Convening: Medication Assisted Treatment for Justice-Involved Populations

---

Eisenhower Executive Office Building
Indian Treaty Room

June 17, 2016

Office of National Drug Control Policy
Washington, DC

DISCLAIMER

The views, opinions, and content expressed herein are the views of the participants and do not necessarily reflect the official position of ONDCP. Nothing in this document constitutes an indirect or direct endorsement by ONDCP of any non-Federal entity's products, services, or policies, and any reference to a non-Federal entity's products, services, or policies should not be construed as such. No official support of or endorsement by ONDCP for the opinions, resources, and medications described is intended to be or should be inferred. The information presented in this document should not be considered medical advice and is not a substitute for individualized patient or client care and treatment decisions.

CONTENTS

SUMMARY OF CONVENING 1

Overview 1

Background 1

Convening 2

Programs: Design and Implementation, Outcomes, and Challenges 2

Roundtable Discussions 15

Roundtable Discussion 1: Adoption of MAT for Justice-Involved Populations 15

Roundtable Discussion 2: Stakeholder Engagement 16

Wrap Up 17

Conclusions 18

APPENDIX A: AGENDA 20

APPENDIX B: PARTICIPANT LIST 24

APPENDIX C: REVIEW OF SELECTED LITERATURE 29

List of Figures

Figure 1: MATADOR Continuum of Care Findings 9
Figure 2: State of Connecticut MAT Programs and Plans 10
Figure 3: Montgomery County Incarceration to Community Initiative 13
Figure 4: A Change in Perception in Sacramento County, CA 15

SUMMARY OF CONVENING

The Office of National Drug Control Policy (ONDCP) convened a meeting to raise awareness of the importance of incorporating medication assisted treatment (MAT) as part of a comprehensive treatment regimen for incarcerated persons with opioid use disorder (OUD).

Overview

> **We should all remember that we have evidence-based community-standard medications that work for the disease of opioid addiction, and this should become the standard of care in corrections, and the criminal justice system broadly.**
> *-Dr. Kathleen Maurer, Connecticut Department of Corrections*

The half-day meeting, attended by participants from the corrections field, researchers, and Federal partners, featured presentations from state and county leaders of programs that have piloted and implemented MAT in America's criminal justice system, including correctional institutions (jails and prisons), drug courts, and during parole and probation. Participants learned about successful implementation of MAT programs for OUD for justice-involved populations. Attendees shared lessons learned during implementation of MAT programs in state and local corrections facilities; described the critical need for such programs to curb the opioid epidemic and promote recovery from OUD; and discussed the role of Federal agencies and professional organizations in combatting the epidemic. ONDCP leaders affirmed the Administration's commitment to addressing the opioid crisis. Participants engaged in two roundtable discussions to exchange ideas and share problems, solutions, and successes.

Background

In 2015, the Administration released an updated National Drug Control Strategy, developed to move the country from a "war on drugs" approach to a strategy focused on "prevention over incarceration." This approach was first articulated in the initial strategy of the Obama Administration, released in 2010, and has been reiterated in every strategy since then. As President Obama and others have noted, "We cannot arrest our way out of the drug problem." The 2015 strategy includes the following statement:

> *The Administration is also committed to criminal justice reform—reforming our sentencing policies so that scarce resources are applied in the most effective ways, supporting evidence-based alternatives to incarceration that mitigate risks to the general public and reduce recidivism, and ensuring access to evidence-based treatment models—including MAT for the treatment of opioid use disorders—and recovery support.*

The strategy includes a focus on reforming the criminal justice system. According to the U.S. Department of Justice (DOJ), at the end of 2014, the corrections system supervised more than 6.8 million people, or 1 in 36 adult Americans (U.S. Department of Justice, Bureau of Prisons, 2016). Of these, nearly 2 million were incarcerated in jails and prisons, and 5 million were on parole or probation. Although DOJ reports that these numbers are at the lowest rate since 1996, they reflect a major cost to taxpayers and to communities.

Examples of drug-related criminal justice reforms include implementation of drug courts, which divert non-violent offenders to treatment, rather than sending them to prison; diversion of first-time offenders who have substance use disorders (SUD) to community health systems, rather than sending them to prison; and supportive programs for reentry to society, such as support for recovery, job training, housing, and other services.

Convening

The June 17, 2016, *Medication Assisted Treatment for Justice-Involved Populations Convening* began with an overview of relevant national and Federal programs with representatives from the DOJ National Institute of Corrections (NIC) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The convening then turned to reports from Corrections facilities in four locations: Middlesex County, Massachusetts, Bridgeport and New Haven, Connecticut, Montgomery County, Maryland, and Sacramento County, California. The convening ended with two roundtable discussions: one on implementation lessons from existing MAT programs for justice-involved populations, and one on facilitation and technical support for adopting MAT in facilities that do not yet have such programs.

Above: Director of National Drug Control Policy, Michael Botticelli

Programs: Design and Implementation, Outcomes, and Challenges

This section of the Convening featured opening remarks from the Director of National Drug Control Policy, Michael Botticelli, who welcomed participants and set the stage for the purpose of the meeting. Following Director Botticelli, Jim Cosby, the Director of the National Institute of Corrections (NIC), took to the podium to describe NIC's role in responding to the opioid crisis. Participants then heard remarks from Dr. Melinda Campopiano, Chief of Regulatory Programs from the Substance Abuse and Mental Health Services Administration (SAMHSA), who provided a scientific overview of MAT. Following Dr. Campopiano's remarks, corrections leaders Sheriff Peter Koutoujian, Middlesex County

Sheriff's Office, Massachusetts; Dr. Kathleen Maurer, Connecticut Department of Corrections; Director Robert Green, Department of Correction and Rehabilitation, Montgomery County, Maryland; and Sergeant Brad Rose, Sacramento, California, all reported on the MAT programs established in their correctional facilities.

Michael Botticelli

Director of National Drug Control Policy

Director Botticelli began his remarks by welcoming attendees and providing a context of the Nation's opioid epidemic. The Director then outlined three necessary steps our Nation must take to respond to the opioid crisis: (1) we must provide individuals with OUD evidence-based treatment; (2) we must end the stigma associated with SUD; (3) we must address prescribing practices that have contributed to the opioid epidemic. In closing his remarks, he called on participants to reflect on what role they could play in expanding access to MAT for justice-involved populations.

