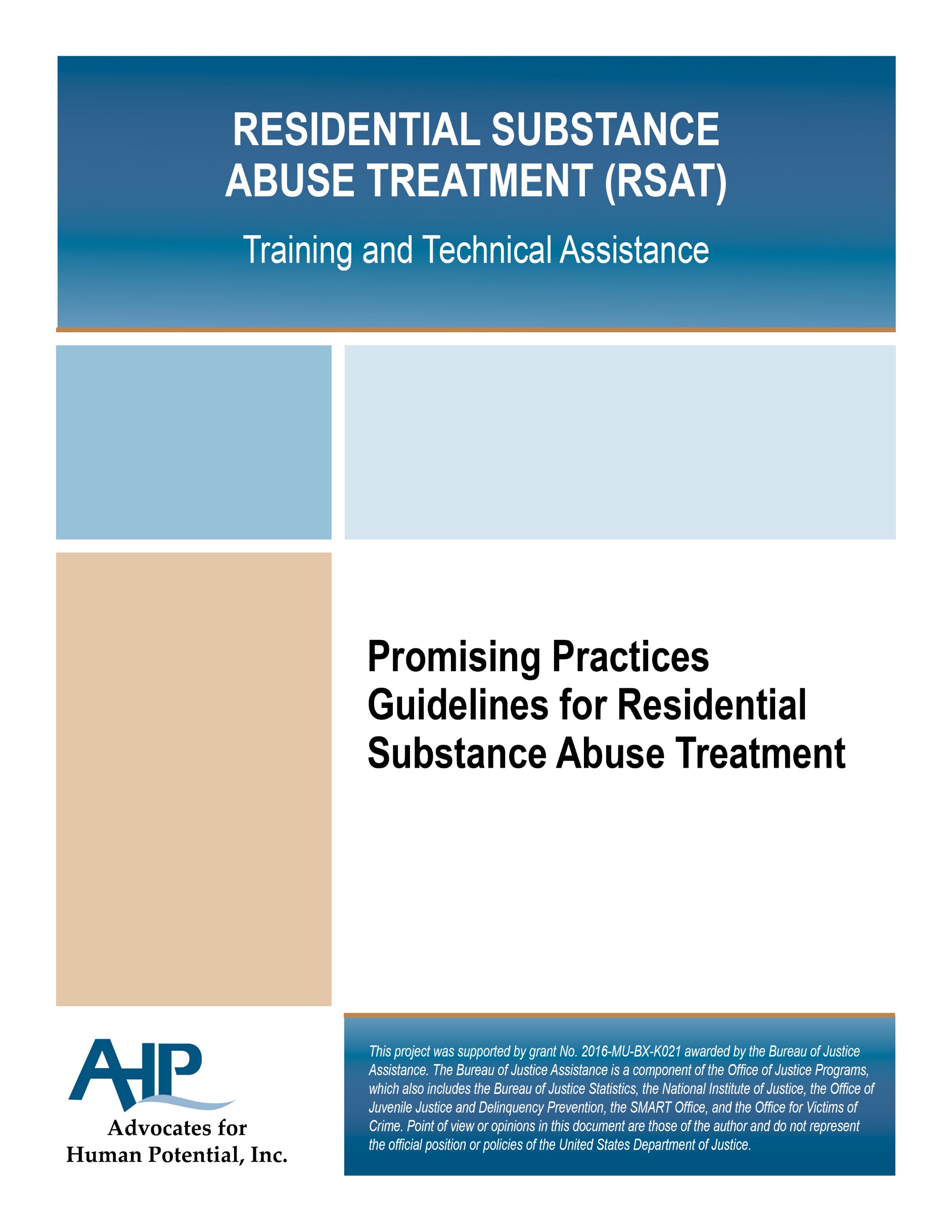
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Promising Practices Guidelines for   
Residential Substance Abuse Treatment

# Introduction

The Residential Substance Abuse Treatment (RSAT) for State Prisoners Program (42 U.S.C. § 3796ff et. seq.) assists states and local governments in the development and implementation of substance use disorder treatment programs in state, local, and tribal correctional and detention facilities. Funds are also provided to create and maintain community-based aftercare services for individuals after they are released from incarceration. As of 2016, there were approximately 77 jail, 80 state prison or juvenile, and 28 aftercare RSAT programs in all but two states, serving more than 12,000 incarcerated individuals.

Congress has set limited basic requirements for RSAT programs. Programs in state correctional facilities must be at least six months in length, and participants must be physically separated from the general population. Jail-based programs must be at least 90 days in length and physically separated from the general population if the facility permits. RSAT participants are required to be randomly tested for illicit drugs at admission into the program and during the program. The RSAT programs, if possible, are to be limited to participants with 6 to 12 months remaining in their confinement so they can be released directly from the treatment facility instead of being returned to the general population after completing the program.

**When funding RSAT programs, states are required to give preference to programs that provide aftercare services. This includes coordination between the correctional treatment program and other human service and rehabilitation programs, such as education and job training, parole supervision, halfway houses, and self-help and peer groups, that may help rehabilitate offenders. This includes more than providing phone numbers of referral agencies in the community.**

The goal of the RSAT program is to break the cycle of drugs and violence by reducing the demand for, use, and trafficking of illegal drugs. RSAT enhances the capabilities of states and units of local and tribal governments to provide residential substance abuse treatment for incarcerated individuals; prepares individuals for reintegration into their communities by incorporating reentry planning activities into treatment programs; and assists individuals and their communities through the reentry process through the delivery of community-based treatment and other broad-based aftercare services.

# RSAT Promising Practices Guidelines Goal

The goal of the following **RSAT Promising Practices Guidelines** is to assist correctional officials and practitioners at the state and county level to establish and maintain RSAT programs that adhere to the best practices suggested by existing research, related standards developed for substance abuse treatment and criminal justice programming, as well as what experts and experienced practitioners have found to work best for individuals with substance use disorders. Unlike drug courts and community-based substance abuse treatment, there is little direct research and few evaluations pertaining specifically to RSAT or correctional substance abuse treatment programming.

The Justice Department National Institute of Justice Crime Solutions registry lists only four studies of RSAT programs that have been found promising. None has received enough study for rating beyond “promising.” Programs rated as promising have some evidence to indicate they achieve their intended outcomes, but they have not been studied enough to be rated as “effective.” Programs rated as “effective,” the highest rating, by contrast have strong evidence to indicate they achieve their intended outcomes when implemented with fidelity. As stressed in the registry, however, the Registry is not intended **“to replace or supersede informed judgment and/or innovation.”** “We recognize that rigorous evaluation evidence is one of several factors to consider in justice programming, policy, and funding decisions. We also recognize the importance of encouraging and supporting innovative approaches that may not yet have extensive evidence of effectiveness.[[1]](#endnote-1)

The four Registry recognized RSAT programs include: 1) the Minnesota Department of Correction substance use disorder treatment program based on the therapeutic community (TC) model; 2) the Forever Free Program at the California Institute for Women that follows a cognitive-behavioral curriculum stressing relapse prevention designed by Gorski;[[2]](#endnote-2) 3) the Amity In-Prison Therapeutic Community located in a medium security prison in San Diego that uses workbooks, teacher’s guides, and videotapes as well as psychodrama groups and “lifer mentors,” highly committed, recovering substance users with criminal histories, and 4) the Delaware Department of Correction Key/Crest programs that begins with a prison TC component and continues with post-release community TC treatment.

The four programs vary considerably, reflecting the wide diversity of RSAT programs around the country and U.S. territories**.** The Minnesota RSAT provides 15-25 hours per week of programming with a staff to participant ratio of 1:15. Minnesota abandoned its 90-day program after it was found to be less effective than two longer term programs, one lasting 180 days and the other 365. The medium program of 180 days proved to be the most effective in reducing recidivism.

The California Forever Free program is six months and reserved for women at the end of their sentences. It provides 4 hours of programming a day, five days a week plus 8 hours of day work or education assignments, individual substance abuse counseling, special workshops, educational seminars, 12-step programs, parole planning and urine testing. The Gorski curriculum was designed to assist clients in identifying symptoms of post-acute withdrawal and relapse and teach clients skills and strategies to successfully deal with them.

The Amity In-Prison program is also a TC program. Research found it had its greatest effect, however, when its In-Prison graduates then completed up to a year of post-release residential TC treatment.

Finally, the Delaware RSAT program lasts 12 to 18 months and includes constant staff oversite and access, but only twice a week meeting group sessions. Aftercare includes six months in the residential Crest program, the last 3 months of which included daily work release. While the Key/Crest Programs were found to be effective, the Key Program alone findings were mixed, with some studies finding it effective and others not.

Again, what the few studies reported above suggest is that RSAT programs that have been studied and found to be promising vary in terms of gender served, geographical locations, treatment modalities adopted, length, structure, and aftercare. As a result of the limited study of RSAT programs, and the diversity of the few evidence-based RSAT programs documented, the following guidelines are considered “promising,” not evidence-based practices, and they are compiled as “guidelines,” not standards. It is the expectation that, once adopted, these guidelines will encourage the requisite specific research as well as practitioner feedback so that, once confirmed, these practices will form the basis of evidence-based standards for measurable improvements within RSAT and other correctional substance abuse treatment programs.

Reading the Guidelines

Each of the following nine sections begin with a general guideline issue/activity, indicated by a Roman Numeral, followed by specific practices that have been found to constitute promising practices in regard to that issue/activity. These are each contained in gray boxed texts and denoted alphabetically. The Guide describes the rationale for each promising practice and a brief description of the practice. It may also include the major relevant research (labeled **Research**) that suggests the evidence behind the practice and an example of a state department of corrections that currently incorporates that practice in its official protocols and procedures (labeled **State Department of Correction Protocol**).

The Appendix includes additional guideline more specifically focusing on medication assisted treatment programming for incarcerated individuals. It is extracted from a larger publication that addresses promising practice guidelines for ensuring access to medication assisted treatment for justice-involved populations at all criminal justice intercept points from police diversion to parole.

# Promising Practices Guidelines for Residential Substance Abuse Treatment

## I. Intake, Screening, and Assessment

The first set of guidelines deals with targeting who should be admitted into RSAT programs. Frequently, this determination is not made by counselors or persons who staff RSAT programs within the correctional institution, but are instead made by the institution’s personnel charged with classifying all new potential participants. For this reason, it is important that these personnel are fully apprised of RSAT eligibility criteria.

### A. Individuals with substance use disorders should be eligible for RSAT. To determine whether a potential participant has a substance use disorder, they should be screened using a validated instrument.[[3]](#endnote-3) However, low risk individuals with substance use disorders may be better treated in less restrictive alterative facilities, including pre-release centers, half-way houses or diversion programs in the community.

Individuals with substance use disorders are in need of treatment to prevent relapse, including increased risk of death from an opioid overdose after release, regardless of their risk for reoffending. Their imprisonment presents a unique opportunity to assist them in beginning to address their substance use disorder, set them up with continuing treatment after release, and put them on the path to long-term recovery. Although mixing low- and high-risk offenders has been found to have negative effects in community-based substance abuse treatment, there is no equivalent research within the context of prison and jail substance abuse treatment programming. Further, in most jails, all individuals, low, medium or high risk are generally housed together anyway, although state correctional systems may maintain separate maximum, medium or minimum security facilities.

As admission generally occurs at the end of an individual’s sentences, risk levels can change since the day of incarceration. Most validated risk instruments are based on historical measures, not contemporary circumstances. Facing the challenge of reentry into the community, some may be at higher risk for reoffending than they were upon entry into the institution. Others may be much lower risk for reoffending, but high risk for relapse and recidivism.

Research: A study of 30,237 released by the Washington Department of Corrections found 443 died during an average follow up period of less than two years. The overall mortality rate was 77.7 deaths per 10,000 person-years. The adjusted death rates for those released from incarceration was 3.5 times than among other state residents. During the first two weeks after release, the risk of death was 12.7 times than among other state residents, with a much more markedly elevated relative risk of death from drug overdose (129 times). Following deaths by overdose were deaths as a result of cardiovascular disease, homicide and suicide.[[4]](#endnote-4) The revised December 2015 overdose death rates posted by the

National Institute of Drug Abuse reports drug overdose deaths rising across the country from the two years before for prescription drugs, prescription opioid pain relievers, Benzodiazepines, Cocaine, and Heroin.

State Department of Correction Protocol: The State of Washington Department of Corrections policy for substance use disorder treatment services includes in its “Triage for Priority Placement” non-criminogenic factors including “pregnant or postpartum offenders,” and “HIV/AIDS or Hepatitis C positive offenders.”[[5]](#endnote-5)

### B. Although RSAT participation is voluntary, incarcerated individuals should be eligible for RSAT regardless of the sincerity of their motivation or commitment to addressing their substance use disorder.

After admission, the RSAT program should provide the motivation for individuals to commitment to treatment through motivational enhancement therapies that incentivize clients to take interest in their substance use disorders. A system should be in place to use social support for participating in programs. Research suggests that, especially when it comes to substance use, mandated treatment can be as effective as voluntary treatment. Individuals should not be referred to RSAT based on rewards or consequences for institutional behavior or plea/sentencing agreements that are antithetical to eligibility for RSAT programming.

RSAT staff should assess potential participants’ readiness to change and adapt programming to match their stage of readiness.

### C. Individuals with co-occurring disorders should be eligible for participation in RSAT as long as they are able to function in the program and not disrupt the treatment of their peers. For this reason, co-occurring disorders should be identified by utilization of a validated screening tool.[[6]](#endnote-6)

The overlap between substance use disorders and mental illness, including trauma, is substantial. Studies have found that up to 59% of state prisoners with mental illness have a co-occurring substance use disorder.[[7]](#endnote-7) To deny individuals admission to RSAT because of mental disorders has the potential to preclude too many individuals with substance use disorders in need of treatment. RSAT programming should be designed and implemented to meet the diverse needs of incarcerated populations. Allowing individuals with mental health disorders to continue to take prescribed antipsychotic medications and incorporating mental health treatment will allow many to be able to participate in RSAT programming.

### D. Following screening, either before or after being admitted to RSAT, individuals should be fully assessed for behavioral, physical health, and criminogenic risks, needs, and responsivity. Assessments should also inform the formulation of individualized treatment plans and case management for RSAT participants.

Once screened for admission into RSAT, individuals should be fully assessed for substance abuse, risk, need, responsivity, trauma, mental health, physical health, literacy, and any other factor that will affect their ability after release to remain abstinent from alcohol and/or prevent relapse and not reoffend. Assessment is the first step in treatment.[[8]](#endnote-8)

Individuals differ in terms of age, gender, ethnicity and culture, substance use disorder severity, readiness to change, recovery stage, and level of required supervision. Individuals also respond differently to different treatment approaches and treatment providers. In general, alcohol and substance use treatment should address issues of motivation, problem solving, and skill building for resisting alcohol, substance use, and criminal behavior. Lessons aimed at supplanting alcohol and substance use and criminal activities with constructive activities and at understanding the consequences of one’s behavior are also important to include. Tailored treatment interventions can facilitate the development of healthy interpersonal relationships and improve the participant’s ability to interact with family, peers, and others in the community.

Although the more limited duration of many jail RSAT programs may also limit the ability of the programs to provide intensive individualized treatment programming, completing individualized assessments may allow programs to at least define subgroups of participants with similar needs so that programming can better meet their specific sets of need.

The American Society of Addiction Medicine (ASAM) calls for the following to constitute comprehensive assessment:[[9]](#endnote-9)

* A physical exam
* A mental status exam
* Medical and psychiatric history
* A detailed past and present substance use history, including assessment of withdrawal potential
* A history of the pathological pursuit of reward or relief through engagement in addictive behaviors such as gambling or exercise
* Substance use disorder and addictive disorder treatment history and response to previous treatment, including history of use of pharmacotherapies and response to such interventions
* Family medical, psychiatric, substance use, addictive behavior and addiction treatment history
* Allergies
* Current medications
* Social history
* Consultation with appropriate collateral sources of information
* A summary of the patient’s readiness to engage in treatment, potential to continue unhealthy use or return to unhealthy engagement in substance use or addictive behaviors, and the recovery environment that can support or impede recovery
* Diagnostic formulation(s)
* Identification of facilitators and barriers to treatment engagement including patient motivational level and recovery environment

State Department of Correction Protocol: The Hawaii Department of Corrections Procedures include the following: “All patients with a drug or alcohol history shall be referred to a provider for a physical examination including:

1. an assessment of their current medical condition;
2. documentation on the medical record regarding health care findings;
3. prescription of condition specific medications, as needed;
4. referral to mental health services for documented assessments and follow-up; and
5. the ordering of appropriate diagnostic tests to evaluate for the occurrence of associated disorders such as liver disease.”[[10]](#endnote-10)

## II. Treatment Programming

REQUIRED BY STATUTE:

Treatment practices/services should be, to the extent possible, evidence- based and should develop participants’ cognitive, behavioral, social, vocational, and other skills to facilitate recovery for the substance use disorders and related problems.

