HB22-1326 Independent Study Fentanyl Accountability and Prevention Act

Analysis Plan

PLAN HIGHLIGHTS:

- **Called for in Section 34 of House Bill 22-1326 (Fentanyl Accountability and Prevention Act),** this document outlines a plan to examine the implementation and short-term outcomes of some of the bill's key provisions.
- **Using literature review, stakeholder interviews, and an assessment of potential data sources,** the Colorado Lab identified three study focus areas.
- The study aims to help **inform policy decision-makers and policy influencers**, support the development of shared language and frameworks, and support stakeholders in identifying opportunities to work cohesively to use a multi systems-approach.

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Note on Gender-Inclusive Language

The Colorado Evaluation and Action Lab affirms our commitment to the use of gender-inclusive language. We are committed to honoring the unique gender identity of each study participant. Throughout this report, we follow the guidance of the Associated Press Stylebook and the Chicago Manual of Style and use the gender-neutral, singular "they" when appropriate.

CDPHE Statement on Equity

The Colorado Department of Public Health and Environment acknowledges that generations-long social, economic and environmental inequities result in adverse health outcomes. They affect communities differently and have a greater influence on health outcomes than either individual choices or one's ability to access health care. Reducing health disparities through policies, practices and organizational systems can help improve opportunities for all Coloradans.

Section 1: Introduction

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The Problem and Opportunity

Fentanyl is having a negative impact on Colorado, contributing to drug overdoses and deaths. Communities are experiencing the trauma of loss, the collateral consequences of substance use disorder (SUD), and the overwhelm of systems not well equipped to respond. Colorado passed House Bill (HB) 22-1326, the Fentanyl Accountability and Prevention Act, in May 2022, with the aim of addressing the distribution of synthetic opioids such as fentanyl; supporting behavioral health interventions, treatment, prevention, and other supportive services; and reducing the number of deaths from fentanyl. Section 34 of the Act called for an independent study to examine the implementation and short-term outcomes of some of the bill's key provisions (Appendix A). The Colorado Department of Public Health and Environment (CDPHE) contracted with the Colorado Evaluation and Action Lab (Colorado Lab) in March 2023 to develop an analysis plan for the study.

How We Developed the Analysis Plan

The Colorado Lab deployed three methods to develop the analysis plan: conducting a comprehensive literature review of the problem and potential solutions; conducting interviews with stakeholders from diverse fields; and reviewing potential data sources (for details, see Appendix B). In applying these methods, we centered on the study priorities called for in the bill with the goal of a) understanding diverse perspectives and approaches; b) understanding the potential impacts of different strategies, including positive, negative, intended, and unintended consequences; c) identifying implementation challenges and opportunities; and d) identifying gaps in knowledge and what types of information would be helpful to support ongoing work and decision-making.

In total, we spoke with 53 stakeholders, including representatives from state agencies (e.g., CDPHE, Behavioral Health Administration [BHA], Department of Corrections [DOC], Attorney General); local government; first responders; police chiefs, sheriffs, and district attorneys (DAs); treatment providers; harm reduction organizations; criminal justice advocacy organizations; and coalitions focused on addressing the negative impacts of fentanyl (Figure 1). We also participated as observers in a series of focus groups with adults with lived experience, including individuals who currently use or previously used fentanyl; individuals who work directly with individuals who use fentanyl (e.g., peer navigators, harm reduction practitioners); and individuals who have been impacted by the justice system for fentanyl-related charges.

Figure 1. Stakeholders that Informed this Analysis Plan

It is important to note that stakeholders did not always agree; we did our best to listen and represent their perspectives in this plan, pointing out areas of tension and bringing in information from the literature review whenever possible. One thing that stakeholders do share is the desire to save lives and support healthy communities. We hope that this study can support that goal.

Conceptualizing the Problem and the Solutions

We began by deepening our **understanding of the problem** because how we define the problem—and its root drivers—impacts the types of solutions implemented. We examined four aspects of the problem: fentanyl supply, fentanyl source, fentanyl use and individuals using fentanyl, and overdose events and death from fentanyl.

A Note on Language

Throughout this plan we aim to be intentional in the language we use (Appendix C). For example, we use the term "deaths from fentanyl" (as opposed to "overdose deaths" or "poisonings") in an effort to value individuals who both knowingly and unknowingly ingested fentanyl and the experiences of their loved ones.

We rooted our investigation into the problem in the following data-grounded assumptions:

- **Some communities are disproportionately impacted** by the negative impacts of fentanyl; this is often correlated with race, class, and/or place, which is rooted in system racism, classism, and a history of under-resourcing some communities.
- **SUD, including opioid use disorder (OUD), is a medical condition**. There are issues of stigma related to substance use and some stakeholders continue to view substance use as a moral failure. This view hinders our ability to effectively respond to the crisis[1] and is antithetical to an approach that values all people. Addressing the problems caused by fentanyl requires an understanding that SUD is a treatable disease from which people can recover[2] and treating individuals with a SUD with dignity, respect, and compassion reduces stigma that can prevent individuals from accessing necessary care and resources.
- There are **interconnections between fentanyl use and other issues**, including use of alcohol, cannabis, and illicit drugs, mental health challenges, and homelessness. It is important to take a person-centered approach to understand individuals and their needs and assets holistically.
- **Fentanyl is one of what is and will be other synthetic drugs** in Colorado. While we refer to "fentanyl" specifically in the study, we hope that lessons learned will be viewed with the context of—and potentially applicable to—other synthetic opioids and emerging substances more broadly.

After deepening our understanding of the problem, we **explored potential solutions**. This was challenging, given that what is known about how to effectively address the negative impact of fentanyl is still emerging. Therefore, as appropriate, we draw from the best available evidence of how to address other opioids and illicit drugs. The best available evidence refers to the weight of the research evidence from the most rigorous studies available about a practice or policy; this includes both number-based (quantitative) and narrative-based (qualitative) data.

There are four types of approaches[3, 4, 5] that can be used—and were employed in HB22-1326—to address fentanyl (Figure 2):

- **Primary prevention**, which aims to prevent substance use initiation, substance misuse, and SUD.
- **Law enforcement**, which aims to decrease the supply of illicit drugs and deter people from possessing, distributing, or selling illicit drugs.
- **Treatment and recovery**, which aims to support individuals with a SUD in accessing and staying engaged in the most effective treatments and long-term recovery supports.
- **Harm reduction**, which focuses on empowering people who use drugs to use strategies to stay alive and as healthy as possible.

Figure 2. Approaches to Address Fentanyl

While these four approaches can be complementary, sometimes they are contradictory. We recognize that there is no "silver bullet" to address the issue of fentanyl; rather, a multi-component strategy is needed. However, this **does not mean that all strategies are equal or that they work best in combination**. We do our best throughout the analysis plan to highlight gaps in knowledge and potential alignment/tension between strategies.

Study Goals and Foci

We defined the study as having three primary goals:

- Inform policy decision-makers and policy influencers at the state- and local-level.
- Support the development and use of shared language and frameworks.
- Support stakeholders in identifying opportunities to work cohesively using a multi systems-approach.

This study will examine strategy implementation and associated short-term outcomes in three areas:

- Acute response that addresses underlying needs and is part of a comprehensive system.
- Increased criminal penalties for the possession of fentanyl.
- Public health and harm reduction approaches for priority populations.

We identified these areas based on the priorities identified in HB22-1326 for the independent study, overlaid with results of the analysis plan development process, which identified gaps and unknowns, opportunities to support actionability, and strategies to advance equity. This **study will not examine**

long-term impacts of the bill, such as how the bill impacted overall rates of overdose or deaths from fentanyl.

Within each of these areas, we identify methods in order to employ a “numbers and narrative” (mixed methods) approach, get perspectives from stakeholders with lived experience (who are directly impacted by changes made in the bill), and identify and elevate promising models/approaches.

Organization of The Plan

Alongside this introduction (**Section 1**), the rest of the document is organized as follows:

- **Section 2** describes what is known and what remains unknown about the problem and potential solutions, synthesizing results from the literature review, complemented by perspectives of stakeholders we interviewed.
- **Section 3** describes the three study areas. For each, we describe the changes made in HB22-1326 and what the strategy is aiming to achieve; what we know and what remains unknown about the area; and the assessment questions and methods to be employed.
- **Section 4** provides a “deep dive” on the primary and secondary data sources that will be used to conduct the study.
- **Section 5** describes the implementation plan for the study, including the timeline and plans for ongoing stakeholder engagement.

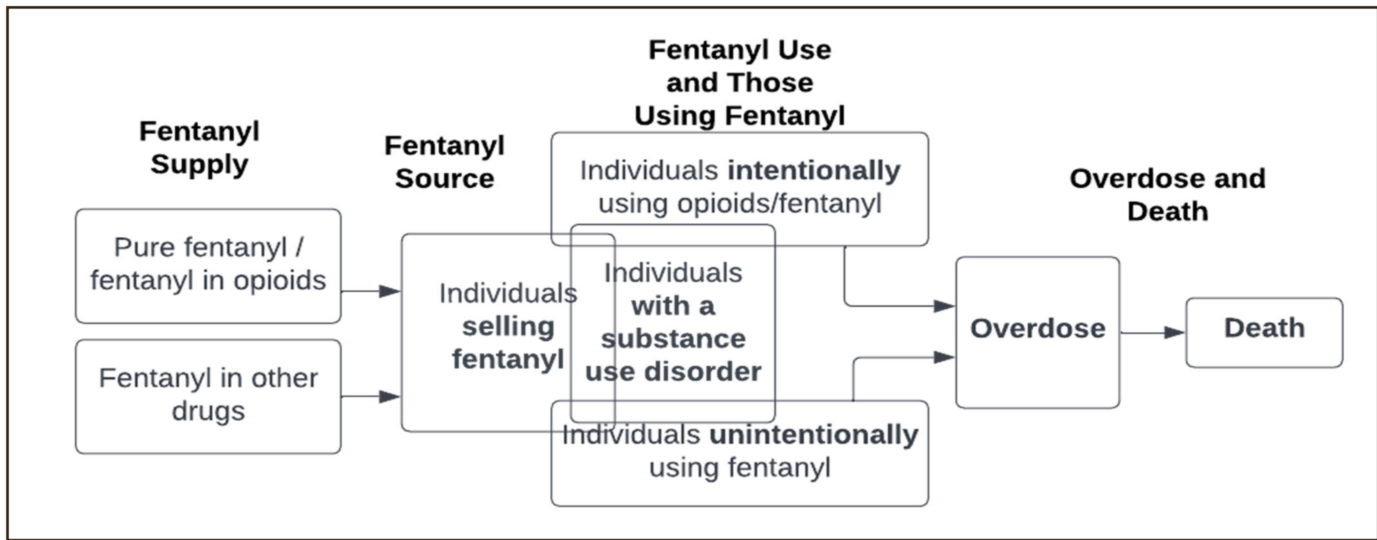
Section 2: What Is Known and Unknown

Section 2: What Is Known and Unknown

Problem

In this section, we summarize information gleaned through the literature review and stakeholder interviews about what is known about the problem. We examined four aspects of the problem: fentanyl supply, fentanyl source, fentanyl use and individuals using fentanyl, and overdose events and deaths from fentanyl (Figure 3).

Figure 3. The Problem of Fentanyl



Key Findings About the Problem

- **Fentanyl is one step in the progression of synthetic drugs; due to the rapidly evolving landscape, research evidence is still emerging.**
- **There has been an increase in quantity and potency of fentanyl prevalence in the United States; however, there is not a clear picture about the prevalence of fentanyl and other synthetic opioids within Colorado's communities. Furthermore, there are gaps in the evidence about the extent to which individuals selling fentanyl are aware of fentanyl within their drug supply.**
- **Some individuals using fentanyl are using it intentionally, whereas others are using it unintentionally by consuming other drugs containing fentanyl. There are gaps in the evidence about the extent to which individuals are seeking out fentanyl specifically and about the extent to which individuals are selling fentanyl or other drugs to support their own use.**
- **Systemic inequities have generated disparate stressors that lead to increased vulnerability for SUD associated with race, class, and sexual identity.**

- **In Colorado, people aged 25-44; Black, Native American, and Hispanic individuals; men; individuals involved in the justice system; and individuals experiencing homelessness are disproportionately impacted by deaths from fentanyl.**
- **Little information is available about individuals experiencing non-fatal overdose events. However, estimates suggest that there are many more non-fatal overdoses than deaths from opioids.**

Fentanyl Supply

As shown in Figure 3, "fentanyl supply" includes pure fentanyl, fentanyl in opioids, and fentanyl in other drugs.

