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# Promising Practice Guidelines for Jail-Based Medication-Assisted Treatment

**Advisory Roundtable, February 3, 2017**

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**Editorial**

These guidelines were drafted by Advocates for Human Potential with much guidance and assistance from the Bureau of Justice Assistance, the National Institute of Corrections and the Advisory Roundtable.

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Promising Practice Guidelines for Jail-Based
Medication-Assisted Treatment

# Introduction

Medication-assisted treatment (MAT), utilizing U.S. Food and Drug Administration (FDA)-approved medications methadone, buprenorphine or naltrexone, is part of a standard of care for substance use disorder treatment.

Evidence based on a meta-analysis of studies from 1995 to 2012 suggests that methadone maintenance therapy improves treatment retention and decreases opioid use. There are also positive impact trends related to criminality, mortality, and drug-related HIV risk behaviors. Buprenorphine maintenance therapy, based on a meta-analysis of studies from 1995 to 2012, showed a reduction in illicit opioid use, but there were mixed results for treatment retention, with some studies suggesting that methadone maintenance therapy may have an advantage.[[1]](#endnote-2) Buprenorphine for non-opioids shows positive trends but is less conclusive. Buprenorphine has a better safety profile and can help improve access to MAT in areas of the country that do not have a methadone treatment provider. The newer, less-studied U.S. Food and Drug Administration (FDA)-approved medication, naltrexone, has also been found effective, and effective specifically for persons involved in the justice system.[[2]](#endnote-3) Two studies found it as effective as buprenorphine, although naltrexone requires 7 to 10 days of abstinence before it can be taken. This results in fewer individuals accessing this medication as opposed to buprenorphine although this should not be a problem when introducing naltrexone to incarcerated individuals.[[3]](#endnote-4)

Using medication to treat substance use disorders began in the 1920s with a medication called disulfiram. In the late 1930s, methadone was developed to treat opioid use disorders and approved by the FDA in 1947. In 2002, the FDA approved buprenorphine and Suboxone (buprenorphine and naloxone) for treating opioid use disorders. The most recent medication, naltrexone, was approved by the FDA to treat opioid use disorders 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. However, the use of medication to treat substance use disorders has lagged far behind the mounting evidence of its effectiveness in promoting long-term recovery for both alcohol and opioid use disorders.

Over the last decade, criminal justice agencies, including drug courts, jails, and state departments of correction (state DOCs), have led the way in promoting access to MAT across the United States. Although prisons and jails traditionally provided methadone for women during pregnancy, in 2011, the Washington County, Maryland, jail became the first to introduce MAT for women who were not pregnant and for men, providing both oral and injectable naltrexone to participants. Other county jails and state DOCs in Missouri, Pennsylvania, and Massachusetts followed.

These guidelines have been developed to help institutional and community correctional agencies ensure access to MAT for individuals with alcohol and opioid use disorders, under probation supervision, when they enter jail before trial or after being sentenced and when they are released into the community, with or without parole supervision.

Although there is limited research on MAT programs specifically for these populations, these guidelines are based on what exists and are supplemented by general research on MAT, related criminal justice substance use disorder treatment programming, and, most importantly, the experiences of expert practitioners who have pioneered the application of MAT in these agencies and institutions.

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

# I. Medication-Assisted Treatment is the Contemporary Standard of Care

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.[[4]](#endnote-5) As described in the 2018 Substance Abuse and Mental Health Services Administration (SAMHSA) *TIP 63: Medications for Opioid Use Disorders: “*Improving access to treatment with Opioid Use Disorder medications is crucial to closing the wide gap between treatment need and treatment availability, given the strong evidence of effectiveness for such treatments. Data indicate that medications for OUD are cost effective and cost beneficial.”[[5]](#endnote-6)

Individuals who are in correctional institutions or under correctional supervision with substance and/or alcohol use, as well as co-occurring disorders, should have access to medication as well as appropriate counseling and support services.

Medicines used in 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 jail and the community. Jail programs should assist individuals in obtaining access to these medications if they, their health care provider(s), or their behavioral health treatment provider(s) deem it appropriate.

If individuals are on prescribed FDA-approved agonist (methadone) or partial agonist (buprenorphine with or without naloxone[[6]](#endnote-7)) or anti-agonist (naltrexone) for opioid use disorders, correctional agencies should facilitate continued access and, as appropriate, provide the option of facilitating safe tapering off the medication while under the supervision of medical experts. Correctional agencies should promote access to naloxone, as appropriate, as well as treatment to minimize the risk of overdose deaths.

Federal disability and antidiscrimination statutes may apply to questions of MAT administration and access. Justice agency policymakers and practitioners may also want to consider the Americans with Disabilities Act (ADA) §504 in their considerations.[[7]](#endnote-8)

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. The same is also true for those diagnosed with an antisocial personality or conduct disorder.[[8]](#endnote-9) The most recent data from the Bureau of Justice Statistics indicates that 58 percent of individuals in jail met the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) criteria for dependence or abuse compared to 5 percent of the general population.[[9]](#endnote-10)

SUPPORT FOR MAT FROM STUDIES:The evidence is clear that the addition of medication increases the likelihood of successful treatment for individuals with opioid and alcohol use disorders, regardless of the (nonmedical) treatment modality used.[[10]](#endnote-11) Research has begun to show that adding MAT to the treatment of individuals involved in the criminal justice system not only increases the likelihood of successful treatment but also reduces recidivism.[[11]](#endnote-12)

Notwithstanding this increasing evidence, substance use treatment providers, both inside and outside of the criminal justice system, have been slow to add MAT to their treatment regimens. As of January 2018, 20 state departments of correction do not offer MAT in their drug treatment programs for incarcerated individuals beyond limited methadone maintenance for women during their pregnancies. Other DOCs that do offer MAT are mostly limited to the provision of injectable naltrexone immediately before individuals are released to the community. Fewer than 200 local and county jails in 30 states out of several thousand provide MAT, which is also mostly limited to the provision of injected naltrexone immediately before individuals are released back into the community.

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

The **National Sheriffs Association** in 2017 resolved that whereas it has been estimated that more than 50% of inmates meet the medical criteria for drug dependence or abuse, and where as the criminal justice system is the largest source of referral to addiction treatment, and whereas substance use disorders are often associated with a revolving door of arrest, incarceration and release to the streets untreated or undertreated, followed by rearrests and return to incarceration, therefore, be it resolved:

 The National Sheriffs’ Association (NSA) supports the use of non-narcotic, evidence-based medication-assisted for opioid dependence after detoxification within the confines of a jail or other secure facility…[[12]](#endnote-13)

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.[[13]](#endnote-14)

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 use 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 case-by-case assessment of the participant’s needs 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 not allowing 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.[[14]](#endnote-15)

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.”[[15]](#endnote-16)

The **American Correctional Association** enacted a resolution August 22, 2017, at its Delegate Assembly at the 147th Congress of Corrections:

THEREFORE, BE IT RESOLVED, all justice-involved individuals who arrive into the correctional system with ongoing opioid use disorder treatment should be evaluated for consideration of continuing medication-assisted treatment (MAT) within correctional systems; and

BE IT FURTHER RESOLVED, sentenced individuals who enter the system and are currently being treated with an opioid agonist, opioid partial agonist, or opioid antagonist as part of an MAT program and who have relatively short sentences should be considered for maintenance on that treatment protocol for a reasonable period (such as 12 to 24 months) to continue their ongoing treatment to facilitate reentry and return to treatment in the community; and

BE IT FURTHER RESOLVED, all individuals with latent or active opioid use disorder should be assessed for behavioral health disorders, especially trauma-related disorders, and offered evidence-based treatment for both disorders if appropriate; and

BE IT FURTHER RESOLVED, four to six weeks prior to reentry or release, all individuals with a history of latent or active opioid use disorder should be re-assessed by a licensed, trained clinician to determine whether MAT is medically appropriate and evidence-based information and options should be offered to the individual; and

BE IT FURTHER RESOLVED, the decision to initiate MAT and the type of treatment to utilize should be a deliberate, voluntary choice made by the individual who has been well informed by the trained, licensed clinician as to the appropriateness of the therapy; and

BE IT FURTHER RESOLVED, MAT should not be mandated as a condition of release.