### A. Treatment should target factors associated with criminal behavior in addition to substance and alcohol use disorders.

“Criminal thinking” is a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior, such as feeling entitled to have things one’s own way, feeling that one’s criminal behavior is justified, failing to accept responsibility for one’s actions, and consistently failing to anticipate or appreciate the consequences of one’s behavior. This pattern of thinking often contributes to alcohol and substance use and criminal behavior. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to alcohol and substance use and criminal behavior may improve outcomes.

### B. RSAT programs should offer treatment that is evidence-based, unless none exists for the specific treatment need being addressed.

As described earlier, almost all of the evidence-based substance use disorder treatment programs are community-based, not located in prisons and jail environments. However, in the absence of specific prison and jail evidence-based substance use disorder treatment programs, RSAT programs should adopt treatment programs that are at least evidence based for justice populations. RSAT staff must then determine that the program is transferable to an institutional correctional setting; that the researched program served an equivalent population in as equivalent a setting as possible (including age, gender, ethnicity and race, special needs, culture, and so on); that the evidence-based program can be implemented with reasonable fidelity in the specific RSAT jail or prison; that RSAT has the resources and capacity to implement the program; and that the staff, treatment and correctional as well as administration, perceive its utility.

In implementing the evidence-based program, it should be aligned with existing process and procedures that will require adaption of the program or modification of existing RSAT or prison/jail practices. As concluded in the Crime Solution Registry of evidence-based correctional programs, however, innovation requires experimentation, trying new approaches, and building on evidence-based programming to both meet the evolving needs of RSAT participants as well as the evolving dictates of research. Treatment and correctional staff need the knowledge and skills to use any program. There needs to be a feedback loop to see that the program fits, is implemented with fidelity, and works as implemented.[[11]](#endnote-11)

Clinical supervision of RSAT treatment staff may both help ensure fidelity to the treatment model as well as offer support to RSAT counselors and staff.

### C. Offenders with co-occurring drug and/or alcohol abuse and mental health issues require an integrated treatment approach.[[12]](#endnote-12)

Personality, cognitive, and other serious mental disorders can be difficult to treat and may disrupt substance use disorder treatment. The presence of co-occurring disorders may require an integrated approach that combines alcohol and substance use disorder treatment with psychiatric treatment, including the use of medication. Individuals with either an alcohol and substance use or mental health problem should be assessed for the presence of the other. Although mental illness is not a general risk factor for recidivism, it is a factor for program responsivity.[[13]](#endnote-13)

### D. Medications should be considered part of the contemporary standard of care for the treatment of individuals with alcohol and opioid use disorders and also for individuals with co-occurring mental illness.

Medicines used in medication-assisted treatment (MAT), such as Methadone, Buprenorphine, and Naltrexone, for opioid use disorders and Naltrexone, Acamprosate Calcium and Disulfiram for alcohol use disorders should be made available to individuals who could benefit from them.[[14]](#endnote-14),[[15]](#endnote-15) Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in both prison/jail and the community. If potential RSAT participants are on licit antipsychotic medication, they should be allowed to continue receiving the medication pending medical and psychiatric assessments. Antipsychotic medication discontinuity has the potential to affect both recidivism and health care costs after release as well as disorder, overuse of solitary confinement, and suicide within prisons/jails.[[16]](#endnote-16)

If RSAT participants are on prescribed FDA-approved agonist (Methadone) or partial agonist (buprenorphine) medications for opioid disorders, they should be allowed into RSAT programs and either allowed to continue the medication or be given the option of safely tapering off the medication while in the program. Programs should also assist RSAT graduates obtain access to appropriate medication upon release if they, their physicians and treatment providers deem it appropriate.

Medication assisted treatment begun or continued in prison or jail results in much higher rates of aftercare treatment entry post-release than inmates who receive in-jail or prison treatment without medication.

The National Governors Association has called upon state corrections to: 1) increase access to MAT in prisons and correctional settings; 2) ensure continued access to MAT upon reentry into the community; and 3) provide overdose education and naloxone for offenders during the re-entry process, when they are most vulnerable to overdose.[[17]](#endnote-17) The National Commission on Correctional Health Care adopted the following position in 2015 that also includes that correctional staff “undergo training that includes education regarding opioid overdose and its signs; correct technique for administration of naloxone, either by intramuscular injection (medical staff) or by nasal inhalation (medical and nonmedical staff); positioning of the individual; and essential related procedures, including performance of cardiopulmonary resuscitation and emergency transfer of the individual to a facility equipped to treat overdose.”[[18]](#endnote-18)

Research: A trio of studies typify the effectiveness of these medications specifically for prison and jail populations. A randomized clinical trial of prison-initiated Buprenorphine provided to male and female individuals who were previously heroin dependent prior to incarceration found that those receiving the medication were significantly more likely to enter community treatment upon release (47.5% vs. 33.7%). However, the researchers noted that, although Buprenorphine can facilitate community treatment entry, concerns remain with in-prison treatment due to attempted diversion of medication.[[19]](#endnote-19) A study at Riker’s Island jail in New York City found the use of injectable Naltrexone decreased illicit opioid use by more than 50% following release.[[20]](#endnote-20) And a Methadone maintenance treatment with counseling in a Baltimore prison that continued upon release reported half the rate of illicit opioid use compared to those who received counseling only.[[21]](#endnote-21)

*Note:*Additional, more detailed and specific guidelines on MAT are included in the Appendix.

### E. BJA RSAT length requirements should be considered minimum, not maximum limits and, optimally, RSAT durations should depend on each participant’s needs and circumstances.

The treatment provided by RSAT programs should be considered the first phase of ongoing treatment that begins in prison or jail but continues after release. Institutional administrators, paroling authorities, and judges should be advised to allow participants to remain in RSAT programs at least for these minimum lengths. Potential RSAT participants should be advised in advance, however, if RSAT program completion will impact on their eligibility to be considered for early release, one way or the other.

Research: Two studies of a jail RSAT program found that those who did not complete their RSAT program, including those who did not complete because they were granted early parole, had significantly higher recidivism rates post release than those who complete the program.[[22]](#endnote-22) Graduation from one phase to the next should be based on behavior, not time.

### F. RSAT treatment programs should be provided in flexible phases, based on participants reaching specified behavioral and recovery milestones.

As recommended by the Adult Drug Court Best Practice Standards Committee, RSAT programming should be designed so that participants receive services in phases. The first addresses responsivity needs such as orientation to the rules of the RSAT pod and program, mental health symptoms, substance-related cravings, withdrawal, anhedonia, or readiness to change and motivation. In the next phase, services address resolution of criminogenic needs that co-occur with substance abuse, including criminal thinking and the like. In the last phase, services are provided that are designed to maintain treatment gains by enhancing RSAT participants’ long-term adaptive functioning.[[23]](#endnote-23)

### G. RSAT programs should be culturally competent.

The development of culturally responsive clinical skills is vital to the effectiveness of behavioral health services. According to the U.S. Department of Health and Human Services (HHS), cultural competence “refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time.” Culturally responsive skills can improve client engagement in services, therapeutic relation-ships between clients and providers, and treatment retention and outcomes. Cultural competence is an essential ingredient in decreasing disparities in behavioral health.[[24]](#endnote-24)

Knowledge of a culture’s attitudes toward mental illness, substance use, healing, and help-seeking patterns, practices, and beliefs is essential in understanding iindividuals’ presenting problems, developing culturally competent counseling skills, and formulating culturally relevant agency policies and procedures. RSAT staff need to learn and understand how identification with one or more cultural groups influences each client’s worldview, beliefs, and traditions surrounding initiation of use, healing, and treatment.[[25]](#endnote-25)

SAMHSA has developed a checklist to evaluate cultural competence in treatment programs and organizations, some of which is applicable for RSAT programs. The checklist as well includes acculturation and ethnic identity measures.[[26]](#endnote-26)

State Department of Correction Protocol: The Virginia Department of Corrections provides that its therapeutic community programs with substance use disorders must include, at a minimum, “culturally sensitive treatment objectives, as appropriate.”[[27]](#endnote-27)

### H. Positive programming should account for the majority of the participants’ day.

Although many RSAT participants will be segregated from the general prison or jail population, negative influences can be further minimized if individuals are involved in positive programming most of the day. For this reason, it is imperative that correctional officers who spend more direct facetime with participants than treatment staff reinforce program behavioral standards and activities promoted by RSAT treatment staff. It is suggested that cross-training officers and RSAT treatment staff will encourage consistent, positive reinforcement for treatment. Keeping RSAT participants positively engaged is one of the reasons why many RSAT programs employ modified therapeutic communities to address participants’ substance use disorders. Some programs use activity logs to track participants’ structured activities. Others provide participants with electronic tablets that can be monitored to measure time spent on specific educational or treatment programming available on the tablet.

### I. Recovery support is a critical component of ongoing recovery success during RSAT treatment and after release.

Connections to safe and supportive peers, other people in addiction recovery, and pro-social networks of support are important components of successful RSAT programs. Often re-entering individuals with long histories of substance use have very few contacts on the outside that are not connected with drug and alcohol use. Some have no contact with supportive family members; even a good friend who does not use drugs may be a thing of the past. Increasing RSAT participants’ connections to pro-social peer support begins in the treatment setting and is a key aspect of the therapeutic community approach. Recovering peers have role in treatment settings - distinct from staff. In RSAT programs, an outside peer recovery presence is desirable; however, peers who have completed treatment and are awaiting release can serve a similar purpose. Just as peers are not qualified to do certain things that counselors do, peers are uniquely qualified to do what professionals cannot. These unique contributions fall into four categories that complement professional services. Peers in addiction recovery can:

1. Promote hope through positive self-disclosure; assuring others that recovery is possible.
2. Model recovery thinking, re-entry success, positive parenting, and gainful employment.
3. Share knowledge, unwritten rules, resources, and pro-social "street smarts,” vital for navigating social services systems.
4. Engage others in informal networks of support that provide an alternative to anti-social companions and activities.

Recovery coaching, mentoring, attendance at recovery support groups, and connections to local recovery community resources are examples of peer-led elements of successful RSAT programs.

Research: Multiple studies have verified the effectiveness of peer support programs for adolescents in the juvenile justice system, women offenders, justice-involved veterans, and adult offenders in addition to treatment.[[28]](#endnote-28)

## III. Treatment Modalities and Structured Program Activities

### A. RSAT treatment programming should be responsive to a diverse population, include both group and individual counseling, delivered in a therapeutic milieu that supports and reinforces the acquisition of skills required to sustain recovery, and be periodically reviewed to ensure adopted modalities provide the best fit for participants.

Treatment programs should include both group and individual counseling to accommodate diverse needs of participants. Both cognitive behavioral therapy and modified therapeutic communities have been found to be effective treatment modalities for RSAT programs. NIDA has listed the following behavioral therapies as helpful to engage people in alcohol and substance use disorder treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for alcohol and other drugs and prompt another cycle of compulsive abuse:

* Cognitive behavioral therapy (CBT)
* Therapeutic Communities (TC)
* Contingency management (CM) interventions/motivational incentives
* Community reinforcement approach (CRA) plus vouchers
* Motivational enhancement therapy (MET)
* The Matrix Model
* Twelve-step facilitation therapy
* Family behavior therapy (FBT)
* Behavioral therapies, including Multisystemic Therapy (MST)[[29]](#endnote-29)

In addition to these behavioral therapies, NIDA also includes pharmacotherapies. For opioid addiction, it lists Methadone, Buprenorphine, and Naltrexone. For alcohol addiction it lists Naltrexone, Acamprosate, Disulfiram, and Topiramate.[[30]](#endnote-30)

The Substance Abuse and Mental Health Services Administration (SAMHSA) lists the following as evidence-based alcohol and substance use disorder treatment programs specifically for youth (ages 18–25) and adults (ages 26–55) in correctional facilities:

* Correctional Therapeutic Community for Alcohol and Substance Abusers (CTC) six months from prison release,
* [Creating Lasting Family Connections Fatherhood Program (CLFCFP) for family reintegration](http://nrepp.samhsa.gov/ViewIntervention.aspx?id=324) 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 Reconation Therapy (MRT) (cognitive behavioral approach), and
* Texas Christian University (TCU) Mapping-Enhanced Counseling (MEC), a communication and decision-making technique designed to support delivery of treatment services.[[31]](#endnote-31)

All of these evidence-based behavioral therapies found effective in addressing alcohol and substance abuse are for particular drugs of abuse and have been studied primarily in community settings. Their use in correctional settings requires adjustments and modifications. As a result, once implemented, it is imperative that RSAT programs evaluate whether they have maintained fidelity to the essential elements of the treatment that have been found effective and that the program, as modified and implemented, achieves commensurate results as that found in the research.

RSAT programs have also found evidence-based manualized treatment interventions to be effective, offering structure and consistency. They are also easy to use and can help focus sessions, although they can be restrictive and counselors need to incorporate personal style and creativity in their use.[[32]](#endnote-32) The quality of the interpersonal relationships between staff and the offenders, along with the skills of the staff, are as important to risk reduction as the specific programs in which offenders participate.[[33]](#endnote-33)

### B. Therapeutic communities should be adapted to function within a prison or jail without sacrificing the essential components of a therapeutic community.

Incarceration-based Therapeutic Communities (TCs) for adults have been found to be effective for multiple crime/offense types. TCs use a comprehensive, residential drug treatment program model for treating substance-abusing and addicted populations to foster changes in attitudes, perceptions, and behaviors related to substance use. The practice is rated “Effective” in Crime Solutions, reducing recidivism rates after release for participants in the TCs. The defining feature of TCs is the emphasis on participation by all members of the program in the overall goal of reducing substance use and recidivism. The TC theory proposes that recovery involves rehabilitation to learn healthy behaviors and habilitation to integrate those healthy behaviors into a routine.[[34]](#endnote-34) TCs differ from other models of treatment by their focus on recovery, overall lifestyle changes, and the use of the “community” as the key instrument for that change.[[35]](#endnote-35) The community includes peers and facility staff. TCs use a stepping-stone model in which participants’ progress through several levels of treatment. As they progress through each treatment level, their level of responsibility also increases. TCs are implemented in a residential setting to help participant adjust to the idea of a community working together toward a common goal.[[36]](#endnote-36) Treatment includes aftercare and reentry services as a means of providing continued support and relapse prevention after leaving the community.[[37]](#endnote-37)

Modified therapeutic communities for offenders with mental illness and chemical abuse disorders have also been found to be “promising” in Crime Solutions.[[38]](#endnote-38)

For TCs to be most effective, the Therapeutic Communities of America, a membership organization of over 650 substance abuse and mental health treatment centers, recommends:

1. It is most desirable to have at least some staff who can serve as ex-addict/offender role models or at least some ex-addict/offender role models involved in the program in some capacity, even as outside guest speakers, especially peers.
2. There must be a prevailing culture of positive peer pressure that counteracts the "inmate code" of the general population.
3. There must be a strong sense of community, with a common language, rituals and rites of passage, that prevents a "we-they dichotomy."
4. There must be a shared locus of control, with residents involved in running the program, but with staff maintaining ultimate control and applying it with rational authority and acting as pro-social role models.
5. Cooperation and continuous communication with security and administration personnel (e.g., warden) is essential to the autonomous functioning of the therapeutic community.
6. There must be a pro-social code of morality—“right living”—that promotes empathic relations between staff and clients along with open communication, honesty, trust, positive work ethic, community responsibility, etc.
7. Members should be organized by job functions in a hierarchical structure with corresponding rewards.
8. The community must adhere to strict behavioral expectations with certain consequences and sanctions applied in a mutual effort by other members and staff.
9. To ensure there is no corruption or programmatic drifting, it is essential to have regular therapeutic community-specific monitoring and training from outside the community.[[39]](#endnote-39)

Therapeutic communities using CBT are the most supported model. Key components include   
the following:

1. having counselor-led groups,
2. having peer-led groups,
3. providing a process for a participant to increase his/her role,
4. using the group to establish norms to socialize the group,
5. having individuals reward others,
6. creating an environment that supports change,
7. having separate housing units,
8. instilling a sense of unity and pride, and
9. including family treatment to develop social support network.