We can have all the treatment that we want, but if people don't feel safe and comfortable, they won't go as a result of stigma.
- Michael Botticelli, Director of National Drug Control Policy

- Leaders in preventing and treating SUD and leaders in criminal justice share a goal: to increase the odds of recovery as a way not only to improve and save lives, but also to prevent recidivism and relapse.
- Diverting people who have SUD from the criminal justice system to the treatment system is a public safety issue. For example, in New York, people incarcerated with drug problems that were left untreated were 50 percent more likely to be imprisoned again.
- Some successes have been achieved by focusing on regulatory changes, such as increased restrictions on opioid prescribing, the number of which decreased last year for the first time in decades.
- When used as part of a comprehensive approach that includes other counseling and support services, medication is a proven method to help people with opioid use disorders achieve and sustain recovery. ONDCP wants to amplify and replicate effective work undertaken by programs that have proven success in helping incarcerated people with OUD receive essential MAT care.
- The criminal justice system shares the national challenge of treatment access, and the stigma associated with OUD treatment. Every state in America has an enormous need for more treatment resources: today's data indicate that as few as one in 10 or one in 20 people with SUD receive needed, evidence-based treatment.
- This low rate of treatment reflects two problems: the lack or absence of necessary treatment resources, and the stigma associated with SUD, and seeking help. People recently released from prison or jail may find these problems even more pronounced.

- Solving these multifaceted challenges requires engaging diverse groups, including the SUD treatment community; medical, nursing, and dental communities; and business leaders. Schools of medicine, nursing, and dentistry should, for example, embed in their curricula the 2016 Centers for Disease Control and Prevention (CDC) guidelines on the use of opioids for pain management.
- Those in the vanguard of MAT know that it is good care and treatment, but all other programs, such as community-based supports and systems, must embrace its use as well.

Jim Cosby
Director, National Institute of Corrections

Director Cosby's remarks addressed the need to provide treatment for individuals with SUD in correctional settings, and highlighted the efforts of NIC to promote and expand MAT for justice-involved populations. During his remarks, he stressed that, due to the high prevalence of co-occurring OUD and mental illness that exists among the incarcerated population, it is crucial that correctional staff be equipped with the knowledge and tools to properly treat these individuals using evidence-based approaches.

In fact, our jails have become de facto mental health and addiction facilities, as a result of this public health crisis… which will take an extraordinary effort to address.
- Jim Crosby, Director, National Institute of Corrections

- NIC members include the Large Jail Network of approximately 77 jail administrators and sheriffs who represent jails that have a bed capacity of more than 1,000. At a recent meeting, when asked to describe their greatest challenge, all reported opioid and alcohol use, followed by co-occurring disorders.
- NIC has increased its commitment to expand knowledge, collaboration, and technical support on working with the growing population of incarcerated people who have co-occurring OUD and mental illness.
- NIC launched the Corrections Executives Coordination Meeting (CEMC), comprised of five Federal agencies (including the White House), one state agency, three local agencies, and leaders of nine professional associations.
- The first CEMC meeting was devoted to MAT, and the second to a presentation on the Stepping Up Initiative, with leaders from the Bureau of Justice Assistance, Council of State Governments, and the National Association of Counties.
- Correctional staff working in local jails may not know how to intervene effectively with people who have co-occurring mental illness and SUD. Staff members need training to respond appropriately, especially when interacting with inmates whose co-occurring disorders prevent them from communicating and responding to directions. Many of these people are released into the community without plans for their care.

- NIC is engaged in projects nationwide to build a knowledge base of *what works* in corrections across multiple states and local sites.
- Examples include pilot studies undertaken with fidelity to the models being tested:
  - Pilots in 3 states and 21 local jurisdictions are addressing specific change targets and harm-reduction goals using the Evidence-Based Decision-Making Model.
  - A pilot of the Dosage Probation Model was conducted to inform the field on the appropriate treatment dosage to effectively change behavior, such as return to use or re-arrest, under community corrections supervision.
  - The Pretrial Justice Initiative focused on comprehensive bail reform using a systems approach (five states, multiple jurisdictions).

Above: Director of National Institute of Corrections, Jim Cosby

- To end the cycle of release, return to use and recidivism, the most effective treatments for addiction and serious mental illnesses must be prioritized.
- Successful programs share common elements: staff education; clinical assessment, counseling and medication; re-entry coordinators or navigators; Medicaid coverage; data collection; performance measurement; and program evaluation.

Melinda Campopiano, M.D.
Chief, Regulatory Programs, Substance Abuse and Mental Health Services Administration

Dr. Melinda Campopiano's remarks provided participants with a scientific overview of MAT. Beginning her remarks by describing SAMHSA's role in expanding access to MAT, she then spoke on the prescribing and dispensing rules for the three FDA-approved medications used for OUD treatment: extended-release naltrexone, methadone and buprenorphine. Prior to ending her remarks, Dr. Campopiano provided an explanation of the proven benefits of using MAT to treat individuals with OUD and outlined possible approaches for implementing an opioid addiction treatment program (OTP) for justice-involved individuals.

- SAMHSA appreciates and supports the work being undertaken by the corrections system to meet the needs of people who are involved with the justice system, especially projects that target people who have OUD or SUD and are in the criminal justice and corrections system. SAMHSA recognizes the need for discussions about MAT to occur at a high-

level across Federal and State organizations and among the leaders of grassroots organizations or grassroots advocates.

- Of particular relevance to this meeting is SAMHSA's role in expanding access to MAT, particularly in efforts to end the opioid crisis. In addition to supporting drug court programs, SAMHSA manages the regulatory process of issuing physician waivers that permit them to prescribe buprenorphine.
- Methadone and buprenorphine are controlled substances, subject to healthcare regulations as well as Drug Enforcement Administration (DEA) oversight and SAMHSA certification/accreditation of Opioid Treatment Programs (OTPs) which are clinics that administer methadone and buprenorphine medications as well as provide additional support services.

Above: Dr. Melinda Campopiano, presenting at the MAT for Justice-Involved Populations Convening.

- Below are prescribing and dispensing rules for FDA-approved MAT for OUD.
    - **Methadone**, taken daily, is available only at SAMHSA-certified OTPs, which either dispense it daily on site or, for patients who are stable, at home.
    - **Buprenorphine**, can also be offered at SAMHSA-certified OTPS and also prescribed by certain office based practitioners on a limited basis. Buprenorphine. also taken daily, with some variation, may only be prescribed by doctors who are board-certified in addiction medicine or addiction psychiatry and/or who have completed special training to qualify for the Federal waiver to prescribe it. There are no special requirements for staff members who *dispense* buprenorphine under the supervision of a waivered practitioner. Prescriptions may be filled at any pharmacy.
- Also approved by the FDA but not regulated by DEA is:
    - **Extended-release injectable naltrexone**, effective for 30 days, may be prescribed by any person who is licensed to prescribe medications. Physicians, physician assistants, and nurse practitioners may prescribe and order its administration by qualified providers.