The **National Drug Court Institute** holds, “Under no circumstances should a drug court have a blanket prohibition against MAT as a matter of policy.”[[16]](#endnote-17)

The **National Governors Association** has called on state correctional facilities to:

1. Increase access to MAT in 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.[[17]](#endnote-18)

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).”[[18]](#endnote-19)

The **World Health Organization** (WHO) reviewing agonist MAT recommends it as “the most cost-effective treatment, and [it] should therefore form the backbone of the treatment system for opioid dependence.”[[19]](#endnote-20)

***Note:*** *Detoxification is the medical management of acute withdrawal and does not alone alter the course of the substance use disorder unless linked with ongoing treatment.[[20]](#endnote-21)*

Promising Practice Guidelines for Jail-Based
Medication-Assisted Treatment

### A. *The decision to obtain medication for opioid or alcohol use disorders, as well as the specific medication chosen, is 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 the individuals they are prescribed for. They are also available through different channels and administered in different manners.

Alcohol Use Disorder: 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.

**Use of Disulfiram:** 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 adverse 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.”[[21]](#endnote-22) 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.

**Use of Acamprosate:** Acamprosate can be prescribed by physicians or nurse practitioners and, in some states, by physician assistants and psychologists. Although not all patients respond to Acamprosate, research suggests it is more likely to be effective for patients who are abstinent from alcohol before Acamprosate is initiated, and it is more likely to benefit patients who intend to abstain from alcohol completely rather than for those who are 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.

Substance Use Disorder

**Initiating Opioid Medications:** If individuals are to be provided with naltrexone, oral or injected, they must first be drug tested for opioids, because abstinence for at least 7 to 10 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 also able to abstain from alcohol for a week prior to injection.[[22]](#endnote-23) Individuals may begin methadone without detoxifying from opioids. However, they must wait to begin buprenorphine until they are in mild to moderate withdrawal. Before being administered buprenorphine (with or without naloxone), the patient, for example, should score a minimum of 5 or 6 on the Clinical Opiate Withdrawal Scale (COWS) described earlier.[[23]](#endnote-24)

**Length of Use:** Research indicates the length of time individuals should spend on medication varies and needs to be reassessed with medical staff considering the individual’s medical history and situation. Both SAMHSA[[24]](#endnote-25) and the American Society of Addiction Medicine (ASAM)[[25]](#endnote-26) 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, “buprenorphine taper and discontinuation is a slow process and close monitoring is recommended.” Further, discontinuation is generally accomplished over several months and “patients and clinicians should not take the decision to terminate treatment with buprenorphine lightly” (p. 34). Similarly, ASAM holds that “the optimal duration of treatment with methadone has not been established; however, it is known that relapse rates are high for most patients who drop out; thus, long-term treatment is often needed” (p. 30). For both oral and injectable naltrexone, ASAM concludes that the duration of treatment should depend on the response of the individual patient, the patient’s individual circumstances, and clinical judgment” (p. 37).

Data show that treatment retention is reduced when patients are tapered off MAT prematurely.[[26]](#endnote-27) For some patients, MAT could be indefinite.[[27]](#endnote-28) The National Institute on Drug Abuse (NIDA) describes addiction medication as an “essential component of an ongoing treatment plan” to enable individuals to “take control of their health and their lives.”[[28]](#endnote-29) For methadone maintenance, 12 months of treatment is the minimum, according to NIDA.[[29]](#endnote-30)

The first long-term follow-up of patients treated with buprenorphine/naloxone for addiction to opioid pain relievers found half were abstinent at 18 months after starting therapy. After 3 ½ years, the number reporting abstinence rose to 61 percent. At each follow-up interview, patients who were currently receiving the medication were much more likely to report abstinence compared to those not taking medication. Only 6.6 percent of the patients maintained abstinence after a brief course of medication (2 weeks of medication, 2 weeks to taper off, and 2 months follow up). Those who relapsed during this phase were provided 12 weeks of medication followed by 4-week taper and 2-month follow up. Nearly half of these patients achieved abstinence during their last 4 weeks, however, fewer than 10 percent were still doing well at the end of the 2 months follow up. At 18 months, 30 months, and 42 months, patients who were engaged in MAT had markedly higher odds of positive outcomes. At 42 months, the advantage associated with MAT had narrowed but was still large, 79.6 percent abstinence vs. 50.8 percent abstinence). During the study, patients only reported abstinence for the prior 30-day period. Many who relapsed re-entered MAT and were then able to remain abstinent for at least the 30 days at reporting periods.[[30]](#endnote-31)

After piloting the use of injected naltrexone, the Pennsylvania Department of Corrections’ MAT program, which initially recommended 6 months of injections, now recommends a full year of injections. A study of individuals involved in the criminal justice system provided with injected naltrexone for 6 months found that those receiving the injections had significantly fewer relapse events, a higher rate of opioid-negative urines, and less serious adverse events, including fatal and nonfatal overdoses, than those engaged in abstinence-only treatment. However, those treated with 6 months of naltrexone injections had 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.[[31]](#endnote-32)

**Comparison of Naltrexone and Buprenorphine:** Two recent studies compared injectable naltrexone and buprenorphine with naloxone. Both found that, once initiated, both medications were equally safe and effective.[[32]](#endnote-33)

Dosage for alcohol and Substance use disorder medications**:** Appropriate doses vary for these medications, except for naltrexone and disulfiram, where the dose is standard. Dosing is an individualized medical decision. In some instances, low doses of methadone, for example, have been found less effective for keeping users in treatment than higher doses.[[33]](#endnote-34) As described earlier, medication and treatment options should be individualized for the person’s needs. The person should receive information on treatment options and make the decision on medication and treatment in consultation with a medical and treatment team.

### B. *MAT assists in the treatment of substance and alcohol use disorders and is coupled with counseling and the appropriate wraparound services typical of substance use disorder treatment.*

All FDA-approved medication for the treatment of substance use disorders is 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 (e.g., patient is on waiting list) improves outcomes.[[34]](#endnote-35)

Treatment programs can include both group and individual counseling to accommodate the diverse needs of participants. Both cognitive behavioral therapy and therapeutic communities have been found to be effective treatment modalities for individuals in correctional facilities.[[35]](#endnote-36)

Most behavioral therapies found to be effective in addressing alcohol and substance use disorders are for specific 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 treatments that have been found effective and that the program, as modified and implemented, achieves commensurate results as those found in the research.