The increase in deaths from opioids over the last decade is largely due to illicit fentanyl manufactured outside of the United States and trafficked in [6, 7, 8] The amount of fentanyl seized by the U.S. Custom and Border Protection increased from 4,800 pounds of fentanyl in 2020 to 14,700 pounds in 2022. As of April 2023, 17,200 pounds had been seized this year. In 2022, the U.S. Drug Enforcement Administration (DEA) seized over 50 million pills containing some amount of fentanyl and over 10,000 pounds of fentanyl powder.[9]

There is not a clear picture about the prevalence of fentanyl and other synthetic opioids within Colorado's communities. In interviews, stakeholders said that fentanyl is easily available across Colorado and found in nearly every drug type, including stimulant drugs. Per CDPHE, illicit fentanyl is found in pills and powders and cross contamination with other illicit substances has been verified by toxicology testing.[10] The DEA reports that fentanyl is being branded and sold as other drugs such Oxycontin, Adderall, and Xanax.[11] There have been no verifiable incidents of fentanyl present in cannabis products or vaporizers in Colorado.[12]

Stakeholders stated that the price for fentanyl has dropped while its potency has increased. The DEA reports that fentanyl is up to 50 times more potent than heroin and 100 times more potent than morphine.[13] Furthermore, in 2022, 60% of fentanyl pills seized by the DEA contained greater than 2 milligrams, up from 40% the previous year.[14] Some stakeholders believe that a heightened demand is the primary driver of the increased supply, whereas others see that suppliers have cultivated demand by lacing fentanyl into other drugs. Demand is fueled by the overwhelming supply and associated low costs.

Fentanyl Source

Research on people who knowingly and exclusively sell fentanyl is limited. Research suggests that wholesale level distributors have made the decision to include fentanyl in their drug supplies, while retail-level suppliers may be unaware of the presence of fentanyl in their supply.[15, 16] It is difficult to determine what level of fentanyl selling is intentional because there is no consensus in the research on the level of fentanyl-specific demand and there is obscurity in fentanyl presence in the supply.

Retail-level suppliers may sell drugs for financial gain, and possibly use that money to secure drugs for themselves.[17, 18, 19, 20] It is also possible that some suppliers are merely securing enough drugs for their immediate contacts for no financial gain.[21] Stakeholders have different perceptions about the extent to which individuals selling drugs overlap with individuals using drugs. Some stakeholders believe

individuals selling drugs stay away from the product whereas others believe some individuals selling are doing so to support their personal use.

The 2023 report from the Attorney General's Office concludes that while difficult to quantify, the Internet (in particular, social media) has facilitated the sale of fentanyl.[22] If previous research on illicit drug selling can be applied to the supply of illicit fentanyl, law enforcement efforts to disrupt the supply of fentanyl would be most productive when targeting higher levels of drug distribution networks rather than lower levels of possession and selling, and are more effective before fentanyl-specific demand is established.[23]

Fentanyl Use and Those Using Fentanyl

As shown in Figure 3, "individuals using fentanyl" includes both those using opioids/fentanyl intentionally and those using it unintentionally.

There is no reliable national or state-level estimate for the number of people using illicit fentanyl in the United States.[24] In interviews, stakeholders agreed that people who use fentanyl are not a monolith: some individuals transition from heroin or prescription opioids to fentanyl, some individuals seek out fentanyl, some individuals regularly consume or are experimenting with other pills or "party drugs." There is no evidence on the percentage of individuals in these groups.

Current evidence suggests that there is not a large demand for fentanyl by itself and that people who use drugs often report they did not know they used fentanyl.[25, 26, 27, 28] However, based on stakeholder interviews, the demand for fentanyl specifically may be rapidly increasing. Nationally, it is speculated that the population intentionally using fentanyl is similar to the population using heroin, but regional variations likely exist. Due to the saturation of fentanyl in the illicit drug supply, those who use illicit opioids may have less access to heroin and be more likely to have the sole option of using fentanyl. Research suggests that people who frequently use illicit drugs may prefer fentanyl since it is more potent than other illicit opioids.[29, 30, 31, 32, 33, 34, 35, 36, 37]

Evidence points to the historical rise in prescription opioids as contributing to the current use of fentanyl. Although opioid overprescribing may have fueled the overdose crisis by increasing the drug supply,[38] the national opioid dispensing rate has declined since 2012.[39]

In 2021, it is estimated that approximately 19% of individuals in Colorado had a SUD, which is higher than the national average of 16% (for individuals 12 years old or older).[40] Nationally in 2021, SUDs were more prevalent among Native American individuals;[41] multiracial individuals;[42] 18-25 year olds; [43] lesbian, gay, or bisexual adults;[44]and individuals involved in the criminal system.[45] Systemic inequities associated with race and class, facilitated by historical policies and programs, have generated disparate stressors—such as poverty, lack of safety, food insecurity, and housing insecurity—that lead to increased vulnerability for SUD.[46]

Stakeholders discussed how there has been more sympathy for those who unintentionally ingest fentanyl, including more media attention and targeted strategies to help; however, it is unclear how representative this group is across total overdose events and deaths from fentanyl. Since fentanyl may be obtained and consumed unintentionally, it is difficult to identify a profile of risk for people who unintentionally use fentanyl. However, some interviewees believe that younger people may be more

likely to be unaware of fentanyl consumption through recreational use of other substances containing fentanyl.

Research suggests there may be differences in the way people consume fentanyl and other opioids. Use may be influenced by the individual's knowledge of drug use, others who use drugs in their community, and others' perception of how "risky" their use is.[47, 48] Some people who use opioids intentionally, and prefer fentanyl, will use strategies to reduce harm (e.g., not using alone, having naloxone) if they know of these strategies.[49, 50, 51]

Overdose and Death from Fentanyl

Stakeholders agree that fentanyl needs to be treated more seriously than previous drugs since the high potency of fentanyl increases the risk of overdose and death. This is especially true if the individual is unaware that they are consuming fentanyl or if they underestimate the dose of opioids they are consuming.

> **Some stakeholders frame the issue of death from fentanyl as "poisoning" rather than "overdosing" since they occur among people who unknowingly ingested fentanyl.**

Since 2016, the number of deaths attributed to synthetic opioids has increased year over year while the number of deaths due to heroin has declined. Nationally, the age-adjusted death rate involving synthetic opioids increased by 1,040% between 2013 and 2019.[52] These trends are true for Colorado; in 2021, there were 1,258 deaths from opioids, with an overall rate of 21.6 per 100,000 people. CDPHE estimates that 76% of these deaths (961 in total) were from synthetic opioids.[53] However, from 2021 to 2022 deaths from drugs, including fentanyl, in Colorado plateaued.[54]

Data points to the role of deaths due to using multiple drugs. Nationally, the Centers for Disease Control and Prevention (CDC) estimates that in 2021 roughly 40% of all deaths by opioid and stimulant involvement were from a mix of opioids and stimulants (whereas 42% were from opioids without stimulants).[55] In Colorado, CDC reports that 23% of drug-related deaths contained *only* illicitly manufactured fentanyl, which was the most frequent category of drug.[56] However, there has also been a recent increase in death due to methamphetamine and stimulants, with a more significant increase when there was a mention of fentanyl.[57]

In Colorado, people aged 25-44, Black and Native American racial identities, Hispanic ethnicity, and men are the groups more likely to experience death from opioids.[58] Since 2019, there has been an increase in youth dying from opioids; in 2021, youth aged 15-24 experienced 21.4 deaths per 100,000.[59] Similarly, the Colorado Department of Human Services Child Fatality Review Team has identified an increase in fatal and near fatal incidents of overdose in children due to fentanyl exposure/ingestion.[60]

Very little information is available on individuals who experience a non-fatal overdose event. Nationally, based on emergency department admissions, it is estimated that there were 305,628 non-fatal opioid overdoses in 2017, which corresponds to 6.4 non-fatal opioid overdoses for each death by opioids. [61] Using emergency medical services (EMS) data, national estimates suggest that EMS responded to 210,881 nonfatal overdoses in the 12 month period ending in March 2023.[62] These data suggest that there are many more non-fatal overdoses than deaths from opioids (at least 3:1 and maybe as many as 6:1).[63] While these estimates do not provide information on how many non-fatal overdoses were due to

fentanyl, given that the primary driver for deaths from opioids (since 2013) is due to fentanyl and synthetic opioids, it is likely that the non-fatal overdoses have a similar link to fentanyl. Data from Colorado hospital admissions show that women and people older than 55 are more likely to appear in non-fatal overdose records.[64] However, sample selection makes it difficult to say whether comparisons between individuals dying and individuals who experience an overdose are meaningful.

People who die from drugs are most often found inside a residence.[65] At the same time people who are unhoused are overrepresented in the data. In 2021, approximately 14% of drug-related deaths in Colorado were associated with individuals who were unhoused or experiencing housing instability.[66] Bystanders with an opportunity to intervene were present at approximately 14% of drug-related deaths in Colorado. However, only roughly 17% of drug-related deaths had naloxone administered.[67]

While the national rural/urban breakdown in drug-related deaths is proportional to the percentage of people living in nonmetro and metro counties, previous research notes that barriers—such as less access to treatment options and greater stigmatization of SUD—place rural individuals at greater risk of harm from opioid use.[68] Stakeholders agreed with these challenges.

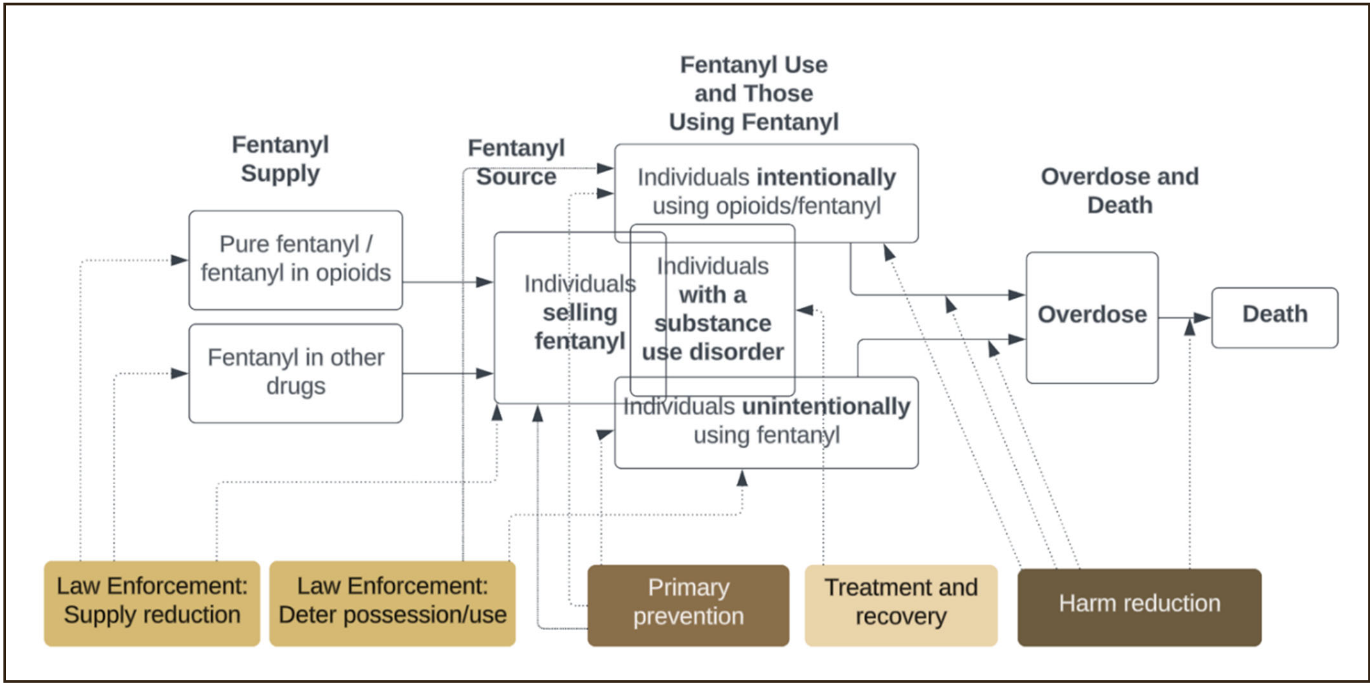
Due to how quickly drug tolerance decreases during even a brief cessation of use, overdose, including opioid overdose, is elevated after prison release, particularly within the first two weeks. For this population, it is the leading cause of death post release.[69,70 71, 72]

Strategies to Address the Problem

In this section we summarize information gleaned through the literature review and stakeholder interviews about what is known about how to address the problem. We explore four approaches to address the problem (Figure 4):

- **Primary prevention**, which aims to prevent substance use initiation, substance misuse, and SUD.
- **Law enforcement**, which aims to decrease the supply of illicit drugs and deter people from possessing, distributing, or selling illicit drugs.
- **Treatment and recovery**, which aims to support individuals with a SUD in accessing and staying engaged in the most effective treatments and long-term recovery supports.
- **Harm reduction**, which focuses on empowering people who use drugs to use strategies to stay alive and as healthy as possible.

Figure 4. Four Primary Approaches to Address the Problem of Fentanyl



Framing the Approaches

Different approaches work on different parts of the problem, therefore how one defines the problem matters. As shown in Figure 4, some law enforcement approaches aim to decrease the *fentanyl supply*, whereas some harm reduction approaches are more directly focused on preventing *deaths from fentanyl*. Likewise, given that there are different profiles of individuals who use fentanyl, different **approaches have different target populations**. For example, an education campaign about testing party drugs may target individuals who use drugs recreationally, whereas a syringe service program may target individuals with more habitual substance use or a SUD.

