Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons

A PLANNING & IMPLEMENTATION *Toolkit*

Vital Strategies

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

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COMMONLY USED ACRONYMS

Acronym	Meaning
ABAM	American Board of Addiction Medicine
ACA	American Correctional Association
ACOG	American College of Obstetricians and Gynecologists
ASAM	American Society of Addiction Medicine
CDC	Centers for Disease Control and Prevention
DATA 2000	Drug Addiction Treatment Act of 2000
DEA	Drug Enforcement Administration
DOC	Department of corrections
DSM	Diagnostic and Statistical Manual of Mental Disorders
FDA	Food and Drug Administration
HIV	Human immunodeficiency virus
MAT	Medication-assisted treatment
MOUD	Medication for opioid use disorder
NCCHC	National Commission on Correctional Health Care
NGA	National Governors Association
NIDA	National Institute on Drug Abuse
OAT	Opioid agonist treatment
OEND	Opioid education and naloxone distribution
OTP	Opioid treatment program
OUD	Opioid use disorder
PDMP	Prescription drug monitoring program
RSAT	Residential Substance Abuse Treatment Training and Technical Assistance
SAMHSA	Substance Abuse and Mental Health Services Administration
SOR/STR	State Opioid Response Grants/State Targeted Response Grants
SUD	Substance use disorder
XR-NTX	Extended-release injectable naltrexone

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INTRODUCTION

Correctional administrators and health care providers are on the frontlines of the opioid epidemic as justice-involved individuals are disproportionately at risk of having opioid use disorder (OUD) and dying from opioid overdose. Despite the high rates of OUD among incarcerated individuals, evidence-based treatment does exist and can be successfully implemented within jails and prisons. The most effective treatment for OUD is the use of U.S. Food and Drug Administration (FDA)-approved medications (methadone, buprenorphine and extended-release injectable naltrexone), a treatment modality commonly known as medication-assisted treatment (MAT) or medication for opioid use disorder (MOUD). Across the nation, a growing number of jails and prisons offer MAT for OUD resulting in positive outcomes for patients, staff and jurisdictions.

WHAT IS IN THIS TOOLKIT?

This toolkit provides correctional administrators and health care providers the information necessary to plan and implement MAT programs within jails and prisons. Organized by core components, each section offers actionable steps, implementation questions, real-world case examples, checklists, tools and resources drawn from the latest research, subject matter experts and experiences from diverse settings across the U.S.

Examples of some of the tools and resources found in the toolkit include:

- Links to guidance from relevant professional trade associations.
- Links to screening and assessment tools.
- Strategies to reduce medication diversion.
- A table to help estimate the total MAT patient population.
- A calculator to estimate the costs of providing buprenorphine.
- A flowchart on how to become an opioid treatment program (OTP).
- A list of no-cost training resources.
- Sample forms for patient information and consent.
- Sample policies and operating procedures.
- Monitoring and evaluation metrics.

WHY PROVIDE MAT IN CORRECTIONAL SETTINGS?

Each day, approximately 130 people in the U.S. die from opioid overdose;[1] however, despite the availability of evidence-based medications to treat OUD, it is estimated that fewer than 1 percent of jails and prisons in the U.S. provide access to medications.[2] Opioid use disorder is highly prevalent among justice-involved individuals leading to increased risk of early death, hepatitis C and HIV;[3] yet, more than 80 percent of

individuals who are incarcerated and have a history of opioid use do not receive treatment.[4, 5] Among a sample of 78,976 individuals living in non-institutional settings who self-reported prescription opioid misuse within the last 12 months, 51.7 percent had some type of criminal justice involvement over their lifespan and 76.8 percent of individuals who self-reported using heroin over the last 12 months had a history of criminal justice involvement.[6]

The consequences for failing to treat OUD within correctional settings are significant. In Massachusetts, opioid-related overdose deaths accounted for 40 percent of all deaths among former inmates released between 2013 and 2014.[7] Within the first two weeks after release, a study of the Washington State Department of Prisons documented that prisoners' risk of death by overdose was more than 100 times more likely than the general population and risk of death by all causes was more than 12 times likely.[8] Similarly, in North Carolina, research showed former inmates' risk of death by opioid overdose at two weeks post-release was 40 times higher than the general population and the risk of death by heroin overdose was 74 times higher.[9] In addition to risk of overdose, most individuals who receive MAT in the community lose access to treatment upon confinement; studies show these individuals experience extreme stress.[10] Individuals with opioid dependence entering correctional facilities are also at high risk for opioid withdrawal syndrome.[11]

A growing body of evidence demonstrates that MAT programs in correctional settings are effective in preventing opioid overdose deaths. After expanding access to MAT statewide in its correctional system, the Rhode Island Department of Corrections (DOC) experienced a reduction in post-correctional overdose death rates by 61 percent in the first year.[12] A study of more than 12,000 people in England found that a prison-based buprenorphine and methadone program was associated with a 75 percent reduction in all-cause mortality and an 85 percent reduction in overdose deaths in the first month after release.[13] Additionally, a study of more than 16,000 people with opioid dependence in prison in Australia found that individuals receiving methadone and buprenorphine had a reduced risk of death in prison, primarily by suicide, of 74 percent. Furthermore, during the first four weeks in prison, a 94 percent reduction in risk of death was documented, also primarily associated with a reduction of suicide deaths among inmates.[14] Access to evidence-based medications for OUD improves health outcomes and fosters long-term recovery.[15]

Supporting adoption of MAT in correctional settings, the National Sheriffs' Association (NSA) and the National Commission on Correctional Health Care (NCCHC) cite a range of potential benefits, including:[16]

- Stemming the cycle of arrest, incarceration and release associated with substance use disorders (SUD), as individuals with SUD often return to the community without connection to treatment.
- Contributing to the maintenance of a safe and secure facility for inmates and staff.
- Reducing costs.
- Minimizing the risk of post-release overdose and death.
- Facilitating a path to recovery for individuals with SUD.

NATIONAL ADOPTION OF MAT MODELS IN CORRECTIONAL SETTINGS

Recognizing the importance of providing evidence-based treatment to individuals with OUD, the NCCHC adopted a position statement in October 2016 advocating for implementation of a set of principles for care of individuals with SUD in correctional facilities. The principles include the use of MAT; screening, evaluation and care coordination upon entry; psychosocial treatments; and medication-assisted withdrawal when indicated (see **Appendix E: National Commission on Correctional Health Care (NCCHC) Principles for Care of Adults and Adolescents with Substance Use Disorders in Correctional Facilities**).[17]

A growing number of other national organizations are also calling for adoption of MAT within correctional settings. In 2018, the American Correctional Association (ACA) and American Society of Addiction Medicine (ASAM) issued a joint public correctional policy advocating for the treatment of OUD for justice-involved individuals. The policy recommends that correctional systems adopt practices related to screening and prevention, treatment, re-entry and community supervision and education to support individuals.[18] In 2019, the NSA adopted a resolution supporting the use of evidence-based MAT for OUD in county jails.[19] Additionally, the National Governors Association (NGA) included increasing access to MAT in prisons and correctional settings as a key state strategy in its 2016 road map, Finding Solutions to the Prescription Opioid and Heroin Crisis.[20]

> "Jails can minimize the risk of post-release overdose by facilitating continued access to MAT for individuals who are on prescribed FDA-approved MAT and by facilitating initiation of MAT prior to release for individuals with OUD who were not receiving MAT prior to arrest — taking into account individual preferences, clinician judgment and medication diversion potential."
>
> *National Sheriffs' Association*

LEGAL ENVIRONMENT

Increasingly, jurisdictions across the nation are establishing the provision of evidence-based treatment for SUD within correctional facilities as a legal requirement. The legality of denying access to medications for OUD in correctional facilities has been challenged in courts as unconstitutional under the Eighth Amendment's prohibition on cruel and unusual punishment and as a violation of federal civil rights laws. The Eighth Amendment, the Americans with Disabilities Act (ADA) and the Rehabilitation Act are the most frequently cited legal authorities for providing MAT to qualifying inmates.[21,22,23,24,25] As research on the science of addiction becomes more advanced, courts have acknowledged that MAT is not only the most effective treatment for OUD, but that denying access to MAT presents a serious risk of harm, including death, to the individual.[26]

WHAT IS OPIOID USE DISORDER?

OUD is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a problematic pattern of opioid use leading to clinically significant impairment or distress.[27] In 2016, an estimated 2.1 million people aged 12 or older had an OUD.[28] To confirm a diagnosis of OUD, at least two of 11 diagnostic criteria should be observed within a 12-month period. Severity is determined by the number of criteria present: two to three symptoms indicate mild severity, four to five indicate moderate severity and six or more symptoms indicate severe OUD.[29] Criteria for diagnosing OUD can be found in **Appendix D: DSM-5 Criteria for Opioid Use Disorder**.

FDA-APPROVED MEDICATIONS FOR OPIOID USE DISORDER

The use of evidence-based medication for OUD is the most effective option for treating individuals with OUD; this treatment modality is commonly referred to as medication-assisted treatment or MAT.[30,31] There are three U.S. FDA-approved medications currently used to treat OUD: methadone, buprenorphine and extended-release injectable naltrexone (XR-NTX). Each FDA-approved medication differs pharmacologically and is governed by different regulations:

- **Methadone** is only provided within Substance Abuse and Mental Health Services Administration (SAMHSA)-certified and Drug Enforcement Administration (DEA)-regulated OTPs.[32] A growing number of correctional settings have either obtained OTP status or partnered with community OTPs to provide methadone.
- **Buprenorphine** can be prescribed in non-specialty settings if physicians, nurse practitioners and physician assistants obtain a SAMHSA waiver (commonly known as the "x-waiver") by completing requisite training. The Drug Addiction Treatment Act of 2000 (DATA 2000) established that qualified providers can offer buprenorphine for OUD in various settings, including correctional facilities.[33]
- **Extended-release injectable naltrexone (XR-NTX)** can be prescribed by any clinician who is licensed to prescribe medication.[34] Unlike methadone and buprenorphine, both opioid agonists, XR-NTX is an opioid antagonist and not a controlled substance.

Table 1 contains a detailed description of each FDA-approved medication for OUD.

TABLE 1. FDA-APPROVED MEDICATIONS FOR OPIOID USE DISORDER [35]

Medication	How It Works	Frequency of Administration	Route of Administration	Who May Prescribe or Dispense
Methadone	Full opioid agonist: binds to and activates opioid receptors in the brain activated by the drug, but in a safer and more controlled manner. Reduces the symptoms of withdrawal and cravings.	Daily	Orally as liquid concentrate, tablet or oral solution of diskette or powder	SAMHSA-certified opioid treatment programs dispense methadone for daily administration either on-site or, for stable patients, for taking at home.
Buprenorphine	Partial opioid agonist: binds to and activates opioid receptors but with less intensity than full agonists	Daily (also alternative dosing regimens)	Oral tablet or film dissolved under the tongue	Physicians, nurse practitioners and physician assistants with a federal waiver may prescribe and dispense. Prescribers must complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.
Buprenorphine implant (Probuphine®)		Every six months	Subdermal	
Buprenorphine injection (Sublocade®)		Monthly	Injection (for moderate to severe OUD)	
Buprenorphine and naloxone (Suboxone®)	Combination of partial opioid agonist (buprenorphine) and agonist (naloxone)	Daily (also alternative dosing regimens)	Sublingual film	Physicians, nurse practitioners and physician assistants with a federal waiver may prescribe and dispense. Prescribers must complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.

Medication	How It Works	Frequency of Administration	Route of Administration	Who May Prescribe or Dispense
Naltrexone (XR-NTX) (injection)	Antagonist: binds to and blocks the activation of certain receptors on cells, preventing a biological response	Monthly	Intramuscular injection into the gluteal muscle by a physician or other health care professional	Any individual licensed to prescribe medicines (e.g., physician, physician assistant or nurse practitioner) may prescribe and/or order administration by qualified staff.
Naltrexone (oral)[i]		Daily	Oral tablet	

While studies show all three FDA-approved medications for OUD are effective in reducing return to illicit opioid use, some medications are more effective than others.[36, 37] Methadone is the most commonly used and studied medication for OUD worldwide and clinical trials have demonstrated that it reduces illicit opioid use, treats OUD and retains patients in treatment better than placebo or no medication.[38] Studies assessing buprenorphine show that it is effective in retaining patients in treatment and reducing illicit opioid use.[39] XR-NTX has demonstrated efficacy in reducing return to illicit opioid use and reducing opioid craving once initiated.[40,41] Research suggests it is more difficult to initiate patients onto XR-NTX, compared to buprenorphine, and this difficulty negatively affected return to use rates among those introduced to XR-NTX.[42] Rates of overdose associated with XR-NTX have been shown to be higher than buprenorphine at four weeks post medication discontinuation.[43] There is currently insufficient evidence to show that oral naltrexone is effective at treating OUD.[44, 45] In-depth implementation considerations related to choosing medications for OUD can be found in **Component 2: Program Planning and Design**.

Does MAT substitute one drug for another?

While methadone and buprenorphine are opioid-based, they are not simply replacements for heroin or misused prescription opioids. XR-NTX is not opioid-based. Methadone and buprenorphine are structurally different from short-acting opioids, such as heroin, which travels directly to the brain causing sedation and a "high." Methadone and buprenorphine, when properly used to treat OUD, reduce drug cravings without causing a "high."

MEDICATION TO REVERSE OPIOID OVERDOSE

The FDA has approved naloxone (commonly known by the brand name Narcan®), a medication to reverse opioid overdoses and prevent overdose death. Naloxone can be administered by non-medically trained individuals and is available in intranasal and injectable formulations. Naloxone begins working within two to five minutes after administration and lasts for approximately 30 to 60 minutes. The NCCHC adopted a position statement supporting increased access and use of naloxone in correctional facilities in 2015.[46]

i. Oral naltrexone in a daily pill form was initially approved for the treatment of OUD; however, treatment adherence of the medication has limited its real-world effectiveness. The National Institutes of Health have found that there is insufficient evidence that oral naltrexone is an effective treatment for OUD.

MEDICATION FIRST GUIDING PRINCIPLES

Patients should always be educated on medications for OUD and provided the choice of whether to engage in MAT as a care modality. Medication First or "low-threshold" models prioritize providing access to evidence-based medications for OUD as quickly as possible, without restrictions or ancillary requirements, while also honoring patients' choices related to treatment. Historically, some SUD treatment models have only provided medication for OUD in conjunction with psychosocial therapies, such as counseling or contingent on other requirements. Additionally, the FDA recommends that counseling and psychosocial support be offered in conjunction with MAT medications. Federal regulations also require OTPs to provide access to behavioral therapies, such as counseling to patients.[47] When possible, a robust continuum of services and care for individuals with OUD should be available; however, access to medication should not depend on receiving or participating in behavioral therapies or other services.

The Missouri Department of Mental Health developed the Medication First approach centered on four main principles:[48]

- Clients receive pharmacotherapy as quickly as possible, prior to lengthy assessments or treatment planning sessions;
- Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
- Individualized psychosocial services are offered but not required as a condition of pharmacotherapy; and
- Pharmacotherapy is discontinued only if it appears to be worsening the client's condition.

To support implementation of Medication First models, the Missouri Department of Mental Health developed a Provider Implementation Guide offering clinical guidelines and recommendations.[49] While not specifically tailored to correctional facilities, the guide's recommendations can be adapted for different settings.

HOW TO USE THIS TOOLKIT

This toolkit is for correctional administrators and health care providers who are exploring adoption of MAT programs within jails and prisons. Key components, strategies and implementation questions to consider related to meeting the needs of individuals with OUD who are incarcerated are identified throughout the toolkit to guide planning efforts. While opportunities exist to address the needs of individuals with OUD across a continuum of criminal justice involvement,[50] this toolkit focuses on individuals who are currently in correctional settings. More specifically, key considerations focus on implementing MAT programs in jails; however, recommendations and findings can be applied to and adapted for prisons and other correctional settings.

Key Components have been identified through research and by subject matter experts as being critical for the successful implementation of MAT programs in jails and provide a guiding framework for the toolkit. The Key Components do not need to be followed in the order they are presented; however, we recommend beginning with **Component 1: Preparing for Change**. Within each Key Component, there are several guiding elements to inform planning and implementation efforts as described in Table 2.