Many programs have found manualized treatment interventions to be effective, offering structure and consistency. They are also easy to use and can help focus sessions, although they can be restrictive, and counselors need to incorporate personal style and creativity in their use.[[36]](#endnote-37) 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.[[37]](#endnote-38)

The SAMHSA *Federal Guidelines for Opioid Treatment 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 opioid treatment program 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.[[38]](#endnote-39)

Best practice includes treatment that also addresses recidivism risk factors. “The concept of RNR [risk-need-responsivity] is considered a best practice for corrections[[39]](#endnote-40) and has been shown to effectively reduce recidivism by as much as 35 percent when implemented in certain settings.”[[40]](#endnote-41) Research has shown that non-adherence to RNR principles in service delivery is not only ineffective but can also be detrimental to offender treatment outcomes.[[41]](#endnote-42) One study examining the effectiveness of treatment programs reported a substantial negative correlation (r = -.28) between risk level and treatment effect size for a program that did not adhere to RNR principles.[[42]](#endnote-43)

### C. *Correctional staff 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 drug courts, for example, that have “buy-in” from their whole teams had 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.”[[43]](#endnote-44)

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

### D. *Residential correctional facilities, as well as community treatment providers, have specific safeguards to prevent the diversion of agonist medications and to safeguard participating individuals.*

The incorporation of MAT programming, especially in jails, can raise challenges based on the medication option(s) available.

Dispensing medications for the treatment of opioid use disorder in facilities that have no previous experience handling and storing them requires preparation and education. Precaution must be exercised to guard against the illicit diversion of agonist medications. Although some studies have found these medications to be effective for 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.”[[44]](#endnote-45)

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.

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 informed about an increased workload for medical personnel in the facilities.

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

i. Absence of recent abuse of drugs (opioid or nonnarcotic), including alcohol;

ii. Regularity of clinic attendance;

iii. Absence of serious behavioral problems at the clinic;

iv. Absence of known recent criminal activity, e.g., drug dealing;

v. Stability of the patient’s home environment and social relationships;

vi. Length of time in comprehensive maintenance treatment;

vii. Assurance that take-home medication can be safely stored within the patient’s home; and

viii. 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:

i. 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.

ii. 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. Opioid treatment programs (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.).[[45]](#endnote-46)

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

### E. *Participants are routinely tested to ensure clients are receiving the appropriate prescribed dosage of medications.*

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.”[[46]](#endnote-47)

There are several different ways to test for drugs, including alcohol. As described by ASAM, “Drug tests do not detect drug use in general.” Instead, drug tests identify specific drugs or drug classes as well as drug metabolites in biological matrices that are represented in particular test panels. Drugs can be identified in any matrix; the most common matrices for typical testing purposes include urine, blood, oral fluid, hair, nails, sweat, and breath.”[[47]](#endnote-48)

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 because 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 a high risk of overdosing. The utilization of drug testing can also ensure that the person is taking medication and not diverting it.

### F. *Community-based treatment and medication providers are carefully selected and may require correctional agency collaboration to encourage providers to meet the needs of referred individuals.*

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.[[48]](#endnote-49) The specific and separate requirements for the provision of buprenorphine and methadone have contributed to the fragmentation of MAT access for persons with opioid use disorders. Jails, therefore, must often search out community-based agencies that provide MAT, as well as appropriate treatment and services for individuals to be released to the community. The Pennsylvania Department of Corrections, for example, has issued a directive that it “will no longer do business with service providers who do not, at all levels, support the use of medication-assisted treatment.”[[49]](#endnote-50)

In selecting a referral agency or working with such an agency to better serve correctional clients, justice agencies should be advised by the *Federal Guidelines for Opioid Treatment Programs*, March 2015, issued by SAMHSA.[[50]](#endnote-51) The community-based agencies should offer recovery-oriented systems of care, in addition to medication. The guidelines specify that:

OTPs [opioid treatment programs] shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services.[[51]](#footnote-2) 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.

i. 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.

ii. 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.

iii. 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.[[52]](#endnote-52)

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.

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

Unfortunately, analysis of Medicaid data suggests that as prescriptions for buprenorphine increased, there appeared to be a decrease in the quality of care. The data found 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. Researchers concluded that “the quality of care received seemed to be generally poor.”[[53]](#endnote-53)

This supports the need for correctional institutions and probation and parole to ensure referrals are made to quality treatment providers. Just because a medical practitioner is certified to prescribe and/or dispense buprenorphine, it does not ensure the quality of care required that should accompany the use of this medication for opioid use disorders.

# II. Components for Implementing Jail-Based MAT Programs

*Implementation of jail MAT programs requires multiple components, including leadership, staff training, negotiating security, and embracing change by medical and treatment contractors, and other people providing services in the correctional agencies.*

### A. *Detoxification protocols support screening for withdrawal severity and poly-substance use, monitoring, and medical management of withdrawal symptoms*.

Detoxification utilizing prescribed and/or over-the-counter medications may be necessary when a person is transitioning to a controlled setting or will begin treatment with any form of naltrexone or after the administration of naloxone. In custody settings, especially jails, this must be addressed early in the intake process, ideally within hours of admission to reduce the risk of medical complications and potential fatalities.

Withdrawal symptoms may begin within 4 to 6 hours of the last opioid use and may last for up to several months.[[54]](#endnote-54)

If a person entering a correctional institution is on a prescribed medication, that person should be allowed to continue for a reasonable period. If the incarceration will be more than a year, the individual can be tapered off the medication under medical supervision. Research has found that forced detoxification of prescribed opioid medication, such as methadone, can undermine an individual’s willingness to engage in MAT in the future, compromising their likelihood of long-term recovery.[[55]](#endnote-55) Jails should have protocols in place to identify people who might require detoxification services. It is of equal importance that there then be a plan to engage them in treatment. As previously stated, detoxication by itself is not considered treatment,[[56]](#endnote-56) although it may constitute the first step to treatment and long-term recovery.

Another issue for correctional facilities to be aware of is poly-substance use. 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 persons entering corrections, institutional or community-based, with an established or suspected history of substance use is widely recommended.[[57]](#endnote-57)

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

**Low**—should be monitored but does not require medical attention

**Medium**—requires immediate medical attention but does not have complicating medical conditions

**High**—requires immediate medical attention and intensive monitoring due to other medical conditions that elevate risk[[58]](#endnote-58)

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.[[59]](#endnote-59) 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.[[60]](#endnote-60)

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.[[61]](#endnote-61) 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 long-term follow-up services, assisting individuals in custody who are withdrawing from substances is an ethical and medical responsibility. ASAM criteria, endorsed by SAMHSA in its *TIP 45: Detoxification and Substance Abuse Treatment*, suggests “that for alcohol, sedative-hypnotic, and opioid withdrawal syndromes, hospitalization (or some form of 24-hour medical care) is often the preferred setting for detoxification, based on principles of safety and humanitarian concerns. When hospitalization cannot be provided, then a setting that provides a high level of nursing and medical backup 24 hours a day, 7 days a week is desirable.”

The belief that the amount of suffering a person with an opioid use disorder endures correlates with their level of motivation to recover is unfounded.[[62]](#endnote-62) Medications combined with psychological support are the standard for medical practice and improve recovery outcomes. To get the best results from detoxification, the person should be immediately connected with medication and counseling.