- **Benefits of MAT may include:**
    - **Adopting MAT reduces all-cause mortality**, helps to reduce HIV risk, improves adherence to medical treatment, supports improved social function, and decreases criminal activity and drug use.

- **Continuing MAT during a brief incarceration** increases the likelihood that upon release, people will return to their community-based treatment program.
- **Starting MAT while incarcerated** reduces heroin and other illicit drug use in prison; reduces heroin use post-release; and increases rates of entering treatment after release.
- **Educating inmates** about the risk of overdose and preventing and treating it is important, and, when possible, it is recommended to add a naloxone kit to inmates' personal property prior to release in the event someone overdoses in their presence.

- **OTPs**
  - MAT medications are regulated, in part through the OTP structure, but certain strategies may help to make these programs more readily available in corrections settings.
  - One strategy is to become a prison-based OTP, which requires SAMHSA certification. With this certification, an OTP can operate within the correctional system. Benefits of this approach include:
    - Patients can be treated and cared for as corrections clinicians deem appropriate.
    - Delivery of buprenorphine in OTPs is not subject to the patient limit faced by individual providers who are not affiliated with such programs.
    - Behavioral intervention, which is critical to treatment, is included.
    - OTP staff can monitor inmates on extended-release injectable naltrexone.
  - Another approach is to partner with a community OTP to open a medication unit in the prison or jail while operating within the appropriate regulatory structure.

Peter J. Koutoujian
Sheriff, Middlesex County Correctional Facility

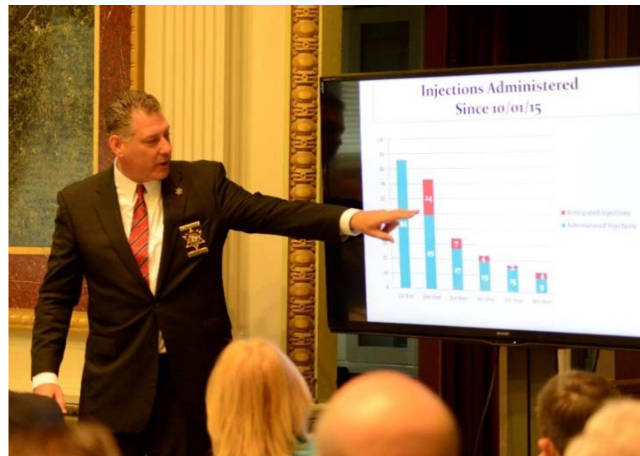
Sheriff Peter Koutoujian took the podium to report on the MAT program he established at the Middlesex County Correctional Facility. Throughout his remarks, he emphasized the important role that data played in establishing the program, both in recognizing the need to provide MAT after an increase in opioid-related deaths throughout the county and in ensuring that the program is effective in producing positive outcomes for participants.

> **We cannot be afraid to learn or to make mistakes. Now, we know to analyze the data, notice problems, and change course.**
> *- Sheriff Peter J. Koutoujian, Middlesex County*

- In recent years, Middlesex County, Massachusetts, has experienced a 67 percent increase in the rate of opioid-related deaths. In an attempt to address that problem, Sheriff Koutoujian and his team developed and tested a treatment program five years ago; however, the program was difficult to launch, and encountered too many barriers to operate effectively. Sheriff Koutoujian characterized it as an "abject failure". The Sheriff

found that it was difficult to obtain the level of buy-in necessary to make the program work: it was hard to convince lifelong corrections officials and community health providers to agree to the program, as well as community health providers and inmates themselves. Lessons learned from that experience informed the development of the MAT and Directed Opioid Recovery (MATADOR) program (see Figure 1). Other localities may adapt and use the program, and improve the model as needed in their own jurisdictions.

- MATADOR is a treatment program initiated *before* inmates are released to help them achieve better outcomes upon their re-entry to society. A key component of re-entry planning is to help inmates enroll in health insurance, so that upon release, they are able to continue to afford and participate in treatment.



Above: Sheriff Peter Koutoujian, presenting at the MAT for Justice-Involved Populations Convening.

- The MATADOR protocol is initiated when staff members identify inmates who have an SUD upon their admission to jail; in 2015, as many as 80 percent of inmates had an SUD; of these 43 percent required opioid detoxification. Referrals to MATADOR also come from the Middlesex House of Corrections and from drug courts. Inmates who agree to participate must sign a six-month, voluntary commitment to the program, sign a medical release, and be screened.
- While still incarcerated, participants receive extended-release injectable naltrexone along with SUD counseling and programming. Upon release, inmates on parole or probation must continue to work with their counselors, who monitor their injection treatments and support their re-entry into the community.
- MATADOR assigns a counselor to each MAT participant to build the personal connection and trust that are critical for the program's success. Counselors maintain contact with inmates for six months post-release to monitor progress and ensure that they make and keep appointments for remaining extended-release naltrexone injections.
- Although follow-up with counselors is not mandatory for those inmates who are released without parole or probation, follow-up is recommended as a way to promote continuity of care as they returns to their community.
- The manufacturer donates the first injection, which is administered while the person is still incarcerated. Massachusetts is a Medicaid expansion state, which helps to cover the costs associated with MAT post-release.

- Ongoing data collection and program monitoring enable program officials to adjust the program over time.

Figure 1: MATADOR Continuum of Care Program Information

MATADOR Continuum of Care

Medical Intake	Classification LSCMI	RSAT/A.R.C.	Enrollment	Pre-Release Planning & Community Monitoring
• In 2015 43% of intakes received detox protocols • Approx. 20% were for opiates, over 50% for polysubstance • 25% of inmates arrive without insurance	• 80% of inmates suffer from substance use • 46% have a history of mental illness • Over 85% with mental health issues have a co-occurring substance use issue	• 126 bed housing unit • 90-day cognitive behavioral program in community setting • 10% increase in opiate addiction ('13-'14) • 38% reported heroin as primary drug	• Previously detoxed • Signed consent forms • Blood work and physical exam • Medication education • Injection 48 hours prior to release	• Enrolled in Medicaid • Appt. w/health care provider • Counseling & second injection scheduled • Regular follow-up contact by MSO for status update & data collection

Above: Slide presented at the MAT for Justice-Involved Populations Convening.
Source: Peter J. Koutoujian, Sheriff, Middlesex County Correctional Facility

Kathleen Maurer, MD, MPH, MBA
Medical Director for the Director of Health Services, Connecticut Department of Corrections

Dr. Kathleen Maurer provided an overview of the MAT program operated by the Connecticut Department of Corrections in two jail facilities. She also described the challenges she has faced in establishing the MAT program and reported on additional programs operated by the Connecticut Department of Corrections, established to address the opioid epidemic.

