁹² Rewards are paid from \$20 to \$1,000, depending on the severity of the crime and the outcome pending a future conviction, and callers are instructed where to pick up their reward upon their follow-up call.²⁹³ In 2014, one year after implementation, Evansville Police reported having received and investigated 10 to 15 anonymous tips per week, with an estimated 10 to 15 arrests made as a result within the one-year period.²⁹⁴ Additional information about We-Tip is available at <http://wetip.com>.

VI. SUBSTANCE USE DISORDER TREATMENT

Addiction is a chronic disease requiring a comprehensive and integrated treatment system to support and encourage recovery. Having evolved considerably during the latter half of the 20th century, the current system of care “has [its] roots in self-help movements and in medical and scientific research findings, and has been shaped by emerging drug trends, public health problems, and uneven treatment financing policies.”²⁹⁵ In recent years, however, scientific discoveries and evidence-based interventions such as MAT are transforming our understanding of how best to treat individuals with an SUD.

A. BACKGROUND

The complexity of the root causes of SUD, coupled with the multitude of consequences, demands a treatment system comprised of many components.²⁹⁶ While some of these components focus directly on the individual’s immediate drug use, others are designed to restore the individual as a productive member of his/her family and community.²⁹⁷ As such, treatment is delivered in a variety of settings (e.g., acute, residential, outpatient, and office-based), by a variety of providers (e.g., physicians, nurses, psychiatrists, psychologists, counselors, and social workers), using a variety of behavioral and pharmacological approaches.

Today, over 14,500 treatment facilities provide counseling, behavioral therapy, medication, case management, and other types of services to Americans suffering from SUDs.²⁹⁸ Medication-assisted treatment in particular has recently gained considerable attention as an important component of the treatment continuum.²⁹⁹ Although individual service components are often associated with specific treatment settings, a variety of interventions may be provided in any given setting.³⁰⁰

A large portion of SUD treatment is funded by public insurance programs. However, private and employer-sponsored health plans also provide coverage for their members. To ensure individuals requiring SUD treatment are not subject to discrimination, the federal government has sought to ensure equal coverage (i.e., parity) between such benefits and medical/surgical benefits for both public and private health insurance plans through the Mental Health Parity and Addiction Equity Act of 2008, the Affordable Care Act, and recent Centers for Medicare and Medicaid Services regulations.³⁰¹

B. INDIANA’S RESPONSE

Indiana has taken great care in recent years to improve access

to SUD treatment. In addition to enhancing coverage for the state’s most vulnerable populations, the current SUD delivery system is comprised of recovery focused models of care designed to support individuals in managing their condition successfully. However, treatment is not without its challenges given professional workforce shortages in the state and often the individual’s inability to voluntarily pursue treatment.

i. Coverage for Vulnerable Populations

As noted earlier, the Healthy Indiana Plan 2.0 (HIP 2.0) has ensured that nearly 400,000 previously uninsured low-income Hoosiers (24% of which are estimated to suffer from an SUD, nearly three times the national average) now have access to health insurance that provides mental health and SUD treatment coverage at parity with physical health services.³⁰² In Scott County, following an HIV outbreak, HIP 2.0 enabled the state to immediately connect the impacted population and those most at-risk with appropriate treatment and prevention services. This increased access to health insurance, paired with the expansion of covered services, is expected to provide new funding to strengthen the mental health and SUDs safety net system that has primarily relied on grants and state funding to serve its growing client base. Further, organizations that previously relied heavily on government funding to offset the cost of charitable care for the uninsured are expected to have significantly fewer uninsured clients.

The expansion of the original HIP program to childless adults also presented an opportunity for the state to target individuals newly released from jails and prisons. Though prevalence estimates vary, research indicates that over half of offenders in state prisons have *symptoms* that meet the full diagnostic criteria for SUD; Indiana reports 53% of prison offenders and 56% of offenders in local jails.³⁰³ Further complicating matters, incarcerated individuals with opioid use disorder are often unable to secure treatment upon release, as federal law prohibits Medicaid payment for incarcerated individuals and prohibits them from purchasing private health insurance through the federal Marketplace.³⁰⁴ To address these potential gaps in coverage, the Indiana General Assembly passed House Enrolled Act 1269 (Indiana Code 11-10-12-5.3, effective July 1, 2015), requiring the IDOC to submit Medicaid applications on behalf of offenders 60 days prior to their release. Following a determination of eligibility, the state will authorize and then immediately suspend an offender’s application if the offender does not require immediate medical attention.³⁰⁵ This suspension means the incarcerated individual does not need to apply for coverage upon release and may simply call the state Medicaid office to begin coverage.

Federal Medicaid law has also historically excluded payments for beneficiaries ages 21–64 who are residents of an Institution for Mental Disease (IMD) (i.e., hospitals, nursing facilities or other institutions of more than 16 beds that primarily care for persons with mental diseases).³⁰⁶ This “IMD exclusion” has been repeatedly cited as a barrier to access for certain Medicaid beneficiaries, particularly in light of the national opioid epidemic; however, recent revisions to Medicaid managed care regulations by the Centers for Medicare and Medicaid Services modify the IMD exclusion to permit coverage, at the state’s discretion, subject to certain limitations. Given this new flexibility, on June 30, 2016, Indiana Medicaid announced that effective for dates of services on or after July 5, 2016, contracted managed care plans may authorize coverage for beneficiaries consistent with the new managed care rule.³⁰⁷ Specifically, for Indiana Health Coverage Program members enrolled in a managed care program (i.e., HIP 2.0, Hoosier Care Connect, or Hoosier Healthwise) the contracted health plans may authorize stays of up to 15 days in an IMD for inpatient services related to mental health, behavioral health, and SUD in lieu of other settings under the Medicaid State Plan.

ii. Delivery System

Many chemically addicted individuals require detoxification as an initial step in their treatment. Detoxification, provided on an inpatient or outpatient basis, is a series of interventions aimed at managing acute intoxication and withdrawal, with the goal of clearing toxins from the body to reduce physical harm and prevent death.³⁰⁹ Detoxification is very difficult to complete, due to the individual’s physical dependence on the chemical substances, which results in severe withdrawal symptoms (e.g., muscle aches, abdominal cramping, nausea, and vomiting) typically lasting 10 to 14 days.³¹⁰ Managing withdrawal symptoms requires specialized treatment expertise that non-opioid exclusive detoxification facilities may not possess.³¹¹ There are currently 56 detoxification facilities in Indiana; however, only eight treat opioid-addicted individuals exclusively and only one accepts Medicaid reimbursement.³¹² Further complicating matters, while inpatient detoxification is covered by Indiana Medicaid,^{xiv} outpatient detoxification is not, despite being less expensive and allowing patients to continue employment and family responsibilities during treatment.³¹³

Residential, or inpatient, treatment facilities provide persons recovering from SUD the opportunity to establish

PERSONAL TESTIMONY ▼

Rodrigo Garcia, Registered Nurse Anesthetist, shared with the Task Force his personal story of addiction and the lack of support for healthcare providers seeking assistance for substance use disorders. Like many opioid addicts, Rodrigo began taking prescription pain medication following surgery for an ankle injury. Rodrigo slowly became dependent on the medication and, as refills were easy to obtain given his status as a healthcare provider, his addiction spiraled out of control. Though he eventually received treatment and is in recovery, it was difficult to get the support he needed without jeopardizing his career. As his story is not unique, Rodrigo warned the Task Force of the high risk of patient harm given healthcare providers’ direct access to drugs, their expert knowledge of pharmacology, and the limited treatment options for these addicted professionals. To address these issues, Rodrigo suggested greater protection for patients from impaired providers, and recommended specialized programs for these providers that acknowledge the challenges they face in treatment and return to practice.

a pattern of healthy behaviors and a meaningful period of sobriety prior to returning to unsupervised daily living. Residential treatment facilities provide 24-hour structured and intensive care, including safe housing and medical attention.³¹⁴ Residential treatment facilities use a combination of therapeutic approaches aimed at helping the patient live a drug-free lifestyle after treatment.³¹⁵ Although there are 25 residential treatment facilities in Indiana, only five offer treatment for low-income individuals.³¹⁶ Collectively, these five facilities have a total of 88 beds.³¹⁷ Indiana Medicaid does not provide direct reimbursement for residential treatment.³¹⁸ Instead, the state provides limited contracts or grants to specific facilities for the provision of limited residential treatment services for specific vulnerable populations (e.g., pregnant women).³¹⁹

Individuals who do not meet the diagnostic criteria for admission into detoxification or residential treatment may receive intensive outpatient treatment (IOT).³²⁰ IOT services typically offer a minimum of nine hours of treatment weekly, delivered through three three-hour sessions.³²¹ As individuals remain in the community during treatment, there is significant cost savings compared to

^{xiv} In 2016, the Indiana General Assembly passed, and Governor Pence signed, Senate Enrolled Act 297. Among other things, the new law required Medicaid coverage for inpatient detoxification for the treatment of opioid or alcohol dependence in accordance with the detoxification admission criteria set forth by the Academy of Substance Abuse Medicine. This change significantly increases access to these services, as former state coverage policy required a showing of immediate danger or death to themselves or others as a prerequisite for admission.

the cost of inpatient care, and the individuals are able to experience recovery in their daily environment.³²² Similar to outpatient detoxification, individuals receiving IOT have the opportunity to sustain their familial and employment-related responsibilities while engaging in SUD treatment.³²³ A recent meta-analysis of 12 different studies of IOT found a “high level of evidence” that IOT is as effective as inpatient and residential treatment.³²⁴ There are currently over 100 IOT facilities in Indiana, and IOT is a covered Medicaid benefit when provided by a Community Mental Health Center.³²⁵

PERSONAL TESTIMONY ▼

Wayne Isailovich, Executive Director of Addiction and Behavioral Counseling Services, Inc. in Merrillville, Indiana, shared with the Task Force his experience treating individuals with substance use disorders. Mr. Isailovich stated that he has seen a sharp increase in demand for heroin treatment in northwest Indiana over the past fifteen years, with opioid abuse now affecting all socioeconomic, racial, and ethnic groups. Further, Mr. Isailovich has found that long-term substance use disorder treatment (90-180 days) is most effective, particularly when addressing the physical, emotional, and spiritual needs of an individual. In his words, “individuals need time to ‘learn to unlearn’ learned behaviors; however, resources are limited and often cost prohibitive, ranging from \$15,000 to \$30,000 per month.” Mr. Isailovich encouraged the Task Force to increase access to long-term treatment options for people without health insurance.

iii. Indiana Neuro-Diagnostic Institute and Advanced Treatment Center

Indiana’s inpatient psychiatric bed capacity has declined considerably over the past 50 years (from over 6,000 beds in 13 state-operated facilities, to approximately 800 beds in five adult hospitals and one children’s facility). This has required many patients with chronic psychiatric diseases or relapsing chemical dependencies to be treated in community-based centers and drug therapy programs that are often insufficient to meet their clinical needs.³²⁶ For some patients, this deinstitutionalization has even led to treatment in inappropriate settings (i.e., nursing homes, emergency departments, and general hospitals), homelessness, or incarceration.³²⁷ To counter these circumstances, FSSA in 2014, began actively engaging and evaluating its existing mental health programs, faculty, and facilities to determine key drivers and partnership opportunities available in the state to promote a new model

of state-operated facility care delivery and best practices.³²⁸

Following a feasibility study, FSSA proposed the development of a state-of-the-art, neuro-diagnostic center to drive precise diagnosis and evidence-based treatment of patients referred to state-operated facilities.³²⁹ The new Indiana Neuro-Diagnostic Institute and Advanced Treatment Center (“Center”) would be a novel model of care for Indiana, not simply a replacement of the current custodial state-operated facility model.³³⁰ The Center would serve as a hub for state-operated facilities where modern genetic and imaging techniques would be used to maximize recovery and stable community placements.³³¹ To accomplish this goal, FSSA proposed co-location of the Center on a major medical campus in Central Indiana, in order to leverage emergency services, specialty medical care, and neuro-diagnostic techniques for the provision of integrated medical services currently unavailable throughout the state system.³³²

On December 16, 2015, Governor Pence announced plans to build the \$120 million Center on the campus of Community East Hospital in Indianapolis.³³³ The 159-bed facility will serve approximately 1,500 patients annually, and will consist of: (1) a short-stay, neuropsychiatric diagnostic unit to refine diagnoses; (2) dual diagnosis units for those patients with intellectual and developmental disabilities or SUD/chemical dependency and mental illness; (3) specialized evaluation and treatment programs to serve complex, severely ill and treatment-resistance patients; (4) a clinical research unit; (5) forensic units to support the state’s criminal justice system; and (6) practice implementation programs to support the implementation of best practices throughout the state-operated facility network.³³⁴ Finally, the Center will enhance the state’s behavioral health workforce by serving as a clinical training site for Community Health Network’s psychiatric residency program.³³⁵ Construction for the center has already begun and is scheduled to begin operations in 2018.³³⁶

iv. Medication Assisted Treatment

As noted earlier, MAT is an approach to SUD treatment that uses pharmacological treatments, often in combination with psychosocial treatments.³³⁷ With an array of FDA-approved medications now available to treat opioid use disorders, the medical community largely agrees that improved access to MAT is the most effective way to address the country’s opioid epidemic.³³⁸ However, the stigma associated with drug addiction and the belief that addiction is simply a moral failure has generated controversy regarding MAT and inhibited its use.³³⁹ Specifically, drugs such as methadone and buprenorphine, two of the drugs used for treatment,

PERSONAL TESTIMONY

Ben Gonzales shared his personal story of long-term recovery with the Task Force. Following several DUI convictions and six overdoses, Ben finally agreed to participate in long term residential treatment at LaVerna Lodge, a program through a nonprofit alcohol and drug treatment center called Fairbanks. With the assistance of Vivitrol, a non-addictive medication that blocks opioid cravings, Ben was able to focus on his recovery plan without “thinking about next dose.” Referring to it as an “assist,” Ben noted that MAT “gives people time, accountability, and peace of mind to work their recovery plan” and that medication alone will not cause an addict to stop using. Now, with two years of continuous recovery, Ben is a full-time employee at Fairbanks, personally involved in relapsed recovery research, and gearing up to start graduate school.

are themselves opioids, leading many to assert that MAT is simply replacing one drug with another.³⁴⁰

Historically, the use of opioid medications to treat addiction was only permissible in federally approved Opioid Treatment Programs (OTPs) (i.e., methadone clinics), using medications that could only be dispensed, not prescribed.³⁴¹ Following enactment of the federal Drug Addiction Treatment Act of 2000 (DATA 2000), qualifying physicians outside the OTP system were permitted to dispense and prescribe FDA-approved medications if specifically indicated for SUDs.³⁴² Under DATA 2000, these physicians must be: licensed under state law, registered with the Drug Enforcement Agency to dispense controlled substances, qualified by training or certification to administer such substances; and must seek a waiver from the Substance Abuse and Mental Health Administration (SAMHSA).³⁴³

Initially, physicians were only permitted to treat up to 30 patients at a time; however, DATA 2000 has since been amended, allowing physicians who have held certification for more than one year to increase their maximum to 100 patients. Federal regulations now allow physicians who have prescribed buprenorphine to 100 patients for at least one year to increase this maximum to 275.³⁴⁴ In July of 2016, Congress passed, and President Obama signed into law, the Comprehensive Addiction and Recovery Act of 2016 (CARA) (further described in Section VII), expanding access to MAT.³⁴⁵ Among other provisions, CARA codifies SAMHSA grant programs to support states in expanding

access to treatment services, including evidence-based MAT, and authorizes nurse practitioners and physician assistants to prescribe buprenorphine.³⁴⁶

A recent evaluation of OTPs in Indiana by the Center for Health Policy at the Indiana University-Purdue University Indianapolis’ Richard M. Fairbanks School of Public Health found these programs to be highly effective in reducing opioid abuse and overall SUD; alcohol abuse; criminal behavior; and associated risky behaviors that spread infectious disease; as well as improving family and social relationships; and increasing educational attainment, vocational training, and employment.³⁴⁷ Dr. Timothy Kelly, a member of the Task Force who specializes in addiction medicine, notes that good quality MAT programs combined with psychosocial treatment have success rates between 40% and 60%, compared to programs utilizing psychosocial treatment only, which have success rates of less than 10%.³⁴⁸ Further, Dr. Kelly states that MAT utilization has superior outcomes by four critical measures: (1) the length of time patients remain in treatment; (2) patients’ ability to pass drug tests; (3) non-transmission of diseases such as hepatitis and HIV; and (4) patients’ commission of illegal behaviors (e.g., buying drugs on the street).³⁴⁹

Despite evidence in support of MAT, there are only 13 SAMHSA approved OTPs in Indiana, one fewer than what existed in 2002.³⁵⁰ Indiana also has far fewer MAT programs than many neighboring states, including Illinois (71 OTPs), Michigan (41), and Ohio (24).³⁵¹ With respect to DATA-certified physicians, SAMHSA reports that in 2016, there were 41 physicians with a 30-patient waiver and 12 with a 100-patient waiver.³⁵² Of note, Indiana law permits approval of not more than five additional OTPs before June 30, 2018, if DMHA determines a need for a new OTP in a proposed program location’s geographic area.³⁵³

Although some medications, including prescription opioids, require specific prescribing guidelines and extensive monitoring due to their high risk for abuse and misuse, the same level of oversight may not be necessary for other medications designed to prevent relapse. Naltrexone, for example, blocks the euphoric effects of drugs such as heroin, morphine, and codeine.³⁵⁴ Because naltrexone binds to and blocks opioid receptors, there is no potential for abuse or diversion.³⁵⁵ Still, naltrexone and other medications that assist in the treatment of addiction often face administrative barriers, such as prior authorization,^{xv} which may delay treatment.

^{xv} Prior authorization is a requirement designed to ensure appropriate treatment and avoid unnecessary costs, whereby providers obtain approval from health insurance plans to prescribe a specific medication. The Academy of Managed Care Pharmacy. (2012, April). *Concepts in Managed Care Pharmacy: Prior Authorization*. Retrieved August 6, 2016 from http://www.amcp.org/prior_authorization/.

TASK FORCE RECOMMENDATION & STATUS UPDATE

On November 19, 2015, the Task Force adopted a recommendation to direct the Indiana Family and Social Services Administration to implement the Gold Card Program, which removes administrative burdens by allowing qualified physicians the ability to prescribe medications without prior authorization. The prior authorization process enables payers like the Indiana Medicaid Program to review the medical evidence of a member’s health condition, as provided by the treating physician, so the medical need for covering the service and treatment costs can be established. In the intervening months between adopting the recommendation and publication of this report, the Gold Card Program was implemented allowing qualified Indiana providers to prescribe individuals with clinically appropriate drug abuse treatment without administrative delays. Criteria includes Indiana Health Care Program enrollment (i.e., must be an Indiana Medicaid enrolled provider); compliance with federal requirements; state licensure; and completion of Gold Card training.³⁵⁶

v. Workforce Development

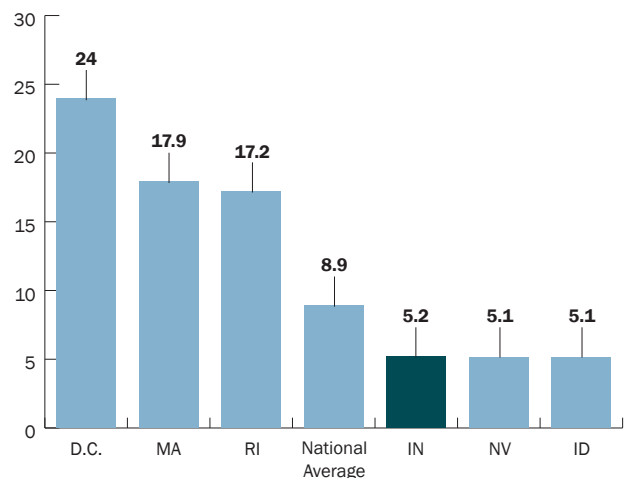
The increased demand for SUD treatment services, coupled with increased health insurance coverage, presents a considerable challenge given the severe shortage of behavioral health professionals in many states. Based on an analysis by the Bureau of Labor Statistics and Department of Health and Human Services data, there are an average of 32 behavioral health specialists (e.g., psychiatrists, psychologists, counselors and social workers) for every 1,000 Americans with an SUD, ranging from a high of 70 in Vermont to a low of 11 in Nevada.³⁵⁷ Complicating matters, much of the current behavioral health workforce lacks the training necessary to meet the treatment needs of the growing population of older adults, approximately 20% of which have one or more mental health disorders and SUDs.³⁵⁸ Further, recruitment and retention are impeded by compensation that is “significantly lower than for other health related or other comparable professions.”³⁵⁹ As an example, social workers in the addiction field earn an average of \$38,600 annually, compared to a salary of \$47,230 in the rest of the health care industry.³⁶⁰

Several indicators suggest the behavioral health workforce shortage is particularly prevalent in Indiana. For example, the state “has one of the lowest per-capita population ratios of psychiatrists in the United States, ranking at 43rd in the year 2000” (i.e., 6.9 per 100,000 persons).³⁶¹ According to more recent reports, this has dropped even further to 48th (5.2 per 100,000 persons) in the year 2015, ranking behind only Nevada and Idaho (both 5.1 per 100,000 persons).³⁶² This shortage is exacerbated by the fact that despite being the second largest medical school in the United States, the Indiana University School of Medicine psychiatry residency program graduates approximately four to six psychiatrists per year, with an average of less than one per year becoming psychiatric addictionologists.³⁶³

While psychiatrists are often a proxy for measuring the

strength of the behavioral health workforce, primary care physicians –often a primary source of treatment for behavioral healthcare, particularly in rural communities –are also lacking in Indiana. Currently, the state has the 38th lowest per-capita population ratio of active primary care physicians in the country (79.5 per 100,000 persons).³⁶⁴ These providers are also “inadequately trained to identify and treat those with mental illness,” which limits their capacity to provide treatment to individuals with an SUD.³⁶⁵ In addition, Licensed Clinical Addiction Counselors, an important resource for treating individuals with an SUD, are reportedly being underutilized as billing limitations prevent treatment centers from hiring them³⁶⁶

FIGURE 5: Psychiatrists per 100,000 Persons, 2015³⁶⁷



Despite the above challenges, novel programs exist that may help mitigate the shortage of behavioral health providers in the state. One example, launched by the University of New Mexico Health Sciences Center in 2003, is the Extension for Community Healthcare Outcomes (ECHO) project. Originally established as a partnership of academic medicine, public health offices, corrections departments, and rural community clinics, ECHO uses telemedicine to

provide evidence-based and protocol-driven health care to patients in rural areas.³⁶⁸ Using case-based knowledge networks and “learning loops” (i.e., case-based educational experiences where community providers learn through longitudinal co-management of patients with specialists, other primary care providers on the network via shared decision making, and brief didactic presentations), ECHO has been able to replicate academic medical center results through community-based treatment.³⁶⁹ Given its success, ECHO has been expanded to over 250 sites, addressing a range of complex health issues including cardiac risk factors, chronic pain, asthma, rheumatologic conditions, and SUD.³⁷⁰

The efficacy of ECHO has prompted federal legislation to advance it as a national model.³⁷¹ Specifically, Senate Bill 2873, the “Expanding Capacity for Health Outcomes Act” or the “ECHO Act,” would require the U.S. Department of Health and Human Services and the Health Resources and Services Administration, in consultation with public and private stakeholders, to examine “technology-enabled collaborative learning and capacity building models” to address, among other things, mental health and SUDs, including prescription drug and opioid abuse, as well as public health programs such as disease prevention, outbreaks, and surveillance.³⁷² Further, Senate Bill 2873 would require analyses and reports by the U.S. Government Accountability Office and both agencies, on the use and integration of such models, their impact on provider retention and provider shortages, barriers to adoption, the impact on provider quality, and efficiencies and potential cost savings.³⁷³ As of this report’s publication, Senate Bill 2873 has been read twice and referred to committee.³⁷⁴

vi. Involuntary Civil Commitment

Because a person with opioid use disorder may lack the capacity to act responsibly on his or her own behalf, many state laws permit, under certain circumstances, mandated treatment without a criminal conviction, referred to as “involuntary civil commitment.”³⁷⁵ Although conflicting and negative findings have been reported, studies largely support involuntary civil commitment for SUD treatment, citing longer retention and comparable or better short-term treatment responses (e.g., reductions in substance use, and criminal activity) to others in treatment.³⁷⁶ Further, early intervention through involuntary civil commitment, without necessitating entry into the criminal justice system, may reduce social costs associated with SUD.