TABLE 2. ELEMENTS OF THE TOOLKIT

Key Component		Critical planning and implementation strategies to consider when implementing MAT in correctional settings.
Action Steps		Planning and implementation steps that appear at the beginning of each Key Component section.
Tools and Resources		Tools to guide the Implementation Team to successfully implement the action steps and recommendations.
Implementation Questions		Detailed questions to consider during implementation efforts.
Checklists		Checklists of items that facilitate implementation, such as implementation tools for each change concept.
Quick Tips		Information and quick insights into approaches and ideas for planning and implementation.
Example from the Field		Real-world examples of MAT programs in correctional settings.

Before acting on any Key Component, we recommend reading the entire toolkit to better understand how the recommendations relate to your organization's structure, resources and priorities. We recognize that every setting is different and there is an array of approaches to implementing MAT programs within correctional settings; however, some level of MAT services can be implemented within any correctional setting. Because a number of planning and implementation decisions are dependent on organizational structure and factors (e.g., whether there is an on-site prescriber, the number and type of behavioral health providers on staff), throughout the toolkit, implementation questions and examples from the field guide planning considerations.

LANGUAGE USED IN THIS TOOLKIT

As research related to substance use continues to evolve, so does the vocabulary used by professionals in the field. Throughout this toolkit we use the term "medication-assisted treatment" or "MAT" to refer to the use of FDA-approved medications to treat OUD because it is currently widely recognized; however, there are a number of emerging terms being used to refer to this treatment modality, including "medications for opioid use disorder" (MOUD), "pharmacotherapy" and "medications for addiction treatment" (MAT). It is likely that these terms will continue to evolve and become more common among professionals and advocates in the field. Additionally, please note that many people believe the term "medication-assisted treatment" is stigmatizing, inaccurate and misleading, since research shows that providing FDA-approved medication for OUD as a standalone treatment can be as effective as providing it in conjunction with behavioral therapies.[51, 52]

Changes to language related to SUD are often in response to increased understanding of the ways language can perpetuate stigma and discrimination. Evidence demonstrates that stigmatizing language can lead to increased negative attributions about patients and negative perceptions among patients.[53]

Table 3 identifies substitutions for stigmatizing terms used to describe issues related to substance use and SUD. The Education Development Center's Words Matter: How Language Choice Can Reduce Stigma is a helpful guide for understanding why language is important and assessing the language used among your Implementation Team and organization. Additionally, a glossary with key terms used in this toolkit can be found in **Appendix B: Glossary of Terms**.

TABLE 3. NON-STIGMATIZING LANGUAGE ASSOCIATED WITH SUBSTANCE USE DISORDERS	
Use This	**Instead of This**
Substance use disorder	Drug habit
Person with a substance use disorder	Addict, abuser, junkie
Person with alcohol use disorder	Alcoholic
Person in recovery	Clean, reformed addict
Urine that tested positive/negative for a substance	Dirty/clean urine
Recurrence; return to use	Relapse
Substance use	Substance abuse
Medications for opioid use disorder, medication-assisted treatment, medication for addiction treatment, pharmacotherapy	Replacement therapy, substitution therapy

MAT MODELS IN CORRECTIONAL SETTINGS

Recognizing that each MAT program is unique, there are six general types of MAT models in correctional settings ranging from partnerships with off-site medical providers to obtaining state and Drug Enforcement Administration (DEA) licensing to become a licensed health care facility. Table 4 describes different types of MAT models commonly implemented in correctional settings.

TABLE 4. MAT MODELS IN CORRECTIONAL SETTINGS[54]		
#	**Model type**	**Description**
1	Off-site medication administration	Patients are transported to community OTPs, hospitals or other medical providers for medication.
2	On-site medication administration by an external provider	External OTPs or other prescribers administer medication to patients within the correctional setting and under the license of the external OTP/provider.
3	On-site XR-NTX	Correctional health care providers administer XR-NTX within the correctional facility for treatment of OUD.
4	Licensed correctional prescribers provide buprenorphine on-site	Correctional physicians, nurse practitioners or physician assistants who are licensed to prescribe buprenorphine administer it within the correctional facility for treatment of OUD and withdrawal.
5	Facility becomes a licensed OTP	The facility obtains an OTP license permitting use of methadone and buprenorphine for treatment of OUD and withdrawal.
6	Facility becomes a licensed health care facility	State and DEA licensing is obtained entitling the facility to the same exemptions as hospitals for use of methadone or buprenorphine during pregnancy or to ensure treatment of other conditions (e.g., HIV, mental illness).

Key considerations related to specific types of models are identified throughout this toolkit. For example, staffing and training needs for MAT models that rely on off-site prescribers are different than for correctional settings that provide medication on-site.

CHECKLIST

KEY COMPONENTS OF MAT PROGRAMS IN CORRECTIONAL SETTINGS

1. Preparing for Change

- [ ] Identify a project champion.
- [ ] Develop an Implementation Team.
- [ ] Obtain buy-in from leadership and staff at all levels.
- [ ] Assess current procedures and policies.
- [ ] Develop goals and action steps.
- [ ] Monitor progress.

2. Program Planning and Design

- [ ] Determine which medications your facility will offer.
- [ ] Determine which program model is best for your facility.
- [ ] Determine who should be eligible for MAT.
- [ ] Determine your program's capacity.
- [ ] Develop a diversion protocol.
- [ ] Determine your program's recommendations for counseling.

3. Workforce Development and Capacity

- [ ] Provide staff training.
- [ ] Develop a care team.
- [ ] Identify appropriate staff-to-patient ratios.
- [ ] Provide ongoing staff supervision and support.

4. Delivery of Treatment

- [ ] Determine where and when MAT services will be delivered.
- [ ] Determine which medication formulations to offer.
- [ ] Develop dosage guidelines.
- [ ] Establish screening protocols to determine eligibility.
- [ ] Develop guidelines for ongoing care.
- [ ] Develop protocols related to drug testing.
- [ ] Develop protocols for special populations.
- [ ] Develop protocols for program discharge and release.

5. Care Coordination and Linkages to Services Post-release

- [ ] Connect patients to health insurance coverage.
- [ ] Coordinate care with community providers.
- [ ] Provide linkages to social services and recovery supports.
- [ ] Provide education and resources to prevent opioid overdose.

6. Data Monitoring and Evaluation

- [ ] Identify who will conduct monitoring and evaluation activities.
- [ ] Identify key metrics to monitor progress and evaluate impact.
- [ ] Develop a plan for monitoring and evaluation.

7. Funding and Sustainability

- [ ] Assess existing resources.
- [ ] Determine program needs.
- [ ] Identify funding sources.

COMPONENT 1
PREPARING FOR CHANGE

Implementing any change within an organization is difficult and this is especially true when that change potentially involves challenging existing organizational culture or staff beliefs. However, thoughtful collaborative planning can help prepare staff and leadership alike for changes related to implementing MAT models in jails and prisons.

Having a project champion and an Implementation Team to lead efforts, gain buy-in and support from all levels of the organization, track progress and communicate effectively are key components to successful planning and implementation of new efforts. Implementing MAT programs in correctional settings often requires a cultural shift and can challenge staff and leadership's perceptions and beliefs related to substance use, SUD and medications for OUD. Taking the following steps to prepare your organization for change will help create an environment that facilitates engagement and support from all levels.

MAT models in correctional settings can be and have been successfully implemented in a range of settings, including jails and prisons, rural and urban geographic locations, small and large facilities, and with a range of existing resources, including funding and staff.

"The implementation of evidence-based treatment protocols for chronic conditions, including opioid use disorder, should be driven by medical professionals. What my general philosophy has been is, don't let perfect be the enemy of the good. Get started with some reasonable safeguards in place and build the MAT program like you would for other chronic conditions."

Tyler Winkelman, Clinician-Investigator, Hennepin Healthcare, Minnesota

ACTION STEPS

- [ ] Identify a project champion.
- [ ] Develop an Implementation Team.
- [ ] Obtain buy-in from leadership and staff at all levels.
- [ ] Assess current procedures and policies.
- [ ] Develop goals and action steps.
- [ ] Monitor progress.

IMPLEMENTATION TOOLS AND RESOURCES

- Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States (SAMHSA)
- Rhode Island DOC video on Getting Buy In
- Medication-assisted Treatment for Opioid Addiction: Myths & Facts (Legal Action Center)

IDENTIFY A PROJECT CHAMPION

Successful MAT programs in correctional settings have cited project champions from a diverse range of roles and professions as the necessary catalysts to move projects forward. Jail administrators, sheriffs, medical directors, social workers and others have acted as key project champions, illustrating that good champions are not tied to specific job descriptions, but are genuinely passionate and invested in the success of the project, are effective leaders, have excellent communication skills and have resources and time made available to lead the effort. Project champions help direct the day-to-day planning and implementation activities with the assistance of an Implementation Team.

> "Internal champions often drive change and implement the policy."
>
> *Kevin Fiscella, Professor, University of Rochester Medical Center, New York*

DEVELOP AN IMPLEMENTATION TEAM

Create an Implementation Team to lead planning and implementation efforts. Ideally, the Implementation Team should be comprised of staff representing the health care, security and administrative divisions of the organization. However, Implementation Teams consisting of two people, a representative from health care and one from security, have led some successful MAT programs in correctional settings. The Team is responsible for the day-to-day planning and implementation tasks of the project. Team members assess the current organization, make recommendations and develop project goals and timelines. The composition of the Implementation Team will change based on the MAT model you choose to implement. Potential Implementation Team members are listed in Table 5. Additionally, key considerations for Implementation Team members follow.

> "You really can't do it without somebody from the health care services and somebody from security really working together as a team."
>
> *Jennifer Clarke, Medical Programs Director, Rhode Island DOC*

TABLE 5. POTENTIAL IMPLEMENTATION TEAM MEMBERS

Team Member	Roles and Responsibilities
Project Champion	Acts as communication liaison across team and as the internal champion of change. The Implementation Team should include one or more individuals who will carry out the change and someone in a supervisory role to ensure that change is implemented. In some models, the Project Champion is also the Clinical Lead.
Clinical Lead	Provides clinical expertise and guidance. Supports care integration and coordination in operations and for patients in need of MAT. Depending on MAT model, may be internal correctional health care provider staff or external community health care provider.
Behavioral Health Lead	Provides clinical expertise and guidance related to behavioral services and supports. Depending on MAT model, may be internal correctional health care provider staff or external community health care provider.
Security Lead	Provides security expertise and guidance. Acts as the main liaison between security staff and health care staff.
Quality Improvement Lead	Leads development of data collection and evaluation plan. Ensures accurate data collection and develops workflow for collecting and communicating data.
Administrative Lead	Provides guidance related to finance and resource considerations, policies and procedures and other administrative matters involved with project planning and implementation.

In addition to the recommended Implementation Team members already listed, the Team should include the voice of individuals with lived experience. While including people with lived experience on the Implementation Team could be a challenge for correctional facilities, it is important that the voice of individuals with lived experience is present and reflected. This can be done by meaningfully engaging and consulting with people who use drugs, have OUD, have received MAT and have been justice-involved.

KEY CONSIDERATIONS FOR IMPLEMENTATION TEAM MEMBERS

- Are there members from leadership positions who are responsible for guiding change processes?
- Will members carry out the change in their day-to-day activities?
- Are members involved who will provide the MAT services?
- Are members able to access resources to support the ongoing implementation of the services?
- Are members highly committed to the aims of the project?

EDUCATE IMPLEMENTATION TEAM MEMBERS

After assembling the Implementation Team, educate Team members on SUD, including OUD, and on MAT as an evidence-based treatment. Team members should also receive education on stigma and discrimination, including implicit bias, as it relates to individuals with SUD. This training will help the Implementation Team develop a shared understanding and language related to the project to communicate effectively for buy-in from staff and leadership. Training is discussed in more depth in **Component 3: Workforce Development and Capacity**.

OBTAIN BUY-IN FROM LEADERSHIP AND STAFF

Buy-in and support from leadership and staff at all levels is critical to a success. Inviting sheriffs and other correctional leaders to discuss their experiences implementing MAT can be effective for gaining buy-in, especially if they address key areas of concern, including staffing, program costs and preventing medication diversion. Additionally, an established and growing body of evidence shows the benefits of MAT in correctional settings. These findings could help correctional leaders and staff better understand how MAT helps patients, staff and the facility. Additionally, national correctional, public health and other organizations are calling for widespread adoption of MAT within correctional settings. Examples

Getting Buy-in

The Rhode Island DOC produced a helpful 12-minute video on getting buy-in to support correctional MAT programs.

of policy positions and national recommendations can be found in **National Adoption of MAT Models**. Key research, resources and tools useful for communicating the value of MAT and gaining buy-in are available in **Appendix A: Resource and Tools Guide**.

In addition to internal organizational leaders, several key informants cited state-level leadership, including governors or state senators, as key catalysts for change. To help make the case for MAT to state leadership, the SAMHSA brief, Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States, provides useful information on MAT in correctional settings from a state government perspective.

> "We had a senator in our state legislature who was really pushing for this. And without him pushing for it, I don't think it would have happened at all."
>
> *Merideth Smith, Director of Clinical Services, PSIMED Corrections, West Virginia*

COMMUNICATE EFFECTIVELY FOR BUY-IN

To gain buy-in from leadership, staff and other stakeholders, it is important to communicate in a consistent and effective manner. Because there are many myths and misconceptions associated with MAT, it is important to equip the Implementation Team with facts to help people understand how these medications work to help individuals with OUD recover. Additionally, understanding the priorities of the leadership team and other stakeholders, such as patients, staff and community partners, will help develop a tailored approach for this communication.

Quick Tips for Effective Communication

- Clearly identify the resources necessary for the initiative to be successful.
- Explain what the expected outcomes of the initiative will be for patients, staff and the community.
- Avoid using stigmatizing language.

ADDRESSING STIGMA

A history of pervasive stigma and discrimination exists against individuals with SUD across the U.S. Many myths about substance misuse and SUD, including OUD, are perpetuated daily through popular culture and media. Furthermore, stigma and misperceptions exist related to MAT as a treatment modality, which impacts adoption of treatment and access to care. A key role of the Implementation Team is to help educate all staff and leadership, including health care providers, security staff and others, on the evidence and facts related to SUD and MAT. The

Legal Action Center's Medication-assisted Treatment for Opioid Addiction: Myths & Facts and the Providers Clinical Support System's Myths and Misconceptions: Medication-Assisted Treatment for Opioid Addiction are helpful resources to understand the facts of MAT. Additional resources for education and training to address stigma can be found in **Component 3: Workforce Development and Capacity**.

EXAMPLE FROM THE FIELD: PHILADELPHIA DEPARTMENT OF PRISONS

The Philadelphia Department of Prisons partnered with Prevention Point Philadelphia, a community-based harm reduction organization, to develop 12-minute videos addressing stigma and myths related to substance use and MAT. The videos are shown to staff and residents in correctional housing units each day and feature people with lived experience who speak about how MAT helped them. The videos are a reminder to staff that OUD is a chronic illness, not a moral failure.

ASSESS CURRENT ORGANIZATIONAL CONTEXT

Existing policies and procedures and organizational norms could help facilitate or hinder success of your project. Implementation Teams should consider how each of the following checklist items will support or impede progress toward your goals to help teams identify opportunities and overcome challenges related to implementation.

ORGANIZATIONAL ASSESSMENT CHECKLIST

- [ ] Existing policies.
- [ ] Capability of the workforce.
- [ ] Capacity of the workforce.
- [ ] Financing and resources.
- [ ] Prevailing culture of the organization.
- [ ] Organizational priorities.
- [ ] Leadership commitment and priorities.

DEVELOP GOALS AND ACTION STEPS

To guide planning efforts, Implementation Teams should develop goals and action steps that are specific, measurable, attainable, relevant and time-framed, or "SMART" goals. These goals and action steps are important to measure progress in the short, medium and long-term and help Implementation Team members remain focused. Table 6 provides guiding questions related to developing SMART goals and action steps.

