

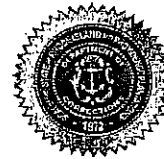
RHODE ISLAND DEPARTMENT OF CORRECTIONS

VIVITROL RELAPSE PREVENTION PROGRAM

PROGRAM MANUAL

The RI Department of Corrections wishes express their sincere appreciation to the Barnstable County Sheriff's Office for their on-going support though out our Vivitrol Program development process. Jessica Burgess and her staff were very patient with us as we continued to ask questions. Having access to their treatment manual and permission to use the forms that they had saved a great deal of work and provided us with templates from which to develop our own.

Once again thank you to the staff at the Barnstable County Sheriff's Office!



Rhode Island Department of Corrections

Vivitrol Relapse Prevention Program

The number of adults involved in the criminal justice system has soared from an estimated 1.8 million in 1980 to 7.2 million in 2009. The connection between drug abuse and crime is well known. One half to two-thirds of inmates in jails and State and Federal prisons meet standard diagnostic criteria (DSM-IV) for alcohol/drug dependence or abuse. (National Institute on Drug Abuse (NIDA), 2011)

Rhode Island Governor's Overdose Prevention and Intervention Task Force states:

Addiction and overdose are claiming lives, destroying families, and undermining the quality of life across Rhode Island. In 2014, 239 people in our state lost their lives to overdose, more than the number of homicides, motor vehicle accidents, and suicides combined.

Opioid use disorder (referred to sometimes as opioid dependence and addiction) is a chronic relapsing disease that can develop with repeated exposure to opioids. There are strong genetic, situational, and societal factors that increase the risk of developing opioid use disorder. Untreated, it can be deadly.

Combining prison-based treatment with community-based treatment upon release reduces an offender's risk of recidivism, decreases substance abuse, improves prospects for employment and increases pro-social behavior (NIDA, 2011).

The Rhode Island Department of Corrections has committed to implementing a pilot project to provide Naltrexone in the form of once monthly injectable Vivitrol to highly motivated offenders pre-release with a strong hand off to a community program to support follow up injections and counseling post discharge. Vivitrol is indicated for the prevention of relapse to opioid dependence, following opioid detoxification. Its purpose is to reduce the cravings for and block the effects of ingested opioids and alcohol.

Vivitrol Program

The Providence Center provides education pertaining to medication-assisted recovery to the Offenders who are currently receiving substance use disorder treatment and recovery services through our contract. This education provides objective information about Methadone, Suboxone, Vivitrol, and other medications used to treat addiction. Offenders will also learn about participating in other non-medical treatment methods, such as counseling and self-help and recovery coaching meetings.

Offenders are informed of the DOC Vivitrol Relapse Prevention Program. If they are interested in being considered for participation in this program they must submit a request slip to The Providence Center (TPC) Lead Clinician in their facility a **minimum of three months** pre-release (See list of TPC Lead

Clinicians at the end of this section and in Appendix I). Upon receipt of a request slip the TPC Lead Clinician will complete and send an "Offender Letter" (see Appendix II Offender Letter). When the TPC Lead Clinician receives the Offender Letter back he/she will assign the Offender to a TPC Clinician. An email will also be sent to the Offender's Adult Counselor informing him/her that the Offender on their case load has expressed an interest in the Vivitrol program.

The TPC Clinician will make arrangements to meet with the Offender to determine his/her eligibility which includes the following:

- History of opioid abuse
- History of multiple incarcerations
- Demonstrated level of motivation for recovery and willingness to engage in all program components.
- Agrees to engage with an identified community provider post release for follow up counseling and support with follow up injections.
- Agrees to sign a release of information form for the identified community provider to support communication between RIDOC staff and agency for discharge planning and follow up.
- Must either have active medical coverage or agrees to apply for coverage pre-release.
- Able to follow up with outside provider.

Exclusion Criteria

- Pre-trial status
- Liver enzymes 3 x normal (e.g., >120)(to be determined by Medical Staff)
- On interferon treatment/therapy (to be determined by Medical Staff)
- Homeless (without a viable plan for housing upon discharge)
- Refuses to sign voluntary participation agreement

Referrals from Outside The Providence Center

Offenders who are **not** currently participating in TPC may still be referred to the Vivitrol relapse Prevention Program. These referrals may be made by Adult Counselors, Social Workers, and Medical Practitioners.

The person making the referral should complete the "Vivitrol Prevention Program Referral Form" (Appendix III Referral Form). This form should be sent to the TPC Lead Clinician in the facility where the Offender is housed (See list of List of TPC Lead Clinicians below and in Appendix I).

Upon receipt of the referral form the TPC Lead Clinician will assign the Offender to one of the TPC Clinician. The TPC Clinician will make arrangements to meet with the Offender and will complete the "Vivitrol Patient Questionnaire" to determine appropriateness (Appendix IV Patient Questionnaire). If the Offender is found appropriate based on his/her opioid use TPC staff will provide two sessions and follow the procedure as outlined above.

The Providence Center Lead Clinicians

Men's Minimum Security

Bethany Contreras
462-2006
No fax...scan and email form
Bethany.Contreras@doc.ri.gov

Men's Medium Security

Gianna Mooney
462-2154
462-0000 (fax)
Gianna.Mooney@doc.ri.gov

Maximum Security

Caitlin Gomes
462-0911
462-1070 (fax) please write attention Providence Center on fax page
Caitlin.Gomes@doc.ri.gov

Women's GM and Bernadette

Laurie Alviti
462-1385
462-1282 fax)
Lauri.Alviti@doc.ri.gov

Note: pre-trial Offenders that request treatment with Vivitrol will be provided with information so that they may independently seek treatment upon release. Due to their undetermined release date, we are unable to schedule follow up treatment, thus disqualifying pre-sentenced Offenders from participation in the Vivitrol program (Appendix V Vivitrol Community Provider List).