In Indiana, an individual deemed to have a mental illness (i.e., psychiatric disorder, developmental disorder, or SUD), and who is either dangerous (i.e., as a result of mental

illness, presents a substantial risk of harm to oneself or others) or is gravely disabled (i.e., as a result of mental illness, is unable to provide for one’s essential human needs or has a substantially impaired judgement), may be involuntarily detained or committed.³⁷⁷ Specifically, a court may order: (1) “immediate detention,” which allows police to transport and commit an individual to a treatment facility (other than a state hospital) to be held for up to 24 hours; (2) “emergency detention,” which allows a court-ordered commitment for transport and commitment into a treatment facility (other than a state hospital) for a specified time period; (3) “temporary commitment,” which allows for a court-ordered commitment to a community mental health center or state hospital for a period of 90 days (with one renewal); and (4) “regular commitment,” which follows the same procedures for temporary commitment but is expected to exceed 90 days, with annual reporting to the court to assess renewal.³⁷⁸

Further, Indiana law allows for involuntary outpatient civil commitment if, upon recommendation by an individual’s examining physician and following a hearing, a court finds that the individual is mentally ill and either dangerous or gravely disabled; is likely to benefit from an outpatient therapy program; and is not likely to be either dangerous or gravely disabled if the individual complies with the therapy program.³⁷⁹ Further, if an individual has been ordered to either temporary commitment or regular commitment as described above and meets the criteria for outpatient civil commitment, “the superintendent of the facility in which the individual is committed or the court at the time of commitment may place the individual on outpatient status for the remainder of the individual’s commitment period.”³⁸⁰ Although outpatient status is not court-ordered, failure to comply can lead to court-ordered inpatient treatment.³⁸¹

While involuntary civil commitment may be an available and effective means of getting Hoosiers with an SUD into treatment, it is not without challenges. For example, funding sources are limited for SUD treatment in inpatient/residential settings.³⁸² This challenge results in fewer immediate and emergency detentions; fewer petitions for temporary or regular commitment following detention; fewer outpatient commitments given the inability to transition to inpatient status if noncompliant; and fewer placements on outpatient status given the lack of inpatient commitment to transition from.³⁸³ In addition, the medical costs and risks associated with detoxification may be discouraging immediate and emergency detentions.³⁸⁴ Finally, the complexity of the civil commitment statutes often requires an expertise and familiarity that may not be present outside of specialized drug courts.³⁸⁵

To address these challenges, in 2015 the Indiana General Assembly passed, and Governor Pence signed, House Enrolled Act 1448 (“Jennifer Act”), aimed at advancing the use of involuntary civil commitment where appropriate.³⁸⁶ A successful collaboration between Sharon Blair, an advocate for improved involuntary commitment laws, and Representative Steve Davisson, along with key supporters such as Senator Patricia Miller, Attorney General Greg Zoeller, and Mental Health America of Indiana, the Jennifer Act provides for training of judges, prosecutors, and public defenders concerning diversion programs and other probationary programs available for individuals with an SUD; and extends the use of funds in the state’s forensic treatment services account (i.e., Recovery Works, described in Section IV) to services provided by licensed mental health or addiction providers (formerly only certified providers).³⁸⁷

PERSONAL TESTIMONY ▼

Jennifer M. Reynolds died January 15, 2009 at the age of 29, after battling drug addiction for 13 years. Her mother **Sharon Blair** fought on Jennifer’s behalf and tried to intervene using Florida’s involuntary commitment laws; however, state law required a filing fee of up to \$400 and only allowed for short-term detoxification (72 hours). Following her daughter’s death, Sharon began advocating for the “Jennifer Act,” model legislation that would reduce or eliminate filing fees for involuntary commitment, increased detoxification time, provide sufficient facilities to house addicted individuals, provide secular or faith-based treatment programs; and build a cohesive plan between law enforcement, the judicial system, and legislature that works to save addicts lives. As a result of Sharon’s efforts, numerous provisions have been enacted in Florida, and now the state of Indiana through House Enrolled Act (HEA) 1448 – “The Jennifer Act”.

C. TREATMENT BEST PRACTICES IDENTIFIED BY THE TASK FORCE

A number of SUD enforcement, treatment, and prevention best practices are being implemented across the state and nationally. The following section outlines several opportunities related to treatment that may serve as models for other communities.

i. Medicaid §1115 Demonstration Waivers

On July 27, 2015, the Centers for Medicare and Medicaid Services announced the availability of a new §1115 demonstration waiver opportunity for individuals suffering from SUDs.³⁸⁸ Citing the increasing rate of SUDs among Medicaid beneficiaries, the waiver allows states to receive federal funding to design and implement comprehensive delivery models for Medicaid-eligible individuals suffering from SUDs, including modification to the IMD exclusion described above.³⁸⁹ To receive a waiver, states must “promote both systemic and practice reforms in their efforts to develop a continuum of care that effectively treats the physical, behavioral and mental dimensions of SUD.”³⁹⁰ Examples of such changes may include, but are not limited to, partnering with drug courts and juvenile justice systems to ensure medically appropriate referrals to SUD treatment; implementing payment models that support project goals such as shared savings or managed care; or enhancing provider competencies to deliver SUD services in alignment with industry standard models, such as the American Society for Addiction Medicine criteria.³⁹¹

ii. Indiana Addiction Hotline

Telephone counseling services (i.e., helplines or hotlines) now represent a significant component of care for individuals with behavioral health concerns. While helplines differ in terms of services provided (e.g., counseling, referral, resource identification, and prevention), they generally

TASK FORCE RECOMMENDATION & STATUS UPDATE

On September 16, 2015 the Task Force adopted a recommendation to direct the Indiana Family and Social Services Administration (FSSA) to study the feasibility of pursuing a Medicaid §1115 Demonstration Waiver for individuals with substance use disorders to broaden Indiana Medicaid benefit packages and provide a more comprehensive continuum of covered services and care. In the intervening months between adopting the recommendation and publication of this report, FSSA conducted an initial financial analysis; identified several interrelated benefits that may have the potential to strengthen the effectiveness of treatment services throughout the continuum of care; analyzed potential funding sources; and is undertaking a comprehensive review of state mental health and substance use disorder programming and structures. FSSA is also considering requesting a waiver of the IMD exclusion in its upcoming HIP 2.0 §1115 demonstration renewal application.

share many of the same characteristics (e.g., confidential, toll-free, provide services in multiple languages). Indiana residents calling the Substance Abuse and Mental Health Services Administration's National Helpline are transferred to the Indiana Addiction Hotline, which provides crisis intervention services for SUDs and gambling.³⁹² The Hotline is available 24 hours per day, seven days a week, and calls are answered by masters-prepared counselors who, using established protocols, refer callers to state-approved agencies or directly transfer calls to a treatment provider.³⁹³ Nearly 7,000 addiction-related calls were received in 2015, representing a 26% increase over the previous year.³⁹⁴ The Hotline is currently evaluating strategies to increase awareness and access to its services, with potential opportunities including use of a single phone number for all SUD issues, improved data collection, and additional methods of communication such as text and social media.³⁹⁵

iii. Indiana Parenting Institute

Parenting is widely regarded as a determinant of social, economic, and health outcomes; however, a parent's ability to make responsible choices regarding his/her children is often conditioned by the parent's resources, his/her own health, and the characteristics of the communities in which he/she lives.³⁹⁶ In the most extreme circumstances, children exposed to strong, frequent, or prolonged adversity (e.g., abuse, neglect, caregiver SUD or mental illness, or the accumulated burdens of family economic hardship) without adequate adult support, often develop unhealthy coping mechanisms and engage in high-risk behaviors.³⁹⁷ Adults in this high-risk group who become parents themselves are less likely to be able to provide a stable environment for their own children, thereby creating an intergenerational cycle of limited economic achievement and poor health.³⁹⁸ As such, support for effective parenting behaviors is reflected in a number of professional and policy initiatives ranging from clinical interventions (e.g., parent-training groups delivered to parents in pediatric primary care settings) to advocacy at the highest levels (e.g., the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program, which, among other metrics, seeks to improve parenting skills related to child development).³⁹⁹

In Gary, Indiana, the Indiana Parenting Institute ("Institute") supports positive and effective parenting behaviors by delivering evidence-based, skill-building, parenting education programs.⁴⁰⁰ For example, the Institute offers a 10-week truancy reduction program ("Zero Tolerance") designed to educate and train caregivers of children with a record of school truancy, or who are showing signs of school disengagement due to chronic absences, in

the tactics of intervention and prevention.⁴⁰¹ Parents are asked to examine their influence on their children's behavior and to consider the changes they need to make in an effort to help their children succeed. In addition, parents learn about the consequences of truancy, conflict resolution and problem-solving techniques, as well as measures to effectively transition youth into adulthood.⁴⁰² The Institute also offers a "Birth2Eighteen" parenting course to provide parents and caregivers with children under 18 the "latest foundational relationship strategies and techniques to enhance parenting and family outcomes."⁴⁰³ The course uses in-class role-playing and group activities to help parents better understand the stages of human development, how to motivate positive behavior, and how to build and sustain healthy relationships.⁴⁰⁴

iv. Indiana Department of Correction Vivitrol Pilot Program

The DMHA coordinates SUD treatment for individuals released from jail or prison through the Recovery Works program described in Section IV; however, in an effort to further reduce the risk of relapse, the IDOC recently implemented a pilot program to provide Vivitrol to severely addicted individuals upon release from Starke County Jail.⁴⁰⁵ An injectable, extended-release form of naltrexone, Vivitrol blocks opioid cravings and the associated opioid high.⁴⁰⁶ Participants in the program will receive one shot prior to release and, along with regular drug testing, continue post-release treatment in their communities.⁴⁰⁷ IDOC will also help eligible offenders prepare to enroll in HIP 2.0 upon

PERSONAL TESTIMONY ▼

Joan Moon, a doctorally prepared nursing faculty member and retired certified nurse midwife and clinical nurse specialist, shared with the Task Force her grandson's positive experience with Vivitrol. In and out of rehabilitation programs for opioids since 2009, Joan's grandson was given access to Vivitrol and had great success remaining drug-free for over a year, finding stable employment, completing probation, and reuniting with his family. Though her grandson eventually began using again, Joan continues to advocate strongly for the use of medication assisted treatment, particularly Vivitrol given its non-addictive nature. While Joan recognizes Vivitrol is not a "cure-all," she encouraged the Task Force to view addiction as a chronic disease that should be treated with medication when available just as we would diabetes or congestive heart failure. Further, Joan recommended increased awareness of Vivitrol among corrections, the judicial system, and the general public.

release, which provides coverage for injections and other mental health services.⁴⁰⁸

v. Eskenazi Health Midtown

Research indicates that nearly half of individuals diagnosed with an SUD also suffer from serious mental illness.⁴⁰⁹ Given this high level of co-morbidity, research indicates that significantly improved treatment outcomes can be achieved for clients with SUDs when programs are designed to treat both conditions.⁴¹⁰ In Marion County, Eskenazi Health's Midtown Community Mental Health Center ("Midtown") uses multidisciplinary treatment teams to provide individual, group, and family treatment for SUDs.⁴¹¹ With nearly 650,000 client visits annually, Midtown provides addiction treatment services to clients in all of its primary care settings.⁴¹² To begin, every Midtown client undergoes a comprehensive assessment that includes screening for problematic substance use.⁴¹³ This allows staff the opportunity to provide education on SUDs and refer clients to intensive SUD treatment programs as necessary.⁴¹⁴ For those clients referred to treatment, Midtown offers a Narcotics Treatment Program (NTP) and an Adult Addictions Clinic (AAC).⁴¹⁵

While NTP provides outpatient addiction treatment to clients with opioid dependence using talk therapies in conjunction with medication-assisted treatment (e.g., methadone in combination with individual, group, and family therapy), AAC provides treatment for a broad range of SUDs, including alcohol, cocaine, opioids, marijuana, and nicotine.⁴¹⁶ Over the past year, both programs have provided treatment to a combined total of more than 1,750 clients, and have demonstrated considerable success. For example, within the first 90 days of participation in NTP, "over 50% of clients see a decrease in symptoms, along with an increase in employment, housing stability, and financial resources;" and after one year, "over 75% of [AAC] clients report stable employment and housing, a significant reduction in mental health and addiction symptoms, and reconnection with their family and other positive social supports."⁴¹⁷ Similarly, clients in the AAC "have achieved a greater degree of stability in symptoms along with a 43% reduction in inpatient and crisis services."⁴¹⁸

vi. Education for Pharmacists

In response to the increase in prescription opioid abuse and overdose deaths, a special committee of the American Association of Colleges of Pharmacy was convened in 2010 to "examine and recommend how pharmacy colleges should prepare all student pharmacists to appropriately assist those who are addicted or affected by others' addiction,

and help support addiction recovery with an emphasis on public safety."⁴¹⁹ The committee's resulting report provided a series of recommendations including, but not limited to, development and implementation of policies to assist students and faculty with addiction and related disorders; utilization of curricular content guidelines for SUD and addictive disease; and sufficient incorporation of SUD and addiction issues in pharmacy education accreditation, the pharmacy licensure examination, and the practice standards of professional organizations.⁴²⁰

The Manchester University College of Pharmacy in Fort Wayne, one of three pharmacy schools in Indiana, has used these recommendations to significantly enhance its curriculum to prepare students to effectively deal with addiction and SUDs. Specifically, Manchester University incorporates an explanation of legal rules relating to controlled substance prescribing and dispensing, a discussion of "responsible prescribing," and an introduction to INSPECT (described in Section VI) during students' first introductory course.⁴²¹ While pursuing their degree, students also participate in skills labs evaluating actual INSPECT reports and receive instruction in pain management, drug dependence/addiction/tolerance pharmacology, social aspects of abuse, smoking cessation, SUD therapeutics, and the toxicology of drugs of abuse.⁴²²

vii. Recovery-Oriented Systems of Care Model

The Recovery-Oriented Systems of Care model entails a network of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families affected by severe SUDs.⁴²³ The model seeks to provide a "whole person" approach rather than the traditional provision of treatment services through disconnected silos, by also addressing housing, legal services, education, and employment, and aims to prevent, treat, and discontinue SUD by improving the individual's personal, family and cultural "recovery capital."⁴²⁴ Personal recovery capital involves physical needs such as health, shelter, food, and transportation, as well as human needs including life skills, values, and self-esteem.⁴²⁵ Family recovery capital relates to strengthening the individual's familial and social networks, while cultural capital focuses on identifying demographically-compatible pathways to recovery within the individual's community.⁴²⁶

viii. Prescription Guidelines

As noted previously, the United States represents 5% of the world's population, yet consumes 75% of the world's prescription drugs.⁴²⁷ Within the United States, Indiana has the ninth highest rate of prescriptions written for pain

medications per capita in the country, and the proportion of Medicare prescriptions for opioid pain medications filled in 2013 was higher than the national average in 80% of the state's counties.⁴²⁸ Moreover, in 12 Indiana counties, the number of Medicare opioid prescriptions submitted exceeded the total county population.⁴²⁹

Given the increase in prescription drug overdose deaths nationally, virtually every state has enacted laws regarding the monitoring and distribution of prescription opioids.⁴³⁰ During the 2015 state legislative session alone, there were at least 1,210 bills and resolutions filed and listed across all 50 states, 266 of which were signed or enacted in 48 states.⁴³¹ Moreover, as of July 2016, states have filed more than 1,100 bills and resolutions, including new legislation and measures carried over from 2015, and 40 states have signed these measures into law.⁴³²

In an effort to address the proliferation of opioid pain medication prescriptions throughout Indiana, the Medical Licensing Board of Indiana adopted an emergency administrative rule on October 24, 2013, regulating the prescribing of opioid controlled substances for pain management treatment.⁴³³ The final rule, adopted on September 25, 2014, only applies to the prescribing of opioid-containing controlled substances for pain management, and does not apply to terminally ill patients, residents of a licensed health facility, hospice patients, or patients enrolled in an inpatient or outpatient palliative care program of a licensed hospital or hospice.⁴³⁴

The final rule also contains requirements that physicians perform an initial evaluation and risk assessment of all patients; utilize non-opioids where medically appropriate; and discuss, among other things, the potential risks of

opioid treatment, proper use, and safe storage practices.⁴³⁵ Providers are prohibited from prescribing pain medications to patients without periodic scheduled visits, or without having run an INSPECT report and documenting whether it is consistent with the patient's controlled substance use history.⁴³⁶ Finally, the rule allows testing to confirm the medication is being used as prescribed.⁴³⁷

While the aforementioned rule provides guidance to providers regarding pain management, it does not address prescribing of pain medication for "acute" or "immediate" pain that is relatively short in duration, not life threatening, and generally prescribed in an acute setting, a physician's office, or an emergency department. As the use of patient pain intensity rating scales has become integral to assessments in inpatient hospitals over the past 15 years, the practice of prescribing specific doses of opioid pain medications based solely on specific pain intensity has become an unforeseen consequence—commonly referred to as "dosing to numbers."⁴³⁸ Further, individual physician evaluation structures, based in part on member satisfaction, encourage physicians to over-prescribe pain medications in order to increase patient satisfaction.⁴³⁹ For example, it is not uncommon for providers to issue a three-month prescription for pain medications for symptoms which may last significantly less than three months.⁴⁴⁰ These over-prescription practices are done, in part, to keep patients from having to return to the physician's office to be issued another prescription which must be filled by a pharmacist.⁴⁴¹ In addition, data indicate that up to two-thirds of the opioid pain medications prescribed by Indiana hospitals are dispensed by emergency departments, and over 20% of individuals visiting an emergency department in Indiana leave with prescribed opioid pain medications in hand.⁴⁴²

TASK FORCE RECOMMENDATION & STATUS UPDATE

On October 15, 2015, the Task Force adopted a recommendation to direct appropriate entities to promulgate and adopt with all expediency chronic pain prescribing rules for all prescribers. In the intervening months between adopting the recommendation and publication of this report, each of the following boards expeditiously promulgated chronic pain prescribing rules: State Board of Nursing, Physician Assistant Committee, Board of Podiatric Medicine, and the State Board of Dentistry.

TASK FORCE RECOMMENDATION & STATUS UPDATE

On October 15, 2015, the Task Force adopted a recommendation to direct the Indiana State Department of Health to work with appropriate entities including those that represent physicians, nurses, dentists, physician assistants, podiatrists, and veterinarians to develop guidelines for prescribing acute pain medications. In the intervening months between adopting the recommendation and publication of this report, the Indiana Hospital Association (IHA) and Indiana State Medical Association (ISMA) have engaged in a review of statewide emergency department pain medication prescribing practices, as well as policies used in other states. Based on this assessment, the organizations have developed draft opioid and controlled substance prescribing guidelines for emergency departments, which are intended to complement pre-existing chronic pain management rules and other laws governing prescribing practices or patient treatment. Support for these guidelines have been received from key stakeholders, including the Indianapolis Coalition for Patient Safety. IHA and ISMA are currently finalizing the draft guidelines to prepare for dissemination; working with stakeholders on a “Safe Prescribing” campaign; and resuming work on other acute prescribing guidelines. On June 21, 2016 the Task Force endorsed the IHA and ISMA opioid and controlled substance prescribing guidelines for emergency departments as part of a larger strategy to combat prescription drug abuse in Indiana.