TABLE 6. SMART GOAL PLANNING[55]

Considerations		Guiding Questions
S	**Specific and strategic**	• What do you want to accomplish? • Who do you need to accomplish it? • Where will it be accomplished? • Why are you accomplishing it?
M	**Measurable**	• How will you demonstrate and evaluate the extent to which the goal has been met?
A	**Attainable**	• Are goals realistic, reasonable and able to be achieved in a specific amount of time?
R	**Relevant**	• How does the goal relate to your key responsibilities and objectives?
T	**Time-framed**	• When will you accomplish the goal? • Do target dates and deadlines support success and achieving your overall goal?

Many correctional organizations have taken a stepped approach to planning and implementation, often beginning with a small cohort of patients. This allows change to be initiated, assessed and improved before expanding to a larger number of patients. While planning for MAT within correctional facilities involves a unique set of opportunities and challenges, it is important to remember that MAT is an evidence-based treatment modality like many others and requires the same types of change steps that implementing other evidence-based practices would require.

EXAMPLE FROM THE FIELD: PHILADELPHIA DEPARTMENT OF PRISONS

In February 2017, the Philadelphia Department of Prisons piloted a MAT program in the city's women's jail facility. The facility was an ideal pilot site because it was the only facility for women; therefore, women would not be transferred to other facilities, providing an opportunity to track outcomes on a cohort of patients. Data was collected to understand the types of services patients engaged in (e.g., medication or medication and cognitive behavioral therapy) and continuity of care in the community post-release. Following the pilot project and informed by the findings, in September 2017, the system expanded its MAT program to all four additional facilities that house men.

MONITOR PROGRESS

The Implementation Team should develop progress indicators related to goals and action steps to ensure that the Team has the information necessary to evaluate progress and take appropriate action. Key considerations related to monitoring progress follow and **Component 6: Data Monitoring and Evaluation** provides detailed information on developing data monitoring and implementation plans to assess the overall effectiveness of the program once implemented.

KEY CONSIDERATIONS RELATED TO MONITORING PROGRESS

- What part of the plan worked well?
- What did not work well?
- What was surprising?
- What assumptions did you make that were accurate and not accurate?
- What do you need to do differently?
- Do you need to put the next action steps on hold until you make needed changes?
- If it is too early to tell what needs to change, should you continue the process and give it more time?

COMPONENT 2
PROGRAM PLANNING AND DESIGN

An early step in the planning process is to determine the type of model best suited for your facility. As described in **Table 4. MAT Models in Correctional Settings**, there are several different types of MAT models within correctional facilities and the design of each model can affect subsequent planning and implementation decisions. Discuss key implementation considerations based on your patient population, available resources, facility type and existing policies and procedures. This section describes considerations related to program planning and design.

ACTION STEPS

- [ ] Determine which program model is best for your facility.
- [ ] Determine which medications your facility will offer.
- [ ] Determine eligibility criteria.
- [ ] Determine program capacity.
- [ ] Develop protocols to control medication diversion.
- [ ] Develop recommendations for counseling.

IMPLEMENTATION TOOLS AND RESOURCES

- **Regulatory and certification guidelines and tools.**
  - Federal Guidelines for Opioid Treatment Programs (SAMHSA)
  - Becoming a Correctional OTP Flowchart (Franklin County Sheriff's Office)
  - NCCHC Standards for OTP Accreditation
- **Tools and resources for partnering with community MAT providers.**
  - Buprenorphine Practitioner Locator (SAMHSA)
  - OTP Directory (SAMHSA)
  - Findtreatment.gov
- **Medication diversion control resources.**
  - Medication-assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion (SAMHSA and Department of Justice [DOJ])

DETERMINE WHICH PROGRAM MODEL IS THE BEST FIT

There are six general types of MAT programs within correctional settings:

1. Off-site medication administration.
2. On-site medication administration by an external provider.
3. Correctional health care providers administer XR-NTX on-site.
4. Licensed correctional prescribers provide buprenorphine on-site.
5. Facility becomes an OTP.
6. Facility becomes a licensed health care facility.

Most jails and prisons currently offering MAT utilize one of the models listed in **Table 4. MAT Models in Correctional Settings** or a combination of them. Key considerations for choosing a program model follow.

"We had this ACLU court case, Gray versus Arpaio, that said any health care service you receive in the community you should be able to receive in jail. Well, the chief medical officer for the jail took that opportunity as saying, 'I want to start providing methadone to people coming into the jail that are suffering from opioid use disorder. All these individuals need this support. I believe in the treatment. I'm going to go this route.' Up until that point, we had been providing services, but only for pregnant women. Over a year-and-a-half, we walked through policies and procedures, how to work with the DEA, along with how to get credentialed and licensed as an opioid treatment program."

Michael White, Director of Community Programs, Community Medical Services, Arizona

WHAT PROGRAM MODEL IS THE BEST FIT?

There are several ways to implement MAT programs in correctional settings. For facilities with limited clinical capacity, partnering with an outside provider may be the most feasible model, while for facilities with a large population of patients in need of MAT, providing services in-house may make more sense logistically and economically.

Becoming an OTP Flowchart

The Franklin County, Massachusetts Sheriff's Office created a helpful flowchart mapping the steps they took to become a correctional OTP.

Only federally certified and accredited OTPs can offer methadone for OUD. Opioid treatment program status also allows for the prescription of buprenorphine without a limit on the number of patients.[56] The process of obtaining an OTP license within a jail, however, can be lengthy. It requires SAMHSA certification, NCCHC accreditation, a state license and DEA registration. The SAMHSA Federal Guidelines for Opioid Treatment Programs is a helpful resource to understand regulatory requirements.

Physicians, nurse practitioners and physician assistants can prescribe buprenorphine after receiving a waiver, commonly referred to as an x-waiver, from SAMHSA. To obtain an x-waiver, prescribers must complete an in-person or online training, which is described in more detail in **Component 3: Workforce Development and Capacity**.

To identify potential MAT partners, FindTreatment.gov offers a database for state-licensed providers who specialize in treating SUD and mental illness. Additionally, the SAMHSA OTP Directory offers state-based listings of certified OTPs and the SAMHSA Buprenorphine Practitioner Locator offers listings of waivered buprenorphine prescribers based on information submitted by waivered prescribers.[ii]

EXAMPLE FROM THE FIELD: PHILADELPHIA DEPARTMENT OF PRISONS

Philadelphia Department of Prisons employs a combination of Model 2 — on-site medication administration by an external provider, Model 3 —correctional health care providers administer XR-NTX, and Model 4 — licensed correctional prescribers provide buprenorphine on-site for its MAT program. The jail partners with a community-based OTP to provide methadone and buprenorphine maintenance for its patients. Once a day, staff from the OTP come to the facility to provide medication. Additionally, all physicians from the jail's medical provider have obtained x-waivers to prescribe buprenorphine.

ii. Prescribers must opt in to be listed on the Buprenorphine Provider Locator; therefore, the listing could be incomplete in your area.

DETERMINE WHICH MEDICATIONS TO OFFER

As described in **Table 1. FDA-approved Medications for Opioid Use Disorder**, there are three FDA-approved medications for treatment of OUD: methadone, buprenorphine (brand names include Suboxone®, Subutex®, Sublocade®, Probuphine®) and XR-NTX (brand name Vivitrol®). When choosing medications to offer at your correctional facility, SAMHSA notes that blanket prohibitions against certain medications, such as methadone or buprenorphine, are "medically unjustified and potentially harmful" and that requiring inmates to change or discontinue a previously successful medication regimen is associated with poor outcomes, including a lower likelihood of continuing MAT upon release.[57] The Implementation Team should work with clinicians and administrators to identify the medications that will be offered in the facility based on maximizing choice, patient needs, medication availability and resources needed to administer and manage each medication.

Methadone and buprenorphine are opioid agonists (methadone is a full agonist and buprenorphine is a partial agonist), meaning that they bind to the opioid receptors and activate them. Opioid agonists are successful at reducing or eliminating withdrawal symptoms, blunting or blocking the effects of other opioids and reducing cravings to use opioids. Research shows that treatment with methadone or buprenorphine reduces mortality. In the four weeks post-release, agonist treatment is associated with an 85 to 94 percent reduction in mortality[58, 59] and during incarceration, agonist treatment is associated with a 74 percent reduction in mortality, primarily related to reductions in suicide.[60] Overdose mortality rates in and out of treatment have been found to be higher for methadone than buprenorphine.[61] Methadone and buprenorphine are also associated with reduced rates of other opioid use.[62, 63] Methadone has been associated with reduced levels of criminal activity.[64, 65] The impact of buprenorphine treatment on criminal activity has not been well-studied to date. Initial studies have not found any significant differences between buprenorphine and methadone with regard to their impact on criminal activity.[66]

XR-NTX is an opioid antagonist, meaning it blocks the effects of opioids. XR-NTX reduces cravings, but does not reduce symptoms of withdrawal. Initiating individuals on XR-NTX generally requires medically supervised withdrawal followed by a minimum of seven to ten days without opioids, including opioid-based MAT medications.[67, 68] This initiation process has been cited as a barrier to effectively meeting the needs of individuals with OUD within correctional settings. A study reviewing a jail-based XR-NTX program found a concerning rate of treatment attrition and overdose death following treatment discontinuation, calling for increased adoption of opioid agonist treatments within correctional settings.[69] Systematic reviews of medication effectiveness and outcomes and other resources for research on MAT medications can be found in **Appendix F: Research and Information on MAT Medication Effectiveness**.

WHAT MEDICATION(S) SHOULD WE OFFER?

In addition to assessing the relative strength of the evidence of the three medications previously discussed, also consider the following questions when determining which medications to offer.

What medications are available in the community?

Patients will experience a smoother transition into your facility (if already on treatment) and back into the community at time of release if the same medications are available in your facility as are available in the

community. Similarly, for those who transfer from your facility to other facilities, it may be worthwhile to consider which medications are offered there and what the treatment plan will be for individuals on MAT at your facility who are transferred.

> On the decision of which medications to offer, "It was based on best practices within the medical community. We understood that we needed a public health model to respond to this public safety crisis. We also felt like, sooner or later, everyone was going to be doing this… why would you not offer the same medication inside as outside?"
>
> *Ed Hayes, Assistant Superintendent,*
> *Franklin County Jail and House of Correction, Massachusetts*

What are the regulatory requirements to dispense each medication?

Unlike XR-NTX, buprenorphine and methadone each have their own sets of regulatory requirements which are important to consider as they affect the number of patients served, staffing, medication storage and other factors.

Only a physician, nurse practitioner or physician assistant who has obtained a federal waiver can prescribe buprenorphine. Only an accredited, federally certified OTP can dispense methadone for treatment of OUD and OTPs can also administer and dispense buprenorphine. Any provider can prescribe XR-NTX.

What formulations are available of each medication and how is it dispensed?

Medications for OUD can be dispensed as a pill, liquid, dissolvable sublingual film or an injection. There are logistical, staffing and security considerations for each of these formulations. See **Component 4: Delivery of Treatment** for more details on medication formulations.

What does it cost?

When deciding which medication(s) to offer, consider the cost of the medications, as well as the cost of the associated staffing. Medication costs and total MAT program costs vary widely. Methadone is often the least

expensive medication. A 2018 study found that the average per patient weekly cost of methadone was $115 in a large urban jail in New Mexico and the total cost for an average treatment episode was $689 (based on an average length of stay of six weeks).[70] Clinical staff must dose methadone daily. Extended-release injectable medications are generally the most expensive, but can be administered monthly. One injection of XR-NTX, lasting four weeks, can cost approximately $1,000 (as of data from 2016).[71] Buprenorphine is generally more expensive than methadone and less expensive than XR-NTX. A jail-based MAT treatment provider in Rhode Island noted that in 2018 buprenorphine pills cost $4 each and films cost $8 each.[72] Buprenorphine is typically dosed daily; however, the FDA approved an extended-release injectable formulation (brand name Sublocade) in 2017.[73] The wholesale cost for Sublocade is $1,580 per monthly dose (according to information provided in 2019).[74] See **Component 7: Funding and Sustainability** for further discussion of program costs and ways to fund MAT programs.

What medication do patients prefer?

It is important for medical providers to educate their patients on all treatment modalities so they can make educated decisions. If a medication is disfavored, due to side effects, reputation or stigma, patients will be less likely to opt in and may be less likely to adhere to their treatment regimen, thus decreasing the effectiveness of your MAT program.[75, 76] Studies of the Vermont and Rhode Island correctional systems suggest that methadone was the most popular choice among their OUD population (60 to 70 percent, followed by buprenorphine.[77,78]

> "It's way easier for a jail to say, 'Hey, we got the injectable medication. You'll never see him at a daily med line and you'll never worry about diversion. We're going to give him an injection and they're going go back to their cell.' From a resources' standpoint, I understand where they're coming from. If you're offering more than one medication or even all three, such as Rhode Island, naltrexone accounts for 1 percent [of the MAT patient population]... So, the amount of effort to go in and do those types of services even before the person can be medically cleared to be on the medication is a lot compared to the proven efficacy and price of buprenorphine or methadone. It's not worth the investment unless it is the only medication facility staff are comfortable with."
>
> *Michael White, Director of Community Programs, Community Medical Services, Arizona*

Table 7 provides examples of the types of medications offered in MAT programs in correctional settings. While many facilities provide only one medication, an increasing number of facilities offer all three FDA-approved medications.

TABLE 7. EXAMPLES OF MEDICATIONS OFFERED IN MAT PROGRAMS IN CORRECTIONAL SETTINGS[79, 80]

Location	Type of Correctional MAT Model(s)	Medications Offered	Description	Utilization
Rhode Island DOC	**Model #2** (On-site medication administration by an external provider) and **Model #3** (On-site XR-NTX)	Buprenorphine, methadone and XR-NTX	Rhode Island DOC was the first in the nation to offer all three FDA-approved medications for OUD in their correctional facilities. Rhode Island partners with a community-based treatment provider to provide MAT within their correctional facilities.	Between January and June 2017, 303 patients received MAT: 180 received methadone, 119 received buprenorphine and four received XR-NTX.
Vermont DOC	**Model #2** (On-site medication administration by an external provider) and **Model #3** (On-site XR-NTX) and **Model #4** (Licensed correctional prescribers provide buprenorphine on-site)	Buprenorphine, methadone and XR-NTX	Correctional facilities in Vermont offer all three FDA-approved medications, with a predominance of buprenorphine dispensed.	Between 575 and 620 individuals receive buprenorphine daily, five to 60 people receive methadone and 10 to 15 people receive oral naltrexone system-wide.
Franklin County Jail and House of Correction, Massachusetts	**Model #3** (On-site XR-NTX) and **Model #4** (Licensed correctional prescribers provide buprenorphine on-site) and **Model #5** (Facility becomes a licensed OTP)	Buprenorphine, methadone and XR-NTX[iii]	Franklin County Jail and House of Correction has provided buprenorphine since 2016. In August 2019 the facility was approved to provide methadone as an OTP.	Out of an average daily population of 225, 40 people receive buprenorphine. Additionally, two to three individuals are given XR-NTX each month.

iii. At the time this toolkit was developed Franklin County Jail and House of Correction had recently received its OTP status and had not yet begun providing methadone to patients.

Location	Type of Correctional MAT Model(s)	Medications Offered	Description	Utilization
Maricopa County Sheriff's Office, Arizona	**Model #3** (On-site XR-NTX) and **Model #5** (Facility becomes a licensed OTP)	Methadone, naltrexone	In 2014, Maricopa County certified its first jail as an OTP. Currently, four of its six county jails are certified OTPs. Methadone and XR-NTX are offered to patients.	Daily, 60 to 75 people receive methadone. A very small number of patients receive XR-NTX.
New York City Health + Hospitals/ Correctional Health Services	**Model #3** (On-site XR-NTX) and **Model #4** (Licensed correctional prescribers provide buprenorphine on-site) and **Model #5** (Facility becomes a licensed OTP)	Buprenorphine, methadone, XR-NTX	New York City Health + Hospitals/Correctional Health Services operates the oldest correctional MAT program in the country, started in 1987, providing methadone and, later, buprenorphine to patients.	Daily, 250 patients receive buprenorphine, 750 to 800 patients receive methadone and one to two patients receive XR-NTX.
Atlantic County Jail, New Jersey	**Model #2** (On-site medication administration by an external provider)	Methadone	John Brooks Recovery Center has partnered with Atlantic County Jail to provide methadone on the jail's campus via a mobile van.	Approximately 450 patients are served each year.

