Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons

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Putting policy ideas into practice

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Acronyms used throughout this report.

ACEP – American College of Emergency Physicians

ACA – American Correctional Association

ASAM – American Society of Addiction Medicine

BJA – Bureau of Justice Assistance

CMS – Centers for Medicare & Medicaid Services

COWS – Clinical Opiate Withdrawal Scale

CARF – Commission on Accreditation of Rehabilitation Facilities

DSM-V – Diagnostic and Statistical Manual of Mental Disorders – 5th Edition

FDA – Food and Drug Administration

IOP – Intensive Outpatient Program

MOUD – Medications for Opioid Use Disorder

NCCHC – National Commission on Correctional Health Care

NSA – National Sherrifs' Association

OBOT – Office-Based Opioid Treatment

OTP – Opioid Treatment Program

OUD – Opioid Use Disorder

SAMHSA – Substance Abuse and Mental Health Services Administration

SUD – Substance Use Disorder

EXECUTIVE SUMMARY

The unprecedented and growing rates of overdose deaths in the U.S. have brought new attention to policies that would increase access to opioid use disorder (OUD) services; in particular, medications for OUD (MOUD) for individuals who are incarcerated. Nationally, overdose deaths more than doubled since 2015.[1] Individuals with a substance use disorder (SUD), including OUD, are involved with the criminal legal system and incarcerated at high rates.[2] Overdose deaths of individuals in jails and prisons have increased dramatically and individuals recently released from jail or prison are at extremely high risk of dying from an overdose.[3,4,5,6,7]

People with OUD who are incarcerated could greatly benefit from treatment with MOUD, but historically, very few receive it.[8,9,10,11] Allowing Medicaid to cover OUD services provided in prisons and jails could expand access to OUD services for individuals who are incarcerated.[12] Historically, financing of health care services in prisons and jails has been a state and local responsibility. Despite its central role in covering health care services for low-income people in the U.S., Medicaid has been barred from covering services in prisons and jails except for inpatient hospital stays. Federal Medicaid policy is now evolving, and state Medicaid programs may, through waivers of federal law, cover some services, including OUD services, in prisons and jails in the period immediately prior to an individual's release.[13] In addition, some state and federal policymakers have proposed going beyond the pre-release period to authorize Medicaid to cover MOUD or a broader set of health care services during the entirety of a prison or jail stay.

Medicaid's financing power and accompanying programmatic standards would advance access to evidence-based OUD services in prisons and jails and improve health outcomes for people with OUD. Doing this successfully requires developing a set of services and standards of care for Medicaid coverage of OUD services in prisons and jails, comparable to standards for Medicaid-covered OUD services in the community. This report recommends such a set of services and standards, with the programmatic standards presented in two types: (1) standards that jails and prisons *are required* to provide to qualify for Medicaid coverage, and (2) standards that jails and prisons *should have but are not required to have* to qualify for Medicaid coverage. These were developed to advance quality, evidence-based OUD services in prisons and jails and could be applied if federal Medicaid policy changes to allow the program to cover OUD services to Medicaid beneficiaries during incarceration.

These recommendations were developed by reviewing existing evidence-based programmatic standards developed by national organizations that guide the delivery of community and carceral OUD services, including Medicaid policies for community OUD services. The development of these standards also considered the specific circumstances of correctional settings that do not pertain to community settings, such as security concerns, high population turnover rates, and substantial organizational variation. The recommended services and standards aim to advance timely, evidence-based, person-centered OUD services that promote continuity of care; leverage Medicaid as a new financing source to drive significant improvements in access to and quality of OUD services in prisons and jails; reduce spending in other parts of the health and criminal legal systems; and advance progress on national health and public safety goals. Developed in 2023, they use current evidence-based standards which may evolve and be updated.

This report is intended to inform a wide range of health and criminal justice policymakers and stakeholders. The primary audience is state Medicaid program administrators and administrators who oversee health service provision in prisons and jails. If Medicaid's role were changed to allow states to cover OUD services, including MOUD, in prison and jail throughout an individual's incarceration the recommendations in this report could be

used by state Medicaid agencies to make decisions with their state and local correctional counterparts about what services will be financed by Medicaid in jails and prisons and what programmatic standards they will meet. These recommendations can also be used to inform services provided during shorter time periods, such as the period immediately prior to an individual's release from prison or jail, although they were not developed for that purpose and would require adaptation and modification. Additional audiences for this report are federal and state policymakers, health care providers and community-based organizations, Medicaid managed care organizations, advocates, and people with direct experience of incarceration and OUD.

OVERVIEW OF METHODS AND RECOMMENDATIONS

The overall approach was to develop services and programmatic standards for the entirety of an individual's incarceration that are comparable to those in the community, currently covered by Medicaid, while taking into account the uniquely challenging circumstances that affect the provision of health care services in jails and prisons.

Summary of Methods

To develop standards that advance correctional standards of care and recognize and account for the unique characteristics of correctional health care services, recommendation development was guided by three principles for effective OUD service provision in jails and prisons: (1) continuity of care, (2) timeliness of treatment, and (3) person-centered care. Methods are described in detail in Appendix A. Briefly, existing standards for correctional and community OUD care were identified and compared. Existing standards reviewed for this report were developed by national organizations that provide guidance including the American College of Emergency Physicians (ACEP), American Correctional Association (ACA), American Society of Addiction Medicine (ASAM), Bureau of Justice Assistance (BJA), Commission on Accreditation of Rehabilitation Facilities (CARF), National Commission on Correctional Health Care (NCCHC), and Substance Abuse and Mental Health Services Administration (SAMHSA). National standards were supplemented with position papers that provided recommendations for policymakers and providers for implementing services in jails and prisons. In addition, recommendations were informed by a review of Medicaid policy pertaining to community OUD services. Lastly, operational considerations that influence the provision of OUD services in jails and prisons, discussed in this report's background section, were assessed and integrated into draft recommendations.

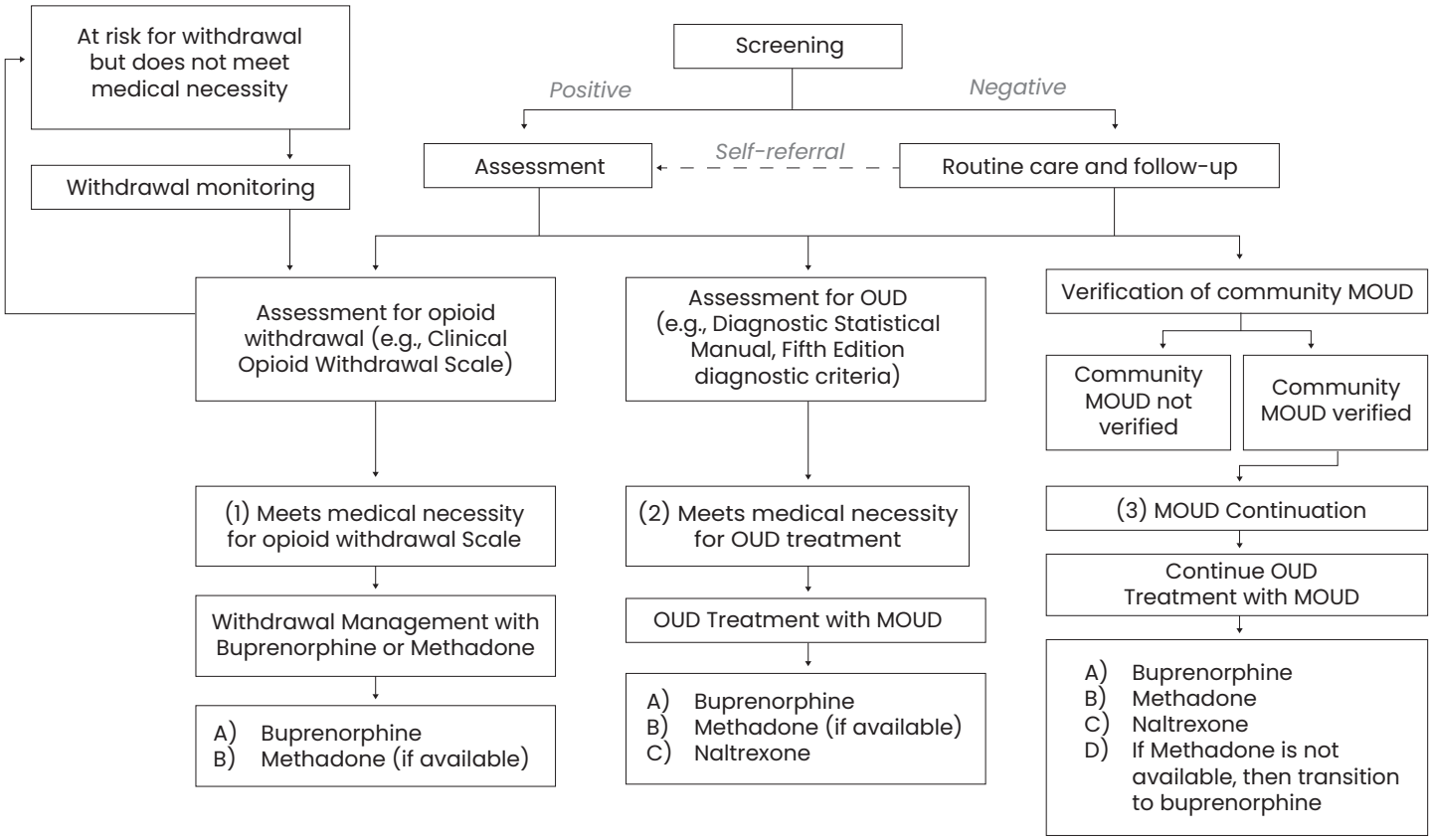
Draft recommendations were reviewed an advisory council that included individuals with direct experience providing SUD services in correctional environments, individuals with lived experience of having had SUD and been incarcerated, and payers including former Medicaid directors and Medicaid managed care executives who administered OUD services for Medicaid beneficiaries. Revised recommendations were then reviewed with two external experts in the provision of OUD services in jails and prisons. See Appendix B for members of the advisory council and external reviewers.

Summary of Recommendations

Recommendations address five specific categories of OUD services for people who are incarcerated. They are:

- OUD Screening
- OUD Assessment
- MOUD Initiation and Continuation
- Counseling and Intensive Outpatient Care
- Reentry Services

Figure 1: Flowchart of three pathways for receiving MOUD in jails and prisons*



* Individuals with opioid withdrawal and/or OUD may receive adjunctive behavioral health services, such as counseling, and individuals who are pregnant require MOUD to be managed by a provider with training in treatment of OUD in pregnancy.

Throughout these five categories of services, recommendations address the specific needs of people who are experiencing withdrawal or are at risk of withdrawal. The report also addresses issues that cut across these five service categories in a separate, sixth category, "Other Service-Related Issues".

Except for reentry services, these service categories are generally available to people who receive OUD services in the community and are sometimes offered in jails and prisons. The specific circumstances of jails and prisons, however, may make it difficult for them to offer all services. For that reason, the services are presented in two groups - "required" or "optional" - as outlined in Table 1. For this report, "required" services are defined as those that jails and prisons be required to provide for Medicaid to cover OUD services within that facility. "Optional" services are those that jails and prisons have the option to provide but are not required to provide for Medicaid to cover

Table 1: Recommended Medicaid-Covered OUD Services in Jails and Prisons

Required	• Screening • Clinical Assessment • MOUD Initiation for Opioid Withdrawal • MOUD Initiation for OUD • MOUD Continuation • Reentry Services
Optional Services *(Not Required)*	• Multidimensional Assessment • Counseling • Intensive Outpatient

OUD services within that facility. Within each service are programmatic standards that are also presented in two groups:

1. Standards that jails and prisons should be required to meet to qualify for Medicaid coverage
2. Standards that jails and prisons should meet, but are not required to meet to qualify for Medicaid coverage

For a jail or prison to receive Medicaid reimbursement for OUD services, the facility should provide required services and meet all required service standards. A jail or prison that meets these requirements could, at the option of the facility and the state Medicaid agency, also receive Medicaid reimbursement for "optional" services and for standards that are not required but that they opt to provide.

The overall goal of differentiating between "required" and "optional" services is to prioritize timely MOUD initiation and continuation and promote continuity of care after release. MOUD has been demonstrated to reduce opioid use, reduce risk of overdose, and improve mortality among people who have OUD.[14] Therefore, Medicaid coverage of MOUD services should be required. However, although outpatient behavioral health therapies are standard of care in community settings, there is limited evidence that they improve clinical outcomes for people with OUD, and requiring them might pose significant burden on carceral facilities without commensurate increases in positive outcomes for patients.[15,16,17] In addition, outpatient behavioral health therapies are adjunctive to MOUD and not required for MOUD initiation or continuation. Outpatient behavioral health services and therapies that are provided in the community setting include multidimensional assessments, counseling, and intensive outpatient. These services were recommended as "optional" services to be consistent with community settings. They are not recommended requirements because these services do not prioritize MOUD initiation or continuation.

Designating a set of required services to be provided in prisons and jails is similar to requirements that pertain to federally qualified health centers and certified community behavioral health centers, which are required to provide a set of services. This is especially important to ensuring MOUD access in prisons and jails because people who do not receive a specific service are unlikely to have either autonomy to seek such services or an alternative venue in which to receive it. In this way, health care service provision in jails and prisons fundamentally differs from community service provision.

For each of these services, there are specific recommended standards that Medicaid agencies can apply to advance access to evidence-based OUD services that promote continuity of care, timely access to care, and person-centeredness.

For each category of service, the recommended standards address:

Who receives the service?

- Defines criteria jails and prisons can apply to identify individuals to receive the service.
- Establishes clinical criteria that Medicaid agencies can use to define medical necessity for individuals to receive services.

What is included in the service?

- Defines the components and processes of the service.
- Provides Medicaid agencies with standards to set for jails and prisons to be reimbursed for that service.

When should the service be rendered?

- Defines expected timeframes for individuals to access services in a timely manner.
- Provides guidance to jails and prisons on when services should be provided to ensure individuals receive services that meet their medical needs.

Who should provide the service?

- Defines provider types, credentialing, and licensing requirements for service delivery.
- Identifies roles, expectations, and training to ensure providers have the background and competencies for providing that service.

Underlying this report's recommendations is an assumption and goal that OUD services provided in jails and prisons should be provided in accordance with clinical best practice standards established by national organizations. These standards have been developed to drive clinical decisions about who receives OUD care regardless of setting. In jails and prisons, correctional needs can limit the extent to which clinical decision-making can be applied. In accordance with clinical practice, the availability of OUD treatment in jails and prisons should not be a reason to prolong a person's prison or jail stay, and jail and prison is not a preferred treatment setting. Community OUD services should be available and accessible to all people who need them and have the potential to reduce individuals' involvement in the justice system.[18]

This report focuses specifically on developing OUD services and standards. In jails and prisons, as in the community, OUD services are provided alongside other health and behavioral health services. The authors recognize that reality, but developing recommendations for the broader range of other correctional health and behavioral health services was beyond the scope of this report. Additionally, this report focuses specifically on jails and prisons that incarcerate adults. It did not examine the role of other criminal legal entities, such as the courts, probation and parole entities, or juvenile justice facilities, although these entities will all play roles in implementing any new OUD policies.

SECTION 1: BACKGROUND

This section offers context for the recommendations made in this report. It provides background information on how jails and prisons generally provide health care services; the prevalence of OUD and access to OUD treatment in prisons and jails; Medicaid and its coverage of OUD services in the community; Medicaid policy regarding coverage of services provided in jails and prisons; and the role that services and program standards play in Medicaid coverage.

Prisons, Jails and Health Care Services

The nation's system of incarceration is diverse, complex, and fragmented. As of year-end 2021, there were 1.2 million people incarcerated in prisons and 636,000 people incarcerated in jails.[19] Jails are generally a person's initial entry point into the criminal justice system, and from July 1, 2020, to June 30, 2020, there were 6.9 million jail admissions.[20] There are nearly 2,000 state and federal prisons in the U.S., and more than 3,000 local jails.[21] Jails are run locally and incarcerate people awaiting trial or who have been convicted and typically serve sentences of less than a year. Some people are in jail for more than a year while others may be there for just a few hours.[22] Prisons incarcerate people convicted of crimes and who serve sentences of typically more than a year. Roughly half of the jail population turns over each week and release dates are unpredictable.[23] Following release from prisons and jails, many people are under community supervision through probation or parole.

Historically, financing and administering health care services in state prisons and local jails has been a state and local responsibility, except for federal prisons, which are federally funded and administered. Jails and prisons have a constitutional obligation to provide health care services.[24] But the scope and quality of health care services in jails and prisons varies widely, reflecting variation in state and local laws, resource commitments, policy priorities, facility size, and organizational structures. Modes of health care delivery in jails and prisons vary as well. Jails and prisons may employ health care providers, contract with private vendors or contract with community health care providers such as hospitals to provide on-site care. The number and type of staff employed to deliver health care in jails and prisons also varies. Some small jails have very few staff with no full-time clinicians on site. Health insurance coverage plays a very small role in paying for services in jails and prisons, especially relative to the role it plays in community settings.[25] Historically, federal policy has only allowed Medicaid to cover inpatient hospitalizations of individuals who are incarcerated.

Providing health care services in jails and prisons entails addressing a range of circumstances that rarely present in community settings, including the need to ensure facility security, respond to unpredictable circumstances, and limitations on physical space that can challenge the delivery of clinical services and privacy. The cycling of individuals in prisons and particularly in jails, coupled with an inconsistent approach to providing health care across those settings, makes it particularly challenging to design and implement a robust set of OUD services for incarcerated individuals. Historically, health care services in jails and prisons have been walled off from community health care services, with little communication between them, although prison, jail, and community providers serve many of the same people at different points of their lives. From the perspective of a person who is incarcerated, the extent to which one's health care needs are met during incarceration depends primarily on the capabilities of and services provided by the facility. Individuals who are incarcerated have no autonomy and ability to obtain health care services through other providers outside of the facility in which they are incarcerated.

Opioid Use Disorder and OUD Services in Prisons and Jails

Individuals who are incarcerated have a much higher prevalence of SUD, including OUD, compared to the general population. Based on data from the Bureau of Justice Statistics, between 2007 to 2009, an estimated 58% of state prisoners and 63% of sentenced jail inmates met criteria for SUD and 17% of state prisoners and 19% of sentenced jail inmates regularly used opioids.[26] More recently, in June 2019 an estimated 64% of individuals entering jail received screening for OUD and 15% screened positive for OUD.[27] Between 2010 and 2018, the number of people who died of an overdose in state prisons rose by more than 500%.[28] In county jails, overdose deaths increased by more than 200%.[29] In addition, studies of some jurisdictions have shown that overdose deaths account for over 70% of all deaths during the first two weeks following release from prison or jail.[30,31] One analysis found that nearly a third of fatal overdoses that occurred in Minnesota from 2015 to 2016 were among people with criminal justice involvement in the past year.[32] People who are incarcerated also have a range of other health needs, including higher rates of chronic conditions, infectious disease, and mental illness.[33,34]

Nationally, efforts to address overdose deaths and to expand OUD treatment tend to prioritize community settings and focus on providing access to MOUD, specifically methadone, buprenorphine, and naltrexone, which have proven to effectively reduce opioid use and retain individuals in OUD care.[35,36] Randomized control trials, the gold standard for demonstrating clinical efficacy, have found that methadone, extended-release injectable naltrexone, and buprenorphine are effective in reducing illicit opioid use.[37] In addition, methadone and buprenorphine have been shown to reduce risk of overdose death.[38,39] However, there is a lack of evidence that naltrexone reduces risk of death associated with opioid use.[40] All three medications are approved by the Food and Drug Administration (FDA) for OUD treatment, and buprenorphine and methadone are approved for the treatment of opioid withdrawal.[41] Hereafter, MOUD refers to all three FDA-approved medications (buprenorphine, methadone, naltrexone) unless otherwise stated.

Despite the high prevalence of OUD in prisons and jails and the evidence of MOUD's effectiveness, MOUD is rarely offered in jails and prisons.[42,43,44,45] It has been estimated that about 12% of correctional facilities in the U.S. offer any form of MOUD and that only a fraction of the overall population of people who are incarcerated receive such treatment.[46,47] These unmet correctional and reentry health needs are concerning given the high incarceration rates in the U.S. in general; and since people of color and people who are poor in the U.S. have disproportionately high rates of incarceration, this large treatment gap disproportionately affects them.[48,49] Providing evidence-based MOUD treatment for people with OUD while they are incarcerated and once they are released can be lifesaving and may help mitigate racial inequities in the health and criminal legal systems.

