



JAIL-BASED MEDICATION-ASSISTED TREATMENT

PROMISING PRACTICES, GUIDELINES,
AND RESOURCES FOR THE FIELD

October 2018

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To find this resource online, visit www.ncchc.org/jail-based-mat.

To request MAT-related technical assistance, visit www.rsat-tta.com/On-Site-TA-Teleconferences/Training-and-Technical-Assistance-Request-Form.aspx.



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NATIONAL SHERIFFS' ASSOCIATION

FOREWORD

Jails have become a revolving door for individuals struggling with mental health and substance use disorders. More than 10 million individuals pass through jails around the country annually, with at least half of those individuals having substance use disorders, half of whom are opioid abusers. Individuals suffering with mental health and substance use disorders come in and out of the jail, with arrests, incarceration, and release to the community, where the abuse restarts and the cycle continues when they commit another crime. Without effective intervention, this drives our nation's crime rate dramatically, while those who are most vulnerable remain sick. Jails not only oversee individuals struggling with substance use disorders and withdrawal, but are also in a unique position to initiate treatment in a controlled, safe environment.

Historically, it has not been the responsibility of the sheriffs and jail administrators to be primary providers of substance use disorder treatments. But with thousands of Americans dying every week from drug overdoses and those recently released from jail among the most defenseless, the situation has changed—sheriffs have taken on the challenge.

In 2017, the nation's sheriffs resolved to support the most current, evidence-based substance use disorder treatment within their jails to respond to the opioid and drug epidemic. Sheriffs have become this nation's pioneers in establishing medication-assisted treatment (MAT) programming, expanding jail MAT programs into 30 states at present.

The following guidelines introduce what has been learned from the sheriffs' and jail administrators' innovative use of MAT, describing the essential components of these programs and analyzing the latest research on how these programs are best implemented, as well as the medications approved for opioid use disorders. The guidelines are a result of the extraordinary collaboration of our federal, national, and private partners. Our nation's sheriffs and jail administrators are deeply appreciative for their contributions and commitment to assisting the jails in addressing the opioid epidemic for our justice-involved populations.

Jails represent perhaps the most unique place to get individuals off drugs and on the path to long-term recovery. But jails can only help individuals begin that journey—communities must shepherd those in need through that journey. As illustrated by the examples of several successful jail programs captured in the guidelines, the sheriffs and jail administrators reach beyond the walls of their jails to collaborate with treatment and support services in the community to ensure that what has begun in jail continues upon release.

We hope that sheriffs and jail administrators will find the *Promising Practices, Guidelines, and Resources* helpful in making these programs available to those who so desperately need them for their health and well-being as well as the safety of our communities.



Jonathan F. Thompson
Executive Director and CEO
National Sheriffs' Association

NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

FOREWORD

As my colleague Jonathan Thompson notes, jails are on the front lines of the opioid epidemic in the United States.

Over the past 40 years, sheriffs and jail administrators across the country have sought to improve the quality of health services provided to the individuals in their care. In the mid-1970s, 30 jails served as the pilot sites for the first health services standards for correctional settings and an accompanying accreditation program. Today, the National Commission on Correctional Health Care (NCCHC) continues to help jails address the most complex problems in health services, including care for individuals suffering from mental illness and substance use disorder. In addition to its standards for jail health services, NCCHC also offers standards and accreditation specifically for opioid treatment programs.

As this publication makes clear, pharmacotherapy—i.e., medication-assisted treatment (MAT)—is widely held to be a cornerstone of best practice for recovery from substance abuse. Effective treatment, including MAT, particularly when coupled with evidence-based behavioral treatment, improves medical and mental health outcomes and reduces relapses and recidivism.

MAT provides a significant opportunity to help individuals with substance use disorder, especially those who participate in a community-based opioid treatment program (OTP). OTPs are licensed facilities that provide methadone and often other MATs for individuals diagnosed with an opioid-use disorder. Effective treatment for substance use disorder, including long-term MAT, has been shown to reduce drug use, overdose, and mortality. Fundamentally, it is key to halting the national epidemic of drug abuse, particularly opioid use disorder, and interrupting the costly cycle of recidivism resulting from this underlying disorder. We encourage sheriffs and our jail-based colleagues to take the lead in this effort.



James R. Pavletich, MHA, CAE, CCHP
Chief Executive Officer
National Commission on Correctional Health Care

ACKNOWLEDGMENTS

So many people and organizations made the document *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* possible. Although it is not feasible to recognize each of these contributions individually, the National Sheriffs' Association (NSA) and the National Commission on Correctional Health Care (NCCHC) would like to highlight the distinctive roles of several people involved in this two-year effort.

First, the NSA and NCCHC staffs would like to thank the co-chairs of the project: Ruby Qazilbash, Associate Deputy Director, Bureau of Justice Assistance, and Stephen Amos, Chief of the Jails Division, National Institute of Corrections. They initiated this effort and provided the leadership to realize a vision of consensus around issues that initially seemed to many as hopelessly complex and controversial.

An initiative of the scope and complexity of *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* never would have gotten beyond the concept phase without considerable funding and technical support. Officials from the U.S. Department of Justice (specifically, the Bureau of Justice Assistance and the National Institute of Corrections), the Office of National Drug Control Policy, the National Institute on Drug Abuse, and the Substance Abuse and Mental Health Services Administration (SAMHSA) demonstrated how the federal government can effectively partner at the state and local levels.

The staffs of the NSA and NCCHC are enormously indebted to Project Director and principal author Andrew Klein, PhD, of the Advocates for Human Potential, Inc. No other expert in the country knows more about the application of medication-assisted treatment (MAT) in correctional settings than Dr. Klein. He contributed his expertise, ideas, and suggestions about how to improve access to MAT and made substantial contributions to the design and early drafts of this document.

Through his thoughtful engagement and input of the project partners, Dr. Klein brought to life a document that will be of significant service to the field. In addition, special recognition goes to Jennie M. Simpson, PhD, Office of Policy, Planning, and Innovation, SAMHSA, who provided invaluable technical knowledge and input. A third crucial contributor is Kevin Fiscella, MD, MPH, an addiction medicine expert who serves on the NCCHC board of directors; he is a professor in the department of family medicine at University of Rochester, New York.

The NSA and NCCHC are grateful to the members and staff of the organizations that composed the roundtable discussion and provided a bedrock of strategic expertise: the American Probation and Parole Association, the National Association of Counties, the American Jail Association, the National Association of Drug Court Professionals, the Massachusetts Sheriffs' Association, the California State Sheriffs' Association, the Texas Sheriffs' Association, the Rhode Island Department of Corrections, the Kentucky Department of Corrections, the American Society of Addiction Medicine, the National Governors Association, the Council of State Governments Justice Center, The Pew Charitable Trusts, New York University School of Medicine, and Sam Houston State University.

Finally, the NSA and NCCHC staffs and project partners thank the many correctional, addiction, and mental health professionals who strive daily to provide a better quality of life to people in their charge. Their devotion to providing the best possible services to people with substance use disorders can enhance the security and the well-being of our communities. It is for them that this document has been written.

WHAT'S IN IT FOR ME AS A CRIMINAL JUSTICE EXECUTIVE?

Medication-assisted treatment (MAT), utilizing the U.S. Food and Drug Administration (FDA)-approved medications methadone, buprenorphine, or naltrexone, is considered a central component of the contemporary standard of care for the treatment of individuals with opioid use disorders (OUDs).¹ It may also be used for individuals with co-occurring mental illnesses, in consultation with a physician.

Two-thirds of people in jail meet the criteria for drug dependence or abuse.

—Bureau of Justice Statistics

Evidence strongly supports that the use of MAT increases the likelihood of successful treatment for individuals with OUDs² and reduces morbidity and mortality. Research has begun to show that adding MAT to the treatment of those involved in the criminal justice system confers the same benefits and also reduces recidivism.³

These findings are particularly relevant for criminal justice decision makers—including sheriffs and corrections department officials—given that Bureau of Justice Statistics

surveys found that nearly two-thirds (63 percent) of people in jail meet criteria for drug dependence or abuse. Many of these individuals have OUDs and could benefit from access to MAT, a combination of behavioral interventions and medications that have been shown to decrease opioid use, increase treatment retention, reduce overdose, and reduce criminal activity.⁴

By thoughtfully and carefully including MAT, when appropriate, as a tool in the range of jail-based treatment options, the value proposition to criminal justice executives may include:

- Stemming the cycle of arrest, incarceration, and release associated with substance use disorders (SUDs), as individuals with SUDs return to the community without connection to treatment.
- Contributing to the maintenance of a safe and secure facility for inmates and staff.
- Reducing costs: Comprehensive drug treatment programs in jails are associated with reduced system costs.⁵ According to the 2018 Substance Abuse and Mental Health Services Administration (SAMHSA) TIP 63: Medications for Opioid Use Disorders, “Data indicate that medications for OUD are cost effective and cost beneficial.”⁶



Medication-assisted treatment (MAT)—utilizing the FDA-approved medications methadone, buprenorphine, or naltrexone—is considered a central component of the contemporary standard of care for the treatment of individuals with opioid use disorders.

Most important, MAT can help rebuild and save the lives of those with substance use disorders:

- By facilitating continued access to MAT for individuals who are on prescribed FDA-approved MAT, correctional agencies can minimize the risk of postrelease overdose and death. For individuals with OUDs who were not receiving MAT prior to arrest, correctional facilities can offer MAT prior to release, taking into account individual preferences and clinician judgment. Importantly, facilities should offer all three MAT options.
- When MAT is not feasible (e.g., the individual is facing transfer to a facility that does not offer MAT), FDA-approved medications (e.g., methadone or buprenorphine) should be used to provide medically managed opioid withdrawal.
- Considering that the criminal justice system is the largest source of organizational referrals to addiction treatment,⁷ justice leaders have a unique and valuable opportunity to facilitate the path to recovery.

Notwithstanding the increasing evidence and formal support from many prominent public health and public safety organizations (including the NSA and NCCHC), substance use treatment providers—both inside and outside of the criminal justice system—have been slow to add MAT to their treatment regimens. In 2011, the Washington County, Maryland, jail became the first to introduce MAT for nonpregnant women and for men. Other county jails and state departments of corrections (DOCs) in Missouri, Pennsylvania, and Massachusetts followed suit.

However, as of January 2018, 20 state DOCs did not offer MAT in their drug treatment programs for incarcerated individuals beyond limited methadone maintenance for pregnant women. Out of several thousand local and county jails, fewer than 200 in 30 states provide MAT, and the protocol is primarily limited to the provision of injected naltrexone immediately before individuals are released back into the community. Jails that provide MAT for pregnant women typically discontinue it postpartum, although this is not the recommended standard of medical care (C. Sufrin, personal communication, September 27, 2018).

RESOURCE GOAL

A main goal of this resource is to support and inform institutional and community corrections leaders and personnel as they consider MAT for individuals with SUDs at various stages of engagement with the criminal justice system: pre- and posttrial and upon reentry, with or without supervision. While evidence-based findings on MAT programs specifically for this population continue to grow, the contents of this resource are based on the currently available research on MAT and the use of MAT in correctional settings, programming for SUD across the criminal justice system, and, most important, the experiences of expert justice leaders and practitioners who have pioneered the application of MAT in these agencies and institutions. (See *Appendix III: Advisory Roundtable Membership* for the roster of experts who contributed time, talents, and guidance to this resource.)

HOW TO USE THIS RESOURCE

To advance informed consideration and support for the appropriate use of jail-based MAT, this document includes the following:

- **An overview** of general tenets and best practices associated with developing, implementing, and sustaining a jail-based MAT program. This outline of key issues and questions is well-suited for a quick read by criminal justice executives.
- **A deeper exploration of the topics** highlighted in the overview, including existing standards, related guidelines, and examples from the field. While suitable for (and hopefully of interest to) the range of readers, given the sometimes technical and detailed nature of the content, this section may be most appropriate for MAT program developers and practitioners involved in hands-on activities.
- **Programs in action**, providing a window into several real-world, jail-based MAT programs, including outcomes and lessons learned.
- **Tools, treatment programs, references, and supporting documentation** related to MAT.

BEST PRACTICES AND GUIDELINES FOR JAIL-BASED MEDICATION-ASSISTED TREATMENT

CLIENT ENROLLMENT IN A JAIL-BASED MAT PROGRAM

- ALL INDIVIDUALS ENTERING A JAIL SHOULD BE SYSTEMATICALLY SCREENED FOR SUBSTANCE USE DISORDERS, INCLUDING ANY HISTORY OF ALCOHOL/SEDATIVE OR OPIOID WITHDRAWAL.
- THE DECISION TO OBTAIN MEDICATION FOR OPIOID OR ALCOHOL USE DISORDERS, AND THE SPECIFIC MEDICATION CHOSEN, SHOULD BE THE INDIVIDUAL'S, AFTER CONSULTATION WITH MEDICAL AND TREATMENT PROVIDERS, NOT IMPOSED BY A JUSTICE OR TREATMENT AGENCY.
- INDIVIDUALS SHOULD BE CLINICALLY ASSESSED BY A QUALIFIED TREATMENT PROVIDER TO DETERMINE WHETHER MAT IS CLINICALLY INDICATED.

THE CORRECT MEDICATION, DOSAGE, AND LENGTH OF TREATMENT DETERMINED FOR A CLIENT IN MAT

- ASSISTING INDIVIDUALS WITH CHOOSING THE MEDICATION THAT IS RIGHT FOR THEM REQUIRES SHARED DECISION MAKING.
- CERTAIN WIDELY AGREED-UPON CONSIDERATIONS SHOULD BE DISCUSSED AND CONSIDERED PRIOR TO DETERMINING THE APPROPRIATE MEDICATION (OR SWITCHING MEDICATIONS), DOSAGES, AND LENGTH OF TREATMENT.
- CLIENTS SHOULD BE ROUTINELY TESTED TO ENSURE RECEIPT OF THE APPROPRIATE PRESCRIBED DOSAGE OF MEDICATIONS.