DETERMINE ELIGIBILITY CRITERIA

Establishing policies and guidelines related to MAT eligibility is an important early step in the planning process. As discussed earlier, some MAT programs in correctional settings launched their services with a subset of the population, such as pregnant patients or sentenced individuals, before expanding to the greater population of individuals with OUD as part of the planning process. MAT should be considered a gold standard and offered to all patients with OUD. Additional eligibility considerations are discussed in the next section.

WHO SHOULD RECEIVE MAT?

Systematically screen all patients for SUD and signs of withdrawal using validated screening instruments to determine which patients have an OUD. There are several free and short tools for screening described in **Table 11. Screening and Assessment Tools and Resources.**

It is important to remember that the decision to take medication for OUD belongs to the individual patient, not the medical provider or the security staff.

Depending on your facility's capacity and resources, you may need to consider additional eligibility restrictions. Criteria that some jails have applied include:

- Individuals previously on MAT in the community prior to arrest.
- Individuals diagnosed with a moderate or severe OUD.[iv]
- Individuals at the highest risk of return to use or overdose, according to a validated risk assessment.
- Individuals who are within a few weeks of release to the community.

Jails can be entry points into treatment for some patients who have never been in treatment before or who have tried treatment unsuccessfully. As such, jails are discouraged from limiting treatment to those already on MAT in the community at the time of arrest and, instead, encouraged to perform inductions among treatment-naïve patients.

Undetermined Release Dates

A common concern among jails is whether to provide MAT to individuals for whom a release date is unknown. The concern, particularly among jails with a short average length of stay, is related to patients released prior to stabilization.

There are several jails that serve a large population of patients who are pre-trial with unknown release dates that successfully administer MAT.

Both methadone and buprenorphine stabilization occurs in a few days, which is often less than the average length of stay, even among pre-trial detainees. For facilities that primarily serve pre-trial detainees, restricting MAT to those with a known release date may dramatically hinder the uptake of your program.

"If initiation of a MAT medication is held up by a complicated pre-release planning process, the treatment window for these high-risk individuals may be missed when a person gets an unexpected court date and is released, makes bail, etc. The unfortunate result may be that you had a patient willing to start treatment, delayed them for non-medical reasons and lost the opportunity to treat them."

Sharif Nankoe, MAT Medical Director, Vermont DOC

iv. For jails looking for criteria to help them prioritize their MAT-eligible population, facilities using this criterion have not found individuals with mild OUD to make up a significant portion of their OUD population. According to one key informant, "We've treated several hundred people now and I have yet to treat anyone who didn't have severe opioid use disorder."

To manage challenges in a step-wise fashion, some jails have had success rolling out their MAT program in stages. It may be advantageous to pilot your MAT program with a smaller cohort of eligible patients and expand over time to include all eligible patients. Several MAT programs in correctional settings began with their pregnant population and expanded from there.

EXAMPLE FROM THE FIELD: MARICOPA COUNTY SHERIFF'S OFFICE, ARIZONA

The Maricopa County Sheriff's Office implemented its correctional OTP program in four stages. First, methadone was offered only to pregnant women. Second, methadone eligibility expanded to individuals seen by therapeutic courts, including drug courts. Third, methadone was offered to any individual already enrolled in a community-based OTP at the time of arrest. Last, the program expanded to take in new patients and start them on methadone. In total, this phased roll-out took approximately 14 months.

DETERMINE PROGRAM CAPACITY

After identifying who will be eligible to receive services, it is important to determine if your organization has the resources available to meet the needs of your patient population. Determining program capacity requires understanding the number of people who will need services and the number of providers required to provide MAT services to patients.

> "The Vermont DOC felt confident that we had data on how many people were coming into the facilities on buprenorphine and about how many people were coming in and experiencing withdrawal. What we did not know was how many people who were already incarcerated were going to meet medical necessity for the medication. And we did not know, since this is all voluntary, how many [already incarcerated] people were going to elect to be assessed for opioid use disorder and to be considered for treatment. So that was our blind spot and it ended up being a very big blind spot. In the beginning of our implementation, at one point we had between 400 and 500 people requesting assessment."
>
> *Annie Ramniceanu, DOC Addiction and Mental Health Systems Director, Vermont DOC*

HOW SHOULD WE PLAN FOR PROGRAM CAPACITY?

Research shows that individuals with OUD are disproportionately over-represented in jails and prisons,[81, 82, 83] but how do you know exactly how many patients will qualify for MAT at your facility? In order to plan your program model, staffing, space and costs, you first need to estimate how many patients at your facility will be eligible for MAT. Questions that can help you estimate patient need include:

- How many individuals entering your facility are currently enrolled in a community-based OTP?
- How many individuals entering your facility are currently prescribed buprenorphine?
- How many individuals enter your facility in opioid withdrawal or demonstrating other signs of OUD who are not currently enrolled in an OTP or prescribed buprenorphine?

If you do not currently have information to answer these questions, you may want to consider a short exploratory phase where you systematically ask all patients who enter your jail these questions at the time of admission.

If your program is considering additional restrictions to eligibility criteria, such as sentenced individuals or individuals two weeks from release, you will need to account for those factors in your estimate. Of the individuals who are eligible, only a certain proportion will opt in (all MAT is voluntary, though anecdotal evidence from key informants suggests that opt-in rates are very high. Your MAT patient population will also depend on the average length of stay of your MAT patients. Some jails with MAT programs have reported that between 15 percent and 33 percent of their average daily population is on MAT.[v]

Once you have an estimate of how many patients your MAT program will typically serve daily, you can estimate the number of providers needed. Buprenorphine-waivered prescribers can prescribe up to 30 patients at a time in the first year they receive their x-waiver and can then apply to increase the limit to 100 patients.[84] In some circumstances, waivered physicians can apply to increase their patient cap to 275.[vi] Nurse practitioners and physician assistants are not eligible to increase their caps beyond 100 patients.[85] Opioid treatment programs are not subject to any federal patient caps, but must state their capacity in their application to SAMHSA. There are no patient caps related to prescribing XR-NTX.

Note that when planning for staffing, resources and storage, typically research has found that females have a higher rate of SUD in jails, compared to males.[86] If you have separate facilities for females and males, you may need to separately estimate prevalence of OUD and not apply the same percentage to all facilities.

v. New York City reports approximately 15 percent of their average daily population on MAT. Franklin County estimates 16 percent of their daily population is on MAT. The state of Vermont estimates 33 percent of their inmate population are on MAT.

vi. There are two ways physicians can increase their patient cap to 275:

1. **Hold additional credentialing:** board certification in addiction medicine or psychiatry by the American Board of Addiction Medicine or the American Board of Medical Specialties or certification by the American Board of Addiction Medicine or the American Society of Addiction Medicine.
2. **Practice in a qualified practice setting:** a) provides coverage for medical emergencies outside hours of operation, b) provides access to case management, c) uses health information technology if it is already required in practice setting, d) is registered for state prescription drug monitoring program and e) accepts third-party payment for some services.

DEVELOP PROTOCOLS TO CONTROL MEDICATION DIVERSION

Diversion of agonist medications (methadone and buprenorphine for OUD is a common concern in correctional facilities that have or are considering MAT. According to the Rhode Island experience, "One critical challenge we faced in implementing MAT prior to release was the correctional staff's concern with safety and security. Wardens worried about methadone being diverted to the general population. Diversion would represent a loss of control and the possibility that inmates may get 'high' or even overdose. This was both a liability as well as a public health, medical and public safety concern."[87]

While our key informants noted that the topic of diversion frequently arose prior to a new MAT program's implementation, with careful planning and rigorous systems in place, medication diversion can be minimized, if not fully prevented.

HOW DO WE CONTROL MEDICATION DIVERSION?

Several localities found that by introducing MAT in their facilities the incidence of medication diversion decreased, since patients with a legitimate medical need for MAT were receiving it formally. Additionally, jail staff anecdotally reported a decrease in disciplinary infractions after introducing MAT as well as increased inmate and officer safety.

> "I constantly hear from prison administrators that 'I already have (illicit) buprenorphine in the facility. I'm trying to get it out.' But the irony is when you bring it in clinically all that diversion and illicit use goes away because you're actually meeting a medical need and implementing controls. You take away the illicit market."
>
> *Michael White, Director of Community Programs, Community Medical Services, Arizona*

Developing a diversion control protocol is one way to formalize the systems in place to reduce events of diversion and is required of licensed OTPs. A diversion control protocol may include guidance on the medication formulation, dispensing and ingestion practices, medication storage and steps to take in the event of a diversion incident. The roles and responsibilities of correctional staff, health care staff and patients should be clearly delineated.

Jails have employed several strategies to reduce medication diversion, including:

- Counseling patients on diversion protocol and having patients sign a patient contract that clearly explains the rules and responsibilities of taking MAT and the consequences of medication diversion.
- Separating medication lines for MAT.

- Dispensing medications in areas with video surveillance.
- Housing all MAT patients together in one housing unit or facility.
- Choosing medications (buprenorphine/naloxone combination instead of mono-buprenorphine) and formulations that are more difficult to divert (such as a crushed buprenorphine tablet instead of a film or a methadone diskette mixed with water).
- Requiring patients to drink, eat or talk and open their mouths, in the presence of correctional or health care staff after ingesting medication.
- Conducting random urine drug screening to confirm people who are prescribed MAT are taking it.
- Using automatically unlocking pill boxes that only unlock at pre-set times and only dispense a designated amount of medication.
- Conducting medication inventory weekly, at a minimum, and ensuring procedures are in place to control diversion and accounting of all medications.

> "It can get stressful for nursing because they feel like they need to police patients and it creates a fairly antagonistic relationship sometimes. So, we're considering a new approach to this, which is to put the responsibility back on the patient. It's not the nurse's responsibility to catch the patient taking it incorrectly, but it's the patient's responsibility to show the nurse that they are taking it correctly. This is through a mouth check, which is at 30 seconds after it's administered. If it [the film] is not in the patient's mouth, it's just a failed mouth check. The nurse is not going to get the DOC to search the patient. They're just going to say, 'Sorry, that's a failed mouth check.' After two failed mouth checks, patients have a dose reduction."
>
> *Jonathan Giftos, Director of Substance Use Treatment, Correctional Health Services, NYC Health + Hospitals*

Changes to patients' medications or doses should be clinical decisions made only after taking into consideration patients' overall clinical status.

A diversion protocol should also include steps to address diversion when it occurs. It is not recommended that patients are immediately discharged from the MAT program after they have been found to be diverting medication, as "punitive 'no tolerance' approaches with automatic discharge from treatment are highly unlikely to help patients" since opioid dependence, when left untreated, is frequently associated with return to use and increases in mortality. Instead, consider alternatives first.[88] Practical solutions can best be formulated when clinicians understand the patient's reasons for diverting medication.[89] Studies have found beneficial effects of MAT, including decreased illicit drug use, reduced overdose risk and decreased criminal

activity, even with patients who do not take the medication as prescribed 100 percent of the time. Clinicians should evaluate treatment benefits and harms for each patient and develop a treatment plan accordingly that minimizes harm without removing the benefits, if possible.[90] For more discussion on this topic, see **Protocols for Program Discharge and Release**.

Sample diversion protocols and policies are in **Appendix G: Sample Policies and Forms**. Additionally, Medication-assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion from SAMHSA and the DOJ offers recommendations and tips related to controlling diversion.

DEVELOP RECOMMENDATIONS FOR COUNSELING

In the past, medications for OUD were often only offered to patients in conjunction with mandatory behavioral therapies, such as counseling. The following section discusses considerations related to counseling recommendations. The FDA recommends counseling in conjunction with all three MAT medications and OTPs are mandated by federal regulation to provide adequate substance use counseling to each patient as clinically necessary. However, there is no federal mandate requiring that patients must receive counseling. Evidence shows that medications for OUD can be effective as a standalone treatment.[91, 92] Counseling must be provided by a qualified program counselor who can assess the psychological and sociological background of patients, contribute to an appropriate treatment and monitor patient progress.[93]

> "No justification exists for denying access to MAT because psychosocial services are unavailable or individuals are unwilling to avail themselves of those services. For many individuals, MAT alone may be enough to begin them on the road to recovery."
>
> *From SAMHSA's Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*

SHOULD MEDICATION BE CONTINGENT ON GOING TO COUNSELING?

Medication alone is an effective treatment for OUD;[94] however, counseling and other supportive services are part of a continuum of care that can help people succeed in long-term recovery and should be made available to all MAT patients. While some patients may benefit from counseling or behavioral therapy, it is not required for treatment efficacy.[95, 96, 97, 98] Medication alone can prevent death and stabilize patients medically. According to the National Academies of Science, "Lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat OUD. Behavioral interventions, in addition to medical management, do not appear to be necessary as treatment in all cases. Some people may do well with medication and medical management alone."[99]

Individuals with OUD may have unique and complex problems that could benefit from a treatment plan with psychiatric or behavioral support. A recovery-oriented system of care aims to offer a coordinated set of services and supports that assist individuals in improving health, wellness and quality of life.[100]

According to SAMHSA, counseling can help:[101]

- Improve problem-solving and interpersonal skills.
- Find incentives for reduced use and abstinence.
- Build a set of techniques to resist drug use.
- Replace drug use with constructive, rewarding activities.

Counseling should be voluntary and client-centered, focusing on the problems that are of greatest concern to the patient. This improves engagement in treatment.[102] A variety of professionals, including medication prescribers, psychologists, psychiatrists and licensed clinical social workers can provide counseling and coaching and support can be provided by recovery coaches and peer recovery specialists. Techniques or modes commonly employed by counselors in MAT include motivational interviewing, cognitive-behavioral therapy, contingency management and case management. All counseling should be trauma-informed, as histories of trauma are highly prevalent among people with OUD.[103, 104, 105]

Counseling

Counseling and ancillary services greatly benefit many patients; however, such services should target patients' needs and should not be arbitrarily required as a condition for receiving OUD medication, especially when the benefits of medication outweigh the risks of not receiving counseling. For programs considering licensing as an OTP, note that federal guidelines require OTPs provide access to adequate counseling to each patient as clinically necessary.

"I am a counselor, so I am very passionate about that part of my work. I also feel equally strongly that counseling should be available for those who want it. I was cognizant that people wanted to tie counseling as a mandatory requirement to receiving the medication. I was opposed to that, because that is a lack of parity and it's not following science. We do not mandate inmates go to counseling if they're on an antidepressant. There are many people who are very stable in their recovery, were on it in the community and are just fine. I really wanted to create a recovery-oriented system of care that offers multiple levels of intensity and styles of psychosocial support."

Annie Ramniceanu, DOC Addiction and Mental Health Systems Director, Vermont DOC

COMPONENT 3
WORKFORCE DEVELOPMENT AND CAPACITY

To ensure appropriate access to services and quality care, organizations must have an adequate and trained workforce equipped with the knowledge and tools necessary to provide medication and other evidence-based treatment for OUD. Workforce needs will vary depending on the type of model developed within your facility; however, regardless of the treatment model, all staff, including health care providers and security staff, should receive basic training on SUD and evidence-based treatments for SUD, including MAT. This section provides implementation questions and recommended actions steps based on the type of model you are considering for your facility.

ACTION STEPS

- [ ] Provide staff training.
- [ ] Develop a care team.
- [ ] Identify appropriate staff-to-patient ratios.
- [ ] Provide ongoing staff supervision and support.

IMPLEMENTATION TOOLS AND RESOURCES

- **Training Tools**
  - SUD 101 Core Curriculum (Providers Clinical Support System)
  - Residential Substance Abuse Treatment (RSAT) Training and Technical Assistance Request (Advocates for Human Potential)

- **Staffing Tools**
  - Role of Correctional Officers in Jail/Prison Substance Use Disorder Treatment Programs (RSAT)

PROVIDE STAFF TRAINING

Training health care and security staff alike is essential to ensure that your workforce is adequately prepared to assist individuals with OUD. Online and in-person training has been shown to effectively increase knowledge and positively change attitudes related to adoption of MAT in correctional settings; however, online training alone has been shown to be less effective at sustaining change.[106, 107] While training needs will differ based on the type of model implemented in your facility, all staff will benefit from basic training on SUD, including OUD. Furthermore, all staff should be aware of the facility's MAT program and receive an overview of MAT as an evidence-based practice for treating OUD. A range of trainings could be offered based on your facility's model, staffing design and organizational needs. Additionally, trainings will be more effective if offered with ongoing opportunities for staff to recall information, share and apply knowledge and deepen their understanding.[108] Trainings should be delivered to staff at the outset of the MAT program and when new staff are onboarded, as well as delivered periodically as "refresher" courses.