Therapeutic communities have a history of treating clients involved in the criminal justice system, and the therapeutic community focus on treating the whole person (as opposed to drug problems exclusively) is particularly appropriate for RSAT populations. A considerable body of research supports the effectiveness of therapeutic community treatment for offenders, particularly in a continuum of care that involves prison treatment followed by community treatment.[[40]](#endnote-40)

Research: Synthesized results from 30 studies that examined the effectiveness of incarceration-based therapeutic communities for adults on recidivism post-release indicated that treatment group offenders were significantly less likely to recidivate than comparison group offenders after release (odds ratio = 1.38 for the treatment group). This means that if the comparison group has an assumed recidivism rate of 35 percent, treatment group offenders have a 28 percent recidivism rate.[[41]](#endnote-41) Another analysis of 18 effect sizes on the effectiveness of incarceration-based therapeutic communities for adults on recidivism indicated that treatment group offenders were significantly less likely to recidivate than comparison group offenders (effect size = –0.12).[[42]](#endnote-42)

### C. Cognitive behavioral therapy (CBT) should not be limited to specific CBT sessions, but instead should be practiced and reinforced across the program and staff, including both treatment staff and correctional officers.

Cognitive behavioral therapy (CBT) is a problem-focused, therapeutic approach that attempts to help people identify and change dysfunctional beliefs, thoughts, and patterns of behavior that contribute to their problem behaviors. For adult offenders, CBT explains how cognitive deficits, distortion, and flawed thinking processes can lead to criminal behavior. CBT programs emphasize individual accountability and attempt to help adult offenders to understand their thinking processes and the choices they make before they commit a crime.[[43]](#endnote-43)

CBT is based on a theoretical foundation that focuses on how “criminal thinking” contributes to criminal behavior and offending. For instance, distorted cognition is a characteristic very often found in criminal offenders. This can include self-justificatory thinking, misinterpretation of social cues, feelings of dominance and entitlement, and a lack of moral reasoning. CBT is based on the idea that an offender’s cognitive deficits and criminal-thinking patterns are learned, and not inherited, behavior. Therefore, CBT interventions typically use a set of structured techniques that attempt to build cognitive skills in areas in which offenders show deficits. CBT can also restructure cognition in areas where offenders show biased or distorted thinking.

RSAT staff, officers and treatment staff, should focus on changing behavior and thinking, provide skills training and opportunities for skill rehearsal, and teach participants to become aware of his/her thinking verbalize his/her thoughts; stop reacting to automatic thoughts; and understand how thoughts and beliefs trigger criminal and addictive behaviors. All RSAT staff should understand the program’s basic CBT approach and key terms and on-site behavior should be consistent with the CB principles; CBT sessions should be monitored periodically to assure that proper techniques are employed; Staff should reinforce CB principles or skills outside of CBT sessions; Other treatment tools and program rules should be consistent with CB principles; Participants should be held accountable for CB homework and for applying CB skills or principles in their ongoing program activities.[[44]](#endnote-44)

The National Institute of Corrections (NIC) has developed a cognitive-behavioral curriculum called Thinking for a Change. The program is rated “promising” by Crime Solutions. The curriculum has made a statistically significant difference in the proportion of offenders who recidivated between the treatment group and the control group, with the latter being 57 percent more likely to be arrested during the follow-up period.[[45]](#endnote-45)

SAMHSA’s National Registry of Evidence-based Programs and Practices lists more than 20 CBT-based programs, <http://nrepp.samhsa.gov/AdvancedSearch.aspx>. Crime Solutions finds Cognitive Behavioral Therapy (CBT) for moderate and high risk adult offenders has been found to be “promising.”

Research: Aggregating the results from 32 studies to examine the impact of cognitive behavioral therapy (CBT) on crimes committed by moderate- and high-risk adult offenders, researchers found a significant effect size (-0.14) favoring the treatment group, meaning that moderate- and high-risk adult offenders who received CBT were significantly less likely to commit crime, compared with adult offenders who did not receive CBT. [[46]](#endnote-46)

### D. Motivational Interviewing (MI) for Substance Abuse strengthens participants’ motivations to stop using drugs and alcohol and constitutes an important component of RSAT programming for participants who have volunteered for treatment but with varying degrees of commitment to abstinence.

Motivational Interviewing (MI) has been found to be “effective.” MI is a brief client-centered, semi-directive psychological treatment approach that concentrates on improving and strengthening individuals’ motivations to change. MI aims to increase an individual’s perspective on the importance of change. When provided to those who abuse substances, the long-term goal is to help them reduce or stop using drugs and alcohol. MI targets individuals who are less motivated or ready to change, and who may show more anger or opposition. MI can target substance abusers who may be ambivalent about changing their behavior. MI is a brief intervention. The substance abuser and the MI counselor will typically meet from one to four times, for about 1 hour each session. The settings of delivery can vary and consist of aftercare/outpatient clinics, inpatient facilities, correctional facilities, halfway houses, and other community-based settings. MI incorporates four basic principles into treatment: 1) expressing empathy, 2) developing discrepancy, 3) rolling with resistance, and 4) developing self-efficacy.

Research: Twelve studies looking at the extent of substance use when comparing individuals who received motivational interviewing (MI) with individuals who received no treatment at follow-up periods between 6 and 12 months showed that individuals in the MI treatment groups significantly reduced their use of substances compared with individuals in the no-treatment control groups. However, the effect size was small (standardized mean difference=0.15).[[47]](#endnote-47)

### E. Treatment plans must be assessed and modified periodically to meet changing needs of participants and incorporate planning for transitioning into the community.

The adoption of an evidence-based treatment program does not guarantee the same results found in the research. while RSAT program should adopt evidence-based practice, this requires definable and measurable outcomes so program effectiveness can be determined. In addition, it requires documentation of case information, including formal, valid mechanism for measuring outcomes. RSATs must routinely assess offender change in cognitive and skill development, and evaluate recidivism and relapse rates of RSAT graduates. Also, there should be periodic staff performance evaluations to achieve greater fidelity to the evidence-based program design, service delivery principles and outcomes. Staff monitoring, measuring and reinforcing promotes staff cohesiveness and greater support to the program mission.[[48]](#endnote-48) Just as RSAT participants need feedback, so to RSAT staff.[[49]](#endnote-49)

### F. RSAT programs should include compatible treatment and social services.

Although all RSAT participants are engaged in treatment for alcohol and/or substance use disorders, other needs must be addressed while they are incarcerated to prepare them for reintegrating into the community. Examples include the following, also identified by drug court researchers:[[50]](#endnote-50)

* clinical case management,
* housing assistance (sober/drug-free)
* mental health treatment,
* trauma-informed and specific services,
* criminal thinking interventions,
* family and social support and interpersonal counseling,
* recovery community support
* peer recovery support
* pro-social and recreational activities
* vocational and educational services,
* medical and dental treatment,
* prevention of health-risk behaviors, and
* overdose prevention and reversal, including provision of Naloxone (Narcan) to individuals after they are released or their family member/significant other.

### G. RSAT programs should be trauma-informed regardless of whether trauma-specific services are provided.

At least one third of males and two thirds of females in RSAT programs may be experiencing lasting effects of trauma exposure that play a role in their continued use of drugs and alcohol.[[51]](#endnote-51) Part of responsivity is ensuring that RSAT programming is accessible to participants who have experienced trauma. For this reason, all programming should be trauma-informed as much as possible, given that prisons and jails present challenging settings for trauma-informed approaches. Prisons and jails are designed to house perpetrators, not victims. For an individual with Post Traumatic Stress Disorder (PTSD), there are scores of unavoidable triggers—shackles, overcrowded housing units, lights that are on all night, loud speakers that blare without warning and severely limited privacy. Pat downs and strip searches, frequent discipline from authority figures and restricted movement may all mimic certain dynamics of past abuse. All of these factors are likely to aggravate trauma-related behaviors and symptoms that can be difficult for staff to manage.[[52]](#endnote-52) Individuals with Post-Traumatic Stress Disorder (PTSD) may have used alcohol and drugs to cope with trauma responses and triggers. With the removal of these from the individual’s life, trauma-related symptoms may worsen.[[53]](#endnote-53)

Integrating trauma stabilization and coping skills training in RSAT’s alcohol and substance abuse programs will make the substance abuse treatment more accessible for individuals who have experienced trauma. Trauma-informed programs and cognitive behavioral trauma-specific interventions can help offenders master the skills that will set the stage for engagement in effective recovery programming. Trauma-informed RSAT programs have staffs who understand trauma and its impact on the addiction and recovery process; services designed to enhance safety, minimize triggers, and prevent re-traumatization; encourages relationships between staff and participants based on equity and healing, empowering trauma survivors with information, hope and appropriate referrals upon release. Although there cannot be equity in relationships between staff and RSAT participants, participant councils, for example, can be formed to give participants some input into how the RSAT programs or pods operate that do not compromise the security and safety of the institution. Trauma-specific services include specific groups and effective interventions aimed at coping with the aftermath of trauma, decreasing symptoms of trauma-related disorders and increasing knowledge about trauma. Individuals are empowered with skills and techniques to manage and lesson the effects of trauma in their ongoing recovery. Although trauma-specific interventions have been found to be more powerful in reducing symptoms of trauma-related disorders than trauma-informed services alone, even they are most effective when delivered in a trauma-informed environment. The combination of the two is more effective than either one alone.[[54]](#endnote-54)

State Department of Correction Protocol: New York Department of Corrections provides a Female Trauma Recovery Program utilizes the Trauma Recovery Empowerment Model (TREM).[[55]](#endnote-55) Other issues addressed include substance abuse, parenting, health issues, and building interpersonal and resource networks. The program is followed by development of an aftercare plan for participants with ongoing treatment needs.[[56]](#endnote-56)

### H. RSAT programs that serve individuals with co-occurring disorders should offer integrated treatment as appropriate.

For many RSAT participants, the justice system may be their first exposure to substance use disorder treatment. Others may have made multiple attempts at treatment and recovery, but untreated mental health issues have sabotaged each period of recovery, resulting in a revolving door of recidivism. Still others may have accessed mental health services while their substance use problems went unaddressed and eventually contributed to their criminal justice involvement. Co-occurring mental health conditions among individuals with substance use disorders should to be considered more the rule rather than the exception. Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime.[[57]](#endnote-57) Therefore, within specialty mental health and substance use clinical settings, it is the norm rather than the exception to see consumers with co-occurring disorders. RSAT programs should establish procedures for collaboration with mental health treatment staff.

RSAT staff should receive training on the signs and symptoms of mental health disorders and information on how the presence of one disorder can impact treatment and recovery from the other. Although those participating in RSAT programs may have been screened for mental health disorders, symptoms can emerge or develop during the course of substance use disorder treatment. RSAT staffs need to know how to identify RSAT participants that may require further screening and assessment by a qualified mental health professional.

There are different strategies RSAT programs can employ in dealing with individuals with co-occurring disorders. Some RSAT programs may be geared specifically to the needs of individuals with both mental health and substance use disorders, offering integrated treatment. Other programs work with mental health staff providing parallel treatment to RSAT participants with mental health issues. In some cases, services may be delivered sequentially, with RSAT participants completing a required course of mental health treatment to stabilize and manage their symptoms prior to their admission into addiction treatment.

According to the [National Institutes of Health](http://www.nih.gov/) and the [Substance Abuse and Mental Health](http://www.samhsa.gov/) Services Administration, both substance use and mental health disorders are brain conditions that respond better to integrated approaches that combine elements helpful to both mental health and addiction recovery into a comprehensive treatment program. The challenge for RSAT staff is to understand how these conditions interact, to provide RSAT participants with tools to manage recovery from both, and to ensure pre-release planning facilitates connections to the full range of required services and supports. Fortunately, a number of evidence-based approaches are effective for both substance use and mental health disorders. Fortunately, there are a number of evidence-based approaches that have proven effective for both substance use and mental health disorders, including: 1) Pharmacotherapies; 2) Motivational Approaches such as motivational interviewing, motivational enhancement therapy and contingency management; and 3) Illness Management and Recovery. The latter refers to a set of practices that teach people with mental illness how to manage their disorder, how to work with treatment providers, and friends and family to sustain recovery. These strategies align with current substance use disorder treatment principles, which impart information, tools and resources that empower people to effectively manage ongoing recovery.

SAMHSA has developed practice principles for integrated treatment as follows:

* Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders;
* Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses;
* Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages;
* Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage;
* Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages;
* Multiple formats for services are available, including individual, group, self-help, and family;
* Medication services are integrated and coordinated with psychosocial services.

Research shows that consumers in Integrated Treatment programs are more successful than consumers in non-integrated programs in the following areas: Reduced substance use; Improvement in psychiatric symptoms and functioning; Decreased hospitalization; Increased housing stability; Fewer arrests; and Improved quality of life.[[58]](#endnote-58)  In short, individuals with co-occurring disorders have high rates of recovery when provided Integrated Treatment for Co-Occurring Disorders. Briefly stated, research shows that consumers in Integrated Treatment programs were more successful than consumers in non-integrated programs in the following areas: Reduced substance use; Improvement in psychiatric symptoms and functioning; Decreased hospitalization; Increased housing stability; Fewer arrests; and Improved quality of life. In short, consumers with co-occurring disorders have high rates of recovery when provided Integrated Treatment for Co-Occurring Disorders.[[59]](#endnote-59)

Seeking Safety, a manualized cognitive–behavioral intervention for incarcerated women with co-occurring posttraumatic stress disorder (PTSD) and substance use disorders is rated “Promising” by Crime Solutions. Evaluation results suggest that the program significantly reduced PTSD and depression scores in program participants

**State Department of Correction Protocol:** The Georgia Department of Corrections provides an example, having opened two integrated treatment facilities in 2012. The program is nine months, highly structured, actively combining interventions intended to address both mental health and substance use disorder issues in persons with co-occurring disorders with the intention of treating both disorders, related problems and the whole person more effectively in a residential therapeutic community including a balance of individual and group sessions. Elements include screening, assessment to include risk-need responsivity, individualized treatment, on-going monitoring of mental health symptoms, cognitive behavioral treatment, illness management, trauma-focused treatment, psychoeducational, therapy, cognitive restricting groups, motivational enhancement therapy, relapse prevention, medication assisted therapies, psycho-pharmacologic interventions and illness management, problem-solving skills, dual recovery mutual self-help recovery, and a reentry plan to include a Wellness Recovery Action Plan (WRAP).[[60]](#endnote-60) Similarly, the New York Department of Corrections provides for “Integrated Dual Disorder Treatment” where “substance abuse services are co-facilitated by trained substance use treatment staff and mental health professionals.”[[61]](#endnote-61)

## IV. Drug-Free Environments

REQUIRED BY BJA/STATUTE: A state must also agree to implement or continue to require urinalysis or other proven forms of testing, including both periodic and random testing—  
1) of an individual before the individual enters a residential substance abuse treatment program and during the period in which the individual participates in the treatment program; and 2) of an individual released from a residential substance abuse treatment program if the individual remains in the custody of the state.

### A. Urine testing should be supervised, periodic, and random. In addition, it should be done to ensure abstinence for participants who will be provided injected Naltrexone prior to their release.

Alcohol and substance use during treatment should be carefully monitored. Individuals trying to recover from alcohol and drug addiction may experience a relapse, and return to drug use. Triggers for relapse are varied; common ones include mental stress and associations with peers and social situations linked to drug use. An undetected relapse can progress to serious alcohol and substance abuse, but detected use 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—determining rewards and sanctions to facilitate change, and modifying treatment plans according to progress. In jails that do not have the facilities to separate RSAT participants from the general population, alcohol and other drug testing should be more prevalent.

If RSAT participants are to be provided Naltrexone, oral or injected, they must be drug tested first for opioids as abstinence for at least seven days is required before they can take this medication. Although Naltrexone also blocks the effects of alcohol, individuals do not have to be alcohol free before taking Naltrexone.

## V. Health Insurance

### A. In order for RSAT graduates to take full advantage of aftercare treatment and medication assisted treatment after release, it is essential that they have obtained access to Medicaid or any other health insurance for which they are eligible. In addition, they must have basic health care literacy so that they use the health care system appropriately to meet their physical and behavioral health needs, including access to preferred medication for assisted treatment.

Any gains in substance abuse treatment obtained in RSAT may dissipate upon release, especially if the RSAT graduates return to the same environments and peers which contributed to their drug use. RSAT treatment should be considered preliminary or the first phase of treatment for long term recovery. Insurance or access to free care is essential for the necessary continued treatment in the community.