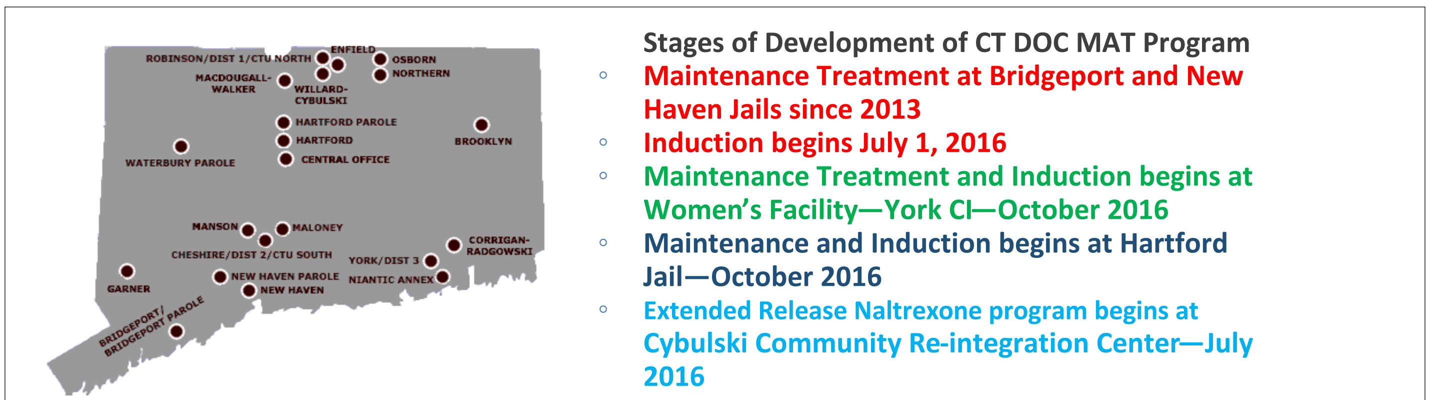
We call them inmates but they are really my patients.
-Dr. Kathleen Maurer, MD, MPH, MBA, Connecticut Department of Corrections

- The American Correctional Association (ACA) has many efforts underway to update its accreditation process, and to highlight the use of MAT in corrections in conferences and presentations. Dr. Maurer noted her work with the ACA, and its work with the American Society of Addiction Medicine (ASAM) to stop opioid overdoses.

Above: Dr. Kathleen Maurer presenting at the MAT for Justice-Involved Populations Convening.

- Connecticut has approximately 15,500 patients in its 15 facilities (see figure 2). Of these, 80 to 90 percent have an SUD. Women comprise about 30 percent of this total. Opioids are the drug of choice for men and women, but especially among women.
- The Connecticut Department of Corrections has three MAT-related programs operating in two facilities; in addition to MAT itself, components include:
    - Providing a naloxone kit to all parole officers, halfway houses, and methadone patients; this is being tested with inmates being released;
    - Testing MAT in jail diversion programs; and
    - The goal is to have a system-wide program in five years. Figure 2 below indicates where and when new programs are to begin.
- The State of Connecticut contracts with external OTPs, which are licensed by the DEA and regulated by SAMHSA, to deliver approved MAT medications into the facility. Several agencies, including the Connecticut Department of Public Health and the DEA, are involved in the approval process for this approach.

Figure 2: State of Connecticut MAT Programs and Plans



Above: Slide presented at the MAT for Justice-Involved Populations Convening.
Source: Dr. Kathleen Maurer, Connecticut Department of Corrections

Key findings:

- As of May 31, 2016, the majority of individuals participating in the New Haven and Bridgeport programs have no health insurance and are unmarried, with the majority of referrals among people ages 25-35. Three-quarters of individuals participating in the New Haven program are white and three-quarters of individuals participating in the Bridgeport program are African American.

  - The recidivism rate (calculated as the number of people re-arrested) for individuals participating in the Bridgeport program is 3 percent at 30 days post-release and 11 percent at 90 days post release.
  - Bridgeport provides a "Connect-to-Care" program for those re-entering society: 83 percent are released to the community with care in place.

- The following challenges must be addressed in ensuring an effective MAT program:
  - Corrections officials must be willing to modify how they think about the people being cared for and the care they receive.
  - Custody and medical staff must support the MAT program. It has proven so successful that now many insist on expanding it.
  - Effective programs have made jails and prisons more manageable: safety and security are paramount.
  - Criminal justice concerns (e.g., court visits, sentencing, early release) must be considered.
  - It is important to find ways to support deputies and other staff who participate in the program, not only with training, but also in coping with grief when an overdose death occurs.
- In addition to the MAT programs operated in the two facilities, several other pilots and programs are underway:

  - A naloxone kit is given to all parole officers and halfway houses, as well as to people on methadone, upon release; a pilot program is underway to provide one for all inmates who are MAT participants upon release. As of March 2016, the naloxone kits provided though the pilot program have reversed three overdoses in a halfway house. A research program is being developed and is now before an Institutional Review Board.
  - A pre-arraignment diversion program (Treatment Pathway Program) was launched in April 2015. A licensed clinical social worker (LCSW) is assigned to the courthouse, and detainees with an SUD or OUD are referred to the LCSW for screening. Treatment options are developed, then presented to judges as a way for convicted people to avoid prison.

- As of May 2016, of 124 individuals enrolled in the Treatment Pathway Program, 45% had already completed the program.

Robert Green
Director, Department of Correction and Rehabilitation, Montgomery County, MD

Director Robert Green began his remarks by describing the impact the opioid epidemic has had on the State of Maryland and then provided an overview of the key features of the Montgomery County Correctional Facility MAT program. In his remarks, Mr. Green stated the importance of ensuring that previously incarcerated individuals have access to treatment once released into the community. He also provided an overview of the Incarceration to Community Initiative, which was launched to address the lack of available treatment in the community.