Training Resource

The Providers Clinical Support System (PCSS) offers an extensive catalog of 22 self-guided training modules on a range of introductory topics related to substance use disorders in its Substance Use Disorder 101 Core Curriculum. All trainings are free-of-charge.

While all health care and correctional staff should receive basic training, correctional health care staff and security staff directly involved with the provision of MAT services should receive more extensive training on a range of topics. Additionally, for facilities implementing MAT program Model 1 (external providers administering MAT within the correctional facility), the external provider should receive training related to facility security protocols and MAT policies. The following checklists provide trainings by staff type. Additional training resources by staff type can be found in **Appendix C: Staff Training Resources**. Organizations can also seek free training and technical assistance resources from Advocates for Human Potential, Inc. using the Residential Substance Abuse Treatment (RSAT) Training and Technical Assistance Request.

ALL STAFF TRAINING TOPICS CHECKLIST

- [ ] Overview of SUD, including OUD.
- [ ] Overview of MAT.
- [ ] Overview of the facility's MAT program.
- [ ] Avoiding stigmatizing language.
- [ ] MAT policies and procedures.
- [ ] Signs of medication diversion.

STAFF DIRECTLY INVOLVED WITH MAT TRAINING TOPICS CHECKLIST[109]

- [ ] Science of SUD, including OUD.
- [ ] Science of opioid withdrawal.
- [ ] Recovery-oriented principles and approaches.
- [ ] Trauma-informed principles and approaches.
- [ ] Science of MAT, including the different forms of FDA-approved medications.
- [ ] Benefits and effectiveness of MAT.
- [ ] Medication diversion control techniques.
- [ ] Security issues related to MAT, including staff concerns about safety and security during program implementation.
- [ ] Federal, state, local and accreditation bodies' rules and regulations related to storage, mixing, administration, disposal and ordering of MAT medications.
- [ ] Culture change around the treatment of people with SUD.

TRAINING FOR COMMUNITY ORGANIZATIONS PROVIDING MAT ON-SITE CHECKLIST[110]

- [ ] Security protocol, unacceptable behaviors and expectations related to conduct.
- [ ] Critical differences in the environment of correctional settings versus the community setting.
- [ ] Overview of the facility's systems, including information systems and records management.
- [ ] MAT program policies and auditing processes.

OPIOID OVERDOSE RESPONSE TRAINING

Correctional facilities should also be prepared to respond to opioid overdose by administering naloxone. In 2015, NCCHC adopted a position statement recommending that correctional and medical staff undergo training that includes education regarding opioid overdose and its signs, correct techniques for administration of naloxone, positioning of the inmate and related procedures, including cardiopulmonary resuscitation (CPR) and emergency transfer to a facility equipped to treat overdose.[111] Additionally, the Rhode Island DOC provides a recorded online training on administering naloxone, including a step-by-step demonstration.

Naloxone is also an important tool to reverse opioid overdose post-release and is discussed in **Component 5: Linkages to Care and Services Upon Release**.

DUAL LOYALTY TRAINING

Dual loyalty is a term used in public health research referring to an ethical dilemma that many correctional health care providers face due to the perceived conflict between professional duties to patients and obligations to the prison or jail administration. In addition to the trainings previously listed, all correctional health care staff should attend training on the subject of dual loyalty. The New York City Bureau of Correctional Health Services Human Rights Collective developed a training on dual loyalty using six real-world scenarios. All incoming staff complete the module during new employee training.[112] The training aims to raise awareness of dual loyalty issues common in the correctional workplace and educate staff on strategies to mitigate its impact on the health care they provide.

TRAINING REQUIREMENTS FOR BUPRENORPHINE PRESCRIBERS

To prescribe buprenorphine by obtaining an x-waiver, physicians, nurse practitioners and physician assistants must complete a set number of training hours. To obtain OTP status to prescribe methadone, organizations must comply with training-related requirements; there are no training requirements to prescribe XR-NTX. Table 8 provides information on buprenorphine training requirements and resources. In 2019, Health Management Associates, in partnership with ASAM, developed a DATA 2000 waiver training that incorporates best practices for MAT programs in correctional settings. Training topics include addressing trauma, preventing medication diversion, dosing, treating pregnant and adolescent patients and issues related to probation and parole. This training focuses on justice-involved populations and the unique density of trauma in this cohort.

TABLE 8. TRAINING REQUIREMENTS FOR WAIVER TO PRESCRIBE BUPRENORPHINE FOR OPIOID USE DISORDER

Provider Type	Training Hours Required	Training Resource
Physicians	8	• Waiver Training for Physicians (PCSS) • ASAM Treatment of Opioid Use Disorder Course 8-Hour Online Course for Physicians
Nurse Practitioners	24	• Waiver Training for Eligible Nurses (PCSS)
Physician Assistants	24	• Waiver Training for Physician Assistants (PCSS) • American Academy of Physician Assistants (AAPA) and ASAM 16-Hour Waiver Training (also intended for eligible nurses)

EXAMPLE FROM THE FIELD: NEW YORK CITY JAILS

The New York City jails invited a staff person from the City's Health Department to train all jail-based MAT staff on "Meaningful Engagement with People Who Use Drugs." The goal of the training was to support staff to be more successful when engaging with people who use drugs by discussing incremental change, honoring people's experiences, redefining "success" and recognizing the importance of language.

Training components included:[vii]

1. **Context: Drug Policy and Stigma**
   - Social determinants of health.
   - Historical U.S. approach to drugs: criminal/moral model.
   - Factors shaping drug policy, stigma, the effects on people who use drugs and on providers.
2. **Harm Reduction**
   - Definition and key components.
   - Word choice: potentially stigmatizing versus more compassionate language.
3. **Stages of Change and Realistic Goal Setting**
   - Stages of change.
   - Matching strategy to stage.
   - Cycle of problematic engagement.
4. **Meaningful Engagement**
   - Elements of meaningful engagement.
   - Practice exercise.

DEVELOP A CARE TEAM

Care teams within correctional MAT programs will differ depending on the type of model implemented, for example, whether delivering services off-site or on-site. As described in **Determine Program Capacity**, staffing models will depend on the expected patient population.

Regardless of the type of MAT model, correctional officers and other security staff are integral members

vii. This training was developed and presented by Emily Winkelstein, MSW, NYC Department of Health and Mental Hygiene, in collaboration with Correctional Health Services.

of a multidisciplinary team. Due to their constant presence in the facility and regular interaction with patients, security staff have the greatest capacity to assess who may be eligible to participate in a MAT program and monitor those who are in treatment. As such, include security staff as full members of the treatment team.

After identifying who will be involved in the care team based on the model type, it is important for both clinical and correctional staff to recognize the collaborative effort required to successfully deliver MAT. Understanding and acknowledging the role that each team member plays eliminates the "us versus them" attitude that can arise in the provision of health care in correctional settings and instead focuses on supporting patients' recovery efforts.[113]

Security Staff

This short video from the Rhode Island DOC describes the role of security staff on the MAT team.

INTEGRATING PEER SUPPORT

In addition to clinical and correctional staff within the facility, peer recovery coaches have an important role on the MAT team. Peer recovery specialists are people who have lived experience with substance use and SUD who are trained to assist others with their recovery. Peer recovery coaches offer knowledge that treatment staff often lack based on life experiences. Forensic peer specialists are peer specialists who have a history of justice-involvement. An increasing number of MAT programs in correctional settings have integrated peer supports within MAT teams. Many correctional facilities rely on community-based providers that come on-site to deliver services and facilitate re-entry into the community while some facilities have developed their own forensic peer specialist programs within their jails and prisons. The Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS provides helpful resources, tools and technical assistance support to help organizations integrate recovery supports as part of care teams.

"This goes back to our mission of creating a culture of health and wellness and resilience in the facilities. So they (forensic peer specialists) are the emissaries and frontline of this endeavor. They are on the front lines of this work and we are working with them to spread all kinds of other health initiatives, peer to peer, inside of the facilities."

Annie Ramniceanu, DOC Addiction and Mental Health Systems Director, Vermont DOC

EXAMPLE FROM THE FIELD: PEER SUPPORT

Vermont DOC

The Vermont DOC established a forensic peer support program based on the principles of a recovery-oriented system of care. Vermont trains forensic peer support specialists in developing Wellness Recovery Action Plans (WRAP), active listening skills, peer support skills and Question, Persuade, Refer (QPR) technique for suicide prevention. From July 1, 2018, to June 30, 2019, across the six correctional facilities, more than 11,500 individual coaching sessions took place in addition to daily tours in segregation, restricted housing units and the infirmary. Vermont is currently expanding the model to include re-entry group sessions to support people pre-release.

Franklin County Jail and House of Correction in Massachusetts[114]

Franklin County Jail and House of Correction implemented a peer recovery program as part of a three-year SAMHSA grant. Peer-led groups are held once a week on-site in housing units by individuals with lived experience. Additionally, individuals are brought from the jail to a community group meeting for individuals who are currently and were formerly incarcerated.

WHAT IS THE APPROPRIATE STAFF-TO-PATIENT RATIO?

Ratios of MAT staff to patients vary widely, depending on program model and jail size. If you plan to provide MAT internally, when planning for staffing, consider the number of medical providers needed, including medical doctors as well as nursing staff and physician assistants. For waivered buprenorphine providers, there are patient caps of 30 and 100 (after one year) for physician assistants, nurse practitioners and physicians. Some physicians can increase their cap to 275 if they meet specific requirements.[115] While there are no federal caps related to OTPs, state licensing agencies may have patient-to-staff ratio requirements. XR-NTX prescribing has no recommended staff-to-patient ratios.

In addition to licensed prescribers, consider nursing staff needed for daily medication dosing as well as intake screening and assessment, pharmacy staff and any behavioral health staff for internally-staffed programs. Regardless of program model, consider the number of correctional staff needed for patient escort or transport and monitoring of medication lines.

To demonstrate the range of staffing models, consider the following programs representing three different geographic settings and types of models.

EXAMPLE FROM THE FIELD: STAFFING MODELS

Franklin County Jail and House of Correction in Massachusetts is a small rural jail that provides MAT (methadone, buprenorphine and XR-NTX) to approximately 40 individuals daily. The jail employs an addiction doctor for six hours each week, a full-time nurse practitioner, 16 nursing staff (registered nurses or licensed practical nurses) and a psychiatrist for four hours each month. The medical clinic is staffed 24 hours a day, seven days a week and provides primary medical care in addition to being a fully licensed OTP. The medication line typically has two security staff in addition to a nurse. A post-release/re-entry team of three case workers was recently added to the team to work with released clients who were sentenced. Additionally, a peer recovery provider from the community comes into the facility weekly to lead groups.

Hennepin County Jail in Minnesota is an 800-bed urban jail that provides buprenorphine and XR-NTX to 35 to 40 patients daily. Buprenorphine is prescribed by two physicians who each practice in the jail one to two half days per week and a nurse practitioner who practices 20 hours per week. In addition, there is a full-time nurse who assists with intake and screening and coordinates care upon release for patients who received buprenorphine in the jail. There is also additional nurse time allocated for dispensing buprenorphine.

New York City Health + Hospitals/Correctional Health Services, which provides buprenorphine to approximately 250 patients, methadone to 750 to 800 patients and XR-NTX to a small number of patients each day, embeds MAT services into the larger medical service. A portion of the hundreds of doctors, nurses and physician assistants on staff, while not a part of the OTP, serve individuals with OUD at medical intake, screening and care. The jail-based OTP also employs a full-time medical director, deputy medical director, nine counselors, three supervisors and three nurses.

PROVIDE ONGOING STAFF SUPERVISION AND SUPPORT

In addition to initial training, it is important that staff receive ongoing support and supervision. Offer in-service trainings and annual review trainings as refresher courses to initial training. Give health care staff and correctional staff the opportunity to collaborate on identifying training topics and during trainings. Collaboration and communication between staff and supervisors and health care and security staff will help identify potential program issues early. Team meetings provide an opportunity to review retention rates, potential drop out points and other challenges.[116]

Mentorship is also a useful tool to help staff increase knowledge and develop skills related to providing MAT services. The Providers Clinical Support System provides mentoring and technical assistance through a nationwide network of clinical experts in addiction and pain management.

COMPONENT 4
DELIVERY OF TREATMENT

After determining the type of MAT model to implement, there are several considerations related to provision of treatment services. The following section provides information, resources and tools related to the budgetary, regulatory and logistical planning considerations for MAT programs in correctional settings.

ACTION STEPS

- [ ] Determine where and when to deliver MAT services.
- [ ] Determine which medication formulations to offer.
- [ ] Develop dosage guidelines.
- [ ] Establish screening protocols to determine eligibility.
- [ ] Develop guidelines for ongoing care.
- [ ] Develop protocols related to drug testing.
- [ ] Develop protocols for special populations.
- [ ] Develop protocols for program discharge and release.

IMPLEMENTATION TOOLS AND RESOURCES

- Decisions in Recovery: Treatment for Opioid Use Disorder (SAMHSA)
- Screening and Assessment of Co-Occurring Disorders in the Justice System (SAMHSA)
- Narcotic Treatment Programs Best Practice Guideline (DEA)
- Center for Connected Health Policy
- Confidentiality resources
  - Center for Excellence for Protected Health Information (SAMHSA)
  - Basics of 42 CFR Part 2 (Justice and Health Connect)

DETERMINE WHERE AND WHEN TO PROVIDE SERVICES

Unless your program implements a model that transports patients who are on MAT to an external treatment facility, you will need to plan for the location and time of delivering MAT services. Both methadone and buprenorphine are administered daily (except for the monthly buprenorphine injectable, Sublocade); XR-NTX is administered monthly. Facilities must ensure that they have clinical staff to deliver the medications directly, rather than allow patients to keep a supply of medications in their housing areas. As such, your facility will need to find space for MAT service delivery daily. Generally, offer MAT services, like other clinical services, in a centralized location such as a medical clinic, where all patients come to a centralized location, or take the medical services, both staff and medications, to patients in their housing units.

WHERE SHOULD SERVICES BE DELIVERED?

When determining where to deliver MAT services, security issues, risk of medication diversion, patient confidentiality and logistics should be considered.

MEDICATION DIVERSION CONTROL

Locations where opioid agonist MAT medications are administered should be secure and minimize a patient's ability to divert medication. There should be space for adequate security staff and clinical staff, and, ideally, locations will have cameras installed. For buprenorphine, which requires several minutes to dissolve, patients will need to have space to wait and be observed for up to 15 to 20 minutes. XR-NTX is not a diversion risk and does not require control measures beyond those that apply to all medications generally.

CONFIDENTIALITY

Similar to a community setting, patients in correctional settings deserve to receive medical care in a private and confidential manner. This can be particularly challenging with MAT in correctional settings, unless it is dispensed at the same time as other medications in your clinic's medication line. With buprenorphine, however, that may be impossible. If delivering medications in housing units, explore options for space to provide private conversations apart from the rest of the unit.

If your facility's MAT program receives federal funding or you obtain certification as an OTP, the federal regulations that govern confidentiality of SUD records will apply. The regulations, commonly known as 42 CFR Part 2, establish protections against disclosure of information relating to a patient's SUD status, including through sharing written records or verbally disclosing information. Justice and Health Connect provides a fact sheet on the basics of 42 CFR Part 2 for criminal justice settings, SAMHSA provides regulatory guidance related to 42 CFR Part 2 and the Center for Excellence for Protected Health Information, funded by SAMHSA, offers resources and tools related as well as direct technical assistance upon request.

LOGISTICS

If administering MAT services out of a central location, consider the availability of security staff and escorts, if needed. Ensure that medications are securely stored. If administering MAT services in patient housing areas, consider the logistics of transporting medications safely and bringing patient records to the housing

areas. If using an electronic medical record or pharmacy record, tablets or laptop computers will be needed.