Insurance

Offenders who do not currently have medical coverage must be asked to complete an Affordable Care Act application two months prior to release.

Vivitrol Counseling Meetings

Candidates for the Vivitrol Relapse Prevention Program will receive three individual counseling sessions. The first session will focus on the completion of either a review of the offender's current psychosocial assessment on the Electronic Medical Record (EMR) or on the completed Vivitrol Patient Questionnaire. If the assessment indicates that the Offender is initially appropriate for the program the TPC Clinician will schedule two follow up sessions. These 30-45 minute counseling sessions will focus on three main themes:

- 1.) An assessment of motivational state and commitment to treatment.
- 2.) Psychological education appropriate to the inmates; readiness for change.
- 3.) Supportive and reinforcing counseling intended to strengthen commitment to recovery.

Upon completion of all three sessions and with the recommendation of the TPC Clinician the Offender will be referred to Dr. Jennifer Clarke, Medical Program Director at 462-2678; by fax at 462-2000; or Jennifer.Clarke@doc.ri.gov (Appendix IX Medical Referral Form). Offenders who are in need of will also be referred to David Lema at the Department of Behavioral Health, Development

and Hospitals (BHDDH) for an assessment and referral to transitional housing. Please see the discharge planning section below for contact information.

Vivitrol Medical Assessment

Upon receipt of a referral and within 6 weeks of release Dr. Clarke or her designee will meet with the Offender. The Medical Provider and the Offender will discuss whether Vivitrol treatment is appropriate from a medical perspective. If it is determined that the Offender is appropriate for participation the medical provider will begin to make arrangements for medical clearance which will consist of overall health and Liver Function Tests (Blood Lab).

If the lab work is within normal range and the Offender is deemed medically appropriate for participation in the program a Naltrexone tolerance trial will be arranged prior to the first injection of Vivitrol. The Medical Provider will have the Offender complete the "Vivitrol Consent Form" (Appendix VI Vivitrol Consent Form).

Naltrexone Tolerance Trial

Offenders participating in the Vivitrol Program will be prescribed Naltrexone 50 mg. daily for 2 days prior to beginning Vivitrol therapy by the Medical Program Director or her designee. The purpose of this trial is to assess for any adverse effects of the medication.

Initiation of Vivitrol

Offenders participating in the Vivitrol Program will receive the first injection of Vivitrol approximately 7 days prior to release.

Alkermes, the manufacturer of Vivitrol has agreed to provide 50 injections of the medication to RIDOC's medical department for use in this program. There is no cost incurred by RIDOC for the medication.

Alkermes' State Government Relations Manager Pamela O'Sullivan will work with Gordon Bouchard, Director of Nursing Services 462-3795 to schedule delivery of the medication to RIDOC. The medication will be delivered in increments of 4 injections as needed.

Vivitrol injections will be stored in the refrigerator at the Nursing Supervisor's Office at Medium Security. Doses of the medication will be carefully recorded in a log book because each dosing kit contains a hypodermic needle.

The Medical Provider working with the Offender must complete the letter for verification participation provided in Appendix X. This letter must be given to the Offender's Discharge Planner.

Trained medical staff members at RIDOC will administer the medication.

Contacts from Alkermes:

- Pamela O' Sullivan, State Government Relations Director (508) 944-8436
- Robert W Ambrefe, RPh, (978) 502-4257 or Robert.Ambrefe@alkermes.com

RIDOC Contact for Alkermes:

- Gordon Bouchard, Director of Nursing Services, (401) 462-3795

Craving Assessment

Offenders receiving treatment with Vivitrol will be asked to complete a short survey inquiring of their cravings to use opioids (Appendix VIII). This survey will be administered at time of acceptance into the Vivitrol Prevention Program, one day pre-release, and again in the community 30 – 60 days post release. The Community Provider will be given a copy of the post release craving assessment and asked to complete it with the offender approximately 40 days post release. A copy of the post release craving assessment should be sent to the Discharge Planner upon completion.

Discharge Planning

A Substance Use Disorder (SUD) Discharge Planner will begin to meet with Offenders who have been approved to participate in the Vivitrol Program a minimum of 30- 60 days pre-release.

BHDDH has funded a number of beds in four different recovery houses that are prioritized for offenders who initiate Vivitrol while incarcerated. The providers of these beds are required to offer wrap-around services that support the Offender's on-going treatment with Vivitrol. In order to make a referral Discharge Planners must secure a signed "Authorization to Request/Release Health Care Information Form" (Appendix VII Release of Information Form) allowing communication between DOC and David Lema at BHDDH. Once signed the Discharge Planner must contact Mr. Lema at 462-0075 or David.Lema@bhddh.ri.gov. Mr. Lema will complete an assessment and determine bed availability.

Discharge Planners must immediately determine health coverage status. Offenders who had insurance while in the community will still have coverage however it will be suspended and will require reactivation upon release. Offenders who do not have insurance must complete an application as soon as possible to insure that they will have coverage to support the on-going injections in the community. Discharge Planners must also secure a letter from the Doctor that is working with the Offender that attests to the Offenders' involvement in the Vivitrol Relapse Prevention Program (Appendix IX Verification Letter). This letter must be provided to the community based program that will treat the Offender and should also be provided to the Transitional Housing Director if the Offender is referred to one of these programs.