Expanded MOUD in prisons and jails has the potential to increase access to MOUD for people who would benefit from it but are presently unlikely to receive it. The treatment can help improve the health and mental health outcomes of people who are incarcerated, many of whom have co-occurring physical and/or mental health conditions. Ensuring timely receipt of correctional OUD services, including MOUD, has been associated with decreased deaths due to suicide, overdose, accidental injury, and violence within correctional facilities.[50] Thus, MOUD may also advance safety within prisons and jails and reduce potential disciplinary problems.[51]

People who would benefit from greater access to evidence-based MOUD in prisons and jails fall into three groups:

- People with OUD who could benefit from MOUD but have not been able to access it.

- People who are currently using opioids and would experience opioid withdrawal symptoms, ranging from mild physical discomfort to life-threatening seizures and cardiovascular collapse, upon entering incarceration if they didn't receive buprenorphine or methadone.
- People with OUD who are receiving MOUD in the community and would continue to receive these medications when they are incarcerated rather than abruptly discontinuing them upon admission, which could precipitate withdrawal.

Medicaid and Its Emerging Role in Advancing OUD Services in Prisons and Jails

Federal, state, and local governments increasingly recognize the need to address overdoses and overdose deaths within jails and prisons and during reentry. One way of advancing provision of OUD services, including MOUD, in jails and prisons would be to allow Medicaid to cover them for eligible incarcerated individuals. This would require the federal government to make significant policy changes, some of which have recently been set in motion.

Medicaid finances health and behavioral health services, including MOUD, for community-residing low-income adults, children, people with disabilities, seniors, and pregnant women. As of May 2023, Medicaid covered over 85 million people in the U.S.[52] All but 10 states have adopted the Medicaid expansion of coverage to low-income adults established in the 2010 Affordable Care Act.[53] State and federal Medicaid spending totaled $728 billion in fiscal year 2021.[54] The federal government provides most Medicaid funding and matches state spending on services in accordance with federal standards. Federal matching rates vary by state, and in some cases by population and service. Medicaid has significant purchasing power, as it accounts for more than one out of every six dollars spent in the U.S. health system.[55] States are required to cover some populations and services; others are optional for states. State Medicaid agencies can determine specific programmatic policies, including eligibility, covered benefits, provider selection and provider payment, and delivery systems (e.g., use of managed care organizations) within federal standards. State Medicaid agencies are accountable for and oversee the services the program covers.

Many individuals in jails and prisons have low incomes and are eligible for Medicaid. There are no national estimates of how many people who are incarcerated are Medicaid-eligible, but 80-90% of state prison inmates have been estimated as being likely eligible for Medicaid in some Medicaid expansion states.[56] However, while people who are incarcerated remain eligible for Medicaid, there is a long-standing statutory bar called the "inmate exclusion," which prevents Medicaid from covering services other than inpatient hospital stays when people are incarcerated.[57] Congress established this exclusion when it created Medicaid in 1965, and the exclusion is regarded as having been intended to prevent the federal government from supplanting a significant state and local financial obligation. In recent years, as attention to the health needs of people who experience incarceration has increased, some in Congress have advanced proposals to amend or remove the inmate exclusion. As of July 2023, these proposals had not been enacted, except for changes enacted in 2022 that require Medicaid to cover care coordination services to youth prior to release, and to allow states the option to cover services to youth who are incarcerated prior to the courts adjudicating their cases.[58]

In the meantime, some administrative changes to the inmate exclusion have started taking place. The Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicaid, issued guidance in April 2023 that encourages states to increase continuity of care for people who are leaving prison, jail, or youth

detention by providing targeted services to people in the period immediately before they are released from jail or prison.[59] States can do this by seeking demonstration waivers. Under section 1115 of the Social Security Act, CMS can waive some federal requirements so that states can test Medicaid approaches to the extent that the demonstration promotes the objectives of the Medicaid program. The CMS guidance allows states to waive part of the inmate exclusion to provide some services during a period of up to 90 days prior to an individual's release from prison or jail. The guidance sets high-level policy, as well as a few specific operational requirements that support the policy. In January 2023, CMS approved the first 1115 Medicaid reentry waiver, allowing California to provide under Medicaid a limited set of health and SUD services, including MOUD, for individuals up to 90 days before reentry.[60] In June 2023, a second reentry waiver, proposed by Washington state, was approved, with policies similar to those that CMS authorized in California.[61]

Some notable aspects of the new pre-release policy guidance and approved waivers are:

- States taking up the waiver option to provide pre-release services must provide case management, MOUD, and a 30-day supply of medications at release. States may offer additional services above this benefits floor.
- CMS expects states and carceral facilities that provide Medicaid-covered pre-release services to make active efforts to ensure that all eligible beneficiaries are enrolled in Medicaid.
- States with pre-release service waivers are expected to suspend, rather than terminate, eligibility, when someone is incarcerated. This, and timely enrollment, can promote seamless access to care for beneficiaries with OUD and improve continuity of care at release.
- States have the option to determine which jails and prisons participate and whether correctional or community providers provide pre-release services.
- Longstanding provisions of federal law that require beneficiaries to be offered a choice of health care provider do not apply.
- States are required to reinvest any state and local funds to ensure that new federal Medicaid funds do not supplant existing state and local spending, but instead increase quality and access to care.
- States may seek temporary federal financial support for some of the costs associated with implementing new services in prisons and jails.

As of August 2023, another 14 states have proposed similar changes for Medicaid beneficiaries who are incarcerated. Nearly all these proposals seek to cover OUD services. Most of these proposals focus exclusively on the immediate pre-release period. However, Kentucky's Medicaid program seeks to use waiver authority to cover SUD services (including MOUD) for all people who are incarcerated who qualify for Medicaid and does not propose to limit the availability of these services to the pre-release period.[62]

Whether new Medicaid policies apply only in the pre-release period, as CMS's recent policy allows, or for the entirety of a prison or jail stay, which is the approach that this report explores, they provide a new opportunity to expand access to health services, including MOUD, for people incarcerated in jails or prisons and to begin building a system of care that provide services during incarceration and following release, strengthening continuity of care and services for people with SUD, among other health conditions.

The Medicaid OUD services and standards recommended in this report are intended to apply during the full continuum of someone's jail or prison incarceration. They can inform consideration of future policies that may authorize Medicaid-covered OUD services during an entire jail or prison incarceration. These standards were not developed specifically to apply during the pre-release period. Although not specifically discussed in this report, applying

the policy parameters that CMS established in its pre-release services waiver policy, summarized above, could support effective OUD service provision in carceral settings, consistent with this report's recommendations.

The Role of Service Standards in State Decisions about Services and Service Delivery

Implementing effective, Medicaid-covered, evidence-based OUD services in jails and prisons requires identifying services and programmatic standards informed by policies that exist for Medicaid beneficiaries in their communities. If Medicaid covers services provided in prisons and jails, these service standards should leverage Medicaid financing to advance a community standard of care, which has not historically been the standard expected of prisons and jails. As noted, the type, scope, quality, and delivery of health care services in prisons and jails vary widely, and there is limited transparency about service provision.[63] At the same time, the specific operational, legal, security, and other constraints of prison and jail settings also need to be recognized in developing standards.

State Medicaid agencies will face several decision points throughout the process of developing specific programmatic standards for Medicaid beneficiaries with OUD in jails and prisons. First, state Medicaid agencies will need to decide which services should be provided to individuals who are Medicaid-eligible and incarcerated. Some of these decisions will be driven by existing Medicaid and other federal requirements. For example, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act requires that state Medicaid programs cover MOUD, including all drugs approved by the FDA (methadone, buprenorphine, naltrexone).[64] This requirement sunsets in September 2025 but may be extended by Congress. More recently, the Department of Justice has identified people with OUD as protected from discrimination under the Americans with Disabilities Act (ADA), which applies to prisons and jails.[65] In addition, there are statewide and facility-specific lawsuits in eight states that require jails and prisons to offer MOUD.[66] These recommendations were developed to pertain to Medicaid coverage and payment standards; they do not pertain to or interpret civil rights or other legal obligations on the part of correctional facilities.

Second, states will need to decide if and how programmatic standards will reflect the differences between jails and prisons. While various OUD services should be available in any adult correctional facility, jails' and prisons' goals and operations characteristics vary widely. This will impact the ability of each type of facility to offer various services effectively. For instance, jails on average have shorter stays compared to prisons. Individuals may be quickly released, often with little preparation time. Jails can help identify individuals with OUD (through screening and assessment) and offer them initial treatment, such as MOUD, before release or transition to a prison. In this respect, jails can be thought of as playing a similar role to that of hospital emergency departments - they address acute conditions address acute conditions, stabilize those conditions, and for individuals with OUD, initiate MOUD treatment, and then quickly hand off an individual's OUD care to a community-based provider.

On the other hand, prisons incarcerate individuals convicted of felonies and, as such, have much longer sentences and generally known release dates. In addition, individuals may enter prisons directly from the community in some instances (e.g., violations of parole) although most are transferred from a jail. Given the difference in the expected length of stay, prisons will likely be better-resourced and offer more OUD services than jails. Within prisons and jails, there is variation in size and service capacity, and states will also need to decide whether Medicaid covered OUD services are offered in all jails and

prisons, or just some of them, and what impact those decisions will have on access, outcomes, effectiveness, and facility operations.

A third decision point is if and how states' current policies regarding Medicaid-covered OUD services in the community will apply to Medicaid enrolled individuals in jails and prisons. Medicaid coverage of OUD is established through various mechanisms and authorities. The Affordable Care Act and Mental Health Parity Equity and Addiction Treatment Equity Act expanded mental health and SUD benefits, making them available to far more people. The SUPPORT Act, as previously noted, expanded access to MOUD services. In addition, 35 states have taken an additional step to expand access to OUD services through an 1115 waiver opportunity created by CMS in 2015 to cover a continuum of OUD services that includes residential treatment, which Medicaid has historically not covered.[67] These policies, and perhaps especially the 1115 waiver policies, set the policy parameters for Medicaid-covered community OUD services.

New policies in California, as part of their pre-release services waiver that CMS approved in January 2023, illustrate the types of decisions states will need to make in expanding access to OUD services in jails and prisons. California jails and prisons will be able to cover screening, assessment, and all three MOUD medications, in addition to pre-release and post-release services, to support the continuity of OUD care. Pre-release and post-release services include reentry case management, physical and behavioral health clinical consultation (to diagnose, provide treatment, and support post-release planning), MOUD, and other health care services.

To authorize and operationalize any policy changes, states will need to include a description of the changes in their Medicaid State Plan, which CMS approves, or other Medicaid authorities (e.g., Research and Demonstration 1115 Waivers). These descriptions generally include 1) high-level description of the service, 2) the organizations or staff that will deliver the service, and 3) a reimbursement strategy for each service. CMS has also provided guidance and information to state Medicaid agencies regarding behavioral health benefits over the past decade, specifically focusing on SUD and OUD services.[68]

States will also develop specific guidance, or service standards, for participating providers regarding how each service will be provided and to whom. States often develop provider manuals offering more detail on the specific activities that comprise the service, establish who can provide the service, and establish specific instructions for providers when seeking Medicaid reimbursement for these services. They also give organizations and practitioners detailed information that serves as a foundation for developing training, technical assistance, supervision, and monitoring and audit strategies to ensure uniformity and quality for service delivery. The following recommendations are a resource to states navigating these decision points and looking to implement effective, Medicaid-covered evidence-based OUD services in jails and prisons (Table 2).

SECTION 2: RECOMMENDATIONS FOR STANDARDS OF OUD SCREENING

Table 2: Summary of Recommendations for Standards of Opioid Withdrawal and OUD Screening in Jails and Prisons

Recommendations	
What is screening for opioid withdrawal and OUD and why is it important?	
Recommendation 2.1.A:	Jails and prisons are required to provide screening for OUD and opioid withdrawal.
Who receives Screening?	
Recommendation 2.2.A:	Jails and prisons are required to provide screening for OUD and opioid withdrawal to all individuals as part of their intake process.
Recommendation 2.2.B:	Jails and prisons should provide access to screening for OUD and opioid withdrawal to individuals as needed throughout their incarceration but are not required to.
What is included in the screening?	
Recommendation 2.3.A:	Jails and prisons are required to use validated screening instruments for opioid withdrawal and OUD.
Recommendation 2.3.B:	Jails and prisons are required to screen for current substance use, history of SUD treatment, opioid use, opioid withdrawal risk, pregnancy, mental health, and need for urgent or emergent services.
Recommendation 2.3.C:	Jails and prisons are required to provide structured observations as part of screening to identify individuals who do not participate in screening instruments but may benefit from MOUD.
When should screening occur?	
Recommendation 2.4.A:	Jails and prisons are required to provide screening for opioid withdrawal and OUD as part of the intake process and the screening should occur within four hours of arrival.
Recommendation 2.4.B:	Jails and prisons should provide screening for opioid withdrawal and OUD throughout an individual's incarceration but are not required to.
Who should provide screening?	
Recommendation 2.5.A:	Jails and prisons are required to ensure that screening services are required to be performed by qualified health care personnel and health care-trained correctional personnel.

1. What is screening for opioid withdrawal and OUD and why is it important?

Jails and prisons conduct screenings at intake to identify individuals with health conditions that need immediate attention and/or follow-up. For example, a person with diabetes who needs to take insulin regularly. Screening for OUD and opioid withdrawal in the correctional setting is fundamental to identifying individuals who may benefit from OUD services, including MOUD, or who may have emergent/urgent conditions related to OUD that need to be addressed before

they can receive MOUD. Screening for OUD and opioid withdrawal should be conducted as part of the intake process, incorporated into existing screening procedures, and not be conducted as a stand-alone activity. BJA, ASAM, SAMHSA, and CARF provide standards for OUD screening. Screening for OUD and opioid withdrawal provides early identification of:

- Whether an individual was receiving MOUD before incarceration to ensure continuity of OUD medication
- Whether an individual is actively using opioids (and other substances) and would benefit from immediate administration of OUD treatment or withdrawal management.
- Other significant issues such as pregnancy, mental illness, suicide risk, and other emergent and urgent health issues that may be an indication for early triage.

The overarching goal of screening for OUD and withdrawal is to rapidly identify individuals who can benefit from OUD services, with a specific focus on MOUD and the need to receive a clinical assessment (described later in this document) to determine if they should be initiated on MOUD for withdrawal management or OUD treatment, or MOUD continuation. Thus, screening is fundamental to identifying individuals incarcerated in jails and prisons who are at risk of withdrawal and/or have a diagnosis of OUD and can benefit from MOUD.

Recommendation 2.1.A: Jails and prisons are required to provide screening for OUD and opioid withdrawal.

2. Who should be screened?

Five organizations - BJA, ACA, ASAM, NCCHC, and SAMHSA - recommend that all individuals entering a jail or prison must be screened for OUD at admission. NCCHC and ACA recommend screening for opioid withdrawal risk in addition to OUD as part of intake. In addition, individuals transferred from a jail to a prison after screening negative in that jail setting, or not receiving any previous screening, need to be screened for withdrawal risk and OUD. Lastly, individuals arriving at a prison, including individuals transferred from a jail, may be receiving MOUD and should be screened to ensure continuity of MOUD.

Opioid use in jails and prison happens. Between 2010 and 2018, the number of people who died of an overdose in state prisons rose by more than 500% and rose by more than 200% in county jails.[69,70] While the extent of opioid use in jails and prisons in jails and prisons is unknown, increasing mortality rate from drug overdoses during incarceration suggests it is a worsening problem. Individuals may develop OUD or opioid withdrawal symptoms after screening negative at intake. To ensure access to timely access to MOUD, individuals should be able to access screening throughout their incarceration.

Recommendation 2.2.A: Jails and prisons are required to provide screening for OUD and opioid withdrawal to all individuals as part of their intake process.

Recommendation 2.2.B: Jails and prisons should provide access to screening for OUD and opioid withdrawal to individuals as needed throughout their incarceration but are not required to.

3. What is included in an OUD screening?

Standards support screenings that consist of at least two components: validated screening instruments and structured observations. ACA, ASAM, and SAMHSA recommend using validated screening instruments for screening. SAMHSA also recommends using brief interviews and/or self-reports. ACA, NCCHC, and SAMHSA recommend screenings should include measures of:

- Substance use – Measures should include history of substance use, current substance use (including timing and quantity of last use), risk of withdrawal, withdrawal symptoms, history of SUD treatment.

- Mental health status – Measures should include but are not limited to suicide risk and a history of trauma and trauma-related disorders.
- Need for urgent or emergent services – Measures should include the presence of withdrawal symptoms, opioid use, need for MOUD continuity, and possibility of pregnancy.

NCCHC recommends that all OUD screenings identify whether the individual is pregnant. Early identification of individuals who are pregnant will allow for early triage of these individuals to be initiated on MOUD by a provider trained in the treatment of OUD in pregnancy. ASAM, NCCHC, and BJA, consider pregnant individuals a special population. Recommendations for the OUD services for people who are pregnant are discussed in section 7. If the facility does not have the resources to provide specialized care for pregnant individuals, the individual should be transferred as soon as possible.

State Medicaid agencies should recommend a valid screening tool(s) to determine program participation and referral for an assessment. For instance, the recently approved California reentry 1115 waiver requires that an individual meets criteria for SUD, such as OUD, according to current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or International Statistical Classification of Diseases and Related Health Problems, or based on a state-approved screening tool for SUD. California recommends that jails and prisons use the NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), The ASAM Criteria®, or other state-approved screening tools.[71] There are several other recommended screening instruments jails and prisons should consider for each area. Appendix C identifies potential OUD screening instruments.

A positive screen can also be determined through structured observation. NCCHC recommends that jails and prisons develop structured inquiry and observation processes to identify potential emergencies among new arrivals and ensure that individuals with known illnesses and those on medications are identified for further assessment and continued treatment. The ACA also recommends these observations. Structured observations allow for jails and prisons to identify individuals who do not participate in validated screening instruments but may benefit from MOUD. The ACA recommends observation of general appearance and behavior, evidence of abuse and/or trauma, symptoms of mental illness, conditions of the skin (e.g., recent tattoos and needle marks), and indications of substance use.

The goal of including structured observation is to supplement the screening process by identifying individuals who may need urgent or emergent services or further assessment and treatment but may have been missed by or not consented to using the screening instrument(s). Structured observation allows staff to identify evidence of abuse and/or trauma and symptoms of psychosis and/or aggression that can inform the need for urgent or emergent services. Structured observations are important to:

- Identify physical signs of substance use, such as needle marks or intoxication.
- Recognize possible opioid withdrawal, such as sweating, restlessness, runny nose, nausea, vomiting, and diarrhea.
- Determine the need for urgent or emergent services, such as poor responsiveness, difficulty breathing, intolerable pain, and difficulty ambulating.

There is no need to conduct a screening with a validated tool if, through a structured observation, an individual exhibits signs of substance use, withdrawal, or need for urgent or emergent services by a structured observation.

Recommendation 2.3.A: Jails and prisons are required to use validated screening instruments for opioid withdrawal and OUD.

Recommendation 2.3.B: Jails and prisons are required to screen for current substance use, history of SUD treatment, opioid use, opioid withdrawal risk, pregnancy, mental health, and need for urgent or emergent services.

Recommendation 2.3.C: Jails and prisons are required to provide structured observations as part of screening to identify individuals who do not participate in screening instruments but may benefit from MOUD.

4. When should screening be administered?

The NCCHC identifies four purposes of the intake process: (1) identify and meet urgent health needs, (2) identify and meet health needs that require medical intervention, (3) identify and isolate individuals who may be potentially contagious, (4) obtain a medical clearance. Thus, it is fundamental that all individuals entering a jail or prison receive screening for OUD and opioid withdrawal risk at intake.