Some jails have considered cohorting individuals with MAT into one housing unit to reduce inefficiencies and limit diversion. However, this does not allow for patient confidentiality and may limit patients' interest in MAT.

For jails planning to partner with community-based programs to deliver services off-site, consider the availability of transportation and correctional staff escorts.

MAT Medication Line

To understand how the Rhode Island DOC manages its MAT medication line, watch this short video.

EXAMPLE FROM THE FIELD: JOHN BROOKS RECOVERY CENTER, NEW JERSEY

John Brooks Recovery Center's (John Brooks) Project Kickstart is the first methadone re-entry program in New Jersey. Using a bus as a mobile clinic, Project Kickstart provides methadone treatment to patients in Atlantic County Jail. A medical doctor and registered nurse assist with physical exams and dispensing methadone to patients on the bus, which is parked on the jail campus, so patients do not have to be transported elsewhere. John Brooks works collaboratively with CFG Health Systems, the jail health care provider, to ensure individuals in the jail are screened for OUD. Jail security staff assist with transporting patients to and from the bus. Additionally, a John Brooks' licensed clinician is embedded within the jail. Project Kickstart can treat up to 50 patients at any given time and approximately 450 patients are treated annually.

WHEN SHOULD SERVICES BE DELIVERED?

Generally, medications for OUD are taken daily by patients, except for extended-release injectable medications, which are administered monthly. Both methadone and buprenorphine remain effective in the body for approximately 24 hours. Most jails dispense medication directly to patients daily and remain with patients for a period of time after ingesting to ensure they have consumed the medication. Some jails have opted to dispense MAT in the morning after finding that a small proportion of patients receiving agonist medication experience insomnia as a side effect, particularly in the first few weeks of treatment. As part of setting up your program, you will need to determine when you will dispense medications to your MAT patients. If your jail has medical staff available fewer than seven days a week, consider additional staff time to facilitate daily medication dosing.

There are advantages and disadvantages to combining MAT with other medication distribution processes at your facility. Some advantages include increased efficiency by distributing all medications at once, particularly when delivering medications to each patients' housing units, and de-stigmatizing MAT and promoting

patient confidentiality, so MAT patients are not differentiated and separated from patients taking other medication.

Most facilities, however, dispense agonist medications (methadone and buprenorphine) for OUD separately from other medications. This decreases the potential for diversion and allows for easier and more streamlined observation after ingesting medications.

If your program provides counseling or therapy to MAT patients as part of your MAT program, this could be timed to coincide with dosing or be provided separately. When determining the timing of MAT counseling, consider which staff will be providing the counseling (e.g., the same staff that are administering medications or different staff), the space needed to ensure patient privacy and how frequently MAT patients will receive counseling.

EXAMPLE FROM THE FIELD: DISPENSING MEDICATION

Franklin County Jail and House of Correction in Massachusetts

The Franklin County Jail dispenses MAT medications each day from 6 to 8 a.m. to approximately 40 individuals. Patients are brought in for medication dispensing in groups, starting with those who have court, off-site work or community service obligations, followed by male general population, female general population and individuals in segregated housing. A nurse administers the medication. After the group has received their medication, they wait 15 to 18 minutes and are observed by the nurse and an officer, then each patient's mouth is checked to ensure the medication has fully dissolved before being escorted back to their housing units.

Hennepin County Jail in Minnesota

Hennepin County Jail, an 800-bed facility, dispenses buprenorphine in each housing unit in the same medication line as other medications. Patients receiving buprenorphine get in line first, so their buprenorphine can dissolve while other patients receive their medications.

TELEHEALTH FOR TREATING OPIOID USE DISORDER

A growing number of correctional settings are implementing telehealth to provide SUD care. For programs providing buprenorphine with limited clinical staff, telehealth may be a valuable option to allow for more timely dose adjustments. Using telehealth as a component of MAT to treat individuals with OUD requires that providers understand and comply with federal and state prescribing regulations. State laws and regulations vary and regulatory changes are happening at a rapid pace as states identify strategies to address the opioid epidemic. Examples of state requirements for online prescribing include a physical exam administered prior to prescribing and criteria related to establishing a patient-provider relationship.

Prescribing controlled substances in-person and through telehealth requires compliance with federal

regulations in addition to state regulations. Enacted in 2008, the Ryan Haight Act prohibits dispensing controlled substances online or through internet prescribing without a "valid prescription." For a prescription to be valid, in most cases, a physician must conduct an in-person medical evaluation. Because XR-NTX is not a controlled substance, the Ryan Haight Act does not apply to prescribing XR-NTX. Although the Ryan Haight Act permits medical evaluations via telemedicine, it restricts the practice of telemedicine to patient encounters in which the patient is "being treated by, and physically located in, a hospital or clinic" or "while the patient is being treated by, and in the physical presence of a practitioner."[117] Presently, SAMHSA does not allow OTPs to provide medical assessment on patients remotely. Few states now allow prescribing of controlled substances within federal limits (without additional state requirements). For example, West Virginia recently passed legislation allowing a practitioner to provide aspects of MAT through telehealth if it is within his or her scope of practice.[118] The Center for Connected Health Policy provides a comprehensive database of current state laws and reimbursement policies related to telehealth, a helpful resource for navigating regulations.

Despite regulatory challenges, correctional facilities with MAT programs are utilizing telehealth for medication management and finding that increased efficiency and timeliness has led to improved provision of care. For example, the titration process of getting to the correct dose can more quickly be accomplished by seeing patients via telehealth, rather than making the patient wait to adjust a dose until the prescribing physician is at the facility.

EXAMPLE FROM THE FIELD: SALT LAKE COUNTY METRO JAIL[119]

In June 2019, the University of Utah Health partnered with the Salt Lake County Metro Jail to provide telehealth services to pregnant patients within the jail. The Substance Use and Pregnancy-Recovery, Addiction and Dependence (SUPeRAD Clinic provides preconception, pregnancy and postpartum care for women with SUD at Salt Lake County Metro Jail. An on-site women's clinic led by a physician assistant provides hands-on care, including physical exams and anatomy scans.

> "In the community, people can self-titrate. When you're at home, you can figure out what dose works for you. In jail, it's much more controlled. So when we were only relying on in-person visits [for dose adjustments], it was taking so long to get people on the right dose. Telemedicine has allowed us to get people to an adequate dose faster."
>
> *Tyler Winkelman, Clinician-Investigator, Hennepin Healthcare, Minnesota*

DETERMINE WHICH MEDICATION FORMULATIONS TO OFFER

In addition to choosing which medication your program will offer (see **Component 2: Program Planning and Design**), you will need to choose the medication formulation your facility will dispense. Each of the medications for OUD come in a variety of formulations, including oral pills, drinkable liquids, injections and implants. Tables 9 and 10 define and describe the different types of formulations available for the medications approved for the treatment of OUD.

TABLE 9. DEFINITIONS OF KEY MEDICATION FORMULATION TERMS

Term	Definition
Sublingual	Under the tongue
Transmucosal	Absorbed through a mucous membrane, most commonly inside the mouth
Oral	By mouth
Buccal mucosal/buccal film	Lining of the cheeks, placing a film between the cheek and gum
Subdermal/subcutaneous	Beneath the skin

WHAT FORMULATION(S) OF MEDICATIONS SHOULD BE OFFERED?

For methadone and buprenorphine, no evidence exists to suggest that any formulation is more effective than another.[120, 121] When you are deciding on a formulation, consider frequency of administration, cost (of both the medication itself and staff time associated, time to dissolve, ease of diverting and which formulations are available in the community.

Frequency of Administration

While medications most frequently dispensed, such as pills, tablets and dissolvable films, are administered daily, some medications are administered less frequently. Injections of XR-NTX and buprenorphine are administered monthly and subdermal buprenorphine implants are administered every six months.

Cost

Some formulations are more expensive than others. Budget for the cost of medications as well as the staffing associated with administering the medications. For example, for a medication administered daily that requires directly observed ingesting, more staff time is required compared to a medication that is injected monthly. For a detailed breakdown of cost estimates, see **Component 2: Program Planning and Design**.

Time to Dissolve

Sublingual tablets, sublingual films and buccal films often require staff to watch while dissolving. Films dissolve more quickly than tablets, requiring less staff time to observe.[122] As you consider the logistics and staffing of your medication line, consider these time obligations.

Diversion

Some formulations are diverted more easily than others. Monthly injections and implants are less likely to be diverted than daily medications in oral or film formulations. Some facilities have crushed buprenorphine

or liquefied methadone diskettes to reduce the risk of diversion, as liquids are harder to divert than pill or tablet forms. Evidence suggests that crushing buprenorphine does not decrease its effectiveness.[123] Oral buprenorphine is available both with naloxone (Suboxone) and without (Subutex). When taken as directed, the naloxone in Suboxone is inert and both medications are functionally identical. When injected, the naloxone in Suboxone is activated, resulting in precipitated withdrawal. For more strategies to prevent diversion, see **Develop Protocols to Control Medication Diversion**.

Formulations Available in the Community

For ease of patients' transition back to the community, consider offering the same formulations available in the community.

TABLE 10. MAT MEDICATION FORMULATIONS AVAILABLE

Medication	Formulations available
Methadone	Liquid, tablet, dispersible tablet (diskette)
Buprenorphine	Sublingual tablet, subdermal implant
Buprenorphine/naloxone	Sublingual tablet, sublingual film, buccal film
Naltrexone	Tablet, injection

When deciding which medication formulations to use in your organization, it is important to make the decision to meet the unique needs of your facility. Key informants came to different determinations based on their organizational and staffing culture and experiences. The two following quotes illustrate decision-making in two different facilities.

"We use the pill form. The reason we do that is that the most frequent contraband in the jail is Suboxone in the film. So, we didn't want to use the film form and be blamed for all that stuff. When we were using buprenorphine (mono, without naloxone), by the way, we crushed it, which was even more comfortable for security."

Bruce Herdman, Chief of Medical Operations, Philadelphia Department of Prisons

"A buprenorphine pill is the least expensive. I thought that's the way to go. It costs the least. It drove security crazy. It takes a long time to dissolve, and it's easy to divert. People would spit it out and have it fall down their shirt. Hiding it in dentures. So, we moved over to the film, which is a little bit more difficult, but still can be diverted. So, we're in the process of now going to crushing buprenorphine and using that sublingually."

Jennifer Clarke, Medical Programs Director, Rhode Island DOC

WHERE SHOULD MEDICATIONS BE STORED?

If your program chooses to provide MAT directly, rather than partner with an outside provider, identify a space to store medications. Carefully store medications for OUD. While regulations and storage needs differ for each medication, generally, when you identify a location to store medications for OUD, consider security, safety, logistics and convenience.

To prevent diversion, opioid agonists (methadone and buprenorphine) are required by law to be stored in locked cabinets and routinely counted. Return missed doses to the locked cabinet. Programs licensed as OTPs are additionally subject to the DEA's storage and security regulations. These regulations include locking cabinets or safes to the wall or floor and installing alarm systems to protect against unauthorized entry. The DEA's Narcotic Treatment Programs Best Practice Guideline is a helpful resource for medication storage.

Safe storage is important to ensure proper handling of medications and that they are used prior to their expiration dates. Refrigerate injectable buprenorphine and XR-NTX. If your program stores medications outside of the areas in which you deliver service, consider transportation needs.

DEVELOP DOSAGE GUIDELINES

When you implement a MAT program at your facility, it may helpful to develop dosing guidelines. Each of the three FDA-approved medications for OUD are dosed differently. A detailed discussion of dosing guidelines is beyond the scope of this toolkit; however, implementation questions and resources for more information follow.

WHAT DOSAGES SHOULD BE GIVEN TO PATIENTS?

Like all clinical decisions, your facility's medical provider should make all dosing decisions. XR-NTX is only available in one monthly dose (380 mg). Research indicates that dosing for methadone and buprenorphine is associated with treatment retention. For methadone, patients dosed at 60 mg or greater have higher rates of treatment retention.[124] For jail-based methadone programs specifically, research indicates that higher doses are associated with higher rates of community continuation of treatment post-release.[125] For buprenorphine, higher doses (12 to 16 mg or greater) are associated with greater treatment retention and lower rates of heroin and cocaine use.[126, 127, 128] Research does not support limits or caps on medication dosing and the Federal Guidelines for Opioid Treatment Programs advises against it.[129]

For patients entering your facility already on MAT, continue the dose the patient is already taking. Verify the community dose by communicating with the community treatment provider by phone or electronically. Links to sample policies can be found in **Appendix G: Sample Policies and Forms**.

ESTABLISH SCREENING PROTOCOLS TO DETERMINE ELIGIBILITY

After you have determined the patient populations that are eligible for your facility's MAT program, you need to develop processes to screen for and identify those patients. An efficient way to do this is by adding a short screening questionnaire to your already existing medical intake process, if one exists. Sample protocols can be found in **Appendix G: Sample Policies and Forms**.

WHAT SCREENING MECHANISMS SHOULD BE USED TO DETERMINE ELIGIBILITY?

There are a variety of free, validated, evidence-based, short screening tools that can help providers determine whether a patient has an OUD. Table 11 provides examples of validated screening tools for OUD and other SUD. Note that some screening tools are validated for drug use only, for alcohol use only or for both. There are also specific tools for adolescent and adult populations. By using a validated screening tool with all patients, you ensure that all patients are objectively assessed and that eligibility determinations do not vary depending on which staff person is conducting the screen. It is important that screening tools are administered by staff who have received training specific to the tool, who are experienced at conducting screening and who are appropriately licensed or credentialed for conducting the screening.

In addition to these short questionnaires, you may consider urine drug screens and consulting your state's Prescription Drug Monitoring Program (PDMP). These tools can help determine if a patient has an OUD. If your program has additional eligibility criteria, such as pre-trial/post-trial or current enrollment in a community-based MAT program at the time of arrest, incorporate these elements into the screening process.

When you first begin implementing MAT in your jails, in addition to screening all incoming patients systematically at intake, you will need a method for screening patients already housed within your jail. This is a one-time issue, as eventually all patients will cycle out of your jail and you will screen everyone at intake. However, at the beginning you need to determine a method for gathering MAT eligibility information among those already housed, such as screens at other medical appointments, education and outreach to patients and an avenue for requesting screens, such as sick call slips.

Once patients are determined eligible for your jail's MAT program, you must give them the choice to voluntarily opt into the MAT program after learning about what the program is, advantages and risks and patient responsibilities. A patient contract can help clarify the program's responsibilities and the patient's responsibilities; sample MAT patient contracts are included in **Appendix G: Sample Policies and Forms**. It is important to note that patients can never be forced or compelled to take any medications for OUD.

Decisions in Recovery: Treatment for Opioid Use Disorder

A useful tool to educate patients about MAT is Decisions in Recovery, a SAMHSA-funded initiative that provides fact sheets, testimonials, and videos about MAT and other recovery services and supports for OUD.

TABLE 11. SCREENING AND ASSESSMENT TOOLS AND RESOURCES

Tool Name	Source	Description
DSM-5 Criteria for Diagnosis of Opioid Use Disorder	**IT MATTRs Colorado**	DSM-5 criteria for diagnosing OUD among individuals.
Screening Tools and Prevention Resources	**National Institute on Drug Abuse (NIDA)**	Provides resources for providers to increase awareness of the impact of substance use on patients' health and help identify drug use early and prevent it from escalating to misuse or SUD.
Screening Tools and Prevention Chart	**NIDA**	Provides a catalog of evidence-based screening tools and assessment resource materials (updated June 2018).
Screening and Assessment of Co-Occurring Disorders in the Justice System	**SAMHSA**	A comprehensive guide for screening for SUD, mental health and co-occurring disorders in criminal justice settings, including recommended screening instruments.
Texas Christian University (TCU) Core Forms Matrix	**Texas Christian University Institute of Behavioral Research**	Provides a catalog of screening and assessment tools to be used across a treatment continuum for behavioral health needs.

"[I want to emphasize] the importance of an upfront clinical assessment. A lot of correctional settings don't have anything up front. And so a lot of it is just wait and see, and then when somebody is seeking treatment, they don't have all the information they need. An early comprehensive clinical assessment is critical."