> **We refer to staff as corrections treatment officers.**
> *-Robert Green, Director, Montgomery County Department of Corrections and Rehabilitation*

- Montgomery County has one of the largest populations in the State of Maryland, which, between 2011 and 2014, experienced an 88 percent increase in heroin overdoses. The county has produced a 14-minute video about its MAT program. The video features the Residential Substance Abuse Treatment for State Prisoners (RSAT) program, which is underway in Montgomery County. In 2012 the county launched an MAT initiative that focused on improving treatment in the community (see figure 3); the County's MAT program was first piloted in the correctional facility in 2015.
- Key features of the program include:
  - An existing licensed clinical substance use disorder treatment provider in the facility;
  - Strong criminal justice/community heath collaborations and relationships;
  - Full institutional staff support, including a culture that understands the scientific evidence for MAT, and that supports treatment and innovative program delivery;
  - Support for correctional officers who interact most frequently with the inmates, as well as understanding how to provide MAT inmates an "umbrella of support"; and
  - Advocacy and outreach to the inmate population, their families, and their support structures.

Above: Robert Green presenting at the MAT for Justice-Involved Populations Convening.

- Each year, the MAT program returns approximately 345 inmates to the community. Because of ongoing work with these individuals, and because of their

recovery work while imprisoned, the former inmates are better prepared to function as members of the community. They are able to contribute to community life, rather than constantly cycling through the prison.

- The County no longer starts any re-entry program without first having a referral system to community-based providers in order to maintain continuation of treatment.
- The County continues to work on several issues:
    - Engaging people who are in court;
    - Ensuring that facilities remain secure; and
    - Working with inmates who, at the last minute, decide they don't want to try MAT. In these cases, staff members explain how using the MAT approach will let him or her become part of life in the community.

Figure 3: Montgomery County Incarceration to Community initiative

Re-Entry For All MAT – Incarceration to Community Initiative

Community Program Began in 2012
Office of Addiction Serves County HHS

Qualifying Institutional Participants
Montgomery County Resident
Sentenced
Opiate/Alcohol Abuse History
Pending direct release (no detainers)

Commonly Referenced Institutional Barriers
Facility Security
Misperceptions, Myths, Realities
Cost

September 7, 2016 6

Above: Slide presented at the MAT for Justice-Involved Populations Convening.
Source: Robert Green, Director, Department of Correction and Rehabilitation, Montgomery County, MD

Sergeant Brad Rose
Reentry Coordinator, Sacramento County, CA

Sergeant Brad Rose took the podium to describe the MAT program operated by the Sacramento Sheriff's Department Reentry Services Bureau. Sergeant Rose described the change in perspective of correctional officers upon the recognition that punishment will not cure individuals of SUD. He also noted that effective treatment programs must be provided for justice-involved individuals.

- Sacramento County has faced and responded to OUD for 12 years. Incarceration is now viewed as an opportunity to provide treatment
  - The City of Sacramento experienced an upturn of opioid use among inmates: 18 percent in 2013, up from 3 percent in 2000; and
- Sacramento County developed its program by strengthening relationships with community-based organizations, and with the Department of Human Assistance, which evaluates people for health insurance coverage under the Affordable Care Act (ACA). In order to succeed, people in the MAT program must be motivated to remain in that program and maintain their recovery upon completion of the detoxification.
- Other elements of the MAT re-entry program include:

Above: Sergeant Brad Rose presenting at the MAT for Justice-Involved Populations Convening.

  - Extended release injectable naltrexone
  - Re-entry specialists who are credentialed substance abuse counselors;
  - Aftercare services, including provision of re-entry program specialists to follow individuals for one year to help them experience a "soft landing" in the community. For MAT participants re-entering the community, the program also helps them to find employment opportunities;

- To date, Sacramento has experienced lower rates of recidivism and higher rates of employment post-release among its 174 MAT participants than among non-participants; and
- Benefits of the Sacramento program include avoiding the cost of incarceration, which, in California, averages $125 per day.

Figure 4: A Change in Perception in Sacramento County

Punishment vs. Treatment
A Change in Perception

Studies and Practical Experience have shown us the following:

- Punishment alone has little effect
- Traditional treatments (methadone, buprenorphine have shown limited success
- Incarceration used for period of sobriety and to deliver treatment is effective.
- Use of risk needs assessments
- Innovation in treatment methods
  - Extended-release injectable naltrexone (Vivitrol®)

Above: Slide presented at the MAT for Justice-Involved Populations Convening.
Source: Sergeant Brad Rose, Reentry Coordinator, Sacramento County, CA

Roundtable Discussions

This section of the Convening featured two consecutive discussion sessions for all meeting attendees to participate. The discussions were led by facilitators, with the first focused on the "Adoption of MAT for Justice-Involved Populations" and the second focused on "Stakeholder Engagement".

Roundtable Discussion 1: Adoption of MAT for Justice-Involved Populations

***Facilitator*: Ruby Qazilbash, Bureau of Justice Assistance**

Roundtable 1 facilitated by Ruby Qazilbash included discussion on a wide range of topics. Stakeholders noticed that incarcerated drug users often have healthcare imposed on them and unlike civilians may not experience choice. Major issues discussed include how to screen and triage people in corrections, which includes the importance of knowing that clients' histories may include prior treatment with methadone or buprenorphine. Also noted was the importance of

disclosing how the program will guarantee privacy and confidentiality. It was discussed that computerized programs may offer solutions for this. Staff resistance or trauma may be a barrier and additional education or support may be required. The issue of capacity, especially for rural jails, which have limited access to care, and few resources was raised. Additionally mentioned, once a corrections leader supports and implements a MAT program, the commitment travels through the ranks and other corrections staff accept it too. Through education and leadership, people understand the importance of the MAT initiatives.

Above: Ruby Qazilbash facilitating the Roundtable Discussion at the MAT for Justice-Involved Populations Convening.

The Centers for Medicare and Medicaid Services (CMS) mentioned *recent release of a letter to state officials with guidelines* about Medicaid coverage for incarcerated people who are being transitioned back into the community. These rules are complex and address important issues about when and how an inmate is able to apply for Medicaid, how to request Federal Financial Participation, and other factors related to service provision and eligibility. People who are involved with the corrections system must be able to communicate with their state agencies about CMS regulations and their ability to purchase healthcare coverage through the exchange after they are released from jail or prison.

Roundtable Discussion 2: Stakeholder Engagement

What Can Stakeholders Do To Adopt MAT For Justice-Involved Populations In Their Training, Program, and Policies and Overcome Challenges?