Existing standards do not provide specific screening timeframes. For instance, CARF standards recommend that programs minimize the time between first contact and screening, recommending that screening be conducted immediately upon admission into a correctional facility. The BJA guidelines recommend that screenings should be completed immediately upon arrival at a jail. It is important to note that before arriving at a jail, individuals will have spent a variable amount of time in police custody. Depending on the type of opioid used, the onset of withdrawal may occur as soon as two hours and peak as soon as eight to 12 hours after the last use.[72] Thus, individuals who use opioids are at risk of withdrawal starting at the time of arrest and, after spending time in police custody for arraignment, may arrive at a jail already experiencing withdrawal symptoms.

Recommendation 2.4.A: Jails and prisons are required to provide screening for opioid withdrawal and OUD as part of the intake process and the screening should occur within four hours of arrival.

In addition to screening at intake, screening should be available throughout an individual's incarceration. SAMHSA guidelines recommend ongoing screening at different stages of the criminal legal process to identify individuals who are reluctant to discuss their substance use at intake but become receptive to screening later in their incarceration. Other organizations' standards did not include subsequent screening. Opioid use occurs in jails and prisons, and screenings may need to be repeated during an individual's incarceration. Ensuring screenings are available to incarcerated individuals throughout their incarceration increases opportunities to engage more individuals in care.

Recommendation 2.4.B: Jails and prisons should provide screening for opioid withdrawal and OUD throughout an individual's incarceration but are not required to.

5. Who should administer OUD screenings?

Screening for opioid withdrawal and OUD is conducted along with other health screenings that are part of the intake process and can be conducted by intake staff, including non-clinicians with appropriate training. However, as discussed above, individuals may develop withdrawal symptoms or OUD during incarceration which would be missed by restricting screening to intake. Thus, screenings may be performed by clinical and non-clinical staff who are not involved with intake. BJA recommends that screenings may be conducted by well-trained and supervised

custody staff members when health care staff are not available. While the CARF standards recommend that staff be trained on the use of instruments prior to administration, the SAMHSA guidelines emphasize that non-clinicians and individuals can administer instruments without extensive training. Thus, this report does not recommend that jails and prisons should be required to train staff on specific instruments. However, staff conducting screenings should receive training on recognizing the need for urgent or emergent services (especially withdrawal management), providing effective referral services, and administering naloxone.

Recommendation 2.5.A: Jails and prisons are required to ensure that screening services are required to be performed by qualified health care personnel and health care-trained correctional personnel.

SECTION 3: RECOMMENDATIONS FOR STANDARDS OF OUD ASSESSMENT

Table 3: Summary of Recommendations for Standards of Clinical and Multidimensional Assessments in Jails and Prisons

Recommendations	
What are assessments and why are they important?	
Recommendation 3.1.A:	Jails and prisons are required to provide clinical assessments.
Recommendation 3.1.B:	Jails and prisons should provide multidimensional assessments but are not required to.
Who receives a clinical assessment?	
Recommendation 3.2.A:	Jails and prisons are required to provide all individuals who have a positive screening for risk of opioid withdrawal, possible OUD, or need for MOUD continuity at intake with a clinical assessment.
Recommendation 3.2.B:	Jails and prisons are required to provide a clinical assessment to individuals who initiate a self-referral at any point during their incarceration without requiring the individual to complete a screening beforehand.
When is a clinical assessment administered?	
Recommendation 3.3.A:	Jails and prisons are required to provide a clinical assessment at intake, immediately following screening, for individuals who receive a positive screening result, and the clinical assessment should be completed within 24 hours of arrival at a jail or prison.
Recommendation 3.3.B:	Jails and prisons are required to provide a clinical assessment to individuals who initiate a self-referral process at any point during their incarceration immediately, not exceeding 24 hours after the self-referral was initiated.
What should be included in a clinical assessment?	
Recommendation 3.4.A:	Jails and prisons are required to provide clinical assessments that determine an individual's medical necessity for MOUD initiation or continuation, which must include a measure of withdrawal (e.g., COWS), a measure of OUD (e.g., DSM-V diagnostic criteria), a process to verify community MOUD prescription, and assess pregnancy.
Recommendation 3.4.B:	Jails and prisons should include the time of last opioid use in clinical assessments but are not required to.
Recommendation 3.4.C:	Jails and prisons are required to not penalize individuals for disclosure of recent drug use.

Table 3: Summary of Recommendations for Standards of Clinical and Multidimensional Assessments in Jails and Prisons (Cont.)

Who should provide a clinical assessment?	
Recommendation 3.5.A:	Jails and prisons are required to have clinical assessment services provided by qualified DEA-registered practitioners with the appropriate license and certification in compliance with the state practice acts and trained to use the assessment instrument.
Recommendation 3.5.B:	Jails and prisons should have clinical assessment services provided by practitioners with the competencies set forth below but are not required to.
Recommendation 3.5.C:	Jails and prisons should ensure that verification of community MOUD prescription are completed by correctional staff with the appropriate training or by health care practitioners but are not required to
Who should receive a multidimensional assessment?	
Recommendation 3.7.A:	Jails and prisons providing multidimensional assessments should provide them to individuals who are stable and have already received a clinical assessment at intake but are not required to.
When is a multidimensional assessment administered?	
Recommendation 3.8.A:	Jails and prisons should provide multidimensional assessments within seven days of arrival at the facility as part of the general health assessment processes but are not required to.
What is included in a multidimensional assessment?	
Recommendation 3.9.A:	Jails and prisons providing multidimensional assessments should ensure that multidimensional assessments evaluate biological, psychological, and social aspects of OUD using standardized and validated tools but are not required to.
Who should provide multidimensional assessments?	
Recommendation 3.10.A:	Jails and prisons providing multidimensional assessments are required to ensure that they are conducted by providers who are licensed and credentialed in compliance with state practice acts and trained to use the assessment instrument.
Recommendation 3.10.B:	Jails and prisons providing multidimensional assessments should ensure that they are conducted by providers with the competencies set forth in section 3.5 but are not required to.

1. What are assessments and why are they important?

There are multiple approaches for assessing service needs for individuals with an OUD. Two approaches include (1) clinical assessments that occur immediately after screening and (2) multidimensional assessments that generally occur simultaneously with a general health assessment within several days to weeks following admission to a jail or prison. This report provides recommendations for these two different types of assessments: clinical assessments that focus on timely initiation or continuation of MOUD, and multidimensional assessments that focus on developing treatment plans.

Clinical assessments are performed by qualified practitioners soon after screening in order to maintain or initiate MOUD. A clinical assessment can provide a diagnosis of opioid withdrawal or OUD to meet medical necessity for initiating MOUD. BJA also recommends jails and prisons include MOUD prescription verification as part of a clinical assessment. BJA and NCCHC/NSA recommend a clinical assessment to determine if an individual is at risk for withdrawal, and if an individual is currently taking MOUD. Promising practices and guidelines co-published by the NSA and NCCHC recommend that individuals should be clinically assessed to determine whether MOUD is clinically indicated. BJA provides recommendations for assessments aimed at MOUD initiation and continuation with an emphasis on timeliness.

Standards for clinical assessments were also informed by guidelines for the treatment of OUD in the emergency department by ACEP.[73] Emergency departments are purposefully structured to provide timely clinical assessments, diagnoses, and immediate provision of MOUD and may serve as a model for timely provision of correctional health care.

Multi-dimensional assessments are also provided by qualified practitioners often as part of a general health assessment. As indicated above, the timing of this assessment may vary—from several days to a few weeks depending on the facilities' standard operating procedures. Multidimensional assessments identify an individual's needs across various domains and ultimately inform treatment planning. Assessments may include diagnosis and other information that may establish the medical necessity for OUD services such as counseling, intensive outpatient program (IOP) and recovery supports.

There are various standards for performing multidimensional assessments. ASAM and CARF recommend multidimensional assessments to determine appropriate behavioral health services or levels of care (e.g., counseling, IOP or inpatient). Other organizations, such as ACA and NCCHC have established standards for general health assessment that include a multidimensional assessment of OUD. SAMHSA provides recommendations for assessing co-occurring mental and SUDs in jails and prisons.

Multidimensional assessments can be lengthy and are not required to initiate or continue an individual on MOUD. The role of multidimensional assessments in the community are to inform patient placement, such as outpatient or residential treatment settings, which have limited applicability in jails and prisons where levels of care beyond outpatient are not often available. Thus, although multidimensional assessments are a community standard, it should not be required that jails and prisons provide multidimensional assessments.

Recommendation 3.1.A: Jails and prisons are required to provide clinical assessments.

Recommendation 3.1.B: Jails and prisons should provide multidimensional assessments but are not required to.

2. Who receives a clinical assessment?

BJA, NCCHC, and ACEP recommend that individuals who screen positive for OUD or risk for opioid withdrawal at intake receive a clinical assessment. NCCHC/NSA guidelines do not provide criteria for who receives a clinical assessment for OUD or risk of opioid withdrawal. Overall, existing standards from national organizations support providing clinical assessments at intake for OUD initiation and continuation to individuals with risk of opioid withdrawal or OUD based on initial screening.

Existing standards provide recommendations for clinical assessments at intake but do not address the need for clinical assessments throughout incarceration. Intake can be a

hectic process, and individuals at risk of opioid withdrawal or OUD may be missed by initial screening and clinical assessment. A self-referral process for receiving a clinical assessment for MOUD initiation or continuation after intake, and throughout an individual's incarceration, provides a pathway to ensure that individuals at risk of opioid withdrawal and OUD have access to MOUD. Requiring OUD or opioid withdrawal screening for individuals self-referring for MOUD can create delays in care. Thus, individuals self-referring for MOUD should be provided a clinical assessment without requiring a screening.

Recommendation 3.2.A: Jails and prisons are required to provide all individuals who have a positive screening for risk of opioid withdrawal, possible OUD, or need for MOUD continuity at intake with a clinical assessment.

Recommendation 3.2.B: Jails and prisons are required to provide a clinical assessment to individuals who initiate a self-referral at any point during their incarceration without requiring the individual to complete a screening beforehand.

3. When is a clinical assessment administered?

BJA guidelines recommend that individuals with a positive OUD screen be referred for an immediate clinical assessment. BJA does not provide a specific timeframe for completing a clinical assessment but does recommend same-day MOUD initiation. NCCHC/NSA guidelines and ACEP best-practices do not provide a timeframe for completing clinical assessments for OUD. NCCHC recommends completing an assessment (as part of a general health evaluation) for MOUD within two days. An initial clinical assessment must occur sooner than the NCCHC standard of two days to ensure timely MOUD initiation or continuation given individuals who use short-acting opioids, such as heroin, can experience opioid withdrawal within 12 hours of last use, which can peak within 24-48 hours and last for 3-5 days. For individuals using long-acting opioids, such as methadone, withdrawal can typically occur within 30 hours of last use and may last for up to 10 days.[74] Therefore, a clinical assessment completed at intake immediately following a positive screen is consistent with BJA guidelines and would prevent unnecessary suffering from opioid withdrawal. In addition, NCCHC recommends that individuals be able to submit requests for health care on a daily basis and be seen within 24 hours of when those requests are received by health staff. Thus, for individuals who self-refer for MOUD, clinical assessments should be conducted within the same timeframe as clinical assessments conducted during intake.

Recommendation 3.3.A: Jails and prisons are required to provide a clinical assessment at intake, immediately following screening, for individuals who receive a positive screening result, and the clinical assessment should be completed within 24 hours of arrival at a jail or prison.

Recommendation 3.3.B: Jails and prisons are required to provide a clinical assessment to individuals who initiate a self-referral process at any point during their incarceration immediately, not exceeding 24 hours after the self-referral was initiated.

4. What should be included in a clinical assessment?

A clinical assessment must determine whether an individual meets medical necessity for MOUD in any of three different scenarios: 1) initiation for withdrawal management, 2) initiation for OUD treatment or 3) continuation of MOUD when an individual was receiving these medications prior to incarceration.

For initiation of MOUD for opioid withdrawal management, BJA, ACEP, and NCCHC/NSA recommend using a validated tool, such as the Clinical Opiate Withdrawal Scale (COWS). The

COWS is an 11-item scale designed to assess and monitor signs and symptoms of opiate withdrawal. In addition to using the COWS, ACEP also recommends assessing for pregnancy as part of a clinical assessment for initiating MOUD.

In 2021, ACEP published a review of emergency department buprenorphine initiation protocols.[75] A component in over half of these protocols was determining the time since the last opioid use (measured in hours). Peak withdrawal symptoms from short-acting opioids, such as fentanyl, may not occur until 8 hours after last use, and assessing the time of last use can help determine the onset of opioid withdrawal and the need for withdrawal monitoring.[76] For example, an individual whose last short-acting opioid use took place within four hours may not meet COWS score criteria for MOUD initiation, and the individual would benefit from withdrawal monitoring and repeated COWS scoring as their withdrawal symptoms have yet to peak. Importantly, recent drug use must not result in punitive actions, which are likely to discourage individuals from disclosing use.

For individuals who are not in withdrawal and not currently receiving MOUD, ACEP recommends that clinical assessments use questions derived from the DSM-V to determine moderate to severe OUD. However, among the reviewed buprenorphine initiation protocols, the predominant approach to assess eligibility for OUD treatment was clinical judgment, and less than a quarter of protocols required meeting DSM-V criteria to diagnose OUD.[77] Existing standards and emergency department best-practices support using both DSM-V diagnostic criteria for OUD and clinical judgement to initiate MOUD for OUD treatment.

BJA, SAMHSA, NCCHC, and ASAM all recommend continuing MOUD for individuals previously receiving community MOUD. These organizations recommend jails and prisons verify an individual's MOUD prescription from a community prescriber prior to continuing MOUD. BJA recommends two approaches for jails and prisons to verify community MOUD prescriptions: checking the Prescription Drug Monitoring Program (PDMP) and establishing memoranda of understanding with local methadone treatment providers to facilitate verification procedures. Verifying community MOUD can also be accomplished by directly contacting an opioid treatment program (OTP) or office-based opioid treatment (OBOT) clinic where the individual reports receiving the prescription. Verification of prescriptions can also be used to verify a diagnosis of OUD that will determine the medical necessity for MOUD.

Recommendation 3.4.A: Jails and prisons are required to provide clinical assessments that determine an individual's medical necessity for MOUD initiation or continuation, which must include a measure of withdrawal (e.g., COWS), a measure of OUD (e.g., DSM-V diagnostic criteria), a process to verify community MOUD prescription, and assess pregnancy.

Recommendation 3.4.B: Jails and prisons should include the time of last opioid use in clinical assessments but are not required to.

Recommendation 3.4.C: Jails and prisons are required to not penalize individuals for disclosure of recent drug use.

5. Who should provide a clinical assessment?

States and jurisdictions have laws and regulations that govern who can perform clinical assessments. Federal and state Medicaid policies defer to state licensing, credentialing, and scope of practice policies. In many states, a credentialed health care practitioner is required to perform an assessment, especially if rendering a diagnosis. Individuals performing clinical assessments should work within their scope of practice. Clinical assessments should be conducted by DEA-registered practitioners

(MD, NP, or PA) because individuals who meet eligibility presumably would be able to receive MOUD quicker if the provider has the appropriate certification and license to prescribe it.

ASAM recommends that staff administering any assessment of OUD in correctional settings should be trained in the applicable assessment tools and have several competencies. These competencies include expertise and/or experience in the following areas:

- OUD and MOUD
- overdose reversal using intranasal naloxone
- criminogenic risk, need, and responsivity
- trauma-informed care
- co-occurring SUDs and mental illness
- suicide prevention
- evidence-based practices, including:
  - cognitive-behavioral therapy
  - contingency management
  - motivational interviewing
  - motivational enhancement therapy
- emergency services
- cultural and gender responsiveness

Verification of a community MOUD prescription does not need to be conducted by health care practitioners; allowing health trained correctional staff to verify community MOUD can promote timely MOUD continuity. BJA describes approaches for verifying community MOUD prescription as administrative tasks, such as checking the PDMP or directly contacting community OTP and OBOT providers.

Recommendation 3.5.A: Jails and prisons are required to have clinical assessment services provided by qualified DEA-registered practitioners with the appropriate license and certification in compliance with the state practice acts and trained to use the assessment instrument.

Recommendation 3.5.B: Jails and prisons should have clinical assessment services provided by practitioners with the competencies set forth above but are not required to.

Recommendation 3.5.C: Jails and prisons should ensure that verification of community MOUD prescription are completed by correctional staff with the appropriate training or by health care practitioners but are not required to.

6. Multidimensional Assessment

The ACA, NCCHC, CARF, SAMHSA, and ASAM provide standards and guideline to inform recommendations for multidimensional assessments. The NCCHC, ACA and CARF recommends assessments include substance use, mental illness, harm to self and others trauma, educational status, and a physical exam. ACA recommends using a tool for appropriate drug and alcohol program assignment. CARF includes a social history in community standards but not in standards designated for criminal justice settings. SAMHSA recommends domains of assessments include mental illness, SUDs, and motivation for change. All standards and guidelines review recommend including criminal justice history in assessments completed in correctional facilities.

Currently, many state Medicaid agencies require or recommend that providers use ASAM's Patient Placement Criteria to determine the need for community SUD/OUD services. CMS suggests that states consider using The ASAM Criteria® to complete a multidimensional assessment with beneficiaries to determine the appropriate level of care placement and length of service.[78]

The ASAM Patient Placement Criteria assesses various domains of a multidimensional assessment and provides direction to the assessor regarding the scope of services an individual might need. Similar to the other standards reviewed, ASAM's assessment includes

substance use, physical health, harm to self and others . Similar to SAMHSA, ASAM's assessment includes an individual's readiness to change using an evaluation of motivation. Similar to CARF's community standards, ASAM's assessment includes social factors that impact recovery such as legal, living, and childcare needs. Lastly, ASAM's assessment includes the individual's history and potential for relapse.

7. Who receives a multidimensional assessment?

ASAM and CARF do not provide recommendations for who should receive multidimensional assessments. ACA, CARF, and NCCHC recommend conducting multidimensional assessments for OUD as part of a general health assessment. Existing standards support providing multidimensional assessments to individuals who are clinically stable (e.g., withdrawal symptoms or urgent and emergent needs have been addressed) and received a clinical assessment at intake. Individuals who receive a multidimensional assessment may already be initiated or continued on MOUD.

For several reasons, individuals in prisons, rather than jails, are more likely to receive and benefit from a multidimensional assessment. First, prisons are more likely to have more resources to complete multidimensional assessments. Second, individuals in prisons are likely to have sentences that extend beyond a year and may be more likely to benefit from ongoing treatment based on their needs identified in a multidimensional assessment.

Recommendation 3.7.A: Jails and prisons providing multidimensional assessments should provide them to individuals who are stable and have already received a clinical assessment at intake but are not required to.

8. When is a multidimensional assessment administered?

While it is key that a clinical assessment for initiating or continuing MOUD be conducted immediately following a positive screen, it is not necessary to complete a multidimensional assessment at intake. If a jail or prison does provide a multidimensional assessment, then it should be integrated into existing processes for completing general health assessments and not as a separate activity. However, MOUD initiation or continuation should never be delayed until a multidimensional assessment is completed.

The standards reviewed for this report had conflicting guidance for when to complete a multidimensional assessment; recommended timelines for an assessment varied from two to 14 days. NCCHC recommends multidimensional assessments for OUD be included in an initial health assessment that occurs within seven days of admission to a prison. However, NCCHC provides two approaches for when to perform an initial health assessment in jails: (1) administering the assessment within 14 days regardless of screening results or (2) administering the assessment within two days when clinically indicated based on initial screening. The ACA recommended conducting a health assessment within 14 days of admission across all correctional settings. CARF recommends completing an OUD multidimensional assessment as part of a physical examination within 14 days of admission to an opioid treatment program. CARF does not provide timing specific to correctional settings.

Recommendation 3.8.A: Jails and prisons should provide multidimensional assessments within seven days of arrival at the facility as part of the general health assessment processes but are not required to.

9. What should be included in a multidimensional assessment?

The existing standards and guidelines reviewed for this report align with a biopsychosocial approach for multidimensional assessment to identify an individual's OUD needs. CARF, ASAM, SAMHSA, and ACA provide standards for multidimensional assessments. CARF recommends using valid and reliable assessment tools and instruments to assess a person's severity of symptoms and level of functioning and determine the level of care placement. There are several validated tools used for the assessment process. For instance, the ASAM Multidimensional Assessment (See Table 4) is well recognized nationally as the community standard of care for matching individuals' OUD with the appropriate services. SAMHSA recommended two other validated tools: the Texas Christian University Criminal Justice Comprehensive Intake (TCU CJ CI), which matches individuals' needs to OUD services, and the Structured Clinical Interview for the Diagnostic Statistical Manual (SCID), which assesses co-occurring substance use and mental health disorders.