Many medications are used to help ease withdrawal symptoms. The Federal Bureau of Prisons (BOP) offers clinical guidelines for safe detoxification from alcohol, opioids, barbiturates, 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 the following:

* 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 high blood pressure
* Methocarbamal—normally used as muscle relaxant[[63]](#endnote-63)

Alcohol withdrawal is usually treated with short-term, gradually tapering doses of long-acting benzodiazepines. Additional medications include clonidine; thiamine, also called vitamin B1; and carbamazepine, an anti-seizure medication. All medications should be administered under the supervision of trained medical personnel. Many individuals entering corrections may suffer from liver disease, which is contraindicated for the use of certain medications.

#### 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](file:///C%3A%5CUsers%5Caklein%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.Outlook%5CSXG00H4U%5Cwww.ncchc.org%5Cfilebin%5CResources%5CDetoxification-Protocols-2015.pdf)

*●Detoxification of Chemically Dependent Inmates*. Federal Bureau of Prisons clinical practice guidelines, February 2014. [www.bop.gov/resources/pdfs/detoxification.pdf](file:///C%3A%5CUsers%5Caklein%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.Outlook%5CSXG00H4U%5Cwww.bop.gov%5Cresources%5Cpdfs%5Cdetoxification.pdf)

*●TCU Drug Screen V Opioid Supplemental.* Texas Christian University, September 2017.<https://ibr.tcu.edu/forms/tcu-drug-screen/>

*●TIP Series 45: Detoxification and Substance Abuse Treatment*. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2006. <https://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA15-4131>

*●Opioid Substitution Treatment in Custodial Settings – A Practical Guide*. World Health Organization (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 correctional agencies is made to those who have the required certification and are knowledgeable about addiction, the medication sought, substance abuse or behavioral health programs, and the role of MAT in substance use treatment, whenever possible.*

**MAT Prescriber Information**

Because 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. Buprenorphine is prescribed by physicians. SAMHSA maintains a buprenorphine treatment physician locator by state (www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator). The locator lists physicians who have completed the training, but may not be actively prescribing the medication, and it 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 doctor’s office. The company that manufactures injectable naltrexone (Vivitrol®), Alkermes, maintains a list of doctors who provide the medication at [www.vivitrol.com/getstarted/findadoctor?s\_mcid=url-vivproviders](http://www.vivitrol.com/getstarted/findadoctor?s_mcid=url-vivproviders).

Access to opioid medications may be limited in the community, especially in rural areas.[[64]](#endnote-64)

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

### C. *Jails implementing comprehensive MAT programs develop collaborative relationships with treatment and MAT providers.*

Continued collaboration and regular communication between the correctional agencies referring individuals to treatment and/or medical or MAT providers and those providers will optimize success. Although, ultimately, a person must be motivated to pursue recovery, research provides “overall support for the dictum that legally referred clients do as well or better than voluntary clients in and after treatment.”[[65]](#endnote-65) Jail personnel using motivational interviewing can assist in helping individuals commit to their recovery, even if their initial motivation for treatment came from wishing to avoid conviction, wishing to avoid a jail or prison sentence, or was ordered as a condition of probation or parole.

For this reason, by maintaining collaboration, the correctional agency and the treatment providers should work together to enhance the prospects of long-term recovery for each shared client.

example from the field: A New York jail in collaboration with a state treatment court, where most individuals choose buprenorphine as their medication, maintains a list of approved providers that has evolved based on the department’s experiences with individual providers. For example, providers who communicate effectively and cooperate with the probation department remain on the list; those who do not are removed. Almost all the probationers receive their medication at outpatient programs designated by the officers. A small number receive it directly from physicians. All participants must also attend the outpatient program for counseling and other services.[[66]](#endnote-66)

### D. *Individuals are clinically assessed by a treatment provider to determine whether MAT is recommended.*

Once it has been determined by an appropriately administered needs assessment that an 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 based on what has been proven to work, and appropriate medical treatment should not be withheld as a sanction or provided as a reward.

Clinical assessments for MAT begin with a general assessment for substance use disorders. There are several instruments that have been developed for such need assessments. Specifically, the Clinical Opiate Withdrawal Scale (COWS), an 11-item scale, is used to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time,[[67]](#endnote-67) and the Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CTWA-Ar),[[68]](#endnote-68) a five-item scale, is used to measure symptoms of alcohol withdrawal. More generally, the Rand Corporation developed *Procedures for Medication-Assisted Treatment of Alcohol or Opioid Dependence in Primary Care* for NIDA.[[69]](#endnote-69) It includes scales for opiate dependence (pp. 75–77) and alcohol dependence (pp. 24–25). These scales describe the symptoms associated with these use disorders. The RAND publication was revised when the DSM-V replaced the DSM-IV criteria for these disorders to indicate that its scales could still be used to assess the appropriateness of treatment. The Rand publication also includes a pre-injection sample checklist for naltrexone for alcoholuse disorder (p. 15) and one for use 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” (p. 65). Texas Christian University (TCU) Drug Screen Vis an updated version of the TCU Drug Screen II and is also based on the DSM-V. The TCU Drug Screen V screens for mild to severe substance use disorder and is particularly useful when determining an individual’s placement and level of care in treatment.[[70]](#endnote-70) The TCU Drug Screen V also has an opioid supplement to identify the needs of people with opioid use disorders and the specific risk of overdose the person may be facing.

### E. *MAT programs include ongoing monitoring through drug screening.*

Alcohol and drug use during treatment should be carefully monitored as outlined in NIDA’s *Principles of Drug Abuse for Criminal Justice Populations.[[71]](#endnote-71)* Individuals trying to recover from alcohol and drug addiction may experience a relapse and return to drug use. This is considered a part of the recovery process for people with substance use disorders. Those on MAT, like others in substance use disorder treatment, may relapse, take other drugs, or misuse prescription medication. Individuals on antagonist drugs such as naltrexone may switch to cocaine or other drugs that are not blocked by naltrexone.

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

Correctional and treatment agencies can employ a range of methods to monitor for return to drug use in addition to urine tests, including pill or 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. Most correctional agencies do the monitoring themselves, not relying primarily on treatment programs or correctional health providers within correctional institutions.

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

States with an operational prescription drug monitoring program (PDMP) collect all Schedule II, III, IV, and in some states Schedule V, controlled substance prescription data that can be accessed by authorized users, including physicians and pharmacists. By regularly checking the PDMP, providers can become aware if the patient receives a controlled substance from another prescriber and address the possible return to drug use. Every state and the District of Columbia now has an operational PDMP, although Missouri’s is not statewide—it is operated by the St. Louis County Department of Public Health, and other counties/jurisdictions have joined them. A list of the capabilities for each PDMP can be found at [http://www.pdmpassist.org/content/state-profiles and maps/tables](http://www.pdmpassist.org/content/state-profiles%20and%20maps/tables%20) and at <http://www.pdmpassist.org/content/pdmp-maps-and-tables>.