VII. SUBSTANCE USE DISORDER PREVENTION

A. BACKGROUND

As described in Section IV, United States efforts to curb SUD over the past 40 years have heavily focused on enforcement (i.e., punishment and interdiction). However, during the latter part of the 20th Century, stated national drug policy began emphasizing a balanced set of interventions that include enforcement, treatment, and prevention. Specifically, the Anti-Drug Abuse Act of 1988 established the Office of National Drug Control Policy in order “to set priorities and objectives for national drug control, promulgate The National Drug Control Strategy [(NDCS)] on an annual basis, and oversee the strategy’s implementation.”⁴⁴³ In 1989, President George Bush presented the first NDCS, which, while continuing to emphasize traditional enforcement activities, recognized prevention as a “long-term solution” to SUD and called for “increasing Federal support for prevention programs ... that help high-risk youth, particularly those who reside in high-crime neighborhoods, to remain drug-free, as well as those that help communities to mobilize against drugs and violence.”⁴⁴⁴

In the years following the inaugural NDCS, SUD prevention continued to be an integral part of comprehensive national drug policy; however, the effectiveness of specific prevention methods remains a subject of great debate. Perhaps the most cited example is the Drug Abuse Resistance Education (“D.A.R.E.”) program. Established in 1983, the D.A.R.E. model uses police officers to “lead educational sessions in local schools that are designed to help students resist peer pressure and live drug-free lives.”⁴⁴⁵ Since its inception, D.A.R.E. has become one of the most well-known and widespread crime prevention programs in the country—as of 2009, D.A.R.E. was taught in approximately 75% of school districts and was the country’s largest single school-based prevention program in terms of federal expenditures.⁴⁴⁶ While adoption and support for the program has, for over 25 years, been nothing short of impressive, there have been more than 30 evaluations of the program documenting negligible long-term impacts on teen drug use, with studies indicating marginally better outcomes for individuals participating in D.A.R.E. relative to participants in control conditions.⁴⁴⁷

As the field of SUD prevention has emerged over the past two decades, researchers, program designers, and policymakers have gained a greater understanding of the “underlying psychosocial risks and protective factors associated with drug use onset and progression to

abuse.”⁴⁴⁸ Further, research has demonstrated the efficacy of a number of theory-based SUD prevention programs and policies that are now being applied in the practice community with great success.⁴⁴⁹ National drug policy has followed suit, with the 2010 NDCS citing the need to “prepare communities to efficiently and effectively assess the unique nature of their local drug problems and to deliver evidence-based prevention targeted specifically toward those problems,” as opposed to developing new or novel programs and prevention techniques.⁴⁵⁰ Perhaps the most notable examples of research-informed SUD prevention and intervention strategies in recent years are prescription drug monitoring programs and the use of naloxone, an opioid overdose antidote, by first responders and third parties.⁴⁵¹

B. INDIANA’S RESPONSE

Indiana’s commitment to treating SUDs as a public health concern is exemplified by its collaborative approach to prevention. In recent years, professionals across multiple disciplines have worked together to implement a series of evidence-based strategies designed to help communities, schools, parents, and health professionals prevent both the onset and deleterious effects of drug use. The below section outlines several key initiatives reviewed by the Task Force.

i. Neonatal Abstinence Syndrome

The current rate of illicit drug use among pregnant women aged 15 to 44 is 5.4%, though it is considerably higher among teens (14.6%) and women age 18 to 25 (8.6%).⁴⁵² Further, a recent study of more than 1.1 million Medicaid-enrolled women with completed pregnancies illustrated that 21.6% filled at least one prescription for an opioid during her pregnancy, and 2.5% of these women received a prescription for greater than 30 days.⁴⁵³ This latter figure is of particular importance, as the overall proportion of pregnant SUD treatment admissions has remained stable over the past 20 years (4%); however admissions of pregnant women reporting prescription opioid abuse has increased substantially from 2% to 28%, especially in the southern United States.⁴⁵⁴ Among all women of child-bearing age, studies also show that 27.7% of privately insured and 39.4% of Medicaid-enrolled women filled a prescription for an opioid from an outpatient pharmacy each year between 2008 and 2012.⁴⁵⁵ These figures are particularly troubling, as prenatal use of opioids by pregnant women can be associated with considerable health risks to both mother and fetus.⁴⁵⁶

In recent years, the incidence of neonatal abstinence syndrome (NAS), a postnatal withdrawal syndrome caused by prenatal opioid exposure, has nearly tripled in the United States, with one study showing an increase of 1.2 cases per 1,000 hospital births per year in 2000 to 3.4 cases per 1,000 hospital births in 2009. The syndrome is characterized by a constellation of symptoms including central nervous system hyperirritability (e.g., excessive crying, tremors, and seizures) and dysfunction of the autonomic nervous system (e.g., yawning, sweating, and sneezing), gastrointestinal tract (e.g., poor feeding, vomiting), and respiratory system (e.g., tachypnea).⁴⁵⁸ “Most, if not all opioid exposed infants experience NAS to some degree,” and presenting symptoms typically occur within the first 48 to 72 hours after birth.⁴⁵⁹ Treatment for NAS typically requires extended hospitalization, pharmacotherapy, and extensive neonatal monitoring, resulting in increased healthcare costs—up to five times the costs of treating other newborns, with more than three quarters of cases paid for by Medicaid.⁴⁶⁰ While studies indicate that prenatal exposure to opioids increases a child’s risk for neuropsychological dysfunction, the precise

long-term effects are largely unknown given difficulties isolating independent effects of opioid treatment, comorbid substance exposure, and environmental and medical factors.⁴⁶¹

Prompted by a lack of state-level data on NAS, in 2014, the Indiana General Assembly passed, and Governor Pence signed, Senate Enrolled Act 408 (SEA 408), which required the Indiana State Department of Health (ISDH) to meet with various stakeholder associations to study and make recommendations on issues concerning NAS. Further, it required production of a report identifying: (1) the appropriate standard clinical definition of NAS; (2) a uniform process of identifying NAS; (3) the estimated time and resources needed to educate providers in implementing said process; (4) options available for NAS data reporting to the state; and (5) available or needed reimbursement for identifying and reporting NAS.⁴⁶² Pursuant to SEA 408, ISDH convened a task force comprised of approximately 50 members who met monthly to accomplish the statutory deliverables.⁴⁶³ The task force reviewed national guidelines,

TABLE 5: NAS TASK FORCE DELIVERABLES⁴⁶⁴

DELIVERABLE	OUTCOME
Clinical Definition	The NAS Task Force recommended that the diagnosis of NAS be applied to babies who are symptomatic, have two or three consecutive Modified Finnegan scores equal to or greater than 24, and have a positive toxicology test, or a maternal history with a positive verbal screen or toxicology test.
Identification Process	<p>The NAS Task Force developed a process for both pregnant women and newborns to correctly identify pregnant women at risk for delivering a baby with NAS.</p> <p><i>Prenatal Visit (Obstetric Protocol)</i> – As part of routine prenatal screening, the primary care provider will conduct one standardized and validated verbal screening; and one toxicology screening (urine) with an opt out.^{xvi} At the discretion of the primary care provider, INSPECT and/or repeat verbal and toxicology screenings may be performed at any visit.</p> <p><i>At Presentation for Delivery (Perinatal Protocol)</i> – When the laboring woman arrives at the hospital for delivery, hospital personnel will conduct a standardized and validated verbal screening on all women; conduct toxicology screening (urine) on women with positive or unknown prenatal toxicology screening results; conduct toxicology screening (urine) on women with a positive verbal screen at presentation for delivery; and conduct toxicology screening (urine, meconium or cord tissue) on babies whose mothers identified at risk or who had positive toxicology screening results.</p>

^{xvi.} As of March 2016, one state allows assault charges to be filed against a pregnant woman who uses certain substances; 18 states consider SUD during pregnancy to be child abuse under civil child-welfare statutes, and three consider it grounds for civil commitment. Further, 18 states require health care professionals to report suspected prenatal drug abuse, and four states require them to test for prenatal drug exposure if they suspect abuse. Indiana law allows for a child to be taken into protective custody by the State Department of Child Services (DCS) if the child is born with fetal alcohol syndrome or a controlled substance or legend drug in its body, or if the child is at risk from the mother’s use of alcohol, a controlled substance, or legend drug during pregnancy. Indiana law does not mandate drug testing for pregnant women.

TABLE 5: NAS TASK FORCE DELIVERABLES (continued)

DELIVERABLE	OUTCOME
Required Resources	In order to identify a cost effective and consistent approach to the identification of NAS, the Task Force recommended that the state employ a “train the trainer” model. This would include conducting a one-day training for hospital/birthing center perinatal educators who would then return to their facility and develop a training plan that would ensure that perinatal hospital personnel have the knowledge and skills necessary to properly identify NAS. Two training programs were identified to support inter-rater reliability for Finnegan scoring necessary to make the official diagnosis of NAS, both of which are already in use in some hospitals around the state. In addition, a more comprehensive training initiative was recommended by the NAS Task Force that would extend beyond the initial identification process and hospital personnel. This training initiative would require additional resources to reach the broader audience.
Reporting Options	ISDH proposed that the portal used to collect newborn metabolic and hearing screenings be expanded to add de-identified NAS screening data. The proposed data elements capture hospital, maternal, infant, and diagnostic information. This minimum information would allow ISDH to obtain data on incidence and on types of drugs identified.
Reimbursement	Both public and private insurance typically cover toxicology screening for opioids, alcohol, and benzodiazepines; however, universal screening would likely result in an increase in the number of screens and therefore an increase in cost to third-party payers. With respect to training, ISDH would sponsor a one-day training and individual hospitals would be responsible for incorporating training into their orientation for new staff. Data collection costs (e.g., portal development, support staff, monitoring/analyzing data) will cost approximately \$50,000.

relevant literature, and best practices related to NAS developed by other states to inform the decision-making process.⁴⁶⁵ After completion of the review and substantive discussion of the issues related to NAS, the task force developed a consensus position for submission to the Indiana General Assembly.⁴⁶⁵

With SEA 408’s research and reporting requirements, the new law also contained language permitting ISDH to establish a voluntary pilot program with hospitals to implement appropriate and effective models for NAS identification, data collection, and reporting.⁴⁶⁷ Beginning January 1, 2016, ISDH partnered with four volunteer hospitals—Community East Hospital in Indianapolis, Schneck Medical Center in Seymour, Hendricks Regional Health in Danville, and Columbus Regional Health in Columbus—to perform umbilical cord tissue testing, compare results with national samples, provide informational materials to pregnant women (e.g., brochures regarding substance use and family guides for taking home infants with NAS), and provide NAS treatment protocol to providers.⁴⁶⁸ In addition,

ISDH is collaborating with managed care organizations, community health centers and IDCS to connect patients to high-risk obstetric care coordinators and support services in their local communities.⁴⁶⁹ Preliminary data, based on 301 cases, indicates umbilical cord positivity rates higher than national averages for a number of drugs, most notably opiates (20.6% compared to 9.3%). ISDH indicates these figures would likely be higher with universal screening.⁴⁷⁰ Additional findings demonstrate that the “drug of choice” varies depending on location, more than one drug is often being used, there is a lack of treatment programs to refer patients to, and there are limited wrap-around services for women with SUDs both during and after pregnancy.⁴⁷¹

ii. Prescription Drug Monitoring

According to the Centers for Disease Control and Prevention, state-based electronic databases used to track prescribing and dispensing of controlled substances to patients (i.e., prescription drug monitoring programs, or PDMPs) “continue to be among the most promising state-level

interventions to improve painkiller prescribing, inform clinical practice, and protect patients at risk.”⁴⁷² Designed to monitor for suspected abuse or diversion, PDMPs provide information regarding a patient’s prescription history, which may assist providers and pharmacists in identifying high-risk patients who may benefit from early interventions.⁴⁷³ States have implemented a range of strategies to enhance PDMPs, with prominent features including policies for prescriber delegation and “universal” use (i.e., prescribers are mandated to check PDMP prior to writing an opioid prescription), real-time data submission, active management by state agencies (e.g., use as epidemiological tool and proactive reporting), electronic health record integration, and streamlined prescriber registration.⁴⁷⁴

Indiana’s PDMP was established in the mid-1990s, requiring licensed pharmacies to report on dispensed Schedule II controlled substances.⁴⁷⁵ In 2006, the Indiana General Assembly enhanced the state’s PDMP by expanding reporting requirements to include Schedule II through V controlled substances,^{xvii} and creating the “Indiana Scheduled Prescription Electronic Collection and Tracking” program (INSPECT). INSPECT is an online database that serves as a clearinghouse of patient information for healthcare providers, as well as an investigative tool for law enforcement entities engaged in an active, ongoing investigation pertaining to the subject of the request and where the request involves controlled substances.⁴⁷⁶ INSPECT is funded by the Harold Rogers Prescription Drug Monitoring grant program and controlled substance licensing fees.⁴⁷⁷ The ISDH reports that 39% of professionals licensed to prescribe medications in Indiana are currently registered with INSPECT and, of the approximately 13,000 professionals registered for INSPECT, only half are physicians.

While Indiana does not maintain a universal use policy, INSPECT users are encouraged when writing prescriptions for controlled substances to request a prescription history report, which provides a patient’s controlled substance history, including products obtained, dates prescriptions were written and filled, as well as prescriber and dispensing pharmacy.⁴⁷⁸ As INSPECT shares data with 22 other states, users may also use the system to identify potential doctor-shoppers or patients seeking controlled substances across state lines.⁴⁷⁹ In addition to patient reporting, registered prescribers may perform “self-lookup” requests, which allow the prescriber to access their full controlled substance prescribing history in the event of prescription pad theft or fraud.⁴⁸⁰ Pursuant to state statute, INSPECT is also required to notify prescribers and dispensers of patients that have exceeded a predetermined number of controlled substance dispensations.⁴⁸¹

INSPECT has undergone a number of improvements in recent years. For example, the Indiana Professional Licensing Agency (PLA) now requires that all data must be reported to INSPECT within 24 hours of dispensing, or by the close of the next business day, thereby providing near real-time data to users (PLA currently reports 99% compliance with the new requirement).⁴⁸² In addition, the provider enrollment process has been streamlined to encourage greater adoption, and the PLA is working to develop continuing medical education opportunities to incentivize use of the program.⁴⁸³ Finally, several system upgrades are planned over the coming years to improve accessibility, and the Indiana Board of Pharmacy and the INSPECT Oversight Committee recently approved a hospital electronic medical records integration pilot program, using Centers for Disease Control and Prevention funds.⁴⁸⁴

TASK FORCE RECOMMENDATION & STATUS UPDATE

On October 15, 2015, the Task Force adopted a recommendation to direct the ISDH to convene a working group to send recommendations on improvements and best practices related to INSPECT, to the INSPECT Oversight Committee. In the intervening months between adopting the recommendation and publication of this report, State Health Commissioner Dr. Jerome Adams identified a series of best practices including: universal use; mandatory physician dispenser reporting; increased public health access and use; criteria for questionable patient activity and dangerous drug combinations; improved data quality; electronic health record integration; and enhanced program evaluation. Each of the aforementioned is supported by the Brandeis PDMP Center of Excellence, the Centers for Disease Control and Prevention, and the Association of State and Territorial Health Officials. Further detail is provided in Appendix F.

^{xvii.} INSPECT does not collect information on non-controlled substance, drugs administered in an inpatient or hospice setting, or drugs dispensed with less than a 72-hour supply.

TASK FORCE RECOMMENDATION & STATUS UPDATE

On November 19, 2015, the Task Force adopted a recommendation to direct the Indiana Professional Licensing Agency to request that the INSPECT Oversight Committee explore possible measures to increase access to INSPECT for prescribers and dispensers. In the intervening months between adopting the recommendation and publication of this report, both the INSPECT Oversight Committee and the Indiana Board of Pharmacy approved the use of the prescription monitoring program (PMP) Gateway integration method, which simplifies integration for state PMPs and for hospitals/pharmacies by providing a single point of access to PMP data. In addition, the Indiana Professional Licensing Agency established the INSPECT Integration Initiative to fund integrated access for healthcare practitioners, incentivizing their participation. By integrating INSPECT reports into patient electronic medical records, a more comprehensive view of a patient's health and controlled substance prescription history will be easily accessible by practitioners. With practitioners enrolling and participating in the integration initiative, especially those in emergency room settings for hospitals, the initiative seamlessly complements the Task Force's recommendation regarding guidelines for opioid prescribing in the emergency department, which suggests that emergency department providers prescribe or administer opioids and other controlled substances only after reviewing INSPECT or other prescription monitoring programs that incorporate INSPECT data. By integrating INSPECT reports, the program will be easier to use and practitioners will save time; a win-win, which will increase usage in the program. A second initiative to increase use of the INSPECT program will be the automatic registration feature for qualified practitioners. Once a licensed practitioner is approved for their state Controlled Substance Registration and their federal Drug Enforcement Agency license, the INSPECT program will generate an email notifying the practitioner that they are now enrolled in the INSPECT program with additional information being provided about INSPECT, how to access the program, the benefits of using the program, and so forth. This will result in 100% enrollment for eligible Hoosier healthcare practitioners.

TASK FORCE RECOMMENDATION & STATUS UPDATE

On September 20, 2016, the Task Force adopted a recommendation to direct the Professional Licensing Agency to begin implementing a pilot program, the INSPECT Integration Initiative, to allow for the integration of INSPECT data with hospital patient records. The purpose of this program is to improve hospital physicians' access to prescribing patterns for patients. The INSPECT Integration Initiative is one of the recommendations within the Indiana Guidelines for Opioid Prescribing in the Emergency Department. In the intervening months between adopting the recommendation and publication of this report, the INSPECT Program established a pilot program with Deaconess Hospital in Evansville, Indiana, to integrate INSPECT data directly into electronic health records. Through the pilot program, at least 300 emergency department physicians will have integrated access, which will decrease users' INSPECT inquiries from approximately five minutes per search to three seconds per search. This will significantly improve practitioners' access to prescribing patterns for patients and ultimately improve health outcomes. PLA anticipates a swift statewide deployment of this capability once the pilot is completed.

iii. Naloxone Access (Fatality Prevention Strategy)

As noted previously, opioid overdoses may be reversible with timely administration of naloxone, an FDA-approved medication that blocks opioid receptor sites, thereby reversing the toxic effects of the overdose. Naloxone is administered when an individual is showing signs of opioid overdose. It may be administered through an intranasal spray or an intramuscular, subcutaneous, or intravenous injection.⁴⁸⁶ Historically, community access to naloxone has been limited due to state medical practice laws discouraging or prohibiting "third-party prescriptions" (i.e., prescribing to a person other than the intended patient) and "standing

orders" (i.e., prescribing to a person the provider has not personally examined).⁴⁸⁷ Further, liability concerns among prescribers, bystanders who may be in a position to administer the naloxone, and bystanders who fear being prosecuted for possession of illegal drugs or similar crimes has limited use of the medication.⁴⁸⁸

In recent years, at the urging of organizations including the National Governor's Association, United States Conference of Mayors, the American Medical Association, the American Public Health Association, and the National Association of Boards of Pharmacy, many states have removed some of the legal barriers associated with using naloxone as a

prevention strategy.⁴⁸⁹ These changes generally encourage wider prescription and use of naloxone by “clarifying that prescribers acting in good faith may prescribe the drug to persons who may be able to use it to reverse overdose and by removing the possibility of negative legal action against prescribers and lay administrators,” and by establishing immunity for bystanders who summon emergency responders.⁴⁹⁰ Given few foreseeable negative effects of such laws, as well as their cost-effectiveness, increased access to naloxone may be one of the most effective fatality prevention strategies currently available to policymakers.

In Indiana, the Indiana General Assembly passed, and Governor Mitch Daniels signed, the state’s first “Lifeline Law” in 2012, which provides immunity for certain alcohol related crimes (i.e., public intoxication, minor possession, minor consumption, and minor transport) to a person who calls for help in a medical emergency; a person who assists the caller in a medical emergency; a person who calls to report a crime; or a person who is the victim of a sexual assault.⁴⁹¹ In order to receive immunity under the law, the individual reporting must provide their full name and any other information requested by authorities; remain on the scene until first responders arrive; and fully cooperate with authorities.⁴⁹²

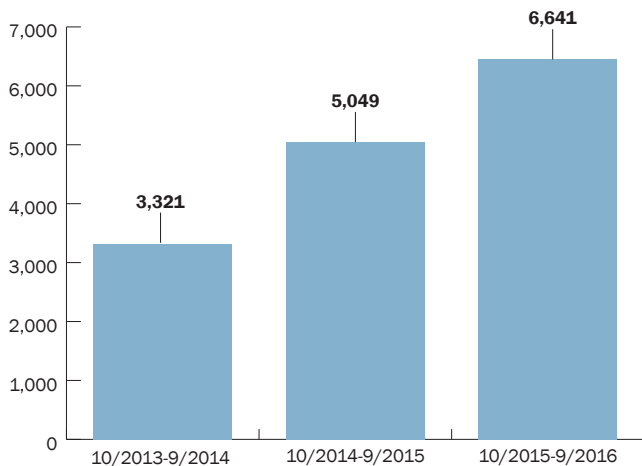
In 2014, Senate Enrolled Act 227 (SEA 227) was signed into law extending immunity under the Lifeline Law to individuals who report any medical emergency (e.g., sexual assault or drug overdose) if alcohol is involved.⁴⁹³ Further, SEA 227 contained a requirement that the Indiana Emergency Medical Services Commission also

establish standards for distribution, administration, use, and training in the use of an overdose intervention drug, such as naloxone, by qualified first responders, including police officers, firefighters and other emergency medical professionals.⁴⁹⁵ Lastly, SEA 227 granted civil immunity to first responders who administer the intervention drug in the course of their duties.⁴⁹⁶ Between 2013 and 2016, there were total of 14,831 incidents where naloxone was administered by first responders in Indiana.⁴⁹⁷

PERSONAL TESTIMONY

Aaron Sims (1993-2013) was an “athletic, red-headed charmer of a son” with a big heart and a love for football, according to his mother **Justin Phillips**. An Indiana native and a quarterback for the varsity football team at Lawrence North High School, Aaron’s life drastically changed after using prescription pain medication and turning to heroin. In just four short years, despite his family’s efforts to guide and watch over him, the chronic disease of addiction would take his life. After using heroin for only four months Aaron acknowledged his disease and asked his family for help. Aaron spent time in a local treatment center and began to put his life together. He remained drug free for nine months but at some point the drugs re-entered his life and on October 9, 2013, Aaron was found dead from an overdose. After losing her son, Justin was determined to prevent similar tragedies. Thanks to her efforts, in 2015 the Indiana Legislature passed “Aaron’s Law”, which allows anyone to get a prescription for naloxone and to legally administer it. Justin also created Overdose Lifeline, a nonprofit program that provides free naloxone and training, education and prevention for youth, support for families, and advocacy to address addiction as a healthcare issue, not a criminal justice issue.