SAMHSA recommends assessments should include a standardized severity rating for mental health, substance use, physical health, and conditions that affect treatment. CARF recommended including validated screening tools (e.g., risk of suicide) in an assessment. ASAM and CARF support and recommend the inclusion of social factors in a full multidimensional assessment, given that integrating social aspects of health into treatment plans can promote continuity of care across correctional and community settings. Regarding biological aspects of the full multidimensional assessment, CARF and ACA recommend the assessment include a medical examination, and NCCHC recommend assessments include medical history.

Several organizations integrate criminogenic risk, need, and responsivity (RNR) into a multidimensional assessment. ASAM and SAMHSA recommend including RNR in multidimensional assessments conducted in correctional settings. RNR examine a range of "static" (e.g., unchanging) and "dynamic" (e.g., changeable) factors, which include substance use but also social networks and personality patterns, which contribute to recidivism and have historically been used in correctional settings to determine level of treatment. However, requiring jails and prisons to integrate RNR into multidimensional assessments may present an additional barrier to treatment.

The review of existing national organizations' standards informs the recommendation that a multidimensional assessment include, but not be limited to, the components outlined below.

Biomedical aspects of health include, but are not limited to:

- a history of chronic health conditions
- a physical exam, including vital signs
- the need to stabilize acute physical health conditions, such as opioid withdrawal pregnancy, active infections, traumatic injuries, and exacerbations of chronic health conditions
- historical review of biomedical aspects of an individual's health can include past records from community and/or correctional settings

Psychological aspects of individuals' health include, but are not limited to:

- intoxication and withdrawal risk
- current and history of substance use
- current and history of mental health conditions and psychiatric treatment
- readiness to change
- risk of suicide
- historical review of psychological aspects of an individual's health can include records from community and/or correctional settings

Social aspects of individuals' health include, but are not limited to:

- health insurance
- housing
- employment
- education
- social support

The NCCHC and SAMHSA include laboratory testing in assessments (as part of a physical exam) to evaluate and diagnose acute and chronic conditions. Individuals with OUD entering a correctional setting may be more likely to have conditions such as hepatitis C, HIV, sexually transmitted infections, and liver disease.[79,80] However, including a list of clinically indicated laboratory testing is outside the scope of these recommendations. Testing for pregnancy is included because treatment of individuals who are pregnant and have OUD requires expertise in providing MOUD during pregnancy.

Recommendation 3.9.A: Jails and prisons providing multidimensional assessments should ensure that multidimensional assessments evaluate biological, psychological, and social aspects of OUD using standardized and validated tools but are not required to.

10. Who should provide a multidimensional assessment?

States and jurisdictions have laws and regulations that govern who can perform multidimensional assessments. Federal and state Medicaid agencies defer to state licensing and credentialing policies. In many states, a credentialed health care practitioner is required, especially if rendering a diagnosis is included in the assessment. Several national standard setting organizations recommended credentials and competencies of staff rendering multidimensional assessments. All organizations reviewed recommend staff administering assessments of OUD in correctional settings should be trained on the applicable assessment tools. In addition, all organizations recommended various competencies for staff performing assessments, which are listed above in section 3.5.

Recommendation 3.10.A: Jails and prisons providing multidimensional assessments are required to ensure that they are conducted by providers who are licensed and credentialed in compliance with state practice acts and trained to use the assessment instrument.

Recommendation 3.10.B: Jails and prisons providing multidimensional assessments should ensure that they are conducted by providers with the competencies set forth in section 3.5 but are not required to.

SECTION 4: MOUD INITIATION AND CONTINUATION SERVICES

Table 4: Summary of Recommendations for Standards of MOUD Initiation and Continuation Services in Jails and Prisons

Recommendations	
What are MOUD initiation and continuation services?	
Recommendation 4.1.A:	Jails and prisons are required to provide MOUD treatment for opioid withdrawal and OUD and the provision of MOUD treatment must not prolong an individual's incarceration.
Who receives MOUD services?	
Recommendation 4.2.A:	Jails and prisons are required to provide MOUD initiation for withdrawal management to individuals who meet medical necessity criteria for opioid withdrawal, which includes but is not limited to being diagnosed with opioid withdrawal, determined to be at risk for opioid withdrawal, or having symptoms of intoxication.
Recommendation 4.2.B:	Jails and prisons are required to provide MOUD initiation for OUD treatment to individuals who meet medical necessity criteria for OUD, which includes but is not limited to meeting DSM-V diagnostic criteria for OUD or clinical judgement.
Recommendation 4.2.C:	Jails and prisons are required to provide MOUD continuation to individuals who have verified community MOUD provider.
Recommendation 4.2.D:	Jails and prisons are required to not deny individuals access to MOUD based solely on the results of toxicology.
Recommendation 4.2.E:	Jails and prisons are required to not deny individuals access to MOUD based on co-occurring SUDs or polysubstance use.
What is included in correctional MOUD care?	
Recommendation 4.3.A:	Jails and prisons are required to provide access to buprenorphine for treatment of opioid withdrawal and OUD.
Recommendation 4.3.B:	Jails and prisons are required to provide access to naltrexone for the treatment of OUD.
Recommendation 4.3.C:	Jails and prisons are required to provide access to methadone for the treatment of opioid withdrawal and OUD. If jail or prison does not have the capacity to provide methadone then that facility must transition individuals on methadone to buprenorphine under the supervision of trained medical personnel
Recommendation 4.3.D:	Jails and prisons that do not have the capacity to provide methadone are required to work with the necessary stakeholders to establish and implement a plan to start providing methadone during a time limited transition period.
Recommendation 4.3.E:	Jails and prisons are required to provide follow-up visits after MOUD initiation for opioid withdrawal, MOUD initiation for OUD treatment, or MOUD continuation.
Recommendation 4.3.F:	Jails and prisons are required to provide monitoring to individuals at risk for opioid withdrawal but not yet receiving MOUD as well as individuals initiated on MOUD for opioid withdrawal at least daily, and more frequently as determined by clinical judgement, medical protocols, procedures, or policies.

Table 4: Summary of Recommendations for Standards of MOUD Initiation and Continuation Services in Jails and Prisons (Cont.)

Recommendation 4.3.G:	Jails and prisons are required to have physician-approved protocols for MOUD initiation and continuation in places that are consistent with nationally accepted standards.
Recommendation 4.3.H:	Jails and prisons are required to provide individuals with MOUD throughout their incarceration once they are initiated or continued on MOUD.
Recommendation 4.3.I:	Jails and prisons are required to ensure that decisions about MOUD dosing are made between the provider and the individual being served.
Recommendation 4.3.J:	Jails and prisons are required to provide management of opioid withdrawal symptoms with non-opioid medications to individuals who are diagnosed with opioid withdrawal regardless of if the individual accepts or refuses MOUD initiation.
Recommendation 4.3.K:	Jails and prisons should advise individuals receiving opioid withdrawal management on the benefits of OUD treatment but are not required to.
Recommendation 4.3.L:	Jails and prisons should provide individuals who complete opioid withdrawal management transitional services to OUD treatment that includes a brief assessment of needs but are not required to.
When should MOUD services be provided?	
Recommendation 4.4.A:	Jails and prisons are required to initiate MOUD immediately after an individual meets medical necessity, such as a diagnosis of opioid withdrawal or a diagnosis of OUD and must continue MOUD immediately after an individual is verified to be receiving MOUD in the community.
Who should provide MOUD care?	
Recommendation 4.5.A:	Jails and prisons are required to have MOUD initiation and continuation services provided by qualified practitioners with the appropriate license and/or certification from the appropriate licensing or certification body in the jurisdiction of the jail or prison.
Recommendation 4.5.B:	Jail and prison MOUD initiation and continuation services are required to include, at a minimum, a physician who is responsible for establishing clinical protocols and procedures but does not need to be on-site at all times.
Recommendation 4.5.C:	Jails and prisons should orient staff providing MOUD initiation and continuation services to their role in the correctional facility but are not required to.
Recommendation 4.5.D:	Jails and prisons are required to staff MOUD initiation and continuation services with, at a minimum, a licensed physician and/or a licensed nurse and a pharmacist. If a pharmacist is unavailable on-site, there must be a procedure to receive pharmacy consultations. The physician and/or licensed nurse may be consulted via telehealth if they are not on-site.
Recommendation 4.5.E:	Jails and prisons should have a designated administrator responsible for ensuring that correctional MOUD services meet current clinical standards but are not required to.
Recommendation 4.5.F:	Jails and prisons should regularly train all staff involved in MOUD initiation and continuation services in emergency response but are not required to.
Recommendation 4.5.G:	Jails and prisons are required to provide monitoring of individuals admitted to opioid withdrawal management services by either qualified health care staff or correctional personnel with the appropriate training, including the use of validated withdrawal symptoms scales.

1. What is MOUD initiation and continuation and why is it important?

MOUD includes three medications: methadone, buprenorphine, and naltrexone. Methadone and buprenorphine are used to treat opioid withdrawal, whereas all three medications are used to treat OUD. The standard of care is for individuals receiving MOUD in a correctional setting is to have access to all three FDA approved medications for OUD treatment, which ASAM, NCCHC, and BJA support. However, as of midyear 2019 only 19% of jails initiate any form of MOUD.[81]

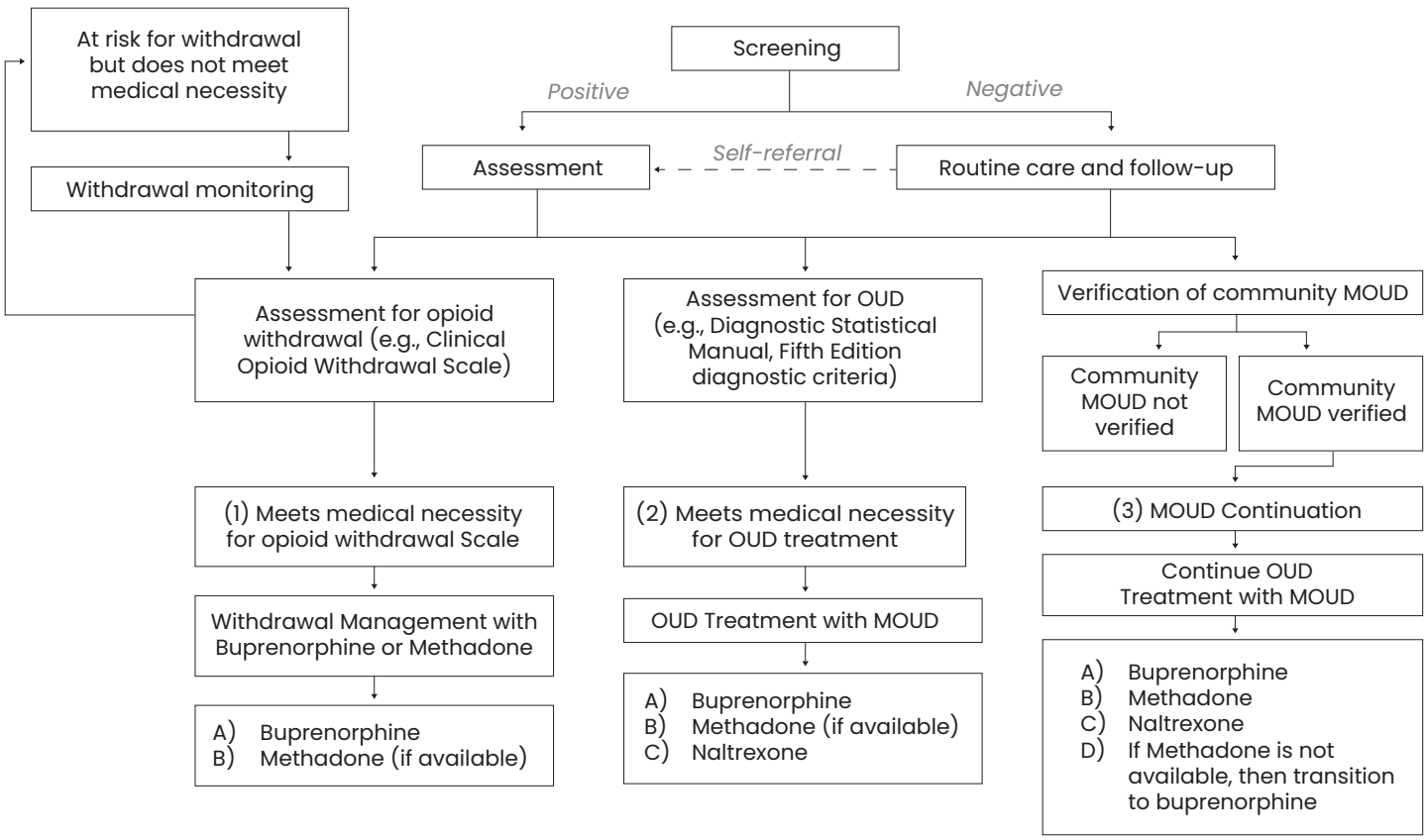
Providing MOUD in jails and prisons is an evidence-based approach to improving the morbidity and mortality of incarcerated people with OUD. Thus, methadone, buprenorphine, and naltrexone should all be provided in all jails and prisons. The availability of Medicaid coverage for OUD services would provide a substantial new source of financing for this care. There are three pathways for individuals to be initiated or continued on MOUD in jails and prisons. First, individuals diagnosed with opioid withdrawal are initiated on buprenorphine or methadone for withdrawal management. Second, individuals diagnosed with OUD are initiated on MOUD for OUD treatment. Third, individuals who have a verified community MOUD provider are continued on MOUD.

Figure 1, below, outlines the required services a jail and prison must provide to establish three pathways for individuals to be initiated or continued on MOUD in a jail or prison.

Withdrawal management with buprenorphine and methadone

Individuals who use opioids regularly can develop withdrawal symptoms if they abruptly stop. Opioid withdrawal symptoms include strong

Figure 1: Flowchart of three pathways for receiving MOUD in jails and prisons*



* Individuals with opioid withdrawal and/or OUD may receive adjunctive behavioral health services, such as counseling, and individuals who are pregnant require MOUD to be managed by a provider with training in treatment of OUD in pregnancy.

cravings, anxiety, irritability, vomiting, diarrhea, heightened pain sensation, depression, sweating, high blood pressure, and increased heart rate.[82]

Withdrawal management serves to make withdrawal from opioids more comfortable, which can be accomplished by using buprenorphine or methadone. Thus, the priority for the management of opioid withdrawal is to initiate buprenorphine or methadone as soon as possible. ASAM highlights that treating opioid withdrawal helps prevent return to use, overdose, and overdose death. In addition, ASAM recognizes that not treating opioid withdrawal during an individual's incarceration increases adverse consequences of drug use such as suicide and self-harm. Thus, treating opioid withdrawal in jails and prisons can be a strategy to save lives and improve the safety of carceral settings.

It is important to differentiate opioid withdrawal management from medically supervised withdrawal, which is also called detoxification. Medically supervised withdrawal, or detoxification, may involve treating the symptoms of opioid withdrawal without using buprenorphine or methadone. The ASAM clinical guidelines do not recommend using medically supervised withdrawal or detoxification without buprenorphine or methadone for managing opioid withdrawal, and the NCCHC cautions that this approach increases risk of overdose following release due to loss of opioid tolerance. ASAM clinical guidelines for correctional settings recommend that individuals should not be forced withdraw from opioids, which includes not forcing an individual to transition from methadone or buprenorphine to naltrexone.

OUD treatment with MOUD

In contrast to withdrawal management, where the goal is to treat the symptoms of opioid withdrawal, the goal of initiating MOUD for the treatment of OUD is to treat opioid dependence. Initiating MOUD for OUD treatment has been shown to reduce opioid use, retain individuals in care, and decrease mortality associated with opioid use.[83] There is strong evidence that OUD treatment with methadone and buprenorphine is associated with lower rates of other opioid use but limited evidence that extended-release naltrexone reduces opioid use.[84] OUD treatment with methadone and buprenorphine has also been associated with improved social functioning and decreased risk of infectious complications of substance use.[85] Most importantly, OUD treatment with methadone and buprenorphine is associated with a mortality reduction of up to 50%.[86] Individuals released from prison have more than 100 times higher risk of death due to an opioid overdose in the first two weeks compared to the general population.[87] Receiving OUD treatment with buprenorphine or methadone during incarceration has been shown to decrease mortality in the month post-release by 80%.[88] Currently, there is insufficient evidence demonstrating the mortality benefit of extended-release naltrexone.[89]

For OUD treatment, including MOUD, there are no consensus guidelines of the ideal length of a treatment/recovery episode other than recommendations that OUD be treated as a chronic condition, not an acute one. For opioid withdrawal management, the BJA guidelines recommend that MOUD should be initiated without regard to the expected duration of incarceration. However, it is important that individuals do not have their incarcerations prolonged to demonstrate a response to OUD treatment or withdrawal management. Rather, the individual should continue OUD treatment as they return to the community, and active clinical issues requiring close monitoring should be incorporated into reentry services described in section 6.3.A.

Recommendation 4.1.A: Jails and prisons are required to provide MOUD treatment for opioid withdrawal and OUD and the provision of MOUD treatment must not prolong an individual's incarceration.

Continuation of OUD treatment with MOUD

Individuals with OUD entering jails and prisons may already be taking MOUD prescribed by a community provider. ASAM, NCCHC, BJA, and SAMHSA provide recommendations that individuals must not be required to discontinue methadone, buprenorphine, or naltrexone when they are incarcerated. OUD is a chronic condition and stopping MOUD treatment can lead to return to opioid use and overdose. In addition, abruptly stopping methadone or buprenorphine can result in opioid withdrawal. Jails and prisons that do not provide continuation of MOUD may be in violation of the Americans with Disabilities Act.[90]

2. Who receives MOUD initiation and continuation services?

Medical necessity

The assessment section (section 3) of this report provides recommended standards for completing clinical assessments to determine if an individual meets medical necessity criteria for MOUD initiation or continuation in jails and prisons. Increasing rates of overdose death within correctional facilities suggest that opioid use occurs during incarceration.[91,92] Thus, it is important to recognize that an individual may meet medical necessity criteria for MOUD initiation at any time during their incarceration.

i. MOUD Initiation for Opioid Withdrawal

Individuals who are diagnosed with opioid withdrawal using a COWS score or clinical judgement meet medical necessity criteria for MOUD initiation for the management of opioid withdrawal in a jail or prison. The NCCHC, ACA, and BJA define medical necessity for opioid withdrawal management as individuals experiencing intoxication or withdrawal. NCCHC recommends monitoring individuals with signs of intoxication or withdrawal, and that treatment with MOUD is initiated when findings from patient monitoring meet criteria for withdrawal management.

BJA recommends that individuals who are at risk of opioid withdrawal, but do not meet criteria for MOUD initiation, receive withdrawal monitoring services. In addition, BJA recommends providing treatment for opioid withdrawal to individuals even if they do not meet diagnostic criteria for OUD. In summary, a COWS score or clinical judgment can be used to establish medical necessity for MOUD initiation for opioid withdrawal management, a diagnosis of OUD is not required for an individual to receive MOUD for opioid withdrawal, and an individual may receive withdrawal monitoring services before receiving MOUD if they are intoxicated or at risk of withdrawal but do not meet criteria for MOUD initiation.

ii. MOUD Initiation for OUD

Individuals who are diagnosed with OUD based on a diagnosis using DSM-V criteria or clinical judgement, and are not already taking MOUD, meet medical necessity criteria for MOUD initiation for management of OUD in a jail or prison.

iii. MOUD Continuation

Individuals who have a verified community MOUD prescription are eligible for MOUD continuation for the management of OUD in a jail or prison.

Recommendation 4.2.A: Jails and prisons are required to provide MOUD initiation for withdrawal management to individuals who meet medical necessity criteria for opioid withdrawal, which includes but is not limited to being diagnosed with opioid withdrawal, determined to be at risk for opioid withdrawal, or having symptoms of intoxication.