Jonathan Giftos, Director of Substance Use Treatment, Correctional Health Services, NYC Health + Hospitals

"We started off with a standardized screening: the TCU, Texas Christian University. It's specific for prison and jail populations, but we found that just asking the question, 'Have you used opiates?' was getting people sooner and basically getting everybody that we needed to get on treatment. So, from the screen, 'Have you used opiates?' then there is an assessment done according to ASAM criteria."

Jennifer Clarke, Medical Programs Director, Rhode Island DOC

DEVELOP GUIDELINES FOR ONGOING CARE

Establish guidelines and systems for regular ongoing MAT care, after a patient has begun MAT and their initial dose is established. These guidelines may cover frequency of medical visits, dose adjustments and any additional services that are required or offered, such as counseling. It is important to note that any dose adjustments must be made with the patient's consent, unless they sign a document stating they waive consent.

HOW LONG SHOULD PATIENTS STAY ON MAT?

Do not limit the duration of MAT treatment; it should be based on clinical need. Evidence shows that longer treatment duration results in greater benefits.[130, 131, 132, 133, 134] According to SAMHSA, "The longer patients take medication, the less likely they are to return to opioid use, whereas short-term medically supervised withdrawal rarely prevents return to use."[135] Additionally, there is a significant risk of opioid withdrawal associated with tapering opioids rapidly or discontinuing them suddenly. The U.S. Department of Health and Human Services advises that, unless there are indications of a life-threatening issue, such as warning signs of impending overdose, opioids should not be abruptly reduced or discontinued.[136]

DEVELOP PROTOCOLS RELATED TO DRUG TESTING

Drug testing in the provision of MAT has several benefits as a treatment tool. It is generally recommended that health care providers employ random drug tests, with greater frequency at the beginning of induction and treatment and decreasing frequency as the patient stabilizes. The SAMHSA Center for Substance Abuse Treatment recommends administering toxicology tests for all relevant illicit drugs at least monthly during treatment for OUD using buprenorphine.[137] While urine screening is most common, testing can be performed using other sources, including blood, saliva, sweat and hair.[138]

Benefits of drug testing include:

- Monitoring medication adherence (a positive test result for the analog of the prescribed medication is desirable.
- Monitoring for potential diversion (a negative test result for the analog of the prescribed medication.
- Detecting other substances used that may complicate treatment response, including benzodiazepines.[139]

In 2017, the ASAM Board of Directors adopted a consensus statement calling for the use of drug testing as a supporting tool for recovery rather than for punishment.[140] Drug tests showing a positive result should not result in a person being removed from a treatment program or prohibited from receiving medication, but should be taken as an indicator for additional or different service needs. In a correctional setting, this has important implications. If corrections staff routinely administers drug testing for security purposes, these processes should remain separate from drug testing by clinical staff for care purposes.

> "Drug testing should be used as a tool for supporting recovery rather than exacting punishment. Every effort should be made to persuade patients that drug testing is a therapeutic, rather than punitive, component of treatment. This process may require time and multiple conversations. If drug testing is used in such a way that it creates an 'us versus them' mentality, it is at odds with the therapeutic alliance. In fact, drug testing can be thought of as a tool to improve the therapeutic alliance in that it transfers the role of detector from the provider to the test."
>
> *ASAM Consensus Statement on Appropriate Use of Drug Testing in Clinical Addiction Medicine*

DEVELOP PROTOCOLS FOR PREGNANT WOMEN AND INDIVIDUALS WITH CO-OCCURRING DISORDERS

While MAT should be offered to any individual with OUD, facilities should consider developing policies and protocols for specific sub-populations of patients when necessary, including pregnant women and individuals with co-occurring mental and physical health disorders. The American College of Obstetricians and Gynecologists (ACOG and ASAM recommend using opioid agonist pharmacotherapy to treat pregnant women with OUD. Pregnant women should be be made aware of the risk of neonatal abstinence syndrome (NAS) and babies should be monitored and managed for NAS after birth. Opioid agonist treatment is preferred due to risk of return to use associated with medically supervised withdrawal.[141] Tools and resources that provide helpful guidance related to MAT for specific patient populations can be found in Table 12.

Co-occurring Disorders

The SAMHSA GAINS center hosted a 90-minute webinar discussing best practices related to screening and assessment for individuals with co-occurring disorders in the justice system.

TABLE 12. TOOLS FOR IMPLEMENTING MAT WITH PREGNANT WOMEN AND INDIVIDUALS WITH CO-OCCURRING DISORDERS

Population	Tool	Source
Pregnant women	Vermont Guidelines for Medication Assisted Treatment (MAT) for Pregnant Women	Vermont Department of Health, Division of Substance Abuse Programs and the Department of Vermont Health Access
	Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants	SAMHSA
	ACOG Committee Opinion on Opioid Use and Opioid Use Disorder in Pregnancy	ACOG and ASAM
	Improving care for pregnant people with opioid use disorder in U.S. jails: Research to implement medication assisted treatment	Carolyn Sufrin, Department of Gynecology and Obstetrics, Johns Hopkins University School of Medicine and Department of Health, Behavior & Society, Johns Hopkins Bloomberg School of Public Health
Individuals with co-occurring disorders	Screening and Assessment of Co-Occurring Disorders in the Justice System	SAMHSA
	Substance Abuse Treatment for Persons with Co-Occurring Disorders, Treatment Improvement Protocol 42	SAMHSA
	Understanding Co-Occurring Disorders and Applying Integrated Treatment Strategies for Adult Correctional Populations, Training Tool	RSAT Training and Technical Assistance

DEVELOP PROTOCOLS FOR PROGRAM DISCHARGE AND RELEASE

Establishing clear criteria, policies and protocols related to how and when patients are discharged from the MAT program and when patients are released into the community are important planning steps. As a general rule, discharging patients from the MAT program should be a clinical decision, made by medical professionals only; considerations for program discharge are discussed in the next section. Information related to pre-release planning is discussed in greater depth in **Component 5: Linkages to Care and Services Upon Release**.

CAN PATIENTS BE DISCHARGED FROM MAT FOR ADMINISTRATIVE REASONS?

In addition to clinical contraindications or release from the correctional facility or transfer, there may be other non-medical or administrative reasons to terminate a patient's medications for OUD. A patient contract can be a useful tool to guide these decisions and make them transparent and clearly understood by the patient.

Importantly, medications for OUD should not be seen as a reward or a privilege that can be removed as a consequence for bad behavior. Instead, like other medications for chronic conditions, MAT is an evidence-based treatment that should be offered to all individuals with OUD, as long as they can meet the requirements and responsibilities of the MAT program. As mentioned earlier, failure to attend counseling or groups should not be a reason to discharge a patient from MAT.

"In Vermont DOC, security does not make medical decisions to take patients off the medication. It's completely a medical determination. Security will do the sanctioning, but that is separate from the medical staff. We did not want those things intertwined. The DOC does not direct medical care. While people do not tend to divert essential medications like insulin, even if they did, security would not make the decision to stop their diabetes treatment. So that's the approach we took. Even when an inmate diverts their medication, they still have an opioid use disorder and an alternative treatment plan is needed."

Annie Ramniceanu, DOC Addiction and Mental Health Systems Director, Vermont DOC

"You can get taken off [MAT] for diversion, but all the decisions are made by the medical team. The jail staff don't play any role whatsoever in who gets medical treatment. Our policy is, 'let's have a conversation.' If there are concerns, it's not really about punishment, it's more about, 'Why isn't this working?'"

Tyler Winkelman, Clinician-Investigator, Hennepin Healthcare, Minnesota

Before taking a patient off medication for OUD, counsel the patient to ensure they understand the expectations and patient responsibilities. It is important that all decisions to remove a patient from a MAT program are made by clinical staff only and not by security staff, as illustrated in the following key informant statements.

COMPONENT 5
LINKAGES TO CARE AND SERVICES UPON RELEASE

Providing MAT to individuals while they are incarcerated is effective to reduce rates of post-release overdose death, recidivism and future criminal behavior; however, there are several additional steps jails and prisons can take to enhance individuals' likelihood of success in the community and their recovery upon release.

ACTION STEPS

- [ ] Connect patients to health insurance coverage.
- [ ] Coordinate care with community providers.
- [ ] Provide linkages to social services and recovery supports.
- [ ] Provide education and resources to prevent opioid overdose.

IMPLEMENTATION TOOLS AND RESOURCES

- Resources for identifying community-based MAT providers
  - Behavioral Health Treatment Services Locator (SAMHSA)
  - Opioid Treatment Program Directory (SAMHSA)
  - Buprenorphine Practitioner Locator (SAMHSA)
- Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison (Policy Research Associates)
- A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons (RTI International)

"Every place I know that has expanded access to agonist therapy and that measures post-release overdose deaths has seen significant reductions in post-release overdose deaths just by making medications available. And that's not contingent upon linkage into continued treatment. It's just the impact of having medication on board when you leave [jail]. My approach to this is three goals of making medication available in correctional settings: One is to reduce illicit substance use in correctional settings and therefore reduce overdose death risk in correctional settings. The second is to reduce post-release mortality. And then the third is to set the set the stage for potential facilitation of linkage into long-term treatment."

Jonathan Giftos, Director of Substance Use Treatment, Correctional Health Services, NYC Health + Hospitals

CONNECT PATIENTS TO HEALTH INSURANCE COVERAGE

Individuals receiving MAT in correctional facilities need to be able to access and afford ongoing medication and care in the community after release. To facilitate continuity of care and reduce barriers to medication, many MAT programs in correctional settings have established processes to connect individuals to Medicaid pre-release. Medicaid eligibility and prescription drug coverage vary by state; therefore, staff should work with their state Medicaid agency to determine the most effective ways to connect patients to insurance for MAT medication.

Many states have enacted policies to increase enrollment in Medicaid coverage among individuals who are incarcerated. As of 2018, 32 states established Medicaid outreach or assistance strategies to facilitate enrollment prior to release in jails and 38 states established enrollment strategies within prisons.[142] Correctional enrollment program designs vary. Some correctional facilities have partnered with external organizations or state Medicaid agencies to provide enrollment services to individuals with the help of insurance navigators or enrollment counselors. Other states have trained correctional staff as enrollment counselors to help facilitate the process within the facility.

If patients are returning to the community expecting to be employed, but without health insurance coverage, they can apply for health insurance, including possible subsidies, through the Health Insurance Marketplace within 60 days of release from custody. Additionally, individuals under the age

Health Insurance

Healthcare.gov provides information and resources to assist connecting individuals who have been incarcerated to health insurance.

of 26 who are returning to the community are eligible for coverage through their parents' plans even if they do not intend to reside with their parents.

In addition to enrollment assistance, many states have enacted policies that suspend, rather than terminate, Medicaid eligibility for individuals who are incarcerated. When coverage is suspended it can be reinstated more quickly upon release. As of 2018, 35 states enacted Medicaid suspension rather than termination policies for jails and 37 states for prisons.[143] The Kaiser Family Foundation's state-by-state information on corrections-related Medicaid enrollment policies is a helpful tool for determining opportunities to facilitate enrollment prior to release.

COORDINATE CARE WITH COMMUNITY PROVIDERS

Navigating access to MAT services in the community after release can be a challenging experience. Establishing procedures to coordinate care with community providers will help to increase patients' likelihood of engaging in treatment and long-term recovery during re-entry.

EXAMPLE FROM THE FIELD: ARIZONA'S ENROLLMENT SUSPENSE AND REINSTATEMENT PROCESS[144]

The Arizona Health Care Cost Containment System (AHCCCS) established a statewide process to enroll incarcerated individuals in Medicaid prior to release through a collaboration between AHCCCS health plans, the Arizona DOC and participating county jails. In addition to enrollment, AHCCCS health plans coordinate care with physical and behavioral health providers in the community upon release. Each day, prisons and jails submit booking and release files to AHCCCS to automatically suspend or reinstate Medicaid coverage for individuals. For individuals who are applying for Medicaid coverage for the first time, prisons and jails submit pre-release applications through an electronic system to AHCCCS approximately 30 days prior to release. To facilitate care coordination, each AHCCCS health plan has a dedicated staff member, a justice liaison, who provides "reach-in" care coordination, including connecting case managers to patients prior to release and scheduling appointments for care to take place after release. Additionally, AHCCCS health plans are required to have a court coordinator who works with the court system, including Mental Health Courts and Drug Courts, for members who need to be connected to care.

Watch this short video to learn more about Arizona's Justice Initiatives that help connect incarcerated individuals with SUD to community care upon release.

To better facilitate care with community MAT providers, correctional MAT staff should work with the facility's re-entry coordinator to identify local MAT providers for all three MAT medications in the community. The identification of current waivered buprenorphine providers, OTPs, and XR-NTX providers should be done on an ongoing basis as providers change. Correctional MAT staff and re-entry coordinators should work to build relationships with community-based MAT providers to facilitate scheduling appointments and transitioning care upon release. Establishing memoranda of understanding with community-based MAT providers offering all three types of medication can help ensure the availability of treatment for patients upon release. In addition, your state may host a local portal for identifying state-based resources. Establishing relationships with local universities and academic centers, health departments and tertiary care medical centers could also provide opportunities for better linkages to care and services for individuals post-release. Table 13 provides resources for locating community-based MAT providers.

TABLE 13. RESOURCES TO IDENTIFY COMMUNITY-BASED MAT PROVIDERS

Resource	Description
American Academy of Addiction Psychiatry (AAP)	State-based listing of addiction psychiatrist specialists.
American Board of Addiction Medicine (ABAM)	Searchable database for board-certified addiction specialists.
American Society of Addiction Medicine (ASAM)	Searchable database for ASAM member providers.
SAMHSA Behavioral Health Treatment Services Locator	Searchable database for substance use facilities and mental health providers nationwide that have responded to the SAMHSA National Survey of Substance Abuse Treatment Services and National Mental Health Services Survey.
SAMHSA Buprenorphine Practitioner Locator	State-based database of practitioners authorized to prescribe buprenorphine for OUD (providers voluntarily submit information to SAMHSA).
SAMHSA Opioid Treatment Program Directory	State-based listing of OTPs.
FindTreatment.gov (SAMHSA)	Searchable database for SUD and mental health treatment providers.

HOW CAN PRESCRIPTIONS BE COORDINATED UPON RELEASE?

Because the period immediately after release is a period of heightened risk for opioid overdose,[145] it is especially important to ensure individuals who are on MAT in your facility can continue to take their medications after release. In addition to linking patients with a community-based provider, some correctional facilities provide patients on buprenorphine with a "bridge prescription," a short-term prescription or supply of medication to support adherence and prevent overdose before obtaining a new prescription in the community. For bridge medications, consider the number of days of medication dispensed and the logistics of medication dispensing at the time of release.

In addition to the number of days of medication prescribed, determine the process for giving patients prescriptions at time of release. This can be challenging when date of release is unknown. Some facilities enter bridge prescriptions for patients as soon as they are stabilized on a dose, so patients have access to it regardless of unexpected release. E-prescribing can make this process less cumbersome. A strong partnership, referral, and personal accompaniment to the pharmacy at time of release are all strategies that jails have employed to increase the likelihood that MAT patients continue medication post-release. When choosing a pharmacy to partner with, consider location and ease of access for patients, and hours of operation, particularly if your facility releases individuals at night. For bridge medications and bridge prescriptions, include processes that account for people released directly from court.

Facilities offering XR-NTX often coordinate medication administration immediately prior to release, so patients have four weeks before needing their next dose. For individuals on methadone, to link patients to community-based OTP providers, some facilities will accompany patients to their first visit.

"We have an electronic prescription system. This existed in the community in the '90s, but in jails it doesn't. So, we purchased some software to do it, and we send a script over to one pharmacy that we work with in particular, we'll use other ones if there are extenuating circumstances. [The partnering pharmacy] is right next to the jail, so our re-entry case worker will go with them to pick it up [the prescription]. We usually write the prescription for seven days. And again, if there's extenuating circumstances, we'll do something different. We're small enough that we can do a lot case-by-case."

Ed Hayes, Assistant Superintendent, Franklin County Jail and House of Correction, Massachusetts

"Everyone gets their blister pack when they leave, just like if someone were on lisinopril for hypertension. We give them the blister pack with whatever the number of pills is that remains in the pack. If there are fewer than five days of medication, we either give them an additional blister pack containing two weeks of medication or we give whatever pills remain in the blister pack plus a prescription for five days of Suboxone. And since almost everybody here is leaving with Medicaid, they have the ability to fill those prescriptions."