In addition to substance use disorders, many RSAT participants are likely to have other significant physical and behavioral health care needs requiring regular access to care after release.[[62]](#endnote-62),[[63]](#endnote-63) Without access to health services immediately upon release, recently incarcerated individuals’ physical and mental health conditions may deteriorate. In fact, research shows that individuals face a markedly increased risk of death—more than 12 times that of other individuals—during the first two weeks after release. For drug addiction, the death risk is 129 times more likely.[[64]](#endnote-64) Research suggests that providing access to Medicaid upon release can promote more timely access to care, which may reduce that risk, particularly for individuals with chronic physical or mental health conditions.[[65]](#endnote-65) In addition, continuous access to health care immediately after release may reduce the risk of re-arrest and reincarceration.[[66]](#endnote-66)

In Medicaid expansion states, eligible RSAT participants (as all incarcerated populations) should be enrolled in their state’s Medicaid program. There is no federal statute, regulation, or policy that prevents individuals from being enrolled in Medicaid while incarcerated. Notably, in 2004, CMS issued guidance reminding states that “[i]ndividuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during and after the time in which they are held involuntarily in secure custody of a public institution.” Federal law requires states to allow individuals to apply for Medicaid at any time. In all states, incarcerated populations may be enrolled in available subsidized or non-subsidized insurance plans offered through their state’s market exchanges.

While all incarcerated populations should be enrolled in Medicaid or obtain available health insurance before release, RSAT programs should also assist participants and provide basic information for utilization of same. Enrollment is just the first step. The second is appropriate utilization of the treatment and services covered.

The Bureau of Justice Assistance (BJA) and the American Correctional Association (ACA) released July 18, 2016, Health Care Reform, The Patient Protection and Affordable Care Act, A Practical Guide for Corrections and Criminal Justice Professionals that outlines enrollment strategies, structure for delivery of Medicaid services within states, and specifically a section on reentry from jails/prisons to the community. The latter section describes important linkages to community health services including Federally Qualified Health Centers (FQHC) and Medicaid health home referrals, as well as the need to establish processes for transmitting prison/jail health records to community providers. Other innovative linkages for justice-involved populations are described in Coordinating Access to Services for Justice Involved Populations, released by the Milbank Memorial Fund in August 2016.[[67]](#endnote-67)

The National Governors Association has called for states to consider suspending, rather than terminating Medicaid coverage during incarceration to facilitate access to treatment upon release.[[68]](#endnote-68)

### B. If RSAT participants require hospitalization, RSAT programs should recommend out-of-institution in-patient care as appropriate with security needs to reduce institutional health care costs.

Although Medicaid will not generally cover RSAT participants while incarcerated, it will cover care received by them in an inpatient hospital or other medical institution outside the prison or jail. States may receive Medicaid reimbursement for care provided to eligible individuals admitted as inpatients to a medical institution, such as a hospital, nursing facility, psychiatric facility, or intermediate care facility. This is also another reason why states should suspend as oppose to terminate the Medicaid enrollment for incarcerated populations. Temporary suspensions will facilitate reimbursement for these out of prison/jail hospitalizations.

### C. RSAT programs should work with their correctional systems to encourage state Medicaid managed care contract provisions that require plans to provide care coordination services to individuals upon release from jail or prison and recommend that eligible participants enroll in them.

Medicaid managed care entities, including “health homes,” may be well-positioned to help Medicaid enrollees quickly access necessary community-based services during this time period. Colorado, for example, requires behavioral health plans to “collaborate with agencies responsible for the administration of jails, prisons and juvenile detention facilities to coordinate the discharge and transition” of enrollees. In addition to ensuring that enrollees leaving incarceration receive medically necessary behavioral health services, plans must propose innovative strategies to meet the needs of enrollees involved with the criminal justice system.

Florida, for example, requires Medicaid managed care plans to “make every effort…to provide medically necessary community-based services for Health Plan enrollees who have justice system involvement.” Among other things, plans must: (1) provide psychiatric services to enrollees and likely enrollees within 24 hours after release from a correctional facility; (2) ensure that enrollees are linked to services and receive routine care within 7 days after release; (3) conduct outreach to populations of enrollees “at risk of justice system involvement, as well as those Health Plan enrollees currently involved in this system, to assure that services are accessible and provided when necessary.” In addition, plans must work to develop agreements with correctional facilities that will enable the plans to anticipate the release of individuals who were enrolled prior to incarceration.[[69]](#endnote-69)

## VI. RSAT Sanctions and Rewards

### A. There should be more rewards than sanctions to encourage pro-social behavior and treatment participation.

When providing correctional supervision of individuals participating in alcohol and drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary “social reinforcers,” such as recognition for progress or sincere effort, can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less punitive responses are used for early and less serious noncompliance, with increasingly severe sanctions issuing for continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior. Consequences for participants’ behavior should be predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification

Confrontation should focus on negative behavior and attitudes and not on the individual.

Research: As summarized by NIDA,[[70]](#endnote-70) research has demonstrated the effectiveness of treatment approaches using contingency management (CM) principles, which involve giving patients tangible rewards to reinforce positive behaviors such as abstinence. Studies conducted in both Methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.

State Department of Correction Protocol: The Michigan Department of Corrections provides in its Policy Directive that “a prisoner’s refusal to actively participate in required programming may be considered in determining whether to grant special good time or special disciplinary credits as set for in ‘Good Time Credits’ or ‘Disciplinary Credits/Drug Law Credits,’ as appropriate.”[[71]](#endnote-71)

## VII. RSAT Staffing

### A. In group activities, the ratio of RSAT participants to staff should be no more than 20 to 1.

Regardless of treatment modalities employed, the ratio of treatment staff to participants and correctional officers to participants should be sufficient to provide an environment conducive to achieving RSAT program goals and objectives. The RSAT pod should provide for a safe environment where participants are not distracted by extraneous commotion, noise and confusion and where they can think, reflect, and engage in constructive conversation with staff and their peers.

### B. Both treatment and security staffs should receive training about substance and alcohol use disorders, trauma, and mental illness, as well as specific training about the RSAT program itself, including its mission, operations, policies, and practices. Training should also promote cultural competence.

Both treatment staff and correctional officers should understand RSAT standards, philosophy, benchmarks, and objectives. Both should be expected to attend and participate in relevant program activities, including daily or weekly meetings and community meetings (with RSAT participants). Both should be involved in discipline, performance reviews, including whether participants advance to the next phase of treatment, assessments, and clinical supervision. Both should be involved in cross training, including implementation of assessment instruments, MI techniques, accountability training, and addiction-related trainings.

Treatment staff should attend correctional officer training and security-related training and correctional officers should be exposed to treatment training. In addition to initial training, all staff should be required to complete a regimen of in-service training to keep up with latest evidence-based treatment. Whether the primary modality of treatment is a modified therapeutic community or not, counselors and correctional officers should be trained and work as a team.

### C. Correctional officers should not be assigned to RSAT pods that lack training and should have an interest in working in RSAT programs.

To be effective, substance and alcohol abuse treatment programming should take up 50 to 70% of an abuser’s time. This requires a joint correctional officer and treatment staff collaborative effort so that RSAT participants are involved in the program beyond the limited hours counselors are available in the institution. In turn, this means that correctional officers must understand RSAT programming and be as committed to treatment as RSAT counselors and administrators.

### D. Treatment and correctional officers should be represented in program administration.

Treatment providers and correctional officers, whether the former is contracted out or in house, should be centrally involved in program administration, operation, and direction. The most promising RSAT programs represent a collaboration among treatment staff, correctional officers and prison/jail administrators where each recognizes the needs of the others.

## VIII. Transition and Aftercare Planning

REQUIRED BY BJA/STATUTE: States must give preference to subgrant applicants who will provide aftercare services to program participants. Such services must involve coordination between the correctional treatment program and other human service and rehabilitation programs, such as education and job training, parole supervision, halfway houses, and self-help and peer groups, that may help in rehabilitating offenders.

There have been two national evaluations of RSAT programs.[[72]](#endnote-72) Both reached the same conclusion that the major challenge facing RSAT programs was development of post-release continuing treatment and care in the community.

As summarized in the first 2003 study: “Although research shows that aftercare leads to a reduction in re-offense rates, less than half of RSAT programs were able to include an aftercare component, largely because RSAT funds can be used only for residential treatment for offenders in custody” (p. 6). In the second, two years later, concern for aftercare programming was repeated, admonishing RSAT programs to “(f)ocus on providing coordinated treatment and reentry into the services for offender aftercare community” (p. 13).

For many years, RSAT funding for aftercare was limited to 10% of the grants provided. This was lifted two years ago, but at the same time RSAT funding was greatly reduced so that no additional monies were actually available for RSAT funded aftercare. Nonetheless, RSAT programs should help participants connect to the community resources, mobilize family and pro-social peers, and help them develop a pro-social peer network, by encouraging Peer-To-Peer Learning, Peer Reentry Liaison and engagement in Twelve Step/Mutual Help/Faith Networks. All of this, in addition to specific treatment and service referrals.

Aftercare requires transition planning/programming, pre-release planning, a warm handoff to community-based treatment provider where practical, health insurance, Medicaid enrollment pre-release, referrals for employment/education, treatment, physical and behavioral case management, coordination with parole/probation, and first dose of medication where appropriate.

State Department of Correction Protocol: The Massachusetts Department of Correction mandates under “Continuity of Care” that “follow up shall be conducted in a manner consistent with the recommendations of the treatment plan. Substance abuse program providers shall update a participant’s personalized program plan prior to program completion to ensure continuity of care. Upon impending discharge, parole or transfer to pre-release, staff shall update the personalized program plan and develop aftercare plans. The aftercare plan is a separate plan that shall be incorporated into the personalized program plan. The plan shall be based upon the completed substance abuse specific assessment, input from program staff, the participant, community based treatment program staff and the institution parole officer, if applicable. All referrals and placements shall be entered in the designated (record) screen. When an actual placement is arranged (e.g. inpatient program), the Release Address screen shall also be completed.”[[73]](#endnote-73)

### A. Continuity of care is essential for drug abusers re-entering the community.

Offenders who complete prison-based treatment and continue with treatment in the community have the best outcomes.[[74]](#endnote-74) Continuing drug abuse treatment also helps the recently released offender deal with problems that become relevant after release, such as learning to handle situations that could lead to relapse, learning how to live drug-free in the community, and developing a drug-free peer support network. Treatment in prison or jail can begin a process of therapeutic change, resulting in reduced drug use and criminal behavior post-incarceration. Continuing drug treatment in the community is essential to sustain these gains. Regardless of the choice of intervention, positive outcomes from prison-based drug treatment programs are most likely to persist when offenders participate in post-release community treatment. The success of a continuing care model, which involves prison treatment followed by community treatment, is contingent on the released individual appearing for admission to the community treatment program and continuing to attend. Many individuals upon release do not do so, even in States where post-release treatment is a condition of release, parole or probation.

### B. Pre-and post-release case management systems should be included in RSAT programming to help support a smooth transition to the community.

Preparing an individual for release to the community involves linkages to various departments and staff both inside and outside the corrections facility. One of the major obstacles faced by many reentry programs is poor follow through and follow up after release. It is important to accomplish as much as possible regarding recommended services prior to release. This includes ongoing communication with treatment staff, providers, and community corrections personnel. Some of these tasks include:

* Making after care appointments prior to release.
* Having multidisciplinary staffings at regular intervals during treatment.
* Reassessing criminogenic needs at regular intervals.
* Collaborating with Community Corrections staff to ensure continuity of treatment and other services, including the transfer of treatment records.

If individuals will not be under correctional supervision after release, RSAT programs must motivate graduates to continue treatment on their own and help them put together a plan to get the supports they will need to assist them to remain drug-free after release.

Drug addiction is a serious problem that can be treated and managed throughout its course. Effective drug abuse treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence. Multiple episodes of treatment may be required. Outcomes for drug abusing offenders in the community can be improved by monitoring drug use and by encouraging continued participation in treatment.

### C. If individuals will be under correctional supervision upon release, the RSAT program should collaborate with probation/parole workers to incorporate aftercare treatment and services.

RSAT personnel should work with participants’ post-release supervisors to plan for the participants’ transition to community-based treatment and links to appropriate post-release services to improve the success of drug treatment and reentry. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication to prevent relapse. Ongoing coordination between corrections and treatment providers is important in addressing the complex needs of these re-entering individuals.

### D. Treatment planning for drug abusing offenders who are re-entering the community should include strategies to prevent and treat serious chronic medical conditions such as HIV/AIDS, hepatitis B and C, and tuberculosis, as well as overdose prevention.

The rates of infectious diseases, such as hepatitis, tuberculosis, and HIV/AIDS, are higher in drug abusers, incarcerated offenders, and offenders under community supervision than in the general population. Infectious diseases affect not just the offender, but also the criminal justice system and the wider community. Consistent with Federal and State laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and on ways to modify risk behaviors. Released RSAT graduates should be linked with appropriate health care services, encouraged to comply with medical treatment, and re-establish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail. RSAT participants and their families should be informed on the availability of Naloxone and its use to prevent overdose deaths. Where available, they should be encouraged to have the medication on hand in case of emergency need.

## IX. Measuring Results

The performance measures required by the Bureau of Justice Assistance are not sufficient in and of themselves to provide adequate measures of RSAT outcomes necessary for evidence-based practice and/or to determine if programming maintains fidelity to the evidence-based programs adopted. Although no program can be implemented with the exact same population of participants or under the same circumstances as the model, it is crucial that the key components of the model are implemented without compromising their integrity.

### A. In-program outputs should include program participation, completion rates, urine test results and like activities that can be measured. Program outcomes should include rearrests, reincarcerations, entrance and retention in treatment, relapses, drug overdose emergency room visits, and drug overdose deaths.

How an individual performs in a RSAT program, called program outputs, does not reveal how well they will do once released. To determine program effectiveness, RSAT programs should follow how program graduates do after they are released, called program outcomes. The most easily obtained outcome measures are recidivism, new arrests and reincarcerations. Other important outcomes are measures of substance abuse relapse, generally associated with length of time in treatment. The most critical relapse outcomes that should be measured are death from overdoses and emergency room treatment for overdoses.

State Department of Correction Protocol: The Vermont Department of Corrections has reviewed its Intensive Substance Abuse Program since 1998. The most recent review demonstrated its statistically significant reduction in recidivism with completers recidivating within one year at a rate of 10% compared to 21% for non-completers. After three years, the rates were 30% compared to 21% for non-completers. For inmates with at least three prior convictions, the recidivism reduction was even greater for completers compared to non-completers, 22% versus 42%. According to the Department, the results “demonstrate a positive treatment outcome, affirming the hypothesis that the program achieves desired results with the population it serves.”[[75]](#endnote-75)

### B. RSAT programs should encourage independent evaluations to determine how the outcome measures compare to other participants involved in other correctional programs or no programming. Generally speaking, the comparison of participants who complete the RSAT program with those who do not does not provide the best measure of program effectiveness. Evaluations should also determine whether the program serves all subpopulations equally well.

It is difficult to evaluate a program’s effectiveness without a random comparison group of like individuals. Generally, sophisticated evaluative research requires an independent research effort where there is no conflict of interest between the program and the researcher. It is important, however, that the researcher has a full understanding of the program and the population studied and the criminal justice context as well as allowing program officials to comment on the findings to ensure that the research has adequately interpreted the data found. For example, given the subjects involved, some RSAT grads may be reincarcerated subsequent to release but for charges that arose prior to their RSAT participation. Researchers must know how to read criminal records to decipher such circumstances.

To ensure that the RSAT program works as well for members of historically disadvantaged groups than non-disadvantaged groups, females as well as males, the outputs and outcomes of the former should be compared against those of the latter. Differences may reveal a programmatic bias that is not obvious or may require more investigation to diagnose.

Evaluations should include all individuals initially referred to the RSAT program, including those who may drop out or be terminated before completing the program. Although an RSAT program might boast, for example, a perfect record among those that successfully complete the program, it may be that the vast majority of individuals that enter the program never complete it. Further, an analysis of the non-completers might reveal that the completers are only those with the lowest risk/need scores of those admitted into the program or disproportionately one race or ethnicity suggesting the program lacks the cultural competence to deal with diverse populations. Intent-to-Treat analysis will inform the program whether it should limit its admission to those it is most effective for, or change its program to accommodate more diverse participants.

The shorter the follow up, the more successful the program is likely to appear. Many criminal justice interventions appear to be successful in terms of recidivism at six months. However, if the time period is lengthened, the success rates decline dramatically. Generally speaking, to have much validity, follow up measures should be for at least a year or more.

### C. Timely and reliable data entry is key for RSAT programs to make course adjustments to improve participant outcomes.

Although in-depth independent evaluations are recommended, RSAT programs should review performance data periodically to measure progress and make incremental adjustments as indicated. There should be a system in place to capture data in a timely manner with as much accuracy as possible. If programs are to learn from their results, the results should be as current as possible because no program is stagnant. RSAT programs evolve and change over time as staff, correctional officers, prison/jail policies, and participant populations change.