***Facilitators*: Sheriff Koutoujian, Middlesex County, MA, and Andrew Klein – RSAT Technical Assistance Program**

Topics covered in Roundtable 2 facilitated by Sheriff Koutoujian and Dr. Andrew Klein included the importance of discussing treatment options with incarcerated individuals prior to re-entry, including families of those in recovery, and ways that help former inmates stay invested in their own recovery which may be provided through support services associated with both pre and post release treatment programs. Participants discussed the importance of providers discussing treatment options with patients prior to re-entry, and the importance of coordinating recovery work being done in corrections facilities with community-based programs that support re-entry and recovery.

Discussions included the National Commission on Correctional Health Care, which credentials corrections-based MAT programs, and has released a document that includes 47 standards in 9 topic areas. This group has also released how-to guidelines regarding OTP certification. Participants mentioned coordinating with the State Medicaid office on an 1115 waiver from CMS, which allows states to demonstrate or test programs within their own Medicaid plans. A person who is receiving MAT and is arrested and sent to jail should be able to continue MAT treatment while there. It is helpful to have peer supports that come to the facility to discuss their successful re-entry experiences and how they have managed to return to life in the community.

Above: Andrew Klein facilitating the Roundtable Discussion at the MAT for Justice-Involved Populations Convening.

Wrap Up

Mary Lou Leary

Deputy Director for Policy, Research, and Budget, Office of National Drug Control Policy

Deputy Director Leary closed the meeting by reviewing key points that were made throughout the discussions. She emphasized that it is important to appreciate that corrections staff need training on OUD and the science and purpose of MAT. Corrections staff also grieve, and may need bereavement support in the event a current or former inmate overdoses and dies.

Above: Deputy Director of National Drug Control Policy, Mary Lou Leary, at the MAT for Justice-Involved Populations Convening.

She also asserted that those who ask "How much will the MAT program cost?" should be countered by asking, "How much will it save?" This response offers a more open and positive approach to policymakers, elected officials, and corrections officials, and may ultimately lead to more funding and more effective processes.

And she highlighted that the underlying critical elements to increase access to MAT for justice-involved individuals are:

- Increasing awareness and acceptance of MAT for justice-involved individuals;

- Reducing resistance to such treatment, including the stigma that may be associated with it; and,
- Developing effective communication with all stakeholders to ensure that MAT programs are available in corrections and court systems.

Conclusions

ONDCP, along with its Federal, state, tribal and local partners, continues its efforts to promote and expand MAT for justice-involved individuals. As of October 2016, the Bureau of Justice Assistance's Residential Substance Abuse Treatment Program (RSAT) estimates that there are 114 jail facilities implementing MAT, and 18 state-wide MAT programs. Although this is a start, we need to continue this momentum by implementing MAT programs in any correctional facility where individuals with OUD are present. This way, we can ensure that all individuals receive the treatment that they deserve.

APPENDIX A: AGENDA

MEDICATION ASSISTED TREATMENT FOR JUSTICE-INVOLVED POPULATIONS
CONVENING AGENDA
June 17, 2016
9:00 am – 1:00 pm
Eisenhower Executive Office Building
Indian Treaty Room

Hosted by

Office of National Drug Control Policy

LIVESTREAMING BEGINS

9:00AM – 9:05AM **Opening & Introduction of Director Michael Botticelli**

June Sivilli
Chief, Public Health & Public Safety Division
National Drug Control Policy

9:05AM – 9:15AM **Welcome & Meeting Purpose**

Michael Botticelli
Director
National Drug Control Policy

9:15AM – 9:25AM **National Institute of Corrections**

Jim Cosby
Director

9:25AM – 9:40AM **MAT 101**

Melinda Campopiano
Chief, Regulatory Programs
Substance Abuse and Mental Health Services Administration

9:40AM – 9:50AM **Middlesex County Correctional Facility**

Peter J. Koutoujian
Sheriff

9:50AM – 10:00AM **Connecticut Department of Corrections**

Kathleen Maurer, MD, MPH, MBA
Medical Director and Director of Health and Addiction Services

10:00AM – 10:10AM **Montgomery County, MD**

Robert Green
Director, Department of Correction and Rehabilitation

10:10AM- 10:20AM **Sacramento County, CA**

Sergeant Brad Rose
Reentry Coordinator

10:20AM – 10:40AM **Q&A**

LIVESTREAMING ENDS

10:40AM – 10:55AM **Break**

Projection of Video:
RSAT Medication-Assisted Treatment Training: Client Voices

10:55AM – 11:55AM **Roundtable Discussion: Adoption of MAT for Justice-Involved Populations**

Facilitator: Ruby Qazilbash, Bureau of Justice Assistance

11:55AM – 12:05PM **Break**

12:05PM – 12:45PM **Roundtable Discussion: Stakeholder Engagement**

What Can Stakeholders Do To Adopt MAT For Justice-Involved Populations In Their Training, Program, and Policies and Overcome Challenges?

Facilitators:
Sheriff Koutoujian, Middlesex County, MA
Andrew Klein – RSAT Technical Assistance Program

LIVESTREAMING BEGINS

12:45PM – 1:00 PM **Wrap Up**

Mary Lou Leary
Deputy Director for Policy, Research, and Budget
Office of National Drug Control Policy

APPENDIX B: PARTICIPANT LIST

Medication Assisted Treatment for Justice-Involved Populations

Participant List*

Office of National Drug Control Policy

CORRECTIONAL ORGANIZATIONS AND RESEARCHERS

Veronica Cunningham
Executive Director
American Probation and Parole Association
vcunningham@csg.org

Maeghan Gilmore
National Association of Counties
Program Director, Health, Human Services and Justice
mgilmore@naco.org

Robert Kasabian
Executive Director
American Jail Association
robertk@AJA.org

Mitchell Lucas, CJM
Assistant Sheriff
Charleston County Sheriff's Office
Major County Sheriff's Association
mlucas@charlestoncounty.org

Gary Maynard
Associate Director
Association of State Correctional Administrators
gmaynard@asca.net

Daniel Mistak
General Counsel
Community Oriented Correctional Health Services
dmistak@cochs.org

Michael Miskell
Correctional Health Specialist
American Correctional Association
MichaelM@aca.org

Pamela F. Rodriguez
President & CEO
TASC, Inc. (Treatment Alternatives for Safe Communities)
prodriguez@tasc.org

Eric Schultz, Jr.
Director of Government and Public Affairs
American Correctional Association
EricS@aca.org

Faye Taxman, PhD
University Professor
Director, Center for Advancing Correctional Excellence
George Mason University
ftaxman@gmu.edu

*The participant list was updated to include individuals who attended the meeting but were not on the participant list distributed at the meeting.