Jails report a major challenge in terms of contraband drugs, including agonist medications used for opioid treatment. For example, the Ohio Department of Corrections reported that based on random drug tests conducted on 5 percent of the prisoners in December 2016, 1 in 20 tested positive for illicit drugs, with most testing positive for marijuana followed by Suboxone.[[72]](#endnote-72) It should be noted, however, that many jails have been providing methadone to pregnant women for decades and, currently, there are jails as well as prisons that regularly provide agonist medications to incarcerated individuals. At least one jail that provides agonist medications to several hundred incarcerated individuals each day as of January 2018 has found that its MAT program appears to have reduced the demand for illicit drugs within its institutions. However, the same department reports that the provision of agonist medication requires procedures for monitoring the dissemination of the medication each day by both nursing and correctional staff.[[73]](#endnote-73)

### F. *Jails facilitating MAT engage their state Medicaid agencies to facilitate health care coverage*.

Lack of insurance or gaps in insurance coverage inhibit the use of MAT. According to a 2016 U.S. Government Accountability Office (GAO) report,[[74]](#endnote-74) 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 be triple that cost. Even if the individuals have Medicaid, a 2014 SAMHSA report found that most state Medicaid programs do not reimburse for all three of the 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 persons with substance use disorders. In 2016, for example, there were more than 900,000 physicians who could prescribe opioid painkillers such as OxyContin, Percocet, and Vicodin by simply signing on to a federal registry, but only 32,000 physicians were certified to prescribe buprenorphine. Some states have stringent prior authorization requirements before medications such as buprenorphine or extended-release injectable naltrexone can be covered. For example, Idaho requires pre-authorization to receive Medicaid coverage for Suboxone, Vivitrol, or oral naltrexone. A breakdown of state coverage is contained in *A Comprehensive Listing of What States Cover for Substance Use Disorder*, including medications which can be found at <http://www.rsat-tta.com>.[[75]](#endnote-75)

Staff at either correctional or treatment agencies can help ensure individuals 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 Patient Protection and 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, such as pharmaceutical company coupons or access to generic versions of buprenorphine.

In almost every state, there are resources available for assisting individuals released from jail with obtaining health care coverage, as well as assistance in paying for their medications. In 2013, the Centers for Medicare & 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 3 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 the following:

* **Navigators**—Navigators receive extensive training from CMS and are responsible for providing unbiased information about public and private health insurance programs in a culturally competent manner. They regularly report on their outreach and consumer education activities and accomplishments.
* **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 of the consumer and are compensated by insurers or consumers. Agents are compensated by insurers. Some states contract with brokers or agents to act as “navigators.” They may be required to forgo compensation or abide by other guidelines that mitigate potential conflicts of interest.

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). 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 correctional populations out of state block grant funding or state appropriations.

### G. *Assisting individuals with choosing 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 definitive guidelines to reliably match the individual to the optimal medication.[[76]](#endnote-76) Nor is there a set period 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 individual, a physician or medical provider, and a treatment provider or knowledgeable counselor.

Before any specific medication is considered, the individual needs to be assessed. The person should then be introduced to the full array of FDA-approved medications and the rules that govern how each is obtained and used, as well as the need for accompanying treatment, support, and appropriate services. All potential adverse reactions to the medications should be fully disclosed, including consequences of continued drug use. It is important that the 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.

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

A physical examination to 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, including tuberculosis and liver conditions. People who use drugs are at a high risk of contracting HIV, hepatitis, and/or other ailments.

After the assessment, the physician, substance use 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. Because there is a limited number of MAT providers, especially in rural communities, not all FDA-approved medications may be available to all individuals in the community.

RELATED PROFESSIONAL GUIDELINES:**The American Society of Addiction Medicine (ASAM)** advises physicians treating patients with opioid use disorders that “(t)he choice of available treatment options for addiction involving opioid use should be a shared decision between clinician and patient.” ASAM continues: “Clinicians should consider the patient’s preferences, past treatment history, and treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone in the treatment of addiction . . . .“[[77]](#endnote-77) 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 those 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 regularly use alcohol or other sedatives but do not have addiction or a specific substance use disorder related to that class of drugs. The prescribing of benzodiazepines or other sedative-hypnotics should be used with extreme caution in patients who are prescribed methadone or buprenorphine for the treatment of an opioid use disorder.

Oral naltrexone for the treatment of opioid use disorders 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. 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, although this practice is not advised or required by the FDA. Of the medications on the market, the least amount of research is available for naltrexone. Two recent studies have found that once individuals have their first injection of naltrexone, their retention and relapse rates are the same as those taking buprenorphine with naloxone. However, individuals who initially sign up for naltrexone injections are more likely to balk initially than those who sign up for buprenorphine.[[78]](#endnote-78)

### H. *There are widely agreed-upon considerations that should be discussed and considered regarding each potential medication prior to determining the appropriate medication.*

**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. Electrocardiograms can be done on patients prior to starting methadone to prevent risk of sudden death in those with a prolonged QT (required time for ventricular and repolarization) interval.

The usual daily dose of methadone ranges from 60 to 120 milligrams (mg). Some patients may respond to lower doses, and some patients may need higher doses. Switching from methadone to another medication for the treatment of opioid use disorders may be appropriate if the patient experiences intolerable side effects or is not successful in attaining or maintaining their treatment goals when using methadone. Patients switching from methadone to buprenorphine in the treatment of opioid use disorders should be on low doses of methadone prior to switching medications. Patients on low doses of methadone (30 to 40 mg per day or lower) generally tolerate the transition to buprenorphine with minimal discomfort, whereas patients on higher doses of methadone may experience significant discomfort when 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 to 12 hours after the last use of heroin or other short-acting opioids or 24 to 72 hours after their last use of long-acting opioids such as methadone. 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.

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

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

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

**Naltrexone** is a recommended treatment for preventing the relapse of opioid use disorders. Oral formula naltrexone may be considered for patients where adherence can be supervised or enforced. Extended-release injectable naltrexone may be more suitable for patients who cannot be observed or supported when taking their medication daily.

There is no recommended length of treatment with oral naltrexone or extended-release injectable naltrexone. The duration depends on clinical judgment and the patient’s 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 a physical dependence on opioids; therefore, the initial doses of methadone or buprenorphine should be low.

Patients should not be switched until a significant amount of the naltrexone is no longer in their system. This requires a 1-day wait for oral naltrexone and a 30-day wait after a naltrexone injection.

**Switching from Methadone to Buprenorphine**

Some correctional institutions may not be equipped to provide methadone, which may require switching individuals from methadone to buprenorphine with or without naloxone. Individuals with opioid use disorders can safely be switched from methadone to buprenorphine maintenance. According to SAMHSA’s *Quick Guide for Physicians: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*, “Induction of patients from long-acting opioids (e.g., methadone) onto buprenorphine should be managed by physicians experienced with the procedure. Patients taking methadone should have their dose tapered to 30 mg or less per day for at least 1 week before buprenorphine induction. Twenty-four hours must elapse between the final dose of methadone and the first dose of buprenorphine. The first dose of buprenorphine should be 2 mg of monotherapy. A second 2 mg dose can be given and repeated up to 8 mg per day if signs of withdrawal appear.” The guide goes on to chart the steps in the induction from Day 2 and forward. When the individual has no withdrawal symptoms, minimal side effects, and no uncontrollable cravings, they are considered stabilized. During stabilization (1 to 2 months), adjustments in the dose and frequent physician–patient contact help establish the proper level of medication. Until full stabilization is achieved, weekly assessments are indicated. Doses of buprenorphine/naloxone may be increased in 2/0.5–4/1 mg increments until stabilization is achieved. Nearly all patients stabilize on daily doses of 16/4–24/6 mg; some may require up to 32/8 mg daily. The maintenance phase follows.