To best address the fentanyl problem, stakeholders agree that there needs to be a **proactive multi-component set of approaches** that anticipate the continued emergence of new synthetic drugs and rapidly evolving substance use. Each actor (law enforcement, treatment providers, harm reduction practitioners, etc.) is using the **tools at their disposal**; therefore, the **approaches currently being implemented align with how resources are dispersed—for better or worse**.

Research evidence suggests that **some approaches and strategies can be complementary**, as harm reduction services may provide an individual with the stability and support needed to seek treatment and recovery. Likewise, some areas can benefit from greater collaboration, for example, to help match individuals with the support they need. However, **some approaches and strategies may be contradictory**, for example, providing a space for safe use may not be beneficial if law enforcement arrests individuals engaging with the safe use site. Likewise, as described below, **not all strategies have the same level of evidence of impact**—rather, for many areas, the best available evidence is still emerging. Moreover, some strategies may have **unintended consequences**.

Stakeholders felt that **response needs to be localized to different parts of the state** as Colorado's communities have different law enforcement practices, harm reduction practices, and various degrees

of treatment and recovery resources available. Differences in resourcing, culture, and norms should influence how strategies are implemented.

Lastly, **some communities are disproportionately impacted** by the negative impacts of fentanyl; this is often correlated with race, class, and/or place, which is rooted in system racism, classism, and a history of under-resourcing some communities. Stakeholders noted that **marginalized communities are being systematically missed** and that strategies need to be considered and applied with an equity lens that considers race, class, and geography.

Deep Dive: Four Approaches and Specific Strategies

Approach #1 - Primary Prevention

Primary prevention. This approach aims to prevent substance use initiation, substance misuse, and SUD. The goal is to increase protective factors such as housing, employment, and social support and decrease demand for fentanyl and other illicit drugs.

Efforts to prevent substance use, substance misuse, and SUD include tiered, multidisciplinary activities, ranging from population-level strategies to targeted interventions aimed at high-risk individuals.[73] Programs such as the Drug-Free Communities Program provide funding to local coalitions to promote positive youth engagement and address the local conditions that drive youth substance use. Policies and activities can help address risk factors for youth substance use and promote protective factors, such as strong relationships with trusted adults.[74]

Because opioid overprescribing has contributed to the current overdose crisis,[75] primary prevention also includes strategies to ensure appropriate access to prescription opioids. These fall in two categories: a) clinical practices to manage pain that lower the risk of addiction, such as application of CDC guidance for opioid prescriptions as a standard of care and use of evidence-based treatments to effectively manage pain, and b) structures to control the supply to prescription opioids including changing physician prescribing patterns, increasing prescription drug monitoring programs (PDMPs), and implementing medication take back efforts.

Table 1. Primary Prevention Strategies and Evidence of Impact

Strategy#	Evidence of Impact
Programs that increase protective factors	Evidence shows that this strategy has a **high** impact on reducing the use of fentanyl.[76, 77, 78, 79, 80, 81, 82] Evidence indicates that protective factors, such as increased connection to housing, access to comprehensive healthcare, and strong familial or social networks, reduces the likelihood of substance use.
Clinical practices to manage pain that lower the risk of addiction	Evidence shows that this strategy has a **high** impact on increasing the safety of opioid use for pain treatment and reducing the risk of OUD.[83]
Structures to control prescription opioid drug supply	Evidence shows that this strategy has **mixed** results on reducing opioid-related harms. PDMPs may not reduce OUD, but can support activities of non-public health actors, such as criminal justice stakeholders, to pursue supply reduction.[84]

Approach #2 - Law Enforcement

Law enforcement. For decades law enforcement has played a role in reducing the supply of illicit drugs, including illicit opioids, for example, by targeting opioid manufacturers, disrupting smugglers, investigating domestic trafficking, and prosecuting retail drug selling.[85] For example, the Rocky Mountain High Intensity Drug Trafficking Area's mission is to facilitate cooperation and coordination among federal, state, local and tribal law enforcement with efforts to reduce availability by disrupting or dismantling violent drug trafficking organizations.[86]

Law enforcement also plays a role in deterring people from distributing, selling, or possessing illicit drugs through imposing criminal penalties for such behavior, for example, through charging practices and mandatory sentencing.

Table 2. Law Enforcement Strategies and Evidence of Impact

Strategy#	Evidence of Impact
Law enforcement investigations	Evidence shows that this strategy has **mixed** results on reducing the supply of fentanyl.[87, 88] Law enforcement efforts are more successful in reducing supply when drugs are scarce or new drugs are introduced to a market with a precarious supply chain. Heroin research indicates that increases in seizures may disrupt supply but overall does not impact price or consumption. Due to the wide, fragmented nature of drug supply, seizure or arrest is often followed by the regeneration of labor and supply. Evidence shows the potential for **unintended consequences** of this strategy, for example, disrupting local drug markets can increase overdose events and deaths.[89]
Criminal penalties to support deterrence	Evidence shows that stiffer criminal penalties and imprisonment have a **low** impact on drug use and drug availability.[90] Laws and policies designed to deter crime by focusing mainly on increasing the severity of punishment are ineffective partly because criminals know little about the sanctions for specific crimes.[91] In addition, research evidence suggests that imprisonment has no impact on post-incarceration recidivism.[92] Evidence shows the potential for **unintended consequences** of this strategy, for example, involvement in the criminal justice system can place individuals with SUD at greater risk for overdose and death.[93]

Approach #3: Treatment and Recovery

Treatment and recovery. This approach aims to increase effective treatment and recovery services and support individuals with a SUD in accessing and staying engaged in effective treatments and long-term recovery supports.

There are four levels of treatment available for SUD: outpatient, intensive outpatient/partial hospitalization, residential/inpatient, and intensive inpatient. The right level of treatment considers a patient's needs, obstacles and liabilities, as well as their strengths, assets, resources, and support structure.[94]

Treatment standards for OUD recognize the importance of medications for opioid use disorder (MOUDs), sometimes called Medication Assisted Treatment (MAT). MOUD includes medications that reduce or suppress opioid cravings or block euphoric effects of opioids (buprenorphine, methadone, and/or naltrexone) alongside counseling and behavioral therapies.[95] MOUDs are promising in treating OUD and improving health and life outcomes for individuals with OUDs.[96] Robust counseling and behavioral health therapies help support MOUD and a path to recovery through connecting individuals with other support and services.[97]

There are several barriers to individuals accessing treatment, including stigma, access, and cost. In 2019, nearly half (47%) of Coloradans who said they did not get needed mental health care cited stigma as a reason; for people of color, cultural factors can make the stigma around mental health especially difficult.[98,99] Likewise, systemic barriers prevent people from accessing care. MOUD faces numerous challenges, including inadequate professional education and training, and challenges in connecting individuals with treatment due to delivery system fragmentation, regulatory and legal barriers, barriers related to public and private health insurance coverage, and reimbursement and payment policies.[100] Stakeholders noted that many rural counties in Colorado lack treatment providers or have limited services.

Treatment is most effective when it is paired with long-term recovery services, that may include support services, such as connection to employment and housing services, and access to peer support services (i.e., support from individuals with lived experience).[101] Strong recovery services support individuals during periods of substance use.

There are several strategies that can be used to enhance connection to and retention in treatment and recovery for OUD. We consider four here:

- *Structures to screen for substance use* in healthcare settings, treatment settings, or as part of the entry to institutionalized settings, to connect individuals to support and services.
- *Mandated treatment* for people convicted of drug-related offenses and/or involuntary holds for people with SUDs.
- *Continuity of care for individuals who are incarcerated*, expanding treatment options such as withdrawal care, MOUD, and recovery services across all levels of incarceration, and access to ongoing treatment and recovery including for people returning from incarcerated settings.
- *Peer support models,* including mentoring, education, and support from individuals with previous experience with SUD.[102]

Table 3. Treatment and Recovery Strategies and Evidence of Impact

Strategy#	Evidence of Impact
Structures to screen for substance use	Evidence shows that this strategy has **mixed** results on connecting individuals to treatment and recovery. [103, 104] It is effective for surveillance, but not necessarily for connecting individuals to recovery. Increased urine testing with informed consent could provide opportunities for education and harm reduction.
Mandated treatment	Evidence shows that this strategy has **mixed** results on improving health and life outcomes for individuals with OUDs.[105, 106] There are mixed outcomes of the effectiveness of compulsory treatment by program and program type and there is mixed evidence on whether the coercive nature of mandated treatment reduces the self-motivation needed for sustained success.
Continuity of care for individuals who are incarcerated	Evidence shows that this strategy has a **high** impact on improving healthcare and avenues to recovery.[107,108, 109] Evidence indicates that providing MOUD to individuals who are incarcerated is essential for continuity of care (from community to facility to return to community).
Peer support models	Evidence shows that this strategy has a **high** impact on improving avenues of support to help navigate substance use and associated life circumstances. While evidence is limited, peer support models have promising outcomes.[110]

Approach #4: Harm Reduction

Harm reduction. Harm reduction focuses on keeping people who use drugs alive and as healthy as possible and providing tools and information to empower positive change.[111] Strategies include:

- *Safer use services* such as sterile supplies/syringe exchange and safe use sites.
- *Naloxone access, training, and distribution* including standing orders for naloxone, wider groups/professions that can obtain naloxone, immunity from civil damages for good faith administration of naloxone, and expansion of state rules for federal billing for naloxone.
- *Good Samaritan laws* that provide immunity from prosecution if reporting an overdose or immunity from civil charges if administering naloxone.[112]
- *Fentanyl test strips*, including bulk purchase and free distribution efforts.
- *Communication and education to reduce stigma*, for example, through awareness campaigns, promotion of treatments for SUDs through healthcare providers, and naming addiction as a medical condition.

Table 4. Harm Reduction Strategies and Evidence of Impact

Strategy#	Evidence of Impact
Safer drug use services	Evidence shows that this strategy has a **high** impact on reducing the negative outcomes associated with fentanyl use.[113, 114, 115] Evidence on syringe service programs show that they reduce disease and risk of death. Furthermore, they provide opportunities for education, emergency/medical care, and act as a bridge to other health services, for example through referrals to MOUD. Research evidence suggests that overdose prevention sites (i.e., safe injection sites), where people who use drugs under medical supervision, are effective in reducing drug-related deaths and serve as a low barrier gateway to treatment and other services without increasing opioid use or crime.[116, 117]
Naloxone access, training, and distribution	Evidence shows that this strategy has a **high** impact on reducing death from fentanyl and does not have other adverse medical consequences (besides some display of withdrawal symptoms).
Good Samaritan laws	Evidence shows that this strategy has **mixed** results on reducing the negative outcomes associated with fentanyl use.[118] Although the evidence is limited, some studies show that individuals using drugs do not know about these laws while others show that they increase calls to EMS.
Fentanyl test strips	Evidence shows that this strategy has a **high** impact on reducing unintended fentanyl use.[119, 120] However, test strips do not quantify fentanyl within the supply and therefore this strategy is less effective for those seeking to safely consume fentanyl.
Communication and education to reduce stigma	Evidence shows that this strategy has a **high** impact on reducing the negative associations towards people with SUDs which can increase the likelihood that they will seek out safe use practices and treatment.[121, 122] While evidence on combating stigma is developing, interventions have shown to lower negative attitudes, particularly when they include direct contact with and personal narratives from individuals with SUD, are solution-oriented, and emphasize societal not individual causes of addiction.

Cross-Cutting Approaches

In addition to the four approaches described above, we identified two **cross-cutting approaches**.

Public awareness/education campaigns. This includes efforts to inform, educate, or provide the public and stakeholder groups with the tools needed to address the fentanyl problem. A variety of information campaigns can be used, depending on the goals of the campaign and the target audience. Campaigns may include information on the presence and risk of fentanyl, information on associated criminal penalties, promotion of harm reduction strategies, immunity awareness to support seeking help in emergency situations, tactics to engage with or seek needed support, stigma reduction awareness,

and/or strategies to better support loved ones with SUD. Colorado's Keep the Party Safe and Bring Naloxone Home campaigns are examples of harm reduction promotion, and Colorado's Lift the Label and Changing Minds campaigns are examples of information for families and friends to better support loved ones and reduce stigma.[123]

System capacity. This includes efforts to improve surveillance, reporting, and research and to strengthen inter-agency collaboration about the opioid response.[124] Research and more robust systems for surveillance could include data dashboards, data reports, or evaluations of the implementation or impacts of strategies. Inter-agency collaboration may take the form of committees that review evidence and recommended policy changes and/or strategic workgroups that collaborate across and within local/state agencies to inform a coordinated response.