Tracey Titus
Vice President, Accreditation
National Commission on Correctional Health Care
traceytitus@ncchc.org

Terrence Walton
Chief Operating Officer
National Association of Drug Court Professionals
twalton@allrise.org

John Wetzel
Secretary of Corrections
Pennsylvania Department of Corrections
Association of State Correctional Administrators
dsahd@pa.gov

Julie M. White
Senior Director of Operations
Health and Criminal Justice Programs
University of Massachusetts Medical School
Julie.white@umassmed.edu

GOVERNMENT AGENCIES AND PROGRAMS

Stephen Amos
Chief, Jails Division
National Institute of Corrections
samos@bop.gov

Kirsten Beronio
Director
Division of Behavioral Health & Intellectual Disability
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Kirsten.beronio@hhs.gov

Robert Brown
Deputy Director
National Institute of Corrections
rbrown@bop.gov

Melinda Campopiano
Medical Officer
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services
Melinda.campopiano@samhsa.hhs.gov

Jim Cosby
Director
National Institute of Corrections
jcosby@bop.gov

Beverly Cotton
Director, Division of Behavioral Health
Department of Health and Human Services
Beverly.cotton@ihs.gov

Stephen Haas
Chief, Community Corrections
National Institute of Corrections
shaas@bop.gov

Susan Hayashi
Vice President
JBS International
shayashi@jbsinternational.com

Eliza Heppner
Director, Office of Strategic Initiatives
Health Resources & Services Administration
eheppner@hrsa.gov

Annie Hollis
Health Insurance Specialist
Division of Benefits and Coverage
Centers for Medicare & Medicaid Services
Annie.hollis@cms.hhs.gov

Alexis Horan
Expert Consultant
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Alexis.horan@hhs.gov

Nancy Kirchner
Deputy Director
Division of Benefits and Coverage
Centers for Medicare & Medicaid Services
Nancy.kirchner@cms.hhs.gov

Andrew Klein
RSAT T/TA Director for BJA RSAT program
Advocates for Human Potential, INC
aklein@ahpnet.com

Ruby Qazilbach
Associate Deputy Director
Bureau of Justice Assistance
Ruby.qazilbash@usdoj.gov

Nancy Rodriguez
Director
National Institute of Justice
Nancy.rodriguez@usdoj.gov

Joanie Shoemaker
Registered Nurse
Formerly Colorado Department of Corrections
BJA Visiting Fellow
Joan.M.Shoemaker@usdoj.gov

Esan Simon, M.D.
Associate Medical Director
Department of Homeland Security
Esan.o.simon@ice.dhs.gov

Jack Stein
Director
Office of Science Policy and Communications
National Institute on Drug Abuse
Jack.stein@nih.hhs.gov

Andrea Wells
Public Health Analyst
Health Resources & Services Administration
awells@hrsa.gov

Tisha Wiley
Health Scientist Administrator
National Institute on Drug Abuse
Tisha.wiley@ni.gov

JAIL AND PRISON MAT PROGRAMS

Terence Carl
Kenton County Jailer
Kenton County Detention Center
Terry.Carl@kentoncounty.org

Dr. Elina Chernyak
Director of Addiction Medicine
Sweetwater Memorial Hospital
Sweetwater County, WY
echernyak@sweetwatermemorial.com

Jennifer Clarke, M.D.
Medical Program Director
Rhode Island Department of Corrections
jennifer.clarke@doc.ri.gov

Kathleen Glunz Skarin
Chief of Staff
Sheriff Peter J. Koutoujian
Middlesex County, MA
kgskarin@sdm.state.ma.us

Robert Green
Director
Department of Correction and Rehabilitation Office
Montgomery County, MD
Robert.Green@Montgomerycountymd.gov

Brent Kelsey
Assistant Director
Utah Division of Substance Abuse and Mental Health
bkelsey@utah.gov

Kathleen Maurer, MD
Director of Health and Addiction Services
Medical Director
Connecticut Department of Corrections
kathleen.maurer@ct.gov

Ross MacDonald, M.D.
Medical Director
Rikers Island Correctional Facility
rmacdonald@nyc.hhc.org

Jason Merrick
Director of Addiction Services
Kenton County Detention Center
Jason.merrick@kentoncounty.org

Michael Meulemans
Wisconsin Department of Corrections
Michael.Meulemans@wisconsin.gov

Sergeant Brad Rose
Re-entry Coordinator
Sacramento County
bros@sacsheriff.com

Meredith Smith, Ph.D.
Director of Clinical Services
PSIMED CORRECTIONS, LLC
msmith@psimedinc.com

Robert Tierney, M.Ed.
Supervisor
NorthEast Treatment Center
robert.tierney@net-centers.org

CORRECTIONAL HEALTH VENDORS

John May, M.D.
Chief Medical Officer
Armor Correctional Health Services, Inc.
jmay@armorcorrectioanl.com

POLICY RESEARCH ORGANIZATIONS

Lisa Dubay
Senior Fellow
Urban Institute
ldubay@urban.org

Cynthia Reilly
Director, Prescription Drug Abuse Project
The Pew Charitable Trusts
creilly@pewtrusts.org

Robert Schwartz, M.D.
Medical Director/Senior Research Scientist
Friends Research Institute
rschwartz@friendsresearch.org

Hayne Yoon
Government Affairs Director
Vera Institute of Justice
hyoon@vera.org

Katie Zafft
Senior Associate
The Pew Charitable Trusts
cepps-temp@pewtrusts.org

APPENDIX C: REVIEW OF SELECTED LITERATURE

Medication Assisted Treatment for Justice-Involved Populations: Selected Literature Review

Office of National Drug Control Policy

The seven articles provided in the literature review include two review articles and five recent primary studies. All articles focus on the effectiveness of MAT for treating opioid dependence.

1. Mattick RP, Breen C, Kimber J, Davoli M. (2014). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews. Issue 2.*

The objective of this systematic review was to evaluate the research literature on the effectiveness of buprenorphine maintenance compared to placebo and to methadone maintenance in the management of opioid dependence, including its ability to retain people in treatment, suppress illicit drug use, and reduce criminal activity and mortality. The study reviewed 31 randomized controlled trials of buprenorphine maintenance treatment versus placebo or methadone in management of opioid dependent persons. The researchers measured the effectiveness of both forms of MAT in terms of treatment retention and abstinence (measured by urinalysis). They found compelling evidence that buprenorphine (at a variety of doses) was superior to placebo medication in patient retention. They also found that buprenorphine was more effective than placebo in reducing illicit opioid use. Buprenorphine, however, was found to be less effective than methadone in terms of patient retention. The results from two trials suggest there is no difference between methadone and buprenorphine for reducing criminal activity, although four studies reported an association between methadone dosing in the first 2 weeks of induction and heightened risk of death from methadone overdose.