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

The *ASAM Practice Guidelines* highlights the following: “Patients switching from methadone to buprenorphine in the treatment of opioid use disorder should be on low doses of methadone before switching medications. Patients on low doses of methadone (30 to 40 mg per day or less) generally tolerate transition to buprenorphine with minimal discomfort, whereas patients on higher doses of methadone may experience significant discomfort when switching medications. Generally, buprenorphine initiation should occur at least 6 to 12 hours after the last use of heroin or other short-acting opioids or 24 to 72 hours after their last use of long-acting opioids such as methadone. Buprenorphine doses after induction and titration should be, on average, at least 8 mg per day. The FDA approves dosing to a limit of 24 mg per day, and there is limited evidence regarding the relative efficacy of higher doses. In addition, the use of higher doses may increase the risk of diversion.”[[79]](#endnote-79)

**What the Research Suggests Regarding Opioid Medications**

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

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

However, compared to methadone, buprenorphine retains fewer people when doses are flexibly delivered and at low fixed doses. If fixed medium or high doses are used, buprenorphine and methadone appear no different in effectiveness (retention in treatment and suppression of illicit opioid use); however, fixed doses are rarely used in clinical practice, so the flexible dose results are more relevant to patient care. Methadone is superior to buprenorphine in retaining people in treatment, and methadone equally suppresses illicit opioid use.[[80]](#endnote-80)

There have also been studies comparing the mortality risk in and out of treatment with methadone and buprenorphine. Researchers examined 19 eligible cohorts, following 122,885 people treated with methadone over 1.3 to 13.9 years and 15,831 people treated with buprenorphine over 1.1 to 4.5 years. “Overdose mortality evolved similarly, with pooled overdose mortality rates of 2.6 and 12.7 per 1,000-person years in and out of methadone treatment (unadjusted out-to-in rate ratio 4.80, 2.90 to 7.96) and 1.4 and 4.6 in and out of buprenorphine treatment.” The authors concluded, “Retention in methadone and buprenorphine treatment is associated with substantial reductions in the risk of all cause and overdose mortality in people dependent on opioids. The induction phase onto methadone treatment and the time immediately after leaving treatment with both drugs are periods of particularly increased mortality risk . . . .”[[81]](#endnote-81)

There have been far fewer studies of naltrexone use. A 2017 study was conducted to evaluate the long-term safety, tolerability, and treatment outcomes of injectable naltrexone. The small study of less than 49 screened opioid-dependent individuals screened by health care professionals concluded that “(l)ong-term (2 years) (of injections) was associated with no new safety concerns . . . .” The NIDA study described above of a larger sample found “(a)ll recorded overdose events, fatal or nonfatal, occurred among participants assigned to usual treatment” (0 events in the extended-release naltrexone group vs. 5 in the usual-treatment group from week 0 to 25, P=0.10; 0 vs. 7 events from week 0 to 78, P=0.02); no overdoses occurred in the extended-release naltrexone group after discontinuation of the agent.”[[82]](#endnote-82)

There have been only two studies that compared buprenorphine and injectable naltrexone as mentioned previously. Both found that, once begun, they were equally effective in terms of retention over six months. The larger NIDA study found that “a monthly shot of naltrexone (sold as Vivitrol) is as effective as its main competitor, the daily pill of buprenorphine and naloxone (sold as Suboxone).” Researchers found that about half of people with opioid addiction who took either drug remained free from relapse 6 months later. However, because naltrexone required abstinence for 7 to 10 days, 28 percent of those assigned naltrexone did not follow through and receive their first injection. For those who did, 52 percent subsequently relapsed, as opposed to 56 percent who relapsed on buprenorphine with naloxone.[[83]](#endnote-83)

**Related Federal Guidelines:**

*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), 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…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 health risks during pregnancy.*

Opioid withdrawal during pregnancy is associated with miscarriage, premature delivery, and other serious complications. MAT is readily available to stabilize pregnant women with opioid use disorders during pregnancy. 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 women with a history of substance use should also be screened for pregnancy in community corrections. All women who come in contact with the criminal justice system should be educated about the risks of substance use during pregnancy and offered tobacco cessation supports and services, which all public and private health insurance plans are now required to cover.[[84]](#endnote-84)

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, stopping opioids too quickly during pregnancy is also risky. Opioids cross the blood barrier to the developing fetus. If the pregnant woman suddenly quits, the fetus also experiences withdrawal and dangerous complications can result. Children of women treated for opioid use disorders with opioid replacement therapies during pregnancy have improved birth outcomes.[[85]](#endnote-85) There are also services for tobacco cessation, which is important for this population.

Methadone maintenance for pregnant women is an accepted best practice that has been used safely for years and has been widely researched.[[86]](#endnote-86) As with any treatment, there are some risks, but they are weighed against the risks pregnant women with untreated opioid addiction may face, such as with opioid withdrawal and relapse.

Infants exposed to opioids in utero may experience withdrawal symptoms at birth, sometimes severe enough to require medication and delay discharge from the hospital. 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 because the benefits greatly outweigh the very small trace amounts of medication that may be found in breastmilk.[[87]](#endnote-87)

There are fewer long-term studies of safety and effectiveness of buprenorphine during pregnancy, but some suggest that buprenorphine reduces NAS.[[88]](#endnote-88) The American College of Obstetricians and Gynecologists supports treating pregnant women with buprenorphine if they are already on it or prefer it.[[89]](#endnote-89) Pregnant women should generally only receive the single-drug formula, without added naloxone.

Women with opioid use disorders who are under community supervision should be referred to treatment providers that offer specialized services for pregnant and postpartum women. They require an intensive level of support after delivery to prevent relapse, and many will benefit from additional services, including parenting skills training and supports or family reunification planning.[[90]](#endnote-90)

EXISTING STANDARDS AND GUIDELINES

●A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. SAMHSA, 2016. [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); *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants.* SAMHSA, 2018. <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

●Disorder and their Infants, A Foundation for Clinical Guidance. SAMHSA, 2016. <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 webpage, n.d. <https://ncsacw.samhsa.gov/resources/opioid-use-disorders-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

# III. Jail-Based MAT Programs

### A. *Jail-Based MAT Programming—Pre-Trial*

Most individuals’ entry into jail occurs after arrest and arraignment, pending trial or case resolution for those not able to raise bail or who are ordered held for trial. Traditionally, there has been little programming available for these individuals because their stay is limited and they haven’t been found or admitted guilty of a crime. However, the opioid epidemic has inundated jails with an increased number of individuals under the influence of opioids. Jails have found that they have become *de facto* detoxification centers. Once the individuals have gone through detoxification, many jails have found they are in a unique position to initiate treatment for these individuals, launching them on the path to long-term recovery. Increasing numbers of jails have begun to establish treatment programs for these individuals. In addition to detoxification needs, these jails have established medical screening for MAT as well as in-jail provision of these medications to promote continued abstinence from illicit opioids upon release. To ensure continuity of treatment, these jails link the released individual to treatment, support, and medical providers in the community.