# Postscript and Additional Resources

This collection of promising practices guidelines is designed to be a living document. As more research is completed and as more feedback is received from RSAT programs across the nation and U.S. territories, these guidelines will be updated and revised. Lest it be forgotten, however, research has found that the quality of the interpersonal relationship between staff and the offender, along with the skills of the staff, is as important or more important to reducing risk than the specific programs in which offenders participate.[[76]](#endnote-76) In short, there will never be a substitute for the work of dedicated counselors, correctional officers and other program staff who make up prison and jail RSAT programs.

To learn of the latest research establishing evidence-based substance abuse and correctional treatment programming, two cites will prove of particular value, the Justice Department National Institute of Justice **C**r**ime Solutions** that can be found at <http://www.crimesolutions.gov/> and the Substance Abuse and Mental Health Services Administration **Evidence-Based Practices Web Guide**, <http://www.samhsa.gov/ebp-web-guide>. In addition, the National Institute on Drug Abuse maintains **Principles of Drug Addiction Treatment: A Research-Related Guide,** now in its 3rd edition, that can be found at <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment>.

Various professional organizations also maintain related standards and promising practice guidelines that may be of interest, including the National Association of Drug Court Professionals **Adult Drug Court Best Practice Standards** that can be found at <http://www.nadcp.org/Standards>.

Some of the best research that specifically focuses on prison substance use disorder treatment and was relied upon in the development of these guidelines, in addition to the many studies cited in the footnotes, has been completed by Dr. Faye Taxman and her colleagues. The research includes the following:

Belenko, S. & Taxman, F. (2012). Implementing Evidence-based practices in community corrections and Addiction Treatment. Springer Series on Evidence-Based Crime Policy.

Taxman, F. & Belenko, S. (2012). Implementing evidence-based practices in community corrections and addiction treatment. Springer Series on Evidence-Based Crime Policy, New York.

Taxman, F. & Boufford, J. (2001). [Residential Substance Abuse Treatment (RSAT) in Jail: Comparison of Six Sites in Virginia](http://www.ncjrs.gov/pdffiles1/nij/grants/182858.pdf), U.S. Justice Department, Office of Justice Programs, National Institute of Justice

Taxman, F., Silverman, R., & Bouffard, J. (2001). [Residential Substance Abuse Treatment (RSAT) in Prison: Evaluation of the Maryland RSAT Program,](http://www.ncjrs.gov/pdffiles1/nij/grants/184953.pdf) U.S. Justice Department, Office of Justice Programs, National Institute of Justice.

To learn of Promising Practice Guidelines updates, trainings and technical assistance in their implementation, and to join the continuing discussion of them, the RSAT Training and Technical Assistance Project will keep you post on its website, [www.rsat-tta.com](http://www.rsat-tta.com).

# Appendix

## RSAT Promising Practices Guidelines Roundtable Attendees

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## Description of Evidence-Based Programs

National Institute on Drug Abuse / Cognitive Behavioral Therapy

CBT was originally developed to prevent relapse for problem drinking, and was later applied to cocaine addicted individuals. The program emphasizes the importance of learning processes in the development of maladaptive behaviors. Participants identify and correct these maladaptive behaviors by applying different skills to deal with drug abuse as well as other co-occurring problems. CBT in particular focuses on the enhancement of a participant’s self-control through a variety of coping strategies. (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral>)

Contingency Management Interventions/Motivational Incentives

CM principles involve reinforcing positive behaviors (e.g., abstinence) in substance misusers with tangible rewards. Incentive-based treatments have proven to be highly effective in promoting abstinence from drugs. They typically are done using either voucher-based reinforcement, in which patients receive vouchers with monetary value that increase with every drug-negative urine sample, or through prize incentives in which patients are given the chance to win prizes for every drug-negative test they receive. (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-0>)

Community Reinforcement Approach Plus Vouchers

CRA is an “intensive 24-week outpatient therapy for treating people addicted to cocaine and alcohol.” The two goals of CRA are: to maintain short term abstinence among its patients so that they can develop new life skills that serve to sustain abstinence in the long term; and to reduce alcohol consumption in patients whose cocaine use is associated with their drinking. To do this, CRA uses a range of social reinforcers and material incentives to make a drug-free lifestyle more rewarding than substance abuse. (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-1>)

Motivational Enhancement Therapy

MET promotes rapid and internally motivated change among patients through a counseling approach that helps individuals resolve their uncertainty about taking part in treatment and stopping their drug use. In general MET is most effective with adults who are addicted or dependent on alcohol and marijuana. It is seen as a more effective method for engaging drug abusers in treatment rather than as a way to produce changes in their drug use. (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-2>)

The Matrix Model

The Matrix Model provides a framework for patients to reach abstinence. In this treatment patients are instructed and supported by a therapist who acts as both a teacher and a coach. Patients learn about critical issues regarding their addictions and are familiarized with self-help programs. The Matrix Model uses a wide variety of treatment materials drawn from other tested treatment approaches (e.g., family and group therapy, 12-step programs). (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-3>)

Twelve-Step Facilitation Therapy

This therapy uses the principles of acceptance, surrender, and active involvement to increase the likelihood of a substance abuser becoming affiliated with a 12-step self-help group. Acceptance that drug addiction is a disease over which the patient has no control and that abstinence is the only alternative. Surrender to the fellowship and support of other recovering addicts and to the activities of the 12-step programs. Active involvement in 12-step meetings and associated activities. (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-4>)

Family Behavior Therapy

FBT focuses on addressing both substance abuse problems and co-occurring problems like conduct disorders, child mistreatment, depression, family conflict, and unemployment. It includes both the patient and at least one family member or significant other. Skills taught in this therapy are aimed at improving the home environment of patients. (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-5>)

Behavioral Therapies/Multisystemic Therapy

Behavioral therapies are uniquely adapted for drug-abusing adolescents to often include family involvement. One adaptation of behavioral therapy is multisystemic therapy (MST). MST examines the factors associated with antisocial behavior in drug-abusing children and adolescents. Treatment is often done in natural environments and addresses factors like: the child’s characteristics, their family, their peers, their school, and their neighborhood to reduce drug use and incarcerations. (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-6>)

Substance Abuse and Mental Health Services Administration

Creating Lasting Family Connections Fatherhood Program

Provides services to reduce substance misuse, support recovery, and reduce repeat offenses among fathers and father-like figures who experience dissonance due to incarceration, substance misuse, or military service. (SAMHSA.gov)

Forever Free

Provides individualized substance abuse treatment with case planning for incarcerated women influenced by a 12-step model. The program teaches clients life skills to cope with life stress while helping them gain self-respect and a sense of empowerment. Serves the psychological needs of the women through in prison counseling, group services, educational workshops, 12-step programs, relapse prevention training, and community aftercare. (<https://www.ncjrs.gov/pdffiles1/Digitization/152194NCJRS.pdf>)

Helping Women Recover and Beyond Trauma

Two programs combined to serve women with substance use disorders who have co-occurring trauma histories. They aim to reduce substance use, encourage involvement in voluntary aftercare treatment upon parole, and reduce the likelihood of reincarceration. The programs use a series of trauma informed treatment sessions in group settings with female counselors. (<http://mha.ohio.gov/Portals/0/assets/Initiatives/TIC/SAMHSAEvidenceBasedProgramsandPractices/Helping%20Women%20Recover%20and%20Beyond%20Trauma.pdf>)

Interactive Journaling

“A structured and experimental writing process that motivates and guides participants toward positive life changes.” The program provides resources that help people apply meaningful information to their own lives to promote lasting change. (<http://mha.ohio.gov/Portals/0/assets/Initiatives/TIC/SAMHSAEvidenceBasedProgramsandPractices/Helping%20Women%20Recover%20and%20Beyond%20Trauma.pdf>)

Living in Balance

A program for adults in correctional facilities with issues relating to substance abuse, crime, treatment, and violence. It consists of a series of psychoeducational training sessions both on an individual basis and in groups. These sessions involve a large amount of role play to improve the client’s level of functioning in a variety of life areas. (<http://www.nrcpfc.org/ebp/downloads/AdditionalEBPs/Living_in_Balance_(LIB)_8.26.13.pdf>)

Moral Reconation Therapy

MRT is a treatment strategy that aims to reduce reincarceration among juveniles and adult offenders by increasing moral reasoning. Through group and individual counseling MRT addresses ego, social, moral, and positive behavioral growth. It focuses on seven basic treatment issues: “confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning.” (<http://www.nrcpfc.org/ebp/downloads/AdditionalEBPs/Moral_Reconation_Therapy_(MRT)_8.26.13.pdf>)

TCU Mapping Enhanced Counseling

Provides evidence based guides for adaptive treatment services. They are developed from cognitive behavioral models designed for substance abuse treatment counselors. The manuals provide focused, time-limited strategies for engaging clients in important recovery discussions. (<http://jpo.wrlc.org/bitstream/handle/11204/2151/3310.pdf?sequence=1>)

Correctional Therapeutic Community

A program for clients with substance use disorders provides for an isolated community of participants to promote recovery and prevent relapse. The program separates participants from the general prison populace in order to enhance the effectiveness of the rehabilitative communities. (<https://www.ncjrs.gov/ondcppubs/treat/consensus/lipton.pdf>)

## Pharmacotherapies

Methadone

Methadone is a long-acting synthetic opioid agonist medication that can prevent withdrawal symptoms and reduce craving in opioid-addicted individuals. It can also block the effects of illicit opioids. It has a long history of use in treatment of opioid dependence in adults and is taken orally. Methadone maintenance treatment is available in all but three States through specially licensed opioid treatment programs or Methadone maintenance programs. It should be combined with behavioral treatment.

Buprenorphine

Buprenorphine is a synthetic opioid medication that acts as a partial agonist at opioid receptors—it does not produce the euphoria and sedation caused by heroin or other opioids but is able to reduce or eliminate withdrawal symptoms associated with opioid dependence and carries a low risk of overdose. Buprenorphine is currently available in two formulations that are taken sublingually: (1) a pure form of the drug and (2) a more commonly prescribed formulation called Suboxone, which combines Buprenorphine with the drug naloxone, an antagonist (or blocker) at opioid receptors. Naloxone has no effect when Suboxone is taken as prescribed, but if an addicted individual attempts to inject Suboxone, the naloxone will produce severe withdrawal symptoms.

Buprenorphine treatment can be provided in office-based settings by qualified physicians who have received a waiver from the Drug Enforcement Administration (DEA).

Naltrexone

Naltrexone is a synthetic opioid antagonist—it blocks opioids from binding to their receptors and thereby prevents their euphoric and other effects and reduces cravings for opioids. It can be taken orally, either daily or three times a week or injected for 28 days (Vivitrol®). Addicts must be opioid free 7 to 10 days before an injection. Naltrexone also blocks receptors that are involved in the rewarding effects of drinking and the craving for alcohol.

Acamprosate

Acamprosate (Campral®) acts on the gamma-aminobutyric acid (GABA) and glutamate neurotransmitter systems and is thought to reduce symptoms of protracted withdrawal, such as insomnia, anxiety, restlessness, and dysphoria. Acamprosate has been shown to help dependent drinkers maintain abstinence for several weeks to months, and it may be more effective in patients with severe dependence

Disulfiram

Disulfiram (Antabuse®) interferes with degradation of alcohol, resulting in the accumulation of acetaldehyde, which, in turn, produces a very unpleasant reaction that includes flushing, nausea, and palpitations. if a person drinks alcohol. The utility and effectiveness of disulfiram are considered limited because compliance is generally poor. However, among patients who are highly motivated, disulfiram can be effective, and some patients use it episodically for high-risk situations, such as social occasions where alcohol is present. It can also be administered in a monitored fashion, such as in a clinic or by a spouse, improving its efficacy.

Topiramate

Topiramate is thought to work by increasing inhibitory (GABA) neurotransmission and reducing stimulatory (glutamate) neurotransmission, although its precise mechanism of action is not known. Although topiramate has not yet received FDA approval for treating alcohol addiction, it is sometimes used off-label for this purpose. Topiramate has been shown in studies to significantly improve multiple drinking outcomes, compared with a placebo.  
<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapi-1>

## Promising Practice Guidelines for Ensuring Access to Medication-Assisted Treatment for Justice-Involved Individuals

Introduction

The first medication, disulfiram, to treat alcohol use was discovered in the 1920’s and methadone, the first medication to treat opioid use disorder, was developed in the late 1930’s and approved to treat opioid use disorder in 1947. The most recent medication, naltrexone, was approved by the FDA to treat opioid use disorder in 1984 and alcohol use disorder in 1995. In 2006, the FDA approved injectable naltrexone for alcohol use disorders and in 2010 for opioid use disorders. This has begun to change over the last decade and in many respects, criminal justice agencies, including drug courts, jails and state departments of correction, are leading the way in promoting access to medication assisted treatment (MAT) across the United State, with the latter building on long standing methadone programs for pregnant women to provide access to the other FDA approved medications for alcohol and opioid use disorders.

These Guidelines have been developed to assist agencies ensure access to MAT to justice-involved individuals at all criminal justice intercept points beginning when law enforcement first comes into contact with individuals with alcohol and opioid use disorders to when parole supervises those with these disorders after release from incarceration. While there is limited research on MAT programs specifically for justice-involved populations, these guidelines are based on what exists, supplemented by general research on MAT and related criminal justice substance use disorder treatment programming and, most importantly, the experiences of expert practitioners that have pioneered the application of MAT for justice-involved populations.

The development of these guidelines culminated in the broad participation of experts from multiple federal agencies, including the Bureau of Justice Assistance, National Institute of Corrections, Office of National Drug Control Policy, National Institute of Justice, Bureau of Prisons, Substance Abuse and Mental Health Services Administration, and National Institute of Drug Abuse, and national professional organizations, including the American Society of Addiction Medicine, Pew Charitable Trust, National Commission on Correctional Health Care, National Governors Association, and National Sheriffs Association, as well as individual experts and practitioners who are directly involved in the administration of criminal justice MAT programs in drug courts, jails, prisons, and community corrections. The Guidelines were researched and drafted by Advocates for Human Potential, Inc..

Promising Practice Guidelines for Ensuring Access to Medication-Assisted Treatment for Justice-Involved Individuals

# I. Guiding Principles for Justice Agency Medication-Assisted Treatment (MAT) Programs

### A. Medication is considered part of the contemporary standard of care for the treatment of individuals with alcohol and opioid use disorders and also for individuals with co-occurring mental illness. Justice-involved populations with substance and/or alcohol use, as well as co-occurring disorders, should have access to medication and behavioral therapies.

Medicines used in medication-assisted treatment (MAT), such as methadone, buprenorphine (with or without naloxone) and naltrexone for opioid use disorders and naltrexone, acamprosate calcium, and disulfiram for alcohol use disorders should be made available to individuals who could benefit from them.Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in both prison/jail and the community.Justice programs at all intercept points should assist justice-involved individuals to obtain access to these medications if they, their healthcare and behavioral health treatment providers deem it appropriate.

If justice-involved individuals are on prescribed FDA-approved agonist (methadone) or partial agonist (buprenorphine with or without naloxone[[77]](#endnote-77)) for opioid use disorders, justice agencies should facilitate continued access and, as appropriate, provide the option of facilitating safe tapering off the medication while under the supervision of courts or corrections. Justice agencies should promote access to naloxone as appropriate as well as treatment to minimize risk of overdose deaths.

Federal disability and anti-discrimination statutes may apply to questions of MAT administration and access. Justice agency policy makers and practitioners may also want to consider the Americans with Disability Act §504 in their considerations.[[78]](#endnote-78)

MAT is appropriate for persons with co-occurring mental disorders. Compared to the general population, people with substance use disorders are roughly twice as likely to suffer from mood and anxiety disorders, with the reverse also true. The same is true for those diagnosed with an antisocial personality or conduct disorder.[[79]](#endnote-79) This is much too significant a population in need of treatment to deprive of evidence-based treatment.

RESEARCH:The evidence is clear that the addition of medication increases the likelihood of successful treatment of individuals with opioid and alcohol use disorders, regardless of the (non-medical) treatment modality utilized.[[80]](#endnote-80) It is also becoming increasingly clear that the addition of MAT for the treatment of justice-involved individuals not only increases the likelihood of successful treatment but reduces recidivism.[[81]](#endnote-81)

Notwithstanding this increasing evidence, substance use treatment providers, in and out of the criminal justice system, have been slow to add MAT to their treatment regimens. As of January 2017, fewer than a dozen state departments of correction offered MAT in their drug treatment programs for incarcerated individuals, beyond limited methadone maintenance for women during their pregnancies. Only 130 local and county jails in 21 states out of several thousand provide MAT, almost exclusively limited to the provision of injected naltrexone immediately before individuals are released back to the community. Surprisingly, the latest survey of drug courts (released in 2015) found that drug courts in only 17 states offered MAT.[[82]](#endnote-82) The latest census of problem-solving courts, relying on 2012 data, similarly found that only 22.5 percent of adult drug, 29.2 percent of hybrid drug and drunk driving, and 19.7 percent of drunk driving courts offered MAT.[[83]](#endnote-83)

Support for MAT: Many national organizations have passed resolutions and formal position statements supporting MAT.