Table 5. Cross-Cutting Strategies and Evidence of Impact

Strategy#	Evidence of Impact
Public awareness/education campaigns	The evidence shows that this strategy has **mixed** results on reducing demand for fentanyl and reducing the negative outcomes associated with fentanyl.[125] There are inconsistent findings across evaluations of public awareness campaigns meant to deter illicit drug use, but there are effective campaigns around deterring tobacco.
System capacity	Surveillance, reporting, and research have a **high** impact on increasing effective policy making and resource allocation.[126, 127] Successful approaches for inter-agency collaborations include considering outcomes, accountability measures, leadership, and resources.[128] Promising models exist for partnerships between public health and public safety.[129,130]

Section 3: Study Focus Areas, Assessment Questions, and Methods

Section 3: Study Focus Areas, Assessment Questions, and Methods

In this section we describe the three study focus areas:

- Acute response that addresses underlying needs and is part of a comprehensive system.
- Increased criminal penalties for the possession of fentanyl.
- Public health and harm reduction approaches for priority populations.

For each of these areas, we summarize the changes made in HB22-1326 and what the strategy is aiming to achieve; what we know and what remains unknown (based on literature reviews and stakeholder interviews); and the assessment questions and methods to be employed. In identifying study methods, we employed a "numbers and narrative" approach, in which the study team will simultaneously seek to understand the "what," "why," and "how." The study team will aim to get perspectives from a variety of stakeholders, prioritizing those who are directly impacted by changes made in the bill, and identify and elevate promising models/approaches to inform decision-making.

Assessment Area 1: Acute Response That Addresses Underlying Needs and is Part of a Comprehensive System

What Changes Did the Bill Make?

HB22-1326 (Section 36) appropriated $10 million for managed service organizations (MSOs) to contract to provide short-term residential placement with withdrawal management, crisis stabilization, and MAT for persons in immediate need of detoxification and stabilization services. MSOs are required to provide training to and coordinate with first responders concerning the available services in lieu of arrest and transport to jail.

What is this Strategy Aiming to Achieve?

First responders—including law enforcement, EMS, paramedics, and fire—are on the front lines of responding to the negative impacts of fentanyl and other synthetic opioids including overdose, behavioral health crisis, illegal activity such as theft and drug distribution, and public disorder. Individuals using fentanyl are often experiencing multiple challenges, including substance use and other mental health disorders and homelessness. First responders are on the front lines in keeping communities safe, and thus they are often the "entryway" to engaging with individuals negatively impacted by fentanyl. However, first responders are often under-equipped to meet the challenges they encounter.

This provision aims to direct resources to augment the mental health crisis infrastructure, such as mental health walk-in clinics and crisis stabilization units, to make sure they are equipped to address the needs of individuals with co-occurring SUDs. There is a specific focus for service providers to connect and build the capacity of first responders to make these services available in lieu of arrest and transportation to jail.

What Do We Know? What Remains Unknown?

Law enforcement alone will not solve the problem. Stakeholders agreed that law enforcement alone will not solve the problems caused by fentanyl. In particular, law enforcement is operating from a premise of needing to enforce laws and respond to the needs of the victim; this may or may not align with an approach that centers the person using fentanyl. Law enforcement receives training to deal with life threatening situations, such as use of naloxone. They are not trained to address substance use and other behavioral health issues and may not know what resources are available. Law enforcement and other first responders described situations in which they respond to the same individual repeatedly, for example, bringing them to the emergency department. But because the system cannot envelope people, there is no way to address the individuals' needs and be impactful in the long run.

There are few promising models for a holistic system that supports continuity of care. Acute response cannot operate in a silo. Rather, stakeholders emphasized the need for a holistic system that addresses underlying needs and supports continuity of care. As identified in Substance Abuse and Mental Health Services Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care*, crisis response should include three programmatic components: quality dispatch, timely response, and short-term stabilization.[131] Access to treatment and recovery services are then needed to support continuity of care (Figure 5).

Figure 5. Holistic System for Responding to Acute Situations that Involve Individuals with a Substance Use Disorder

Quality Dispatch	Timely Response	Short-term Stabilization	Access to Treatment and Recovery Services

Stakeholders emphasized that a crisis response system will differ based on the relationships that are in place (among stakeholders and systems) and the services that are available; in particular, rural Colorado faces challenges with access to services. Each component should strive for culturally competent programming that respects language, citizenship, traditional treatments,[132] and privacy considerations.

First, in responding to a crisis, is quality dispatch. As noted by several stakeholders, community is the true first responder; when systems become involved, it is often triggered by a call to 911. To be effective in getting the right individuals to the scene, 911 dispatchers need to gather the right information to understand the situation. It is important for crisis response personnel to build relationships with community members to understand community context and needs—and to ensure they are well-informed on the steps they can take in an overdose or substance use related crisis.[133]

Second is a timely response that puts the right individuals on the scene. Responding to individuals with a SUD often requires a specialized response, that may or may not need to involve law enforcement, EMS or paramedics, and behavioral health personnel. The Bureau of Justice Assistance identifies four police-mental health collaboration models: crisis intervention teams, co-responder models, mobile crisis teams, and case management teams.[134] Coordination and appropriate staffing are required for a timely, adequate response.[135] Models designed specifically for substance use intervention may include specialized elements such as a recovery coach. Stakeholders identified the value of co-responder models, noting that law enforcement should only be involved if needed, in order to use resources effectively and ensure that the situation is resolved productively.

Third, individuals need to be connected to the right short-term resources, based on their needs and preferences. Stakeholders shared that it was difficult in Colorado to identify the right place to take people to: emergency departments and jails are not well equipped to meet the needs of individuals with OUD; likewise, withdrawal management facilities and crisis stabilization units also face barriers. In particular, withdrawal management facilities often lack medical facilities, while crisis stabilization units are often not positioned to offer MOUD; to be effective, these facilities need to be able to offer treatment and initiate care. In addition to knowledge and access, first responders face systemic barriers to transporting individuals to the right location, which are driven by contracts (e.g., destination agreements), reimbursement models, and liability (e.g., need for individuals to be medically cleared).

Finally, after short-term stabilization, individuals need to be connected to treatment, including options for residential treatment that is close to their home, so they can receive social support. Programs come in all shapes and sizes; what will be most effective will depend on an individual's needs and goals; but, if there are no options for continuity of treatment, individuals will be less likely to successfully maintain recovery. To provide support in the long term, individuals need to be connected to recovery supports, such as options for sober living.

Colorado Model for Supporting Connections to Care

The Colorado Opioid Synergy for Larimer and Weld counties (CO-SLAW), a network of care coordinators (including peer navigators) and clinics, offer MOUD and counseling services. Care coordinators help to bridge the gap between short-term settings (e.g., emergency departments, jails, crisis stabilization units) to assist individuals in accessing services and reducing barriers such as obtaining identification, transportation, and housing. Importantly, they are agnostic to payer source (addressing potential insurance barriers) and can connect individuals to services that are most geographically and philosophically appropriate.

There are implementation challenges to provide short-term residential placement. Despite the need for such services, stakeholder shared challenges that MSOs face in executing on contracts to provide short-term residential placement. First is finding the right providers/facilities that can take on this work. While some providers are already doing this work, some areas (especially rural areas) lack providers that are willing and able to provide these services due to staffing shortages, social norms (e.g., issues of stigma), and administrative challenges (e.g., low reimbursement rates, administrative complexities of billing). Second are issues related to the workforce, including confusion over licensing requirements. Third is the limited scope of the funding, which inhibits providers' ability to provide services to populations in need (e.g., individuals in need of these services to address alcohol issues) and provide holistic, coordinated care, including lack of funding to combine these short-term services with aftercare support and care coordination.

First responders need additional education and emotional support. Stakeholders noted the need to provide additional education to first responders to help increase their knowledge around synthetic opioids (e.g., that you cannot overdose from fentanyl by touching it), increase their awareness and acceptance of harm reduction approaches (e.g., naloxone) and community resources (e.g., alternatives to emergency departments), and support them in building positive relationships with the community, using language and practices that help reduce stigma, and in implementing coordinated strategies to address the needs of those with SUD. Stakeholders mentioned the need to better understand the

trauma that first responders are experiencing—and how that is negatively impacting how they are showing up to emergency situations.

Assessment Questions

To help address these gaps in knowledge, this study will examine two questions:

- What are the challenges and opportunities with responding to acute situations in Colorado?
- How can we develop systems to meet individual and societal needs?

Methods

Review of Managed Service Organizations Performance Data on Short-Term Residential Placement

The study team will review monthly report data for State Fiscal Year (SFY) 2024 collected by the state's three MSOs in order to describe program reach, including facilities contracted with, services provided, and people served; and the types of strategies they are using to connect with first responders. The study team will use this review as a jumping off point to support focus groups with MSO leaders, first responders, and behavioral health providers.

Gathering Stakeholder Perspectives and Experiences

The study team will conduct three 60-minute focus groups with state/MSO leaders, first responders, and behavioral health providers in order to better understand opportunities and challenges to first response and connection to short-term residential resources. These will be geographically based to understand variation among urban/rural communities and different parts of the state—and support practitioners in hearing from each other. The study team will explore what individuals need to feel equipped to respond to individuals with OUD, promising models, and implementation challenges and gaps.

The study team will conduct one 60-minute focus group with individuals who have interacted with first responders and/or short-term residential resources for a situation that involved fentanyl. Through a series of open-ended questions, the study team will ask individuals to reflect on their experiences, what aspects of their experience were/were not supportive, and what positive and negative outcomes they experienced. Participants will be recruited in partnership with a community-based organization and compensated for their participation.

Deep-Dive Examination: Response Models

The study team will identify at least one response model on which to conduct a deep-dive exploration. Model(s) will be identified using the focus groups described above. The research team will select models based on approach (aligned with best practices) and data availability (valid and reliable data available). The study team will describe the program's key components/activities and examine data over at least a one-year period in order to describe who was reached and any outcomes (e.g., connection/engagement in treatment). The study team will disaggregate outcome data to better understand what types of individuals the model is most supportive for.

Assessment Area 2: Increased Criminal Penalties for the Possession of Fentanyl

What Changes Did the Bill Make?

HB22-1326 (Section 6) changed the criminal penalties associated with possession of one to four grams of a drug that contains any amount of synthetic opiates from a misdemeanor to a level 4 drug felony. Sentences associated with the conviction of a level 4 drug felony include probation (for up to two years), with the possibility of 180 days in county jail, jail alternative, or community corrections; for a third or subsequent offense, the court may impose a sentence of to up to 364 days in jail. For those convicted of either of felony or a misdemeanor (Section 7), the court must require a substance use assessment and, if recommended by the assessment, completion of a community-based or residential treatment (as a sentencing condition); funding is allocated to cover treatment costs for indigent individuals. Individuals must also complete a fentanyl education program developed by the BHA. This change, which took effect in July 2022, was a reversal of HB19-1263, which classified the possession of 4 grams or less of most controlled substances as a misdemeanor.

What is this Strategy Aiming to Achieve?

Increasing penalties for the possession of fentanyl was one of the most contested provisions of HB22-1326. The general assembly noted the need for the changes in HB22-1326 to "reflect the high risk of addiction and death" of synthetic opiates. In interviews, stakeholders in support of this provision—including several individuals from local law enforcement and District Attorneys' offices—described it as having two primary goals: 1) impose consequences and set norms and 2) deter use by providing opportunities for treatment and increasing potential negative consequences.

Impose consequences and set norms. Stakeholders in support of this provision saw it as an opportunity to impact fentanyl use as well as the presence (supply) of fentanyl more broadly. Many stakeholders in support of this provision felt that one to four grams was above an amount that was intended for personal use. Likewise, they were unsure whether individuals with this quantity of illicit drugs were primarily selling them to support their own use. By targeting individuals who possess fentanyl, stakeholders felt that they could help influence norms, making it clear that using and distributing fentanyl is not acceptable. They felt "there needs to be a cost to peoples' choices" and law enforcement needs to "at least try" to combat the overwhelming presence of cheap synthetic opioids in communities. Some stakeholders described the provision as a means to "get justice," which, alongside other bill provisions, could help hold those using and selling fentanyl accountable, thereby helping to prevent deaths from fentanyl.

Deter use by providing opportunities for treatment and increasing penalties. Stakeholders in support of this provision felt that it has the potential to provide "a moment of opportunity" for some individuals, providing both an opportunity and system of accountability. They noted that the justice system may be the only opportunity some individuals have to connect with treatment or support, for example, treatment resources available through diversion programming or access to MOUD. The potential for a felony charge provides DAs with additional leverage: in light of being faced with a felony charge, some individuals may be motivated to comply with treatment. Through increased penalties stakeholders believe that they can better communicate the "seriousness" of fentanyl and address "repeat offending that does not have any consequences."

What Do We Know? What Remains Unknown?