MAT FOR PREGNANT WOMEN

- PREGNANT WOMEN WITH OPIOID AND ALCOHOL USE DISORDERS REQUIRE SPECIALIZED SERVICES TO PREVENT AND REDUCE HEALTH RISKS DURING PREGNANCY.

MEDICATION ALONE IS NOT THE ANSWER: THE FORCE MULTIPLIER OF PARTNERSHIPS AND SUPPORT SERVICES

- FOR MAXIMUM BENEFITS IN THE TREATMENT OF OPIOID AND ALCOHOL USE DISORDERS, COUPLE MAT WITH COUNSELING AND THE APPROPRIATE WRAPAROUND SERVICES.
- JAILS IMPLEMENTING COMPREHENSIVE MAT PROGRAMS—AND THE CLIENTS THEY SERVE—WILL BENEFIT FROM COLLABORATIVE RELATIONSHIPS WITH COMMUNITY-BASED TREATMENT, MAT, AND OTHER BEHAVIORAL HEALTH PROVIDERS.

MAT PROGRAM COMPONENTS: ASSEMBLING THE RIGHT TEAM, SAFEGUARDS, PROTOCOLS, AND STRUCTURE FOR A SUCCESSFUL JAIL-BASED PROGRAM

- CORRECTIONAL STAFF SHOULD RECEIVE TRAINING AND EDUCATION ABOUT MAT.
- RESIDENTIAL CORRECTIONAL FACILITIES, AS WELL AS COMMUNITY TREATMENT PROVIDERS, SHOULD HAVE SPECIFIC SAFEGUARDS TO PREVENT THE DIVERSION OF AGONIST MEDICATIONS⁸ (FOR EXAMPLE, METHADONE) AND TO SAFEGUARD PARTICIPATING INDIVIDUALS.
- COMMUNITY-BASED TREATMENT AND MEDICATION PROVIDERS SHOULD BE CAREFULLY SELECTED. CORRECTIONAL AGENCY COLLABORATION MAY BE REQUIRED TO ENCOURAGE PROVIDERS TO MEET THE NEEDS OF REFERRED INDIVIDUALS.
- CORRECTIONAL PERSONNEL SHOULD REFER CLIENTS TO PRESCRIBING PROVIDERS AND OTHER TREATMENT PROVIDERS WHO HAVE THE REQUIRED CERTIFICATION AND ARE KNOWLEDGEABLE ABOUT ADDICTION, SUBSTANCE ABUSE, OR BEHAVIORAL HEALTH PROGRAMS, AND THE ROLE OF MEDICATION IN SUBSTANCE USE TREATMENT.
- THERE ARE PRETRIAL AND POSTTRIAL MAT PROGRAMS.

THE IMPORTANCE OF CLIENT SCREENING TO ADDRESS TREATMENT CONTINUATION, WITHDRAWAL, AND RELAPSE

- SYSTEMS SHOULD BE IN PLACE TO ENSURE CONTINUATION OF METHADONE OR BUPRENORPHINE WHEN APPROPRIATE.
- MEDICALLY MANAGED WITHDRAWAL PROTOCOLS SHOULD BE IN PLACE TO SUPPORT SCREENING FOR WITHDRAWAL SEVERITY AND POLYSUBSTANCE USE, MONITORING, AND MEDICAL MANAGEMENT OF SYMPTOMS.
- JAIL MAT PROGRAMS SHOULD INCLUDE ONGOING MONITORING THROUGH DRUG SCREENING AND OTHER DIVERSION/RISK MITIGATION STRATEGIES.

ENGAGING MEDICAID AND POSTRELEASE FINANCIAL ASSISTANCE

- JAILS FACILITATING MAT SHOULD ENGAGE THEIR STATE MEDICAID AGENCIES AND OTHER PUBLIC PAYERS TO FACILITATE HEALTH CARE COVERAGE.

BEST PRACTICES AND GUIDELINES FOR JAIL-BASED MEDICATION-ASSISTED TREATMENT

CLIENT ENROLLMENT IN A JAIL-BASED MAT PROGRAM

ALL INDIVIDUALS ENTERING A JAIL SHOULD BE SYSTEMATICALLY SCREENED FOR SUBSTANCE USE DISORDERS, INCLUDING ANY HISTORY OF ALCOHOL/SEDATIVE OR OPIOID WITHDRAWAL.

Receiving screening should be conducted immediately upon acceptance into jail custody. Screeners should explain the reason for the questions, e.g., “We ask these questions to ensure you receive appropriate treatment while you are here.” Questions should address physical and mental health, prescribed medications including MAT, previous drug or alcohol treatment, recent drug or alcohol use including types and amount, and current or past history of drug or alcohol withdrawal. Individuals showing evidence of intoxication or who report MAT or past or current drug or alcohol use should be referred to medical for further evaluation.

THE DECISION TO OBTAIN MEDICATION FOR OPIOID OR ALCOHOL USE DISORDERS, AND THE SPECIFIC MEDICATION CHOSEN, SHOULD BE THE INDIVIDUAL’S, AFTER CONSULTATION WITH MEDICAL AND TREATMENT PROVIDERS, NOT IMPOSED BY A JUSTICE OR TREATMENT AGENCY.

FDA-approved MAT medications vary, as do their impact, and they are available through different channels and administered in different manners. Options should be tailored and individualized, and individuals should receive complete information to make informed decisions in consultation with a medical and treatment team.

INDIVIDUALS SHOULD BE CLINICALLY ASSESSED BY A QUALIFIED TREATMENT PROVIDER TO DETERMINE WHETHER MAT IS CLINICALLY INDICATED.

When the results of an appropriately administered needs assessment indicate that an individual needs treatment (and that treatment can be provided), law enforcement officers, probation and parole agents, judges, and correctional officers do not determine the clinical needs of the individual.

RELATED PROFESSIONAL GUIDELINES

The American Society of Addiction Medicine (ASAM) advises physicians treating patients with opioid use disorders that “(t)he choice of available treatment options for addiction involving opioid use should be a shared decision between clinician and patient.” ASAM continues: “Clinicians should consider the patient’s preferences, past treatment history, and treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone in the treatment of addiction”⁹

In accordance with federal law (21 CFR §1306.07), office-based opioid treatment (OBOT), which provides medication on a prescribed weekly or monthly basis, is limited to buprenorphine. Clinicians should consider a patient’s psychosocial situation, co-occurring disorders, and risk of diversion when determining whether an opioid treatment program or OBOT is most appropriate. OBOT may not be suitable for patients with active alcohol use disorder or sedative, hypnotic, or anxiolytic use disorder (or those who are in treatment for addiction involving the use of alcohol or other sedative drugs, including benzodiazepines or benzodiazepine receptor agonists). It also may be unsuitable for persons who regularly use alcohol or other sedatives but do not have addiction or a specific substance use disorder related to that class of drugs. The prescribing of benzodiazepines or other sedative-hypnotics should be used with extreme caution in patients who are prescribed methadone or buprenorphine for the treatment of an opioid use disorder.



This is particularly important when it comes to prescribing medications, including those for alcohol and OUDs. All medications carry different risks and benefits for different individuals; treatment decisions, including medication, should be based on what has been proven to work and what is most likely to benefit the individual patient.

Clinical assessments for MAT begin with a general assessment for SUDs. Such assessments allow tailoring of treatment to a person's withdrawal symptoms, often helping to reduce the amount of medication needed. Several instruments have been developed for such purposes:

- The **Clinical Opiate Withdrawal Scale (COWS)**, an 11-item scale, is used to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.¹⁰
- The **Clinical Institute Withdrawal Assessment of Alcohol Scale**, revised (CTWA-Ar),¹¹ a five-item scale, is used to measure symptoms of alcohol withdrawal.
- The Rand Corporation-developed **Procedures for Medication-Assisted Treatment of Alcohol or Opioid Dependence in Primary Care** for NIDA¹² includes scales for opiate dependence (pp. 75–77) and alcohol dependence (pp. 24–25), which describe the symptoms associated with these use disorders. The RAND publication was revised when the DSM-5 replaced the DSM-IV criteria for these disorders to indicate that its scales could still be used to assess the appropriateness of treatment. The Rand publication also includes sample checklists for pre-injection naltrexone for alcohol use disorder (p. 15) and pre-initiation of buprenorphine/naloxone (p. 65). The former includes, for example, “Patient is motivated to reduce or stop alcohol use” (p. 15). The latter includes, for example, “perform a urine drug screen (expect positive for opioid[s] but be cautious if positive for benzodiazepines)” (p. 65).
- **Texas Christian University (TCU) Drug Screen V** is an updated version of the TCU Drug Screen II and is also based on the DSM-5. The TCU Drug Screen V screens for mild to severe substance use disorder and is particularly useful when determining an individual's placement and level of

care in treatment.¹³ The TCU Drug Screen V also has an opioid supplement to identify the needs of people with opioid use disorders and the specific risk of an overdose that a person may be facing.

THE CORRECT MEDICATION, DOSAGE, AND LENGTH OF TREATMENT DETERMINED FOR A CLIENT IN MAT

ASSISTING INDIVIDUALS WITH CHOOSING THE MEDICATION THAT IS RIGHT FOR THEM REQUIRES SHARED DECISION MAKING.

No one medication will guarantee that an individual will sustain long-term recovery from opioid or alcohol use disorders, and there are currently no definitive guidelines to reliably match an individual to the optimal medication.¹⁴ Nor is there a set period during which any of the medications must be taken to correlate with long-term recovery. The medication and the length of its use must be matched to the needs of the individual. The decision about which medicine is best for which person should be made jointly among the individual, a physician or medical provider, and a treatment provider or knowledgeable counselor.

However, correctional withdrawal alone actually increases the chances the person will overdose following community release due to loss of opioid tolerance.¹⁵ For this reason, all individuals with OUD should be considered for MAT. Both methadone and buprenorphine have been shown to reduce mortality.¹⁶ In addition, all persons with OUD should be offered naloxone (Narcan) kits that can be used to reverse an overdose.¹⁷

Before any specific medication is considered, the individual needs to be assessed. The person should then be introduced to the full array of FDA-approved medications and the rules that govern how each is obtained and used, as well as the need for accompanying treatment, support, and appropriate services. All potential adverse reactions to the medications should be fully disclosed, including consequences of continued drug use. It is important that the potential adverse consequences be presented in a manner and with a vocabulary that the individual can understand. This may require alternative or supplementary explanations by persons other than physicians.

It should also be explained that agonist medications—i.e., buprenorphine and methadone—cannot be abruptly discontinued, unlike naltrexone. Although the length of time that treatment with medication is required needs to be individualized, generally individuals should be advised that relapse can occur if the medication is stopped too soon.

A physical examination to determine general health is also part of the assessment.¹⁸ The physical exam should include a drug test and tests for medical conditions, including tuberculosis and liver conditions. People who use drugs are at a high risk of contracting HIV, hepatitis, and other diseases.



After the assessment, the physician and the patient should discuss the best course of treatment, including which medication the patient should take and what dosage may be appropriate. Substance abuse counselors, or, with permission, close family members or friends may be valuable participants in treatment planning, monitoring, and support. Because the number of MAT providers is limited, especially in rural communities, not all FDA-approved medications may be available to all individuals in the community.

Oral naltrexone for the treatment of OUDs is often adversely affected by poor medication adherence. Clinicians should reserve its use for patients who are able to comply with special strategies to enhance their adherence (for example, observed dosing). Extended-release injectable naltrexone reduces, but does not eliminate, issues with medication adherence. It should be noted that individuals may be provided with oral naltrexone for several days prior to injections of naltrexone to ensure that there are no negative reactions to the medication, although this practice is not advised or required by the FDA. Of the medications on the market, the least amount of research is available for naltrexone. Two recent studies have found that once individuals have their first injection of naltrexone, their retention and relapse rates are the same as those taking buprenorphine with naloxone; however, they are more likely to initially balk at the treatment than those who sign up for buprenorphine,¹⁹ in part because of the need for a 7- to 14-day medically supervised withdrawal before starting naltrexone.

CERTAIN WIDELY AGREED-UPON CONSIDERATIONS SHOULD BE DISCUSSED AND CONSIDERED PRIOR TO DETERMINING THE APPROPRIATE MEDICATION (OR SWITCHING MEDICATIONS), DOSAGES, AND LENGTH OF TREATMENT.

OUD medications include the following:

METHADONE

Methadone is recommended for patients who are physiologically dependent on opioids, are able to give informed consent, and have no specific contraindications for agonist treatment, including the taking of benzodiazepines, when prescribed in the context of an appropriate plan that includes psychosocial intervention. Electrocardiograms can be done on patients prior to starting methadone to prevent risk

of sudden death in those with a prolonged QT (required time for ventricular and repolarization) interval.

The usual daily dose of methadone ranges from 60 to 120 milligrams (mg). Some patients may respond to lower doses, and some patients may need higher doses.

Methadone can be prescribed only by licensed opioid treatment programs. While some jails have obtained OTP licenses, most will need to partner with a community-based OTP. There are two exceptions to DEA methadone regulations. First, methadone may be dispensed daily for up to three days for the purpose of ensuring treatment continuity (e.g., the community OTP is closed on weekends or the individual is serving weekends). The second exception applies to correctional facilities that are “licensed by both the state and DEA as a clinic, a hospital, or a hospital/clinic.” These licensed facilities may use methadone when needed to effectively treat medical conditions, psychiatric conditions, alcohol withdrawal, or pregnancy. However, few correctional facilities have such clinic/hospital licenses.²⁰

BUPRENORPHINE

Buprenorphine is recommended for opioid-dependent patients and can be prescribed outside of OTPs by physicians, nurse practitioners, and physician assistants who have obtained buprenorphine licenses (also called “waivers”).²¹

Individuals should wait until they are experiencing moderate opioid withdrawal before taking the first dose to reduce the risk of precipitated withdrawal. Generally, buprenorphine initiation should occur at least 6 to 12 hours after the last use of heroin or other short-acting opioids or 24 to 72 hours after the last use of long-acting opioids such as methadone. Home-based induction is recommended only if the patient or prescribing physician is experienced with the use of buprenorphine.