The Discharge Planners will determine where the Offender will be living in the community and together the Discharge Planner and Offender will decide which community based program listed below would be the best fit for their needs. **The community providers on this list are the only providers that have a Memorandum of Understanding (MOU) with DOC and therefore are the only programs that offenders should be referred to.** If an exception needs to be made contact the Substance Abuse Coordinator at 462-3794.

Once a community provider has been selected the Discharge Planner will ask the Offender to complete a release of information form provided in Appendix VII. Once completed the Discharge Planner will contact the community provider to make a referral and to invite a member of their staff to come in to meet with the Offender. The focus of this meeting is to initiate the engagement process between the Offender and the program staff. Initial pre-admission paper work may be completed at this time. The treatment provider is invited to meet with the Offender as often as necessary. Discharge Planners will provide a "Letter of Verification of Participation in the Vivitrol Relapse Prevention Program" signed by a Doctor (Appendix X) and a copy of the "EOHHS Letter to Health Providers" (Appendix XI) to the referral agency.

Post Release Treatment Providers with MOU's

At this time three community program have agreed to collaborate with RICDOC on the Vivitrol Program. The shared goal is to facilitate transition into substance use disorder treatment in the community that includes support with follow up Vivitrol injections in the community. A list of these programs is provided below.

The Journey of Hope, Health, and Healing

Johnston Program

985 Plainfield Street
Johnston, RI 0299
946-0650
Diana Chekrallah, Executive Director X 126
Chris Baker, Supervisor x 120

Providence Program

160 Narragansett Avenue
Providence, RI 02907
941-4488
Debra Jean Laurent, Supervisor x 140

Westerly Program

86 Beach Street
Westerly, RI 02914
941-4488
Trisha McCurdy, Supervisor x 109

Discovery House

Providence Program

66 Pavilion Avenue
Providence, RI 02905
401-461-9110
Jamie Savage

Woonsocket Program

1625 Diamond Hill Road
Woonsocket, RI 02895
762-1511
Peggy Sakosky

The Providence Center

Recovery Net (outpatient for criminal Justice involved clients)
530 North Main Street
Providence, RI 02904
415-8859

Roads to Recovery Men's Residential
111 Howard Avenue
Cranston, RI 02920
462-1020

Roads to Recovery Women's Residential
2198 Wallum Lake
Pascoag, RI 02859
568-6670

Intensive Outpatient
134 Thurbers Ave., 2nd Floor Suite 212
Providence, RI 02905
453-7618

Crisis Stabilization Unit (CSU)
530 North Main Street
Providence, RI 02904
383-5150

THESE FORMS ARE INTENDED
TO BE USED AS ORIGINAL
COPIES

PLEASE DO NOT USE THEM
EXCEPT TO MAKE COPIES

APPENDIX I
PROVIDENCE CENTER LEAD CLINICIANS

**Rhode Island Department of Corrections
Vivitrol Relapse Prevention Program**

The Providence Center Lead Clinicians

Men's Minimum Security

Bethany Contreras

462-2006

No fax...scan and email

Bethany.Contreras@doc.ri.gov

Men's Medium Security

Gianna Mooney

462-2154

Gianna.Mooney@doc.ri.gov

Maximum Security

Caitlin Gomes

462-0911

462-1070 (fax) please write attention Providence Center on fax

Caitlin.Gomes@doc.ri.gov

Women's GM and Bernadette

Laurie Alviti

462-1385

462-1282 (fax)

Lauri.Alviti@doc.ri.gov

APPENDIX II
OFFENDER LETTER



RHODE ISLAND DEPARTMENT OF CORRECTIONS

HEALTH CARE SERVICES

PO Box 8249

Cranston, Rhode Island 02920

Telephone: 401-462-2678

Fax: 401-462-2000

Patient Name:

D.O.B. / /

Facility:

ID#:

Letter to Offender

Date _____

Dear _____

Your request form in which you expressed interest in VIVITROL treatment was received by the Lead Clinician at the Providence Center. Planning for support in your recovery after release is a smart idea.

***In order to participate in treatment, you must be willing to continue in comprehensive substance-abuse treatment following release. This involves attending multiple appointments at a community based program for medical appointments and counseling.**

What you need to do:

- 1.) **As early as THREE months before your CONFIRMED release date:** You need to request to be registered for the Affordable Care Act Health Coverage.
- 2.) **Complete the Vivitrol Patient Questionnaire and review it with your assigned Counselor.**
- 3.) **A member of the health services staff will contact you to discuss planning for Pre- and Post-release VIVITROL treatment.**

Thank you,

Lead Clinician
The Providence Center

APPENDIX III
REFERRAL FORM



RHODE ISLAND DEPARTMENT OF CORRECTIONS

HEALTH CARE SERVICES

PO Box 8249

Cranston, Rhode Island 02920

Telephone: 401-462-2678

Fax: 401-462-2000

Relapse Prevention Program Referral Form

I am making a referral to the Vivitrol Relapse Prevention Program for the following offender:

OFFENDER'S NAME: _____ DOB: _____

ID#: _____ FACILITY: _____

My Name: _____

Title: _____

Date: _____

Signature _____ Date: _____

****Please forward this form to The Providence Center Lead Clinician in the facility where the offender is housed:

Men's Minimum Security, Bethany Contreras, 462-2006, Bethany.Contreras@doc.ri.gov

Men's Medium Security, Gianna Mooney, 462-2154, Gianna.Mooney@doc.ri.gov

Maximum Security, Caitlin Gomes, 462-0911, Caitlin.Gomes@doc.ri.gov

Women's GM and Bernadette, Laurie Alviti, 462-1385, Lauri.Alviti@doc.ri.gov

APPENDIX IV
OFFENDER QUESTIONNAIRE



RHODE ISLAND DEPARTMENT OF CORRECTIONS

HEALTH CARE SERVICES

PO Box 8249

Cranston, Rhode Island 02920

Telephone: 401-462-2678

Fax: 401-462-2000

VIVITROL Patient Questionnaire

Please fill out the following questionnaire as honestly as possible and return to your Counselor.