2. Crits-Christoph P, Lundy C, Stringer M, Gallop, R. Gastfriend, DR. (2015). Extended-release naltrexone for alcohol and opioid problems in Missouri parolees and probationers. *Journal of Substance Abuse Treatment* 56:54-60.

This study compared the naturalistic outcomes of parolees and probationers with alcohol and/or opioid use problems who were treated with extended-release naltrexone (XR-NTX) to those treated with other medication-assisted therapies or psychosocial treatment only. The sample included 2,882 men and women on parole or probation who reported alcohol or opioid use as their primary, secondary, or tertiary substance use problem. Researchers studied the effectiveness of XT-NTX compared to traditional MAT therapies in parolees and probationers using SAMHSA's Treatment Episode Data Set and data from the Missouri Department of Behavioral Health. They found that patients on XT-NTX received longer duration of care compared to oral naltrexone, buprenorphine/naloxone, and psychosocial

treatment. Furthermore, they found that patients on XT-NTX were more likely to become abstinent compared to oral naltrexone, buprenorphine/naloxone, and psychosocial treatment.

3. Friedmann PD, Hoskinson R, Gordon M, Schwartz R, Kinlock T, Knight K, Flynn PM, Welsh WN, Stein LAR, Sacks S, O'Connell DJ, Knudsen HK, Shafer MS, Hall E, Frisman LK. (2012). Medication-assisted treatment in criminal justice agencies affiliated with the Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS): availability, barriers, and intentions. *Substance Abuse,* 33(1): 9-18.

This study surveyed criminal justice agencies affiliated with the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) to assess the factors influencing the use of MAT. According to the survey results, pregnant women and people suffering from withdrawal were most likely to receive MAT for opioid dependence. Individuals reentering the community following incarceration were the least likely to receive MAT. Survey results also revealed differing opinions regarding MAT across agencies—some agencies were found to cite common misperceptions and myths regarding MAT rather than evidence-based arguments. Overall, researchers concluded that lack of information, negative attitudes toward MAT, and philosophical differences (e.g. preferences for drug-free policies) contributed toward lower than optimal usage of MAT. Common barriers against MAT also varied by setting. Drug courts cited liability concerns, lack of access, and reimbursement difficulties, while prisons and jails commonly cited security concerns and existing, community-based MAT alternatives as barriers to treatment. Thus, the authors recommend that in addition to overcoming educational gaps and negative attitudes about MAT, better partnerships with community pharmacotherapy programs can help increase MAT usage.

4. Matusow H, Dickman SL, Rich JD, Fong C, Dumont, DM., Hardin C, Marlowe, D, Rosenblum A. (2013). Medication assisted treatment in US drug courts: results from a nationwide survey of availability, barriers, and attitudes. *Journal of Substance Abuse Treatment,* 44(5):473-80.

The purpose of this study was to examine the availability and barriers to MAT provision in drug courts. The results of a nationwide survey showed that half of drug courts had no available MAT therapy (agonist medication) for opioid-dependent participants, while only 34 percent reported that such therapy was even allowed. The most commonly cited reasons for this limited availability were: 'cost' (43 percent), 'participants already detoxed prior to supervision' (42 percent), 'lack of local providers' (41 percent), and 'court does not permit it' (40 percent). Lack of local providers proved to be the largest barrier for rural courts in particular. Beyond cost and lack of availability, many of the courts were not convinced of the effectiveness of MAT therapy. The authors recommend a targeted educational initiative to promote awareness about MAT efficacy in drug courts.

5. Binswanger IA, Blatchford PJ, Mueller SR, Stern MF. (2013). Mortality after prison release: opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. *Annals of Internal Medicine,* 159(9):592-600.

The objective of this study was to examine changes in post-release mortality in criminal justice populations with an emphasis on overdoses between 1999–2009 compared to mortality in the non-institutionalized population. The study also aimed to discover whether there were risk factors associated with opioid-related deaths in criminal justice populations. The researchers found that the leading cause of death in former prisoners was overdose, with opioids being the most common substances involved. Compared to the general population, the criminal justice population had a 10.33-fold increased risk for overdose. The study also showed that increased age was the strongest risk factor for overdose deaths, while increased length of incarceration was associated with a small reduction in risk for overdose death. The researchers determined that there is a need for improved overdose education and substance use treatment in prisons. In particular, enforced abstinence may have counterintuitive effects on mortality, and access to methadone or buprenorphine may be a possible intervention for this population.

6. Sharma A, O'Grady KE, Kelly SM, Gryczynski J, Mitchell SG, Schwartz RP. (2016). Pharmacotherapy for opioid dependence in jails and prisons: research review update and future directions. *Substance Abuse and Rehabilitation,* 7:27-40.

The authors conducted a review of the recent literature on the effectiveness of opioid agonists prior to release in criminal justice populations to prevent relapse or overdose. The study reviewed eight randomized controlled trials (RCT) and six observational studies that examined participant outcomes associated with different MAT strategies. The researchers found that there are significant benefits to starting opioid agonists or antagonist medications prior to release including increased entry into community treatment and reduced heroin use after release. However, researchers acknowledged that more research needs to be done in comparing the different approaches to increasing treatment post release. As a whole, the research supports the position that methadone or buprenorphine should be available to prisoners for maintenance/management of opioid withdrawal as a best practice. In addition, one pilot RCT showed that providing extended-release naltrexone prior to discharge resulted in significantly lower rates of opioid relapse compared to no medication.

7. Lee JD, Friedmann PD, Kinlock TW et al, Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders. (2016). *N Engl J Med.* Mar 31;374(13):1232-42.

The objective of this study was to examine the effectiveness of extended-release naltrexone among community-dwelling criminal justice offenders who were at high risk for opioid relapse and related adverse outcomes. This was a large, multisite, randomized trial with a total of 153 participants assigned to extended-release naltrexone and 155 to usual treatment. During the 24-week treatment phase, participants assigned to extended release naltrexone had a longer median time to relapse, a lower rate of relapse, and a higher rate of opioid-negative urine samples than did those assigned to usual treatment. Over the total 78 weeks observed, there were no overdose events in the extended-release naltrexone group and 7 in the usual-treatment group. The researchers concluded that extended-release naltrexone was associated with a lower rate of opioid relapse compared to usual treatment.