Recommendation 4.2.B: Jails and prisons are required to provide MOUD initiation for OUD treatment to individuals who meet medical necessity criteria for OUD, which includes but is not limited to meeting DSM-V diagnostic criteria for OUD or clinical judgement.

Recommendation 4.2.C: Jails and prisons are required to provide MOUD continuation to individuals who have verified community MOUD provider.

Toxicology testing and polysubstance use

Given the volatility of the illicit drug supply, most people who use illicit drugs often do not know exactly what they are taking.[93] Toxicology testing may be used to inform an individual's need for increased monitoring, such as when an individual with recent sedative use is initiated on buprenorphine or methadone may be at increased risk of respiratory depression.[94] However, there are a variety of available toxicology tests and ASAM clinical practice guidelines recognize that a negative toxicology test does not rule out OUD or opioid dependency. In addition, BJA states that urine toxicology tests should not be used to deny patients access to MOUD. Lastly, BJA and ASAM further recommend that individuals with co-occurring SUDs or polysubstance use not be denied MOUD. In summary, toxicology testing does not have a clear role for determining an individual's medical necessity for MOUD and should not be solely relied upon to determine an individual's MOUD eligibility, and polysubstance and co-occurring disorders should not be used as criteria to deny access to MOUD.

Recommendation 4.2.D: Jails and prisons are required to not deny individuals access to MOUD based solely on the results of toxicology.

Recommendation 4.2.E: Jails and prisons are required to not deny individuals access to MOUD based on co-occurring SUDs or polysubstance use.

3. What is included in correctional MOUD initiation and continuation?

MOUD

Under Medicaid, states must cover all three forms of MOUD: buprenorphine, methadone, and naltrexone. This requirement, established by Congress in 2018, has thus far pertained only in a community setting; Medicaid's inmate exclusion has prevented Medicaid from covering MOUD or other services in prisons or jails. CMS's recent Medicaid reentry guidance reiterates the importance of providing all three forms of MOUD, and the approved California 1115 reentry waiver meets that standard.[95] In addition, the Department of Justice has identified people with OUD, including those incarcerated in prisons and jails, as protected from discrimination under the Americans with Disabilities Act.

As discussed above, different forms of MOUD are used to treat opioid withdrawal and OUD:

- MOUD initiation for opioid withdrawal can be provided with buprenorphine or methadone.
- MOUD initiation for OUD can be provided with buprenorphine, methadone, or naltrexone.
- MOUD continuation for OUD can be provided with buprenorphine, methadone, or naltrexone.

i. Providing Methadone in Jails and Prisons

Dispensing of methadone is complicated by federal regulations that generally limit methadone dispensation to licensed OTP. OTPs provide MOUD for people diagnosed with OUD, and must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body.[96] Although there is a lack of comprehensive data that describes how many prisons and jails offer methadone, given current policy and operational barriers, it is likely few of these facilities offer it. But providing methadone in correctional settings has been shown to be feasible, improve post-incarceration

engagement in care, and help prevent post-incarceration overdose deaths.[97,98] Buprenorphine and naltrexone are not subject to the same regulatory barriers. However, limiting access to correctional MOUD services to buprenorphine and naltrexone, and not including methadone, will deny people with OUD who are incarcerated evidence-based care and may perpetuate health inequities.

Correctional facilities have many strategies that they can use to provide methadone. First, a correctional facility can contract with an OTP. This approach could involve transporting individuals to an OTP for methadone dosing on a daily basis, which can be facilitated by leveraging OTPs with mobile methadone services. Alternatively, either OTP or correctional staff could bring the methadone from the OTP to the correctional facility through an approach known as "guest dosing," which is recommended by the NCCHC. "Guest dosing" was developed by the American Association for the Treatment of Opioid Dependence to allow individuals to receive methadone from a licensed OTP that is not their "home" clinic and is cited in SAMHSA's Federal Guidelines for Opioid Treatment Programs as a strategy to support recovery.[99,100]

Second, a jail or prison may obtain an OTP license from SAMHSA. However, this requires significant upfront resources; of the 632 correctional facilities reviewed by the Jail & Prison Opioid Project, only 18 had an OTP license and dispensed methadone.[101]

Third, DEA regulations also allow for jails and prisons to provide methadone in the same capacity as hospitals. To use this provision, the facility must be registered with the DEA as a "hospital/clinic" and the person must be receiving treatment for another condition, including pregnancy. Jails and prisons could petition DEA for an exception that would let them use methadone to treat anyone with OUD who meet that criteria.[102]

Facilities are also able to provide methadone under the three-day rule. As described in 21 CFR 1306.07(b), methadone can be dispensed for up to three days by a DEA-registered provider who is not registered with an OTP during medical emergencies. NCCHC provides further approaches to ensure the continuity of methadone using the three-day rule. Correctional staff may contact the community prescriber to verify that individual's prescription, including the time and amount of the last dose. After community-based methadone is verified, it can be provided in a correctional setting by a verbal order from the community prescriber. Although this approach is limited to just three days and does not provide a longer-term solution to the provision of methadone, it can fill in short-term gaps in care and is supported by ASAM, NCCHC, SAMHSA, and ACEP.

Providing methadone to people in prison and jail has several public health benefits. However, the current realities of policy and service provision make it extremely difficult for all prisons and jails to meet current federal requirements to offer methadone. In addition, jails and prisons in remote locations may not have access to community OTPs to facilitate access to methadone. Federal agencies should review policies related to methadone provision to identify ways to support the provision of methadone in correctional settings. Until these policy realities change, it will be challenging for many correctional facilities to provide methadone, and significant transition time may be needed for facilities to do so. However, not providing methadone to an individual with OUD who is incarcerated in a jail or prison may constitute a violation of the ADA or other federal laws.[103] Thus, jails and prisons without the capacity to provide methadone must work with the necessary stakeholders to establish and implement a plan for providing methadone during a time limited transition period.

During this transition period, when individuals need services, including methadone, that are beyond the resources available at the facility, the ACA and CARF recommend transferring such individuals to a setting where they can receive those services. There may be jails and prisons with limited options for transferring individuals, such as in rural settings. In jails and prisons that cannot provide methadone or transfer individuals to a setting that provides methadone, ASAM and SAMHSA recommend that individuals be transitioned to buprenorphine. Both ASAM and SAMHSA specify that transitioning from methadone to buprenorphine requires close monitoring and should be done under the supervision of trained medical personnel. In addition, both ASAM and SAMHSA recommend against forcing or requiring individuals to transition from methadone to naltrexone. Thus, if providing methadone is not an option after every effort is made to obtain it or transfer the individual to a facility where they can receive it, then correctional MOUD programs must transition individuals to buprenorphine under the supervision of trained medical personnel.

In summary, providing all three FDA-approved forms of MOUD in jails and prisons would align with the community standard for OUD services. Jails and prisons should initiate individuals who meet medical necessity on methadone, and those without the capacity to do so should establish a plan with the necessary stakeholders to scale methadone treatment.

ii. Providing buprenorphine in jails and prisons.

Prescribing buprenorphine does not entail the same regulatory challenges as methadone. The X-waiver is no longer required for DEA registered physicians, nurse practitioners, or physician assistants to prescribe buprenorphine. There are no more caps on the number of patients a prescriber can treat with buprenorphine, which were historically in place.[104]

Buprenorphine can be provided in several formulations that can be administered orally or as an injection. Long-acting injectable buprenorphine (e.g., Sublocade or Brixadi) is an MOUD formulation that may benefit individuals with OUD who are incarcerated and may address operational considerations in correctional facilities. Currently, long-acting injectable buprenorphine is administered monthly or weekly rather than daily which decreases the need for daily movement of individuals within correctional facilities for MOUD dosing. In addition, compared to oral formulations, there is decreased concern for diversion with an injectable. Most importantly, providing an individual with a long-acting injectable dose of buprenorphine at reentry may reduce gaps in treatment at a time of increased risk for overdose fatality. The cost of long-acting injectable buprenorphine may be a barrier, which may be addressed by correctional facilities participating in Medicaid working with their state authorities to add long-acting injectable buprenorphine to the Medicaid formulary.

iii. Providing naltrexone in jails and prisons

Prescribing naltrexone also does not entail the same regulatory challenges as methadone, and can be prescribed without a DEA registration. In contrast to methadone and buprenorphine, naltrexone cannot be used to manage opioid withdrawal. There are two formulations of naltrexone, oral and long-acting injection. Only long-acting injection naltrexone is FDA approved for OUD treatment. Using naltrexone for OUD treatment requires an individual to be abstinent from opioids for at least six days. For individuals regularly using opioids, this abstinence period would entail experiencing withdrawal without receiving buprenorphine or methadone.

The abstinence period requirement also limits the ability of naltrexone to be initiated in a timely manner for individuals entering prisons and jails. Lastly, since using naltrexone to treat

OUD requires abstinence that can lead to loss of tolerance to opioids, there is an increased risk of overdose if an individual returns to use.[105]

Recommendation 4.3.A: Jails and prisons are required to provide access to buprenorphine for treatment of opioid withdrawal and OUD.

Recommendation 4.3.B: Jails and prisons are required to provide access to naltrexone for the treatment of OUD.

Recommendation 4.3.C: Jails and prisons are required to provide access to methadone for the treatment of opioid withdrawal and OUD. If jail or prison does not have the capacity to provide methadone then that facility must transition individuals on methadone to buprenorphine under the supervision of trained medical personnel.

Recommendation 4.3.D: Jails and prisons that do not have the capacity to provide methadone are required to work with the necessary stakeholders to establish and implement a plan to start providing methadone during a time limited transition period.

Follow-up, and Monitoring

i. MOUD Initiation for Opioid Withdrawal

BJA, CARF, ASAM, ACA, and NCCHC recommend that individuals receiving opioid withdrawal services receive monitoring at regular intervals, and CARF, NCCHC, and BJA further specify that monitoring include the use of standardized tools, such as the COWS or Objective Opiate Withdrawal Scale. BJA also emphasizes that individuals who do not meet criteria for MOUD initiation, but are at risk for opioid withdrawal, receive regular monitoring with a validated tool, such as the COWS. Although including regular monitoring is well supported by the standards reviewed for this report, the intervals for monitoring are not defined. The ASAM Criteria® provides guidance that services should be regularly scheduled and delivered under a defined set of policies and procedures, or medical protocols, but differentiates between ambulatory withdrawal management without onsite monitoring and ambulatory withdrawal management with onsite monitoring. The ASAM Criteria® provides guidance that services should be regularly scheduled and delivered under a defined set of policies and procedures, or medical protocols, but differentiates between ambulatory withdrawal management without onsite monitoring and ambulatory withdrawal management with onsite monitoring. ASAM defines withdrawal management without onsite monitoring as an outpatient service that can be delivered in an office setting by a trained clinician who provides withdrawal management and referral services. ASAM defines withdrawal management with onsite monitoring as a day hospital service. In withdrawal management without onsite monitoring assessments should be conducted at least daily and in withdrawal management with onsite monitoring ASAM recommends conducting serial assessments. BJA recommends monitoring every four hours during the first three days of withdrawal management, which may not be feasible for most jails and prisons. BJA also recommends using nationally accepted protocols to initiate MOUD for management of opioid withdrawal but recommends that registered nurses follow physician-approved protocols when initiating MOUD.

ii. MOUD Initiation for OUD

MOUD initiation for OUD in a prison or jail must be accompanied by a plan for following up on the individual's clinical response to MOUD. NCCHC and ASAM specify that MOUD initiation requires follow-up to assess an individual's response to MOUD. NCCHC specifies the following goals for an individual's response to MOUD for OUD treatment:

- suppressing opioid withdrawal
- blocking the effects of illicit opioids
- reducing opioid craving

- stopping or reducing the use of illicit opioids
- promoting and facilitating engagement in recovery-oriented activities, including psychosocial interventions
- preventing relapse to use among individuals who have been detoxified and are no longer physically dependent

The NCCHC recommends that jails and prisons use clinical protocols that are approved by a responsible physician, and current and consistent with nationally accepted treatment guidelines. Having physician-approved protocols for MOUD initiation that are consistent with nationally accepted treatment guidelines is supported by correctional standards and can improve access to MOUD for individuals who are incarcerated in jails and prisons.

iii. MOUD Continuation for OUD

Existing standards did not differentiate follow-up recommendations between MOUD continuation for OUD and MOUD initiation for OUD. Thus, jails and prisons should follow the same protocols for MOUD continuation for OUD as for MOUD initiation for OUD unless otherwise indicated by their community provider.

In summary, correctional and community standards support follow-up visits for individuals who are initiated on MOUD for opioid withdrawal or OUD treatment, or continued on MOUD. Withdrawal monitoring is also well supported and is a service that can be provided to both individuals who are risk for opioid withdrawal but not yet receiving MOUD as well as individuals who are initiated on MOUD for opioid withdrawal. Monitoring on a daily basis or more frequently as determined by clinical judgement, protocols, procedures, or policies consistent with nationally accepted standards is aligned with ASAM recommendations and allows jails and prisons to meet BJA guidelines if resources are available.

Recommendation 4.3.E: Jails and prisons are required to provide follow-up visits after MOUD initiation for opioid withdrawal, MOUD initiation for OUD treatment, or MOUD continuation.

Recommendation 4.3.F: Jails and prisons are required to provide monitoring to individuals at risk for opioid withdrawal but not yet receiving MOUD as well as individuals initiated on MOUD for opioid withdrawal at least daily, and more frequently as determined by clinical judgement, medical protocols, procedures, or policies.

Recommendation 4.3.G: Jails and prisons are required to have physician-approved protocols for MOUD initiation and continuation in places that are consistent with nationally accepted standards.

Medication Management

Initiating, adjusting, and monitoring MOUD should follow clinical best practices, such as the *ASAM National Practice Guidelines for the Treatment of OUD*, and be reviewed and updated periodically based on the individual's response. CARF and NCCHC specify that a physician should decide about MOUD dosing. ASAM recommends that decisions about the initial dose, maintenance dose, dose adjustments, and dose administration are based on individual outcomes such as cessation of withdrawal symptoms, cessation of illicit opioid use, reduced drug-seeking behavior, the establishment of a dose that blocks the euphoric effects of opioids, absence of problematic craving, and absence of signs and symptoms of too large a dose. BJA states that it is not appropriate to require a change in or discontinuation of OUD medication for nonclinical reasons. CARF and SAMHSA recommend that programs should not have any dose caps or ceilings because they are contrary to the principle of individualized dosing and undermine the effectiveness of MOUD. ASAM further recommends no time limit for treatment with MOUD, and clinicians should not encourage individuals to discontinue medications based on

a pre-determined duration of treatment. NCCHC and the NSA recommend that if an individual is incarcerated for more than a year, they can be tapered off MOUD and restarted 30 days prior to release. This approach is not evidence-based and may result in harms associated with OUD such as overdose. Thus, when MOUD is initiated or continued in a jail or prison it should be continued throughout the duration of an individual's incarceration, and decisions to taper off MOUD should be made between the provider and the individual being served.

Recommendation 4.3.H: Jails and prisons are required to provide individuals with MOUD throughout their incarceration once they are initiated or continued on MOUD.

Recommendation 4.3.I: Jails and prisons are required to ensure that decisions about MOUD dosing are made between the provider and the individual being served.

Non-MOUD Medications for Treatment of Opioid Withdrawal

The *ASAM National Practice Guidelines for the Treatment of OUD* recommend using non-opioid medications to treat specific opioid withdrawal symptoms, including but not limited to clonidine, lofexidine, benzodiazepines, loperamide, bismuth, acetaminophen, non-steroidal anti-inflammatory medications, and ondansetron. The BJA guidelines support using the *ASAM National Practice Guidelines for the Treatment of OUD* to treat opioid withdrawal. The American Academy of Emergency Medicine also recommends using several non-opioid medications such as gabapentin, baclofen, tizanidine, diphenhydramine, and olanzapine, in addition to the medications listed above.[106] Treatment of opioid withdrawal symptoms with non-opioid medication is a best practice recommended by ASAM and BJA, and should be made available to individuals who are initiated on MOUD as well as individuals who are eligible for MOUD initiation whether or not they accept MOUD.

Recommendation 4.3.J: Jails and prisons are required to provide management of opioid withdrawal symptoms with non-opioid medications to individuals who are diagnosed with opioid withdrawal regardless of if the individual accepts or refuses MOUD initiation.

Transitioning from withdrawal management to OUD treatment

BJA, NCCHC, and ASAM make the distinction that opioid withdrawal management is not OUD treatment and emphasize the need to continue buprenorphine or methadone as maintenance therapy after completing withdrawal management. CARF and The ASAM Criteria® standards for opioid withdrawal management include linkage to appropriate treatment programs. BJA recommends that individuals receiving withdrawal management be advised of the risk of returning to use, overdose, and overdose death if they choose not to engage in ongoing medication treatment. Thus, when opioid withdrawal management services have sufficiently resolved an individual's signs and symptoms of opioid withdrawal, jails and prisons must offer transitions to OUD treatment with MOUD.

In contrast with reentry services described in section 6, an individual may be transitioned from opioid withdrawal management services to OUD treatment and remain within the same jail or prison. Nevertheless, jails and prisons must be able to ensure continuity of care between opioid withdrawal management and OUD treatment. Thus, an individual transitioning from opioid withdrawal management to MOUD services within a correctional facility must receive a brief assessment of their transitional needs.

In summary, advising an individual receiving opioid withdrawal management on the benefits of OUD treatment and providing services for an individual to transition from opioid withdrawal management to OUD treatment ensures continuity of care.

Recommendation 4.3.K: Jails and prisons should advise individuals receiving opioid withdrawal management on the benefits of OUD treatment but are not required to.

Recommendation 4.3.L: Jails and prisons should provide individuals who complete opioid withdrawal management transitional services to OUD treatment that includes a brief assessment of needs but are not required to.

4. When should MOUD initiation and continuation services be provided?

Screening and/or assessment must precede the initiation or continuation of MOUD, and as discussed above, the maximum timeframe for completing screening and assessment should not exceed 24 hours. BJA recommends that once a diagnosis of opioid withdrawal is made that MOUD should be initiated immediately, and that all jails should provide same-day access to buprenorphine and methadone. However, other service standards do not specify a timeframe for initiating MOUD for OUD treatment. ACA and NCCHC recommend providing MOUD in a "timely" manner, and NCCHC recommends avoiding "unreasonable" delays in providing MOUD. For example, it would be unreasonable if the MOUD administration was delayed so long that an individual went into withdrawal. The ASAM clinical guidelines provide timeframes for the onset and duration of opioid withdrawal symptoms. Among individuals who use short-acting opioids, such as heroin and fentanyl, withdrawal symptoms can peak within eight to 12 hours and up to 10 days.[108] It is likely that a jailed individual's last opioid use will have been several hours before they receive screening and assessment services.

In summary, standards are not specific in timing for when individuals should receive MOUD, and the most immediate approach to MOUD initiation or continuation can minimize unnecessary suffering.

Recommendation 4.4.A: Jails and prisons are required to initiate MOUD immediately after an individual meets medical necessity, such as a diagnosis of opioid withdrawal or a diagnosis of OUD and must continue MOUD immediately after an individual is verified to be receiving MOUD in the community.

5. Who should provide MOUD initiation and continuation?

The ASAM Criteria®, ACA, NCCHC, BJA, and CARF recommend that qualified providers who directly provide MOUD have the appropriate licenses and/or certifications required to prescribe MOUD according to the jurisdiction's licensing or certification body. The ASAM Criteria® describes providers for outpatient opioid withdrawal management service as either physicians, advanced practice practitioners, or nurses with controlled substance prescribing authority. Furthermore, ASAM does not require providers to be certified in addiction medicine or to be present in the treatment setting at all times. ASAM and CARF describe the qualifications for staff providing opioid withdrawal management services as requiring training and expertise in assessing and managing intoxication and withdrawal. CARF adds that all direct service providers receive training in emergency response, and ASAM adds that providers should have knowledge about the biopsychosocial dimensions of OUD. ASAM and CARF standards both specify that behavioral health practitioners, such as counselors, psychiatrists, and social workers be made available to individuals receiving MOUD.