FIGURE 6: Indiana First Responder Naloxone Incidents 2013-2016⁴⁹⁴



In 2015, the naloxone related provisions of SEA 227 were expanded by Senate Enrolled Act 406. Named after a young Hoosier who lost his battle with heroin addiction, “Aaron’s Law” authorizes prescribers to use standing orders to dispense naloxone.⁴⁹⁸ Under Aaron’s Law, a provider with prescriptive authority may issue a written order, to be carried out by other healthcare professionals or qualifying entities,^{xviii} that naloxone can be distributed to any individual that may be in a position to assist a person experiencing

^{xviii}. The Indiana Attorney General recently issued an opinion asserting that “qualifying entities under the statute could include organizations such as community health centers, jails, counseling and recovery centers, and others.” Zoeller, G. (September 3, 2015). *Standing Orders by Prescribers Under Aaron’s Law: Official Opinion 2015-1*. Retrieved July 19, 2016 from http://www.in.gov/attorneygeneral/files/ADMINISTRATIVE.Official_Opinion_2015-01.09.03.15.pdf.

an opioid overdose, provided certain conditions are met. Specifically, the order to the individual or entity must: (1) instruct the individual receiving the overdose intervention drug or prescription to summon emergency services immediately before or after administering the drug; (2) provide education and training on drug overdose response and treatment, including the administration of naloxone; and (3) provide information and referrals to drug addiction treatment and programs, including local programs that offer medication-assisted treatment.⁴⁹⁹ Aaron's Law also provides civil immunity to prescribers, pharmacists, and individuals who obtain and administer the medication in good faith.⁵⁰⁰

In September 2015, Governor Pence directed state agencies to increase awareness of Aaron's Law. Executive branch agencies have done so through various means, which included producing a public service announcement video to raise awareness of the medication; publishing a variety of informational materials (e.g., the Indiana State Department of Health toolkit describing the medication and its effects, signs and symptoms of an opioid overdose, intranasal and intramuscular naloxone administration, and available

treatment resources); and providing naloxone training to both first responders and lay persons.⁵⁰¹

The Indiana Attorney General's Prescription Drug Abuse Prevention Task Force (Rx Task Force) has also developed and disseminated information for both first responders and lay persons including, but not limited to, a video, sample training modules, charts detailing the various paths to access naloxone, and guides for naloxone administration.⁵⁰² In addition to increasing awareness through the Rx Task Force, the Indiana Attorney General recently announced a grant program, funded through a pharmaceutical settlement, that will fund a surge in naloxone distribution, with the goal of ensuring all first responders are equipped with the life-saving treatment and trained to administer it.⁵⁰³ Nonprofit organizations registered with ISDH to distribute naloxone and provide training on the use of naloxone to first responders are eligible to apply for funding, to be distributed throughout 2016.⁵⁰⁴ To date, three organizations have received funding including Overdose Lifeline, the Indiana Naloxone Project, and Health and Hospital Corporation of Marion County.⁵⁰⁵

TASK FORCE RECOMMENDATION & STATUS UPDATE

On September 16, 2015, the Task Force adopted a recommendation to direct state agencies to raise awareness of Aaron's Law. As such, state agencies are aggressively working to improve both internal and external awareness of the law via new and existing websites, social media, internal staff communications, partner organization communications, public events, and training events, etc. For example, the Indiana Department of Homeland Security (IDHS) actively communicates information on Aaron's law to Indiana emergency medical services (EMS) related constituent groups through EMS Commission meetings, provider forums, and district seminars. The IDHS has also made model training programs available for law enforcement agencies and EMS organizations across the state. Similarly, the Indiana Department of Natural Resources (IDNR) is working with medical professionals to develop an educational program for agency personnel regarding the signs and symptoms of a drug overdose, and is planning to incorporate efforts into a comprehensive training program that will include informational materials for officers' patrol vehicles, a review of the law and training on naloxone administration. Further, the Indiana Professional Licensing Agency (IPLA) has initiated a statewide campaign to raise awareness of Aaron's Law in public pharmacies that includes pamphlets explaining the law and how the public can access naloxone, as well as "static-clip" advertisements to increase general awareness among pharmacy patrons. The IPLA is also partnering with Indiana State Health Department to craft a public service announcement to increase awareness of the law. A detailed listing of all Agency activities to date is provided in Appendix G.

TASK FORCE RECOMMENDATION & STATUS UPDATE

On October 15, 2015, the Task Force adopted a recommendation to direct the Indiana Department of Homeland Security (IDHS) to identify gaps in naloxone availability compared with overdose demographics. In the intervening months between adopting the recommendation and publication of this report, IDHS prepared a report summarizing the available data on drug overdose rates and first responders carrying naloxone by county, which was distributed to the Task Force in December 2015. All 211 paramedic level ambulance services in Indiana, as well as many other intermediate and basic life support services, carry Naloxone. Additionally, Naloxone kits were made available to first responders through funding by the Office of the Attorney General. Overdose Lifeline, Inc. provided training to the agencies and distributed kits. According to Overdose Lifeline, Inc., as of November 30, 2016, 27 fire departments, 46 law enforcement agencies, four ambulance services, and five other agencies have received kits.

TASK FORCE RECOMMENDATION & STATUS UPDATE

On November 19, 2015, the Task Force adopted a recommendation to support legislation that would amend state law to require the Indiana State of Department of Health (ISDH) to issue a standing order for the dispensing of an overdose intervention drug, such as naloxone, and to expand the state's Lifeline Law to include immunity beyond alcohol offenses. In the intervening months between adopting the recommendation and publication of this report, the Indiana General Assembly passed, and Governor Pence signed, Senate Enrolled Act (SEA) 187.⁵⁰⁶

Whereas Aaron's Law required a provider to write a prescription in order for a pharmacist to dispense Naloxone, Senate Enrolled Act 187 required the ISDH to issue a statewide standing order to dispense naloxone over the counter at local pharmacies.⁵⁰⁷ In order to use either the standing order, qualifying entities must maintain a current registration with ISDH and meet the conditions of dispensing under Aaron's Law noted above.⁵⁰⁸ Entities could include organizations such as community health centers, jails, counseling and recovery centers, and others that want to dispense naloxone and train lay people in its use.⁵⁰⁹ In addition, SEA 187 provides immunity from certain drug offenses for "Good Samaritans" who save another's life using naloxone and follow procedures to notify and cooperate with law enforcement.⁵¹⁰

On July 1, 2016, ISDH Commissioner Dr. Jerome Adams issued a statewide standing order for naloxone, and as of November 28, 2016, there are 110 entities serving more than 786 locations across the state.⁵¹¹ In order to use either the ISDH standing order or an order from another licensed prescriber, entities must maintain a current registration on the state's www.optIN.in.gov website, and report the dates and number of doses distributed annually.⁵¹² Indiana Medicaid also reimburses for naloxone dispensed in a pharmacy using the statewide standing order.⁵¹³

The need for a larger, more accessible supply of naloxone is becoming increasingly evident as highly toxic adulterants, such as fentanyl and Carfentanil, are being added to heroin in certain markets.⁵¹⁴ The former is a synthetic opioid analgesic similar to morphine but 50 to 100 times more potent, while the latter is an animal opioid sedative (a fentanyl analog) with a potency approximately 10,000 times that of morphine.⁵¹⁵ In both instances, the user is unaware of the adulterant and wrongly assumes the potency of the dosage, which often results in overdose and death.⁵¹⁶ Most recently, in August 2016, there were more than 78 overdoses and two deaths reported in Cincinnati, Ohio, during a two-day period.⁵¹⁷ During this same timeframe, at least 15 overdoses, one of them fatal, were observed in neighboring Indiana counties 90 miles away.⁵¹⁸ Though not immediately

clear whether overdoses in the two states were connected to the same supply of adulterated heroin, officials in Ohio have since reported drug seizures linked to some combination of heroin, fentanyl, and Carfentanil, while officials in Indiana have reported additional overdoses from Carfentanil-laced heroin that came from Cincinnati.⁵¹⁹ Typically one dose of naloxone is sufficient to revive someone experiencing a pure heroin overdose; however, someone experiencing an overdose of fentanyl or Carfentanil laced-heroin may require as many as six doses to be revived.⁵²⁰ Following the multi-state series of overdoses described above, supplies of naloxone were quickly exhausted and law enforcement were required to seek additional resources from emergency medical services personnel and local hospitals.⁵²¹

TASK FORCE RECOMMENDATION & STATUS UPDATE

On September 20, 2016, the Task Force adopted a recommendation to direct the ISDH to implement a central repository naloxone distribution program for first responders should Indiana experience increased numbers of overdoses that would deplete local responders' supplies. Immediately following this recommendation, ISDH announced plans to provide naloxone doses to communities in the event of a shortage, though a "just-in-time" supply of 50 doses maintained in each of the state's 10 public health districts.⁵²² Indiana's rural counties will be the most likely beneficiaries of the new supply, as first responders in urban areas are more capable of maintaining sufficient stock of naloxone.⁵²³ The approximately \$100,000 cost of the supply will come from a more than \$519,000 grant the Centers for Disease Control and Prevention awarded to the state in August of 2016.⁵²⁴

iv. Local Coordinating Councils

In 1989, the Governor’s Commission for a Drug-Free Indiana (“Commission”) was established to provide a comprehensive and coordinated statewide approach to alcohol and other drug problems by coordinating the alcohol and other drug efforts of state government; advising the Governor and the Indiana General Assembly on policy and legislative strategies; and mobilizing communities throughout the state to activate local responses.⁵²⁵ The Commission works in collaboration with countywide citizen groups, or “Local Coordinating Councils” (LCCs), approved and appointed by the Commission to plan, monitor, and evaluate comprehensive local alcohol and SUD plans.⁵²⁶ Each of Indiana’s 92 counties maintains an LCC, the primary purpose of which is “not to provide programming, but sustain and support successful programs in the community with priority given to evidence-based programs.”⁵²⁷ LCCs are eligible to receive Indiana Drug-Free Communities

grant funds for services or activities identified in their Commission-approved plans by applying to ICJI.⁵²⁸

Over the past 25 years, LCCs have proven to be a powerful tool in addressing drug use at the local level. Not only do LCCs serve to identify available community resources and collaborate with local law enforcement in their anti-drug efforts, they collect and monitor local data; evaluate supporting entities; and provide funding for local programming and scholarships.⁵²⁹ While LCCs are responsible for identifying their own membership, a variety of professions (i.e., healthcare providers, legal/community corrections professionals, and law enforcement officers) and entities/organizations are typically involved (i.e., faith based, schools).⁵³⁰ Recent LCC projects brought to the Task Force’s attention include placement of medication drop boxes in local police stations and purchasing of naloxone for first responders.⁵³¹ Several LCCs are also providing financial assistance to citizens who cannot afford treatment.⁵³²

TASK FORCE RECOMMENDATION & STATUS UPDATE

On November 19, 2015, the Task Force adopted a recommendation to support legislation that would modify the DFI in a way that maintains support for LCCs but brings together state agencies and stakeholders to address the drug abuse issues Indiana is facing today. In the intervening months between adopting the recommendation and publication of this report, Senate Enrolled Act 271 was passed by the Indiana General Assembly and signed by Governor Pence, repealing the DFI and establishing the Indiana Commission to Combat Drug Abuse (ICCDA).⁵³³ ICCDA membership largely mirrors the list of Task Force appointees outlined in the Governor’s Executive Order 15-09, with slight modification: Representative of the Governor’s Staff Appointed by the Governor; Appellate or Trial Court Judge Appointed by the Chief Justice of the Indiana Supreme Court; One Legislative Member Appointed by the President Pro Tempore of the Indiana Senate; One Legislative Member Appointed by the Minority Leader of the Indiana Senate; One Legislative Member Appointed by the Speaker of the Indiana House of Representatives; One Legislative Member Appointed by the Minority Leader of the Indiana House of Representatives; Superintendent of Public Instruction; Director of Indiana Department of Child Services; Executive Director of the Indiana Prosecuting Attorneys Council; Executive Director of the Public Defender Council of Indiana; Secretary of Indiana Family and Social Services Administration; Commissioner of Indiana State Department of Health; Commissioner of Indiana Department of Correction; Superintendent of Indiana State Police; Director of the Office of Management and Budget or Budget Director (as selected by the Governor); Executive Director of the Indiana Criminal Justice Institute (ICJI); Executive Director of the Professional Licensing Agency; Attorney General (serving as a nonvoting member).⁵³⁴

The new law further outlines ICCDA governance structure in terms of membership tenure, voting procedures, meeting requirements, annual reporting, and scope of responsibility.⁵³⁵ Relative to substance use disorder prevention, treatment, and enforcement programming and funding, the Commission is specifically tasked with: (1) identifying effective means of coordination between state agencies; (2) promoting information sharing; (3) promoting best practices; (4) cooperating with other commissions, government entities, and stakeholders; (5) studying local programs; (6) seeking guidance from LCCs; (7) studying and evaluating service delivery; (8) coordinating data collection and evaluation efforts; and (9) recommending roles, responsibilities, and performance standards for LCCs.⁵³⁶ Finally, the law requires the ICJI to assume certain former DFI duties concerning approval of community plans and grants.⁵³⁷

Beginning in 2017, the ICCDA will be responsible for coordinating substance use disorder prevention, treatment, and enforcement throughout the state, transitioning from and building on the work accomplished by the Task Force.⁵³⁸

C. PREVENTION BEST PRACTICES IDENTIFIED BY THE TASK FORCE

A number of SUD enforcement, treatment, and prevention best practices are being implemented across the state. The following outlines several opportunities related to prevention that may serve as models for other communities.

i. Marion County First Responders

As noted above, in 2014, Senate Enrolled Act 227 was signed into law granting civil immunity to first responders who administer naloxone in the course of their duties.⁵³⁹ In the months following, Indianapolis Emergency Medical Services (IEMS) and the Indianapolis Metropolitan Police Department (IMPD) established a unique partnership to create a pilot naloxone administration training program for law enforcement officers in the City's Southwest District.⁵⁴⁰ The rationale behind the project was placement—officers are vehicle-based and an officer is assigned to every overdose dispatch; typically, they arrive sooner than an ambulance, sometimes minutes sooner.⁵⁴¹ Participating officers receive training on the signs and symptoms associated with opiate overdose, administration of intranasal naloxone, and behaviors associated with coming back from an opiate overdose before being issued a Mucosal Atomizer Device that turns the medication into a fine mist in order to absorb through nasal mucosa (i.e., intranasal administration).⁵⁴² A prospective investigation of officer attitudes toward the training demonstrated overwhelmingly positive attitudes

PERSONAL TESTIMONY ▼

In early 2016, an Indianapolis EMS unit responded to an emergency dispatch for an overdose. Upon arrival, paramedics recognized the home as one they had been to before for similar calls. As they entered the home, a resident indicated that his partner had been using opioids throughout the previous evening and described classic signs and symptoms consistent with opioid misuse. Layperson intranasal naloxone was administered prior to arrival of first responders. During assessment and in care of the paramedic team, the patient became lethargic and a second dose of naloxone was administered by first responders. The patient was transported to a local emergency department with care continued throughout transport. If not for the administration of naloxone by both the resident and the first responders, the patient would not likely have survived the overdose. – **IEMS Paramedic**

towards naloxone training and that, consistent with other studies, officers were receptive to harm reduction interventions.⁵⁴³ Success of the pilot project led to implementation of the training in the remaining five IMPD Districts in 2015, and as of January 2016, there have been a total of 121 naloxone administrations by IMPD officers, with 95% of overdose victims surviving, and 90% being discharged from hospitals.⁵⁴⁴ The program has since been replicated in other communities throughout the state.⁵⁴⁵

In addition to IEMS's naloxone training initiative, it recently launched a new prevention initiative called Project POINT (Planned Outreach, Intervention, Naloxone, and Treatment). By leveraging relationships with IMPD, Eskenazi Health, and Midtown Community Mental Health, Project POINT seeks to engage individuals who have been administered naloxone and connect them with treatment and services to meet their individual needs.⁵⁴⁶ Typically, these individuals are transported to an emergency department once revived, where they undergo observation until medically cleared.⁵⁴⁷ Upon discharge they are given a list of resources to contact if they need help; however, many lack financial resources, are uninsured or underinsured, or have little resolve to seek treatment.⁵⁴⁸ Project POINT uses a multi-disciplinary outreach team, comprised of a social worker and emergency medical technician, to establish a relationship with the individual and provide direct assistance to connect him or her with various no-cost or low-cost services and supports available in the community.⁵⁴⁹ Contact begins with a brief intervention in the emergency department and linkage to additional supports, followed by rapid outreach post-discharge to determine whether the individual has enrolled in treatment, to continue to encourage enrollment, or to provide support through completion of their treatment regimen.⁵⁵⁰ Preliminary findings show long-standing SUD and other mental health issues among patient contacts, with a significant portion reporting hepatitis C diagnoses and acknowledging shared needle use.⁵⁵¹ Project administrators also report that nearly all patient contacts are interested in engaging in care including, but not limited to, naloxone use/prescription, referral for harm reduction strategies (e.g., clean needles), HIV/hepatitis C testing, insurance coverage, and referrals to treatment.⁵⁵² The most common barriers cited were access to affordable treatment, prolonged intake times, housing and transportation issues, insurance complexities, and fear of criminal justice or child welfare systems.⁵⁵³

ii. Youth Prevention Programs

Indiana has a long history of SUD prevention programs targeting youth. Established in 1998, Youth First, Inc., a nonprofit headquartered in Evansville and primarily

servicing the southwest Indiana region, seeks to transform and strengthen the lives of young people and their families.⁵⁵⁴ In addition to offering a number of community-based programs, Youth First places masters-prepared social workers in schools to assist youth with behavioral health issues, bullying, peer pressure, divorce and grief adjustment, suicide prevention, and SUD prevention. Staff are also available to consult with school faculty and staff, parents, and caregivers, and provide student referrals to community resources and family programs.⁵⁵⁵ Programs and services are generally free of charge and incorporate evidence-based strategies to reduce risk factors, increase protective factors, and improve social skills.⁵⁵⁶ Youth First currently employs 39 social workers that are accessible to more than 26,000 students in 57 schools and 11 school systems across six counties.⁵⁵⁷ Organization leadership reports that 91% of students working with Youth First advance to the next grade level or graduate, and 89% of graduates have college or career plans.⁵⁵⁸ Youth First is governed by a Board of Directors and funded by charitable donations, grants, and fees for services.⁵⁵⁹

In 2011, the Indiana General Assembly passed, and Governor Mitch Daniels signed, House Enrolled Act 1107, which authorized juvenile courts to create preventative programs to identify and offer services to at-risk children^{xix} before they are formally identified by a school or the judicial system.⁵⁶⁰ Any individual may request that an at-risk child receive assistance through the program; however, the child's parent, guardian, or custodian must consent to their participation.⁵⁶¹ Once identified, an "Early Intervention Advocate" is responsible for creating, implementing, and maintaining an individualized plan for the child and his/her family.⁵⁶² House Enrolled Act 1107 has led to the establishment of a number of successful juvenile court prevention programs, including the Hamilton County Youth Assistance Program, which operates as a public/private partnership in the cities of

Westfield, Noblesville, and Fishers, Indiana.⁵⁶³ Modeled after a successful, decades old program in Oakland County, Michigan, the Hamilton County Youth Assistance Program operates as a public/private partnership bringing together local mayors, public safety officials, judges, school leaders, and faith-based institutions to identify at-risk youth and encourage participation in a variety of services including family-centered case management and referral services, counseling, tutoring, and mentoring.⁵⁶⁴ Services are free, confidential, typically short-term, and are coordinated with the help of other local agencies and health and wellness organizations within the child's community.⁵⁶⁵

More recently, the nonprofit "Overdose Lifeline" was created in by Justin Phillips, following the death of her son Aaron in 2013, to address the opioid epidemic through education, harm reduction, prevention, and support.⁵⁶⁶ Overdose Lifeline programs and initiatives include naloxone distribution and training; support groups for those recovering from an overdose loss; and "This is (Not) About Drugs," a prevention education program to help inform students of opioid risks.⁵⁶⁷ The latter is an evidence-based, turn-key program targeting grades six through 12, designed to educate students using a guided and practical exercise consisting of a pre-assessment, informational film, discussion, post-assessment, and after lesson support.⁵⁶⁸ Upon completion, students should understand that drug use can lead to heroin use, addiction, overdose, and death; the risks of heroin and prescription pain drug misuse; the impact of heroin, drugs and alcohol on the user and the user's family and friends; alternatives to using heroin, drugs, and alcohol; and the many ways to ask for help and available information and resources.⁵⁶⁹ Initially piloted in five Indianapolis high schools in 2015, "This is (Not) About Drugs" is now being delivered in classrooms across the state, reaching more than 9,000 students.⁵⁷⁰ Though currently undergoing review by researchers at Indiana University-Purdue University Indianapolis, interim analyses indicate significant attitudinal changes among participants.⁵⁷¹

TASK FORCE RECOMMENDATION & STATUS UPDATE

On September 16, 2015, the Task Force adopted a recommendation to direct the Indiana Department of Workforce Development to work closely with existing youth assistance programs and identify best practice models to replicate statewide. In the intervening months between adopting the recommendation and publication of this report the state has contracted with Dr. Mark Keen to offer assistance to any school district interested in implementing the Youth Assistance Program. In late April, Dr. Keen corresponded with all school superintendents, providing information on the program and offering to visit schools to assist with exploration and implementation. Dr. Keen has visited several school districts around the state that expressed interest in response to the letter. Additionally, numerous emails were exchanged between Dr. Keen and districts. Dr. Keen will continue to provide consultation and technical assistance as needed.