Stakeholders were split on whether this provision was a step backward or a step forward. In interviews, many individuals, including those who supported the provision, expressed that on its own, it was *unlikely to have a large impact on use, overdoses, or death*. This aligns with the best available research evidence which suggests that incarceration alone has not been effective in reducing drug crimes or drug overdoses.[136]

Changing criminal penalties might not impact who enters the system and how cases are resolved. Law enforcement, DAs, and judges all have discretion in how this provision is implemented (Figure 6). For an individual to enter the justice system, they must be arrested or cited by law enforcement. The DA's office then reviews the case and decides whether (for felony referrals) and at what level (for felonies and misdemeanor referrals) to charge the case. The DA and defense counsel then work together to resolve the case. There are five primary ways a case can be resolved: 1) the case can be dismissed, 2) the individual can be referred to a diversion program, 3) the individual can plead guilty and enter in to a plea agreement, 4) the individual can temporarily plead guilty and receive a deferred judgment (if they comply with the terms, the guilty plea is withdrawn), or 5) the individual can plead not guilty and go to trial (where they are either found guilty or acquitted). If the individual pleads guilty or is found guilty at trial, they are sentenced by a judge.

Figure 6. Potential Justice System Involvement: System Decision Points

Is the person arrested/cited?	Is the person charged?	How is the case resolved?	How is the case sentenced?

Law enforcement stakeholders described how they perceive this discretion playing out. First, they noted that many individuals are not being arrested simply for possession. Second, they felt that prosecutorial discretion is working to determine what outcome will be most appropriate and helpful for the individual (based on their background and needs). They pointed to plea guidelines and diversion options, which reflect wanting to provide support to individuals with a SUD. Despite the option to charge possession as a felony, they felt that most cases were unlikely to be resolved as felonies.

Mandated treatment is unlikely to have a large impact. Research evidence suggests that the impact of mandated treatment is mixed, with overall limited impact on ongoing drug use and criminal recidivism.[137] The type of program matters: therapeutic communities show the most promise, while boot camps have been shown to have poor impacts on relapse and recidivism.[138] In order for mandated treatment programs to have any positive impact, programs need to be a) aligned with the wishes and needs of the individual and b) evidence-based, including options for MOUD. To support long-term recovery, individuals who are incarcerated or leaving confinement may need different or complementary interventions to support sustained reductions in opioid use and criminal behavior such as support networks and stable housing.[139]

Stakeholders we interviewed grappled with both the philosophical and practical challenges of treatment associated with the justice system, a system that is not well equipped to deal with medical issues. Stakeholders in support of the provision noted that incentivized/mandated treatment was likely to impact *only a small percent of individuals*, namely those with the resources or motivation/incentive to complete programming or those experimenting with drug use (versus individuals with a SUD). Other

stakeholders noted that for many individuals, justice system involvement can worsen SUD and contribute to worse mental health. Likewise, stakeholders noted the justice system often lacks evidence-based, culturally appropriate services that are aligned with individuals' needs. Medicaid cannot act solely on a judge's orders for treatment. Furthermore, re-entry back into the community for individuals with an SUD is difficult and can be life threatening.

Not everyone getting caught up in the system is the same. Stakeholders noted the importance of acknowledging the diversity of individuals who use fentanyl and are involved in the justice system, in terms of whether they have a SUD, their need for/receptiveness to treatment, their housing status, their previous criminal history, and what factors lead them to come to the attention of the justice system. Stakeholders differed vastly in how they viewed individuals selling fentanyl, ranging from "individuals pedaling poison" to those in need of compassion because they are experiencing trauma, mental health disorders, and/or "selling drugs to support their own addiction."

Increasing criminal penalties may have significant negative consequences. Stakeholders who were not in support of this provision—including individuals working in harm reduction or public health, as public defenders, or providing treatment as well as directly impacted populations—raised concerns about a number of potential negative consequences, many of which have been noted in the literature. These include:

- *Stigmatization*. Felonizing possession of fentanyl can further stigmatize individuals with a SUD. Criminalization of a medical condition is at odds with a harm reduction approach, thereby discouraging individuals from seeking treatment or reaching out for help during emergency situations.[140] Evidence shows that criminality and substance use stigmas intersect to lower psychological well-being that leads to continued substance use and recidivism.[141]
- *Decreased stability*. Stakeholders noted that justice system involvement can cause individuals to lose their housing and job, break up families, and disrupt social networks. These impacts are both acute and potentially long lasting. People arrested for or convicted of drug felonies may be subject to bans from government assistance like the Supplemental Nutrition Assistance Program and public housing assistance, putting them at greater risk for food insecurity and homelessness.[142, 143]
- *Failing to address the root drivers.* Substance use and associated crimes are a manifestation of underlying issues, such as addiction or trauma. Without evidence-based practices, the justice system is ill-equipped to support individuals with mental health needs or SUD.[144, 145]
- *Death*. Involvement in the criminal justice system can place people with SUD at greater risk for overdose, for example, if treatment is not supported upon release.[146, 147, 148]
- *Exacerbate disparities*. This provision may disproportionately impact communities of color; historically, there has been over-policing and stricter enforcement in communities of color for drug crimes compared to the actual rates of drug use[149, 150] and increased legal repercussions for drugs consumed primarily by people of color.[151] Research shows that people of color experience harm in terms of future economic success due to greater odds of incarceration and disruptions in their community life due to drug arrests.[152, 153]

Overall, those who were not in support of this provision felt that it was likely to do more harm than good, especially for individuals with a SUD. They felt it would be better to have treatment options available in the community (outside of the justice system), which could address the root causes of the problem.

Assessment Questions

To help address these gaps in knowledge, this study will examine three questions:

- Who is getting referred to the DA's office for charges related to fentanyl possession?
- How did increased penalties for possessing fentanyl in HB22-1326 change case processing and case outcomes?
- What are the characteristics and experiences of individuals referred to the criminal justice system for possessing fentanyl?

Methods

Analysis of Data from the Colorado Judicial Branch

The study team will analyze data from the Colorado Judicial Branch on the number, nature, and outcomes of cases involving fentanyl possession (without distribution or manufacturing), filed with the courts. Specifically, the study team will examine who is being referred for such charges (e.g., race/ethnicity, age, gender) and trends in case processing, outcomes, and sentencing, including available results of the substance use screening assessment and treatment ordered. For cases that received a deferred judgment with conditions of probation or were sentenced to probation, the study team will examine results from the risk assessment, the level of probation, and whether probation/the deferred judgment was successfully completed, and reasons for revocation/termination (if applicable). To the extent possible, results will be disaggregated by geographic location and defendant characteristics.

The study team will examine data over three time periods: prior to March 2020, between March 2020 and July 2022 (implementation of HB19-1263), and July 2022 to June 2024 (implementation of HB22-1326). Because fentanyl-related charges were not specifically identified prior to July 1, 2022, the study team will examine schedule I and II drug possession charges more broadly. To provide context, the study team will also examine the number, nature, and outcomes of cases involving fentanyl distribution and manufacturing (or distribution and manufacturing of schedule I and II drugs more broadly, prior to July 2022).

Gathering Stakeholder Perspectives and Experiences

The study team will administer an anonymous online survey to all 22 elected DAs in partnership with the Colorado District Attorneys' Council (CDAC). The survey will ask DAs to provide information on their guidance/practices related to charging, plea guidelines, and diversion programming, for cases where the primary charge is fentanyl possession (without distribution or manufacturing). DAs will be asked to provide information on if and how their practices have changed as a result of HB22-1326.

The study team will conduct two 60-minute focus groups with individuals who have been involved in the justice system for charges related to fentanyl possession, with a focus on those sentenced to jail or probation or referred to a diversion program, as well as stakeholders who work directly with these individuals (e.g., harm reduction practitioners, public defenders). Through a series of open-ended questions, the study team will ask individuals to reflect on their experiences, what aspects of their experience were/were not supportive, and what positive and negative outcomes they experienced. Participants will be recruited in partnership with a community-based organization and compensated for their participation.

Deep-Dive Examination: Diversion Program

The study team will identify at least one diversion program being offered by a DA's office to conduct a deep-dive exploration. Program(s) will be selected based on self-nomination by the DAs office, using the survey described above. The research team will select program(s) based on program approach (is aligned with best practices) and data availability (has valid and reliable data elements available). The study team will describe the program's screening process and eligibility criteria, referral processes, requirements, and key components/activities. The study team will examine data over at least a four-year period to describe who participated in the program, the rate of successful program completion (who completed/did not and why), and outcomes of the program (e.g., recidivism, engagement in treatment). The study team will disaggregate participation, completion, and outcome data to better understand what types of individuals are being served by the program and for whom the program is most supportive.

Assessment Area 3: Public Health and Harm Reduction Approaches for Priority Populations

What Changes Did the Bill Make?

HB22-1326 includes several provisions focused on expanding harm reduction and public health approaches. For the independent study, three primary components are relevant:

First, the requirement for jails to provide MOUD. HB22-1326 (Section 45) requires jails to provide "MAT, and other appropriate withdrawal management care to a person with a SUD through the duration of the person's incarceration, as medically necessary." Jails are required to develop a policy and protocol for these services (Section 26) and support continuity of care upon release, including providing prescriptions and linkages to care (Section 15). Jails are encouraged to use county funding from the state opioid settlement to comply.

Second, the expansion of the funding for harm reduction. HB22-1326 expanded the harm reduction grant program run by CDPHE, broadening the types of entities that are eligible and the permissible activities and increasing funding by $6 million (Section 24). In addition, the bill appropriated $19.7 million for the opiate antagonist bulk purchase fund and increased the types of organizations eligible to receive opiate antagonists (Section 21) and appropriated funding for non-laboratory synthetic opiate detection tests (Section 22).

Third, education efforts. HB22-1326 required CDPHE to develop a statewide prevention and education campaign and provide at least five regional training sessions for community partners to implement youth health development strategies (Section 23).

What is this Strategy Aiming to Achieve?

Working at the population level, public health tries to prevent problems from happening or recurring through implementing educational programs, recommending policies, administering services, and conducting research. Harm reduction acknowledges that for better or worse, fentanyl is a part of our world and works to minimize its harmful effects. Through provisions in these two areas, the bill sought to support implementation of solutions that have existing evidence.

What Do We Know? What Remains Unknown?

Certain individuals and communities are disproportionately impacted. The negative impacts of fentanyl, including rates of SUD and death, impact some communities more than others. Stakeholders identified the following, sometimes overlapping groups as being disproportionately impacted: people of color (Black, Native American, and Hispanic individuals), low-income populations, individuals leaving jail or prison, individuals experiencing homelessness, individuals with disabilities, rural communities, and youth (middle school, high school, and college-age individuals). Stakeholders noted that the disproportionate impact bore by people of color is rooted in racism and classism associated with substance use. Evidence shows that systemic inequities associated with race and class, driven by historical policies and programs, have generated disparate stressors—including poverty, lack of safety, food insecurity, housing insecurity—that lead to adverse health outcomes, including increased risk for SUD.[154] Public health and harm reduction approaches can help address—or exacerbate—such disparities, depending on the extent to which issues of equity are taken into account.

Harm reduction can have a positive impact. Research shows that harm reduction reduces negative health and safety outcomes associated with substance use. It equips individuals with the tools and information they need to reduce risk and lead healthier lives.[155] There was agreement among almost all stakeholders about the importance and value of harm reduction approaches. Strategies such as wide distribution of naloxone were seen as having saved many lives; however, given the lack of data, there is no way to quantify the specific impact. Wide distribution of naloxone has helped additional types of individuals, including peers, serve as first responders and, in some situations, has negated the need for 911 or law enforcement involvement.

A few stakeholders questioned the extent to which Colorado's current harm reduction work is reaching priority populations. While harm reduction was created by people most affected and is well positioned to help individuals using fentanyl who have fewer supports, current implementation often misses communities of color and rural communities. Very little of the current research on harm reduction strategies focus on populations that are already stigmatized or more vulnerable; an equity-oriented framework to interventions is needed.[156]

Historical stigma has undermined harm reduction and treatment services.[157] Stakeholders reported more stigma among rural and politically conservative communities for harm reduction approaches; however, given the magnitude of the problem, norms seem to be shifting. In particular, stakeholders spoke to controversy surrounding the secondary distribution of naloxone (providing naloxone for distribution directly to affected friends and family members). A couple of stakeholders expressed skepticism about harm reduction approaches, describing them as "providing a bandage" or "discouraging people from seeking treatment." However, the literature shows that harm reduction leads to improvements in dealing with drug use, legal problems, and improved life circumstances such as housing and income[158] and there is no evidence that syringe exchange or naloxone distribution increase drug use.[159, 160]

MOUD can have a positive impact. Research evidence shows that jail-based MOUD decreases illicit opioid use and increases engagement in community-based treatment programs after release.[161] There was agreement among almost all stakeholders about the importance and value of providing MOUD in jails. In particular, this strategy was seen as an important complement to making fentanyl possession a felony (so that individuals have resources to help address their SUD while in custody). Stakeholders saw

high demand for MOUD among individuals in custody, which sometimes can only be partially fulfilled due to funding constraints.

A successful MOUD approach requires systematic screening and assessment, access to appropriate medications and therapeutic programming, and comprehensive re-entry support.[162, 163] Stakeholders, including those working in jails and prisons, underscored the importance of re-entry support that includes continuity of care, linkages to Medicaid/health care coverage, and support to address other mental health, physical health, and social needs such as housing. Stakeholders also note the importance of appropriate trained staff, [164] that MOUD should be voluntary,[165] and continued support for MOUD even if individuals test positive for another illicit drug.