Your Name: _____ Age: _____ Date of Birth: _____

Facility: _____

Your EXACT Release Date: _____ *If changes, notify your Counselor ASAP

Address where you will live after release: _____

Phone Number : _____

Drug Use History

Please fill out information regarding your substance abuse history:

SUBSTANCE	Check ones you have used in your lifetime	Check ones you were currently using at time of incarceration	Route of use (IV, snort, smoke, etc)	Frequency of use at time of incarceration (Daily, Weekly, Monthly, etc)	For how long have you abused this substance?
Alcohol					
Cocaine/Crack					
Marijuana					
Hallucinogens (Acid/Mushrooms)					
Designer Drugs (Ecstasy, Liquid G, Bath Salts, etc)					
Amphetamines (Crystal Meth, Adderall)					
Benzodiazepines					

(Xanax, Klonopin, Ativan, Valium, etc)					
Opiates (heroin, OC's, percocets, vicodins, methadone, etc)					
Suboxone (NOT prescribed)					

Overdose

Have you ever overdosed? YES NO

What Substance did you overdose on? _____

Number of lifetime overdoses: _____

Have you ever been hospitalized due to an overdose? YES NO

Substance Abuse Treatment History

Have you had any substance abuse treatment? YES NO

How many times have you been to detox? _____

Have you ever been prescribed Suboxone or Methadone? _____

If Yes, was it helpful? Why or Why not?

Clean Time History

How many serious attempts have you made to get clean? _____

How long was the longest period of time that you have been clean?

When was this? _____

Criminal History

How many times have you been incarcerated? _____

How long is your current sentence at BCCF? _____

Have you ever been incarcerated at another facility besides BCCF? _____

Was your offense related to your substance abuse? _____

Mental Health

Have you ever received counseling? YES NO

If yes, was it helpful? Why or Why not?

Have you ever attempted to end your life or to hurt yourself? YES NO If yes, when was this?

Have you been diagnosed with a mental illness? YES NO If yes, what is your diagnosis?

Have you ever been hospitalized for mental health issues? YES NO If yes, when was this?

Health Status

Do you have any chronic medical conditions? If yes, please name:

Do you have Hepatitis C? _____ If Yes, When were you diagnosed?

Medications/ Surgeries

Are you taking any medications? YES NO

If yes, what medications are you taking? _____

Insurance

What kind of medical insurance do you have? _____

Social Support

What is your relationship status (Single/Married/In a relationship/etc)?

Do you plan to live with your partner/significant other? YES NO

Does your partner have an active substance use/abuse problem? YES NO

Is your partner/significant other currently in treatment? YES NO

Transportation

Do you own a car? YES NO

If not, how do you plan to get around? _____

Do you have a driver's license? YES NO

Planning for Treatment

Is your goal to stop using all substances, or just some of them?

Are you interested in participating in individual counseling, group counseling and/or Substance Abuse Meetings as part of your treatment after release?

APPENDIX V
COMMUNITY PROVIDER LIST

**RHODE ISLAND DEPARTMENT OF CORRECTIONS
VIVITROL RELAPSE PREVENTION PROGRAM**

Vivitrol Community Provider Resource List

Clinical Services of Rhode Island

600 Putnam Pike
Greenville, R
I 02828
401-949-2220

Compass Rose Psychiatry

11 King Charles Dr. Unit 2A
Portsmouth, RI 02871
401-293-5930

Meadows Edge Recovery Center

580 Ten Rod Road
North Kingston, RI 02852
401-294-6170

Ocean State Addiction Medicine

105 Sockanosset Cross-Road, Suite 320
Cranston, RI 02920
401-964-7600

Primacare Pawtucket

100 Smithfield Avenue
Pawtucket, RI 02860
401-305-3434

The Providence Center

530 North Main Street
Providence, RI 02904
401-276-4020

Discovery House

66 Pavilion Avenue
Providence, RI 02905
401-461-9110

Medical Assisted Recovery

875 Centerville Road
North Kingston, RI 02886
401-615-8500
Dr. Skip Sviokla

The Journey of Hope, Health, and Healing

- **Johnston Program**
985 Plainfield Street
Johnston, RI 0299
946-0650
Diana Chekrallah, Executive Director X 126
Chris Baker, Supervisor x 120
- **Providence Program**
160 Narragansett Avenue
Providence, RI 02907
941-4488
Debra Jean Laurent, Supervisor x 140
- **Westerly Program**
86 Beach Street
Westerly, RI 02914
941-4488
Trisha McCurdy, Supervisor x 109