^{xix} At-risk children are defined as those children at risk of becoming involved in a juvenile proceeding, being suspended or expelled from school, or dropping out of school; children previously considered "children in need of services" who are in need of ongoing supervision and assistance; or children who have been victims of domestic violence. 117th Ind. Gen. Assemb., 1st Reg. Sess. (2011). H.E.A. 1007.

TASK FORCE RECOMMENDATION & STATUS UPDATE

On October 15, 2015, the Task Force adopted a recommendation to request that the Commission for Improving the Status of Children make recommendations through its Educational Outcomes Task Force and Substance Abuse and Child Safety Task Force on the following: (1) developing age-appropriate substance abuse curriculum for students and (2) finding ways to better connect affected youth with substance abuse services. In the intervening months between adopting the recommendation and publication of this report the Joint Subcommittees of the Commission on Improving the Status of Children worked together on recommendations concerning evidence-based prevention, community partnerships, best practices, early identification, and referral. A formal report was made available concerning these topics in late 2016.

VIII. NEXT STEPS

The following is included for awareness and consideration as the administration continues to support SUD enforcement, treatment, and prevention efforts throughout Indiana.

A. COMPREHENSIVE ADDICTION AND RECOVERY ACT OF 2016

As described in Section IV, United States efforts to curb SUD over the past 40 years have heavily focused on enforcement.

In July of 2016, Congress passed, and President Obama signed into law, the Comprehensive Addiction and Recovery Act of 2016 (CARA).⁵⁷² In summary, CARA authorizes a series of grant programs for SUD prevention and education; expands access to treatment and recovery options for individuals with opioid use disorder; expands grants to law enforcement agencies and prescription buy-back programs; and provides additional opioid abuse services and resources to veterans, women, and children.⁵⁷³ Highlights include the following:

- Requires the Secretary of Health and Human Services (HHS) convene a task force to assess gaps between best practices for chronic and acute pain management.
- Allows the National Institutes of Health to intensify and coordinate research regarding pain, development of chronic pain therapies, and development of alternatives to opioids.
- Reauthorizes the National All Schedules Prescription Electronic Reporting Act grant program (NASPER) to support state-based prescription drug monitoring programs.
- Encourages the Secretary of HHS to make grants available for states to implement standing orders for opioid reversal drugs.
- Codifies Substance Abuse and Mental Health Services Administration (SAMHSA) grant programs to expand access to opioid reversal drugs, and support states expanding access to treatment services, including evidence-based medication-assisted treatment.
- Expands access to medication-assisted treatment by authorizing nurse practitioners and physician assistants to prescribe buprenorphine.
- Reauthorizes and increases state flexibility of a grant program for residential treatment for pregnant and postpartum women with opioid use disorders and for their children.
- Authorizes HHS to award grants to states and

combinations of states to carry out comprehensive opioid abuse response.

- Clarifies that pharmacists coordinating with prescribers and patients may not fill the entire amount of a prescription for a Schedule II substance (i.e., opioid).
- Allows Medicare prescription drug plans to develop a safe prescribing and dispensing program for beneficiaries at risk of abuse or diversion, and allows HHS to facilitate the creation and management of “lock-in” programs.⁵⁷⁴

B. COMPACT TO FIGHT OPIOID ADDICTION

On July 13, 2016, the National Governors Association (NGA), a bipartisan organization of the nation’s governors, announced that 46 governors, including Indiana Governor Pence, had signed a Compact to Fight Opioid Addiction.⁵⁷⁵ Developed by the NGA, signatories commit to build on their efforts to fight opioid addiction by: (1) taking steps to reduce inappropriate opioid prescribing (e.g., prescribing guidelines, prescriber education, and prescription drug monitoring program reforms); (2) leading efforts to improve public understanding of opioids and addiction (e.g., campaigns to reduce the stigma of addiction and increase awareness of the risks associated with opioid use, particularly among youth and other at-risk groups); and (3) taking actions to improve access to treatment for people with opioid use disorder (e.g., reduce reimbursement and administrative barriers in both public and private health insurance, pursue overdose prevention and harm reduction strategies including access to opioid reversal drugs, support programs that provide treatment as an alternative for non-violent people with opioid use disorder charged with low-level drug crimes).⁵⁷⁶ During the NGA’s 2017 Winter Meeting, the Association will report on steps signatories have taken to meet the compact commitments and build on existing efforts.⁵⁷⁷

C. INDIANA COMMISSION TO COMBAT DRUG ABUSE

As noted in Section VI, Senate Enrolled Act 271 was recently passed by the Indiana General Assembly and signed by Governor Pence, establishing the Indiana Commission to Combat Drug Abuse (ICCD).⁵⁷⁸ Among other things, the ICCDA will be responsible for coordinating SUD prevention, treatment and enforcement throughout the state, and will take effect January 1, 2017 transitioning from and building on the work accomplished by the Task Force.⁵⁷⁹

IX. ACKNOWLEDGEMENTS

The Task Force members would like to express their gratitude to:

All of the individuals who provided testimony, expertise, and support to help the state combat the growing drug crisis being faced by Hoosiers.

Indiana's Congressional Delegation for their input and support of the Comprehensive Addiction and Recovery Act.

The following organizations who hosted the Task Force:

- Sidney and Lois Eskenazi Hospital
- University of Southern Indiana
- University of Notre Dame
- Community Hospital North
- Ivy Tech
- Wabash Valley Correctional Facility
- Manchester University College of Pharmacy
- Richmond State Hospital
- Community Hospital East
- Indiana University Northwest
- Mid-America Science Park
- Fairbanks

The following organizations who presented to the Task Force:

- Community Health Network
- Hendricks County Superior Court
- Hendricks County Sheriff's Office
- Midtown Community Mental Health and Addiction
- Centerstone
- Hamilton County Superior Court
- Vanderburgh County Prosecutor's Office
- Goodman Campbell Brain & Spine
- Vigo County Sheriff's Office
- Extension for Community Healthcare Outcomes (ECHO) Institute
- Youth First, Inc.
- Indiana Department of Correction

- Starke County Circuit Court
- Allen County Department of Health
- Indiana Family and Social Services Administration
- Partnership for Education and Prevention of Substance Abuse
- Elkhart County Drug-Free Partnership
- Indiana Department of Child Services
- Hamilton County Prosecutor's Office
- Boone County Prosecutor's Office
- Indiana Office of Management and Budget
- Indianapolis Emergency Medical Services (EMS)
- Schneck Medical Center
- Marion General Hospital
- Indianapolis Coalition for Patient Safety, Inc.
- Indiana State Department of Health
- Manchester University College of Pharmacy
- Indiana Hospital Association
- Indiana State Medical Association
- Indiana Judicial Center
- Allen County Superior Court
- Overdose Lifeline, Inc.
- Rocky Mountain High Intensity Drug Trafficking Area (HIDTA)
- Union County Opiate Treatment Center
- Indiana Perinatal Quality Improvement Collaborative
- Indiana University School of Medicine
- Indiana Professional Licensing Agency
- Indiana Board of Pharmacy
- Indianapolis Metropolitan Police Department
- Indiana Pharmacists Alliance
- Indiana Parenting Institute
- Addiction and Behavioral Counseling Services, Inc.
- Porter County Sheriff's Office
- Starke County Sheriff's Office
- Starke County Regional Therapeutic Community
- Scott County Sheriff's Office
- Indiana Criminal Justice Institute
- Progress House
- Fairbanks

APPENDIX A

FULL LIST OF TASK FORCE RECOMMENDATIONS

ENFORCEMENT RECOMMENDATIONS

Support legislation to enhance penalties for persons dealing drugs convicted of serious and aggravated offenses.

Direct the Indiana Department of Correction to work with Starke and other northwest Indiana counties to pilot and adopt the Regional Therapeutic Communities program, which provides more treatment options for local officials in addressing addiction.

Direct the Indiana Criminal Justice Institute (CJI) and the Indiana Division of Mental Health & Addiction (DMHA) to identify a county criminal justice entity and implement a therapeutic substance use disorder treatment program for offenders awaiting adjudication and for those service sentences while in jail.

TREATMENT RECOMMENDATIONS

Direct the Indiana Family and Social Services Administration to implement the Gold Card program, which removes administrative burdens by allowing qualified physicians the ability to prescribe medications without prior authorization. The prior authorization process enables payers like the Indiana Medicaid Program a chance to review the medical evidence of a member's health condition, as provided by the treating physician, so that the medical need for covering the service and treatment costs can be established.

Direct the Indiana Family and Social Services Administration to pursue a Medicaid §1115 Demonstration Waiver for individuals with substance use disorders to broaden Indiana Medicaid benefit packages and provide a more comprehensive continuum of covered services and care.

Direct appropriate entities to promulgate and adopt with all expediency chronic pain prescribing rules for all prescribers.

Direct the Indiana State Department of Health (ISDH) to work with appropriate entities including those that represent physicians, nurses, dentists, physician assistants, podiatrists, and veterinarians to develop guidelines for prescribing acute pain medications. Endorse opioid and controlled substance prescribing guidelines for emergency departments as part of a larger strategy to combat prescription drug abuse in Indiana.

(continued)

PREVENTION RECOMMENDATIONS

Direct the ISDH to convene a working group to send recommendations on improvements and best practices related to INSPECT, to the INSPECT Oversight Committee.

Direct the PLA to begin implementing a pilot program, the INSPECT Integration Initiative, to allow for the integration of INSPECT data with hospital patient records.

Direct the Indiana Professional Licensing Agency (PLA) to request that the INSPECT Oversight Committee explore possible measures to increase access to INSPECT for prescribers and dispensers.

Direct state agencies to raise awareness of Aaron's Law.

Direct the Indiana Department of Homeland Security (IDHS) to identify gaps in naloxone availability compared with overdose demographics.

Support legislation that would amend state law to require the Indiana State Department of Health (ISDH) to issue a standing order for the dispensing of an overdose intervention drug, such as naloxone, and to expand the state's Lifeline Law to include immunity beyond alcohol offenses.

Direct the ISDH to implement a central repository naloxone distribution program for first responders should Indiana experience increased numbers of overdoses that would deplete local responders' supplies.

Support legislation that would modify the Governor's Commission for a Drug-Free Indiana in a way that maintains support for Local Coordinating Councils but brings together state agencies and stakeholders to address the drug abuse issues Indiana is facing today.

Direct the Indiana Department of Workforce Development to work closely with existing youth assistance programs and identify best practice models to replicate statewide.

Request that the Commission for Improving the Status of Children make recommendations through its Educational Outcomes Task Force and Substance Abuse and Child Safety Task Force on the following: 1) developing an age-appropriate substance abuse curriculum for students; and 2) finding ways to better connect affected youth with substance abuse services.

APPENDIX B

EXECUTIVE ORDER

STATE OF INDIANA

EXECUTIVE DEPARTMENT

INDIANAPOLIS

EXECUTIVE ORDER 15-09

FOR: ADDRESSING INDIANA'S DRUG ABUSE CRISIS

TO ALL WHOM THESE PRESENTS MAY COME, GREETINGS.

WHEREAS, Indiana's drug abuse crisis tears apart families and imposes an overwhelming burden on the medical community, social services, and the State of Indiana as a whole;

WHEREAS, from 1999 to 2009, Indiana saw a 500% increase in the rate of drug overdose deaths;

WHEREAS, drug abuse is a chronic problem that often originates from prescription medication usage and has been linked to the spread of infectious diseases such as HIV and Hepatitis C;

WHEREAS, 21% of Indiana's teenagers have admitted to using a controlled prescription for non-medical reasons;

WHEREAS, the number of Child in Need of Services ("CHINS") cases are 26% higher than this time last year;

WHEREAS, it is vital to Indiana's citizens, families and children to take immediate steps to reverse this dangerous trend of drug abuse;

WHEREAS, a comprehensive approach including law enforcement, drug abuse prevention and drug abuse and mental health treatment is essential to effectively curb drug abuse in Indiana.

NOW, THEREFORE, I, Michael R. Pence, by virtue of the authority vested in me as Governor of the State of Indiana, do hereby order that:

The Governor's Task Force on Drug Enforcement, Treatment and Prevention ("Task Force") is hereby established as an advisory body reporting directly to the Office of the Governor.

- a. The purpose of the Task Force is to identify solutions to Indiana's drug problem that take into account the many factors and stakeholders involved in combating drug abuse, including the areas of law enforcement, prevention, and treatment. By bringing together a diverse group of experts and seeking input from individuals impacted by the drug problem in Indiana at various levels, the Task Force will assess the resources and programs available statewide, encourage collaboration among agencies and identify local models that may be extended to other areas of the state.
- b. The Task Force shall:
 - i. Evaluate existing drug abuse resources and existing drug abuse commissions across the state;
 - ii. Identify effective strategies so federal, state and local law enforcement can partner together to combat drug abuse;
 - iii. Analyze available resources for treatment and identify best practices for treating drug addiction;
 - iv. Identify programs and/or policies which are effective in preventing drug abuse, including early youth intervention programs.

- c. The Task Force shall begin meeting in September 2015.
- d. The Task Force shall hold regional meetings in the state to hear from local government leaders, substance abuse treatment providers, medical professionals, law enforcement, community leaders and others affected by drug abuse.
- e. The Task Force shall make recommendations to the Governor on how to combat drug abuse in a holistic manner based on the Task Force expertise, research, and testimony received during the meetings.
- f. The Task Force shall include the following members appointed by and serving at the pleasure of the Governor:
 - i. One representative of the Governor's Office
 - ii. Commissioner of Indiana State Department of Health
 - iii. Commissioner of Indiana Department of Correction
 - iv. Director of Indiana Department of Child Services
 - v. Superintendent of Indiana State Police
 - vi. Secretary of Indiana Family and Social Services Administration
 - vii. Chief Medical Consultant of Indiana State Department of Health
 - viii. One representative from the Indiana Prosecuting Attorneys Council
 - ix. One representative from the Indiana Supreme Court
 - x. One physician with expertise in treatment and addiction
 - xi. One representative of the Indiana Sheriffs' Association
 - xii. One judge recommended by the Chief Justice of the Indiana Supreme Court
 - xiii. One representative of the Indiana Association of Chiefs of Police
 - xiv. One representative of the emergency medical services community
 - xv. One representative of faith-based and community outreach
 - xvi. One representative from the Indiana Minority Health Coalition
 - xvii. One representative from the insurance industry
 - xviii. Four members of the Indiana General Assembly
- g. The chairperson and co-chairperson shall be appointed by and serve at the pleasure of the Governor.
- h. Members of the Task Force shall serve on a voluntary and unpaid basis.
- i. The Task Force shall be staffed by the Indiana Judicial Center ("IJC") and the Indiana Criminal Justice Institute ("CJI"), and other involved agencies will contribute staff to assist.
- j. All other Executive Branch agencies shall assist with the Task Force as needed.



ATTEST: *Connie Lawson*
 Connie Lawson
 Secretary of State

IN TESTIMONY WHEREOF, I,
 Michael R. Pence, have hereunto set
 my hand and caused to be affixed the
 Great Seal of the State of Indiana on
 this 1st day of September 2015.

Michael R. Pence
 Michael R. Pence
 Governor of Indiana

APPENDIX C

TASK FORCE MEMBER BIOGRAPHIES

Dr. Jerome M. Adams, M.D., M.P.H., Commissioner of the Indiana State Department of Health

Dr. Adams was appointed to serve as the Indiana State Health Commissioner in October of 2014. In addition to this role, he also serves as Assistant Professor of Clinical Anesthesia at Indiana University School of Medicine and as a staff anesthesiologist at Eskenazi Health, where he is Chair of the Pharmacy and Therapeutics Committee. He has served in the leadership of several professional organizations, including the Indiana State Medical Association, Indiana Society of Anesthesiologists, and the American Medical Association, and currently serves as Chair of the Professional Diversity Committee for the American Society of Anesthesiologists.

Senator Jim Arnold, Indiana Senate District 8

Senator Arnold represented Senate District 8, which encompasses the majority of LaPorte County and portions of St. Joseph and Starke County in northwest Indiana. He served as Minority Caucus Chair and as a Ranking Member in four committees – Civil Law, Homeland Security, Transportation and Veteran Affairs, and Public Policy. He was also a member of the Pensions and Labor, Ethics, and Rules and Legislative Procedures Committees. In 2007, Senator Arnold retired as the LaPorte County Sheriff after serving 36 years in law enforcement. During his 32 years with the LaPorte County's Sheriff's Office, he served as a Deputy, Sergeant, Captain, and Chief Deputy before being elected Sheriff in 1999. During his time as La Porte County Sheriff, he served on the Indiana Sheriff's Association and on the National Sheriffs' Association Board of Directors. In November 2016, he retired from the Indiana State Senate.

Judge Mary Beth Bonaventura, J.D., Director of Indiana Department of Child Services

Judge Bonaventura was appointed Director of the Indiana Department of Child Services (DCS) by Governor Pence in January of 2013. She currently serves on the Indiana Commission on Improving the Status of Children. Prior to her role as Director of DCS, Judge Bonaventura served Hoosiers in Lake County for more than 30 years, most recently as Senior Judge of the Lake County Superior Court, Juvenile Division. She was appointed to this role in 1993 by then-Governor Evan Bayh after having served more than a decade as Magistrate in the Juvenile Court. Judge Bonaventura has served in a number of roles dedicated to children including as a member of the Indiana Commission on Disproportionality in Youth Services, as Chair of the Civil Rights of Children Committee for the Indiana State Bar Association, and as Chair of the Child Welfare Improvement Committee.

Bernard A. Carter, J.D., Lake County Prosecutor

Prosecutor Carter is the Prosecuting Attorney for the 31st Judicial Circuit – Lake County. Carter has served as Prosecuting Attorney since he was appointed by Governor Evan Bayh in 1993. He was then elected as Prosecuting Attorney in 1994 and has served in the position since then. From 1990 – 1993, Carter successfully ran for Judge of the Lake Superior Court, County Division III. Prosecutor Carter was the first elected African-American judge in the history of Lake County, the first elected African-American Prosecutor in the history of both Lake County and the state of Indiana, and the first elected African-American President of the Indiana Prosecuting Attorneys Council for two terms. Carter is active in community affairs, having served in many capacities with charitable associations, legal groups, and professional organizations on both state and local levels.

Doug Carter, Superintendent of the Indiana State Police

Superintendent Carter became Indiana's 20th Superintendent of the Indiana State Police in January of 2013. He served as sheriff of Hamilton County from January 2003 to December 2010. During this time, the office earned national accreditation through the Commission on Law Enforcement Accreditation, making the Hamilton County Sheriff's Office one of only two accredited sheriff's offices in Indiana. Superintendent Carter also served eighteen years with the Indiana State Police from 1984 to 2002 and was assigned to the Pendleton State Police post while serving Hamilton County.

Judge Wendy W. Davis, J.D., Allen Superior Court

Judge Davis was elected Judge in the Allen Superior Court criminal division in 2010. She began a two-year term as the Chief Judge of the Allen Superior Court in January 2014. During her first term, her distinctions have included overseeing implementation of the Hoosiers Opportunity Probation with Enforcement (HOPE) Probation program, a

strategy based on Hawaii's HOPE Probation. Her prior legal experience includes being a partner at Beckman Lawson LLP; a deputy prosecuting attorney for the Allen County Prosecutor's Office; an assistant criminal district attorney for the Bexar County (Texas) District Attorney's Office; a law clerk for the U.S. Attorney's Office in San Antonio, Texas; and a law clerk for Dahlberg & Associates in Fort Wayne. Judge Davis is a member of the Indiana Tech Board of Trustees. She is a board member for the Allen County Bar Association; board chair for United Way of Allen County; and board member for Northeast Allen County Youth for Christ.

Michael Diekhoff, Chief of Police, Bloomington (Indiana) Police Department

With more than 30 years in law enforcement, Chief Diekhoff has served as chief of police in Bloomington for more than seven years. In this role, he oversees the police department, parking enforcement, and central dispatch, serving a population of more than 80,000 individuals. Chief Diekhoff has served in a number of roles within the Bloomington Police Department, including five years supervising detectives, narcotics officers, and evidence technicians. He previously served on the Bloomington City Council from 1998 to 2008.

Judge Roger Duvall, J.D., Scott County Circuit Court

For the last 10 years, Judge Duvall has served as Judge of the Scott County Circuit Court. During this time, he served on the Board of Directors of the Indiana Judges Association, Indiana Sentencing Policy Study Committee, and currently on the Juvenile Justice Improvement Committee. Prior to his role as Judge, he served as a Prosecuting Attorney for Scott County, including as Chief Deputy Prosecuting Attorney. He has also worked on the Board of Directors of the Indiana Prosecuting Attorneys Council (which he chaired for a year), Prosecuting Attorneys Ethics Committee, and the Indiana Juvenile Law Study Commission.

Dr. Joan Duwve, M.D., Associate Dean for Public Health Practice at the IU Fairbanks School of Public Health, Chief Medical Consultant at the Indiana State Department of Health

Dr. Duwve is the Associate Dean for Public Health Practice at the IU Fairbanks School of Public Health and has served since 2008 at the Indiana State Department of Health, where she is Chief Medical Officer following her earlier role as Medical Director. Dr. Duwve spent her pre-medical years serving in the Peace Corps and working in international public health in North Africa and the Middle East and then worked as a private practice family physician for 11 years. Dr. Duwve has served on several state committees, including the Mental Health and Addiction Prevention Advisory Committee, the Indiana Cord Blood Bank Board of Directors, and the State Child Fatality Review Team. She currently co-chairs the State Prescription Drug Abuse Prevention Task Force and serves on the Board of Covering Kids and Families of Indiana. On the national level, she is the Vice Chair of the Association of State and Territorial Health Officers Senior Deputies Committee and serves on the Association of State and Territorial Health Officers Infectious Diseases Policy Committee. She also serves on the Board of Scientific Councilors for the Centers for Disease Control and Prevention National Center for Injury Prevention and Control.