Providing MOUD in jails faces implementation challenges. While much progress has been made in providing MOUD in the 53 jails across the state, stakeholders noted challenges in implementation including the "one-size-fits-all" model and associated resource challenges. Some jails do not have sufficient or appropriate staff (medical staff, multi-disciplinary team) or the ability to connect with treatment providers and access appropriate medications due to geographic availability of or ability to pay for these services. Stakeholder noted particular challenges for rural communities in connecting to opioid treatment providers and supporting continuity of care.

Likewise, some jails are resistant to implement MOUD. Not all stakeholders saw MOUD as the right role for law enforcement and noted issues of liability, given that law enforcement officers do not have qualified immunity. While the legislative requirement in HB22-1326 provides a push for jails to get onboard, stakeholders noted that increasing acceptance of MOUD requires changing "hearts and minds." Stakeholders noted that support needs to come from the top: sheriffs need to understand not only the importance of MOUD in saving lives but also as a strategy to improve inmate behavioral management and support employee health and safety.

Stakeholders noted that the mandate for jails to provide MOUD takes time away from other critical work (which is challenging, given limited staffing) and has contributed to staff turnover. Stakeholder raised concerns about how this work will be sustained, without dedicated funding that all counties can access with limited administrative burden.

Awareness campaigns seen as a key public health strategy. Almost all stakeholders felt that additional public education was an important strategy, in particular, for those using drugs recreationally and young people (middle, high school, and college age individuals) in order to raise awareness about the presence of fentanyl in multiple types of drugs and the associated danger. Most, but not all, stakeholders felt that harm reduction strategies should be a part of such campaigns. Stakeholders noted that education campaigns can support primary prevention (keep individuals from using drugs, provide information before a crisis) and reduce the stigma associated with substance use (support individuals in seeking services, information, and support). Stakeholders also felt that education campaigns were important to inform friends and families how to identify signs of substance use and provide appropriate support and response.

Colorado has several current education campaigns, including Keep the Party Safe, Lift the Label, and Bring Naloxone Home; however, there is limited information available on their effectiveness in changing attitudes or behaviors. Some stakeholders wondered to what extent individuals remain unaware of the presence and dangers of fentanyl. There are inconsistent findings across evaluations of public awareness campaigns meant to deter illicit drug use, but there are effective campaigns around deterring

tobacco.[166] In order to be effective, education campaigns should take a multi-pronged approach that includes wide availability of tools needed (for example, easy access to naloxone) and policies (for example, access to treatment) that support individuals to act on the information provided.[167]

Assessment Questions

To help address these gaps in knowledge, this study will examine two questions:

- To what extent are we reaching communities most impacted by fentanyl with public health and harm reduction approaches?
- What will it take to expand and scale public health and harm reduction approaches to reach those most impacted?

Methods

Analysis of Fentanyl-Related Deaths in Jail, Prison, Community Corrections, or While Under Probation or Parole

The study team will identify the number of drug overdose related deaths, including deaths related to fentanyl, in prisons, community corrections, or while under probation or parole between January 1, 2018, and June 30, 2024, by leveraging the Linked Information Network of Colorado. The study team will disaggregate data by year, geographic location, facility type, and individuals' characteristics including race/ethnicity, gender, and age. To the extent possible, the study team will summarize patterns in type(s) of drug(s) involved and the circumstances surrounding the death.

Because there is no way to identify drug overdose related deaths in jail through this mechanism, the study team will leverage the Death in Custody Reporting System managed by the Department of Criminal Justice. This system has limitations (i.e., fewer years where reliable data is available), which may prevent us from understanding the full scope of the problem and specifically identifying deaths from fentanyl.

Survey On the Status of Jail MOUD Programs

The study team will collaborate with the BHA Jail-Based Behavioral Health Services (JBBS) program, the Division of Criminal Justice, and the Colorado Sheriff's Association to administer a survey to jails in Colorado. The survey, combined with data already collected by JBBS (e.g., jail MOUD policies), will aggregate information about MOUD program characteristics including screening and assessment, medications, therapeutic programming, and re-entry support; current eligibility, reach, and costs; and barriers to providing MOUD, including additional resources/supports needed. The study team will coordinate with learnings from a recent assessment of MOUD in jails (led by BHA in partnership with the Steadman Group) and survey of MOUD practices in community corrections.

Examination of CDPHE's Harm Reduction Efforts and Education Campaign

The study team will review the annual reports from SFY23 (six grantees) and SFY24 (13 grantees) from the Harm Reduction Grant Program. The study team will review reports with the aim of understanding who is receiving funding (grantee characteristics), including type of organization and geographic location; grant activities, the number and types of individuals served, and examples of grant outcomes; to what extent the grants reached priority populations; and challenges encountered in implementing harm reduction programs.

The study team will review the SFY23 and SFY24 data for the Opiate Antagonist Bulk Purchase Fund (annual reports) and Fentanyl Test Strip (orders submitted using the Fentanyl Test Strip Order Form) to describe the number and types of entities the received opiate antagonists and detection tests and the number of opiate antagonists and detection tests distributed.

The study team will review data from the contractor on the education campaign developed by CDPHE to describe the campaign methods, reach of campaign, and to what extent the campaign reached priority populations.

Gathering Stakeholder Perspectives and Experiences

The study team will conduct two 60-minute focus groups with governmental and community-based organizations serving priority populations using harm reduction and public health approaches. Groups may focus on specific entities, for example, Harm Reduction Grant Program grantees or jail leadership/staff responsible for implementing MOUD. Through a series of open-ended questions, the study team will explore what approaches groups are implementing to reach priority populations, what challenges they are facing, opportunities to expand the reach and effectiveness of their work, and what they need to be successful.

The study team will conduct one 60-minute focus group with individuals who currently use or previously used fentanyl and are members of priority populations. Through a series of open-ended questions, the study team will ask individuals to reflect on their experiences, what public health or harm reduction supports they have found helpful, and what supports are missing. Participants will be recruited in partnership with a community-based organization and compensated for their participation.

Deep Dive: Public Health or Harm Reduction Program(s)

The study team will identify at least one program on which to conduct a deep-dive exploration. Program(s) will be identified using the focus groups described above. The research team will select models based on program approach (is aligned with best practices), extent to which it centers issues of equity (focused on reaching priority populations), and data availability (has valid and reliable data available). The study team will describe the program's key components/activities and examine data over at least a one-year period to describe who was reached and any outcomes (e.g., connection/ engagement in treatment). The study team will disaggregate outcome data to better understand what types of individuals the model is most supportive for.

Section 4: Data Sources and Indicators

Section 4: Data Sources and Indicators

For this study, the study team will draw from a mix of existing data sources as well as collect new data. Data sources were selected with the aim of providing rich insight into the assessment questions. As previously described, the study team will aim to employ a "numbers and narrative" approach, gain perspectives from stakeholders with lived experience (who are directly impacted by changes made in the bill), and identify and elevate promising models/approaches.

The study will draw existing data from the following nine existing data sources:

- Performance data collected by Colorado's three MSOs and reported to BHA on the contracts developed to provide short-term residential placement for withdrawal management, crisis stabilization, or MAT.
- Data maintained by the Colorado Judicial Department on the numbers and types of cases filed and resolved in Colorado's courts and on probation programming (except for Denver County Court).
- Data maintained by Denver County Court on the number and types of cases filed and resolved in Denver County Court and on Denver County Court probation programming.
- Records of individuals in prison, residential community corrections, on probation, and on parole linked with fentanyl-related overdose deaths from Colorado's Vital Statistics.
- The Death in Custody reporting system managed by the Colorado Division of Criminal Justice.
- Annual reports completed by organizations who receive funding through the Harm Reduction Grant Program, submitted to CDPHE.
- Tracking maintained by CDPHE on purchases made through the Opioid Antagonist Bulk Purchase Fund.
- Tracking maintained by CDPHE on requests made through the Fentanyl Test Strip Order system.
- Tracking maintained by CPHE on the public education campaign.

The study team will collect new data by administering the following two surveys:

- Survey of practices related to charging and case resolution where the top charge is fentanyl possession, administered to Colorado's 22 elected DAs.
- Survey of the status of MOUD programs, administered to leadership in Colorado's 53 jails.

The study team will collect new data by facilitating focus groups with system stakeholders and individuals directly impacted by the bill:

- Three focus groups with first responders and providers of short-term residential services currently or looking to work together to address the needs of individuals with OUD.
- One focus group with individuals that have interacted with first responders and/or short-term residential resources for a situation that involved fentanyl.
- Two focus groups with individuals who have been involved in the justice system for charges related to fentanyl possession, with a focus on those sentenced to jail or probation or referred

to a diversion program, as well as stakeholders who work directly with these individuals (e.g., harm reduction practitioners, public defenders).

- Two focus groups with organizations using harm reduction or public health approaches serving priority populations.
- One focus group with individuals who currently use or previously used fentanyl and are members of priority populations.

The study team will examine secondary data on three promising approaches, including at least one of each of the following:

- Collaborative response model.
- Diversion program run by a DA's office.
- Public health or harm reduction program reaching priority populations.

Information on each data source, including the specific indicators that will be examined, as well as limitations, is outlined in Table 6.

Table 6. Study Data Sources, Indicators, and Limitations

Data Source#	Indicators	Limitations
Assessment Area 1: Acute Response That Addresses Underlying Needs and is Part of a Comprehensive System		
Review of MSO performance data on short-term residential placement Monthly reports from SFY 2024	• Number, types, and location of facilities contracted. • Number of referrals. • Number of services provided (e.g., admissions, treatment days, emergency room diversions, first responder diversions). • Number of persons served. • Examples of successes, challenges, and barriers.	No standardized reporting information is available for SFY 2023.
Focus groups with state/MSO leaders, first responders, and behavioral health providers Three focus groups with first responders and providers of short-term residential services currently or looking to work together to address the needs of individuals with OUD	• How equipped they feel/what they need to respond to individuals with OUD. • What models are working well and why. • Implementation challenges/gaps, including successes and challenges in coordination efforts and in setting up structures (e.g., licensure, protocols, data tracking). • To what extent services are reaching priority populations. • Opportunities and challenges for rural communities. • Ways to measure progress. • Opportunities to support sustainability.	
Focus group with directly impacted individuals One focus group with individuals that have interacted with first responders and/or short-term residential resources for a situation that involved fentanyl	• The circumstances surrounding their involvement with the first responders and/or short-term residential resources. • Their experiences. • Aspects of their experience that were/were not supportive. • Positive/ negative outcomes they experienced.	
Deep dive examination: Response model(s)	• Partners involved. • Key components and activities. • Number and types of individuals reached.	To be determined based on data availability.

Data Source#	Indicators	Limitations
	• Outcomes, by participant characteristics.	
Assessment Area 2: Increased Criminal Penalties for Possession of Fentanyl		
Analysis of data from the Colorado Judicial Branch and Denver County Court Individual-level data on criminal cases and case outcomes from January 2018 - June 2024	• Number of cases with charge(s) filed for drug and/or fentanyl possession and other drug- or fentanyl-related charges (e.g., distribution, manufacturing, conspiracy, inducement), by year and by county. • Number and type of charges filed alongside drug/fentanyl possession. • Number of cases with a top charge of drug or fentanyl possession that were charged and disposed of as felonies and/or misdemeanors. • Whether an arrest was made or a summons was issued for cases with a top charge of drug or fentanyl possession. • Dispositions, assessments, and sentences of cases with a top charge of drug or fentanyl possession. • Characteristics of individuals with a top charge of drug or fentanyl possession, including age, gender, race/ethnicity, type of counsel, special offender designation, and criminal history. • For cases with a top charge of drug or fentanyl possession that receive a deferred judgment with conditions of probation or were sentenced to probation: results of assessments; risk level; probation level and available information on conditions and type of engagement; whether probation was revoked; whether probation was successfully completed; and reason for termination.	Fentanyl-related charges were not specifically identified prior to July 1, 2022. Limited information is available on defendant characteristics (e.g., housing status). Probation does not collect information on the types of services individuals are referred to. Court system does not systematically track outcomes of cases referred to diversion. Given the length of probation sentences and deferred judgements, few individuals will have had the opportunity to complete their sentence.