States and jurisdictions have laws and regulations that govern who can provide MOUD. Federal and state Medicaid policies defer to state licensing and credentialing policies. An active DEA-license is required by federal regulations to prescribe buprenorphine and methadone, so jails and prisons will be required to have a credentialled health care practitioner to initiate and continue MOUD. While an X-waiver is no longer required to prescribe buprenorphine, health care practitioners newly applying or renewing their DEA license will be required to meet a training requirement for opioid use, OUD

and SUD.[107] Jails and prisons must ensure that health practitioners providing MOUD have the appropriate training and certifications to meet state and federal regulations.

CARF and BJA recommend having a physician available to the program 24 hours/day and seven days/week, which can be provided via telehealth, to provide real-time direction regarding care. However, 24-hour access to a physician is not included in other standards reviewed for this report. Additionally, CARF standards include having a program director who is responsible for establishing procedures and protocols, educational activities, and program modifications, as well as a medical director with training in withdrawal management who oversees the program and develops procedures and protocols. CARF doesn't recommend that the program director have a background in any specific discipline, but does recommend training and experience in opioid withdrawal or that the role may be filled by the medical director.

In summary, including a physician in MOUD initiation and continuation services ensures that jails and prisons have someone with the appropriate training and experience to establish policies and procedures.

Recommendation 4.5.A: Jails and prisons are required to have MOUD initiation and continuation services provided by qualified practitioners with the appropriate license and/or certification from the appropriate licensing or certification body in the jurisdiction of the jail or prison.

Recommendation 4.5.B: Jail and prison MOUD initiation and continuation services are required to include, at a minimum, a physician who is responsible for establishing clinical protocols and procedures but does not need to be on-site at all times.

CARF emphasizes clinical and correctional boundaries and the maintenance of current clinical knowledge and skills through continuing education. The boundaries between clinical and correctional services are exemplified throughout this report and addressed in section 7, including, but not limited to, balancing confidentiality and security, preventing diversion, and prohibiting clinical decisions by non-clinical personnel. Staff providing MOUD initiation and continuation services will need to be knowledgeable of how jails and prisons function to minimize any hinderance of service delivery due to institutional policies and procedures.

Recommendation 4.5.C: Jails and prisons should orient staff providing MOUD initiation and continuation services to their role in the correctional facility but are not required to.

Correctional MOUD initiation and continuation services require an interdisciplinary staff. CARF defines the minimum staff to be a licensed physician, a licensed nurse and/or pharmacist, and a primary counselor and recommends that in a small setting or a jail, the physician or nurse may provide counseling instead of a primary counselor. Counseling is addressed in the counseling/intensive outpatient section (section 5). CARF, ACA, and NCCHC recommend that MOUD initiation and continuation services include a pharmacist to maintain a medication formulary. NCCHC recommends a consulting pharmacist in instances where a staff pharmacist is unavailable. Guidelines do not provide staffing ratios, but NCCHC provider recommendations call for assessing the sufficiency of staffing by factors such as the achievement of timely and thorough clinical encounters and the number of prescribers and support staff necessary to provide MOUD care. In summary, counseling does not need to be part of MOUD initiation or continuation services, but including a clinician, physician or nurse, and having a pharmacist available for consultation provides the interdisciplinary staffing necessary to provide quality, evidence-based MOUD initiation and continuation services.

Recommendation 4.5.D: Jails and prisons are required to staff MOUD initiation and continuation services with, at a minimum, a licensed physician

and/or a licensed nurse and a pharmacist. If a pharmacist is unavailable on-site, there must be a procedure to receive pharmacy consultations. The physician and/or licensed nurse may be consulted via telehealth if they are not on-site.

CARF and NCCHC recommend designating a primary sponsor responsible for ensuring that correctional MOUD initiation and continuation services meet current clinical standards. The program sponsor may be a physician, health administrator, or another authorized official. According to 42 CFR Part 8, the program sponsor is the person responsible for the operation of an OTP and who is responsible for staff providing MOUD and counseling services. Thus, the program sponsor is an administrator that does need not to be a licensed physician, but whose responsibilities includes ensuring MOUD clinical standards are being met. If the program sponsor is not a licensed physician, then they cannot develop protocols to meet clinical standards. As discussed above, clinical protocols must be developed by a licensed physician. In summary, designating an administrator for MOUD initiation and continuation services provides a mechanism for oversight and accountability for service delivery.

Recommendation 4.5.E: Jails and prisons should have a designated administrator responsible for ensuring that correctional MOUD services meet current clinical standards but are not required to.

ASAM, NCCHC, and CARF standards recommend that all staff, including correctional officers, who work with individuals receiving MOUD services should receive training in emergency response. This training should include, but is not limited to, recognizing mental health-related crises, recognizing signs and symptoms of mental illness, responding to violent behavior, performing basic first aid, administrating naloxone, recognizing acute intoxication and withdrawal, and implementing suicide/self-injury prevention intervention. In addition, recommendations include that training should be repeated every one to two years to account for turnover. Training all staff involved in MOUD initiation and continuation in emergency response ensures safety of individuals receiving services, and can promote acceptability of OUD services among clinical and non-clinical staff.

Recommendation 4.5.F: Jails and prisons should regularly train all staff involved in MOUD initiation and continuation services in emergency response but are not required to.

As discussed above in section 4.3, opioid withdrawal management includes monitoring. BJA recommends that withdrawal monitoring includes the use of validated scales, such as the COWS, and that custody staff should be trained to administer the COWS and collect vital signs. NCCHC recommends that individuals be monitored by qualified health care professionals, and The ASAM Criteria® recommends that monitoring be completed by a physician or nurse. Requiring monitoring to be completed by licensed health care professionals may not be feasible in jails and prisons that have limited health care staffing. In section 2, recommendations for screening standards include providing health care training to correctional personnel to provide structured observation. Applying a similar approach to the staffing requirements for opioid withdrawal monitoring of individuals receiving opioid withdrawal management can increase the capacity of jails and prisons without compromising safety or quality of services. Thus, correctional personnel with the appropriate health care training, including on the use of validated withdrawal symptoms scales, should provide opioid withdrawal monitoring.

Recommendation 4.5.G: Jails and prisons are required to provide monitoring of individuals admitted to opioid withdrawal management services by either qualified health care staff or correctional personnel with the appropriate training, including the use of validated withdrawal symptoms scales.

SECTION 5: RECOMMENDATIONS FOR STANDARDS OF COUNSELING AND INTENSIVE OUTPATIENT (IOP) SERVICES

Table 5: Summary of Recommendations for Standards of Counseling and IOP in Jails and Prisons

Recommendations	
What is counseling and IOP and why are they important?	
Recommendation 5.1.A:	Jails and prisons should provide counseling but are not required to.
Recommendation 5.1.B:	Jails and prisons should provide IOP but are not required to.
Who receives counseling and IOP care?	
Recommendation 5.2.A:	Jails and prisons are required to ensure individuals admitted to correctional counseling or IOP in jail or prison settings meet clinical criteria demonstrating medical necessity.
What is included in counseling and IOP?	
Recommendation 5.3.A:	Jails and prisons should provide counseling and IOP services which include evidence-based therapies that meet the needs of the individual served but are not required to.
Recommendation 5.3.B:	Jails and prisons should ensure all individuals who receive counseling and IOP have a treatment plan that includes goals and objectives, is developed with shared decision-making, specifies the frequency of services provided, and is regularly reviewed, but are not required to.
When should counseling and IOP be provided?	
Recommendation 5.4.A:	Jails and prisons should ensure the frequency with which counseling and IOP are provided are individualized and defined in the treatment plan but are not required to.
Who provides counseling and IOP?	
Recommendation 5.5.A:	Jails and prisons are required to ensure counseling and IOP services be provided consistent with state practice acts.
Recommendation 5.5.B:	Jails and prisons providing counseling and IOP services should include peers but are not required to.
Recommendation 5.5.C:	Jails and prisons providing counseling and IOP should ensure all staff are trained to address co-occurring mental and SUDs but are not required to.

1. What is counseling and IOP and why are they important?

Counseling and IOP are behavioral health services that are an adjunct to MOUD that may improve outcomes for some individuals with OUD. For example, individuals who have co-occurring mental illness or other SUD may benefit from a limited number of counseling therapy sessions, such as cognitive behavioral therapy. The ASAM Criteria® recommend using a multidimensional assessment to determine the severity of an individual's OUD and/or mental illness and functioning. An individual with more severe OUD and/or mental illness may benefit from more long-term, intensive, structured counseling and education, which would be provided in a IOP service. Making counseling and IOP services optional, rather than required, makes it possible for jails and prisons that don't have the capacity to provide counseling and IOP to still meet the recommended requirements for Medicaid coverage of screening, clinical assessment, MOUD, and reentry.

Recommendation 5.1.A: Jails and prisons should provide counseling but are not required to.

Recommendation 5.1.B: Jails and prisons should provide IOP but are not required to.

2. Who receives counseling and IOP?

Most existing standards and guidelines focus on the components and processes included in counseling and IOP, and do not specify clinical criteria to determine whether an individual has medical necessity for counseling or IOP. Of the standards and guidelines reviewed for this report, The ASAM Criteria® provides clinical criteria for counseling and IOP services. The ASAM Criteria® emphasizes that matching individuals to treatment options should be made based on the individual's needs identified in the multidimensional assessment, consistent with earlier recommendations that clinical decisions should not be made by non-clinical personnel.

Importantly, the existing standards and guidelines do not support mandating individuals to a particular service without an assessment. Below is a summary of some clinical criteria used for counseling and IOP.

i. **Clinical criteria for counseling include:**
   1. not having signs or symptoms of withdrawal or an individual's withdrawal symptoms can be managed in the outpatient services setting
   2. having stable biomedical conditions/problems and/or stable psychiatric symptoms (However, mental status problems should not preclude participation.)
   3. not being at risk of harm to self or others
   4. being willing to participate
   5. being assessed as able to achieve recovery goals by engaging in a counseling service
   6. being willing to engage with a support system

ii. **Clinical criteria for intensive outpatient services include:**
   1. not having signs or symptoms of withdrawal or an individual's withdrawal symptoms can be managed in the intensive outpatient services setting
   2. having stable biomedical conditions/problems
   3. being willing to participate
   4. being assessed as unable to achieve recovery goals at a lower level of care
   5. being assessed as not having the skills to engage with a support system

Recommendation 5.2.A: Jails and prisons are required to ensure individuals admitted to correctional counseling or IOP in jail or prison settings meet clinical criteria demonstrating medical necessity.

3. What is included in counseling and IOP?

i. Counseling

In counseling services, addiction, mental health, or general health, personnel provide treatment and ongoing recovery and disease management services in regularly scheduled sessions. Counseling services are tailored to the individual's clinical severity and function and designed to achieve change in drug use by addressing lifestyle, attitudinal, and behavioral issues that undermine the goal of treatment or impair coping without the use of drugs.

ii. IOP

IOP services provide 9-19 hours of structured programming per week of general counseling and education about addiction-related and mental health problems to address the individual's psychiatric and medical needs. IOP provides the appropriate intensity of services to address an individual's psychiatric symptoms that are not sufficiently stable to transition to a lower level of care without exacerbation and recurrence of signs and symptoms. Providing 9-19 hours of structured programming may not be feasible for many jails or prisons; facilities that have the capacity should provide IOP.

iii. Therapies

Existing standards and guidelines identify several evidence-based practices to include in counseling and IOP. Importantly, NCCHC highlights that most behavioral therapies are effective in community settings, and using these practices in correctional settings requires adjustments and modifications. For that reason, NCCHC recommends that when therapies are implemented, correctional programs evaluate whether they have maintained fidelity to the essential elements of the treatments found to be effective.

Specifically, therapies recommended to be included in counseling and IOP by ASAM, NCCHC, and CARF include, but are not limited to:

- motivational interviewing
- motivational enhancement therapy
- cognitive behavioral therapy

In addition to evidence-based practices, innovative promising practices may also be provided as a supplement to correctional counseling and IOP services. Furthermore, ASAM and CARF recommend that IOP offer modalities, such as skill development and psychoeducation, which assist individuals in achieving their goals related to psychological and social functioning, self-esteem, and coping. CARF further specifies that IOP should provide two or more services: individual counseling/therapy, family counseling/therapy, and group counseling/therapy.

Recommendation 5.3.A: Jails and prisons should provide counseling and IOP services which include evidence-based therapies that meet the needs of the individual served but are not required to.

iv. Treatment plans

ASAM, ACA, NCCHC, and CARF recommend that all individuals receiving counseling and IOP have a treatment plan. ASAM, ACA, and CARF emphasize that the treatment plan should be individualized. ASAM highlights that the appropriate health provider should develop that treatment plan based on shared-decision making with the individual. CARF specifies that treatment plans should consist of two main components, goals and objectives, which incorporate the individual's preferences and identify challenges and potential solutions. Consistent with this approach, ASAM and NCCHC recommend treatment plans that include short-term, measurable goals and tasks the individual

must perform to complete the short-term goals. ASAM further defines treatment goals to include modifying the underlying process that maintains or reinforces use behaviors, encouraging engagement with the treatment plan, including pharmacotherapy and treating any concomitant psychiatric disorders that either complicate a SUD or act as a trigger for relapse. ASAM, CARF, NCCHC, and ACA identify specific treatment plan components, including psychosocial assessments, individual and group counseling, educational services, vocational services, recovery support service, linkages to community resources, medication management, and psychotherapy. Lastly, CARF, ASAM, and NCCHC recommend treatment plans that include use of support systems, which are discussed in section 7.

Other components highlighted in the existing guidelines and standards were suicide and criminogenic risk-need-responsivity (RNR). ASAM, NCCHC, and CARF recommend that treatment plans address suicide risk and develop suicide prevention programs when indicated. In The ASAM Criteria®, RNR is identified alongside suicide risk as an emotional, behavioral, or cognitive condition that should be addressed in a treatment plan. Including RNR in treatment plans is also supported by NCCHC and CARF to address the relationship between OUD and the risk of recidivism.

NCCHC and ASAM specify that treatment plans must identify the frequency with which these services are provided. CARF and ASAM specify that the treatment plan must be reviewed and updated regularly, and ASAM recommends that IOP treatment plans be reviewed at least monthly. Most standards referenced in this section comport with existing state Medicaid agency requirements for treatment planning for individuals with behavioral health conditions.

Recommendation 5.3.B: Jails and prisons should ensure all individuals who receive counseling and IOP have a treatment plan that includes goals and objectives, is developed with shared decision-making, specifies the frequency of services provided, and is regularly reviewed, but are not required to.

4. When should counseling and IOP be provided?

The existing standards and guidelines do not provide a timeframe for initiating counseling and IOP. Consistent with this report's guiding principle of timeliness, counseling and IOP provided in jails and prisons should be initiated in a timely manner, following completion of a multidimensional assessment that demonstrates medical necessity. The frequency of services is defined in the treatment plan that the qualified health care provider develops with the individual receiving services.

Recommendation 5.4.A: Jails and prisons should ensure the frequency with which counseling and IOP are provided and individualized and defined in the treatment plan but are not required to.

5. Who should provide counseling and IOP?

Requirements for who provides counseling and IOP must align with state practice acts. Of the existing guidelines and standards, only ASAM provides staffing recommendations for counseling and IOP. ASAM recommends that counseling or IOP staff should be appropriately credentialed and/or licensed treatment professionals, and offers examples such as psychologists, master's level clinical social workers, counselors, and addiction-credentialed physicians. When co-occurring mental health and general medical conditions are present, ASAM specifies that in the community setting, counseling and IOP should be provided by the most highly skilled clinician available. For IOP, The ASAM Criteria®

recommends that physicians providing care should have specialty training and/or experience in addiction medicine or addiction psychiatry.

ASAM and CARF recommend that counseling and IOP staff include peers with lived experience and who have successfully maintained recovery. CARF specifies that peers should complete a recognized competency-based curriculum that includes advocacy, engagement, recovery and resiliency principles, community supports/connections, effective sharing of lived experiences, and parenting skills. Applying this standard to correctional settings could be challenging in states that prohibit anyone with a felony conviction to render Medicaid services. In states that allow individuals with a criminal legal history to render Medicaid services, jails and prisons may not readily authorize such individuals to provide OUD services. Nevertheless, peer services address stigma and discrimination experienced by people living with OUD that is compounded by incarceration and provides a model of care that promotes recovery and community integration.

Lastly, ASAM recommends that all staff in counseling and IOP be able to obtain and interpret information regarding individuals' biopsychosocial needs and understand the signs and symptoms of mental disorders and the use of psychotropic medications, and their interactions with SUDs.

Recommendation 5.5.A: Jails and prisons are required to ensure counseling and IOP services be provided consistent with state practice acts.

Recommendation 5.5.B: Jails and prisons providing counseling and IOP services should include peers but are not required to.

Recommendation 5.5.C: Jails and prisons providing counseling and IOP should ensure all staff are trained to address co-occurring mental and SUDs but are not required to.

SECTION 6: RECOMMENDATIONS FOR TRANSITIONAL/REENTRY SERVICES

Table 6: Summary of Recommendations for Transitional/Reentry Services in Jails and Prisons

Recommendations	
Where are transitional/reentry services provided?	
Recommendation 6.1.A:	Jails and prisons are required to provide reentry services.
Who receives transitional/reentry services?	
Recommendation 6.2.A:	Jails and prisons are required to provide reentry services for all individuals who received opioid withdrawal management, OUD treatment, and/or community MOUD continuation services during their incarceration.
What is included in Reentry Services? Case management	
Recommendation 6.3.A:	Jails and prisons are required to provide reentry case management services, which must include, but not be limited to, completing a comprehensive assessment of the individual's needs, development and revision of a care plan, arranging referrals and appointments to community-based care, and monitoring and follow up to ensure continuity of care to community providers.
Recommendation 6.3.B:	Jails and prisons should facilitate pre-release in-reach with community providers, including but not limited to case managers, as part of reentry services but are not required to.
Recommendation 6.3.C:	Jails and prisons should offer reentry recovery support services that include peer support from individuals with lived experience, harm reduction education, overdose prevention training, and either a naloxone prescription or naloxone in-hand at release but are not required to.
Recommendation 6.3.D:	Jails and prisons are required to provide a 30-day supply of MOUD and other medications at reentry, and the individual's medical and prescription records must be transferred to the primary care practitioner and MOUD provider in advance of the first appointment.
When should Reentry Services occur?	
Recommendation 6.4.A:	Prisons are required to begin reentry services at a minimum of 90 days prior to release and should include a schedule for their reentry process that provides target dates for key activities.
Recommendation 6.4.B:	Jails are required to begin reentry services at intake. For individuals who are sentenced to more than 90 days in a jail setting, reentry services must resume at a minimum of 90 days prior to release and should include a schedule of reentry processes with target dates for key activities.

Table 6: Summary of Recommendations for Transitional/Reentry Services in Jails and Prisons (Cont.)

Who should provide Reentry Services?	
Recommendation 6.5.A:	Jails and prisons should staff reentry services with case managers and peer support specialists and/or community health workers, ideally with relevant lived experience but are not required to.
Recommendation 6.5.B:	Reentry providers should have training in motivational interviewing, trauma informed care, person-centered care, and the needs of people who have experienced incarceration but are not required to.

1. What are reentry services and why are they important?

For people with OUD, reentry to the community is the most high-risk time for overdose. In the first two weeks after release from prison, individuals face a risk of a fatal overdose over 100 times greater than the general public.[109] Achieving continuity of OUD services at reentry and helping Medicaid beneficiaries with OUD reenter communities can improve these outcomes.

In its criminal justice standards, CARF recommends a pre-release reentry plan that includes reentry services and continuing care in the community. NCCHC recommends that jails and prisons start planning for release at admission, as well as assist with health insurance applications before release, make arrangements or referrals for follow-up services with community providers, and provide patients with a "reasonable supply" of current medications. CARF and NCCHC recommend pre-release plans with the active involvement of the person served, based on a comprehensive needs and risk assessment. ACA's reentry standards include a medical screen and arrangements for community follow-up where needed. BJA recommends establishing a discharge plan throughout withdrawal management, providing patient navigation services at release, ensuring patients with ongoing emergent medical needs are transferred to an appropriate facility at release, and sharing health records with the patient's community providers.