There is a dual incentive for incarcerated individuals to take advantage of these programs. Not only can their participation lead to recovery in the long term, but in the short term, their participation can influence prosecutors and courts to consider noncustodial treatment alternatives once they return to court for further hearings. In many jurisdictions, prosecutors and courts let defendants know at arraignment that they will take into consideration their participation in the jail pre-trial program in resolving their criminal case. Although many defendants may be more concerned with avoiding a custodial sentence than long-term abstinence and recovery, research has shown that successful treatment is not dependent on entry into treatment being voluntary. In other words, coerced treatment has been found as, if not more, effective than voluntary treatment.[[91]](#endnote-91)

However, if it is likely the prosecutor and court will not consider a non-custodial sentence, beginning agonist treatment pre-trial may not be indicated if the individuals are expected to return to jail for a long period of time or be sentenced to prison.

Before a jail enrolls individuals in its MAT program, individuals are educated about the medications offered and the choice they must make as described earlier. Detoxification is provided as described earlier. Finally, the jails introduce concurrent initial drug counseling and set up referrals in the community for follow-up counseling as well as continued access to medication.

An increasing number of jails are providing agonist medications to those entering who already have been prescribed these medications, especially if they are not expected to remain in jail for prolonged periods of times. While certified medical personnel can dispense buprenorphine, methadone must be dispensed by a licensed methadone clinic. For this reason, most jails rely on community methadone clinics coming into the facility each day to dispense methadone under the supervision of the jail authorities, rather than going through the process of being licensed as a methadone provider.

### B. *Jail-Based MAT Programming—Post-Trial*

Many more jails provide MAT for post-trial, sentenced individuals. Generally, access is provided for those individuals who are also enrolled in the facility’s drug treatment program. These post-trial MAT programs operate like the jail programs except that most participants do not need to detox before entry. If they have been allowed to continue prescribed agonist medications before entrance into the jail, some of the programs allow them to remain on these medications, but generally for up to a year only. After that, they are medically tapered off the agonist medication.

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

There have been two studies that provide some support for this rationale. Both found that when individuals receive their first injection before release, they are significantly more likely to have a second injection than if they receive their first injection immediately after they are released from jail.[[92]](#endnote-92) This suggests that, for whatever reason, there seems to be some significance to initiating the medication before release. If one shot pre-release is more likely to promote follow-up in the community, might not multiple injections pre-release result in even better follow-up post-release?

Similarly, a randomized clinical trial of buprenorphine maintenance that compared individuals who began receiving the medication while in jail compared to those who receive it upon release found that the former was associated with more days in buprenorphine treatment in the designated community treatment program during the 12-month post-release assessment. The study, however, did not find it was associated with superior outcomes in terms of reduction of heroin or cocaine use or criminal behavior.[[93]](#endnote-93)

The research does make clear that receiving MAT in jail along with treatment is associated with better follow-up in the community than treatment alone. For example, a randomized controlled trial of methadone maintenance and counseling for some inmates compared to counseling only found that in the year following release, those who had methadone in jail and counseling compared to counseling-only participants spent seven times as many days in treatment for drugs during the year post-release. None of the counseling-only participants continued in treatment for the entire year, whereas 37 percent of the methadone participants remained in treatment for the year. The counseling-only individuals were also significantly more likely to test positive for opioids 12 months post-release. [[94]](#endnote-94)

To ensure the continuity of medication after release, it is essential that funding be arranged. If continued, and medication is to be paid for through the state Medicaid program, the individuals should be enrolled before release so there is no gap between release and eligibility to access the 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 jail should facilitate participants’ first post-release community treatment appointment.

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

Examples from the field

# 1) Sacramento Jail, California

## Background

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

## Program Participation Procedures

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

* A re-entry specialist meets with the offender to explain the program and to obtain consent to proceed.
* A signed copy of the “Sacramento County Correctional Health Services and WellSpace Health Vivitrol Consent Form” is placed in the inmate file, a second copy is forwarded to the reentry resource officer, and a copy is sent to County Health Services and Wellspace Health.
* Verification is made of participation in a substance use treatment program. If the offender is not participating in a substance use treatment program, the re-entry specialist will coordinate enrollment with the re-entry resource officer.
* Probation verification is made although probation status is not required for participation.
* The offender is referred to the Department of Human Assistance Eligibility Specialists for eligibility verification for Covered California or other health insurance pursuant to the Affordable Care Act.
* Correctional Health Services conducts a medical evaluation of the offender to approve participation in the program.
* When approved by Correction Health Services, the doctor prescribes naltrexone to the participant and ensures the first injection is scheduled for thirty-five (35) to forty (40) days prior to release and the second injection scheduled for seven (7) days prior to the participant’s release.
* The reentry specialist notifies the post-release medical program (WellSpace Health) of the participants anticipated injections and release from custody. An appointment is scheduled for the third injection prior to the offender’s release from custody.
* The reentry specialist assigned to the participant serves the participant post-release for the duration of the offender’s use of naltrexone. Reentry services continue based on the need after the individual discontinues naltrexone or completes the recommended six (6)-month participation.
* If the program participant is serving a period of supervised release, the reentry resource officer ensures that the reentry specialist coordinates the individual’s program participation with their probation officer of record.

## Outcomes

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

# 2) Middlesex County House of Correction, Massachusetts

## Origin and Development of the Program

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

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

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

* The need for a navigator or recovery coach to remain in touch post-release;
* The need for real-time data to provide areas in need of improvement; and
* Increased participation by community health providers.

## Program Development

MATADOR has evolved significantly since its October 2015 inception date. One of the major drivers of its success has been the increased participation of community health care providers and substance use counseling centers. The MATADOR program began with four community health care providers willing to accept patients and administer naltrexone injections. As of May 2017, that number expanded to 35 health care providers, 70 support program locations, and four drug courts. In addition to the community support necessary to initiate and sustain a successful MAT program, key stakeholders include data experts, medical/mental health treatment providers, dedicated recovery navigators/coaches, and courts willing to accept MAT as a legitimate forms of relapse prevention and recidivism reduction.

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

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

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

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

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

The MATADOR team has gone to great lengths to establish open lines of communication with health care providers in the community, including identifying a primary point of contact at all the community health care providers and support program offices. This allows for a streamlined flow of information and when necessary, the adjustment of treatment options, services, and health insurance plans. Communication between the health care provider and the program is initiated when the program navigator notifies a provider of a new program participant and schedules a medical follow-up appointment. In the event of a missed appointment, the MSO’s research team is notified via phone call. The health care provider attempts to reengage the participant; however, failure to do so results in a call to a navigator, who attempts to reach the individual separately.

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

## Outcomes

Eighty one percent (81%) of the 370 individuals who have completed the program have not been re-arrested for a new crime as of January 2018.

# 3) Louisville Metro Department of Corrections, Kentucky

## Origin and Development of the Program

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

## Implementation

In the spring of 2016, LMDC partnered with Correct Care Solutions (CCS), its contracted medical/mental health provider, to launch its MAT program. Flow charts, consent to treat forms, and informational handouts were developed for the program and training for medical staff was provided. Originally, the program was designed to be provided only to inmates who were active participants in the Enough is Enough program, a 90-day voluntary drug treatment program. Shortly after, staff realized there were more inmates who would benefit who could not be enrolled in the Enough is Enough program due to shorter incarceration periods. LMDC partnered with the courts and prosecutors to refer pre-trial offenders who were interested in Vivitrol treatment and continued treatment in the community in lieu of further custodial sentencing. A senior social worker/coordinator for the MAT program established contacts with community providers that committed to taking on the task of the care continuum for the MAT program participants.