Buprenorphine doses after induction and titration should be, on average, ≥ 8 mg per day. The FDA approves dosing to a limit of 24 mg per day, but there is limited evidence regarding the relative efficacy of higher doses. In addition, the use of higher doses may increase the risk of diversion.

Buprenorphine tapering and discontinuation is a slow process, and close monitoring is recommended. Buprenorphine tapering is generally accomplished over several months.

When a switch from buprenorphine to naltrexone is being considered, 7 to 14 days should elapse between the last dose of buprenorphine and the start of naltrexone to ensure that the patient is not physically dependent on opioids prior to starting naltrexone.

When a switch from buprenorphine to methadone is being considered, there is no required time delay because this switch does not typically result in any type of adverse reaction.

Patients who discontinue agonist therapy and resume opioid use should be made aware of the risks.



SWITCHING FROM METHADONE TO BUPRENORPHINE

Some correctional institutions may not be equipped to provide methadone, which may require switching individuals from methadone to buprenorphine with or without naloxone. Individuals with OUDs can safely be switched from methadone to buprenorphine maintenance. According to SAMHSA's *Quick Guide for Physicians: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*:

Induction of patients from long-acting opioids (e.g., methadone) onto buprenorphine should be managed by physicians experienced with the procedure. Patients taking methadone should have their dose tapered to 30 mg or less per day for at least 1 week before buprenorphine induction. Twenty-four hours must elapse between the final dose of methadone and the first dose of buprenorphine. The first dose of buprenorphine should be 2 mg of monotherapy. A second 2 mg dose can be given and repeated up to 8 mg per day if signs of withdrawal appear.

The guide goes on to chart the steps in the induction from Day 2 and forward. When an individual has no withdrawal symptoms, minimal side effects, and no uncontrollable cravings, he or she is considered stabilized. During stabilization (1 to 2 months), adjustments in the dose and frequent physician–patient contact help establish the proper level of medication. Until full stabilization is achieved, weekly assessments are indicated. Doses of buprenorphine/naloxone may be increased in 2/0.5–4/1 mg increments until stabilization is achieved. Nearly all patients stabilize on daily doses of 16/4–24/6 mg; some may require up to 32/8 mg daily. The maintenance phase follows.

The same SAMHSA guide advises that “(a)ppropriate dosages of buprenorphine are more effective than low dosages (20–35 mg) of methadone. A buprenorphine dosage of 8–16 mg/day is equivalent to about 60 mg/day of methadone.”

The *ASAM Practice Guidelines* highlights the following:

“Patients switching from methadone to buprenorphine in the treatment of opioid use disorder should be on low doses of methadone before switching medications. Patients on low doses of methadone (30 to 40 mg per day or less) generally tolerate transition to buprenorphine with minimal discomfort, whereas patients on higher doses of methadone may experience significant discomfort when switching medications. Generally, buprenorphine initiation should occur at least 6 to 12 hours after the last use of heroin or other short-acting opioids or 24 to 72 hours after their last use of long-acting opioids such as methadone. Buprenorphine doses after induction and titration should be, on average, at least 8 mg per day. The FDA approves dosing to a limit of 24 mg per day, and there is limited evidence regarding the relative efficacy of higher doses. In addition, the use of higher doses may increase the risk of diversion.”²²

NALTREXONE

Naltrexone is a recommended treatment for preventing the relapse of OUDs. Naltrexone does not require a special license to prescribe. Oral formula naltrexone may be considered for patients where adherence can be supervised or enforced. Extended-release injectable naltrexone may be more suitable for patients who cannot be observed or supported when taking their medication daily.

There is no recommended length of treatment with oral naltrexone or extended-release injectable naltrexone. The duration depends on clinical judgment and the patient's circumstances. Because there is no physical dependence associated with naltrexone, it can be stopped abruptly without withdrawal symptoms. Importantly, patients should be informed that discontinuation of naltrexone is associated with enhanced sensitivity to opioids and heightened risk of overdose. The FDA warning label for extended release naltrexone states: “It is important that patients inform family members and the people closest to the patient of this increased sensitivity to opioids and the risk of overdose.”²³

Switching from naltrexone to methadone or buprenorphine should be planned, considered, and monitored. Switching from an antagonist such as naltrexone to a full agonist (methadone) or a partial agonist (buprenorphine) is generally less complicated than switching from a full or partial agonist to an antagonist, because there is no physical dependence associated with antagonist treatment and, thus, no possibility of precipitated withdrawal. Patients being switched from naltrexone to buprenorphine or methadone will not have a physical dependence on opioids; therefore, the initial doses of methadone or buprenorphine should be low.

A patient should not be switched until a significant amount of naltrexone is no longer in his or her system. This requires a 1-day wait for oral naltrexone and a 30-day wait after a naltrexone injection.

WHAT THE RESEARCH SUGGESTS REGARDING DIFFERENT OPIOID MEDICATIONS

A Cochrane study of 31 experimental trials of high to moderate quality involving 5,430 participants examined the use of buprenorphine compared with a placebo and then compared it with methadone. The authors concluded the following:

Buprenorphine is an effective medication in the maintenance treatment of heroin dependence, retaining people in treatment at any dose above 2 mg, and suppressing illicit opioid use (at doses of 16 mg or greater) based on placebo-controlled trials.

However, compared with methadone, buprenorphine retains fewer people when doses are flexibly delivered and at low fixed doses. If fixed medium or high doses are used, buprenorphine and methadone appear no different in effectiveness (retention in treatment and suppression of illicit opioid use); however, fixed doses are rarely used in clinical practice so the flexible dose

results are more relevant to patient care. Methadone is superior to buprenorphine in retaining people in treatment, and methadone equally suppresses illicit opioid use.²⁴

Studies have also compared the mortality risk in and out of treatment with methadone and buprenorphine. Researchers examined 19 eligible cohorts, following 122,885 people treated with methadone over 1.3 to 13.9 years and 15,831 people treated with buprenorphine over 1.1 to 4.5 years.

Overdose mortality evolved similarly, with pooled overdose mortality rates of 2.6 and 12.7 per 1,000-person years in and out of methadone treatment (unadjusted out-to-in rate ratio 4.80, 2.90 to 7.96) and 1.4 and 4.6 in and out of buprenorphine treatment.

The authors concluded:

Retention in methadone and buprenorphine treatment is associated with substantial reductions in the risk of all cause and overdose mortality in people dependent on opioids. The induction phase onto methadone treatment and the time immediately after leaving treatment with both drugs are periods of particularly increased mortality risk²⁵

There have been far fewer studies of naltrexone use. One national study found that use of oral naltrexone was associated with higher risk of mortality than methadone.²⁶ A 2017 study was conducted to evaluate the long-term safety, tolerability, and treatment outcomes of injectable naltrexone. The small study of fewer than 49 screened opioid-dependent individuals screened by health care professionals concluded that "(l)ong-term (2 years) (of injections) was associated with no new safety concerns . . ." The NIDA study described above of a larger sample found that "(a)ll recorded overdose events, fatal or nonfatal, occurred among participants assigned to usual treatment (0 events in the extended-release naltrexone group vs. 5 in the usual-treatment group from week 0 to 25, $p=0.10$; 0 vs. 7 events from week 0 to 78, $p=0.02$); no overdoses occurred in the extended-release naltrexone group after discontinuation of the agent."²⁷ A recent study compared use of methadone, buprenorphine, and extended-release naltrexone among patients who had previously survived an overdose.²⁸ Findings showed that use of methadone or

buprenorphine was associated with reduction in death, but the use of naltrexone was not. Small numbers and inclusion of both oral and injectable naltrexone limit firm conclusions regarding this drug's effect on mortality.

Only two studies have compared buprenorphine and injectable naltrexone, as mentioned previously. Both found that, once begun, the medications were equally effective in terms of retention over 6 months. The larger NIDA study found that "a monthly shot of naltrexone (sold as Vivitrol) is as effective as its main competitor, the daily pill of buprenorphine and naloxone (sold as Suboxone)." Researchers found that about half of the people with opioid addiction who took either drug remained free from relapse 6 months later. However, because naltrexone required abstinence for 7 to 10 days, 28 percent of those assigned naltrexone did not follow through and receive their first injections. For those who did, 52 percent subsequently relapsed, as opposed to 56 percent who relapsed on buprenorphine with naloxone.²⁹ As previously noted, the ASAM National Practice Guideline states:

Oral naltrexone for the treatment of opioid use disorder is often adversely affected by poor medication adherence. Clinicians should reserve its use for patients who would be able to comply with special techniques to enhance their adherence, for example, observed dosing. Extended release injectable naltrexone reduces, but does not eliminate, issues with medication adherence.

LENGTH OF TREATMENT

Research indicates that the length of time an individual should spend on medication varies and needs to be reassessed with the medical staff, considering the individual's medical history and situation. Opioid use disorder is a chronic condition representing alterations in brain function.³⁰ Relapse rates are common and often fatal. Long-term MAT is often required in the same way that long-term medications are needed for other chronic conditions such as diabetes or high blood pressure.

Both SAMHSA³¹ and ASAM³² have suggested guidelines for determining when and how medication should be discontinued. The latter, for example, concludes that there is no recommended time limit for treatment with buprenorphine, methadone, or naltrexone. It advises, however, that "buprenorphine taper and discontinuation is a slow process and close monitoring is recommended." Further, discontinuation is generally accomplished over several months and "patients and clinicians should not take the decision to terminate treatment with buprenorphine lightly" (p. 34). Similarly, ASAM holds that "the optimal duration of treatment with methadone has not been established; however, it is known that relapse rates are high for most patients who drop out; thus, long-term treatment is often needed" (p. 30). For both oral and injectable naltrexone, ASAM concludes that the duration of treatment should depend on the response of the individual patient, the patient's individual circumstances, and clinical judgment (p. 37).



RELATED FEDERAL GUIDELINES

Federal Guidelines for Agonist Maintenance in Opioid Treatment Program (OTP) Settings

- 1. Maintenance treatment.** An OTP shall maintain current procedures designed to ensure that patients are admitted to maintenance treatment by qualified personnel who have determined, using accepted medical criteria such as those listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, that a person is currently addicted to an opioid drug and that the person became addicted at least 1 year before admission for treatment. In addition, a program physician shall ensure that each patient voluntarily chooses maintenance treatment, that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient, and that each patient provides informed written consent to treatment.
- 2. Maintenance treatment for persons under age 18.** A person under 18 years of age is required to have had two documented unsuccessful attempts at short-term medical withdrawal (detoxification) or drug-free treatment within a 12-month period to be eligible for methadone maintenance treatment. No person under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment.
- 3. Maintenance treatment admission exceptions.** If clinically appropriate, the program physician may waive the requirement of a 1-year history of addiction . . . for patients released from penal institutions with a documented history of opioid use disorder (within 6 months after release), for pregnant patients (program physician must certify pregnancy), and for previously treated patients (up to 2 years after discharge).
- 4. Medically managed withdrawal treatment.** An OTP shall maintain current procedures that are designed to ensure that patients are admitted to short- or long-term medically managed withdrawal by qualified personnel, such as a program physician, who determines that such treatment is appropriate for the specific patient by applying established diagnostic criteria. Patients with two or more unsuccessful medically managed withdrawal episodes within a 12-month period must be assessed by the OTP physician for other forms of treatment. A program shall not admit a patient for more than two medically managed withdrawal treatment episodes in one year.

Data show that treatment retention is reduced when patients are tapered off MAT prematurely.³³ For some patients, MAT could be indefinite.³⁴ NIDA describes addiction medication as an “essential component of an ongoing treatment plan” to enable individuals to “take control of their health and their lives.”³⁵ For methadone maintenance, 12 months of treatment is the minimum, according to NIDA.³⁶

The first long-term follow-up of patients treated with buprenorphine/naloxone for addiction to opioid pain relievers found that half were abstinent at 18 months after starting therapy. After 3 ½ years, the number reporting abstinence rose to 61 percent. At each follow-up interview, patients who were currently receiving the medication were much more likely to report abstinence compared with those not taking medication. Only 6.6 percent of the patients maintained abstinence after a brief course of medication (2 weeks of medication, 2 weeks to taper off, and 2 months follow-up). Those who relapsed during this phase were provided with 12 weeks of medication followed by 4-week tapering and 2-month follow-up. Nearly half of these patients achieved abstinence during their last 4 weeks; however, fewer than 10 percent were still doing well at the end of the 2-month follow-up. At 18 months, 30 months, and 42 months, patients who were engaged in MAT had markedly higher odds of positive outcomes. At 42 months, the advantage associated with MAT had narrowed but was still large, 79.6 percent abstinence versus 50.8 percent abstinence. During the study, patients reported abstinence only for the prior 30-day period. Many who relapsed reentered MAT and then were able to remain abstinent for at least the 30 days at reporting periods.³⁷

After piloting the use of injected naltrexone, the Pennsylvania Department of Corrections’ MAT program, which initially recommended 6 months of injections, now recommends a full year of injections. A study of individuals involved in the criminal justice system provided with injected naltrexone for 6 months found that those receiving the injections had significantly fewer relapse events, a higher rate of opioid-negative urines, and less-serious adverse events, including fatal and nonfatal overdoses, than those engaged in abstinence-only treatment. However, those treated with 6 months of naltrexone injections had outcomes similar to those not treated after a year. This suggests that more than 6 months of injections may be indicated for longer-term abstinence.³⁸

ALCOHOL USE DISORDER

Three drugs are approved by the FDA to treat alcohol use disorder (AUD): disulfiram, acamprosate, and naltrexone. An Agency for Healthcare Research and Quality review of 167 studies of medical treatment of AUD in outpatient settings found evidence to support the use of naltrexone and acamprosate, but insufficient evidence to support the use of disulfiram.³⁹ Specific to incarcerated populations, there is less research available on the use of MAT for alcohol use disorder, except for a few older studies on the use of disulfiram during community supervision.