In addition to the review of existing national standards, recommendations for Medicaid coverage of reentry services were informed by a several organizations, including:

- National Institute of Corrections/Urban Institute Justice Policy Center[110]
- The National Reentry Resource Center[111]
- The Council of State Governments Justice Center[111,112]
- The Pew Charitable Trusts[113]
- National Association of Counties[114]
- The Health and Reentry Project[115]

Reentry services recommended by these organizations include pre-release reentry assessment and plan, case management, recovery support, MOUD, in-reach by community-based providers, arranging appointments with community providers, handoffs to community providers, and confirmation of the individual's connection to community providers. As noted earlier in this report, CMS guidance released in April 2023 establishes a new opportunity for states to cover some reentry services through 1115 demonstration waivers. States can cover targeted pre-release services for all or some Medicaid beneficiaries who are incarcerated for a period of up to 90 days before someone is released from a prison and jail. At a minimum, states taking up this option are required to provide case management to identify and coordinate physical health, behavioral health needs and health related social needs, all types of MOUD, and a 30-day supply of MOUD at release.

Implementing best practices for reentry can be limited by operational considerations in correctional settings. Reentry services typically rely on knowing when an individual will be released from incarceration. This is more readily known in prisons, where individuals are more likely to have predictable release dates. In jail settings a "reentry" period is difficult to operationalize. Individuals entering jail settings may be incarcerated for a short period of time, and release dates are hard to predict. Although it is important to provide individuals with reentry services, jails may have a very limited period of time to interact with an individual, which may constrain the provision of the reentry services described in these recommendations. An additional operational challenge is the difficulty of making connections between prisons and jails and community providers, as well as ensuring availability of community reentry resources. Lastly, maintaining continuous Medicaid enrollment post-release is central to people's ability to access community resources.

Recommendation 6.1.A: Jails and prisons are required to provide reentry services.

2. Who Receives Reentry Services?

Review of national standards and recommendations from several organizations on reentry did not provide a common definition of who should receive reentry services. For the purposes of these recommendations, which are specific to Medicaid coverage for OUD services, ensuring continuity at release is a vital objective. ASAM has developed a state brief, and SAMHSA has developed guidelines specific to individuals with OUD in jails and prisons, both of which recommend that people with OUD receive reentry services. BJA recommends integrating reentry services into withdrawal management, so anyone that receives opioid withdrawal management would also receive reentry services. Pew has released information on how best to address reentry for individuals with OUD.[116]

Recommendation 6.2.A: Jails and prisons are required to provide reentry services for all individuals who received opioid withdrawal management, OUD treatment, and/or community MOUD continuation services during their incarceration.

3. What Are the Recommended Reentry Services?

The literature consistently identified three services for individuals with OUD that should be included as reentry services provided as part of a community reentry strategy: case management, recovery supports, and MOUD.

Case management

The National Institute of Corrections/ Urban Institute Justice Policy Center, National Reentry Resource Center, Pew, and other sources reviewed emphasize the importance of case management as a necessary reentry activity. Definitions of what services are included in "case management" vary across these sources, but generally encompass a pre-release reentry plan, social support services, and activities that improve continuity of treatment.

In establishing its policy encouraging states to offer pre-release services through Medicaid, CMS included case management as one of three benefits that states must cover in order to receive federal approval. In that guidance, CMS described case management as a "linchpin for the successful transition of reentering individuals," and applied a longstanding definition of Medicaid case management as necessary for people who are returning to communities. This definition included four activities:

1. Comprehensive assessment and re-assessment of a person's medical, educational, and social or other needs.
2. Development and revision of a care plan, informed by the assessment.

3. Referral and connections to help a person access services to meet the goals identified in the care plan, including facilitating appointments.
4. Monitoring and follow up to ensure that the care plan is followed, and the individual's needs are met.

CMS guidance includes extensive discussion of how these four activities should be provided. The care plan should be person-centered and help people connect to both medical services and other services that can meet their health-related social needs, such as housing, food, transportation, social connections, education, and employment.

CMS's identification of the important role that case management can play at reentry and highlighting of specific case management activities offers a strong approach to addressing the reentry needs of people with OUD. Plans should be developed with the active participation of the individual being released and identify staff and individuals' roles. The plan should be used by all staff interacting with the individuals during the reentry period and transferred to the community provider(s) to avoid duplication and facilitate follow through. Case management should emphasize a strong community handoff to ensure continuity of care. This should include confirmation of follow-up appointments made with at least a primary care practitioner and a provider who can prescribe the MOUD the individual received while incarcerated. Connections to social supports are vital, and housing stands out as a particularly critical need. Formerly incarcerated people are 10 times more likely to be homeless, and experiencing homelessness increases risk of opioid overdose.[117,118]

Recommendation 6.3.A: Jails and prisons are required to provide reentry case management services, which must include, but not be limited to, completing a comprehensive assessment of the individual's needs, development and revision of a care plan, arranging referrals and appointments to community-based care, and monitoring and follow up to ensure continuity of care to community providers.

Pre-release in-reach

In-reach is a strategy that allows for community-based providers to meet with individuals in jail or prison before their release.[119,120] Although in-reach by community providers may not be feasible in rural areas, The Council of State Governments Justice Center recommends using telehealth to address challenges in areas with few community providers or when the person plans to live in a different place than where the CJ facility is located.[122] SAMHSA recommends allowing community providers to bill insurers for pre-release in-reach services to address this challenge to reentry. Thus, Medicaid coverage for in-reach services by community providers, including case managers, is well supported, can improve continuity of care, and directly addresses challenges to improving reentry.

Recommendation 6.3.B: Jails and prisons should facilitate pre-release in-reach with community providers, including but not limited to case managers, as part of reentry services but are not required to.

Recovery support and harm reduction services

Several sources reviewed specifically referenced the need for recovery support and harm reduction services to be available during reentry to community. BJA recommends that all individuals receive naloxone or a prescription for naloxone at release from incarceration. The National Reentry Resource Center recommends that individuals have a recovery plan focused on preventing return to use before release. The National Association of Counties references counties increasingly involving peer support specialists to facilitate engagement while the individual is in jail. Pew mentions self-

management training to help individuals manage, oversee, and advocate for their chronic health conditions. ASAM suggests that all individuals returning to the community with an OUD should receive education and training regarding unintentional overdose and death and a naloxone overdose kit or prescription.

CMS guidance provides flexibility for additional physical and behavioral health services above the benefits floor of case management, MOUD, and providing a 30-day medication supply that can include services provided by peer support workers but does not make those services a requirement. The approved California 1115 reentry waiver also includes community navigators with lived experience as part of the pre-release benefit package. In addition, several of the 14 states with pending Medicaid 1115 reentry waivers include some recovery services for reentry purposes. Providing recovery supports, including harm reduction, is a commonly recognized need in many of the sources we reviewed, and has the potential to improve reentry outcomes, including reducing mortality.

Recommendation 6.3.C: Jails and prisons should offer reentry recovery support services that include peer support from individuals with lived experience, harm reduction education, overdose prevention training, and either a naloxone prescription or naloxone in-hand at release but are not required to.

MOUD and other medication

The provision of MOUD before release, an ongoing supply of MOUD medication, and naloxone were included in most organizations' resource documents. Providing MOUD and a 30-day supply of prescription medications before release is a key element of CMS's pre-release waiver policy and included in many of the states with approved and pending 1115 reentry waiver proposals. BJA recommends individuals receive an "adequate supply" of MOUD at release from incarceration.

For any chronic health conditions, including OUD, ASAM and SAMHSA recommended that individuals receive at least a four-week (and preferably longer) supply or prescription of all needed medications. In addition, the individual's medical and prescription records are to be transferred to the primary care practitioner with whom a pre-release appointment has been made. Given the broad degree of alignment of the need for a supply of MOUD at release, this is an essential reentry recommendation. However, providing methadone at release presents operational challenges for most jails and prisons and requires changes to federal regulations.

Recommendation 6.3.D: Jails and prisons are required to provide a 30-day supply of MOUD and other medications at reentry, and the individual's medical and prescription records must be transferred to the primary care practitioner and MOUD provider in advance of the first appointment.

4. When Are Reentry Services Provided?

Except for ASAM, literature reviewed did not generally indicate a timeframe for beginning and ending reentry services. ASAM and the ACA recommend that at four to six weeks before reentry or release, all individuals with a history of OUD should be re-assessed by a trained and licensed clinician. CMS's reentry guidance anticipates that states with waivers will provide services in up to a 90-day time period prior to release. Release dates are difficult to predict, and especially challenging in a jail setting, where some stays are so short that a reentry period is difficult to apply, and people in pre-trial detention have no specific release date.

Recommendation 6.4.A: Prisons are required to begin reentry services at a minimum of 90 days prior to release and should include a schedule for their reentry process that provides target dates for key activities.

Recommendation 6.4.B: Jails are required to begin reentry services at intake. For individuals who are sentenced to more than 90 days in a jail setting, reentry services must resume at a minimum of 90 days prior to release and should include a schedule of reentry processes with target dates for key activities.

5. Who Administers Reentry Services?

Recent CMS guidance indicates expectations that case managers provide reentry services and should have training to address the medical and social complexities of individuals who experience incarceration, such as:

- trauma informed approaches
- person-centered care planning
- cultural competency
- support for individuals needs related to language and disability
- knowledge of physical and behavioral health needs as well as health-related social needs
- understanding of the unique needs of an individual who experienced incarceration
- skills related to developing trust and rapport with individuals who have been incarcerated

Case management and recovery supports can be provided by case managers, peer support specialists, community health workers. The competencies described for case managers in the CMS reentry guidance align with the principle of person-centered care established in this report; specifically, that reentry case managers provide trauma-informed, culturally appropriate, and person-centered care. In addition, these organizations require staff providing reentry services to be trained in motivational interviewing.

Peer support specialists and community health workers with lived experience can play a vital role, as they do in California reentry 1115 waiver. To support continuity of care, in-reach by community-based practitioners should be encouraged and facilitated.

Recommendation 6.5.A: Jails and prisons should staff reentry services with case managers and peer support specialists and/or community health workers, ideally with relevant lived experience but are not required to.

Recommendation 6.5.B: Reentry providers should have training in motivational interviewing, trauma informed care, person-centered care, and the needs of people who have experienced incarceration but are not required to.

SECTION 7: RECOMMENDATIONS FOR OTHER SERVICE-RELATED ISSUES

Table 7: Summary of Recommendations for Other OUD Service-Related Issues in Jails and Prisons

Recommendations	
Privacy	
Recommendation 7.1.A:	Jails and prisons are required to have policies and procedures that maximize confidentiality and privacy of clinical encounters and sharing information for intake and transitions, as well as protects confidences entrusted to a health care provider.
Informed Consent	
Recommendation 7.2.A:	Jails and prisons are required to observe and document informed consent standards in the jurisdiction that the jail or prison is in.
Services not available at the facility	
Recommendation 7.3.A:	Jails and prisons are required to ensure that individuals have access to the necessary referrals and transfers to receive services necessary to meet their health needs that are not available on-site.
Recommendation 7.3.B:	Jails and prisons are required to provide transfers to another facility, including but not limited to another correctional facility, in a timely manner, provide appropriate security provisions, use a medical escort when indicated, transfer a summary of medical information, and maintain individual confidentiality.
Recommendation 7.3.C:	Jails and prisons should have memoranda of understanding with community providers to provide services not available at the facility but are not required to.
Recommendation 7.3.D:	Jails and prisons are required to provide access to telehealth services to provide individuals with services unavailable at the facility.
Emergency services	
Recommendation 7.4.A:	Jails and prisons are required to be equipped with supplies and medications, including naloxone, to respond to medical emergencies and be able to provide immediate transfer for individuals who need emergency services not available on-site.
Recommendation 7.4.B:	Jails and prisons should provide all correctional staff with appropriate training on emergency services, including administration of naloxone, and be provided naloxone, but are not required to.
Correctional Staff Training	
Recommendation 7.5.A:	Jails and prisons should provide all correctional staff with training on opioid withdrawal, OUD, and MOUD, but are not required to.
Support systems	
Recommendation 7.6.A:	Jails and prisons should provide or facilitate on-site and/or telehealth access to support services, including but not limited to peer services, case management, care coordination, laboratory services, and medical and psychiatric consultation, which can be through a community provider, but are not required to.

Table 7: Summary of Recommendations for Other OUD Service-Related Issues in Jails and Prisons (Cont.)

Diversion	
Recommendation 7.7.A:	Jails and prisons should have safeguards in place to prevent the diversion of MOUD and to safeguard individuals on MOUD but are not required to.
Criminal legal involvement in OUD services	
Recommendation 7.8.A:	Jails and prisons are required to ensure that non-clinical staff are not involved in clinical decisions, and clinical staff are not involved in collecting forensic information.
Pregnant persons	
Recommendation 7.9.A:	Jails and prisons are required to provide pregnant persons with OUD with MOUD services by a clinician with training in treatment of OUD in pregnancy.
Recommendation 7.9.B:	Jails and prisons are required to continue pregnant persons on MOUD after delivery.
Recommendation 7.9.C:	Jails and prisons that do not have on-site specialized obstetrical services for treatment of OUD in pregnancy are required to have an established, functioning referral relationship with community specialized obstetrical services to ensure that individuals who are pregnant and have OUD have access to appropriate care.

There are several issues that have implications for policies and standards for OUD services provided to Medicaid-enrolled individuals in jails and prisons and cut across those services. While some of these issues are germane to services provided in the community, they may present heightened challenges for treating individuals in jails and prisons due to the nature of these facilities. These issues are discussed below and include:

1. Privacy and confidentiality
2. Informed consent
3. Services not available at the facility
4. Emergency services
5. Correctional staff training
6. Support systems
7. Diversion
8. Criminal legal involvement in OUD services
9. Pregnant persons

1. Privacy and confidentiality

The ASAM Criteria® recognizes issues with applying standards of OUD care in correctional settings due to challenges balancing facilities' priority on public safety and a provider's priority to provide treatment. For instance, it may be required that a correctional officer escort an individual to receive a screening and remain outside an open door while a screening is being conducted. Thus, while every effort should be made to conduct screenings in a private setting, this may be limited by correctional policies and procedures.

The NCCHC provides guidance for clinical encounters to be conducted in private, and that security personnel are only present if the individual poses a probable risk to the safety of others. CARF guidelines provide a framework for confidentiality delineating that MOUD care team members have access to information required to perform their function.

Recommendation 7.1.A: Jails and prisons are required to have policies and procedures that maximize confidentiality and privacy of clinical encounters and sharing information for intake and transitions, as well as protects confidences entrusted to a health care provider.

2. Informed consent

Before administering a screening or an assessment, individuals must undergo an informed consent process that includes, but is not limited to, the risks and benefits of treatment, voluntary participation, and limits of confidentiality. Correctional facilities must not coerce individuals into completing a screening. If an individual does not consent to a screening or an assessment, they must not be prevented from undergoing a screening or an assessment later.

NCCHC, ACA, and CARF recommend that, before receiving MOUD, individuals should be provided education and orientation that includes the medications and treatments offered, potential adverse reactions and risks, intent/consent to treat, behavioral expectations, complaint and appeal procedures, access to after-hour services, toxicology testing procedures, and the relationship between the criminal justice entity and MOUD program including the extent and limitations of confidentiality. ACA and NCCHC recommend that enrollment in the MOUD program may require the individual to sign a voluntary participation contract, release information consistent with the Health Insurance Portability and Accountability Act, or an agreement that authorizes the treating staff to provide progress reports to the court or other correctional or parole authorities. However, individuals must not be coerced into sharing health information with non-health entities that are not directly related to providing or coordinating their care.

CARF and ACA recommend that procedures be in place to ensure that each person served provides written, informed consent for treatment before the receipt of counseling and IOP services. Correctional facilities should not coerce individuals into participating in OUD services, and if an individual does not consent to an OUD service, they should not be prevented from participating later.

Recommendation 7.2.A: Jails and prisons are required to observe and document informed consent standards in the jurisdiction that the jail or prison is in.

3. Services not available at the facility

CARF recommends that programs refer individuals with co-occurring health or psychosocial issues not addressed by their program to appropriate services. Conditions such as pregnancy and prenatal care, HIV, chronic pain disorder, and other medical conditions may fall into this category. CARF further specifies that programs utilize linkages with community-based treatment

Transfers between correctional facilities

Available guidelines and standards for correctional OUD care provide minimal guidance on transferring individuals between correctional facilities; for example, when an individual incarcerated in a jail receives their sentence and is transferred to a prison. Such transfers occur because of the criminal legal process and not as a result of a clinical decision-making. A lack of standards for transferring individuals between correctional facilities jeopardizes the efficacy and continuity of MOUD treatment. The available guidance for transferring individuals when services are not available on-site can also be applied to transfers undertaken during the criminal legal process. Thus, transfers between correctional settings must also be conducted in a timely manner, provide appropriate security provisions, use a medical escort when indicated, transfer a summary of medical information, and maintain individual confidentiality.

facilities to facilitate referrals. ACA recommends that correctional facilities provide referrals and admission to mental health facilities for individuals whose psychiatric needs exceed the treatment capability of the facility. NCCHC recommends that when transfer to a psychiatric setting is clinically indicated, the transfer occurs in a timely manner and that the individual is safely housed and monitored until the transfer occurs. ACA, CARF, and NCCHC also recommend that individuals receiving withdrawal management or MOUD services be transferred to an acute care facility if their clinical needs exceed the program's capacity to provide care. Importantly, ACA further specifies that the responsible health care provider should determine the need to transfer an individual to another facility to receive services not available on-site.

Recommendation 7.3.A: Jails and prisons are required to ensure that individuals have access to the necessary referrals and transfers to receive services necessary to meet their health needs that are not available on-site.

Transfers

Correctional MOUD service programs must have policies and procedures for providing individuals with services that are necessary but unavailable at the facility. Consistent with ACA and NCCHC guidance, transferring individuals to another facility must include transferring the person in a timely manner, providing appropriate security provisions, using a medical escort when indicated, transferring a summary of medical information, and maintaining the individual's confidentiality. For further context, California's 1115 reentry waiver, approved in January 2023, authorizes Medicaid to cover transfer services when needed.

Recommendation 7.3.B: Jails and prisons are required to provide transfers to another facility, including but not limited to another correctional facility, in a timely manner, provide appropriate security provisions, use a medical escort when indicated, transfer a summary of medical information, and maintain individual confidentiality.

Community providers

Correctional MOUD service programs may also rely on community partnerships to provide services not available in the facility. Contracting with community providers can be an effective way of providing MOUD and other services, achieving a community standard of care, advancing the billing and oversight infrastructure that Medicaid coverage will require, and promoting continuity of care post-release. Community organizations may offer MOUD, behavioral therapy, case management, recovery coaching, as well as facilitate referrals at release from jail or prison. However, enabling community providers to provide services in jails or prisons also requires developing appropriate approaches to security, contracting, and other logistical issues. For example, community providers performing in-reach or follow-up to ensure continuity of care need to follow correctional facility policies and regulations. NCCHC and SAMHSA recommend establishing written agreements, such as memoranda of understanding, to establish procedures, expectations, and boundaries that should be reviewed annually. In addition, community providers may provide services via telehealth if appropriate.

Recommendation 7.3.C: Jails and prisons should have memoranda of understanding with community providers to provide services not available at the facility but are not required to.

Telehealth

CARF recommends using telehealth for screening and assessment, and both CARF and NCCHC recommend using telehealth for MOUD services when on-site staffing is insufficient to conduct those services. In addition, ASAM recommends providing telehealth services to increase access to behavioral health services in correctional facilities that cannot offer such treatments on-site. For assessment, CARF stipulated that telehealth cannot be used to substitute for a face-to-face full assessment because it requires a physical exam. Telehealth can be used to support

decision-making, but only when a provider qualified to perform a physical exam is located with the individual. However, SAMHSA's Notice of Proposed Rulemaking for Opioid Treatment Programs allows the health care practitioner to complete the screening and full physical examination via telehealth for appropriate individuals admitted for treatment with either buprenorphine or methadone.[121] Recently the DEA proposed a rule change that allows providers to prescribe a 30-day supply of buprenorphine via telehealth, and the final rule is expected at the end of 2023.[123] Neither SAMHSA nor the DEA requires a physical exam to prescribe buprenorphine via telehealth.[124] Lastly, CARF also recommends that programs may use telepsychiatry or telehealth to receive consultation for emergency services and crisis interventions.

The use of telehealth for screening may also be used in rural and lower-volume correctional settings which supports the goal of this report to increase the uptake of evidence-based OUD care in correctional settings.