APPENDIX VI
VIVITROL CONSENT FORM



RHODE ISLAND DEPARTMENT OF CORRECTIONS

HEALTH CARE SERVICES

PO Box 8249

Cranston, Rhode Island 02920

Telephone: 401-462-2678

Fax: 401-462-2000

Vivitrol (naltrexone extended release injection) Consent Form

I _____ DOB: _____ Facility: _____

do hereby voluntarily apply and consent to participate in the Vivitrol Overdose Prevention Program. I am requesting Vivitrol (naltrexone extended release injection) Therapy as a treatment for alcohol and opioid dependence. I understand that, as far as possible, precautions will be taken to prevent any complications or ill effects on my health. I further understand that it is my responsibility to tell the Physician/Nurse in the program as much as I can about my health. It is my responsibility to seek medical attention immediately if any reaction occurs to Vivitrol or if any changes occur in my health status. As a participant, I freely and voluntarily agree to adhere to the treatment protocol as follows:

- 1) I understand that medication alone is not sufficient treatment for managing my disease. After I am released, I agree to participate in substance use disorder treatment program in the community.
- 2) I understand that Vivitrol (naltrexone extended release injection) is being prescribed as part of a comprehensive treatment plan for my alcohol and/or opiate dependence.
- 3) I agree to keep, and be on time, for my scheduled appointment at the community program. If I cannot keep the appointment, I will call to cancel and reschedule.
- 4) I agree to have a blood specimen taken for assessment of liver function prior to beginning Vivitrol therapy.
- 5) I have participated in one verbal assessment measuring my level of motivation and level of risk relating to my substance dependence.
- 6) I have received two individual counseling sessions at RIDOC prior to beginning Vivitrol therapy.

- 7) I understand that I will be prescribed Naltrexone (the pill form of Vivitrol) for up to three days prior to beginning Vivitrol therapy. This trial is to assess for any adverse effects of the medication. I understand that I am to inform the medical staff if I experience any side effects during this time.
- 8) I understand that I will receive the first injection of Vivitrol therapy approximately 3-7 days prior to my release.
- 9) I understand that Vivitrol is well-tolerated in the recommended doses, but may cause liver injury when taken in excess or in people who develop liver disease from other causes. If I experience excessive tiredness, unusual bleeding or bruising, pain in upper right part of my stomach that lasts more than a few days, light-colored bowel movements, dark urine, or yellowing of the skin or eyes, I will stop taking Vivitrol immediately and see my doctor as soon as possible.
- 10) I agree to take Vivitrol only as directed by the prescribing physician and agree that before receiving Vivitrol therapy, I will obtain all known risks and all possible known side effects directly from the prescribing physician.
- 11) I understand that I must inform any medical provider treating me that I am receiving Vivitrol therapy.
- 12) I attest that I have not used opiates within the past 7 to 10 days.
- 13) I understand that I should not take Vivitrol if I am pregnant or if I am contemplating pregnancy.
- 14) I understand that the community treatment provider can terminate my treatment at any time if I do not comply with treatment guidelines
- 15) I understand it is my responsibility to maintain active health insurance coverage, so that I do not have difficulty receiving my Vivitrol injections.
- 16) I understand that a positive urine drug screen for alcohol and/or opiates, such as Heroin, Methadone, Suboxone, may result in discontinuation of Vivitrol Therapy, because these drugs may be lethal if taken while on Vivitrol.
- 17) I agree to allow my community provider to take monthly urine screens after my release from incarceration.
- 18) I agree to sign a Release of Information for: A contact person; and the community treatment provider offering follow-up treatment, so that RIDOC may inquire of my status after release.

19) I agree that violating any of these conditions is grounds for dismissal from participation in the Vivitrol Overdose Prevention Program.

20) I do hereby release and discharge the R.I. Department of Corrections, its respective employees, agents, servants, and their heirs, executors, administrators and successors of and from any and all actions, causes of action, claims and demands of whatever kind and nature which I now have or in the future may have for all losses and damages on account of or in any way related to my participation in the Vivitrol Overdose Prevention Program.

WARNING: IF I ATTEMPT TO SELF-ADMINISTER LARGE DOSES OF ALCOHOL, HEROIN OR ANY OTHER NARCOTIC WHILE ON VIVITROL, I MAY DIE OR SUSTAIN SERIOUS INJURY, INCLUDING COMA.

Patient's Signature

Date

I, the undersigned, have defined and fully explained the above information to this individual.

Medical Staff Signature

Date

APPENDIX VII
RELEASE OF INFORMATION FORM

RHODE ISLAND DEPARTMENT OF CORRECTIONS

Health Information Services
PO Box 8249
Cranston, Rhode Island 02920

Telephone: 401-462-3880
Fax: 401-462-2683

Authorization to Request/Release Health Care Information

Patient: _____ DOB: _____ Inmate ID# _____
Print Name

I hereby authorize: _____

To disclose to: _____ Attention: _____

The following information (be specific):

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Results | <input type="checkbox"/> X-ray Reports/EKGs |
| <input type="checkbox"/> Contact Notes/Physician Orders | <input type="checkbox"/> Consults | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> HIV Test/AIDS related information (RIGL 23-6-17) | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Drug/Alcohol abuse information (42 CFR Part 2) | | |

Covering the period from: _____ to: _____

Purpose of Disclosure: _____

I have read carefully and understand the above statements and voluntarily consent to disclosure of the above information (including alcohol and drug abuse records and/or HIV test, if relevant), to those persons/agencies named above. Information released with this authorization shall not be sold, transferred, or in any way given to any other person without first obtaining my additional written authorization. The Department of Corrections is not responsible for unauthorized re-disclosure by the designated recipient.

This authorization will have a duration of no longer than 90 days after the date on this form. I understand that I may revoke my permission at any time EXCEPT to the extent that action has been taken in reliance on it. If I wish to revoke this authorization, I will forward a request IN WRITING to the Medical Records Administrator at the above address.