- **Disulfiram:** Although disulfiram has been in use for many years, it is no longer considered a first-line treatment choice. Its action interferes with the breakdown of alcohol by the liver, resulting in adverse physical responses to any intake of alcohol. The National Institute on Alcohol Abuse and Alcoholism clinical guidelines state: “The utility and effectiveness of disulfiram are considered limited because compliance is generally poor when patients are given it to take at their own discretion.”⁴⁰ Its use is limited to highly motivated patients and those who can be directly observed while they take the medication. It is contraindicated for patients who are still drinking. Disulfiram is available only with a prescription.
- **Acamprosate:** Acamprosate can be prescribed by physicians or nurse practitioners and, in some states, by physician assistants and psychologists. Although not all patients respond to acamprosate, research suggests it is more likely to be effective for patients who are abstinent from alcohol before acamprosate is initiated, and it is more likely to benefit patients who intend to abstain from alcohol completely rather than for those who plan to reduce their alcohol use. Acamprosate has been successful in European studies at increasing abstinence rates. It works by relieving some of the anxiety and dysphoria associated with postacute withdrawal from alcohol.
- **Naltrexone:** Systematic reviews show that naltrexone is effective for treating alcohol use disorder. It appears to be comparable to acamprosate.⁴¹



agonist, or an antagonist, by taking other drugs or increasing doses of prescribed medications. If persons try to overcome the blocking effects of naltrexone by ingesting increasing amounts of opioid medications or heroin, they are at a high risk of overdosing. The utilization of drug testing also can ensure that a person is taking medication and not diverting it.

MAT FOR PREGNANT WOMEN

PREGNANT WOMEN WITH OPIOID AND ALCOHOL USE DISORDERS REQUIRE SPECIALIZED SERVICES TO PREVENT AND REDUCE HEALTH RISKS DURING PREGNANCY.

Opioid withdrawal during pregnancy is associated with miscarriage, premature delivery, and other serious complications. The American College of Obstetricians and Gynecologists (ACOG) recommends against opioid withdrawal during pregnancy.⁴⁵ MAT is readily available to stabilize pregnant women with OUDs during pregnancy.

Studies find that women who use substances during pregnancy have elevated risk of early birth, babies with lower birth weights, and more problems during labor and delivery. However, stopping opioids too quickly during pregnancy is also risky. Opioids cross the blood barrier to the developing fetus. If the pregnant woman suddenly quits, the fetus also experiences withdrawal and dangerous complications can result. Children of women treated for OUDs with opioid replacement therapies during pregnancy have improved birth outcomes.⁴⁶

Methadone maintenance for pregnant women is an accepted best practice that has been used safely for years and has been widely researched.⁴⁷ As with any treatment, there are some risks, but they are weighed against the consequences of untreated opioid addiction, including withdrawal and relapse.

Infants exposed to opioids in utero may experience withdrawal symptoms at birth, sometimes severe enough to require medication and delay discharge from the hospital.

MEDICATION DOSAGES

Appropriate doses vary for these medications, except for naltrexone and disulfiram, where the dose is standard. Dosing is an individualized medical decision. In some instances, low doses of methadone, for example, have been found less effective for keeping users in treatment than higher doses.⁴²

CLIENTS SHOULD BE ROUTINELY TESTED TO ENSURE RECEIPT OF THE APPROPRIATE PRESCRIBED DOSAGE OF MEDICATIONS.

SAMHSA's *Federal Guidelines for Opioid Treatment Programs*⁴³ requires programs to “provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient, in maintenance treatment, in accordance with generally accepted clinical practice.”

There are several different ways to test for drugs, including alcohol. As described by ASAM, “Drug tests do not detect drug use in general.” Instead, drug tests identify specific drugs or drug classes as well as drug metabolites in biological matrices that are represented in particular test panels. Drugs can be identified in any matrix; the most common matrices for typical testing purposes include urine, blood, and oral fluid.⁴⁴

Because of the risk of overdose, it is important to ensure that individuals not try to circumvent the stabilizing or blocking effects of their medication, whether it be an agonist, a partial

This condition is known as neonatal abstinence syndrome (NAS). Infants born to mothers treated with methadone or buprenorphine are also at risk of NAS but are less likely to be preterm or have low birth weight. Opioid-exposed infants can be monitored and managed in most hospitals. Women receiving medications are usually encouraged to breastfeed because the benefits greatly outweigh the very small trace amounts of medication that may be found in breast milk.⁴⁸

There are fewer long-term studies of safety and effectiveness of buprenorphine during pregnancy, but some suggest that buprenorphine reduces NAS.⁴⁹ ACOG supports treating pregnant women with buprenorphine if they are already on it or prefer it.⁵⁰ Pregnant women should generally receive only the single-drug formula, without added naloxone.

Women with opioid use disorders who are under community supervision should be referred to treatment providers that offer specialized services for pregnant and postpartum women. They require an intensive level of support after delivery to prevent relapse, and many will benefit from additional services, including parenting skills training and supports or family reunification planning.⁵¹

Pregnant women with alcohol use disorders should receive medically managed withdrawal treatment from alcohol as soon as possible. Fetal alcohol spectrum disorders and fetal alcohol effects occur in a small but significant proportion of babies born to women who drink heavily during pregnancy. Alcohol consumption during the first trimester is a particularly high risk. Because some women who drink heavily during the first trimester may not know they are pregnant, treatment providers should include pregnancy tests if clients are unsure.

In custody settings, women are usually screened for pregnancy on intake, but women with a history of substance use should also be screened for pregnancy in community corrections. All women who come in contact with the criminal justice system should be educated about the risks of substance use during pregnancy, including the provision of tobacco cessation support and services (which all public and private health insurance plans are now required to cover).⁵²



EXISTING STANDARDS AND GUIDELINES

- *A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders*. SAMHSA, 2016. <https://store.samhsa.gov/shin/content//SMA16-4978/SMA16-4978.pdf>
- *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. SAMHSA, 2018. <https://store.samhsa.gov/shin/content//SMA18-5054/SMA18-5054.pdf>
- *Advancing the Care of Pregnant and Parenting Women With Opioid Use Disorder and Their Infants: A Foundation for Clinical Guidance*. SAMHSA, 2016. <https://www.regulations.gov/document?D=SAMHSA-2016-0002-0001>
- *Opioid Use Disorders and Medication-Assisted Treatment in Pregnancy*. National Center on Substance Abuse and Child Welfare, n.d. <https://ncsacw.samhsa.gov/resources/opioid-use-disorders-and-medication-assisted-treatment/default.aspx>
- *Pregnancy and Postpartum Care in Correctional Settings*. Carolyn Sufrin, MD, PhD. Endorsed by the American College of Obstetricians and Gynecologists and should be construed as ACOG clinical guidance. <https://www.ncchc.org/filebin/Resources/Pregnancy-and-Postpartum-Care-2018.pdf>
- *Standards for Health Services in Jails*. National Commission on Correctional Health Care, 2018. <https://www.ncchc.org/jail-prison-standards>
- *Standards for Opioid Treatment Programs in Correctional Facilities*. National Commission on Correctional Health Care, 2016. <https://www.ncchc.org/opioid-treatment-programs-2>
- *State Standards for Pregnancy-related Health Care and Abortion for Women in Prison*. American Civil Liberties Union, 2016. <https://www.aclu.org/state-standards-pregnancy-related-health-care-and-abortion-women-prison-0>





MEDICATION ALONE IS NOT THE ANSWER: THE FORCE MULTIPLIER OF PARTNERSHIPS AND SUPPORT SERVICES

FOR MAXIMUM BENEFITS IN THE TREATMENT OF OPIOID AND ALCOHOL USE DISORDERS, COUPLE MAT WITH COUNSELING AND THE APPROPRIATE WRAPAROUND SERVICES.

All FDA-approved medication for the treatment of substance use disorders is intended to be used in conjunction with counseling and behavioral therapies, although some research has found that providing MAT when counseling is not immediately available (for example, when a patient is on a waiting list) still improves outcomes.⁵³

Treatment programs can include both group and individual counseling to accommodate the diverse needs of participants. Both cognitive behavioral therapy and therapeutic communities have been found to be effective treatment modalities for individuals in correctional facilities.⁵⁴

Most behavioral therapies found to be effective in addressing alcohol and SUDs are for specific drugs of abuse and have been studied primarily in community settings. Their use in correctional settings requires adjustments and modifications. Once such therapies are implemented, it is imperative that justice programs evaluate whether they have maintained fidelity to the essential elements of the treatments found to be effective and that the program, as modified and implemented, achieves results commensurate with those found in the research.

Many programs have found manualized treatment interventions to be effective, offering structure and consistency. They are also easy to use and can help focus sessions (although implementation should guard against over-restrictiveness), and counselors need to incorporate personal style and creativity in their use.⁵⁵ The quality of the interpersonal relationships between staff members and participants, along with the skills of the staff, are as important to risk reduction as the specific programs in which individuals participate.⁵⁶

In addition to access to appropriate medication, the SAMHSA Federal Guidelines for Opioid Treatment Programs requires the following considerations in assessing client treatment and services: (1) Each patient accepted for treatment at an opioid treatment program shall be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment. (2) The initial assessment must include preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psychosocial, economic, legal, or other supportive services that a patient needs. (3) The treatment plan also must identify the frequency with which these services are to be provided. (4) The plan must be reviewed and updated to reflect the patient's personal history; his or her current needs for medical, social, and psychological services; and his or her current needs for education, vocational rehabilitation, and employment services.⁵⁷

Inadequately treated substance use disorder is a key risk factor for recidivism. A best practice includes treatment that also addresses recidivism risk factors.

The concept of RNR [risk-need-responsivity] is considered a best practice for corrections professionals⁵⁸ and has been shown to effectively reduce recidivism by as much as 35 percent in certain settings.⁵⁹ Research has shown that non-adherence to the RNR principles in service delivery is not only ineffective but can also be detrimental to offender treatment outcomes.⁶⁰

One study examining the effectiveness of treatment programs reported a substantial negative correlation ($r = -.28$) between risk level and treatment effect size for a program that did not adhere to RNR principles.⁶¹

JAILS IMPLEMENTING COMPREHENSIVE MAT PROGRAMS—AND THE CLIENTS THEY SERVE—WILL BENEFIT FROM COLLABORATIVE RELATIONSHIPS WITH COMMUNITY-BASED TREATMENT, MAT, AND OTHER BEHAVIORAL HEALTH PROVIDERS.

By maintaining collaboration and regular communication, the jail and the treatment providers can work together to optimize success and enhance the prospects of long-term recovery for each shared client. Although a person must ultimately be motivated to pursue recovery, research provides “overall support for the dictum that legally referred clients do as well or better than voluntary clients in and after treatment.”⁶² Jail personnel using motivational interviewing can assist in helping individuals commit to their recovery, even if the initial motivation for treatment came from wanting to avoid conviction, wanting to avoid a jail or prison sentence, or being ordered to seek treatment as a condition of probation or parole.

EXAMPLE FROM THE FIELD

A New York jail relies on a state treatment court where most individuals choose buprenorphine as their medication. The court maintains an evolving list of approved providers based on the probation department's experiences. For example, providers who communicate effectively and cooperate with the probation department remain on the list; those who do not are removed. Almost all of the probationers receive their medication at outpatient programs designated by the officers. A small number receive it directly from physicians. All participants also must attend the outpatient program for counseling and other services.⁶³

MAT PROGRAM COMPONENTS: ASSEMBLING THE RIGHT TEAM, SAFEGUARDS, PROTOCOLS, AND STRUCTURE FOR A SUCCESSFUL JAIL- BASED PROGRAM

CORRECTIONAL STAFF SHOULD RECEIVE TRAINING AND EDUCATION ABOUT MAT.

MAT programs, like all other programs, work best when program staff members are supportive. For example, studies have found that drug courts that have buy-in from their whole teams have a more positive view of their own programs. However, even in courts where key players (for example, a

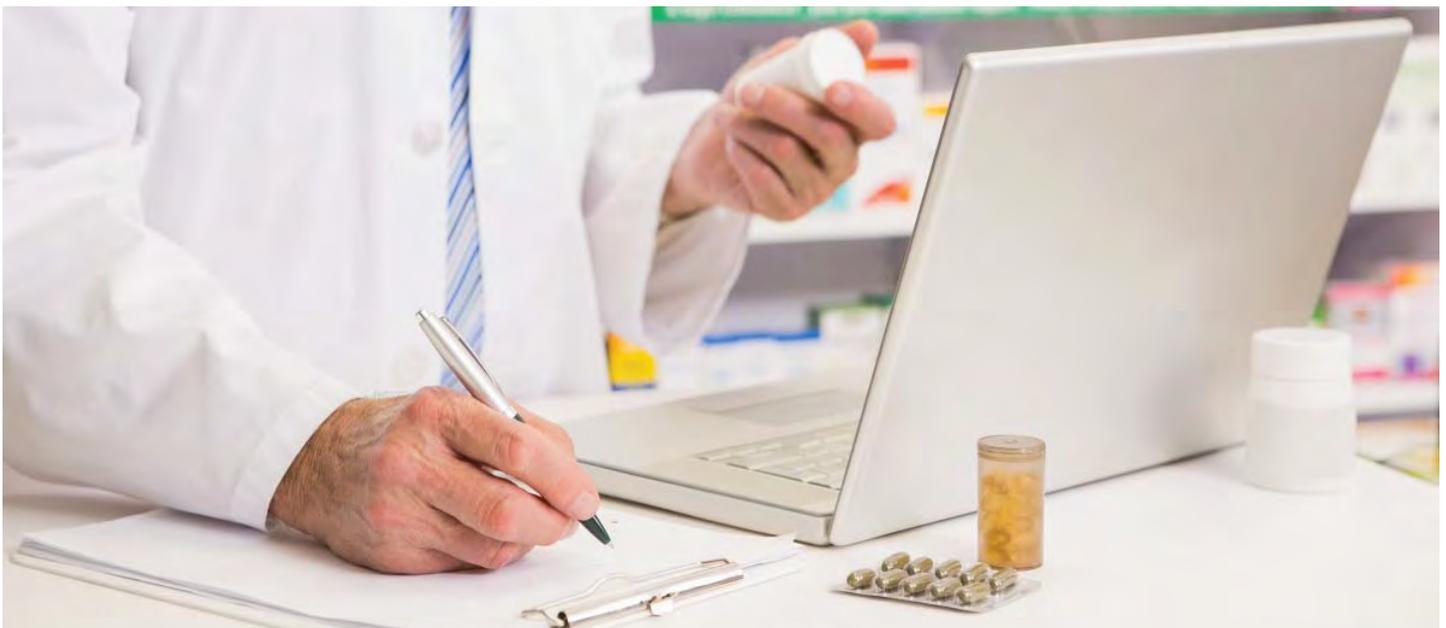
judge or a district attorney) have reservations about addiction medication, "MAT programs can succeed if the program views clinical decisions as the province of clinicians."⁶⁴

Because agonist medication is so highly valued among incarcerated individuals with OUDs, correctional administrators may be tempted to view its use as a reward for "good behavior" for select individuals and may resist allowing access to all people in need. Medication and other forms of behavioral health treatment should not be used as rewards, nor their withholding as a punishment. Loss of privileges or confinement are more appropriate alternatives.