Recommendation 7.3.D: Jails and prisons are required to provide access to telehealth services to provide individuals with services unavailable at the facility.

4. Emergency services

ACA, NCCHC, and CARF recommend MOUD services include access to emergency services and on-site first aid that includes, but is not limited to, naloxone, oxygen, and automated external defibrillators that are approved by the health authority, regularly maintained, and usable by non-medical staff. CARF and ACA recommend that MOUD services provide individuals with access to after-hours emergency services 24 hours a day and seven days a week. CARF provides guidance so that on-call emergency contacts do not need to always be on-site. ACA and NCCHC specify that procedures should be in place to immediately transfer individuals for emergency care at a designated hospital or other appropriate health facilities, including security protocols and using an emergency vehicle. Limited staffing resources in correctional facilities may make it not feasible to offer on-site emergency services outside regular clinic hours.

Recommendation 7.4.A: Jails and prisons are required to be equipped with supplies and medications, including naloxone, to respond to medical emergencies and be able to provide immediate transfer for individuals who need emergency services not available on-site.

Recommendation 7.4.B: Jails and prisons should provide all correctional staff with appropriate training on emergency services, including administration of naloxone, and be provided naloxone, but are not required to.

5. Correctional staff training

Recommendations for screening and management of opioid withdrawal include services provided by correctional staff. The above recommended standards for screening include correctional staff providing structured observations, and, during management of opioid withdrawal, correctional staff providing withdrawal monitoring. In addition, individuals who initiate a self-referral for a clinical assessment during their incarceration may present first to correctional staff. Thus, providing training on opioid withdrawal, OUD, and MOUD to correctional staff will improve access to OUD services.

Recommendation 7.5.A: Jails and prisons should provide all correctional staff with training on opioid withdrawal, OUD, and MOUD, but are not required to.

6. Support systems

NCCHC and SAMHSA guidelines provide recommendations for MOUD programs to include access to mental health services provided by a psychiatrist, psychologist, or psychiatric social worker. CARF specifies a care coordinator role, which can be a peer advocate, case manager, case coordinator, program coordinator, primary

clinician, or team leader, who assists in care coordination for everyone. Peer support services can include, but not be limited to, mentoring, coaching, resource connecting, facilitating, and leading recovery, educational and support groups, advocating for the person/family served, and building community supports. In addition, CARF identifies "natural supports" such as family members as support systems that can be involved in MOUD care.

ASAM, CARF, and NCCHC recommend that counseling and IOP programs integrate support systems into treatment plans. ASAM highlights that support systems are particularly important in a correctional setting to develop working relationships with correctional personnel and relationships with community providers to ensure community re-integration after release. Reentry services are addressed in section 6, but notably, ASAM recommends ongoing support services to help address basic needs such as transportation, housing, employment, and education. Specifically, ASAM and CARF identify peer support services that include mentoring, coaching, resource connecting, facilitating, and leading recovery, educational support groups, advocating for the individual, and building community supports. ASAM and CARF also recommend identifying the individual's natural supports, such as family, to be integrated as support systems in counseling and IOP. CARF recommends that programs have a designated individual such as a peer advocate, a case manager, program coordinator, or the primary clinician, to assist in the coordination of services. NCCHC and ASAM both recommend self-help programming, such as Narcotics Anonymous and 12-step programs.

In summary, jails and prisons providing counseling and IOP should integrate support services, including peer services, case management, care coordination, laboratory services, and medical and psychiatric consultation. This will better equip prisons and jails to address high rates of co-occurrence of mental health and SUD.

Recommendation 7.6.A: Jails and prisons should provide or facilitate on-site and/or telehealth access to support services, including but not limited to peer services, case management, care coordination, laboratory services, and medical and psychiatric consultation, which can be through a community provider, but are not required to.

7. Diversion

There is a lack of data describing the extent of MOUD diversion in correctional facilities, but MOUD diversion was raised as a concern by standards-setting organizations. Anti-diversion strategies offered by ASAM and SAMHSA include frequent clinic visits, drug testing, directly observed dosing, recall visits for pill counts, medication lines and dispersal windows, dual-mouth checks, dedicated observation tables, requiring individuals to consume crackers or juice to avoid cheeking, crushing, liquifying or mixing medications with other fluids, specialized units for people receiving MOUD, and transporting individuals to a secure unit. NCCHC/NSA guidelines highlight that using long-acting injectable buprenorphine is an approach that would likely be effective in avoiding diversion. NCCHC guidelines identify the need to provide individuals with a single "take-home" dose for a day when the clinic is closed for business, such as Sundays and state and federal holidays. ASAM and CARF recommend drug testing to ensure adherence and detection of possible diversion. They advise a minimum of eight drug tests per year while acknowledging that the frequency of drug testing and what drugs to test for has not been definitively established. Drug testing should be based on an individual needs and conducted respectfully. Drug testing results, however, should not be used as the sole or a strong basis for treatment decisions or termination from treatment. Drug testing results demonstrating continued substance use may reflect a need for a change in the treatment plan, including a change in medication, dosage, or level of care. Diversion should not be used to justify denying an individual access to MOUD.

Recommendation 7.7.A: Jails and prisons should have safeguards in place to prevent the diversion of MOUD and to safeguard individuals on MOUD, but are not required to.

8. Criminal legal involvement in OUD services

CARF and NCCHC specify that MOUD should not be used to reinforce positive behavior or to punish negative behaviors. A justice or treatment agency should not impose decisions to start, continue, or adjust MOUD. The ACA specifies that clinical decisions must not be countermanded by non-clinicians and must be made without interference from non-clinical personnel. The NCCHC specifies that health staff not write disciplinary reports or collect forensic information and that individuals should not be coerced into participating in OUD services. BJA also states that policy decisions disallowing or disincentivizing MOUD are not clinically appropriate.

Recommendation 7.8.A: Jails and prisons are required to ensure that non-clinical staff are not involved in clinical decisions, and clinical staff are not involved in collecting forensic information.

9. Pregnant Persons

The ASAM guide identifies pregnant persons as a special population because OUD carries obstetrical risks. As outlined in ASAM, CARF, and NCCHC guidelines, pregnant persons must be given priority to MOUD care and be excluded from admission criteria requiring physical dependence. Per ASAM, pregnant persons should be offered and strongly encouraged to accept buprenorphine or methadone, as there is insufficient evidence for the safety and efficacy of naltrexone during pregnancy. ASAM, BJA, and NCCHC recommend specialized obstetrical services for providing MOUD to pregnant persons. ASAM guidelines recommend hospitalization for initiation of agonist therapy for pregnant persons and emphasize that MOUD should be continued following delivery. When specialized obstetrical services are not available then the individual will need to be transferred, so it is imperative the jails and prisons have functioning referral relationships with community obstetrical services when in-house services are not available.

BJA and ASAM also recommend that pregnant persons on MOUD be continued on MOUD after delivery. In addition to MOUD, NCCHC recommends that pregnant persons should receive counseling that includes the risk of neonatal opioid withdrawal syndrome, as well as prenatal care and postpartum care. Drug testing should also be done with the informed consent of the pregnant person, including the potential for adverse legal and social consequences for substance use (e.g., child custody).

Recommendation 7.9.A: Jails and prisons are required to provide pregnant persons with OUD with MOUD services by a clinician with training in treatment of OUD in pregnancy.

Recommendation 7.9.B: Jails and prisons are required to continue pregnant persons on MOUD after delivery.

Recommendation 7.9.C: Jails and prisons that do not have on-site specialized obstetrical services for treatment of OUD in pregnancy are required to have an established, functioning referral relationship with community specialized obstetrical services to ensure that individuals who are pregnant and have OUD have access to appropriate care.

CONCLUSION

Growing rates of overdose deaths in the U.S. have generated interest in new policies to increase access to OUD services; in particular, MOUD for individuals who are incarcerated. People with OUD who are incarcerated could greatly benefit from treatment with MOUD, although very few receive it. Some state and federal policymakers have proposed to authorize Medicaid to cover MOUD or a broader set of health care services during the entirety of a prison or jail stay. This report recommends a set of services and standards for OUD care that Medicaid cover for Medicaid beneficiaries in jails and prisons to advance quality, evidence-based OUD services in prisons and jails. They could be applied if federal Medicaid policy changes to allow the program to cover OUD services to incarcerated beneficiaries during an entire prison or jail stay. The services and programmatic standards are comparable to the services and standards that pertain to Medicaid-covered OUD services in the community, while taking into account the challenging circumstances that affect prisons and jails. Two subsequent companion reports will be issued later this year to build on these standards by recommending performance measures that align with these standards and assess the outcomes of MOUD services provided in prisons and jails, and reimbursement and payment models that can advance these standards of care in prisons and jails.

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APPENDIX A: METHODS USED TO DEVELOP REPORT RECOMMENDATIONS:

This report recommends services and programmatic standards for potential Medicaid-covered OUD services in prisons and jails that are comparable to the services and standards that pertain to OUD services that Medicaid covers in the community that advance access to treatment. To develop these recommendations, we reviewed existing standards developed by national organizations that provide guidance to organizations and practitioners for treating individuals with OUD in the community and carceral settings as well as federal policies that pertain to provision of Medicaid covered services in the community. We identified and took into account the specific and sometimes challenging circumstances that affect the provision of health care services in prisons and jails that do not pertain in community settings. We aimed to develop standards that advance a community standard of care that also recognize and account for some of the unique characteristics of health care services in carceral environments.

The team established three principles that guide effective OUD service provision and that apply widely to OUD treatment in the community, and applied them as we developed our recommendations. They are:

- Continuity of care: Disruption in OUD care, particularly stopping treatment of key medications such as methadone, buprenorphine, and naltrexone increases the risk of opioid withdrawal during detainment as well as the risk of death from an opioid overdose while incarcerated and after release from incarceration. Thus, these recommendations prioritize standards that ensure the continuity of MOUD across community and correctional settings.
- Timeliness of treatment: Delays in care can worsen withdrawal symptoms, and exacerbate mental and physical conditions, requiring higher levels of care. Thus, these recommendations prioritize timely provision of OUD care based on clinical evidence and existing correctional and community standards.
- Person-centered care: People with OUD experience stigma in the community that can be compounded by incarceration, and correctional OUD care must not contribute to stigma. To ensure that these recommendations do not exacerbate stigma, the recommendations prioritize person-centered care, which affirms an individual's identity and is culturally and linguistically appropriate.

Our approach to developing recommendations for Medicaid coverage in jails and prisons included the following steps: (1) defining correctional OUD services; (2) review, comparison, and assessment of community and correctional standards; (3) review of Medicaid policies that pertain to community OUD services for Medicaid beneficiaries; (4) identification and discussion of specific circumstances that may impact the breadth of services that are needed by individuals in jail and prison settings. We synthesized this information into an initial set of recommendations, which we reviewed and discussed with an expert advisory council and external reviewers. The participants are identified in Appendix B.

Defining which services to consider recommending for Medicaid coverage in prisons and jails relied on a continuum of care framework. The continuum of OUD care starts at screening and assessment, and is followed by treatment initiation, then retention in care. Applications of the continuum of OUD care to correctional settings have highlighted the importance of screenings and care coordination that facilitate successful re-entry. To guide this analysis, four stages of OUD care in correctional settings were identified: screening, assessment, treatment, and reentry. Importantly, the treatment stage included MOUD, withdrawal management, counseling, and IOP as defined in the most recent version of The ASAM Criteria®.

Recommendations for the standards within each stage of the continuum of correctional OUD care were developed by identifying and comparing existing standards for correctional healthcare and community opioid withdrawal and OUD care. Through an environmental scan, national organizations were identified

to have specific standards for the services included in the continuum of care. In addition, position papers were reviewed when national standards did not provide the specificity for informing recommended standards for policy makers and providers for implementing OUD services in carceral settings. When specific standards were not developed or recommended for jails or prisons, existing community standards developed by ASAM or CARF were reviewed and modified for services provided in jails and prisons. For some services, specifically transitions and re-entry services, research and existing community standards for services use by state Medicaid agencies (e.g., case management) were foundational in developing standards. The standards and guidelines reviewed for this report appear in Table 1.

Table 1: Standards for OUD Services Reviewed in Developing Recommendations

ORGANIZATION	DESCRIPTION	SOURCES
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP)	ACEP is professional organization of emergency medicine physicians in the United States. The organization strives to improve the quality of emergency medical services through the development of evidence-based clinical policies, funding emergency medicine research, education on emergency care and disaster preparedness, advocacy efforts, providing continuing medical education, and publishing the Annals of Emergency Medicine and the Journal of the American College of Emergency Physicians Open.	- Hawk K, Hoppe J, Ketcham E, LaPietra A, Moulin A, Nelson L, Schwarz E, Shahid S, Stader D, Wilson MP, D'Onofrio G. Consensus recommendations on the treatment of opioid use disorder in the emergency department. Annals of emergency medicine. 2021 Sep 1;78(3):434-42. - Herring AA, Perrone J, Nelson LS. Managing opioid withdrawal in the emergency department with buprenorphine. Annals of emergency medicine. 2019 May 1;73(5):481-7. - Guo CZ, D'Onofrio G, Fiellin DA, Edelman EJ, Hawk K, Herring A, McCormack R, Perrone J, Cowan E. Emergency department initiated buprenorphine protocols: A national evaluation. Journal of the American College of Emergency Physicians Open. 2021 Dec;2(6):e12606.
AMERICAN CORRECTIONAL ASSOCIATION (ACA)	ACA is an association developed specifically for practitioners in the correctional profession that share a common goal of improving the justice system.	- Performance-Based Standards and Expected Practices for Adult Correctional Institutions (March 2021) - ACA and ASAM Joint Public Correctional Policy on the Treatment of Opioid Use Disorders for Justice Involved Individuals. 2018.

ORGANIZATION	DESCRIPTION	SOURCES
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)	ASAM is a professional medical society representing physicians, clinicians and associated professionals in the field of addiction medicine and is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of individuals with addiction	- Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. The ASAM criteria. Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies®; 2013. - Cunningham C, Edlund MJ, Fishman M, Gordon AJ, Jones HE, Langleben D, Femino J. The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update. J Addict Med. 2020;14(2S Suppl 1):1-91. - Access to Medications for Addiction Treatment in Correctional Settings State Brief. November 2020. - Public Policy Statement on Treatment of Opioid Use Disorder in Correctional Settings. July 15, 2020.
COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES (CARF)	CARF promotes the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of individuals served. Recently Level CARF has developed program standards using The ASAM Criteria® to independently assess and verify the ability of providers to deliver substance use disorder treatment services to adults.	- Behavioral Health Standards Manual, 2022. - Opioid Treatment Program Standards Manual, 2022.
NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE (NCCHC)	NCCHC is an independent, non-profit organization dedicated to improving the standard of care in the field of correctional health care in the United States.	- Standards for Health Services in Jails, 2018. - Standards for Health Services in Prisons, 2018. - Standards for Opioid Treatment Programs in Correctional Facilities, 2016. - Jail-Based Medication Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field. October 2018 (co-published with the National Sheriffs Association [NSA])

ORGANIZATION	DESCRIPTION	SOURCES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)	SAMHSA is the federal agency that leads public health efforts to advance the behavioral health of the nation. SAMHSA has developed service specific standards for some OUD care (Opioid Treatment Programs) and provider information on OUD treatment practices for policy makers and providers.	- Screening and Assessment of Co-Occurring Disorders in the Justice System, 2015. - Use of Medication Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings, Substance Abuse and Mental Health Services Administration, 2019.
BUREAU OF JUSTICE ASSISTANCE (BJA)	BJA is a federal agency provides resources to strengthen programmatic and policy efforts that promote a fair and safe criminal justice system. BJA provides toolkits, training and technical assistance to law enforcement, courts, corrections, treatment, reentry, justice information sharing, and community-based partners to address chronic and emerging criminal justice challenges nationwide. In June 2023, BJA published guidelines for managing substance withdrawal in jails that were endorsed by American Correctional Association (ACA), American Society of Addiction Medicine (ASAM), American Jail Association (AJA), Major County Sheriffs of America (MCSA) National Association of Counties (NACo), National Commission on Correctional Health Care (NCCHC), National Sheriffs' Association (NSA), and Small & Rural Law Enforcement Executives Association (SRLEEA).	Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals, 2023.

The ASAM Criteria® provide the foundation for community standards of most OUD care. The Commission on Accreditation of Rehabilitation Facilities standards provide additional community standards of OUD care. Recommendations from the Substance Abuse and Mental Health Services Administration provide standards for OUD care in correctional and community settings. The National Commission on Correctional Health Care standards for healthcare in jail and prison settings, as well as the American Correctional Association standards for adult correctional institutions, provide standards for correctional healthcare. The Bureau of Justice Assistance provided standards for substance use withdrawal management in the jail setting. In addition, Emergency Medicine standards were used to account for operational considerations of implementing evidence-based OUD care in jail settings.

Our review of Medicaid policies for community OUD services focused primarily on policies that states have authorized through Medicaid section 1115 demonstration waivers to establish a continuum of OUD care in the community that include residential treatment. These demonstration waivers focus specifically on SUD/OUD and allow Medicaid to cover services in large facilities known as institutions for mental disease. These demonstration waivers offer the closest similarities to Medicaid covered OUD services provided in prisons and jails which have not historically been covered through Medicaid. Thirty-five states have approved OUD waivers. These OUD 1115 waivers, which have been available since 2015, require states to: 1) offer a full continuum of OUD services, including counseling (individual and group), MOUD, and withdrawal management; 2) reimburse for assessments based on SUD-specific, multidimensional assessment tools, e.g., The ASAM Criteria® or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and 3) offer Intensive Outpatient Programs as a condition of participation in these 1115 Waivers.

Initial recommendations based on the existing standards for each correctional OUD service were reviewed by an expert advisory council. The advisory council included individuals with lived experience of OUD and incarceration, administrators and providers of correctional and community-based OUD care, health, correctional administrators, and healthcare professionals with experience in managed care. The advisory council and authors convened to discuss significant feedback to inform revisions to the recommendations.

Revised recommendations were reviewed by two external reviewers with expertise in administration and provision of correctional healthcare and Medicaid reimbursement. External reviewers provided detailed written feedback that was reviewed by the authors and discussed with the advisory council at a second convening to inform revisions to the recommendations. The authors further discussed feedback and revisions with the external reviewers to inform the final revisions to the recommendations. The authors also acknowledge the contributions of Sandra Ann Springer, MD for her review of previous drafts of this report.

Although the authors carefully considered the input of the advisory council and reviewers, the recommendations made in this report are those of the authors.

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i Williams AR, et al. Development of a cascade of care for responding to the opioid epidemic. The American journal of drug and alcohol abuse. 2019 Jan 2;45(1):1-0.

ii Yedinak JL, et al. Defining a recovery-oriented cascade of care for opioid use disorder: a community-driven, statewide cross-sectional assessment. PLoS medicine. 2019 Nov 19;16(11):e1002963.

iii Ray B, et al. Developing a cascade of care for opioid use disorder among individuals in jail. Journal of Substance Abuse Treatment. 2022 Jul 1;138:108751.

iv Brinkley-Rubinstein L, et al. Criminal justice continuum for opioid users at risk of overdose. Addictive behaviors. 2018 Nov 1;86:104-10.

v Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. The ASAM criteria. Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies®; 2013.

vi https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table4

vii Brian Neale, Director, Centers for Medicare & Medicaid Services, Letter to State Medicaid Director, SMD # 17-003 RE: Strategies to Address the Opioid Epidemic, November 2017, https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

APPENDIX B

Members of Advisory Council

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APPENDIX C: SELECTED SCREENING TOOLS

Substance Use Disorder

Rapid Opioid Dependency Screen
- Brief and validated in correctional settings.

Texas Christian University Drug Screen V – Opioid Supplement
- Brief and validated in correctional settings.

Drug Abuse Screening Tool - 10
- Brief and recommended for use in correctional settings by BJA and SAMHSA

Mental Health

Brief Jail Mental Health Screen
- Brief and validated in correctional settings.

Correctional Mental Health Screen
- Brief and validated in correctional settings.

Suicide

Beck scale for suicidal ideation
- Recommended by SAMHSA for use in correctional settings.

Adult Suicidal Ideation Questionnaire
- Recommended by SAMHSA for use in correctional settings.