Dr. Joseph B. Fox, M.D., Anthem Senior Clinical Officer for Indiana Health Care Management

Dr. Fox serves as Anthem's Senior Clinical Officer for Indiana Health Care Management. In this role he is responsible for the administration of medical services for commercial health plans managed in Indiana. His primary duties include assurance of proper implementation of medical policies and clinical guidelines, oversight of case and disease management programs, and clinical quality initiatives. He also serves as Chairman of the Indiana Credentials Committee. Prior to his current role, Dr. Fox served as Medical Director for Senior Markets, Central Region. Before joining Anthem, Dr. Fox was Chief Medical Officer of The HealthCare Group, a multi-product health plan in Indianapolis. Dr. Fox was previously Medical Director for Ambulatory Services for the Methodist Medical Group, a 130-member primary care physician group.

Anthony "Tony" Gillespie, Indiana Minority Health Coalition

Mr. Gillespie is the Director of Public Policy and Engagement for the Indiana Minority Health Coalition (IMHC), a statewide organization that addresses chronic disease and other health-related issues that disproportionately affect racial and ethnic minority populations. Mr. Gillespie has more than 20 years of experience working at the state and community level addressing HIV/AIDS and many other chronic disease issues and health disparities. He is a founding member and former Executive Director of Brothers Uplifting Brothers (BUB), a grassroots HIV/AIDS organization in northwest Indiana. Mr. Gillespie served as Chair of the Northwest Continuum of Care Network, addressing affordable housing and homeless issues; was a Technical Assistance Provider for the Indiana HIV Prevention Community Planning Group (CPG); served on the Board of Directors for the Community HealthNet, a federally-qualified community health center; and is the Indiana Delegate for the Midwest AIDS Policy Alliance.

Representative Terry Goodin, Indiana House District 66

Representative Goodin represents Indiana House District 66 in southeastern Indiana. He serves on the Ways and Means Committee, Statutory Committee on Interstate and International Cooperation, and on the Select Committee on Government Reduction. Representative Goodin serves as superintendent of Crothersville Community Schools and is a member of the Indiana Farm Bureau, the Indiana Association of Public School Superintendents, the National Association of Basketball Coaches and the National Rifle Association.

John H. Hill, Deputy Chief of Staff for Public Safety in the Office of the Governor; Co-Chair of the Governor's Task Force on Drug Enforcement, Treatment, and Prevention

Mr. Hill has more than 38 years of public service at the federal and state levels. As Deputy Chief of Staff for Public Safety, he oversees all of the state's public safety agencies. Prior to this role, Mr. Hill served as Executive Director of the Indiana Department of Homeland Security and Director of the Counter Terrorism and Security Council. He was a member of the Indiana State Police for 29 years, working in both public safety and highway safety. He also served as the Field Enforcement Division Commander and was chosen to start and lead the State Police's new Motor Carrier Division. In 2003, President Bush appointed Hill as Chief Safety Officer at the Federal Motor Carrier Safety Administration (FMCSA), and he was unanimously confirmed by the United States Senate to serve as FMCSA's Administrator in 2006.

Dr. Timothy J. Kelly, M.D., Community Health Network

Dr. Kelly has dedicated more than 35 years of his career to the field of addiction medicine. He currently practices at Community Health Network, where he provides direct care and administrative oversight for the Integrated Care inpatient detoxification program and medical-bed consultation throughout the hospital network. Dr. Kelly is the principal partner in the private addiction medicine practice Clearvista Recovery Associates. From 1979 to 2014, he served terms as president, chief executive officer, and medical director of Fairbanks Hospital, one of the nation's oldest alcohol and drug treatment centers. Earlier this year, he offered testimony before the Indiana General Assembly that helped secure passage of several laws greatly increasing treatment options for those suffering from addiction.

John R. Layton, Marion County Sheriff

Sheriff Layton has more than 40 years of law enforcement experience, including time spent as an undercover detective investigating narcotics. As a Captain, Layton was given the task of creating and commanding the Marion County Sheriff's Regional Gang and Intelligence Unit, which melded computer intelligence analysis and gang investigations. He was elevated to the rank of Colonel in 2002 and charged with developing the Marion County Sheriff's Department as a modern 21st century law enforcement agency and served as Chief Executive Officer of the Department for eight years. Layton was elected Sheriff of Marion County in 2010 and won reelection in 2014.

Bruce Lemmon, Commissioner of the Indiana Department of Correction

Commissioner Lemmon was reappointed as Commissioner of the Indiana Department of Correction (DOC) by Governor Pence in January of 2013, having also served in this role under Governor Daniels' administration. Prior to this, Commissioner Lemmon served as Superintendent of the Putnamville Correctional Facility in Greencastle, where he implemented many improvements to the facility including doubling the size of the CLIFF Unit and the PLUS Unit and increasing the number of jobs for the offender population. He has served in various capacities within DOC during his 38-year career including Supervisor of Work Release Services, Assistant Superintendent of the Indiana Girls School, and Regional Director of Adult Operations. Lemmon served in the United States Army and was honorably discharged as a Specialist 5. Commissioner Lemmon retired after 40 years of service at DOC on November 30, 2016.

Justice Mark S. Massa, J.D., Indiana Supreme Court

Justice Massa was appointed to the Indiana Supreme Court by Governor Mitch Daniels in March 2012. Prior to his appointment to the Indiana Supreme Court, Justice Massa served as the Executive Director of the Indiana Criminal Justice Institute. Previously, he served as both General Counsel to Governor Mitch Daniels and as Assistant U.S. Attorney in the Southern District of Indiana, during which time he earned the Inspector General's Integrity Award for the Department of Health and Human Services for his efforts in prosecuting health care fraud. Justice Massa has also served as Chief Counsel to the Marion County Prosecutor's Office from 1995 to 2002.

Representative Wendy McNamara, Indiana House District 76

Representative McNamara represents Indiana House District 76, which includes portions of Posey and Vanderburgh counties. She serves on the Courts and Criminal Code Committee, where she is Vice Chair, as well as the Government and Regulatory Reform Committee, Judiciary Committee, and Select Committee on Government Reduction. Representative McNamara has over 19 years of experience with the Evansville Vanderburgh School Corporation, and

currently serves as the Director of Early College High School. She has worked as an adjunct professor for World History at the University of Southern Indiana and has taught Political Science and Social Studies Methods at the University of Evansville. She is currently seeking her Ph.D. in Educational Leadership through Indiana State University.

Senator Jim Merritt, Indiana Senate District 31

Senator Merritt serves as Majority Caucus Chair and represents District 31, which includes portions of Marion and Hamilton counties. He serves as Chair of the Utilities committee, as Ranking Member of the Commerce and Technology committee, and as a member of the Homeland Security and Transportation, Joint Rules, Public Policy, Rules and Legislative Procedure, and Veteran Affairs and the Military committees. He formerly served as Vice President of Corporate Affairs of the Indiana Railroad Company. He is a member of the Indiana Historical Society Board of Trustees, the Lawrence Chamber of Commerce, the Association of Indiana Museums, and the Indianapolis Museum of Art Government Relations Committee.

Daniel R. Miller, J.D., Indiana Prosecuting Attorneys Council

Mr. Miller serves on the staff of the Indiana Prosecuting Attorneys Council. Prior to this role, he served as Chief Deputy Prosecutor and, earlier, as First Deputy Prosecutor, in Warrick County. From 1990 to 2010, he served as a deputy prosecutor in the Vanderburgh County Prosecutor's Office, during which time he served with the Drug Law Enforcement Program, handling drug felonies and forfeitures. In 2004, he was named Director of the Vanderburgh County Drug Law Enforcement Program.

Dr. Charles Miramonti, M.D., Chief of Indianapolis Emergency Medical Services

Dr. Miramonti is the first Chief of Indianapolis EMS, medical director of emergency medicine and an emergency medicine physician at Eskenazi Health, and an assistant professor of clinical emergency medicine and the medical director at the Michael and Susan Smith Emergency Department and Trauma Center for Eskenazi Health Services at the Indiana University School of Medicine. Board-certified in emergency medicine, Dr. Miramonti has held a number of leadership roles including division chief for the IU School of Medicine Department of Emergency Medicine's Division of Out of Hospital Care and deputy medical director for the Wishard Ambulance Service and the Indianapolis Fire Department. He has served as Chief Executive Officer and currently serves as Chief Medical Officer and Board member of Medical Emergency Surge Healthcare (MESH), a public-private partnership between hospitals and municipalities focused on healthcare emergency management. Dr. Miramonti served as Chairman of the Indianapolis Coalition for Patient Safety from 2011 to 2014.

Reverend Rabon L. Turner, Sr., Pastor of New Hope Missionary Baptist Church

Reverend Turner serves as pastor of New Hope Missionary Baptist Church in Evansville. Since his arrival, the church has implemented several new programs and increased its membership by more than 850 people, and its annual budget has more than tripled. He serves as a chairman on the Mayor's Pastors and Police Partnership Program, as a board member of the Economic Development Commission of Southwest Region, and as President of the New Hope Community Development Corporation. He is currently pursuing a doctorate in theology.

Dr. John J. Wernert, M.D., M.H.A., Secretary of Indiana's Family & Social Services Administration; Co-Chair of the Governor's Task Force on Drug Enforcement, Treatment, and Prevention

Dr. Wernert has more than 25 years of experience practicing psychiatry and is the first physician to lead Indiana's Family and Social Services Administration, a multi-division state agency that includes the Division of Mental Health and Addictions. He is a clinical associate professor of psychiatry at the Indiana University School of Medicine and holds national leadership offices in the American Psychiatric Association and the American Medical Association. Dr. Wernert previously served as the medical director of medical management at Eskenazi Health and has consulted in the past as the medical director for behavioral health integration for the Franciscan Alliance system. He is a past president of the Indianapolis Medical Society and the Indiana State Medical Association.

APPENDIX D

TASK FORCE MEETING SCHEDULE

DATE	LOCATION
September 16, 2015 9 a.m. - 1 p.m. ET	Sidney and Lois Eskenazi Hospital 720 Eskenazi Ave., Indianapolis, IN
October 15, 2015 1:30 p.m. - 5:30 p.m. ET	University of Southern Indiana 8600 University Blvd., Evansville, IN
November 19, 2015 12:30 p.m. - 4:30 p.m. ET	University of Notre Dame 113 Joyce Center, Notre Dame, IN
December 8, 2015 9 a.m. - 1 p.m. ET	Community Hospital North 7250 Clearvista Drive, Indianapolis, IN
January 29, 2016 9 a.m. - 1 p.m. ET	Ivy Tech Community College 2820 N. Meridian Street, Indianapolis, IN
April 13, 2016 1 p.m. - 4:30 p.m. ET	Wabash Valley Correctional Facility 6908 S. Old Highway 41, Carlisle, IN
May 17, 2016 12:30 p.m. - 4:30 p.m. ET	Manchester University College of Pharmacy 10627 Diebold Road, Fort Wayne, IN
June 21, 2016 1:30 p.m. - 4:30 p.m. ET	Richmond State Hospital 498 NW 18th Street, Richmond, IN
July 26, 2016 12:30 p.m. - 4:30 p.m. ET	Community Hospital East 1500 N. Ritter Ave., Indianapolis, IN
August 29, 2016 12:30 p.m. - 4:30 p.m. ET	IU Northwest Hospital 3400 Broadway, Gary, IN
September 20, 2016 12:30 p.m. - 4:30 p.m. ET	Mid-America Science Park 821 S Lake Road S, Scottsburg, IN
December 5, 2016 1:00 p.m. - 2:30 p.m. ET	Fairbanks 8102 Clearvista Parkway, Indianapolis, IN

APPENDIX E

2013-2016 LEGISLATION

In recent years, the Indiana General Assembly has passed, and Governor Pence has signed, a number of bills related to state drug policy, and several have been supported by the Task Force during the course of its work. While many of these new laws are cited throughout this report, the following provides a comprehensive summary of all legislation enacted between 2013 and 2016 related to substance use disorder enforcement, treatment, and prevention. Summaries have been largely taken from the Indiana General Assembly website and each law’s respective digest.

CITATION	SUMMARY
<p>2013 Senate Enrolled Act 246 <i>Controlled Substances</i>⁵⁸⁰</p>	<ul style="list-style-type: none"> ▶ Requires an owner who employs or contracts with individuals to dispense controlled substances to maintain a controlled substance registration. ▶ Allows the attorney general to petition the court to obtain an injunction against an owner who violates the controlled substance registration and control laws ▶ Requires the medical licensing board to adopt emergency rules and permanent rules concerning: (1) standards and procedures for the attorney general to follow in accessing physicians’ records and inventory; and (2) standards and protocol for the prescribing of controlled substances. ▶ Requires the health finance commission to study: (1) issues concerning pharmacy programs designed to take back and dispose of old and expired prescription drugs; and (2) the use of methadone and opioids in treatment programs and clinic settings. ▶ Requires the division on mental health and addiction to provide the health finance commission specified information concerning opioid treatment in Indiana. ▶ Requires the commission on mental health and addiction to study issues concerning treatment and recovery from prescription drug use addiction.
<p>2013 Senate Enrolled Act 277 <i>Methamphetamine Vehicle Disclosure</i>⁵⁸¹</p>	<ul style="list-style-type: none"> ▶ Requires a dealer or seller who knows or reasonably should know that methamphetamine has been manufactured in a motor vehicle within the previous two years to disclose this fact, in writing, to a buyer, prospective buyer, lessee, or prospective lessee of the motor vehicle before the sale. ▶ Permits a dealer or seller to include a decontamination report with the written disclosure. ▶ Provides that failure to disclose gives rise to a cause of action in which the buyer may seek: (1) remediation to a certain standard; or (2) reimbursement for remediation costs. ▶ Provides that, in addition, a court may award a buyer or prospective buyer liquidated damages of not more than \$10,000, and that existing tort remedies that may be available to a buyer or lessee are not eliminated or abrogated.
<p>2013 Senate Enrolled Act 496 <i>Control of Ephedrine and Pseudoephedrine</i></p>	<ul style="list-style-type: none"> ▶ Specifies that ephedrine or pseudoephedrine may be sold only by a pharmacy or a retailer that uses the National Precursor Log Exchange (NPLEx) tracking system. NPLEx is a real-time electronic logging system used by pharmacies and law enforcement to track sales of over-the-counter cold and allergy medications containing precursors (i.e., chemicals and other products that are diverted from legitimate sources to produce an illegal drug). <i>(continued)</i>

CITATION	SUMMARY
<p style="text-align: center;">2013 Senate Enrolled Act 496 <i>Control of Ephedrine and Pseudoephedrine</i>⁵⁸²</p>	<p><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Provides that: (1) a pharmacy may not sell more than 61.2 grams of ephedrine or pseudoephedrine to an individual in a 365-day period; and (2) an individual may not purchase more than 61.2 grams of ephedrine or pseudoephedrine in a 365-day period. ▶ Prohibits a person convicted of certain offenses involving methamphetamine from possessing ephedrine, pseudoephedrine, or phenylpropanolamine within seven years of the person’s conviction, unless dispensed under a prescription. ▶ Increases the penalty for furnishing methamphetamine precursors to another person with knowledge that the recipient will use the precursors to manufacture a controlled substance if the person furnishes more than 10 grams of certain precursors. ▶ Removes a provision requiring certain signage where ephedrine or pseudoephedrine is sold.
<p style="text-align: center;">2013 Senate Enrolled Act 536 <i>Synthetic Drugs</i>⁵⁸³</p>	<ul style="list-style-type: none"> ▶ Permits the attorney general to issue a civil investigative demand to obtain immediate access to records relating to the sale of synthetic drugs. ▶ Provides that the department of state revenue may revoke a retail merchant certificate if the holder commits certain violations relating to synthetic drugs. ▶ Provides that a person may be intoxicated if the person consumes any substance resulting in impairment, with certain exceptions. ▶ Permits the board of pharmacy, on its own initiative or upon formal request from the state police department, the federal Drug Enforcement Administration, or a poison control center, to adopt an emergency rule declaring certain substances to be synthetic drugs. ▶ Permits the attorney general to bring an action to abate a nuisance created in connection with the sale of synthetic drugs. ▶ Authorizes the seizure of certain property used in connection with dealing in synthetic drugs. ▶ Defines additional substances as synthetic drugs (i.e., adds a number of chemical compounds, including compound analogs, to preexisting list), and makes the sale or possession of a synthetic drug lookalike substance a criminal offense. ▶ Adds dealing in synthetic drugs to the list of racketeering offenses.
<p style="text-align: center;">2013 House Enrolled Act 1006 <i>Various Changes to the Criminal Code</i></p>	<ul style="list-style-type: none"> ▶ Makes various changes to the criminal code, including changes to the law concerning community corrections, probation, sentencing, probation funding, drug and alcohol program funding, involuntary manslaughter, communicable disease crimes, battery, hazing, obstruction of traffic crimes, interference with medical services crimes, kidnapping, confinement, criminal mischief, railroad mischief, computer crimes, theft, deception and fraud crimes, timber spiking, offenses against general public administration, criminal gang activity crimes, stalking, offenses against public health, child care provider crimes, weapon crimes, drug crimes, protection zones, and rape. ▶ Repeals the law concerning criminal deviate conduct and consolidates the crime of criminal deviate conduct into the crime of rape. Changes the phrase “deviate sexual conduct” to “other sexual conduct.” ▶ Repeals laws concerning carjacking and failure of a student athlete to disclose recruitment. ▶ Removes the current four-level felony penalty classification and replaces that classification with a six-level felony penalty classification. Assigns new felony penalties to each crime. <i>(continued)</i>

CITATION	SUMMARY
<p style="text-align: center;">2013</p> <p>House Enrolled Act 1006 <i>Various Changes to the Criminal Code</i>⁵⁸⁴</p>	<p><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Permits a judge to contact the local department of child services directly to report suspected cases of child abuse or neglect under certain conditions and provides that a child who lives in the same household as a person charged with and awaiting trial for certain sex offenses is a child in need of services. ▶ Removes the misdemeanor penalty for the entry or attempted entry by a person under the age of 21 into certain facilities that permit gambling and makes the violation an infraction. ▶ Urges the legislative council to: (1) require an existing study committee to evaluate the criminal law statutes in IC 7.1 and IC 9 and to make recommendations to the general assembly for the modification of the criminal law statutes in those titles; (2) study recidivism in Indiana; (3) study criminal justice funding issues; (4) study advisory sentences; and (5) study the suspendibility of sentences.
<p style="text-align: center;">2013</p> <p>House Enrolled Act 1382 <i>Controlled Substances</i>⁵⁸⁵</p>	<ul style="list-style-type: none"> ▶ Adds 16 additional chemical compounds to preexisting Schedule I, II, IV, and V drug lists.
<p style="text-align: center;">2014</p> <p>Senate Enrolled Act 227 <i>Alcohol and Medical Emergencies; Crime Studies</i></p>	<ul style="list-style-type: none"> ▶ Provides that a person is immune from arrest or prosecution for certain alcohol offenses if the arrest or prosecution is due to the person: (1) reporting a medical emergency; (2) being the victim of a sex offense; or (3) witnessing and reporting what the person believes to be a crime. ▶ Establishes a mitigating circumstance for the sentencing of a person convicted of a controlled substance offense if the person's arrest or prosecution was facilitated in part because the person requested emergency medical assistance for an individual in need of medical assistance due to the use of alcohol or a controlled substance. ▶ Allows a court to defer entering a judgment of conviction for an individual arrested for an alcohol offense if the individual was arrested after a report that the person needed medical assistance due to the use of alcohol if certain conditions are met. ▶ Allows an advanced emergency medical technician, an emergency medical responder, an emergency medical technician, a firefighter or volunteer firefighter, a law enforcement officer, or a paramedic to administer an overdose intervention drug to a person suffering from an overdose. ▶ Allows certain health care providers to prescribe, and a pharmacist to dispense, an overdose intervention drug for an advanced emergency medical technician, an emergency medical responder, an emergency medical technician, a fire department or volunteer fire department, a law enforcement agency, or a paramedic. ▶ Requires the commission on improving the status of children in Indiana to study and evaluate: (1) crimes of sexual violence against children; and (2) the impact of social media, wireless communications, digital media, and new technology on crimes against children. ▶ Requires the state department of health or the office of women's health to conduct a study to determine the number of persons who are the victims of crimes of domestic or sexual violence, the reasons why these crimes are underreported, best practices to improve reporting, and the most effective means to connect victims with appropriate treatment services. Establishes a framework for the study and permits the department of health or the office of women's health to contract with a third party to conduct the study. <i>(continued)</i>