The **National Governors Association** has called upon state corrections to:

1. Increase access to MAT in prisons and correctional settings;
2. Ensure continued access to MAT upon reentry into the community; and
3. Provide overdose education and naloxone for offenders during the reentry process, when they are most vulnerable to overdose.[[84]](#endnote-84)

The **National Commission on Correctional Health Care** updated its position statement on the treatment of substance use disorders for incarcerated individuals at the end of 2016 to include the following:

Inmates not receiving MAT prior to entry, or whose MAT is discontinued while incarcerated (which is not preferred), should be offered MAT prerelease when post release continuity can   
be arranged.[[85]](#endnote-85)

The **National Association of Drug Court Professionals Board of Directors** has resolved that:

1. Drug Court professionals have an affirmative obligation to learn about current research findings related to the safety and efficacy of MAT for addiction.
2. Drug Court programs should make reasonable efforts to attain reliable expert consultation on the appropriate use of MAT for their participants. This includes partnering with substance abuse treatment programs that offer regular access to medical or psychiatric services.
3. Drug Courts do not impose blanket prohibitions against the use of MAT for their participants. The decision whether to allow the use of MAT is based on a particularized assessment in each case of the needs of the participant and the interests of the public and the administration of justice.
4. Drug Court judges base their decision whether to permit the use of MAT in part, on competent expert evidence or consultation. In cases in which a participant, the participant’s legal counsel, or a medical expert has requested the possible use of MAT, the judge articulates the rationale for allowing or disallowing the use of addiction medication.
5. Nothing in this Resolution prevents a Drug Court from imposing consequences on a participant for failing to respond to drug‐free counseling, if MAT was made available to the participant but was refused.[[86]](#endnote-86)

The **National Drug Court Institute** holds, “Under no circumstances should a drug court have a blanket prohibition against MAT as a matter of policy.”[[87]](#endnote-87)

The **Surgeon General’s Report on Alcohol, Drugs, and Health** concludes that “(t)he primary goals and general management methods of treatment for substance use disorders are the same as those for the treatment of other chronic illnesses. The goals of treatment are to reduce key symptoms to non-problematic levels and improve health and functional status; this is equally true for those with co-occurring substance use disorders and other psychiatric disorders. Key components of care are medications, behavioral therapies, and recovery support services (RSS).”[[88]](#endnote-88)

The **National Association of State Alcohol and Drug Abuse Directors** (NASADAD) concludes, “In all cases, the use of addiction medications should be considered and supported as a viable treatment strategy in conjunction with other evidence-based practices and as a path to recovery for individuals struggling with substance use disorders.”[[89]](#endnote-89)

The **World Health Organization** (WHO), reviewing agonist MAT recommends it as “the most cost-effective treatment, and should therefore form the backbone of the treatment system for opioid dependence.”[[90]](#endnote-90)

*Note:* Detoxification is the medical management of acute withdrawal and does not alone alter the course of the substance use disorder.[[91]](#endnote-91)

### B. Whether an individual obtains medication for opioid or alcohol use disorders, as well as the specific medication chosen, is to be decided by the individual after consultation with medical and treatment providers, not imposed by a justice or treatment agency.

FDA-approved MAT medications vary, as do their impact on individuals prescribed them. They are also available through different channels and administered in different manners. Research indicates the length of time individuals should spend on medication varies and needs to be reassessed with medical staff taking into account the individual’s medical history and situation.

Methadone and buprenorphine are both agonist medications for opioid use disorders. Both act on opioid receptors, but they are fundamentally different from short-acting opioids, such as heroin or prescription pain medications. When taken appropriately, they do not produce a “high,” but reduce cravings and prevent relapse.

Methadone works by reducing or extinguishing cravings for opioids, allowing the patient to function without experiencing the negative psychological state and withdrawal symptom associated with opioid use disorder. When used as medication for opioid use disorder, methadone can only be dispensed in a certified opioid treatment program (OTP). Opioid treatment programs are any treatment program certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) in conformance with 42 Code of Federal Regulations (CFR) Part 8 to provide supervised assessment and medication-assisted treatment for patients with opioid use disorder. Opioid treatment programs typically provide methadone in liquid form as a daily dose taken under observation. As time progresses, patients determined to be stable and whose recovery would be advanced by the ability to self-administer medication at home may be allowed to take home from a day to a week or more of medication.

Buprenorphine is a partial agonist that functions similarly to methadone but has a lower maximal effect than a full agonist like methadone. Carefully prescribed, monitored and appropriate use of methadone or buprenorphine (with or without naloxone) for maintenance produces no euphoria, intoxication, and relieves withdrawal symptoms in people who are opioid dependent. The addition of naloxone to buprenorphine is designed to deter abuse. The naloxone induces withdrawal symptoms if the medication is misused by being injected. Buprenorphine can be dispensed in an opioid treatment program, or it can be provided by a physician, nurse practitioner (NP), or physician assistant (PA) who completes required training and obtain a special registration from Drug Enforcement Agency (DEA). Individual professionals may treat up to 30 patients at a time in the first year and up to 100 patients at a time thereafter; specially qualified physicians may treat up to 275 but must participate in annual reporting. Individuals can take buprenorphine at home in the form of a sublingual film, often referred to as a “strip,” or as a pill. More recently, the FDA approved its administration as a subdermal implant that provides non-fluctuating blood levels of buprenorphine for a period of 6 months.[[92]](#endnote-92) A clinical study indicated that patients who were clinically stable on eight milligrams or less of buprenorphine per day maintained stability when transferred to the implant (Probuphine®) and were more likely to sustain abstinence from illicit opioids throughout the 6 months of the study than those being treated with sublingual buprenorphine.[[93]](#endnote-93)

Naltrexone is an opioid antagonist which operates by blocking the effects of opioids so patients will not experience a high from using them. It is not opioid-based, does not result in physical dependence and has no potential for abuse. Unlike the agonist medications, individuals who are dependent on opioids must stop their drug use at least 7 days prior to starting naltrexone. Naltrexone may be administered as a daily pill or a 28-day depot injection (Vivitrol®). Vivitrol is used to prevent relapse to opioid dependence after detox, and it also serves to prevent opioid overdose.

Naltrexone to treat opioid dependence is usually delivered in the form ofthe monthly injection (28 days) by a physician, or nurse and other medical personnel. Individuals can receive naltrexone in many settings, including doctors’ offices, opioid treatment programs, and other drug treatment settings. Injectable naltrexone is particularly suited for individuals in residential correctional facilities where they can be monitored for abstinence prior to injections and where the medication presents no risk of diversion within the facility. Alternatively, it can be administered to individuals after they have completed detoxification programs and been released to residential treatment where abstinence can be monitored.

The FDA-approved medications for alcohol use disorder include naltrexone, as described previously, as well as disulfiram (Antabuse®) and acamprosate (Campral®). The FDA approved naltrexone specifically for alcohol use disorder before it approved it for opioid use disorder. Disulfiram blocks an enzyme involved in metabolizing alcohol intake, producing very unpleasant side effects when combined with alcohol in the body. It must be taken daily. Acamprosate works by balancing the brain’s neurotransmitter systems that have been altered by chronic or heavy use of alcohol. Neither of these medications prevent the withdrawal symptoms that people may experience when they stop drinking alcohol. Acamprosate must be taken three times a day and is in pill form.

There is less research available on the use of MAT for alcohol use disorder with incarcerated populations, except for a few older studies on the use of disulfiram during community supervision. Although disulfiram has been in use for many years, it is no longer considered a first-line treatment choice. Its action interferes in the breakdown of alcohol by the liver, resulting in aversive physical responses to any intake of alcohol. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) 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.” [[94]](#endnote-94) 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 only available with a prescription from a physician.

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 more likely to benefit patients who intend to abstain from alcohol completely, rather than for those planning 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 post-acute withdrawal from alcohol.

The length of time someone should take medications for MAT varies. Both SAMHSA[[95]](#endnote-95) and ASAM[[96]](#endnote-96) have suggested guidelines for determining when and how medication should be discontinued. The latter, for example, concludes there is no recommended time limit for treatment with buprenorphine, methadone or naltrexone. It advises, however, “(b)uprenorphine taper and discontinuation is a slow process and close monitoring is recommended.” Further, discontinuation generally is accomplished over several months and “patients and clinicians should not take the decision to terminate treatment with buprenorphine lightly (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 (30).” For both oral and injectable naltrexone, ASAM concludes that duration of treatment depends on the response of the individual patient, the patient’s individual circumstances, and clinical judgment (37).”

Data shows that treatment retention is reduced when patients are tapered off MAT prematurely.[[97]](#endnote-97) For some patients, MAT could be indefinite.[[98]](#endnote-98) The National Institute on Drug Abuse (NIDA) describes addiction medications as an “essential component of an ongoing treatment plan” to enable individuals to “take control of their health and their lives.”[[99]](#endnote-99) For methadone maintenance, 12 months of treatment is the minimum, according to NIDA.[[100]](#endnote-100)

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 justice-involved populations provided with injected naltrexone for 6 months found that those receiving the injections had significantly fewer relapse events, 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 similar outcomes to those not treated after a year. This suggests that more than 6 months of injections may be indicated for longer-term abstinence.[[101]](#endnote-101)

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, too low doses for methadone, for example, have been found less effective in keeping users in treatment than higher doses.[[102]](#endnote-102)

### C. MAT, as its name implies, “assist” in the treatment of substance and alcohol use disorders. It is coupled with counseling and appropriate wraparound services—the same services provided to individuals who do not elect MAT but receive other substance use disorder treatment.

All FDA approved medication for the treatment of substance use disorder are intended to be used in conjunction with counseling and other appropriate services, although some research has found that providing MAT when counseling is not immediately available (i.e. patient is on waiting list) improves outcomes.[[103]](#endnote-103) There are several evidence-based counseling and treatment regimens for these populations. Many are also designed to accommodate justice-involved populations who have high criminogenic needs, in addition to their use disorders.

Treatment programs can include both group and individual counseling to accommodate diverse needs of participants. Both cognitive behavioral therapy and therapeutic communities have been found to be effective treatment modalities for justice-involved populations. NIDA, SAMHSA and the U.S. Department of justice have listed specific behavioral therapies as helpful to engage people in alcohol and substance use disorder treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for alcohol and other drugs and prompt another cycle of compulsive abuse. These listings can be found in the Appendix.

Most evidence-based behavioral therapies found effective in addressing alcohol and substance use disorders are for particular drugs of abuse and have been studied primarily in community settings. Their use in correctional settings requires adjustments and modifications. Once implemented, it is imperative that justice programs evaluate whether they have maintained fidelity to the essential elements of the treatment that have been found effective and that the program, as modified and implemented, achieves commensurate results as that found in the research.

Many programs have also found evidence-based manualized treatment interventions to be effective, offering structure and consistency. They are also easy to use and can help focus sessions, although they can be restrictive and counselors need to incorporate personal style and creativity in their use.[[104]](#endnote-104) The quality of the interpersonal relationships between staff and the participants, along with the skills of the staff, are as important to risk reduction as the specific programs in which individuals participate.[[105]](#endnote-105)

The *Federal Guidelines for Opioid Treatme*nt Programs requires the following considerations, in addition to access to appropriate medication in assessing client treatment and services:

Each patient accepted for treatment at an OTP shall be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment. 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, psycho-social, economic, legal, or other supportive services that a patient needs. The treatment plan also must identify the frequency with which these services are to be provided. The plan must be reviewed and updated to reflect that 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.[[106]](#endnote-106)

### D. Justice agency staff should receive training and education about MAT and its proper application.

MAT programs, like all programs, work best when all program staff support them. Indeed, studies have found that drug courts, for example, that have “buy-in” from their whole teams “evinced a more positive view of their own programs.” But even in courts where key players (e.g., a judge or district attorney) have reservations about addiction medication, “MAT programs can succeed if the program views clinical decisions as the province of clinicians.”[[107]](#endnote-107)

As found in New York, among drug courts, education about MAT has been “found to be critical in getting all team members on the same page about MAT. For some courts, the decision to allow MAT resulted from active discussion among drug court team members. In other courts, team members responsible for treatment recommendations simply started using it without much fanfare. Those team members who had resisted MAT acclimated, as the inclusion of MAT generally turned out to be relatively simple and occurred without significant changes to court practice.”[[108]](#endnote-108)

Because agonist medication is so highly valued among incarcerated individuals with an opioid use disorder, correctional administrators may be tempted see its use as a reward for good behavior and resist allowing access to all addicts in need. Medication should not be used as an award nor its withholding as a punishment.

### E. MAT programming within residential correctional facilities and other justice environments requires special attention to prevent diversion of agonist medications and to safeguard participating individuals.

The incorporation of MAT programming in residential correctional programs, including prisons, jails, and halfway houses, as well as in courts and diversion programs, raises several challenges, depending upon the medications involved.

Dispensing medications for the treatment of opioid use disorder in facilities that have had no previous experience handling and storing them requires preparation and education. Precaution must be exercised to guard against illicit diversion of the agonist medications. While studies have found these medications to be effective for prison and jail populations, these same studies have found that they are subject to diversion. A study of an in-prison buprenorphine program, for example, found buprenorphine “can facilitate community treatment entry. However, concerns remain with in-prison treatment termination due to attempted diversion of medication.”[[109]](#endnote-109)

The agonist medications must be counted, recorded, and then stored in locked cabinets. Administering each dose takes a few minutes and the individual must be observed to lessen the possibility of it not being swallowed and subsequently diverted. Any missed dose must be documented and returned to the locked cabinet. Prior to initiating the daily routine for administering the medications, staff must be trained and a protocol, as well as new routines, developed to accommodate the additional responsibilities entailed.

If some individuals with prior prescriptions are allowed to continue their medication while other individuals with an opioid use disorder undergo detoxification, this can foster resentment, not to mention attempts to take the medication, posing a security risk. The two populations may have to be kept separate.

Special care must be taken in the storage of the medication both in terms of security and making sure the medication is used before its expiration date. Medical staff must be reassured about potentially increased liability for the prescription and dissemination of these medications, as well as increased work load for medical personnel in the facilities.

Although the following 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 diversion and abuse of the dispensed agonist medications made available to appropriate clients, particularly regarding allowing clients medication to take unsupervised. The Guidelines require the following:

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 opioid drugs for unsupervised use.
3. Absence of recent abuse of drugs (opioid or nonnarcotic), including alcohol;
4. Regularity of clinic attendance;
5. Absence of serious behavioral problems at the clinic;
6. Absence of known recent criminal activity, e.g., drug dealing;
7. Stability of the patient’s home environment and social relationships;
8. Length of time in comprehensive maintenance treatment;
9. Assurance that take-home medication can be safely stored within the patient’s home; and
10. Whether the rehabilitative benefit the patient derived from decreasing the  
    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 a patient is responsible in handling opioid drugs, the following restrictions apply:

1. 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.
2. 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 detoxification 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 that is designed to reduce the risk of accidental ingestion, including child-proof containers (see Poison Prevention Packaging Act, Public Law 91-601 (15 U.S.C. 1471 et seq.)).**[[110]](#endnote-110)**

#### Examples of Prison/Jail MAT Protocol: 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.”

Court and diversion programs with clients participating in MAT programs also have an obligation to minimize the chances that the medications will be misused by participants or diverted for illegal purposes. This may require additional monitoring requirements or other conditions, as necessary. Research[[111]](#endnote-111) suggests the following measures can be employed, as summarized in the National Drug Court Institute *Drug Court Practitioner Fact Sheet, XI*:

1. Observed administration of the medication by physician, probation officer, clinical case manager, or approved individual or family member;
2. Adherence monitoring through urine or other tests to confirm medication is being taken as prescribed;
3. Random call backs for pill counts to confirm the medication is being taken as prescribed;
4. Medication event monitoring system requiring a container or cap with a microprocessor that records date, time, and number of pills removed each time cap is opened;
5. Preapprovals required before participants obtain new prescriptions for addictive or intoxicating medication and informing physician that participant has a substance use disorder, enforced by signed release of the participant allowing physician to share patient prescription data;
6. Prescription drug monitoring program checks of state registries of prescription of controlled substances within last 12 months;
7. Abuse deterrence formulations of medications, including combining naloxone with buprenorphine, administering long-acting injectable naltrexone, or methadone in liquid form.[[112]](#endnote-112)

### F. The administration of MAT requires testing of participants to ensure clients are receiving the appropriate doses as prescribed.