Signature _____ Date: _____

If you are currently an inmate and want a copy of your RI DOC medical record – you must sign this voucher as an Authorization for payment from your inmate account
(Note: Unsigned vouchers will not processed – you will not receive your copies)

Fee Schedule: \$0.25 per page for the first one hundred (100) pages
0.10 per page for every page over one hundred (100)

Signature _____ Date: _____

Please note: As a health care provider, there are no funds available for photocopies received from community providers. Please call the number above prior to forwarding copies if you there is a cost associated with this service. Thank you.

Original – Medical Record
Inmate Accounts

Yellow – attach to copies
Gold – Patient (retain this copy for your personal use)

APPENDIX VIII

CRAVING SCALES

Use Scale: OPIATES (At time of Release)

Date: _____

Name: _____

Instructions: The following questions are designed to help you assess an important aspect of your recovery status: the urge to use opiates.

DURING THE PAST WEEK:

1. How often have you thought about using opiates or about how good using opiates would make you feel during the period?

- ☐ Never, that is, 0 times during this period of time.
- ☐ Rarely, that is 1 to 2 times during this period of time.
- ☐ Occasionally, that is, 3 to 4 times during this period of time.
- ☐ Sometimes, that is, 5 to 10 times during this period or 1 to 2 times a day.
- ☐ Often, that is, 11 to 20 times during this period or 2 to 3 times a day.
- ☐ Most of the time, that is, 20 to 40 times during the period this period or 3 to 6 times a day.

2. At its most severe point, how strong was your urge to use opiates during this period?

- ☐ None at all.
- ☐ Slight, that is, a very mild urge.
- ☐ Mild urge.
- ☐ Moderate urge.
- ☐ Strong urge but easily controlled.
- ☐ Strong urge and difficult to control.
- ☐ Strong urge and would have used opiates if it were available.

How much time have you spent thinking about using opiates or about how good using opiates would make you feel during this period?

- ☐ None at all.
- ☐ Less than 20 minutes.
- ☐ 21 to 45 minutes.
- ☐ 46 to 90 minutes.
- ☐ 90 minutes to 3 hours.
- ☐ Between 3 to 6 hours.
- ☐ More than 6 hours.

4. How difficult would it have been to resist using opiates during this period of time if you had known opiates were in your cell.

- ☐ Not difficult at all.
- ☐ Very mildly difficult.
- ☐ Mildly difficult.
- ☐ Moderately difficult.
- ☐ Very difficult.
- ☐ Extremely difficult.
- ☐ Would not be able to resist.

5. Keeping in mind you responses to the previous questions, please rate your overall average urge to use opiates during the past week.

- ☐ Never thought about using opiates and never had the urge to use opiates.
- ☐ Rarely thought about using opiates and rarely had the urge to use opiates.
- ☐ Occasionally thought about using opiates and occasionally had the urge to use opiates.
- ☐ Sometimes thought about using opiates and sometimes had the urge to use opiates.
- ☐ Often thought about using opiates and often had the urge to use opiates.
- ☐ Thought about using opiates most of the time and had the urge to use opiates most of the time.
- ☐ Thought about using opiates nearly all of the time and had the urge to use opiates nearly all of the time.

Name: _____

Date: _____

Instructions: The following questions are designed to help you assess an important aspect of your recovery status: the urge to drink alcohol.

Complete this form by thinking about the PAST WEEK and placing a check mark next to the response that is most true for you.

1. How often have you thought about drinking alcohol or about how good drinking alcohol would make you feel during the past week?
 - ☐ Never, that is, 0 times during this period of time.
 - ☐ Rarely, that is, 1 to 2 times during this period of time.
 - ☐ Occasionally, that is, 3 to 4 times during this period of time.
 - ☐ Sometimes, that is, 5 to 10 times during this period or 1 to 2 times a day.
 - ☐ Often, that is, 11 to 20 times during this period or 2 to 3 times a day.
 - ☐ Most of the time, that is, 20 to 40 times during the period this period or 3 to 6 times a day.
2. At its most severe point, how strong was your urge to drink alcohol during this period?
 - ☐ None at all.
 - ☐ Slight, that is, a very mild urge.
 - ☐ Mild urge.
 - ☐ Moderate urge.
 - ☐ Strong urge but easily controlled.
 - ☐ Strong urge and difficult to control.
 - ☐ Strong urge and would have used opiates if it were available.
3. How much time have you spent thinking about drinking alcohol or about how good drinking alcohol would make you feel during this period?
 - ☐ None at all.
 - ☐ Less than 20 minutes.
 - ☐ 21 to 45 minutes.
 - ☐ 46 to 90 minutes.
 - ☐ 90 minutes to 3 hours.
 - ☐ Between 3 to 6 hours.
 - ☐ More than 6 hours.
4. How difficult would it have been to resist drinking alcohol during this period of time if you had known alcohol was in your cell.
 - ☐ Not difficult at all.
 - ☐ Very mildly difficult.
 - ☐ Mildly difficult.
 - ☐ Moderately difficult.
 - ☐ Very difficult.
 - ☐ Extremely difficult.
 - ☐ Would not be able to resist.
5. Keeping in mind you responses to the previous questions, please rate your overall average urge to drink alcohol for the past week.
 - ☐ Never thought about drinking alcohol and never had the urge to drink alcohol.
 - ☐ Rarely thought about drinking alcohol and rarely had the urge to drink alcohol.
 - ☐ Occasionally thought about drinking alcohol and occasionally had the drink alcohol.
 - ☐ Sometimes thought about drinking alcohol and sometimes had the drink alcohol.
 - ☐ Often thought about drinking alcohol and often had the urge to drink alcohol.
 - ☐ Thought about drinking alcohol most of the time and had the urge to use drink alcohol most of the time.

me: _____

Date: _____

Instructions: The following questions are designed to help you assess an important aspect of your recovery status: the urge to drink alcohol.