Data Source#	Indicators	Limitations
Online survey of elected DAs Online survey to all 22 elected DAs	• Charging or plea guidelines for cases where the primary charge is drug or fentanyl possession. • Diversion programs or other supports available. • Extent to which their practices have changed as a result of HB22-1326.	
Focus groups with directly impacted individuals Two focus groups with individuals who have been involved in the justice system for charges related to fentanyl possession, with a focus on those sentenced to jail or probation or referred to a diversion program, as well as stakeholders who work directly with these individuals (e.g., harm reduction practitioners, public defenders).	• The circumstances surrounding their involvement with the justice system. • Their experiences. • Aspects of their experience that were or were not supportive. • Positive and negative outcomes they experienced.	
Deep-dive examination: Diversion program(s)	• Program eligibility criteria. • Screening and referral process. • Key components and activities. • Program requirements, including cost. • Number of individuals referred, deemed eligible, and enrolled. • Average length of time in the program. • Rates of successful program completion; reasons for non-completion. • Cases outcomes, by defendant characteristics.	To be determined, based on data availability

Data Source#	Indicators	Limitations
Assessment Area 3: Public Health & Harm Reduction Supports		

Fentanyl related deaths in prisons, jails, residential community corrections or while under probation or parole
 	
Individual-level data on fentanyl-related deaths from January 2018–June 2024
	• Drug-overdose related deaths, by
	  ○ Year;
	  ○ Geography;
	  ○ Facility type;
	  ○ Individual characteristics, including race/ethnicity, gender, and age.
	• Any information on drug(s) involved or circumstances surrounding the death.
		Have to rely on Death in Custody reports for jails. These reports are only available starting in SFY 2022 and have no specific manner of death related to overdose.
		
		No systematic data available on deaths from pretrial services.

Survey on the status of MOUD programs in jails Online survey of Colorado's 53 jails	• When MOUD program began. • Who has access to MOUD services. • MOUD program characteristics and services offered, including screening and assessment, medications, therapeutic programming, and re-entry support. • Program staffing and partnerships. • Program reach and costs. • Extent to which jails are able to meet need and/or demand for MOUD. • Barriers to providing MOUD, including additional resources needed. • Unintended consequences of providing MOUD. • Facilitators/barriers for post-release treatment.	Through partnership with BHA's Jail-Based Behavioral Health Services the survey will be distributed to their contracted jails, 49 of the state's 53.
Review of Harm Reduction Grant Program reporting Review grantee annual reports from SFY 2023 and 2024	• Grantee characteristics, including type of organization and geographic location. • Grant activities, number and types of individuals served, and examples of grant outcomes. • To what extent grants reached priority populations. • Challenges encountered in implementing harm reduction programs.	

Data Source#	Indicators	Limitations
Review of Opioid Antagonist Bulk Purchase Fund and Fentanyl Test Strip Order data Review SFY 2023 and 2024 purchasing/order data	• Number and types of entities the received opiate antagonists and detection tests. • Number of opiate antagonists and detection tests distributed.	No data is available on individuals who received opiate antagonists and detection tests, if and how they were used, or outcomes.
Review of educational campaign metrics	• Campaign methods. • Reach of campaign. • To what extent campaign reached priority populations.	
Focus group with governmental and community-based organizations Two focus groups with organizations using harm reduction or public health approaches serving priority populations	• Promising approaches to reach priority populations. • Implementation challenges and opportunities. • Opportunities to expand the reach and effectiveness of their work.	
Focus group with directly impacted individuals One focus group with individuals who currently use or previously used fentanyl and are members of priority populations.	• Their experiences. • What public health or harm reduction support they have found helpful. • What supports are missing.	
Deep-dive examination: Public health or harm reduction program(s)	• Partners involved. • Key components/activities. • Number and types of individuals reached. • Outcomes by participant characteristics.	To be determined based on data availability.

Section 5: Study Implementation and Using the Findings

Section 5: Study Implementation and Using the Findings

Study Timeline

As shown in Table 7, the study will be implemented over a 15-month period (November 2023–January 2025). The specific timeline for data collection and analysis were identified based on data availability, with the aim of collecting and reviewing information as soon as it is available to support ongoing decision-making.

Table 7. Study Timeline

	2023		2024												2025
	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J
Study Preparation															
Develop study materials	■	■													
Data Collection and Analysis															
Review MSO performance data			■	■						■	■				
Focus groups with state/MSO leaders, first responders, and behavioral health providers				■	■	■									
Focus group with directly impacted individuals				■	■	■	■								
Deep dive examination: response model(s)							■	■							
Analysis of data from the Colorado Judicial Branch and Denver County Court											■	■	■		
Online survey of elected DAs			■	■											
Deep-dive examination: diversion program(s)											■	■	■		
Analysis of fentanyl-related deaths											■	■	■		
Survey on the status of MOUD programs in jails			■	■											
Review of Harm Reduction Grant Program reporting			■	■					■	■					
Review of Opioid Antagonist Bulk Purchase Fund and Fentanyl Test Strip Order data			■	■					■	■					
Review of educational campaign metrics									■	■	■				
Focus group with governmental and community-based organizations serving priority populations					■	■									
Deep-dive examination: public health or harm reduction program(s)							■	■							
Stakeholder Engagement / Sharing Results															
Convene advisory team		■			■			■			■			■	

	2023		2024												2025
	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J
Develop and share interim data syntheses for discussion						■	■			■	■				
Develop and share final report													■	■	

Stakeholder Engagement

To meet the study goals—informing decision-making, supporting the development of shared language and frameworks, and supporting stakeholders in identifying opportunities to work cohesively using a multi systems-approach—the study team will engage stakeholders throughout the process. In addition to the qualitative data collection approaches described in the previous section, the study team will employ three processes:

- Forming a **study advisory team**, which the study team will convene quarterly to get input on study implementation and interim results. At minimum, the advisory committee will be made up of individuals from the following organizations/roles: CDPHE, the Colorado Attorney General's Office, an elected DA, a police chief, a MOUD provider, a criminal justice reform organization, and a harm reduction organization.
- Hosting two interim **"meaning making" sessions** where the study team will present draft results, summarized in a policy brief and/or webinar, to a diverse group of stakeholders and ask for input and feedback.
- Conducting **one-on-one meetings** throughout the study to keep stakeholders informed of progress and interim results. The study team will continue to engage with the Colorado Consortium for Prescription Drug Abuse Prevention to coordinate efforts and keep broader networks of state stakeholders informed.

In addition to the full study report (to be delivered in December 2024), the study team will develop a series of policy briefs that summarize key findings and highlight promising practices. These policy briefs will be geared toward decision-makers at state and local level.

Appendix A: HB22-1326, Section 34

THEREOF, AS DESCRIBED IN SECTION 18-18-403.5 (2.5), EVEN IF THE PERSON HAS BEEN PREVIOUSLY CONVICTED OF THREE OR MORE QUALIFYING FELONY CONVICTIONS.

SECTION 34. In Colorado Revised Statutes, **add** part 15 to article 20.5 of title 25 as follows:

PART 15
HOUSE BILL 22-1326 INDEPENDENT STUDY

25-20.5-1501. Independent study - report - repeal. (1) (a) BY JANUARY 1, 2023, THE DEPARTMENT SHALL CONTRACT WITH AN INDEPENDENT ENTITY TO CONDUCT A STUDY AND PUBLISH A REPORT CONCERNING THE IMPACT AND IMPLEMENTATION OF HOUSE BILL 22-1326.

(b) THE DEPARTMENT SHALL CONSULT WITH THE JUDICIAL DEPARTMENT, THE OFFICE OF BEHAVIORAL HEALTH, AND OTHER STAKEHOLDERS IDENTIFIED BY THE DEPARTMENT IN DEVELOPING AND ISSUING A REQUEST FOR PROPOSALS TO ENSURE CANDIDATES HAVE EXPERTISE IN DATA COLLECTION AND PROGRAM ANALYSIS, AND RELEVANT CRIMINAL LAW AND HARM REDUCTION ISSUES.

(2) AT A MINIMUM, THE INDEPENDENT ENTITY SHALL IDENTIFY AND REPORT FINDINGS REGARDING AVAILABLE DATA AND INFORMATION FROM JULY 1, 2019, THROUGH JUNE 30, 2024, OBTAINED FROM THE COLORADO JUDICIAL DEPARTMENT AND TREATMENT PROVIDERS SERVING THE PROBATION POPULATION. DATA AND INFORMATION FROM CASES FILED AND PRACTICES IMPLEMENTED PRIOR TO JULY 1, 2022, MUST BE INCLUDED IN THE STUDY IN AN EFFORT TO ESTABLISH BASELINE INFORMATION, AS NECESSARY. THE DATA AND INFORMATION MUST BE REPORTED BOTH ON A STATEWIDE BASIS AND DISAGGREGATED BY JUDICIAL DISTRICT. THE DATA AND INFORMATION MUST INCLUDE, BUT IS NOT LIMITED TO:

(a) EVERY CASE WITH A CHARGE FILED PURSUANT TO SECTION 18-18-403.5 (2.5) FOR THE UNLAWFUL POSSESSION OF FENTANYL, CARFENTANIL, BENZIMIDAZOLE OPIATE, OR AN ANALOG THEREOF, INCLUDING:

(I) WHETHER A MISDEMEANOR OR FELONY CHARGE WAS FILED;

(II) WHETHER AN ARREST WAS MADE OR A SUMMONS WAS ISSUED FOR THE CHARGE;

(III) WHETHER ANOTHER CRIMINAL CHARGE WAS FILED IN THE CASE, AND IF SO, WHAT CHARGE;

(IV) THE DISPOSITION OF THE CASE, INCLUDING THE SENTENCE IMPOSED;

(V) WHETHER THE DEFENDANT IS CURRENTLY SERVING THE SENTENCE AND IF THE SENTENCE INCLUDES PROBATION SUPERVISION;

(VI) WHETHER THE DEFENDANT SUCCESSFULLY COMPLETED THE SENTENCE, INCLUDING IF THE DEFENDANT SUCCESSFULLY COMPLETED AN INITIAL PROBATIONARY SENTENCE OR WHETHER PROBATION WAS REVOKED AND RESULTED IN INCARCERATION IN JAIL OR PRISON;

(VII) IF PROBATION WAS REVOKED, WHETHER THE REVOCATION WAS FOR A NEW CRIMINAL CASE OR A TECHNICAL VIOLATION;

(VIII) WHETHER SUBSTANCE USE TREATMENT WAS ORDERED AND, IF SO, WHAT TYPE, INCLUDING WHETHER THE COURT ORDERED PLACEMENT IN A RESIDENTIAL TREATMENT FACILITY PURSUANT TO SECTION 18-1.3-410 OR 18-1.3-510; AND

(IX) THE RACE, GENDER, AND AGE OF THE DEFENDANT, AND WHETHER THE DEFENDANT WAS REPRESENTED BY COURT-APPOINTED COUNSEL OR OTHERWISE DETERMINED TO BE INDIGENT.

(3) AT A MINIMUM, THE INDEPENDENT ENTITY SHALL IDENTIFY AND REPORT FINDINGS BASED ON AVAILABLE DATA AND INFORMATION OBTAINED FROM THE OFFICE OF BEHAVIORAL HEALTH, THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, MANAGED SERVICE ORGANIZATIONS, AND OTHER APPLICABLE AGENCIES AND TREATMENT PROVIDERS, REGARDING:

(a) THE PREVENTION AND EDUCATION CAMPAIGN DEVELOPED BY THE DEPARTMENT PURSUANT TO SECTION 25-1.5-115.5 AND THE FENTANYL EDUCATION PROGRAM DEVELOPED BY THE OFFICE OF BEHAVIORAL HEALTH PURSUANT TO SECTION 27-80-128, INCLUDING THE METHOD AND REACH OF THE CAMPAIGN AND PROGRAM;

(b) THE IMPLEMENTATION OF MEDICATION-ASSISTED TREATMENT AND OTHER APPROPRIATE WITHDRAWAL MANAGEMENT CARE BY EVERY JAIL;

(c) THE ELIGIBLE ENTITIES THAT PURCHASED OPIATE ANTAGONISTS THROUGH THE OPIATE ANTAGONIST BULK PURCHASE FUND PURSUANT TO SECTION 25-1.5-115, INCLUDING THE AMOUNT OF OPIATE ANTAGONISTS PURCHASED BY EACH ELIGIBLE ENTITY AND THE REVENUE RECEIVED BY THE BULK PURCHASE FUND;

(d) THE ELIGIBLE ENTITIES THAT RECEIVED NON-LABORATORY SYNTHETIC OPIATE DETECTION TESTS PURSUANT TO SECTION 25-1.5-115.3 AND THE AMOUNT OF NON-LABORATORY SYNTHETIC OPIATE DETECTION TESTS RECEIVED BY EACH ELIGIBLE ENTITY;

(e) THE HARM REDUCTION GRANT PROGRAM, CREATED IN SECTION 25-20.5-1101, INCLUDING:

(I) THE GRANTEES, THE USES OF EACH GRANT, THE AMOUNT OF THE GRANT AWARD, THE NUMBER OF PEOPLE SERVED BY THE GRANT, AND ANY AVAILABLE OUTCOME MEASURES AS A RESULT OF THE GRANT USES;

(II) STRATEGIES DEVELOPED AND IMPLEMENTED THROUGH THE PROGRAM, IF ANY, FOR SERVING POPULATIONS WHO ARE AT A HIGHER RISK OF OVERDOSE AND LIVE IN UNDERSERVED AREAS; AND

(III) EVIDENCE-BASED RESEARCH DEVELOPED THROUGH THE PROGRAM CONCERNING BEST OR PROMISING PRACTICES IN OVERDOSE PREVENTION, EARLY INTERVENTION, HARM REDUCTION, AND MEDICATION-ASSISTED TREATMENT;

(f) EVERY OVERDOSE DEATH CAUSED BY FENTANYL, CARFENTANIL, BENZIMIDAZOLE OPIATE, OR AN ANALOG THEREOF, OCCURRING IN A JAIL, PRISON, OR RESIDENTIAL COMMUNITY CORRECTIONS FACILITY OR WHILE UNDER PROBATION, PAROLE, OR PRETRIAL RELEASE;

(g) THE MANAGED SERVICE ORGANIZATIONS CONTRACTS DEVELOPED PURSUANT TO SECTION 27-80-107.8 TO PROVIDE SHORT-TERM RESIDENTIAL PLACEMENT FOR WITHDRAWAL MANAGEMENT, CRISIS STABILIZATION, OR MEDICATION-ASSISTED TREATMENT, INCLUDING THE NUMBER OF FACILITIES, THEIR LOCATION, SERVICES PROVIDED, AND THE NUMBER OF PERSONS

SERVED; AND

(h) THE TRAINING AND COORDINATION EFFORTS DEVELOPED AND IMPLEMENTED BY THE MANAGED SERVICE ORGANIZATIONS WITH FIRST RESPONDERS AND REFERRING ENTITIES REGARDING THE AVAILABLE SERVICES TO BE UTILIZED IN LIEU OF ARREST AND TRANSPORT TO JAIL.