Although the beginning of the program was slow, it quickly gained momentum and speed once word of mouth spread to the jail population. State funding pays for hepatic function panel labs, drug screens, Vivitrol injections, and days inmates participate in the Enough is Enough program.

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

## Outcomes

As of January 218, 200 individuals have graduated from either the pre-trial or post-trial MAT program. Of those, 47 percent have remained arrest-free in the community and almost none (4 percent) have committed more arrests after release than before they entered the program.

## Lessons Learned for Other States

The program must:

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

# 4) Snohomish County Jail, Washington

## Origin and Development of the Program

The Snohomish County Jail began its buprenorphine MAT program in January 2018, beginning with a buprenorphine/naloxone (marketed as Suboxone) detox program for inmates. The program became necessary due to a huge increase over the past few years of people getting arrested who were addicted to opioids. The jail found its 24-bed medical unit was overwhelmed with individuals in need of detoxification.

## Program Development

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

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

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

Once detoxified, inmates who will be at the jail for at least 6 weeks (and this includes those sentenced as well as those held pre-trial) are offered Suboxone treatment 10 to 14 days before they are released. Three jail staff nurse practitioners and a physician at the jail prescribe the medication for both detoxification and for maintenance. The nurses carefully provide the medication each day under the watchful eyes of correctional officers who provide direct supervision of inmates in the jail.

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

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

The jail limited the program to 25 inmates initially to ensure smooth implementation and protection against any diversion of the medication. The inmates selected are well known by the jail staff because most have been in and out of jail previously because of their opioid abuse.

## Outcomes

The pilot is too new to generate any long-term outcome data, but, according to officials, not only is the detox program easing the strain on deputies by getting inmates in the general population quicker, but it is much more humane. The health administrator reported to local media, “They started their medication yesterday and within a couple hours were night and day difference. They went from vomiting, nausea, diarrhea, body aches to feeling well, eating, drinking, and wanting to shower. So, big difference.”[[95]](#endnote-95) Although the jail pays for the Suboxone tablets, the overall cost of the medication is less than that the jail paid for the medications previously used to ease the symptoms associated with withdrawal.

# 5) Rhode Island Jail

## Origin and Development of the Program

The Rhode Island Department of Corrections (DOC) also runs the state’s jail. It has traditionally allowed inmates committed while on methadone to be maintained on their dose initially for 30 days. That was increased to 60 days several years ago. After that, inmates were tapered off the medication. In December 2015, the DOC initiated a naltrexone (Vivitrol) program as the opioid epidemic grew across the state. Data from Rhode Island documented that 21 percent of all overdose victims in 2014 and 2015 were incarcerated in the 2 years prior to death (up from 9 percent in 2009). More than 250 individuals were entering the jail on agonist medication, either methadone or buprenorphine, and were either detoxed (if on methadone) or provided no taper schedule (if on buprenorphine). Targeting this high-risk population, the DOC began screening all inmates entering the jail and assessing for MAT. The DOC then committed to initiating MAT upon commitment, continuing individuals already on agonist medication, either methadone or buprenorphine for 6 to 12 months, or providing naltrexone prior to release for those not on agonist maintenance.

## Implementation

This new program required an immediate increase in staffing for substance use disorder services. The DOC hired three temporary chemical dependency professionals to initiate the screening of detainees at the time of commitment and the completion of assessments on those who screen as needing a follow-up assessment. It worked with The Providence Center, a treatment program, on placing two recovery coaches to work with offenders who are involved in the MAT program. All levels of DOC staff, from the director to frontline nurses and correctional officers, are involved in the program. The DOC encouraged collaboration among security, medical, behavioral health, and outside vendors. Additionally, the DOC engaged MAT community vendors to ensure continued care and medication upon release for all three FDA-approved opioid medications.

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

The DOC organized separate medical lines for inmates to be provided methadone or buprenorphine each day, carefully monitored by correctional officers. At first, the DOC provided the buprenorphine in pill form but switched to strips (Suboxone) that dissolved faster and were less easily diverted by inmates. The strips are counted every shift to avoid diversion.

There was some resistance on the part of security staff regarding the initiation of Suboxone services out of concern for diversion. The medical director and several staff met with the jail warden and brass to provide education about MAT and to listen to concerns. These meetings went a long way in alleviating fears about the program.

## Outcomes

During the 12 months between October 1, 2016, and September 30, 2017, the Rhode Island Department of Corrections provided MAT to 896 individuals. Of these, 63.5 percent were on MAT at entry and were continued on MAT, and 36.5 percent were initiated onto MAT soon after entry. Most, 61 percent, received methadone and 39 percent received buprenorphine. After release, at least 72 percent were confirmed to have continued with MAT—95 percent of those who were on it at time of entry and 32 percent for those induced after entry.

Appendix I: Substance Use Disorder Screening Tools

**National Institute on Drug Abuse (2015) list of screening tools found to work for adults and adolescents.**

# For Alcohol

Alcohol Screening and Brief Intervention for Adolescent and Youth: A Practitioner’s Guide

Alcohol Use Disorders Identification Test (AUDIT)

Alcohol Use Disorders Identification Test-C (AUDIT-C)

Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)

Center for Adolescent Substance Abuse Research (CRAFFT)

CRAFFT (Part A)

Helping Patients Who Drink Too Much: A Clinician’s Guide

NIDA Drug Use Screening Tool

NIDA Drug Use Screening Tool: Quick Screen

Screening to Brief Intervention (S2BI)

# For Drugs

Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)

CRAFFT

CRAFFT (Part A)

Drug Abuse Screen Test (DAST-10)

DAST 20: Adolescent Version

NIDA Drug Use Screening Tool

NIDA Drug Use Screening Tool: Quick Screen

Opioid Risk Tool

S2BI

Appendix II: Substance Use Disorder Treatment Programs

**National Institute on Drug Abuse (NIDA)**

NIDA lists the following substance use disorder treatment programs:

* 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 multi-systemic therapy (MST)[[96]](#endnote-96)

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

SAMHSA lists the following as research-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) 6 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)
* Texas Christian University (TCU) Mapping-Enhanced Counseling (MEC), a communication and decision-making technique designed to support the delivery of treatment services[[97]](#endnote-97)

**U.S. Department of Justice**

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

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

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

* Adult drug courts (reducing crime and delinquency)
* Cognitive behavioral therapy for moderate to high-risk adult offenders (reducing crime and delinquency)
* Incarceration based Narcotics Maintenance Treatment (reducing drugs and substance use but no effect on crime and delinquency)[[98]](#endnote-98)

It should be noted that the practices that involve MAT have not been shown to be effective in reducing crime and delinquency outcomes. However, as noted in its description of “meta-analysis outcomes” relating to the finding that incarceration-based narcotics maintenance treatment has not been found to be effective in reducing crime and delinquency, this finding is influenced by the presence of a negative outlier. When removed, the difference is no longer significant in terms of recidivism.[[99]](#endnote-99), [[100]](#endnote-100)

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