CITATION	SUMMARY
<p>2014 Senate Enrolled Act 227 <i>Alcohol and Medical Emergencies; Crime Studies</i>⁵⁸⁶</p>	<p><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Urges the legislative council to assign to the appropriate study committee during the 2014 interim the task of studying the causes of violence and violent crime in Indiana.
<p>2014 Senate Enrolled Act 408 <i>Neonatal Abstinence Syndrome</i>⁵⁸⁷</p>	<ul style="list-style-type: none"> ▶ Defines neonatal abstinence syndrome (NAS) as the various adverse effects that occur in a newborn infant who was exposed to addictive illegal or prescription drugs while in the mother's womb. ▶ Requires the state department of health to: (1) meet with representatives of certain associations to study and make recommendations on issues concerning NAS; and (2) report, before November 1, 2014, on certain issues concerning NAS to the legislative council for distribution to the appropriate interim study committee. ▶ Allows the state department of health to establish, before June 1, 2015, one or more pilot programs with hospitals that consent to participate in the programs to implement appropriate and effective models for NAS identification, data collection, and reporting.
<p>2014 House Enrolled Act 1006 <i>Criminal Code Restructuring</i></p>	<ul style="list-style-type: none"> ▶ Changes the nomenclature for felonies from "Class" to "Level" for statutes not amended by HEA 1006-2013. ▶ Removes criminal gang activity, criminal gang intimidation, and certain drug offenses from the list of crimes over which a juvenile court does not have jurisdiction. ▶ Authorizes pretrial diversion for persons charged with a Level 5 or Level 6 felony. Provides that, not later than 365 days after: (1) a convicted person begins serving the person's sentence; and (2) the court obtains a report from the department of correction concerning the convicted person's conduct while imprisoned; the court may reduce or suspend the person's sentence and impose any sentence the court was authorized to impose at the time of sentencing. ▶ Specifies that, if more than 365 days have elapsed since the convicted person began serving the sentence, the court may reduce or suspend the sentence and impose any sentence the court was authorized to impose at the time of sentencing. Limits the filing of subsequent petitions to modify a sentence and removes the requirement that the court hold a hearing. Requires a court to explain its reasons for imposing a sentence unless the court imposes an advisory sentence. Increases the number of crimes that are nonsuspendible. Allows a court to suspend any part of a sentence for a Level 2 felony or a Level 3 felony concerning a controlled substance. ▶ Provides that: (1) after June 30, 2014, and before July 1, 2015, a person convicted of a Level 6 felony may not be committed to the department of correction if the person's earliest possible release date is less than 91 days from the date of sentencing, unless the commitment is due to the person violating a condition of probation, parole, or community corrections and the violation is not technical; and (2) after June 30, 2015, a person convicted of a Level 6 felony may not be committed to the department of correction if the person's earliest possible release date is less than 366 days from the date of sentencing, unless the commitment is due to the person violating a condition of probation, parole, or community corrections by committing a new criminal offense. <i>(continued)</i>

CITATION	SUMMARY
<p style="text-align: center;"> 2014 House Enrolled Act 1006 <i>Criminal Code Restructuring</i> </p>	<p style="text-align: center;"><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Makes changes to the penalties for the crimes of dealing in cocaine or a narcotic drug and dealing in methamphetamine. Enhances the penalties for certain controlled substance offenses if a person commits an offense: (1) within 500 feet of school property or a public park when a child is likely to be present; or (2) in the physical presence of a child less than 18 years of age, knowing that the child was present and might be able to see or hear the offense. Increases the minimum enhancement amount for certain controlled substances from three grams to five grams. Provides that a person may only be convicted of possession with intent to deliver if there is evidence in addition to the amount of the drug possessed that the person intended to manufacture or deliver the drug. Creates a lower offense category for persons who sell less than one gram of a controlled substance. ▶ Provides that a person less than 18 years of age who possesses an indecent image of another person less than 18 years of age commits a Class A misdemeanor if: (1) the persons are in a dating relationship; (2) the age difference between the persons is not more than four years; and (3) the person acquiesced in the taking or transmission of the indecent image. Specifies that a person who is eligible to be prosecuted for possession of an indecent image as a misdemeanor may not be prosecuted for possession of child pornography or child exploitation. ▶ Makes it child seduction, a Level 6 felony, for a law enforcement officer who is at least five years older than a child who is: (1) at least 16 years of age; and (2) less than 18 years of age; to fondle or touch the child with the intent to arouse or satisfy the sexual desires of either the child or the law enforcement officer, if the law enforcement officer's contact with the child occurred in the course of the officer's official duties, and increases the penalty to a Level 5 felony if the law enforcement officer engages in sexual intercourse or other sexual conduct with the child. ▶ Requires a court to sentence a person found to be a habitual offender to an additional fixed term of imprisonment that is between: (1) six years and 20 years, for a person convicted of murder or a Level 1 through Level 4 felony; and (2) two years and six years, for a person convicted of a Level 5 or Level 6 felony. ▶ Increases the advisory sentence: (1) from six years to nine years for a Level 3 felony; (2) from four years to six years for a Level 4 felony; and (3) from two years to three years for a Level 5 felony. ▶ Prohibits a credit restricted felon from obtaining sentence modification. ▶ Provides that educational credit time is deducted from the release date that would otherwise apply to the person. Amends credit time provisions by creating a new Class A that provides that a person: (1) who is not a credit restricted felon; and (2) who is imprisoned for a Level 6 felony or a misdemeanor or imprisoned awaiting trial or sentencing for a Level 6 felony or misdemeanor; earns one day of credit time for every day the person is imprisoned or confined awaiting sentencing. Provides that the: (1) Class I through Class IV credit class system applies to a person who commits an offense before July 1, 2014; and (2) Class A through Class D credit class system effective July 1, 2014, applies to a person who commits an offense after June 30, 2014. ▶ Reduces the sentence for: (1) arson with intent to defraud; (2) an offense against intellectual property; and (3) auto theft; from a Level 5 felony to a Level 6 felony. ▶ Reduces the maximum penalties for: (1) Level 1 felonies from 50 to 40 years; and (2) for Level 3 felonies from 20 to 16 years. <i>(continued)</i>

CITATION	SUMMARY
<p style="text-align: center;">2014 House Enrolled Act 1006 <i>Criminal Code Restructuring</i>⁵⁸⁸</p>	<p><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Provides that before March 1, 2015, the department of correction shall estimate the amount of any operational cost savings that will be realized in the state fiscal year ending June 30, 2015, from a reduction in the number of individuals who are in the custody of the department of correction that is attributable to the sentencing changes made under the bill. Specifies that if the department estimates that such operational cost savings will be realized, the department may, after review by the budget committee and approval by the budget agency, do the following: (1) Make additional grants to counties for community corrections programs from funds appropriated to the department for the department's operating expenses. (2) Transfer funds (from funds appropriated to the department for the department's operating expenses) to the judicial conference of Indiana to be used by the judicial conference of Indiana to provide additional financial aid for the support of court probation services. Provides that the maximum aggregate amount of these additional grants and transfers may not exceed the lesser of the amount of operational cost savings or \$11,000,000. ▶ Requires the Indiana criminal justice institute to monitor and evaluate criminal justice reform. ▶ Specifies that: (1) after June 30, 2014, a sheriff is entitled to a per diem and medical expense reimbursement for the cost of incarcerating a person convicted of a Level 6 felony whose earliest possible release date is less than 91 days; (2) after June 30, 2015, a sheriff is entitled to a per diem and medical expense reimbursement for the cost of incarcerating a person convicted of a Level 6 felony whose earliest possible release date is less than 366 days; and (3) the reimbursement shall be reviewed by the budget committee and is subject to the approval of the budget agency. Provides that a person on home detention as a condition of probation is entitled to earn credit time.
<p style="text-align: center;">2014 House Enrolled Act 1141 <i>Methamphetamine Lab Disclosure in Property Sales</i>⁵⁸⁹</p>	<ul style="list-style-type: none"> ▶ Provides that the state police department (and not the Indiana criminal justice institute) maintains the methamphetamine laboratory web site. ▶ Provides that a property used for the manufacture of methamphetamine may not be placed on the website until 180 days after the methamphetamine laboratory is reported to the state police department, and specifies that the state police department may not place a property on the website if it was decontaminated before being placed on the website. ▶ Provides that a property must be removed from the web site in accordance with the statute that requires the website to be established. ▶ Specifies that if methamphetamine is manufactured in an apartment of a multi-unit complex, only the specific unit in which the methamphetamine was manufactured may be included on the website. ▶ Requires a person who manufactures methamphetamine on property owned by another person to pay restitution to the owner for the owner's actual damages, including lost rents and the costs of decontamination.
<p style="text-align: center;">2014 House Enrolled Act 1218 <i>Drug Treatment and Reporting</i></p>	<ul style="list-style-type: none"> ▶ Expires standards for operation rules concerning prior authorization for a take home supply of opioid treatment medication (prior law required rules to require prior authorization for more than 14 days of medication). ▶ Prohibits an opioid treatment program from prescribing, dispensing, or providing more than a seven-day supply of opioid treatment medication to a patient to take out of the facility. <i>(continued)</i>

CITATION	SUMMARY
<p style="text-align: center;">2014 House Enrolled Act 1218 <i>Drug Treatment and Reporting</i>⁵⁹⁰</p>	<p><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Requires the division of mental health and addiction to establish certain standards and protocols for opioid treatment programs. Requires an opioid treatment program to follow the standards and protocols adopted by the division for each opioid treatment program patient. ▶ Requires the dispenser at an opioid treatment program to transmit certain information to the division within specified time frames. Provides that the information is subject to federal patient confidentiality regulations. Requires a provider to release certain information from a committed patient’s mental health records upon request of a court. ▶ Requires that the board of pharmacy adopt a rule requiring a practitioner and an opioid treatment program to check the Indiana scheduled prescription electronic collection and tracking (INSPECT) program in specified circumstances. Requires the division to report on the information collected. ▶ Increases the penalty to a Level 6 felony for violations of the central repository for controlled substances data laws. ▶ Requires the Indiana professional licensing agency to study the impact of including all prescription drugs in the INSPECT program and sets forth requirements of the study. Requires the legislative council to assign an interim committee to study: (1) the security of the INSPECT program; and (2) whether opioid treatment programs should be prohibited from allowing patients to take home opioid treatment medication. (The introduced version of this bill was prepared by the commission on mental health and addiction.)
<p style="text-align: center;">2015 Senate Enrolled Act 168 <i>Controlled Substance Database</i>⁵⁹¹</p>	<ul style="list-style-type: none"> ▶ Permits physicians who hold a temporary medical license to have access to confidential information in the Indiana scheduled prescription electronic collection and tracking (INSPECT) program.
<p style="text-align: center;">2015 Senate Enrolled Act 406 <i>Overdose Intervention Drugs</i>⁵⁹²</p>	<ul style="list-style-type: none"> ▶ Requires certain emergency personnel (i.e., advanced emergency medical technician, an emergency medical responder, an emergency medical technician, a firefighter, a volunteer firefighter, a law enforcement officer, or a paramedic) to report to the state department of health the number of times an overdose intervention medication is administered. ▶ Allows specified health care professionals with prescriptive authority (i.e., licensed physician, physician assistant, and advanced practice nurse) to dispense, write a prescription, or prepare a standing order for an overdose intervention drug without examining the individual to whom it may be administered if specified conditions are met (i.e., prescribed to person at risk of overdose or person in position to assist, prescriber instructs recipient to notify emergency services immediately before or after administration of prescription, prescriber provides education and training on administration, prescriber provides information on drug treatment and referrals). ▶ Provides for civil immunity.
<p style="text-align: center;">2015 Senate Enrolled Act 461 <i>Health Matters</i></p>	<ul style="list-style-type: none"> ▶ Amends the definition of “basic life support” to include blood glucose monitoring. ▶ Authorizes the state department of health to enter into partnerships to encourage best practices in: (1) identification and testing of populations at risk of disease related to illegal drug use; and (2) the health care treatment of incarcerated individuals for conditions related to illegal drug use. <i>(continued)</i>

CITATION	SUMMARY
<p style="text-align: center;">2015 Senate Enrolled Act 461 <i>Health Matters</i>⁵⁹³</p>	<p><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Authorizes the state health commissioner to declare a public health emergency. ▶ Specifies that hospital discharge information filed with the state department is confidential except under specified circumstances. ▶ Sets forth conditions in which a local health department, a municipality, a county, or a nonprofit organization may operate a syringe exchange program and expires the authorization of a program July 1, 2019. Provides exceptions to certain criminal laws concerning the funding, possession, and distribution of needles and syringes. Urges the legislative council to, during the 2015 interim, assign to a joint committee the topic of needle and syringe exchange programs and a review of the appropriate criminal penalties for certain drug offenses. ▶ Further specifies the circumstances for the review of the death of a child by a local child fatality review team. Allows a local child fatality review team to review the near fatality or serious injury of a child. ▶ Adds hepatitis A to the list of schoolchildren immunizations. Requires the state department, before November 30 of each year, to publish a two-year immunization calendar. Provides information to parents of grade 6 students concerning the human papillomavirus (HPV) infection. (Current language provides this information only to parents of female grade 6 students.) Requires the state department to provide the department of education with immunization materials, and requires the materials to be distributed to students' parents and guardians. Requires a health care provider who administers an immunization to enter the information into the state immunization data registry. Requires a school corporation to ensure that immunization information is complete in the state immunization data registry not later than the first Friday in February. ▶ Specifies that onsite sewage systems of private homes built by the individual are required to comply with state laws and rules.
<p style="text-align: center;">2015 Senate Enrolled Act 464 <i>Mental Health Issues</i></p>	<ul style="list-style-type: none"> ▶ Specifies limitations for reimbursement for methadone by: (1) the state employee health plan; (2) Medicaid; (3) certain policies of accident and sickness insurance; and (4) certain health maintenance organization contracts; if the drug is prescribed for the treatment of pain. Requires the office of Medicaid policy and planning to: (1) develop quality measures and reporting to ensure a managed care organization's compliance with the coverage; and (2) report the clinical use of certain medications to the mental health Medicaid quality advisory committee. Requires coverage under the Indiana check-up plan of nonaddictive medication assistance treatment drugs prescribed for the treatment of substance abuse. ▶ Provides that addiction counseling, inpatient detoxification, case management, daily living skills, and long acting, nonaddictive medication may be required to treat opioid or alcohol addiction as a condition of parole, probation, community corrections, pretrial diversion, or participation in a problem solving court. ▶ Requires the department of correction to estimate the amount of operational cost savings as a result attributable to sentencing changes. ▶ Authorizes the division of mental health and addiction (division) to approve before June 30, 2018, not more than five new opioid treatment programs if: (1) the programs are run by a hospital, a specified institution, or a certified community mental health center; and (2) the division determines that there is a need for a new opioid treatment program in the proposed location. Requires the division to report to the general assembly before July 1, 2018, specified information concerning any new opioid treatment programs. Requires a prescriber who is prescribing methadone for the treatment of pain or pain management to indicate this treatment on the prescription or order. <i>(continued)</i>

CITATION	SUMMARY
<p style="text-align: center;">2015 Senate Enrolled Act 464 <i>Mental Health Issues</i>⁵⁹⁴</p>	<p><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Establishes the mental health and addiction forensic treatment services account within the statutes governing the division, rather than the statutes governing corrections (under current law). Provides that the division may use money in the account to fund grants and vouchers that are provided to the following for mental health and addiction forensic treatment services: (1) Community corrections programs. (2) Court administered programs. (3) Probation and diversion programs. (4) Community mental health centers. (5) Certified mental health or addiction providers. Allows the division to use money in the account as a state match under the Medicaid rehabilitation program and the Primary Health Coordination Program. Requires the division to provide an education and training program concerning involuntary commitment and medication assisted treatment. Specifies that an individual is eligible for such mental health and addiction forensic treatment services if the individual meets certain criteria and if reimbursement for the service is not available to the individual under a health insurance policy, a health maintenance organization contract, the Medicaid program, the Medicare program, or any other federal assistance program. ▶ Requires the division to survey and develop demographic research on individuals receiving services. Makes certain changes to the purposes of the mental health and addiction services development programs board under the loan forgiveness program. Places restrictions on coverage under a health insurance policy and a health maintenance organization contract for methadone used in pain management. Requires the division to work jointly with the department of workforce development to coordinate employment and training services for individuals receiving services.
<p style="text-align: center;">2015 Senate Enrolled Act 534 <i>Rules for Prescribing Controlled Substances</i>⁵⁹⁵</p>	<ul style="list-style-type: none"> ▶ Requires the medical licensing board to adopt standards and protocols for the prescribing of controlled substances, including the use of abuse deterrent formulations. ▶ Requires, before March 1, 2016, the following boards to adopt rules concerning the prescribing of opioid controlled substances for pain management treatment: (1) the medical licensing board, concerning physician assistants; (2) the board of podiatric medicine, concerning podiatrists; (3) the state board of dentistry, concerning dentists; and (4) the Indiana state board of nursing, concerning advanced practice nurses. Requires each board to report before December 31, 2015, to the legislative council with a status report on the board's efforts to adopt the required rules.
<p style="text-align: center;">2015 House Enrolled Act 1006 <i>Criminal Justice Funding</i></p>	<ul style="list-style-type: none"> ▶ Establishes the justice reinvestment advisory council to review and evaluate local corrections programs, grant applications, and the processes used to award grants. ▶ Requires the department to compile certain information and submit reports to the budget committee and advisory council. Specifies the purposes for which the department may award financial aid. Repeals the county corrections fund that provides funding to each county for operation of the county's jail, jail programs, or other local correctional facilities or community based programs. ▶ Requires a probation officer to consult with community corrections concerning programs available to the defendant in preparing the presentence report. Permits a court to delegate the terms of placement in community corrections to the community corrections program director, and permits the director to change the terms of placement or reassign a person in community corrections. Provides that after December 31, 2015, a court may not commit a person convicted of a Level 6 felony to the department of correction, with certain exceptions. <i>(continued)</i>

CITATION	SUMMARY
<p style="text-align: center;">2015 House Enrolled Act 1006 <i>Criminal Justice Funding</i>⁵⁹⁶</p>	<p><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Requires the department of correction, the division of mental health and addiction, and a community corrections advisory board to submit grant applications to the advisory council for review. ▶ Provides that the advisory council shall meet to: (1) work with the department of correction and the division of mental health and addiction to establish the grant criteria; and (2) make recommendations to the department of correction and the division of mental health and addiction concerning the award of grants. ▶ Establishes the mental health and addiction forensic treatment services account within the statutes governing the division of mental health and addiction and provides that the division may use money in the account to fund grants and vouchers for mental health and addiction forensic treatment services. ▶ Permits the department of correction to accept an offender convicted of a misdemeanor if the offender has at least 547 days remaining before the person's earliest release date as the result of a sentencing enhancement applied to a misdemeanor sentence. ▶ Specifies that a sheriff is entitled to a per diem and medical expense reimbursement from the department of correction for the cost of incarcerating certain persons in the county jail. ▶ Makes permanent certain provisions permitting the department of correction to award grants from operational savings attributable to HEA 1006-2014, and provides that these funds may only be used for community corrections or court supervised recidivism reduction programs. Specifies that certain funds may not be used to construct or renovate community corrections facilities.
<p style="text-align: center;">2015 House Enrolled Act 1448 <i>Mental Health Drugs and Coverage</i>⁵⁹⁷</p>	<ul style="list-style-type: none"> ▶ Includes inpatient substance abuse detoxification services as a Medicaid service. ▶ Authorizes the office of Medicaid policy and planning to require prior authorization for addictive medication used as medication assisted treatment for substance abuse. ▶ Allows money in the forensic treatment services account to be used to fund grants and vouchers for licensed mental health or addiction providers. ▶ Requires information and training to judges, prosecutors, and public defenders concerning diversion programs, probationary programs, and involuntary commitment.
<p style="text-align: center;">2016 Senate Enrolled Act 80 <i>Ephedrine and Pseudoephedrine</i></p>	<ul style="list-style-type: none"> ▶ Requires the Indiana board of pharmacy to adopt emergency rules that are effective July 1, 2016, concerning: (1) professional determinations made; and (2) a relationship on record with the pharmacy; concerning the sale of ephedrine or pseudoephedrine. ▶ Requires the board to: (1) review professional determinations made; and (2) discipline a pharmacist who violates a rule concerning a professional determination made; concerning the sale of ephedrine or pseudoephedrine. ▶ Allows the board, in consultation with the state police, to declare a product to be an extraction resistant or a conversion resistant form of ephedrine or pseudoephedrine. ▶ Specifies that a person who is denied the sale of a nonprescription product containing pseudoephedrine or ephedrine is not prohibited from obtaining pseudoephedrine or ephedrine pursuant to a prescription. ▶ Allows a pharmacist to deny the sale of ephedrine or pseudoephedrine on the basis of the pharmacist's professional judgment, and provides the pharmacist with civil immunity for making such a denial. <i>(continued)</i>

CITATION	SUMMARY
<p style="text-align: center;">2016 Senate Enrolled Act 80 <i>Ephedrine and Pseudoephedrine</i>⁵⁹⁸</p>	<p><i>(continued from above)</i></p> <ul style="list-style-type: none"> ▶ Provides that a pharmacist or pharmacy technician may determine that the purchaser has a relationship on record with the pharmacy, in compliance with rules adopted by the board. Provides that a purchaser who has a relationship on record with the pharmacy may purchase pseudoephedrine or ephedrine. Allows the pharmacist to provide certain pseudoephedrine or ephedrine products to a purchaser who does not have a relationship on record with the pharmacy or for whom the pharmacist has made a professional judgment that there is not a medical or pharmaceutical need. ▶ Adds ephedrine and pseudoephedrine to the definition of “controlled substance” for purposes of the Indiana scheduled prescription electronic collection and tracking (INSPECT) program.
<p style="text-align: center;">2016 Senate Enrolled Act 161* <i>Pharmacists, Ephedrine, and Methamphetamine</i>⁵⁹⁹</p>	<ul style="list-style-type: none"> ▶ Requires the division of state court administration to report certain methamphetamine-related felonies to the National Precursor Log Exchange (NPLEx) so that NPLEx can generate a stop sale alert to prevent persons convicted of those felonies from purchasing ephedrine or pseudoephedrine. ▶ Requires the Indiana board of pharmacy to adopt emergency rules that are effective July 1, 2016, concerning: (1) professional determinations made; and (2) a relationship on record with the pharmacy; concerning the sale of ephedrine or pseudoephedrine. ▶ Authorizes the board to: (1) review professional determinations made; and (2) discipline a pharmacist who violates a rule concerning a professional determination made; concerning the sale of ephedrine or pseudoephedrine. ▶ Allows the board, in consultation with the state police, to declare a product to be an extraction resistant or a conversion resistant form of ephedrine or pseudoephedrine. ▶ Specifies that a person who is denied the sale of a nonprescription product containing pseudoephedrine or ephedrine is not prohibited from obtaining pseudoephedrine or ephedrine pursuant to a prescription. ▶ Allows a pharmacist to deny the sale of ephedrine or pseudoephedrine on the basis of the pharmacist’s professional judgment, and provides the pharmacist with civil immunity for making such a denial. ▶ Provides that a pharmacist or pharmacy technician may determine that the purchaser has a relationship on record with the pharmacy, in compliance with rules adopted by the board. Provides that a purchaser who has a relationship on record with the pharmacy may purchase pseudoephedrine or ephedrine. Allows the pharmacist to provide certain pseudoephedrine or ephedrine products to a purchaser who does not have a relationship on record with the pharmacy or for whom the pharmacist has made a professional judgment that there is not a medical or pharmaceutical need. ▶ Requires the Indiana scheduled prescription electronic collection and tracking (INSPECT) program to track ephedrine and pseudoephedrine dispensed pursuant to a prescription. Removes an expired provision.