The *Federal Guidelines for Opioid Treatment Programs* 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.”[[113]](#endnote-113)

There are a number of 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, oral fluid, hair, nails, sweat and breath.”[[114]](#endnote-114)

It is important to ensure that individuals not try to circumvent the stabilizing or blocking effects of their medication, whether it be an agonist, partial agonist or antagonist, by taking other drugs or increasing doses of prescribed medications, as they risk overdose. If persons try to overcome the blocking effects of naltrexone by ingesting more and more opioid medications or heroin, they are at high risk for overdosing.

### G. The selection of community-based treatment and medication providers must be carefully considered and may require justice agency collaboration to encourage providers to meet the needs of justice-involved referrals

Unfortunately, most substance use disorder 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.[[115]](#endnote-115) The specific and separate requirements for provision of buprenorphine and methadone have contributed to the fragmentation of MAT access for persons with opioid use disorders. Justice agencies, therefore, must often search out community-based agencies that provide MAT, as well as appropriate treatment and services for justice-involved clients. 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.”[[116]](#endnote-116)

In selecting a referral agency or working with such an agency to better serve justice-involved clients, justice agencies should be advised by the *Federal Guidelines for Opioid Treatment Programs*, March 2015, issued by SAMHSA.[[117]](#endnote-117) The community-based agencies should offer recovery-oriented systems of care, in addition to medication. The Guidelines specify that:

OTPs shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. 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.[[118]](#endnote-118)

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 the patient and to monitor patient progress.
2. OTPs must provide counseling on preventing exposure to, and the transmission of, human immunodeficiency virus (HIV) disease for each patient admitted or readmitted to maintenance or detoxification treatment.
3. OTPs must provide directly, or through referral to adequate and reasonably accessible community resources, vocational rehabilitation, education, and employment services for patients either who request such services or who have been determined by the program staff to need such services.[[119]](#endnote-119)

Similar criteria can be applied to physicians who prescribe and dispense buprenorphine in their offices. Recommended strategies 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.

Analysis of data from Pennsylvania Medicaid from 2007 to 2012 found prescriptions for buprenorphine increased from 9.8 to 24.2 percent, but a potential decrease in quality of care. Almost a third of enrollees with prescriptions for buprenorphine had no diagnosis for opioid use disorders (although the dosage prescribed was for opioid use disorders), only 60.1 percent had at least one urine drug screen, only 41 percent had behavioral health counseling services, and more than a third had other opioid and benzodiazepine claims—contraindications to buprenorphine care. Almost a quarter of prescriptions for buprenorphine were not preceded by a physician visit in the 30 days prior to the prescription. This is troubling because the prescription of buprenorphine for individuals without an opioid use disorder diagnosis is not monitored by federal agencies and may contribute to illicit diversion and overdoses. Researchers concluded that “the quality of care received seemed to be generally poor.”[[120]](#endnote-120) In other words, just because the medical practitioner is certified to prescribe and/or dispense buprenorphine, it does not ensure the quality of care required that should accompany use of this medication for opioid use disorders. Like any referral, those who are certified to provide buprenorphine should be carefully screened before justice-involved individuals are referred.

# II. Components of Successful Justice Agency MAT Programs: Implementing MAT Programs for Justice-Involved Individuals by Justice Agencies Requires Leadership, Staff Training, Negotiating Security Issues and Embracing Change

### A. Detoxification protocols support screening for withdrawal severity and poly-substance use, monitoring, and medical management of withdrawal symptoms, which may include the use of appropriate over-the-counter and prescription medications.

Detoxification is not considered treatment, but may be necessary when a person is transitioning to a controlled setting or will begin treatment with any form of naltrexone. In custody settings, especially prisons and jails, it must be addressed early in the intake process, ideally within hours of admission to reduce the risk of medical complications and potential fatalities. Medically managed detoxification for justice-involved individuals also reduces demand for contraband in custody settings; for probationers and parolees with opioid or alcohol use disorders, it can reduce the likelihood of violating conditions of community supervision.

However, forced detoxification can undermine individuals’ willingness to engage in MAT in the future, compromising their likelihood for long term recovery.[[121]](#endnote-121)

Justice-involved individuals usually undergo screening for substance use disorders. However, it is unwise to assume that an individual who self-reports a history of opioid use is exempt from the potentially life-threatening consequences of alcohol or benzodiazepine withdrawal as well. 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 of all arrestees and other justice-involved individuals with an established or suspected history of substance use is widely recommended,[[122]](#endnote-122) although studies have indicated that only approximately half of jails have implemented such protocols and practices.[[123]](#endnote-123) In community settings, justice professionals should refer individuals in acute withdrawal from alcohol or chemically related sedative/hypnotic drugs (e.g., benzodiazepines, barbiturates) to a community-based provider that offers medically managed detoxification services or to a hospital emergency department if high risk.

The National Commission on Correctional Health Care, and experts recommend the use of a standardized brief withdrawal severity assessment to help stratify risk levels:

* ****Low****—should be monitored but do not require medical attention
* ****Medium****—require immediate medical attention but do not have complicating medical conditions
* ****High****—require immediate medical attention and intensive monitoring due to other medical conditions that elevate risk[[124]](#endnote-124)

Of course, 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-associate seizures, a history of traumatic brain injury, advanced age, major medical or psychiatric comorbidity, and pregnancy.[[125]](#endnote-125) Referral to community-based detoxification services that are not medically managed (“social detox”) is permissible for low-risk individuals and those withdrawing from opioids who do not report heavy or recent alcohol use, are not displaying alcohol withdrawal symptoms, and do not have other serious medical conditions. Such facilities monitor individuals and transport them to the hospital when necessary. Outpatient detoxification is not uncommon for individuals withdrawing from opioids.[[126]](#endnote-126)

In custody settings, the medical consequences of acute withdrawal from alcohol or chemically related sedative/hypnotic drugs (e.g., benzodiazepines, barbiturates) can be reduced or eliminated when sound protocols are implemented and followed.[[127]](#endnote-127) Symptoms of opioid withdrawal should be treated in accordance with correctional health care guidelines, but they usually do not present a serious threat. The exception to this is pregnancy, which is discussed in depth in the section on specific practice guidelines for pregnant women with opioid use disorders.

Although detoxification is not treatment and relapse is likely to occur without follow-up long-term services, assisting individuals in custody to withdraw from substances is an ethical and medical responsibility. The belief that the amount of suffering a person with an opioid use disorder endures correlates with their level of motivation to recover is completely unfounded.[[128]](#endnote-128) Medications combined with psychological support are humane measures and good medical practice.

Many medications are used to help ease withdrawal symptoms. The Federal Bureau of Prisons (BOP) offers clinical guidelines for safe detoxification from alcohol, opioids, barbiturate, and other substances. These practice guidelines do not differ significantly from community-based medically managed detoxification practices. In addition to recommending the use of withdrawal severity scales, and the substitution of long-acting medication for short-acting drugs of abuse when possible, they contain specific detox protocols for various substances. For example, some of the prescription medications that are used off-label, on a short-term basis, for opioid withdrawal include:

* Clonidine—normally used for blood pressure
* Baclofen—derivative of gamma-aminobutyric acid (GABA) and a muscle relaxant
* Lofexidine—alpha 2-adrenergic receptor agonist, used for blood high pressure
* Methocarbamal—normally used as muscle relaxant[[129]](#endnote-129)

Alcohol withdrawal is usually treated with short-term, gradually tapering doses of long-acting benzodiazepines. Additional medications include: clonidine; thiamine, a vitamin; and carbamazepine, an anti-seizure medication.

*Note:* It is important to re-emphasize that research has shown that medication-assisted short-term detoxification addresses withdrawal, not long term treatment.[[130]](#endnote-130)

#### Standards, Guidelines, and Information on Withdrawal Severity Screening

*Guide to Developing and Revising Alcohol and Opioid Detoxification Protocols*. Kevin Fiscella, M.D., M.P.H., for the National Commission on Correctional Health Care, 2015. [www.ncchc.org/filebin/Resources/Detoxification-Protocols-2015.pdf](http://www.ncchc.org/filebin/Resources/Detoxification-Protocols-2015.pdf%20)

*Detoxification of Chemically Dependent Inmates*. Federal Bureau of Prisons clinical practice guidelines, February 2014. www.bop.gov/resources/pdfs/detoxification.pdf

*TIP Series 45: Detoxification and Substance Abuse Treatment*. U.S. Department of Health and Human Services (DHHS), 2006. DHHS Publication No. SMA 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration.

*Opioid Substitution Treatment in Custodial Settings – A Practical Guide*. World Health Organization (WHO) and United Nations Office on Drugs and Crime (UNODC), 2008. [www.unodc.org/documents/balticstates/Library/PrisonSettings/OST\_in\_Custodial\_Settings.pdf](http://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](http://www.ncchc.org/filebin/CorrectCare/30-3-WOWS.pdf)

### B. Referral to prescribing physicians and treatment providers by justice agencies is selective, restricted, for example, to physicians who have required certification and are knowledgeable about addiction, the medication sought, substance abuse or behavioral health programs, and the role of MAT in substance abuse treatment.

According to SAMHSA, most substance use disorder treatment programs across the country offer abstinence-only treatment. In 2014, only 17.2 percent of substance use facilities—including those offering opioid use disorder medications—offered MAT, with 9.23 percent offering methadone, 23.2 percent offering buprenorphine, and 12.7 percent offering injectable naltrexone. Most of these programs offered more than one medication.[[131]](#endnote-131)

This means that justice agencies must screen which agencies and which physicians they refer clients to. The programs and physicians used to assess clients in need of treatment must consider all clinically appropriate forms of treatment. And they must be able to provide that treatment, including access to all FDA approved-medications either directly or by referral. Treatment providers should be familiar with the full range of medications and not limit offerings to a single formulation of medication.

Since both methadone and buprenorphine are controlled substances, only select medical personnel may prescribe these medications. Except for its use for pain alleviation, methadone must be dispensed by a SAMHSA certified opioid treatment program (OTP). These clinics are strictly regulated by state and federal law.

**SAMHSA maintains a Buprenorphine Treatment Physician Locator by state** (www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator). Unfortunately, the Locator lists physicians who have completed the training, but may not be actively prescribing the medication and is also limited to only those providers who elect to have their information listed. The link is <http://findtreatment.shamhsa.gov>. Unlike methadone, patients may obtain buprenorphine directly from their doctors’ offices.

While physicians need no certification to prescribe and dispense naltrexone, because it is not a controlled substance, relatively few physicians are knowledgeable about the drug, keep it in stock, or are open to treating people with a substance use disorder. The company that manufactures injectable naltrexone (Vivitrol®), Alkermes, maintains a listing of doctors that provide the medication at [www.vivitrol.com/getstarted/findadoctor?s\_mcid=url-vivproviders](http://www.vivitrol.com/getstarted/findadoctor?s_mcid=url-vivproviders)

Many licensed substance use disorder treatment programs will complete an assessment that includes whether medication-assisted treatment may be indicated. If the program does not have a physician on staff, it may refer the client to a physician that can prescribe the appropriate medication and dispense it or administer the monthly shots required for injectable naltrexone. This means that justice agencies must exercise care in making referrals to substance use disorder treatment programs to find one that will assess the need for pharmacotherapy, directly provide the most appropriate medication along with counseling and recovery support services. The justice agency may have to work with and encourage available treatment providers to promote client access to MAT.

### C. Justice agencies implementing comprehensive MAT programs develop strong relationships with treatment and MAT providers, including regular communication regarding participant progress.

Continued collaboration between the justice agency referring the individual to the treatment and/or MAT provider and those providers will optimize success. While ultimately a person with drug or alcohol use disorders must want to avoid relapse, research has long determined that the coercive power of the justice system can assist in recovery. Research reviews provide “overall support for the dictum that legally referred clients do as well or better than voluntary clients in and after treatment.”[[132]](#endnote-132) Justice agency personnel, utilizing motivational interviewing, can assist in getting individuals committed to their recovery, even if their initial motivation for treatment came from wishing to avoid an arrest, conviction, or jail sentence.

For this reason, by maintaining collaboration, the justice agency and the treatment providers can work together to enhance the prospects of long-term recovery for each justice-involved client. It should also be remembered that justice-involved clients may have criminogenic needs not present in the clients the treatment and MAT providers are used to treating. They may need help understanding and responding to this population’s full needs and challenges.

Practice: A central New York state treatment court where most individuals choose buprenorphine as their medication, maintains a list of approved providers that has evolved based on the court’s experiences with individual providers. For example, providers who communicate effectively and cooperate with the court remain on the list; those who do not are removed. Almost all participants receive the medication at outpatient programs designated by the court. A small number receive it directly from physicians. All participants must attend the outpatient program for counseling and other services.[[133]](#endnote-133)

### D. Justice officials rely heavily on the clinical judgment of treatment providers, as well as their agency’s own clinical staff if they have one. Individuals should be assessed before MAT is recommended or promoted.

Once it has been determined by an appropriately administered needs assessment that the justice-involved individual needs treatment and that treatment can be provided, police officers, probation and parole agents, judges, and correctional officers do not determine the clinical needs of the individual. This is particularly important when it comes to prescribing medications, including those for alcohol and opioid use disorders. Among other things, all medications carry with them different risks and benefits for different individuals. Treatment decisions, including medication, should be evidence based and appropriate medical treatment should not be withheld as a sanction or provided as a reward.

Clinical assessments for MAT begins with a general assessment for substance use disorders. There are a number of instruments that have been developed for such need assessments. Specifically, the Clinical Opiate Withdrawal Scale (COWS), an 11item scale, is used to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time[[134]](#endnote-134) and the Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CTWA-Ar),[[135]](#endnote-135) a five item scale, is used to measure symptoms of alcohol withdrawal. More generally, the Rand Corporation developed for NIDA Procedures for Medication-Assisted Treatment of Alcohol or Opioid Dependence in Primacy Care.[[136]](#endnote-136) It includes scales for opiate dependence (pp 75-77) and alcohol dependence (pp 24-25). These scales elicit from individuals symptoms associated with these use disorders. The RAND publication was revised when DSM-V replaced DSM-IV criteria for these disorders to indicate that its scales could still be used to assess appropriateness for treatment. The Rand publication also includes a pre-injection sample checklist for naltrexone for **alcohol** use disorder (p 15) and one for prior to starting 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. (65).” Texas Christian University (TCU) Drug Screen Vis an updated version of the TCU Drug Screen II and is based on the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). The TCU Drug Screen V screens for mild to severe substance use disorder, and is particularly useful when determining placement and level of care in treatment.[[137]](#endnote-137)

### E. Monitoring for illicit use of medication-assisted treatment medication or other drugs is a key component of the program.

Alcohol and drug use during treatment should be carefully monitored. Individuals trying to recover from alcohol and drug addiction may experience a relapse and return to drug use. Those on MAT may relapse, take other drugs or misuse prescription medication. Individuals on naltrexone may switch to cocaine or other drugs not blocked by naltrexone.

Triggers for relapse are varied. Common triggers include mental stress and associations with peers and social situations linked to drug use. An undetected relapse can progress to serious alcohol and drug misuse and use disorders, but detected use 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—determining rewards and sanctions to facilitate change and modifying treatment plans according to progress. In jails that do not have the facilities to separate those receiving treatment from the general population, alcohol and drug testing should be more prevalent.

If individuals are to be provided naltrexone, oral or injected, they must be drug tested first for opioids, as abstinence for at least 7 days is required before they can take this medication. Although naltrexone also blocks some effects of alcohol, it does not induce alcohol withdrawal, therefore individuals do not have to be alcohol free before taking naltrexone, just opioid free, although outcomes are better for individuals who are able to abstain for a week prior to injection[[138]](#endnote-138)

Justice or treatment agencies can employ a range of methods to monitor for return to drug use in addition to urine tests, including pill/strip counting and behavioral observations. These methods generally are not that different from those used to monitor illicit drug use by other non-MAT participants. Some justice agencies do more of the monitoring themselves, while others may rely primarily on treatment programs with which they communicate regularly.

The method and extent of monitoring also depend on the type of medication. Buprenorphine patients typically take home a month’s worth of medication, which requires more vigilant monitoring. Methadone patients, on the other hand, typically take their dose in liquid form under observation by clinic medical staff and do not earn the privilege to take medication home for self-administration until well stabilized so they cannot misuse their medication as easily. Naltrexone, when it is injected by a healthcare provider cannot be diverted and oral naltrexone has no abuse potential.