RESIDENTIAL CORRECTIONAL FACILITIES, AS WELL AS COMMUNITY TREATMENT PROVIDERS, SHOULD HAVE SPECIFIC SAFEGUARDS TO PREVENT THE DIVERSION OF AGONIST MEDICATIONS⁶⁵ (FOR EXAMPLE, METHADONE) AND TO SAFEGUARD PARTICIPATING INDIVIDUALS.

The incorporation of MAT programming, especially in jails, can raise challenges based on the medication options available.

Dispensing medications for the treatment of OUDs in facilities that have no previous experience handling and storing them requires preparation and education. Precautions must be exercised to guard against the illicit diversion of agonist medications. Some studies have found that these medications are both effective for jail populations and are subject to diversion. A study of an in-prison buprenorphine program found that buprenorphine "can facilitate community treatment entry. However, concerns remain with in-prison treatment termination due to attempted diversion of medication."⁶⁶ Yet facilities that do not offer opioid agonist treatments may unwittingly, and paradoxically, be promoting diversion among inmates with OUDs who would benefit from such treatment.



Agonist medications must be counted, recorded, and stored in locked cabinets. Administering each dose takes a few minutes, and patients must be closely observed to lessen the possibility of diversion. Any missed dose must be documented and returned to the locked cabinet. Prior to initiating administration of the medications, staff members must be trained and a protocol must be developed to accommodate the additional responsibilities entailed. The FDA approved a monthly injectable form of buprenorphine sold under the brand name Sublocade. Use of injectable buprenorphine avoids diversion and minimizes postrelease interruption of treatment. It requires refrigeration and must be used within 7 days after being warmed to room temperature.

Special care must be taken in the storage of medications, both for security and to make sure that the medications are used before their expiration dates. For example, injectable naltrexone must be refrigerated and then allowed to warm to room temperature before mixing, followed by intramuscular injection. Once at room temperature, the drug must be used within 7 days or discarded. Medical staff members must be reassured about potentially increased liability for the prescription and dissemination of these medications and informed about the possibility of increased workloads.

Although the following guidelines address only opioid treatment programs, the *Federal Guidelines for Opioid Treatment Programs* (42 CFR Part 9) notes that referred community-based treatment programs should take explicit measures to prevent the diversion and abuse of the dispensed agonist medications, particularly with regard to allowing clients to take medication unsupervised.

To limit the potential for diversion of opioid agonist treatment medications to the illicit market, opioid agonist treatment medications dispensed to patients for unsupervised use shall be subject to the following requirements.

1. Any patient in comprehensive maintenance treatment may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and state and federal holidays.
2. Treatment program decisions on dispensing opioid treatment medications to patients for unsupervised use, beyond that set forth in paragraph (i)(1) of this section, shall be determined by the medical director. In determining which patients may be permitted unsupervised use, the medical director shall consider the following take-home criteria in determining whether a patient is responsible in handling MAT for unsupervised use.
 - No recent abuse of drugs (opioid or nonnarcotic), including alcohol
 - Regularity of clinic attendance
 - Absence of serious behavioral problems at the clinic

- Absence of known recent criminal activity (e.g., drug dealing)
- Stability of the patient's home environment and social relationships
- Length of time in comprehensive maintenance treatment
- Assurance that take-home medication can be safely stored within the patient's home
- Assurance that the rehabilitative benefit the patient derived from a decreased frequency of clinic attendance outweighs the potential risks of diversion

3. Such determinations and the basis for such determinations, consistent with the criteria outlined in paragraph (i)(2) of this section, shall be documented in the patient's medical record. If it is determined that the patient is responsible in handling MAT, the following restrictions apply:
 - During the first 90 days of treatment, the take-home supply (beyond that of paragraph (i)(1) of this section) is limited to a single dose each week, and the patient shall ingest all other doses under appropriate supervision as provided for under the regulations in this subpart.
 - In the second 90 days of treatment, the take-home supply (beyond that of paragraph (i)(1) of this section) is two doses per week.
4. No medications shall be dispensed to patients in short-term medically managed withdrawal treatment or interim maintenance treatment for unsupervised or take-home use.
5. OTPs must maintain current procedures adequate to identify the theft or diversion of take-home medications, including labeling containers with the OTP's name, address, and telephone number. Programs also must ensure that take-home supplies are packaged in a manner designed to reduce the risk of accidental ingestion, including childproof containers (see Poison Prevention Packaging Act, Public Law 91-601 (15 U.S.C. 1471 et seq.).⁶⁷

EXAMPLE FROM THE FIELD

Rhode Island Department of Corrections Distribution of Buprenorphine Protocol, April 22, 2016: "If at any time a correctional officer suspects or observes an inmate putting their hands around their mouth, a mouth check will be immediately performed to determine the presence of the buprenorphine; a strip search of the inmate will/may be performed to ensure compliance with this procedure; and if contraband is discovered (medication cheeked or transferred to another area), the inmate will be issued a disciplinary action."

COMMUNITY-BASED TREATMENT AND MEDICATION

PROVIDERS SHOULD BE CAREFULLY SELECTED.

CORRECTIONAL AGENCY COLLABORATION MAY BE REQUIRED TO ENCOURAGE PROVIDERS TO MEET THE NEEDS OF REFERRED INDIVIDUALS.

Most SUD treatment programs across the country (88.9 percent) have not yet incorporated access to MAT, either within their programs or in partnership with medical providers.⁶⁸ The specific and separate requirements for the provision of buprenorphine and methadone have contributed to the fragmentation of MAT access for persons with OUDs. Jails, therefore, must often search out community-based agencies that provide MAT as well as appropriate treatment and services for individuals to be released to the community. The Pennsylvania Department of Corrections, for example, has issued a directive that it “will no longer do business with service providers who do not, at all levels, support the use of medication-assisted treatment.”⁶⁹

In selecting and working with a referral agency to better serve correctional clients, justice agencies should be advised by the Federal Guidelines for Opioid Treatment Programs, March 2015, issued by SAMHSA.⁷⁰ The guidelines emphasize that community-based agencies should offer recovery-oriented systems of care, in addition to medication, and specify that:

OTPs shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services.⁷¹ These services must be available at the primary facility, except where the program sponsor has entered into a formal, documented agreement with a private or public agency, organization, practitioner, or institution to provide these services to patients enrolled in the OTP. The program sponsor, in any event, must be able to document that these services are fully and reasonably available to patients.

1. OTPs must provide adequate substance abuse counseling to each patient as clinically necessary. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients; to contribute to the appropriate treatment plan for patients; and to monitor patient progress.
2. OTPs must provide counseling on the prevention of exposure to, and the transmission of, HIV disease for each patient admitted or readmitted to maintenance or medically managed withdrawal treatment.
3. OTPs must provide directly, or through referral to adequate and reasonably accessible community resources, vocational rehabilitation, education, and employment services for patients who either request such services or who have been determined by the program staff to need such services.⁷²

In the United States, the treatment of opioid dependence with medications (including the use of buprenorphine) is governed by the Certification of Opioid Treatment Programs, 42 Code of Federal Regulations (CFR) 8.⁷³ Associated treatment standards include frequent office visits (weekly in early treatment), concurrent counseling, urine drug testing (including testing for buprenorphine and metabolites), and recall visits for pill counts if diversion is suspected.

Regarding practitioners dispensing narcotic drugs for narcotic treatment, the Comprehensive Addiction and Recovery Act of 2016 amended Section 303 of the Controlled Substances Act as follows: “In the prescriber’s notification to the Secretary of HHS of their intent to prescribe buprenorphine, they must certify that the practitioner is a qualifying practitioner; they have the capacity to provide directly, by referral, all drugs approved by the FDA for the treatment of opioid use disorder, as well as appropriate counseling and other ancillary services.”

CORRECTIONAL PERSONNEL SHOULD REFER CLIENTS TO PRESCRIBING PROVIDERS AND OTHER TREATMENT PROVIDERS WHO HAVE THE REQUIRED CERTIFICATION AND ARE KNOWLEDGEABLE ABOUT ADDICTION, SUBSTANCE ABUSE, OR BEHAVIORAL HEALTH PROGRAMS, AND THE ROLE OF MEDICATION IN SUBSTANCE USE TREATMENT.

Policies, procedures, and agreements with community providers should ensure that there is no interruption of MAT following correctional release and referral to community MAT providers. Many licensed SUD treatment programs complete an assessment that includes whether MAT may be indicated. If a program does not have a physician on staff, clients may be referred to a physician or a certified OTP that can prescribe, dispense, and/or administer the appropriate medication. This underscores the need to exercise care in making referrals to SUD treatment programs that can conduct proper pharmacotherapy assessments, directly provide the most appropriate medication, and deliver counseling and recovery support services. Access to opioid medications may be limited in the community, especially in rural areas.⁷⁴ Telemedicine is approved in some states for buprenorphine prescribing, particularly in rural areas.⁷⁵

THERE ARE PRETRIAL AND POSTTRIAL MAT PROGRAMS.

JAIL-BASED PRETRIAL MAT PROGRAMS

Most individuals’ entry into jail occurs after arrest and arraignment, pending trial or case resolution for those not able to raise bail or who are ordered held for trial. Traditionally, little programming has been available for these individuals because their stay is limited and they have not been convicted of a crime. However, the opioid epidemic has inundated jails with an increased number of individuals under the influence of opioids. Jails have become de facto detoxification (i.e., medically managed withdrawal) centers.

Once individuals have gone through medically managed withdrawal, many jails are in a unique position to initiate treatment for these individuals, launching them on the path to long-term recovery. An increasing number of jails have begun to establish treatment programs for these individuals. In addition to medically managed withdrawal services, these jails have established medical screening for MAT as well as in-jail provision of these medications to promote continued abstinence from illicit opioids upon release. To ensure continuity of treatment, these jails link released individuals to treatment, support, and medical providers in the community. However, medically managed withdrawal is not treatment. In fact, withdrawal is associated with high risk for overdose and death following release, underscoring the need for MAT.



There is a dual incentive for incarcerated individuals to take advantage of these programs: Not only can their participation lead to recovery in the long term, but in the short term, their participation can influence prosecutors and courts to consider noncustodial treatment alternatives once they return to court for further hearings. In many jurisdictions, prosecutors and courts let defendants know at arraignment that they will take into consideration the defendants' participation in a jail pretrial program to resolve their criminal cases. Although many defendants may be more concerned with avoiding custodial sentences than long-term abstinence and recovery, research has shown that successful treatment is not dependent on voluntary entry into treatment.⁷⁶

However, if it is likely that a prosecutor and a court will not consider a noncustodial sentence, beginning agonist treatment pretrial may not be indicated if the individual is expected to return to jail for a long period of time or be sentenced to prison.

Before an individual is enrolled into a jail's MAT program, he or she is educated about the medications offered and the associated choices to be made (as described earlier). The jail then introduces concurrent initial drug counseling and sets up referrals in the community for follow-up counseling as well as continued access to medication.

An increasing number of jails provide agonist medications for incoming individuals who are already prescribed these medications, especially if they are not expected to remain in jail for prolonged periods of time. While certified medical

personnel can dispense buprenorphine, methadone must be dispensed by a licensed methadone clinic. For this reason, most jails rely on community methadone clinics to come to their facilities daily to dispense medication under the supervision of the jail authorities rather than becoming licensed methadone providers in their own right.

JAIL-BASED POSTTRIAL MAT PROGRAMS

Many more jails provide posttrial MAT for sentenced individuals. Generally, access is provided for those who are also enrolled in a facility's drug treatment program. These posttrial MAT differ from the pretrial programs in that most participants do not need to undergo medically managed withdrawal before entry. If an individual has been allowed to continue prescribed agonist medications before entrance into the jail, some programs allow him or her to remain on these medications, but generally for only a year. After that, the individual is medically tapered off the agonist medication.

Most of these jail programs offer naltrexone shortly before individuals' reentry into the community, either when released on parole or when no further correctional supervision is needed. However, some also offer naltrexone maintenance for several months before release. These jails provide either oral naltrexone daily for approximately 1 month, followed by injectable naltrexone immediately before release, or up to 3 months of monthly injections prior to release. Although there have been no studies on the effectiveness of extended naltrexone maintenance before prerelease injections, it is thought that such maintenance will result in better follow-through after release. Many correctional programs have found that, although individuals sign up for naltrexone 2 or 3 months before release, they often change their minds when it is time for the injections. Despite prolonged abstinence while incarcerated, it is reported that for some, anticipation of imminent release triggers drug cravings and drug dreams, making them anxious and/or resistant to committing to the month's abstinence that the injections will promote. It is thought that the provision of naltrexone months before release will prevent renewed cravings and anxiety and encourage individuals to enroll in the naltrexone MAT program and continue the medication after release.

Two studies provide some support for this rationale. Both found that when individuals receive the first injection before release from jail, they are significantly more likely to have a second injection compared to those whose first injection is given immediately after release.⁷⁷ This suggests some significance to initiating the medication before release.