*Several of these provisions were adopted under Senate Enrolled Act 80-2016; however, Senate Enrolled Act 161-2016 changes the “may” to a “shall” for the Board, under rule or emergency rule, to declare “extraction resistant” or “conversion resistant” forms of ephedrine or pseudoephedrine.

CITATION	SUMMARY
<p>2016 Senate Enrolled Act 174 <i>Criminal Law Matters</i>⁶⁰⁰</p>	<ul style="list-style-type: none"> ▶ Provides that a person who, with intent to: (1) deceive; or (2) induce compliance with the person's instructions, orders, or requests; falsely represents that the person is a public servant (i.e., law enforcement officer, agent or employee of the department of state revenue), commits impersonation of a public servant, a Class A misdemeanor. ▶ Creates a Level 4 offense for dealing in a controlled substance by a practitioner (i.e., licensed physician, veterinarian, dentist, podiatrist, optometrist, advanced practice nurse, or physician assistant) who knowingly or intentionally prescribes without legitimate medical purpose, and enhances the offense to a Level 3 if the offense causes the death of another person.
<p>2016 Senate Enrolled Act 186 <i>Release of Medical Tests of Pregnant Women</i>⁶⁰¹</p>	<ul style="list-style-type: none"> ▶ Prohibits certain practitioners (i.e., licensed physician, physician assistant, direct entry midwife, or advanced practice nurse providing prenatal care) from releasing to law enforcement the results of certain screenings or tests (i.e., verbal screening or questioning concerning drug or alcohol use, a urine test, or blood test) of a pregnant woman without said woman's consent or a court order.
<p>2016 Senate Enrolled Act 187 <i>Overdose Intervention Drugs</i>⁶⁰²</p>	<ul style="list-style-type: none"> ▶ Requires an entity acting under a standing order issued by a prescriber for an overdose intervention drug to report annually certain information to the state department of health. ▶ Requires the state department to ensure that a statewide standing order for the dispensing of an overdose intervention drug is issued for Indiana. ▶ Allows the state health commissioner or a public health authority to issue a statewide standing order for the dispensing of an overdose intervention drug. ▶ Requires emergency ambulance services to report the number of times an overdose intervention drug has been administered by its personnel. Requires the ambulance service to include the information in the emergency ambulance service's report to the emergency medical services commission under the emergency medical services system review. ▶ Provides that, if certain conditions are met (e.g., law enforcement officer makes a reasonable determination that the overdose drug was obtained from a prescriber, the individual complies with the officer's request for information, the individual remained on the scene, etc.), an individual who aided an individual in need of medical assistance due to an opioid related overdose is immune from certain criminal prosecutions for possession of cocaine, methamphetamine, controlled substances, paraphernalia, marijuana, or synthetic drug/synthetic drug lookalike substance.
<p>2016 Senate Enrolled Act 214 <i>Controlled Substances</i>⁶⁰³</p>	<ul style="list-style-type: none"> ▶ Prohibits Medicaid reimbursement for Subutex, Suboxone, or a similar trade name or generic of the drug if the drug was prescribed for the treatment of pain or pain management and the drug is only indicated for addiction treatment. ▶ Requires the office of the secretary and the division of mental health and addiction to develop a treatment protocol containing best practice guidelines for the treatment of opiate dependent patients to be used by certain office based opioid treatment providers. Requires the office of the secretary to recommend certain best practice guidelines to: (1) the professional licensing agency; (2) the office of Medicaid policy and planning (office); and (3) a managed care organization that has contracted with the office.

CITATION	SUMMARY
<p>2016 Senate Enrolled Act 271 <i>Drug Enforcement, Treatment, and Prevention</i>⁶⁰⁴</p>	<ul style="list-style-type: none"> ▶ Establishes the Indiana commission to combat drug abuse (ICCDa). ▶ Repeals the commission for a drug free Indiana. Requires the Indiana criminal justice institute (ICJI) to assume certain duties of the repealed commission for a drug free Indiana concerning the approval of comprehensive drug free community plans and grants. ▶ Provides that the executive director of the ICJI has certain responsibilities concerning the ICCDA and local coordinating councils.
<p>2016 Senate Enrolled Act 290 <i>Criminal Law Matters</i>⁶⁰⁵</p>	<ul style="list-style-type: none"> ▶ Provides that a person may be convicted of possession with intent to manufacture or deliver a controlled substance without additional evidence of intent to manufacture or deliver if the person possesses more than a specified quantity (at least 28 grams) of the controlled substance. ▶ Specifies that the fact that an individual has attended a syringe exchange program may not form any part of a probable cause or reasonable suspicion determination. ▶ Permits a person placed on home detention as a condition of pretrial release to earn one day of good time credit for every four days served on pretrial home detention.
<p>2016 Senate Enrolled Act 297 <i>Opioid Dependence Treatment</i>⁶⁰⁶</p>	<ul style="list-style-type: none"> ▶ Requires Medicaid coverage for inpatient detoxification for the treatment of opioid or alcohol dependence. ▶ Adds requirements for an opioid treatment program to meet in order to operate in Indiana (e.g., approved and certified by the division, provides treatment for opioid addiction using a drug approved by the Food and Drug Administration, is an enrolled Medicaid or Healthy Indiana Plan (HIP) provider, is enrolled as an ordering, prescribing, or referring provider under §6401 of the Affordable Care Act and maintains a memorandum of understanding with a community mental health center for proposes of ordering, prescribing or referring treatments covered by Medicaid and HIP). ▶ Requires the division of mental health and addiction to adopt specified administrative rules concerning opioid treatment by an opioid treatment provider. ▶ Requires the office of the secretary and the division to develop a treatment protocol containing best practice guidelines for the treatment of opiate dependent patients to be used by certain office based opioid treatment providers. ▶ Requires an opioid treatment program to provide specified information upon request by the division. ▶ Urges the legislative council to assign a study committee the topic of patient access to and provider reimbursement for federally approved medication assisted treatment in the Medicaid program
<p>2016 House Enrolled Act 1157 <i>Methamphetamine Matters</i>⁶⁰⁷</p>	<ul style="list-style-type: none"> ▶ Requires the division of state court administration to report certain methamphetamine-related felonies (i.e., dealing, possession of more than 10 grams of ephedrine/pseudoephedrine/phenylpropanolamine, possession or sale of certain chemical reagents or precursors with intent to manufacture a controlled substance, or unlawful sale of a precursor) to the National Precursor Log Exchange (NPLEx) so that NPLEx can generate a stop sale alert to prevent individuals convicted of those felonies from purchasing ephedrine or pseudoephedrine.

CITATION	SUMMARY
<p style="text-align: center;">2016</p> <p>House Enrolled Act 1211 <i>Methamphetamine and Criminal Mischief</i>⁶⁰⁸</p>	<ul style="list-style-type: none"> ▶ Includes the attempted manufacture of methamphetamine in the statutory definition of “methamphetamine abuse.” ▶ Requires law enforcement agencies to report fires related to methamphetamine abuse to the Indiana criminal justice institute. ▶ Makes it institutional criminal mischief, a Class A misdemeanor, for a person to recklessly, knowingly, or intentionally damage property: (1) that is vacant real property or a vacant structure; or (2) after the person has been denied entry to the property by a court order that was issued to the person or to the general public by conspicuous posting on or around the property in areas where a person could observe the order when the property has been designated by a municipality or county enforcement authority to be a vacant property, an abandoned property, or an abandoned structure. ▶ Makes the offense: (1) a Level 6 felony if the pecuniary loss is at least \$750 but less than \$50,000; and (2) a Level 5 felony if the pecuniary loss is at least \$50,000. Provides that, if the offense involved the use of graffiti, the court may order that the person’s operator’s license be suspended or invalidated by the bureau of motor vehicles for not more than one year. ▶ Makes it controlled substances criminal mischief, a Level 6 felony, for a person to recklessly, knowingly, or intentionally damage property: (1) during the dealing or manufacture of or attempted dealing or manufacture of cocaine or a narcotic drug or the dealing or attempted dealing of methamphetamine; and (2) by means of a fire or an explosion. Makes the offense a Level 5 felony if the offense results in moderate bodily injury to any person other than a defendant. Defines “pecuniary loss” for purposes of criminal mischief offenses.
<p style="text-align: center;">2016</p> <p>House Enrolled Act 1235 <i>Drug Offenses</i>⁶⁰⁹</p>	<ul style="list-style-type: none"> ▶ Specifies that Level 2 controlled substance offenses are nonsuspendible if: (1) the offense involves methamphetamine or heroin; and (2) the person has a prior felony conviction for dealing in certain controlled substances.

APPENDIX F

ISDH INSPECT RECOMMENDATIONS - PAGE 1



Michael R. Pence
Governor

Jerome M. Adams, MD, MPH
State Health Commissioner

October 26, 2015

To: John Hill
Office of Governor Mike Pence
Deputy Chief of Staff for Public Safety

FROM: Jerome Adams, MD, MPH *JA*
State Health Commissioner

SUBJECT: INSPECT Recommendations

At your request, I have solicited recommendations from members of the Governor's Task Force regarding Indiana's Prescription Drug Monitoring Program (PDMP), INSPECT. The recommendations presented by Task Force members and to the Task Force members by Senator Donnelly are supported by the PDMP Best Practices Document published by the Brandeis PDMP Center of Excellence, the Centers for Disease Control and Prevention (CDC), and the Association of State and Territorial Health Officials (ASTHO).

Our recommendations include:

- 1) Increasing PDMP utilization. States that require prescribers to register with their PDMP and consult the PDMP prior to prescribing controlled substances have seen significant decreases in inappropriate prescribing.
- 2) Mandatory dispenser reporting to INSPECT, including physician dispensers. Most states that permit practitioners to dispense also require them to submit prescription information to the PDMP.
- 3) Increased Public Health access to and use of INSPECT as an injury prevention and health promotion tool. Primary areas in which PDMPs can be used to meet public health objectives include:
 - Education – Providing information on prescribing trends and raising general awareness of the prescription drug abuse epidemic.
 - Epidemiological Surveillance – Determining incidence and prevalence of certain medical and nonmedical uses of controlled pharmaceuticals statewide and by county, region, or city.
 - Prevention – Enabling healthcare providers to avoid prescribing duplicate therapies and creating deterrents to drug diversion.
 - Early Intervention – Detecting patients at risk of drug abuse at initial stages of drug-seeking behavior.

More than two-thirds of PDMPs are housed in and administered by a state public health agency or a sister health-related agency.



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-
- 4) Establishing criteria for:
 - Questionable activity by setting standard thresholds for numbers of prescribers or pharmacies visited in a given time period—in order to target prescriber reports and improve potential doctor shopping and aberrant prescribing measures.
 - Dangerous drug combinations (such as opiates/opioids, benzodiazepines, stimulants) in order to alert physicians when multiple classes of drugs are being combined and prescribed to the patient.
 - 5) Improve data quality. The quality of a PDMP's output—analyses and reports, whether solicited or unsolicited—depends on the timeliness, completeness, accuracy, and consistency of collected data. Best practices need to be identified for all stages of data collection and data management, and adequate staffing levels need to be maintained to assure their implementation.
 - 6) PDMP/EHR/HIE Integration should be supported with funding and infrastructure. The ultimate goal is to provide secure PDMP data in real time to electronic records systems such that medical providers have continuous access to meaningful prescribing risk indicators and prescription history information vital to safe prescribing and dispensing of controlled substances.
 - 7) Evaluating INSPECT to inform and improve activities and demonstrate the value of a PDMP. Evaluation practices and use of evaluation findings for quality improvement enable PDMPs to respond to changing demands and conditions and ensure their systems and policies permit maximum appropriate use of high-quality, timely PDMP data. Examples of evaluation strategies include:
 - Conduct satisfaction and utilization surveys of end users.
 - Conduct audits of PDMP system utilization for appropriateness and extent of use.
 - Use PDMP data as outcome measures in evaluating program and policy changes.
 - Analyze other outcome data (e.g., overdoses, deaths, hospitalizations, ER visits) to evaluate the PDMP's impact.

APPENDIX G

AGENCY EFFORTS TO INCREASE AWARENESS OF AARON'S LAW

AGENCY	ACTIVITIES
Indiana State Excise Police	<ul style="list-style-type: none"> ▶ Distributing more than 13,600 flyers to alcoholic beverage permit locations and posting a copy on the Alcohol and Tobacco Commission/State Excise Police website ▶ Increasing awareness via social media and including information during community events and the Indiana State Fair
Indiana Department of Homeland Security	<ul style="list-style-type: none"> ▶ Communicating information regarding the law to Indiana emergency medical services (EMS)-related constituent groups through the EMS Commission and provider forums ▶ Discussing the use of naloxone by all levels of responders with EMS Medical Directors at district seminars ▶ Posting model training programs appropriate for law enforcement agencies and EMS organizations on the agency website ▶ Reinforcing the importance of collecting appropriate data regarding the administration of naloxone and the treatment of overdose patients as required ▶ Providing a summary of the law, a link to the law, and an electronic copy of the law to the state college and university emergency management group and leadership of the Indiana Campus Law Enforcement Administrators Association
Indiana State Fair	<ul style="list-style-type: none"> ▶ Making information about the law available to the agency's Safety & Security Department ▶ Directing the Department to train staff and first responders working on the fairgrounds, and to include the law in an upcoming staff training session ▶ Sending email to staff directors summarizing the law and directing them to communicate information with staff ▶ Including information about the law in monthly staff newsletter
Indiana National Guard	<ul style="list-style-type: none"> ▶ Disseminating information regarding the law via the Joint Services Support website and social media
Indiana State Library	<ul style="list-style-type: none"> ▶ Distributing information regarding the law to all employees, and a statewide email list of librarians
Indiana Department of Natural Resources	<ul style="list-style-type: none"> ▶ Working with medical professionals to develop an educational program for agency personnel regarding the signs and symptoms of a drug overdose. ▶ Planning to incorporate efforts into a comprehensive training program that will include informational materials for officers' patrol vehicles, a review of the law and, should medication be available, training on naloxone administration
Indiana Department of Toxicology	<ul style="list-style-type: none"> ▶ Sending information regarding the law to staff via email ▶ Indiana State Police laboratories have naloxone on hand should a staff member be exposed to an opioid in a life-threatening manner when processing mail
Integrated Public Safety Commission	<ul style="list-style-type: none"> ▶ Increasing awareness of the law via social media

(continued)

AGENCY	ACTIVITIES
Professional Licensing Agency	<ul style="list-style-type: none"> ▶ Creating an agency webpage describing the law and its relevance to both practitioners/dispensers and the general public, and working to create a banner for the state webpage linking to the new agency webpage ▶ Distributing pamphlets to pharmacies statewide explaining the law and its ramifications, including information regarding how the public can access naloxone ▶ Distributing “static-cling” advertisements to pharmacies statewide to increase general awareness among pharmacy patrons ▶ Included discussion of the law in Medical Board and Nursing Board Indiana Code compilations to raise awareness among practitioners, as well as their understanding of prescribing procedures for naloxone ▶ Emailing all licensed practitioners and dispensers informing them of the law and its practical effects ▶ Partnering with the Indiana State Department of Health and other agencies in informational capacities to craft a public service announcement to raise awareness
Office of the Utility Consumer Counselor	<ul style="list-style-type: none"> ▶ Sharing information through media feeds, website, and staff communications
Indiana Department of Transportation	<ul style="list-style-type: none"> ▶ Including Aaron’s Law awareness stickers on all fleet vehicles ▶ Offering agency resources to create signs for highway rest areas and to include awareness language on state map ▶ Increasing awareness of the law via social media, local public agencies, and staff communications
Indiana Housing and Community Development Authority	<ul style="list-style-type: none"> ▶ Including information regarding the law in internal bi-monthly staff updates, monthly email communications to partner entities following agency board meetings, and the agency’s quarterly electronic magazine
State Board of Accounts	<ul style="list-style-type: none"> ▶ Including an informational paragraph and informational documents regarding the law on the agency’s website
Indiana Board of Tax Review	<ul style="list-style-type: none"> ▶ Making copies of information sheets regarding the law available in agency reception area and distributing information to staff
Indiana Education Employment Relations Board	<ul style="list-style-type: none"> ▶ Distributing copies of the law to all staff and discussing during staff meetings
Northwest Indiana Regional Development Authority	<ul style="list-style-type: none"> ▶ Including information regarding the law on the agency’s standard construction industry presentations ▶ Distributing information about Task Force activities and the law via social media, weekly newsletters, and all other routine communications
Commission for Higher Education	<ul style="list-style-type: none"> ▶ Distributing information regarding the law to government representatives for all public post-secondary institutions, as well as the Independent Colleges of Indiana central office (ICI), along with links to three organizations offering speakers to schools that want to raise awareness among their students (i.e. Sam’s Watch, Brady’s Hope, and Overdose Lifeline) ▶ Notifying all public post-secondary institutions, ICI, and agency staff about Red Ribbon Week occurring on October 23-31, which is focused on drug awareness

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AGENCY	ACTIVITIES
Office of Community and Rural Affairs	<ul style="list-style-type: none"> ▶ Providing funding for Case Management Assistance and additional medical services in Scott County and adjacent counties. Working with the Indiana State Department of Health regarding the agency’s intent to provide financial assistance to support services. ▶ Communicating information regarding the law to agency staff and identifying opportunities to communicate information to local communities/units of government.
State Employees’ Appeals Commission	<ul style="list-style-type: none"> ▶ Communicating information regarding the law to all staff via email
Criminal Justice Institute	<ul style="list-style-type: none"> ▶ Agency Director presenting information regarding the law at Red Ribbon Breakfasts ▶ Distributing information regarding the law to local coordinating councils
Indiana Department of Labor	<ul style="list-style-type: none"> ▶ Publishing an informational page regarding the law on the agency’s website, and disseminated links to agency notice subscribers
Indiana Department of Administration	<ul style="list-style-type: none"> ▶ Providing assistance to other state agencies as requested ▶ Communicating information regarding the law to all staff via email ▶ Seeking opportunities to strategically place messages regarding the law around campus
Indiana Department of Revenue	<ul style="list-style-type: none"> ▶ Providing collateral materials, as available, to district office locations for public display and dissemination ▶ Increasing staff awareness of the law through the agency’s intranet website and internal employee newsletter ▶ Including information regarding the law in upcoming issues of the agency’s external publications for business taxpayers, tax professionals, and special tax audiences; and providing links on the agency’s external website to notify and educate all constituents, including taxpayers and tax professionals
Indiana Gaming Commission	<ul style="list-style-type: none"> ▶ Communicating information regarding the law to all staff via email ▶ Displaying posters regarding the law in Indiana casinos
Office of State-Based Initiatives	<ul style="list-style-type: none"> ▶ Researching federal grant opportunities to promote information regarding the law ▶ Seeking to ensure agency block grant contingency plans include areas related to the law
Office of Energy Development	<ul style="list-style-type: none"> ▶ Increasing awareness of the law via social media
Hoosier Lottery	<ul style="list-style-type: none"> ▶ Communicating information regarding the law to all staff, major vendor staff, and commission members via email ▶ Posting information regarding the law in common space at the agency headquarters

(continued)

AGENCY	ACTIVITIES
Indiana Family & Social Services Administration	<ul style="list-style-type: none"> ▶ Increasing awareness of naloxone access and training available to patients treated at certified opiate treatment programs and community mental health centers ▶ Researching the availability of federal block grants to be used in purchasing naloxone kits and providing training ▶ Ensuring coverage in the Indiana Health Coverage Programs for the naloxone auto-injector product (i.e., EVZIO) for eligible members diagnosed with an SUD and their families ▶ Implementing strategies for coordinating the provision of naloxone rescue kits and referrals to treatment programs whenever a county-based needle exchange program is authorized ▶ Coordinating with the Indiana State Department of Health to distribute informational materials from organizations like Overdose Lifeline, and to publish additional public information regarding naloxone and SUD treatment
Department of Local Government Finance	<ul style="list-style-type: none"> ▶ Distributing information regarding the law via the agency’s local government listservs
State Personnel Department	<ul style="list-style-type: none"> ▶ Communicating information regarding the law to Capitol Police to ensure first responders are aware of its provisions and have access to naloxone when responding to health emergencies on the Indiana Government Center campus ▶ Communicating information regarding the law to state employee health plan providers to understand any barriers to naloxone accessibility and any supply constraints that may inhibit acquisition by first responders
Ports of Indiana	<ul style="list-style-type: none"> ▶ Circulating information regarding the law to operating units for distribution to all staff, and making general counsel available for any questions
Board of Animal Health	<ul style="list-style-type: none"> ▶ Sharing information regarding the law with staff statewide and requesting suggestions for educating constituencies
Department of Correction	<ul style="list-style-type: none"> ▶ Seeking to procure naloxone for parole districts and to provide training regarding administration
Department of Workforce Development	<ul style="list-style-type: none"> ▶ Sharing information regarding the law with regional youth directors and Jobs for America’s Graduates (JAG) program managers

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