Complete this form by thinking about the PAST WEEK and placing a check mark next to the response that is most true for you.

1. How often have you thought about drinking alcohol or about how good drinking alcohol would make you feel during the past week?

- ☐ Never, that is, 0 times during this period of time.
- ☐ Rarely, that is, 1 to 2 times during this period of time.
- ☐ Occasionally, that is, 3 to 4 times during this period of time.
- ☐ Sometimes, that is, 5 to 10 times during this period or 1 to 2 times a day.
- ☐ Often, that is, 11 to 20 times during this period or 2 to 3 times a day.
- ☐ Most of the time, that is, 20 to 40 times during the period this period or 3 to 6 times a day.

2. At its most severe point, how strong was your urge to drink alcohol during this period?

- ☐ None at all.
- ☐ Slight, that is, a very mild urge.
- ☐ Mild urge.
- ☐ Moderate urge.
- ☐ Strong urge but easily controlled.
- ☐ Strong urge and difficult to control.
- ☐ Strong urge and would have used opiates if it were available.

3. How much time have you spent thinking about drinking alcohol or about how good drinking alcohol would make you feel during this period?

- ☐ None at all.
- ☐ Less than 20 minutes.
- ☐ 21 to 45 minutes.
- ☐ 46 to 90 minutes.
- ☐ 90 minutes to 3 hours.
- ☐ Between 3 to 6 hours.
- ☐ More than 6 hours.

4. How difficult would it have been to resist drinking alcohol during this period of time if you had known alcohol was in your cell.

- ☐ Not difficult at all.
- ☐ Very mildly difficult.
- ☐ Mildly difficult.
- ☐ Moderately difficult.
- ☐ Very difficult.
- ☐ Extremely difficult.
- ☐ Would not be able to resist.

5. Keeping in mind your responses to the previous questions, please rate your overall average urge to drink alcohol for the past week.

- ☐ Never thought about drinking alcohol and never had the urge to drink alcohol.
- ☐ Rarely thought about drinking alcohol and rarely had the urge to drink alcohol.
- ☐ Occasionally thought about drinking alcohol and occasionally had the drink alcohol.
- ☐ Sometimes thought about drinking alcohol and sometimes had the drink alcohol.
- ☐ Often thought about drinking alcohol and often had the urge to drink alcohol.
- ☐ Thought about drinking alcohol most of the time and had the urge to use drink alcohol most of the time.
- ☐ Thought about drinking alcohol nearly all of the time and had the urge to drink alcohol nearly all of the

Use Scale-ALCOHOL (Post-Release)

Date: _____

Name: _____

Instructions: The following questions are designed to help you assess an important aspect of your recovery status: the urge to drink alcohol.

Complete this form by thinking about the PAST WEEK and placing a check mark next to the response that is most true for you.

1. How often have you thought about drinking alcohol or about how good drinking alcohol would make you feel during the past week?

- ☐ Never, that is, 0 times during this period of time.
- ☐ Rarely, that is, 1 to 2 times during this period of time.
- ☐ Occasionally, that is, 3 to 4 times during this period of time.
- ☐ Sometimes, that is, 5 to 10 times during this period or 1 to 2 times a day.
- ☐ Often, that is, 11 to 20 times during this period or 2 to 3 times a day.
- ☐ Most of the time, that is, 20 to 40 times during the period this period or 3 to 6 times a day.

2. At its most severe point, how strong was your urge to drink alcohol during this period?

- ☐ None at all.
- ☐ Slight, that is, a very mild urge.
- ☐ Mild urge.
- ☐ Moderate urge.
- ☐ Strong urge but easily controlled.
- ☐ Strong urge and difficult to control.
- ☐ Strong urge and would have used opiates if it were available.

How much time have you spent thinking about drinking alcohol or about how good drinking alcohol would make you feel during this period?

- ☐ None at all.
- ☐ Less than 20 minutes.
- ☐ 21 to 45 minutes.
- ☐ 46 to 90 minutes.
- ☐ 90 minutes to 3 hours.
- ☐ Between 3 to 6 hours.
- ☐ More than 6 hours.

4. How difficult would it have been to resist drinking alcohol during this period of time if you had known alcohol was in your cell.

- ☐ Not difficult at all.
- ☐ Very mildly difficult.
- ☐ Mildly difficult.
- ☐ Moderately difficult.
- ☐ Very difficult.
- ☐ Extremely difficult.
- ☐ Would not be able to resist.

5. Keeping in mind your responses to the previous questions, please rate your overall average urge to drink alcohol for the past week.

- ☐ Never thought about drinking alcohol and never had the urge to drink alcohol.
- ☐ Rarely thought about drinking alcohol and rarely had the urge to drink alcohol.
- ☐ Occasionally thought about drinking alcohol and occasionally had the drink alcohol.
- ☐ Sometimes thought about drinking alcohol and sometimes had the drink alcohol.
- ☐ Often thought about drinking alcohol and often had the urge to drink alcohol.
- ☐ Thought about drinking alcohol most of the time and had the urge to use drink alcohol most of the time.
- ☐ Thought about drinking alcohol nearly all of the time and had the urge to drink alcohol nearly all of the time.