Similarly, a randomized clinical trial of buprenorphine maintenance that compared individuals who began receiving the medication while in jail with those who received it upon release found that the former approach was associated with more days in buprenorphine treatment in the designated community treatment program during the 12-month postrelease assessment. However, the study did not find an association with superior outcomes in terms of reduction of heroin or cocaine use or criminal behavior.⁷⁸

In addition, research makes it clear that receiving MAT in jail along with treatment is associated with better follow-up in the community than treatment alone. For example, a randomized controlled trial of methadone maintenance and counseling for some inmates compared with counseling only found that in the year following release, those who had methadone and counseling spent 7 times as many days in treatment for drugs during the postrelease year. None of the counseling-only participants continued in treatment for the entire year, whereas 37 percent of the methadone participants remained in treatment for that year. The counseling-only individuals were also significantly more likely to test positive for opioids 12 months postrelease.⁷⁹

These findings are relevant because individuals are at a significantly increased risk of an overdose death during the first 2 weeks postrelease.⁸⁰ Use of methadone and buprenorphine substantially reduces this risk.⁸¹

To ensure the continuity of medication after release, it is essential that funding be arranged. If medication is to be paid for through the state Medicaid program, individuals should be enrolled before release so there is no gap between release and eligibility to access the needed medication. If health coverage requires prior approval for certain medications, it should be arranged before release for the same reason. In addition to financing medication, jails should facilitate participants' first postrelease community treatment appointments.

Several jail-based MAT programs have created recovery support case manager positions to bridge the gap between institutions and communities. These case managers meet with individuals before release and remain available for support and assistance for up to a year after release. Among other duties, recovery support case managers may accompany released individuals when they first enter treatment programs, meet with medical providers, or engage in other recovery-related activities. Unlike probation or parole officers, the case managers' function is solely to provide support, and their engagement by the released individuals is voluntary.

THE IMPORTANCE OF CLIENT SCREENING TO ADDRESS TREATMENT CONTINUATION, WITHDRAWAL, AND RELAPSE

SYSTEMS SHOULD BE IN PLACE TO ENSURE CONTINUATION OF METHADONE OR BUPRENORPHINE WHEN APPROPRIATE.

Jails should establish systems to ensure that detainees and sentenced inmates who had been receiving MAT, particularly methadone and buprenorphine, prior to their arrest have MAT continued when feasible.⁸² Withdrawal of methadone or buprenorphine increases the risk for adverse consequences. Avoidable potential consequences include onset of withdrawal symptoms (requiring medical management and monitoring), increase in disciplinary problems⁸³, drop out from treatment postrelease⁸⁴, and dramatic increases in overdose-related deaths

postrelease among those not maintained on MAT.⁸⁵ In Rhode Island, when MAT continuation was implemented in jails and prisons statewide, postrelease deaths dropped by 60 percent.⁸⁶

MAT continuity can be ensured through appropriate policies and procedures, memoranda of understanding with community programs, established lines of communication with community prescribers, and systems for obtaining MAT and for supervised administration of MAT. Communication upon jail entry is necessary to confirm dosing with the community program or prescriber. Systems for obtaining MAT must be consistent with federal and state regulations. Dosing should be directly supervised to minimize diversion.

Prerelease communication with community prescribers is needed to avoid interruption in dosing. For methadone, this often means requesting that the community OTP "guest dose" the patient in jail—i.e., provide take-out doses of methadone that are secured by the jail and administered under jail supervision. For buprenorphine, this often means prescription of buprenorphine by jail medical staff who are waived to prescribe it and direct observation of its administration. Alternatively, jails can obtain a license as an OTP program.⁸⁷ Prerelease communication with community treatment programs helps to ensure that patients are scheduled with an immediate appointment with the community prescriber, thus avoiding a postrelease interruption in MAT.

MEDICALLY MANAGED WITHDRAWAL PROTOCOLS SHOULD BE IN PLACE TO SUPPORT SCREENING FOR WITHDRAWAL SEVERITY AND POLYSUBSTANCE USE, MONITORING, AND MEDICAL MANAGEMENT OF SYMPTOMS.

Medically managed withdrawal utilizing prescribed, FDA-approved medications may be necessary when a person transitions to a controlled setting or begins treatment with naltrexone. In custody settings, especially jails, this must be addressed early in the intake process (ideally, within hours of admission) to reduce the risk of medical complications and fatalities. Withdrawal symptoms may begin within 4 to 6 hours of the last opioid use and may last for up to several months.⁸⁸ Jails should have protocols in place to identify people who might require medically managed withdrawal services. It is of equal importance to have a plan to engage them in treatment. Medically managed withdrawal by itself is not treatment.⁸⁹ While in some instances, withdrawal can be a step toward treatment, this is largely not the case in correctional settings, where the risk of death from overdose is extremely high.

A person entering a correctional institution on a prescribed medication should be allowed to continue for a reasonable period. If the incarceration will be for more than a year, the individual can be tapered off the medication under medical supervision and then restarted 30 days prior to release in order to minimize risk of postrelease overdose and death. Research has found that forced detoxification of prescribed opioid medication, such as methadone, can undermine an individual's willingness to engage in MAT in the future, compromising the likelihood of long-term recovery.⁹⁰

Another issue to be aware of is polysubstance use. It is unwise to assume that an individual who reports a history of opioid use is exempt from the potentially life-threatening consequences of alcohol or benzodiazepine withdrawal. Opioid-dependent individuals are likely to use other substances, including alcohol, and may increase their alcohol consumption when they attempt to curtail opioid use. Universal withdrawal severity screening, institutional or community-based, of all persons entering corrections with an established or suspected history of substance use is widely recommended.⁹¹

The use of a standardized brief withdrawal severity assessment can help to stratify risk levels:

- **Low**—should be monitored but does not require medical attention
- **Medium**—requires immediate medical attention but does not have complicating medical conditions
- **High**—requires immediate medical attention and intensive monitoring because of other medical conditions that elevate risk⁹²

STANDARDS, GUIDELINES, AND INFORMATION ON WITHDRAWAL SEVERITY SCREENING

- *Guide to Developing and Revising Alcohol and Opioid Detoxification Protocols*. Kevin Fiscella, MD, MPH, for the National Commission on Correctional Health Care, 2015. www.ncchc.org/filebin/Resources/Detoxification-Protocols-2015.pdf
- *Detoxification of Chemically Dependent Inmates*. Federal Bureau of Prisons clinical practice guidelines, February 2014. www.bop.gov/resources/pdfs/detoxification.pdf
- *TCU Drug Screen V Opioid Supplemental*. Texas Christian University, September 2017. <https://ibr.tcu.edu/forms/tcu-drug-screen>
- *TIP Series 45: Detoxification and Substance Abuse Treatment*. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2006. <https://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA15-4131>
- *Opioid Substitution Treatment in Custodial Settings—A Practical Guide*. World Health Organization and United Nations Office on Drugs and Crime, 2008. www.unodc.org/documents/balticstates/Library/PrisonSettings/OST_in_Custodial_Settings.pdf
- *Managing Opiate Withdrawal: The WOWS Method*. CorrectCare, Summer 2016. www.ncchc.org/filebin/CorrectCare/30-3-WOWS.pdf

Even people who do not require medical attention should have easy access to ample, drinkable fluids.

Common factors that can elevate risk levels include a history of delirium tremens or withdrawal-associated seizures, a history of traumatic brain injury, advanced age, major medical or psychiatric comorbidity, and pregnancy.⁹³ Outpatient medically managed withdrawal treatment is not uncommon for individuals withdrawing from opioids.⁹⁴

In custody settings, the medical consequences of acute withdrawal from alcohol or chemically related sedative/hypnotic drugs (for example, benzodiazepines or barbiturates) can be reduced or eliminated when sound protocols are implemented and followed.⁹⁵ Symptoms of opioid withdrawal should be treated in accordance with correctional health care guidelines. Although deaths from inadequately treated withdrawal are uncommon, such deaths are on the rise.

Although medically managed withdrawal is not treatment and relapse is likely to occur without long-term follow-up services, assisting individuals in custody who are withdrawing from substances is an ethical and medical responsibility. ASAM criteria, endorsed by SAMHSA in its TIP 45: Detoxification and Substance Abuse Treatment, suggests “that for alcohol, sedative-hypnotic, and opioid withdrawal syndromes, hospitalization (or some form of 24-hour medical care) is often the preferred setting for medically managed withdrawal, based on principles of safety and humanitarian concerns. When hospitalization cannot be provided, then a setting that provides a high level of nursing and medical backup 24 hours a day, 7 days a week is desirable.”

Medications combined with psychological support are the standard for medical practice and improve recovery outcomes. To get the best results from medically managed withdrawal, an individual should be immediately connected with medication and counseling. Many medications are used to help ease withdrawal symptoms. The Federal Bureau of Prisons offers clinical guidelines for safe, medically managed withdrawal from alcohol, opioids, barbiturates, and other substances.⁹⁶ These practice guidelines do not differ significantly from community-based medically managed practices. Withdrawal should be assessed using the validated scales previously discussed. It should be treated using FDA-approved medications. These include methadone (when provided through an OTP), buprenorphine, or lofexidine. Systematic reviews suggest that clonidine has some benefit in relieving withdrawal symptoms but is less effective than opioid agonists.⁹⁷

All correctional facilities should make naloxone (Narcan) kits available in the event of an overdose. Ideally, all individuals with OUDs should leave their facilities with such a kit (or a prescription for one). Following an overdose, the individual and his or her family should be educated in how to administer this lifesaving drug.⁹⁸

Alcohol withdrawal is usually treated with short-term, gradually tapering doses of long-acting benzodiazepines. Medications include clonidine; thiamine, also called vitamin B1; and carbamazepine, an antiseizure medication. All

medications should be administered under the supervision of trained medical personnel, particularly considering that many individuals entering corrections may suffer from liver disease, a condition that contraindicates the use of certain medications.

JAIL MAT PROGRAMS SHOULD INCLUDE ONGOING MONITORING THROUGH DRUG SCREENING AND OTHER DIVERSION/RISK MITIGATION STRATEGIES.

Alcohol and drug use during treatment should be carefully monitored as outlined in NIDA's *Principles of Drug Abuse for Criminal Justice Populations*.⁹⁹ Individuals trying to recover from alcohol and drug addiction may experience a relapse and return to drug use. This is considered a part of the recovery process for people with SUDs. Those on MAT, like others in SUD treatment, may relapse, take other drugs, or misuse prescription medication. Individuals on antagonist drugs such as naltrexone may switch to cocaine or other drugs that are not blocked by naltrexone.

Different people have different triggers for relapse, and treatment providers work to identify such triggers. Common triggers include mental stress and associations with peers and social situations linked with drug use. An undetected relapse can progress to serious alcohol and drug misuse and potential overdose. When detected, relapses can present opportunities for therapeutic intervention. Monitoring alcohol and substance use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities to intervene to change unconstructive behavior and to determine rewards and sanctions to facilitate change and modify treatment plans according to progress. For individuals on medications, it can also ensure that they are taking the correct dosages.

In addition to urine tests, correctional and treatment agencies can employ a range of methods to monitor for return to drug use, including pill or strip counting and behavioral observations. These methods are generally not dissimilar from those used to monitor illicit drug use by other non-MAT participants. Most correctional agencies perform the monitoring themselves and do not rely on treatment programs or correctional health providers.

Once a patient is released from jail, the method and extent of monitoring depends on the type of medication. Patients prescribed buprenorphine typically take home a month's worth of medication, which requires more vigilant monitoring. Methadone patients, on the other hand, typically take their doses in liquid form under observation by clinic medical staff and do not self-administer medication at home until they are well stabilized to safeguard against misuse. Naltrexone cannot be diverted when it is injected by a health care provider, and oral naltrexone has no abuse potential.

States with an operational prescription drug monitoring program (PDMP) collect all Schedule II, III, and IV (and, in some states, Schedule V) controlled substance prescription data that can be accessed by authorized users, including physicians

and pharmacists. By regularly checking the PDMP, providers can become aware if a patient receives a controlled substance from another prescriber and address the possible return to drug use. Every state and the District of Columbia now has an operational PDMP (although Missouri's is not statewide; it is operated by the St. Louis County Department of Public Health and is joined by other counties/jurisdictions). A list of the capabilities for each PDMP can be found at <http://www.pdmpassist.org/content/state-profiles> and at <http://www.pdmpassist.org/content/pdmp-maps-and-tables>.

Jails report a major challenge in terms of contraband drugs, including agonist medications used for opioid treatment. For example, the Ohio Department of Rehabilitation and Correction reported that in December 2016, based on random drug tests conducted on 5 percent of the prisoners, 1 in 20 tested positive for illicit drugs, with marijuana being most common, followed by Suboxone.¹⁰⁰ While many jails have provided methadone to pregnant women for decades, and currently some jails and prisons regularly provide agonist medications to their inmates, at least one jail has found that its MAT program appears to have reduced the demand for illicit drugs within its institutions. However, the same department underscores that the provision of agonist medication requires daily procedures for monitoring the medication dissemination by both nursing and correctional staff.¹⁰¹ An integrated jail/prison system found that continuation of methadone improved postrelease engagement in treatment and reduced disciplinary problems among inmates.^{102, 103}

ENGAGING MEDICAID AND POSTRELEASE FINANCIAL ASSISTANCE

JAILS FACILITATING MAT SHOULD ENGAGE THEIR STATE MEDICAID AGENCIES AND OTHER PUBLIC PAYERS TO FACILITATE HEALTH CARE COVERAGE.