(4) THE INDEPENDENT ENTITY SHALL REQUEST ALL NECESSARY DATA NECESSARY TO COMPLETE THE STUDY, AND EACH AGENCY OR ORGANIZATION SHALL ESTABLISH ANY DATA SHARING AGREEMENT NECESSARY, SUBJECT TO ALL FEDERAL AND STATE PRIVACY LAWS NECESSARY TO PROTECT PRIVACY, TO SUPPORT THE STUDY.

(5) BY DECEMBER 31, 2024, THE INDEPENDENT ENTITY SHALL SUBMIT A COMPLETED COMPREHENSIVE REPORT OF ITS FINDINGS PURSUANT TO SUBSECTION (2) OF THIS SECTION TO THE DEPARTMENT.

(6) BY JANUARY 31, 2025, THE DEPARTMENT SHALL PUBLISH THE REPORT ON ITS WEBSITE AND SHALL SUBMIT THE REPORT TO THE JUDICIARY COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND THE SENATE, OR ANY SUCCESSOR COMMITTEES.

(7) THIS PART 15 IS REPEALED, EFFECTIVE JULY 1, 2025.

SECTION 35. In Colorado Revised Statutes, **add** part 15 to article 20.5 of title 25 as follows:

PART 15
HOUSE BILL 22-1326 INDEPENDENT STUDY

25-20.5-1501. Independent study - report - repeal. (1) (a) BY JANUARY 1, 2023, THE DEPARTMENT SHALL CONTRACT WITH AN INDEPENDENT ENTITY TO CONDUCT A STUDY AND PUBLISH A REPORT CONCERNING THE IMPACT AND IMPLEMENTATION OF HOUSE BILL 22-1326.

(b) THE DEPARTMENT SHALL CONSULT WITH THE JUDICIAL DEPARTMENT, THE BEHAVIORAL HEALTH ADMINISTRATION, AND OTHER STAKEHOLDERS IDENTIFIED BY THE DEPARTMENT IN DEVELOPING AND ISSUING A REQUEST FOR PROPOSALS TO ENSURE CANDIDATES HAVE EXPERTISE IN DATA COLLECTION AND PROGRAM ANALYSIS, AND RELEVANT

Appendix B: Methods Employed in Developing the Analysis Plan

The Colorado Evaluation and Action Lab deployed three methods to develop the analysis plan: conducting a comprehensive literature review of the problem and potential solutions; conducting interviews with stakeholders from diverse fields; and reviewing potential data sources. In addition, we shared a draft plan with stakeholders for input and feedback.

Literature Review

We reviewed the literature with the aim of getting a better understanding of a) the problem of fentanyl including fentanyl supply, fentanyl source, fentanyl use and individuals using fentanyl, and overdose events and death from fentanyl; and b) potential solutions to address the problem, including primary prevention, law enforcement approaches, treatment and recovery, and harm reduction.

We identified literature by searching both the published and grey literature, using Google and Google Scholar and searching trusted sources, such as Colorado agency websites (e.g., the Colorado Department of Public Health and Environment [CDPHE], Colorado Attorney General), governmental websites (e.g., U.S. Department of Health and Human Services [HHS], Bureau of Justice Assistance), and professional organizations websites (e.g., National Commission on Correctional Health). We used search terms specific to the aspect of the problem/solution we were aiming to answer (for example, “substance use disorder rate Colorado” or “evidence for peer support models in opioid recovery”). Given the limited information available for fentanyl specifically, we also considered information based on other opioids.

We completed the literature review iteratively alongside stakeholder interviews, asking stakeholders to share sources for information they mentioned and querying the literature to better understand information stakeholders were sharing.

We critically reviewed sources, with the aim of including sources with high rigor (e.g., credible source, clearly articulated research questions and goals, systematic methods, conclusions well founded based on results) and relevance (e.g., similar populations/settings to Colorado). When information was not available, we made that explicit.

Literature was synthesized to provide an overall perspective of the problem and solutions (Section 2) as well as provide more in-depth information available related to the implementation and outcomes for three study priority areas (Section 3). To provide context, literature review and results from stakeholder interviews are presented together.

Stakeholder Interviews

We conducted stakeholder interviews with the goal of identifying stakeholder perspectives and approaches; the potential impacts of different strategies, including positive, negative, intended, and unintended consequences; implementation challenges and opportunities; and gaps in knowledge and what types of information would be helpful to support ongoing work and decision-making.

Stakeholders were identified based on entities identified in the study provisions, including responsible Colorado State Agencies (e.g., Behavior Health Administration [BHA], Colorado Department of

Corrections [CDOC]) as well as the associated implementation partners (e.g., managed service organizations [MSOs], sheriffs, and first responders). We also identified stakeholders based on our review of the testimony for House Bill 22-1326. We sought to ensure representation of perspectives from all four types of solutions (primary prevention, law enforcement approaches, treatment and recovery, and harm reduction). To the extent possible, we sought to connect with organizations and individuals who were bringing stakeholders together (e.g., Colorado Attorney General Opioid Response Unit, Colorado Consortium for Prescription Drug Abuse Prevention) or had perspectives from representative members (e.g., County Sheriffs of Colorado, Emergency Medical Services Association of Colorado). We used snowball sampling, concluding each interview by asking who else should we talk to.

We initially conducted outreach with one key informant but allowed them to bring others into the interview. In total we conducted 30 interviews with 53 individuals. We conducted interviews either in person or virtually; all lasted between 30 and 90 minutes. Two team members participated in each interview, with one team member taking detailed notes.

Stakeholder Interviews, Organizations/Roles

- **BHA (n=5)**
- **CDOC (n=2)**
- **Colorado Department of Law (n=3)**
- **CDPHE (n=11)**
- **Colorado Department of Public Safety (n=2)**
- **Colorado State Public Defender (n=2)**
- **Community-based organization supporting state-level harm reduction, criminal justice reform, and/or directly impacted populations (n=4)**
- **District Attorney's Office (n=5)**
- **Governor's Office (n=3)**
- **Leaders of law enforcement or first response organizations (n=2)**
- **Local government leaders (n=1)**
- **Local harm reduction organizations (n=1)**
- **Local law enforcement (n=3)**
- **Local treatment providers (n=1)**
- **MSOs (n=4)**
- **Statewide coalition or inter-state task force (n=4)**

After each interview, each of the team members independently reviewed the interview notes and wrote down key takeaways (themes from the interviews). To develop the analysis plan, two team members reviewed the key takeaways notes and full notes from the interview (as needed) to synthesize stakeholder feedback around the problem, the solutions, and each of the three study priority areas. We noted areas where stakeholder opinion either aligned or differed.

In addition to the interviews, two team members participated as observers in a series of virtual and in-person focus groups conducted by The Missing Us, led by Dr. Josh Barocas, as a part of the project "The Health Impacts of Felonizing Fentanyl Possession." The project employed a participatory action research approach and applied concept mapping to understand what role criminal penalties and law enforcement play in influencing the risk of overdose. Focus groups, which were implemented over four sessions, included eight to ten adults with lived experience, including individuals who currently use or previously

used fentanyl; individuals who work directly with individuals who use fentanyl (e.g., peer navigators, harm reduction practitioners); and individuals who have been impacted by the justice system for fentanyl-related charges.

Finally, to gather additional context, we participated as observers in system meetings that occurred during the planning period, including quarterly Fentanyl Response Stakeholder Sessions (hosted by the Rocky Mountain High Intensity Drug Trafficking Area and the Colorado Consortium for Prescription Drug Abuse Prevention), meetings of the Opioid and Other Substance Use Disorders Study Committee, and the 2023 Colorado Drug Information Opportunity Symposium.

Assessment of Data Sources

We examined data sources to be employed in the study to identify what data elements were available and what linkages with other data sets were needed to answer study questions (as relevant). For each data source, we identified priority indicators as well as limitations (Section 4).

Presentation of Draft Plan for Feedback

We employed two primary strategies to get feedback on the draft plan. First, we shared sections of the plan with stakeholders via email to get feedback, to ensure that we had correctly described the study provisions and the ways the system was operating. We also asked for feedback on the proposed study questions, indicators, and methods to ensure that they would provide useful and actionable information.

Second, we presented key concepts from the draft plan—including the study goals, frameworks, focus areas, and methods—during three meetings:

- We presented on June 28, 2023, to the Governor's Crime Prevention Cabinet Working Group.
- We hosted a virtual webinar on August 2, 2023. We invited all stakeholders with whom we conducted interviews, as well as others who had expressed an interest in the study. We asked for feedback during the meeting (via Google form).
- We presented on August 4, 2023, to the Substance Abuse Trend and Response Task Force (SATF) Meeting. We provided a two-page summary of the study and invited feedback via a Google form.

We asked for feedback on what steps we could take to support the study goals; what type of information will be most supportive for their ongoing work; examples of promising practices to examine; and opportunities to continue to engage with stakeholders throughout the study process.

Appendix C: Definitions

Opioids: Defined by the Centers for Disease Control and Prevention (CDC) as a "class of drugs that interact with opioid receptors on nerve cells in the body and brain and reduce the intensity of pain signals and feelings of pain. This class of drugs includes the illegal drug heroin; synthetic opioids such as fentanyl, which is often made illegally; and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, and morphine."[168]

Synthetic opioids: Drugs produced in a laboratory and act on the same receptors as natural opioids to produce pain relief.[169]

Substance use: Per the CDC, refers to any use of "selected substances, including alcohol, tobacco products, drugs, inhalants, and other substances that can be consumed, inhaled, injected, or otherwise absorbed into the body with possible dependence and other detrimental effects." [170] Substance use describes the behavior, not the individual.

Substance misuse: Refers to any use of prescription medications outside of their intended purpose.

Substance use disorder (SUD): Per the Substance Abuse and Mental Health Services Administration (SAMHSA), substance use disorder(s) (SUD) "occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[171]

Opioid Use Disorder (OUD): Defined by the CDC as "a substance use disorder, is a problematic pattern of opioid use that causes significant impairment or distress. OUD is a treatable, chronic disease that can affect anyone—regardless of race, gender, income level, or social class."[172]

Stigma: Disapproval or unfair judgment about substance use, SUD, and/or fentanyl use.

Medications for Opioid Use Disorder (MOUD), also called Medication-Assisted Treatment (MAT), per SAMHSA, is the use of "medications [to] relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. Medications used are evidence-based treatment options and do not just substitute one drug for another." The use of medications, in combination with counseling and behavioral therapies, provide a "whole patient" approach to the treatment of SUDs. [173]

People who sell or distribute drugs: Any person who gets drugs from one person to another (as opposed to people acquiring drugs specifically for their own use). Per HB-1326, for this study plan we are interested in those who manufacture, distribute, dispense, or sell fentanyl, carfentanil, benzimidazole opiate, and analogs thereof. This may include any level of drug seller, including high-level wholesalers, mid-level drug suppliers, those who transport drugs, retail or street-level sellers, as well as "social suppliers" (those who provide to family and friends with little to no financial gain).[174]

Overdose or non-fatal overdose: Occurs when a toxic amount of a substance overwhelms the body and impedes vital functions, including oxygen intake.

Death from fentanyl: An overdose event that results in death. This terminology aims to value individuals who both knowingly and unknowingly ingested fentanyl and the experiences of their loved ones. We avoid the terms “overdose death” or “fentanyl poisoning," which is often used to refer to someone that unknowingly ingested fentanyl.

Witness: A person that saw a death from fentanyl occur, whereas a **bystander** means that someone was in the same structure (i.e., in the same house but did not see the death occur).[175]

Naloxone: An FDA approved medication to rapidly reverse overdose by binding to opioid receptors and reversing the effects of opioids.[176]

Narcan: The brand name of a popular FDA approved naloxone nasal spray.

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