Use Scale: OPIATES (Post Release)

Date: _____

Name: _____

Instructions: The following questions are designed to help you assess an important aspect of your recovery status: the urge to use opiates.

DURING THE PAST WEEK:

1. How often have you thought about using opiates or about how good using opiates would make you feel during the period?

- ☐ Never, that is, 0 times during this period of time.
- ☐ Rarely, that is 1 to 2 times during this period of time.
- ☐ Occasionally, that is, 3 to 4 times during this period of time.
- ☐ Sometimes, that is, 5 to 10 times during this period or 1 to 2 times a day.
- ☐ Often, that is, 11 to 20 times during this period or 2 to 3 times a day.
- ☐ Most of the time, that is, 20 to 40 times during the period this period or 3 to 6 times a day.

2. At its most severe point, how strong was your urge to use opiates during this period?

- ☐ None at all.
- ☐ Slight, that is, a very mild urge.
- ☐ Mild urge.
- ☐ Moderate urge.
- ☐ Strong urge but easily controlled.
- ☐ Strong urge and difficult to control.
- ☐ Strong urge and would have used opiates if it were available.

How much time have you spent thinking about using opiates or about how good using opiates would make you feel during this period?

- ☐ None at all.
- ☐ Less than 20 minutes.
- ☐ 21 to 45 minutes.
- ☐ 46 to 90 minutes.
- ☐ 90 minutes to 3 hours.
- ☐ Between 3 to 6 hours.
- ☐ More than 6 hours.

4. How difficult would it have been to resist using opiates during this period of time if you had known opiates were in your cell.

- ☐ Not difficult at all.
- ☐ Very mildly difficult.
- ☐ Mildly difficult.
- ☐ Moderately difficult.
- ☐ Very difficult.
- ☐ Extremely difficult.
- ☐ Would not be able to resist.

5. Keeping in mind your responses to the previous questions, please rate your overall average urge to use opiates during the past week.

- ☐ Never thought about using opiates and never had the urge to use opiates.
- ☐ Rarely thought about using opiates and rarely had the urge to use opiates.
- ☐ Occasionally thought about using opiates and occasionally had the urge to use opiates.
- ☐ Sometimes thought about using opiates and sometimes had the urge to use opiates.
- ☐ Often thought about using opiates and often had the urge to use opiates.
- ☐ Thought about using opiates most of the time and had the urge to use opiates most of the time.
- ☐ Thought about using opiates nearly all of the time and had the urge to use opiates nearly all of the time.

APPENDIX IX
REFERRAL TO MEDICAL SERVICES FORM



RHODE ISLAND DEPARTMENT OF CORRECTIONS

HEALTH CARE SERVICES

PO Box 8249

Cranston, Rhode Island 02920

Telephone: 401-462-2678

Fax: 401-462-2000

Patient Name:

D.O.B. / /

Facility:

ID#:

MEDICAL REFERRAL FORM

TO: Dr. Jennifer Clarke

FROM:

DATE:

The individual referenced above has completed the initial psychosocial assessment for participation in the Vivitrol Relapse Prevention Program. I am now referring him/her to you for the completion of his/her medical assessment and final approval for participation.

Please let me know if he/she is approved. Thank you.

TPC Clinician Signature

Date

Email Address

Phone Number

Discharge Planner (if known): _____

APPENDIX X

VERIFICATION OF PARTICIPATION LETTER



RHODE ISLAND DEPARTMENT OF CORRECTIONS

HEALTH CARE SERVICES

PO Box 8249

Cranston, Rhode Island 02920

Telephone: 401-462-2678

Fax: 401-462-2000

Dear Health Care Provider:

I am writing to confirm that _____
Name Date of Birth

Facility: _____ ID#: _____

is a participant in the Vivitrol Relapse Prevention Program at the Rhode Island
Department of Corrections. He/She received the first injection of Vivitrol
on _____
Date

He/She will be receiving follow up services at _____
Name of Agency

If you need further information please contact Dr. Jennifer Clarke, Medical Program
Director at 462-2678.

Practitioner's Name Date

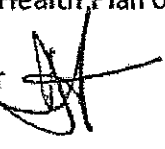
APPENDIX XI

EOHHS LETTER TO INSURANCE PROVIDERS



MEMORANDUM

TO: Patrice Cooper, UnitedHealthcare Community Plan
Peter Marino, Neighborhood Health Plan of Rhode Island

FROM: Deborah Florio, Administrator 

CC: Kristin Sousa
Marlanea Peabody
Joan Pillsbury

DATE: January 7, 2015

RE: Vivitrol Relapse Prevention Program

Background: The Department of Corrections (DOC) has partnered with the department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) to institute the Vivitrol Relapse Prevention Program (VRPP) in which the DOC will provide Vivitrol to participating individuals prior to their release.

Clarification: Due to the proven efficacy of Vivitrol, and the potential for relapse and overdose if treatment is discontinued, EOHHS is requesting that Neighborhood Health Plan (NHP) and UnitedHealthcare (UHC) exempt members who are participating in the Vivitrol Relapse Prevention Program from all PA requirements currently in place for Vivitrol. A Physician attestation of an individual's participation in the VRPP program shall serve as the basis for ongoing authorization.

Questions regarding this benefit clarification should be directed to your Health Plan Liaison. Contact information is included below:

NHPRI:	Joan Pillsbury	401-462-3516	joan.pillsbury@ohhs.ri.gov
	Kristin Sousa	401-462-2395	kristin.sousa@ohhs.ri.gov
UHCP-RI:	Marlanea Peabody	401-462-3521	marlanea.peabody@ohhs.ri.gov