Lack of insurance or gaps in insurance coverage inhibit the use of MAT. For example, according to a 2016 U.S. Government Accountability Office report,¹⁰⁴ out-of-pocket costs for sublingual buprenorphine for individuals who lack insurance coverage for medications can range from \$200 to \$450 a month. The cost of injectable naltrexone can be triple that cost. State Medicaid programs may not reimburse for all three of the approved OUD medications. In some states that cover all or some of the medications, there is a shortage of physicians willing to prescribe medications for persons with substance use disorders.¹⁰⁵ Some states have stringent prior authorization requirements governing the coverage of medications such as buprenorphine or extended-release injectable naltrexone. For example, Idaho requires preauthorization to receive Medicaid coverage for Suboxone, Vivitrol, or oral naltrexone. A breakdown of state coverage (including medications) is contained in *A Comprehensive Listing of What States Cover for Substance Use Disorder* (see <http://www.rsat-tta.com>).¹⁰⁶

Correctional or treatment agency staff members can help ensure that individuals receive the coverage needed to utilize MAT programs, including available state-subsidized medications.

Federal law and regulations do not require states to terminate Medicaid enrollment when a person is incarcerated, but the law does prohibit federal payments for that person's health care costs while he or she is in prison or jail (excluding the inpatient exception). Guidance from the Centers for Medicare & Medicaid Services (CMS) in April 2016 clarifies that states must accept applications from people who are incarcerated and enroll or reenroll them if determined eligible. It encourages states to suspend enrollment or coverage by using markers or other indicators in the claims processing system that help ensure that claims submitted by states are denied for disallowed services provided to people in prisons and jails. Whatever method is used, CMS states that a suspension must be lifted when this exclusion no longer applies—for example, upon a person's release, or when he or she is admitted to a medical institution for treatment that falls within the inpatient exception.¹⁰⁷

In addition, if an individual obtains employment and no longer qualifies for Medicaid, he or she may not be able to afford the subsidized premiums or copays. Such an individual may need additional assistance, such as pharmaceutical company coupons or access to generic versions of buprenorphine.

There are programs for reduced-price medications, some from the pharmaceutical industry itself. There are also federal and state government programs. Congress established the 340B program to allow certain covered entities that serve large numbers of uninsured patients to obtain drugs from pharmaceutical suppliers at the same discounted rates that Medicaid pays (i.e., 25 to 50 percent less). The following website lists 340B-covered entities by state: <http://datawarehouse.hrsa.gov/topics/HealthcareSystems/CE340BDataExplorer.aspx>. Also, some states fund MAT medications for programs that serve correctional populations out of state block grant funding or state appropriations. More than 1,200 Federally Qualified Health Centers are located in inner cities and rural areas and serve uninsured and low-income individuals. Many offer buprenorphine based on discounted fees. The nearest center can be located via <https://findahealthcenter.hrsa.gov>.

THE DIFFERENT TYPES OF ASSISTORS INCLUDE THE FOLLOWING:

- **Navigators**—Navigators receive extensive training from CMS and are responsible for providing unbiased information about public and private health insurance programs in a culturally competent manner. They regularly report on their outreach and consumer education activities and accomplishments. In plan year 2018, the Navigator Program is evolving: Navigators will be encouraged to leverage volunteers as well as strategic partnerships with public and private organizations to identify individuals who would benefit from Exchange coverage. These updates leverage practices from private sector-focused programs like those within Medicare Advantage.
- **Non-navigator assistors (in-person assistors)**—These serve a function similar to navigators, providing in-person assistance and informing consumers about coverage options, but funding for assistors is more flexible than navigator funding. Many states opt to train staff members of existing community-based agencies to carry out in-person assistor duties.
- **Certified application counselors (CACs)**—CMS designates organizations to certify counselors who perform these functions. CACs complete pre-service training and receive ongoing in-service training via CMS webinars and newsletters. They comply with privacy and security standards but have fewer reporting requirements.
- **Brokers, agents, and contracted assistors**—Brokers usually act on behalf of the consumer and are compensated by insurers or consumers. Agents are compensated by insurers. Some states contract with brokers or agents to act as “navigators.” They may be required to forgo compensation or abide by other guidelines that mitigate potential conflicts of interest.

JAIL-BASED MEDICATION-ASSISTED TREATMENT PROGRAMS IN ACTION

SACRAMENTO COUNTY JAIL, CALIFORNIA

ORIGIN AND DEVELOPMENT OF THE PROGRAM

In 2013, the Sacramento County Sheriff's Department Reentry Services Bureau, Sacramento Probation Department, and Correctional Health Services began a pilot program to provide substance use treatment with the administration of naltrexone to a select group of inmates with a history of opiate dependence and/or acute alcohol abuse. The pilot group showed great success. As a result, the program was made available to all consenting inmates who qualified.

PROGRAM PARTICIPATION PROCEDURES

Program participants are identified by self-referrals, reentry specialists, inmates with known drug/alcohol use histories, and referrals from outside sources. When an inmate is identified as a possible program participant, the following screening process is used:

1. A reentry specialist meets with the inmate to explain the program and to obtain consent to proceed.
2. A signed copy of the Sacramento County Correctional Health Services and WellSpace Health Vivitrol Consent Form is placed in the inmate's file, a second copy is forwarded to the reentry resource officer, and a copy is sent to County Health Services and WellSpace Health (the postrelease medical program).
3. Verification is made of participation in a substance use treatment program. If the inmate is not participating in a program, the reentry specialist will coordinate enrollment with the reentry resource officer.
4. Probation verification is made, although probation status is not required for participation.
5. The inmate is referred to the Department of Human Assistance eligibility specialists for eligibility verification for Covered California or other health insurance pursuant to the Affordable Care Act.
6. Correctional Health Services conducts a medical evaluation of the inmate to approve participation in the program.
7. When participation is approved by Correctional Health Services, the doctor prescribes naltrexone to the participant and ensures that the first injection is scheduled for 35 to 40 days prior to release and the second injection for 7 days prior to release.
8. The reentry specialist notifies WellSpace Health of the participant's anticipated injections and release from custody. An appointment is scheduled for the third injection prior to release.
9. The assigned reentry specialist serves the participant postrelease for the duration of his/her use of naltrexone. Reentry services continue based on need after the individual discontinues naltrexone or completes the recommended 6-month participation.
10. If the participant is serving a period of supervised release, the reentry resource officer ensures that the reentry specialist coordinates the individual's program participation with his or her probation officer of record.

OUTCOMES

Of the first 174 total program participants, 54 have been arrested for new offenses (31 percent).

MIDDLESEX JAIL AND HOUSE OF CORRECTION, MASSACHUSETTS

ORIGIN AND DEVELOPMENT OF THE PROGRAM

The Middlesex Sheriff's Office (MSO) Medication-Assisted Treatment and Directed Opioid Recovery (MATADOR) program encourages long-term recovery to improve health outcomes and reduce recidivism. The program, in its current form, was launched in October 2015. The prior attempt at a MAT program resulted in programmatic failure but yielded insights for MATADOR's eventual success. The original Vivitrol program failed because it was missing many of the factors now known to be integral to a successful MAT program:

- The original program lacked buy-in from the correctional officials tasked with overseeing its success.
- It lacked a data collection/performance measures component.
- It had a very limited network of health providers who participated in MAT involving Vivitrol.
- It needed critical casework follow-up to assist participants with navigating medical appointments, health insurance coverage, and other issues associated with life back in the community.

The failure of the initial MAT program provided an opportunity to improve in three areas that became implementation milestones:

- The need for a navigator or recovery coach to remain in touch postrelease
- The need for real-time data to provide areas in need of improvement
- Increased participation by community health providers

PROGRAM DEVELOPMENT

MATADOR has evolved significantly since its October 2015 inception date. One of the major drivers of its success has been the increased participation of community health care providers and substance use counseling centers. The MATADOR program began with four community providers willing to accept patients and administer naltrexone injections. As of May 2017, that number had expanded to 35 providers, 70 support program locations, and four drug courts. In addition to the community support necessary to initiate and sustain a successful MAT program, key stakeholders include data

experts, medical/mental health treatment providers, dedicated recovery navigators/coaches, and courts willing to accept MAT as a legitimate form of relapse prevention and recidivism reduction.

Many MATADOR participants begin with medically managed withdrawal. Just under half (42 percent) of the intakes have drug addictions so severe that they need to be detoxed when they arrive—76 percent of them have some type of opioid in their systems. Following medically managed withdrawal, officers and program staff members provide drug treatment and casework services to treat those suffering from addiction issues. As part of that process, inmates are educated on all forms of MAT, including injectable naltrexone. Individuals interested in participating in MATADOR are educated on program specifics and receive medical screening prior to enrollment.

Prior to release, a participant is given an injection and is in touch with the navigator, who schedules follow-up medical and treatment visits. When an inmate is released from the facility, the program begins in earnest.

At its inception, the MATADOR program required one full-time employee (FTE) as a recovery support navigator and ½ FTE for data collection/analysis. Both initial positions were internal assignments and considered an investment in the program. As the program expanded, a second navigator was hired to keep up with demand. In addition, the program benefited from a grant award that uses Byrne JAG funding to secure two substance use treatment beds for program participants and 20 hours per week for a research assistant to collect data.

It was originally anticipated that the MSO's Residential Substance Abuse Treatment unit would be a natural feeder into the MATADOR program; however, data show that most program participants in the last 3 to 5 months have sought out the program after learning about it through word of mouth in the general population.

The MATADOR program director is a licensed nurse practitioner in the process of becoming a licensed recovery support navigator. Through this unique combination of training and expertise, the program provides clinical/medical guidance while establishing the rapport necessary for a successful postrelease relationship between the participant and the navigator. Potential participants are educated in all forms of MAT (Vivitrol, Suboxone, and methadone) and, if chosen, are provided with only Vivitrol (first injection prerelease) behind the walls of the Middlesex Jail and House of Correction.

The MATADOR team has gone to great lengths to establish open lines of communication with health care providers in the community, including identifying a primary point of contact at each community health care provider's and support program's office. This allows for a streamlined flow of information and, when necessary, the adjustment of treatment options,

services, and health insurance plans. Communication between the health care provider and the program is initiated when the program navigator notifies a provider of a new participant and schedules a medical follow-up appointment. If an appointment is missed, the MSO's research team is notified via phone call. The health care provider attempts to reengage the participant; failure to do so results in a call to a navigator, who attempts to reach the individual separately.

MATADOR team meetings provide ongoing communication among the MSO's research staff, executive staff, and navigators to ensure program integrity. The MATADOR program navigator works in conjunction with nearly 90 community health care providers, support programs, and drug courts throughout Massachusetts. The engagement and collaboration of these critical health care and criminal justice stakeholders have made a key difference in the success of the program reboot.

OUTCOMES

Of the 370 individuals who have completed the program, 81 percent had not been rearrested for new crimes as of January 2018.

LOUISVILLE METRO DEPARTMENT OF CORRECTIONS, KENTUCKY

ORIGIN AND DEVELOPMENT OF THE PROGRAM

The Louisville Metro Department of Corrections (LMDC) began experiencing a significant influx of high-need drug users among the jail population. Heroin-related arrests skyrocketed from 120 in 2010 to 1,501 arrests in 2014. In 2015, the county had the most overdose deaths of any Kentucky county (268) and the most heroin-related overdose deaths (131). In 2016, LMDC was funded to expand the in-jail substance use treatment program Enough is Enough and MAT (Vivitrol) for eligible opioid addicts returning to the community.

IMPLEMENTATION

In the spring of 2016, LMDC partnered with Correct Care Solutions (CCS), its contracted medical/mental health provider, to launch its MAT program. Flowcharts, consent-to-treat forms, and informational handouts were developed, and training for medical staff was provided. Originally, the program was designed to be provided only to inmates who were active participants in Enough is Enough, a 90-day voluntary drug treatment program. Shortly thereafter, staff members realized

that the program would also benefit inmates who could not be enrolled in Enough is Enough because of shorter incarceration periods. LMDC partnered with the courts and prosecutors to refer pretrial inmates interested in Vivitrol treatment and continued treatment in the community in lieu of further custodial sentencing. A senior social worker/coordinator for the MAT program established contacts with community providers who committed to taking on the task of the care continuum for MAT program participants.

Although the program started slowly, it quickly gained momentum and speed once word spread to the jail population. State funding pays for hepatic function panel (liver enzyme) labs, drug screens, Vivitrol injections, and days inmates participate in the Enough is Enough program.

Once an inmate has volunteered as a potential participant for MAT who will be released from LDMC custody within a month, the program coordinator requests hepatic function panel labs to be collected by medical staff members. Once the lab results return, the doctor or nurse practitioner clears or denies prescription based on the results. If prescription is denied, the referral source and the inmate are notified. If cleared, approximately 1 week before the potential release date, the program coordinator conducts a drug screen and has the inmate sign consent-to-treat and release-of-information forms. At that time, medical staff members are informed that the inmate is ready to receive Vivitrol. The nurse administers the naltrexone (pill) and, after the inmate is observed for possible side effects, the first Vivitrol injection is administered. The program coordinator forwards the lab results and the signed consent form to the community provider, and the inmate receives an appointment for follow-up care.

OUTCOMES

As of January 2018, 200 individuals have graduated from either the pretrial or posttrial MAT program. Of these, 47 percent have remained arrest-free in the community; only 4 percent of the individuals were arrested more times after release than before they entered the program.

LESSONS LEARNED

The program must:

- Develop effective collaboration with community providers.
- Keep ongoing meetings with all involved for troubleshooting purposes and progress discussions (LMDC holds biweekly meetings to discuss the program).
- Keep open and continued discussions with the judges, prosecutors, and public defenders.

SNOHOMISH COUNTY JAIL, WASHINGTON

ORIGIN AND DEVELOPMENT OF THE PROGRAM

The Snohomish County Jail initiated its buprenorphine MAT program in January 2018, beginning with a buprenorphine/naloxone (marketed as Suboxone) detox program. The program became necessary because of a huge increase over the past few years in people being arrested who were addicted to opioids. The jail's 24-bed medical unit was overwhelmed with individuals in need of medically managed withdrawal.