There is inevitably some diversion of MAT medication (mainly buprenorphine), but programs operating a various criminal justice intercept points, including correctional institutions, have demonstrated that it is something that can be managed and does not justify a blanket prohibition. In fact, illicit use of both methadone and buprenorphine among justice-involved populations often occurs among people with opioid use disorders who are not enrolled in MAT programs but who use the MAT medications illicitly to self-medicate. With more access to MAT, prison and jail administrators report that illicit use of these medications can be substantially reduced.

States with an operational prescription drug monitoring program (PDMP) collect all Schedule II, III, IV and in some states V controlled substance prescriptions drug data that can be accessed by authorized users, including physicians and pharmacists. By regularly checking the PDMP, treating providers can become aware if the patient receives a controlled substance from another prescriber and address the possible return to drug use.

### F. Justice agencies facilitating MAT work with their state Medicaid agencies to facilitate healthcare coverage for MAT medication

Lack of insurance or gaps in insurance coverage inhibit utilization of MAT. According to a 2016 U.S. Government Accountability Office (GAO) report,[[139]](#endnote-139) out-of-pocket costs for sublingual buprenorphine for individuals who lack insurance coverage for medications, for example, can range from $200 to $450 a month—and the cost of injectable naltrexone can triple that. Even if the individuals have Medicaid, a 2014 SAMHSA report found that most state Medicaid programs do not reimburse for all three approved opioid use disorder medications. In some states that cover all or some of the medications, there is a shortage of physicians willing to prescribe medications for Medicaid enrollees with substance use disorders. Some states have stringent prior authorization requirements before medications such as buprenorphine or extended release injectable naltrexone can be covered.

Staff at either justice or treatment agencies must include someone who can assist individuals to receive the coverage needed to utilize MAT programs, including any available state-subsidized medication, particularly in states that do not have expanded Medicaid under the Affordable Care Act. In addition, if the individual obtains employment and no longer qualifies for Medicaid, they may not be able to afford the subsidized premiums or co-pays. They may need assistance including, for example, pharmaceutical company coupons or access to generic versions of buprenorphine.

In almost every state, there are resources available to assist justice-involved individuals to obtain health care coverage, as well as assistance in paying for their medications. In 2013, the Centers for Medicare and Medicaid Services (CMS) awarded $67 million to 105 organizations, including many Community Action Agencies, to hire and train navigators in the 34 states with federally facilitated or state and federal/ partnership marketplaces. An additional $60 million was awarded in 2014, followed by three years of funding for 2015-2018. Many of these grantees subcontract with local agencies that have experience working with underserved subgroups. Additional funds went to many federally qualified health centers (FQHCs) to support onsite assistors.

The different types of assistors include:

* ****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.
* ****Non-navigator assistors (in-person assisters)****—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 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 on 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.

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 Medicaid pays (25 to 50 percent less). Programs that may qualify are identified in the Public Health Service Act and include safety-net hospitals run by state or local government, FQHCs, family planning clinics, sexually transmitted disease clinics, Ryan White CARE Act grantees, and others. The following website lists 340B-covered entities by state: <http://datawarehouse.hrsa.gov/topics/HealthcareSystems/CE340BDataExplorer.aspx>.

Some states fund MAT medications for programs that serve justice-involved populations out of state block grant funding or state appropriations.

### G. Assisting individuals to choose the medication that is right for them requires shared decision-making.

There is no one medication that guarantees an individual will sustain long-term recovery from opioid or alcohol use disorders. There are currently no evidence-informed guidelines to reliably match the individual to the optimal medication.[[140]](#endnote-140) Nor is there a set period of time any of the medications must be taken that is correlated 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 a joint decision among the person him/herself, a physician or medical provider, and a treatment provider or knowledgeable counselor. Before any specific medication is considered, first the person 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 presentation of potential adverse consequences is presented in a manner and vocabulary that is understandable to the individual. This may require alternative or supplementary explanations by persons other than physicians.

A physical examination to check on the individual’s general health is also part of the assessment. The physical exam should include a drug test and tests for medical conditions for which people who use drugs are at high risk such as HIV and hepatitis. Information about the patient’s medical problems and other tests, such as liver function, tuberculosis tests help to determine potential contraindications and appropriateness for specific medications. For example, chronic pain requiring opioid pain relievers is a contraindication for naltrexone.

After the assessment, the physician, substance abuse treatment counselor, and the patient should discuss the best course of treatment, including which medication to take and what dosage may be appropriate. Close family or friends, with permission, may be valuable participants in treatment planning, monitoring and support. Obviously, due to the paucity of MAT providers, especially in rural communities, not all FDA-approved medications may be available to all justice-involved individuals, requiring justice agencies to work to establish additional resources for their clients.

Agonist medications, buprenorphine and methadone, cannot be abruptly discontinued. While the length of time treatment with medication is required needs to be individualized, it is not unusual for patients to be equally concerned about being “stuck” on medication or being required to discontinue it before they are ready. How medication will be tapered and how readiness for taper will assessed should be discussed at treatment initiation and regularly throughout the course of treatment.

Practice: **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 involving opioid use. The treatment setting described as Level 1 treatment in the ASAM Criteria may be a general outpatient location such as a clinician’s practice site. The setting as described as Level 2 in the ASAM Criteria may be an intensive outpatient treatment or partial hospitalization program housed in a specialty addiction treatment facility, a community mental health center, or another setting. The ASAM Criteria describes Level 3 or Level 4 treatment respectively as a residential addiction treatment facility or hospital.

The venue in which treatment is provided is as important as the specific medication selected. Opioid Treatment Programs offer daily supervised dosing of methadone, and increasingly of buprenorphine. Naltrexone can be prescribed in any setting by any clinician with the authority to prescribe any medication.

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 Opioid Treatment Programs 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 who are in the treatment of addiction involving the use of alcohol or other sedative drugs, including benzodiazepines or benzodiazepine receptor agonists). It may also be unsuitable for persons who are regularly using 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] OUD.

Oral naltrexone for the treatment of OUD 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; e.g. observed dosing. Extended-release injectable naltrexone reduces, but does not eliminate, issues with medication adherence.[[141]](#endnote-141) It should be noted that individuals may be provided oral naltrexone for several days prior to injections of naltrexone to ensure there are no negative reactions to the medication.

### H. In choosing appropriate medications, there are widely agreed on considerations that should be discussed and considered regarding each potential medication.[[142]](#endnote-142)

**Methadone** is recommended for patients who are physiologically dependent on opioids, able to give informed consent, and who have no specific contraindications for agonist treatment, including the taking of benzodiazepines,when it is prescribed in the context of an appropriate plan that includes psychosocial intervention. The usual daily dosage of methadone ranges from 60–120 milligrams (mg). Some patients may respond to lower doses and some patients may need higher doses. Switching from methadone to another medication for the treatment of OUD may be appropriate if the patient experiences intolerable side effects or is not successful in attaining or maintaining treatment goals when using methadone. Patients switching from methadone to buprenorphine in the treatment of OUD should be on low doses of methadone prior to switching medications. Patients on low doses of methadone (30–40 mg per day or less) generally tolerate transition to buprenorphine with minimal discomfort, whereas patients on higher doses of methadone may experience significant discomfort in switching medications. Patients switching from methadone to oral naltrexone or extended-release injectable naltrexone must be completely withdrawn from methadone and other opioids before they can receive naltrexone.

**Buprenorphine** is recommended foropioid-dependent patients. 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 6–12 hours after the last use of heroin or other short-acting opioids, or 24–72 hours after their 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 taper and discontinuation is a slow process and close monitoring is recommended. Buprenorphine tapering is generally accomplished over several months. Patients should be encouraged to remain in treatment for ongoing monitoring past the point of discontinuation.

When considering a switch from buprenorphine to naltrexone, 7–14 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 considering a switch from buprenorphine to methadone, there is no required time delay as 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.

**Naltrexone** is a recommended treatment in preventing relapse in OUD. 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 taking their medication daily.

There is no recommended length of treatment with oral naltrexone or extended-release injectable naltrexone. Duration depends on clinical judgment and the patient’s individual circumstances. Because there is no physical dependence associated with naltrexone, it can be stopped abruptly without withdrawal symptoms.

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 physical dependence on opioids, therefore the initial doses of methadone or buprenorphine used should be low.

Patients should not be switched until a significant amount of the naltrexone is no longer in their system. This requires one day wait for oral naltrexone and 30 days after an injection of naltrexone.

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

1. 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 for Mental Disorders (DSM-IV), that the 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 and 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 under paragraph (e)(1) of this section, 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. Detoxification (medical withdrawal) treatment. An OTP shall maintain current procedures that are designed to ensure that patients are admitted to short- or long-term detoxification treatment 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 detoxification 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 detoxification treatment episodes in one year (21-22).

### I. Pregnant women with opioid and alcohol use disorders require specialized services to prevent and reduce the health risks resulting from these disorders during pregnancy. Medication-assisted treatment is readily available to stabilize pregnant women with opioid use disorders during pregnancy. There are also services for tobacco cessation which is also important for this population.

Opioid withdrawal during pregnancy is associated with miscarriage, premature delivery, and other serious complications. Pregnant women with alcohol use disorders should be detoxified 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 particularly high risk. Unfortunately, some women who drink heavily during the first trimester may not know they are pregnant, so treatment providers should include pregnancy tests if clients are unsure.

In custody settings, women are usually screened for pregnancy on intake, but justice-involved women with a history of substance use should also be screened for pregnancy in community corrections. All justice-involved women should be educated about the risks of substance use during pregnancy and offered tobacco cessation supports and services, which all public and private health insurance plans are now required to cover.[[143]](#endnote-143)

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. Yet, going off opioids too quickly during pregnancy is also risky. When a pregnant woman uses opioids, they cross over into the bloodstream of the developing fetus. If the pregnant woman suddenly quits, the fetus also experiences withdrawal and dangerous complications can result. Children of women treated for opioid use disorders with opioid replacement therapies during pregnancy have improved birth outcomes.[[144]](#endnote-144)

Methadone maintenance for pregnant women is an accepted best practice that has been used safely for years and has been widely researched.[[145]](#endnote-145) As with any treatment, there are some risks, but they are weighed against the risks pregnant women with untreated opioid addiction may face the risks of opioid withdrawal and relapse.

All infants exposed to opioids in utero are at risk for withdrawal symptoms at birth sometimes severe enough to require medication and delay discharge from the hospital. This 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 low birth weight. Opioid exposed infants can be monitored and managed in most hospitals. Women receiving medications are usually encouraged to breastfeed, since the benefits greatly outweigh the very small trace amounts of medication that may be found in breast milk.[[146]](#endnote-146)

There are fewer long-term studies of safety and effectiveness of buprenorphine during pregnancy, but some suggest that buprenorphine reduces NAS.[[147]](#endnote-147) The American College of Obstetricians and Gynecologists supports treating pregnant women with buprenorphine if they are already on it or prefer it.[[148]](#endnote-148) Pregnant women should generally only receive the single-drug formula, without added naloxone.

Justice-involved pregnant women with opioid use disorders who are under community supervision should be referred to treatment providers that offer specialized services for pregnant and post-partum 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.[[149]](#endnote-149)

Existing Standards and Guidelines

A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders, SAMHSA. [http://store.samhsa.gov/product/A-Collaborative-Approach-to-the-Treatment-of-Pregnant-Women-with Opioid-Use-Disorders/SMA16-4978](http://store.samhsa.gov/product/A-Collaborative-Approach-to-the-Treatment-of-Pregnant-Women-with%20Opioid-Use-Disorders/SMA16-4978) and Advancing the Care of Pregnant Women with Opioid Use Disorder and their Infants, A Foundation for Clinical Guidance

<http://files.www.cmhnetwork.org/news/Advancing_the_Care_of_Pregnant_and_Parenting_Women_with_Opioid_Use_Disorder_and_their_Infants_-_A_Foundation_for_Clinical_Guidance_-.pdf>

*Opioid Use Disorders and Medication‐Assisted Treatment*. The National Center on Substance Abuse and Child Welfare. <https://ncsacw.samhsa.gov/resources/opioid‐usedisorders‐and‐medication‐assisted‐treatment/default.aspx>

*National Commission on Correctional Health Care, Pregnancy, and Postpartum Care in Correctional Settings*. Carolyn Sufrin, M.D., Ph.D. Endorsed by the American College of Obstetricians and Gynecologists (ACOG) April 25, 2015 and should be construed as ACOG clinical guidance.

*State Standards for Pregnancy-related Health Care and Abortion for Women in Prison*. American Civil Liberties Union, 2016. [www.aclu.org/map/state-standards-pregnancy-related-health-care-and-abortion-women-prison-map](http://www.aclu.org/map/state-standards-pregnancy-related-health-care-and-abortion-women-prison-map)

# III. Some Special Considerations for MAT for Incarcerated Justice-Involved Individuals

### Jails/Prisons: Jail and prison MAT programs break down barriers between in-house treatment and follow-up treatment in the community post release.

The National Commission on Correctional Health Care (NCCHC) issued the following position on the treatment of substance use disorders and MAT in November 2016, although it did not include use of naltrexone:

1. Continuation of prescribed medications for substance use disorders.
2. Inmates not receiving MAT prior to entry, or whose MAT is discontinued while incarcerated, should be offered MAT prerelease when post-release continuity can be arranged.
3. Appropriate prerelease planning with community OTPs and community buprenorphine prescribers is critical to ensure there is no interruption of treatment.
4. Correctional facilities should have several strategies for provision of buprenorphine or methadone to inmates, including during pregnancy. These strategies differ in the level of planning and licensing required.
5. Transport inmates to community OTPs or a hospital (this is sometimes used during pregnancy).
6. Partner with community OTPs for dosing of inmates within the facility. In this case, the dosing is done under the license of the community OTP.
7. Have correctional physicians obtain buprenorphine licenses. This license permits use of buprenorphine for MAT as well as for medication-assisted withdrawal.
8. Obtain an OTP license for the facility. This permits use of methadone and buprenorphine for both treatment and withdrawal. (Note: NCCHC accredits facilities for OTP.)
9. Obtain state and DEA licensing as a health care facility. This entitles the facility to the same exemptions as hospitals for use of methadone or buprenorphine during pregnancy or to ensure treatment of other conditions, e.g., HIV, mental illness.

5. Attention to the needs of pregnant women with substance use disorders, including following national standard of care to provide MAT, and not withdrawal, to pregnant women with opiate dependence, is essential.[[150]](#endnote-150)

There should be continuity of treatment and timely access to medication before and after release. For this reason, if the medication is to be paid for through Medicaid once individuals are released, the individuals should be enrolled before release so that there is not a gap between release and eligibility to access needed medication. If the health coverage requires prior approval for certain medications, it should be taken care of before release for the same reason. In addition to financing medication, the prison or jail should set up with participants their first post-release appointment so all parties know what to do and where to go upon release.

Practice:A number of different models for setting up collaborations between behavioral health providers and correctional settings to facilitate MAT continuation post-reentry are emerging;[[151]](#endnote-151) following are two from Massachusetts and Rhode Island. The Massachusetts Department of Correction Medication-Assisted Treatment Reentry Program utilizes contracted Recovery Support Navigators (RSN) that meet with participants interested in MAT 3 months before release. RSNs help them enroll in Medicaid or other health insurance plans and help prepare them for aftercare treatment, medication, and other support services. An RSN meets each participant at the prison gate on the day of their release and provides transportation for their first treatment appointment—that day, if possible. The RSNs remain available to individuals post release for one year, providing continued assistance if requested. Unlike parole, RSNs do not enforce treatment conditions, but simply stay in contact with participants and assist them as needed. While participants are provided injectable naltrexone before release, once in the community about 10 percent of participants switch to agonist medications after 1 to 3 months of injectable naltrexone. Approximately 20 percent of participants stop medication upon discharge. In Massachusetts, about 40 percent of individuals incarcerated in state prisons are not under any form of correctional supervision upon release. Their continued participation in treatment is totally voluntary.

The Rhode Island Department of Corrections provides agonist medications for individuals already prescribed these medications prior to their incarceration. It also provides injectable naltrexone for those not on agonist medication. Finally, it provides agonist medications to individuals who do not have prescriptions prior to incarceration if the individuals and medical and treatment staff believe it will assist in their recovery once they are released. Several prison MAT programs provide naltrexone maintenance in the months before release and before an injection immediately prior to release. The maintenance naltrexone is either provided by daily doses of oral naltrexone or multiple injections of naltrexone.

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3. Validated screening instruments can be found on various websites of evidence-based programming, including the U.S. Department of Justice’s Crime Solutions, [www.crimesolutions.gov/](http://www.crimesolutions.gov/), and SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP), [www.nrepp.samhsa.gov/01\_landing.aspx](http://www.nrepp.samhsa.gov/01_landing.aspx). [↑](#endnote-ref-3)
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