PROGRAM DEVELOPMENT

The jail found it was conducting withdrawal watches for 40 to 50 percent of those arrested, mostly for opioids. The medical unit was operating at more than 200 percent capacity. To ease cravings and mitigate the symptoms of withdrawal, the jail began Washington State's first pilot program to provide medically managed withdrawal with Suboxone. Individuals feel the ameliorative effects of 8 mg of buprenorphine within 30 minutes to 2 hours, and it takes 5 days before they are tapered off. Before receiving buprenorphine, individuals complete urine screens and medical exams to screen out those on other drugs, including benzodiazepines and alcohol, or those who have liver disease and other conditions.

The use of the medication has allowed the jail to move these individuals to the general population to free up medical beds and ease the correctional resources required for this special unit. The use of buprenorphine for medically managed withdrawal also introduces the individuals to MAT and gives them a picture of what treatment could include when they leave jail. Upon release, detoxed individuals are connected with treatment and medication providers in the community. Pregnant inmates are provided with buprenorphine without naloxone (marketed as Subutex).

If entering individuals are already on prescribed methadone or buprenorphine, they are maintained until they leave the jail, even if sentenced for the 3 to 6 months typically imposed for jail inmates.

Once through medically managed withdrawal, inmates who will be at the jail for at least 6 weeks (including those sentenced as well as those held pretrial) are offered Suboxone treatment 10 to 14 days before they are released. Three jail staff nurse practitioners and a physician at the jail prescribe the medication for both medically managed withdrawal and maintenance. The nurses carefully provide the medication each day under the supervision of correctional officers who provide direct supervision of inmates.

When individuals are released, they are picked up at the door by a community provider who continues to provide medication and counseling. At their release, the jail provides a prescription for 3 days of Suboxone, which gives the treatment provider time to begin prescribing. It generally takes a day for those on Medicaid to have it reinstated, so medication costs are initially covered by the treatment provider.

These same community providers also conduct group and individual counseling for the in-house jail treatment program, so those referred postrelease are already familiar with them. The jail has four community treatment providers to whom inmates are referred upon release.

Initially, the jail limited the program to 25 inmates to ensure smooth implementation and protection against any diversion of the medication. The inmates selected are well-known to the jail staff, since most have been in and out of jail previously for opioid abuse.

OUTCOMES

The pilot is too new to generate long-term outcome data. However, officials say the medically managed withdrawal program is easing the strain on deputies by getting inmates into the general population quicker and is much more humane. As the health administrator reported to local media, "They started their medication yesterday and within a couple hours were night and day difference. They went from vomiting, nausea, diarrhea, body aches to feeling well, eating, drinking, and wanting to shower. So, big difference."¹⁰⁸ Although the jail pays for the Suboxone tablets, the overall cost of the medication is less than the amount the jail paid for the medications previously used to ease withdrawal symptoms.

RHODE ISLAND CORRECTIONAL FACILITIES

ORIGIN AND DEVELOPMENT OF THE PROGRAM

The Rhode Island Department of Corrections (RIDOC) operates a combined jail/prison system. Data documented that 21 percent of the state's overdose victims in 2014 and 2015 were incarcerated in the 2 years prior to death (up from 9 percent in 2009). More than 250 individuals were entering the system on agonist medication, either methadone or buprenorphine.

Traditionally, RIDOC allowed inmates on methadone to be maintained on their doses for an initial 30 days. That time span was increased to 60 days several years ago. After that period, inmates were tapered off the medication.

In 2016, as the opioid epidemic grew across the state, RIDOC initiated a program to target this high-risk population. All incoming inmates are screened and assessed for MAT. Now, MAT is initiated upon commitment, as needed, or continued for individuals already on methadone or buprenorphine for 6 to 12 months. For those not on agonist maintenance, naltrexone is provided prior to release.

IMPLEMENTATION

This program required an immediate increase in staffing for substance use disorder services. RIDOC hired three temporary chemical dependency professionals to initiate the screening of detainees upon arrival and to conduct follow-up assessments on those identified as needing it. RIDOC worked with The Providence Center, a treatment program, to place two recovery coaches to work with inmates involved in the MAT program. All levels of RIDOC staff, from the director to frontline nurses and correctional officers, are involved in the program. RIDOC encouraged collaboration among security, medical, and behavioral health personnel, as well as outside vendors. In addition, RIDOC engaged MAT community vendors to ensure continued care and medication upon release for all three FDA-approved opioid medications.

Internal communication is supported by the establishment of a MAT process team; weekly and biweekly meetings are held with administration, security, rehabilitative services, and medical staff members. External communication is supported by members of the MAT process team serving on committees such as the treatment subcommittee of the Governor's Overdose Prevention and Intervention Task Force and the Narcan distribution subcommittee.

Each day, inmates are organized into separate medical lines to be provided with methadone or buprenorphine, carefully monitored by correctional officers. At first, buprenorphine was provided in pill form but it was switched to strips (Suboxone) that dissolve faster and are less easily diverted by inmates. The strips are counted every shift to prevent diversion.

Initially, security staff were resistant to the use of Suboxone out of concern for diversion. The medical director and several staff members met with the jail warden and other administrators to educate them about MAT and to listen to concerns. These meetings went a long way in alleviating fears about the program.

OUTCOMES

During the 12 months between October 1, 2016, and September 30, 2017, RIDOC provided MAT to 896 individuals. Of these, 63.5 percent were on MAT at entry and were continued on MAT, and 36.5 percent were initiated on MAT soon after entry. Most (61 percent) received methadone, and 39 percent received buprenorphine. After release, at least 72 percent were confirmed to have continued with MAT—95 percent of those who were on it at time of entry and 32 percent of those induced after entry. Research showed that this program reduced postrelease deaths by 60 percent and all opioid-related deaths in the state by more than 12 percent.¹⁰⁹

APPENDIX I: SUBSTANCE USE DISORDER SCREENING TOOLS

The National Institute on Drug Abuse (2015) offers a list of screening tools that have been found to be effective for adults and adolescents.

FOR ALCOHOL

- Alcohol Screening and Brief Intervention for Adolescent and Youth: A Practitioner’s Guide
- Alcohol Use Disorders Identification Test (AUDIT)
- Alcohol Use Disorders Identification Test-C (AUDIT-C)
- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)
- Center for Adolescent Substance Abuse Research: CRAFFT
- CRAFFT (Part A)
- Helping Patients Who Drink Too Much: A Clinician’s Guide
- NIDA Drug Use Screening Tool
- NIDA Drug Use Screening Tool: Quick Screen
- Screening to Brief Intervention (S2BI)

FOR DRUGS

- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)
- CRAFFT
- CRAFFT (Part A)
- DAST 20: Adolescent Version
- Drug Abuse Screen Test (DAST-10)
- NIDA Drug Use Screening Tool
- NIDA Drug Use Screening Tool: Quick Screen
- Opioid Risk Tool
- S2BI

APPENDIX II: SUBSTANCE USE DISORDER TREATMENT PROGRAMS

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

NIDA lists the following substance use disorder treatment programs:

- Behavioral therapies, including multisystemic therapy (MST)¹¹⁰
- Cognitive behavioral therapy (CBT)
- Community reinforcement approach (CRA) plus vouchers
- Contingency management (CM) interventions/motivational incentives
- Family behavior therapy (FBT)
- The Matrix Model
- Motivational enhancement therapy (MET)
- Therapeutic communities (TC)
- Twelve-step facilitation therapy

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA lists the following research-based alcohol and substance use disorder treatment programs for youth (aged 18–25) and adults (aged 26–55) in correctional facilities:

- Buprenorphine Treatment Practitioner Locator¹¹¹
- Correctional therapeutic community (CTC) for alcohol and substance abusers 6 months from prison release
- Creating Lasting Family Connections Fatherhood Program (CLFCFP), family reintegration for men
- Forever Free for women
- Helping Women Recover and Beyond Trauma for Women (manual-driven treatment)
- Interactive journaling
- Living in Balance (LIB) (manual-based)
- Moral Reconciliation Therapy (MRT) (cognitive behavioral approach)
- Opioid Treatment Program Directory¹¹²

- Texas Christian University (TCU) Mapping-Enhanced Counseling (MEC), a communication and decision-making technique to support the delivery of treatment services¹¹³

U.S. DEPARTMENT OF JUSTICE

Crime Solutions, the Justice Department registry of research-based programs and practices, lists the following practices as “effective,” mostly for reducing drug and substance use, specifically for individuals involved in the criminal justice system:

- Incarceration-based therapeutic communities for adults (effective for reducing crime and delinquency)
- Mentoring at-risk youth (effective for reducing crime and delinquency, promising for reducing drug and substance use)
- Motivational interviewing for substance use (effective for reducing drug and substance use)
- Opiate maintenance therapy for dual heroin-cocaine abusers (effective for reducing drugs and substance use for heroin/opioids)

Crime Solutions also includes the following practices found to be “promising,” also mostly for reducing drug and substance use:

- Adult drug courts (reducing crime and delinquency)
- Cognitive behavioral therapy for moderate to high-risk adults (reducing crime and delinquency)
- Incarceration-based narcotics maintenance treatment (reducing drug and substance use but no effect on crime and delinquency)¹¹⁴

It should be noted that the practices involving MAT have not been shown to be effective in reducing crime and delinquency outcomes. However, as noted in MAT’s description of “meta-analysis outcomes” relating to the finding that incarceration-based narcotics maintenance treatment has not been found to be effective in reducing crime and delinquency, this finding is influenced by the presence of a negative outlier. When this outlier is removed, the difference is no longer significant in terms of recidivism.¹¹⁵

APPENDIX III: ADVISORY ROUNDTABLE

MEMBERSHIP

Advisory Roundtable, February 3, 2017

FEDERAL PARTICIPANTS

- Co-Chair Stephen Amos, Chief, Jails Division, National Institute of Corrections
- Co-Chair Ruby Qazilbash, Associate Deputy Director, Bureau of Justice Assistance
- Anita Grant, Captain, United States Public Health Service, National Institute of Corrections
- Sandora Cathcart, Correctional Program Specialist, National Institute of Corrections
- Ronald Taylor, Chief of the Prisons Division, National Institute of Corrections
- Tim Jeffries, Senior Policy Advisor, Bureau of Justice Assistance
- DeAnna Hoskins, Policy Advisory, Bureau of Justice Assistance
- June Sivilli, Division Chief, Public Health & Public Safety, Office of National Drug Control Policy
- Nataki MacMurray, Public Health & Public Safety Analyst, Office of National Drug Control Policy
- Sidney Hairston, Public Health Advisor, Division of Pharmacological Therapies, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration
- Jennie Simpson, Policy Advisor, Substance Abuse and Mental Health Services Administration
- Annie Hollis, Health Insurance Specialist, Division of Benefits and Coverage, Centers for Medicare and Medicaid
- Tisha Wiley, Health Services Administrator, National Institute on Drug Abuse

REPRESENTATIVES FROM MODEL MAT PROGRAMS

PRISONS

- Chris Bina, Director, Pharmacy Services, Health Services Division, Bureau of Prisons
- Chris Mitchel, Assistant Deputy Commissioner, Massachusetts Department of Correction
- Kevin Pangburn, Director, Division of Substance Abuse, Kentucky Department of Corrections
- Jennifer Clarke, Medical Programs Director, Rhode Island Department of Corrections
- Shannon Robinson, Senior Psychiatry Supervisor, California Department of Corrections and Rehabilitation

SHERIFFS/JAILS

- Brad Rose, Sergeant, Sacramento County Sheriff's Department, California
- Peter Koutoujian, Sheriff, Middlesex County House of Correction, Massachusetts
- Dennis Wilson, President, Sheriffs' Association of Texas, Sheriff of Limestone County, Texas
- Carolina Montoya, Director, Office of Rehabilitation Services, Miami-Dade County Department of Corrections and Rehabilitation, Florida
- Cornita Riley, Jail Administrator, Orange County, Florida

DRUG COURTS

- Kimberly Kozlowski, Project Director, Syracuse Community Treatment Court & Onondaga City Family Treatment Court
- Hon. Robert Ziemian, District Court Judge, Massachusetts

POLICE/ PRETRIAL DIVERSION

- Fred Ryan, Chief, Arlington, Massachusetts, Police Council Chair, Police Assisted Addiction Recovery Initiative
- Elizabeth Simoni, Executive Director, Maine Pretrial Services
- Kathleen O'Toole, Chief of Police, Seattle, Washington

PROBATION AND PAROLE

- Sue De Lacy, Administrative Manager, Orange County Probation, California
- Alison Morgan, Deputy Director, Colorado Department of Parole

CORRECTIONAL AND RELATED ASSOCIATIONS

- Veronica Cunningham, Executive Director, American Probation and Parole Association
- Maeghan Gilmore, Program Director, Health, Human Services and Justice, National Association of Counties
- Jonathan Thompson, Executive Director, National Sheriffs' Association
- Jessica Vanderpool, Special Projects Director, National Sheriffs' Association
- Wayne Dickey, President, American Jail Association, Administrator, Brazos County Jail, Texas
- James Martin, Accreditation Specialist, National Commission on Correctional Health Care
- Beth Haynes, Manager, Quality and Science, American Society of Addiction Medicine
- Jeffrey Locke, Senior Policy Analyst, Homeland Security & Public Safety Division, National Governors Association

RESIDENTIAL SUBSTANCE ABUSE TREATMENT TRAINING AND TECHNICAL ASSISTANCE

- Facilitator, Andrew Klein, Project Director, Advocates for Human Potential
- Steve Valle, President, AdCare Criminal Justice Services
- Lisa Talbot Lundrigan, RSAT Faculty (ACA), Vice President, AdCare Criminal Justice Services
- Neal Shifman, President & CEO, Advocates for Human Potential
- Niki Miller, Senior Research Associate, Advocates for Human Potential

POLICY RESEARCH ORGANIZATIONS AND RESEARCHERS

- Richard Cho, Director of Behavioral Health, Council of State Government Justice Center
- Cynthia Reilly, Director of Prescription Drug Abuse Project, The Pew Charitable Trusts
- Joshua Lee, Associate Professor, New York University School of Medicine
- Mary Alice Conroy, Distinguished Professor of Psychology, Clinic Director, Sam Houston State University

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ABOUT THE NATIONAL SHERIFFS' ASSOCIATION

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