Bruce Herdman, Chief of Medical Operations, Philadelphia Department of Prisons

PROVIDE LINKAGES TO SOCIAL SERVICES AND RECOVERY SUPPORTS

Individuals returning to the community after incarceration face a myriad of challenges, including securing stable housing, employment and income; complying with community supervision requirements; accessing transportation; and rebuilding social connections. When these needs go unmet, the likelihood of accessing and remaining on MAT in the community diminishes. Studies demonstrate that the elevated risk of opioid-related overdose death among people released from jails and prisons is increased through disrupted social networks, poverty, disruptions in health care access, stigma and an exacerbation of underlying mental illness and SUD.[146] People released from jails or prisons are four times more likely to be homeless[147] and individuals without stable housing reported the highest levels of drug use after release from a correctional facility.[148] Lack of transportation was cited as the top reason individuals did not connect to MAT services post-release among individuals who received MAT while incarcerated in the Rhode Island correctional system.[149]

Housing as Critical Component of Reentry

The SAMHSA Gather, Assess, Integrate, Network, and Stimulate (GAINS) Center hosted a 90-minute webinar discussing promising re-entry practices to help secure housing for individuals reentering their communities.

> "It's the pebbles that trip us up, not the boulders. We can see the boulders, the pebbles are the small things we don't think about, that tend to trip us up when we get out."
>
> *Daryl McGraw, Recovery Consultant, The Center for Social Innovation, Connecticut*

To assist clients with accessing critical social supports and resources, prior to release, re-entry coordinators or other staff should identify and secure the resources in the following checklist.

PRE-RELEASE RESOURCES AND SUPPORTS

- ☐ Appointments for necessary and appropriate services and supports.
- ☐ State-approved identification card (to access Medicaid and other services).
- ☐ Housing plan.
- ☐ Transportation plan.

- ☐ Peer recovery support.
- ☐ Information and assistance related to benefits eligibility (e.g., disability benefits, food assistance, income assistance).

A 2018 comparison of MAT programs in correctional settings in six state correctional systems identified the types of pre-release and post-release services offered to patients to facilitate linkages to care, social services and recovery supports in the community. Connecting patients with community providers was the most common type of activity noted and three states employed staff to help coordinate care, including a social service clinician, recovery support navigators and a discharge planner (see Table 14).[150]

TABLE 14. TYPES OF PRE- AND POST-SERVICES OFFERED AMONG CORRECTIONAL MAT PROGRAMS IN SIX STATES[151]

State	Types of pre-release services offered		
Vermont	Connected with community provider upon release		Receives overdose prevention kit with naloxone
New Hampshire	Connected with community provider upon release		
Missouri	Two facilities offer post-release services		
Kentucky	Connected with community provider upon release	Social service clinician coordinates care	Monthly doses of XR-NTX for a minimum of six months while on parole
Rhode Island	Community-based discharge planner identifies resources		Enrolled in community program upon release
Massachusetts	Connected with community counselors upon release		Recovery support navigators guide through transition

EXAMPLE FROM THE FIELD: PSIMED, WEST VIRGINIA

In West Virginia prisons, peer recovery specialists provided in-reach services to MAT participants pre-release. The peer recovery specialists worked with a case manager who established patients' first appointment in the community. The peer recovery specialist and case manager then worked with patients to make sure they can get to their first appointment as transportation is a major barrier. The case manager also worked with patients' parole officers to coordinate services and care. Peer recovery specialists helped patients with everyday problems that can arise and interfere with care continuity.

PROVIDE EDUCATION AND RESOURCES TO PREVENT OPIOID OVERDOSE

Individuals released from jail and prison are at heightened risk of opioid overdose, particularly in the first two weeks after release,[152, 153, 154, 155] probably due to decreased tolerance during incarceration. By offering agonist treatments, buprenorphine or methadone, your program will already be protecting patients against overdose risk, simply by keeping their tolerance stable while incarcerated; however, you should take additional steps prior to release to reduce chances of opioid overdose.

HOW CAN WE REDUCE OVERDOSE POST-RELEASE?

Another critical way your facility can help reduce overdose risk after release is by supplying patients with naloxone, the opioid overdose antidote, at release and training them in how to use it. Several jails and prisons have begun doing this with promising results.[156] If dispensing naloxone is not possible, alternatively, some jails and prisons write a prescription for naloxone for patients at the time of release to be filled in the community and paid for by health insurance. RTI International published A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons that provides step-by-step guidance for implementing a naloxone distribution program in correctional settings.

Because naloxone cannot be self-administered, some jails and prisons have piloted programs to train family members and friends of individuals who are incarcerated and have OUD.[157] These programs make use of waiting time at the facility's visitor center to train visitors in opioid overdose risk, recognition and response and dispense naloxone to them if they opt in.

EXAMPLE FROM THE FIELD: COOK COUNTY JAIL, ILLINOIS[158, 159]

In August 2017, Cook County Jail in partnership with Cook County Health, began providing overdose education and naloxone distribution within the jail. Individuals are screened for substance use upon entry and individuals who have a history of substance use are housed in the jail's detoxification unit. Jail pharmacists conduct one-on-one training with individuals and when training is complete, make a note in the individual's jail medical record. When an individual who received training is discharged, an alert in the medical record system notifies the staff person in discharge that they should receive a naloxone kit upon release. The program uses an "opt out" model to increase dissemination of naloxone kits; individuals are given a kit unless they refuse it. Since project inception, approximately 5,000 naloxone kits have been distributed to inmates. Program evaluation shows that 30 percent of individuals who received the kits upon release self-reported using them to reverse opioid overdoses.

COMPONENT 6
DATA MONITORING AND EVALUATION

Data monitoring and program evaluation plans are important tools to regularly track MAT program activities and understand the program's outcomes and impact. This section describes the necessary steps for MAT programs in correctional settings to develop monitoring and evaluation plans. It discusses the key metrics programs should track to identify and remedy issues quickly, better understand daily activities and identify the impact their services have over a period of time.

ACTION STEPS

- [ ] Identify who will conduct monitoring and evaluation activities.
- [ ] Identify key metrics to monitor progress and evaluate impact.
- [ ] Develop a plan for monitoring and evaluation.

IMPLEMENTATION TOOLS AND RESOURCES

- Rhode Island DOC video on Evaluation and MAT Program Results
- How to Collect and Analyze Data: A Manual for Sheriffs and Jail Administrators (National Institute of Corrections)
- The Busy Person's Guide to Measuring and Improving Program Performance: A Step-by-Step Guide to Using Measurement for Better Results (Bloomberg American Health Initiative)
- A Framework for Program Evaluation (CDC)
- Data Collection Across the Sequential Intercept Model: Essential Measures (SAMHSA)
- Checklist of Information Needed to Address Proposed Data Collection, Access and Sharing (The Network for Public Health Law)

MONITORING AND EVALUATION QUICK TIP

The terms "monitoring" and "evaluation" are often used interchangeably; however, they are two distinct types of activities, each with its own value.

Monitoring

Monitoring refers to the regular collection of information about program activities and is a critical

component of any quality improvement process. Monitoring helps a program understand how it is functioning and identifies where improvements are needed. Programs often set up their monitoring activities to report a set of indicators on a weekly, monthly or quarterly basis.

Evaluation

An evaluation determines if a program is achieving its intended goals by assessing the program's key outcomes and impact over time. Evaluations assess whether the program activities (captured by monitoring led to the intended improvements. Unlike monitoring which occurs regularly, program evaluations take place less frequently and at designated times, such as six months after program implementation, yearly or biannually. It is important to collect data at the beginning of the program so the impact of the program can be observed over time.[160]

An evaluation plan is a comprehensive document that identifies the program's goals, objectives and activities; the key metrics that will be assessed; the sources of data to be collected; the types of analyses that will be conducted; and the timing of data collection and analyses.

Instruction on comprehensive program evaluation is beyond the scope of this document, but the data and metrics discussed will provide a solid foundation for programs that wish to pursue extensive program evaluation.

WHO SHOULD CONDUCT MONITORING AND EVALUATION ACTIVITIES?

Wardens can set expectations for monitoring and evaluation by assigning responsibilities for collecting data and using the data. Because monitoring activities occur regularly, staff involved in the daily operations of the MAT program are well-suited to conduct monitoring tasks. If the MAT program is a collaboration between external providers and correctional staff, these agencies should clearly delineate their monitoring roles and responsibilities. Necessary data sharing agreements should also be in place.

Because incomplete and inaccurate data can severely limit a program's ability to track progress, programs should train staff in the value of monitoring and evaluation activities and the importance of accurate data. All partners should collaboratively engage in a regular review of data to stay informed about project activities and make strategic improvements. Program evaluations can be conducted internally or externally by evaluation experts who can provide technical expertise.

Rhode Island Program Evaluation

The Rhode Island DOC produced a helpful 19-minute video on their program evaluation plan and process.

KEY CONSIDERATIONS FOR CHOOSING MONITORING AND EVALUATION METRICS

Choosing a select set of metrics that have the greatest value to your program is important, especially among correctional

settings with limited resources for monitoring and evaluation. To the extent possible, prioritize metrics that have value to key stakeholders and that reflect the entire system of care for patients.

Can the data be easily captured?

Important data is often readily available for monitoring and evaluation purposes. Programs can assess the types of information they already collect and easily identified metrics that do not create a significant burden to staff. Medical data, for example, is probably already collected and stored in electronic health records or paper charts. Data related to the person's incarceration is probably already stored in the corrections department's records. Getting started with what is available can help pave the way for collecting new data when needed.

Are metrics driven by shared goals?

To maximize limited resources, correctional MAT programs should collaborate with stakeholders across correctional and medical services to identify goals and agree upon a few essential shared metrics. Metrics are useful when they help create a clear system of feedback and accountability to showcase successes and facilitate improvement. Correctional MAT programs should monitor process data that tracks how well the program is being delivered as well as outcome data that demonstrates the program's results. Well-chosen metrics will promote strategic analysis and improvement.

Do metrics reflect a few key aspects of a program that you have the ability to influence?

One of the main purposes of data monitoring is to identify and resolve issues early. There will be many data points that compete for your attention. Too many metrics can be overwhelming and lead to inaction. Focus on a few key metrics that you and your partners value and can act on.

Do metrics identify disparities in access and outcomes?

As discussed previously, MAT has significant disparities related to race, ethnicity, geography, age, gender, income, insurance status and other demographic factors.[161, 162, 163] By collecting data on individual patient characteristics, in addition to program participation and outcomes, program staff will be able to identify any disparities in access, treatment and outcomes. Individual patient characteristics that your program may want to collect include sex or gender, race and ethnicity, age, housing area or facility (if your correctional facility has more than one location, security designation and pre-trial detainee/post-trial status.

Do metrics reflect the continuum of care?

Within correctional settings, it is important to collect data across the continuum of care experienced within the facility, including data related to screening, treatment and pre-release planning. This continuum is detailed in the next section.

Some correctional MAT programs may have the capacity to collect data across a comprehensive continuum of care, including post-release outcomes. The guide, Data Collection Across the Sequential Intercept Model (SIM: Essential Measures, from the SAMHSA GAINS Center, is a useful tool for mapping interventions across this system.

EXAMPLE FROM THE FIELD: ALBANY COUNTY CORRECTIONAL FACILITY

Albany County Correctional Facility designed a comprehensive program evaluation for its correctional MAT program to monitor processes and measure impacts for individuals during incarceration and post-release. Data was collected between January and June 2019. Metrics collected on incarcerated individuals prior to release included sociodemographic factors from the jail management system, clinical data from the electronic medical record intake assessment and psychological services records; drug court status; and knowledge, attitudes and beliefs related to MAT. After release, data was collected on linkage to care and community support; housing and employment status; social support; history of overdose; recidivism; and knowledge, attitudes and beliefs around MAT. Zero opioid overdose deaths occurred post-release during the evaluation period. Evaluators also measured metrics for the facility as a whole such as readiness for implementing the MAT program, successes and challenges. The jail worked closely with community partners to establish data sharing agreements and protocols to collect impacts after release.

IDENTIFY MONITORING METRICS

The steps to OUD identification and treatment within correctional settings include:

1. Screening incarcerated individuals for OUD and assessing those who screen positive.
2. Offering and initiating MAT treatment to incarcerated individuals with OUD.
3. Retaining incarcerated individuals in MAT treatment.
4. Referring individuals to a community MAT provider upon release.[164]

Attention to and measurement of each of these steps is essential when developing a MAT program in a correctional setting.

Appendix H: Data Elements for MAT Programs in Correctional Settings provides a list of data elements that should be considered when developing monitoring and evaluation plans. **Appendix I: Formulas for Monitoring and Evaluating MAT Programs in Correctional Settings** details how to use these data elements to measure each step of OUD identification and treatment. **Appendix J: Sample Tables for Collecting MAT Data in Correctional Settings** provides examples of tables your facility could use to collect monitoring and evaluation data.

To capture the most critical aspects of your MAT program, we recommend organizing monitoring plans around four key questions that reflect the steps in the identification and treatment of OUD. The next section outlines these questions, their relevant metrics and considerations for each step. For each question, programs could select one or several of the metrics most appropriate to their setting.

Question 1: How many incarcerated individuals have an OUD?

Question 1 Relevant Monitoring Metrics

Of the individuals entering the facility during a given time frame:

- Number of individuals entering the facility.
- Number of individuals screened for OUD.
- Number of individuals diagnosed with OUD.

Correctional MAT providers should include demographic data such as gender, age, race and ethnicity in their reporting to understand the characteristics of the population with OUD and to identify treatment disparities. Data on the prevalence and demographics of OUD among the incarcerated, along with characteristics such as health insurance status and place of residence will also help community MAT providers and public service agencies anticipate program needs and facilitate better care for individuals upon release.

Question 2: How many patients with OUD participate in the correctional MAT program?

Question 2 Relevant Monitoring Metrics

Of individuals diagnosed with OUD in a given time frame:

- Number of individuals offered MAT, by medication type.
- Number of individuals who initiate MAT, by medication type.

Correctional MAT programs should report the proportion of incarcerated individuals with OUD who receive MAT by the form of MAT used (buprenorphine, methadone, or XR-NTX). Considerations for this question follow.

Specific Medication

If your facility offers more than one of the three FDA-approved medications for OUD, report all metrics as a whole (all MAT medications combined) and also separated into metrics for each medication type. For example, among people who screen positive for OUD, track how many are offered MAT in total and how many are offered buprenorphine, methadone and XR-NTX.

Length of Stay

It may not be feasible to provide MAT to individuals who are incarcerated for very short periods. When calculating metrics on MAT treatment initiation, programs may choose to exclude individuals with a length of stay under 24 hours. Nonetheless, programs should aim to measure the number of individuals who screen positive for OUD but whose brief length of stay precludes MAT evaluation and treatment.

Timing of Treatment Initiation

Receipt of MAT is typically measured by when the first dose is administered.[viii] Programs that delay the initiation of MAT until shortly before release should anticipate their data on treatment initiation will be delayed until the time of an individual's release.

Continued Versus New Treatment

There are several reasons to measure the proportion of participants who are continuing community treatment versus starting treatment while incarcerated. Correctional MAT participants who were receiving MAT prior to arrest are more likely to follow-up with their community provider after release, whereas participants who start MAT while incarcerated have lower follow-up rates and may require more pre-release planning.[165] Second, if programs find they have low rates of new treatment initiation, they should closely assess and improve their OUD screening and treatment counseling process.

Question 3: What percent of correctional MAT program participants are retained in treatment while incarcerated?

Question 3 Relevant Monitoring Metrics

Of individuals who initiate MAT in a given time period:

- Number of individuals who remain on MAT at the time of release to the community, by medication type.
- The average maintenance dose of methadone or buprenorphine/naloxone.

In addition to tracking initiation of patients on MAT, it is important to track retention of individuals in treatment. Similar to Question 2 above, consider length of stay and the medication type, if your facility offers more than one. In some situations, it may be helpful to examine treatment retention only among individuals with a minimum length of stay such as two weeks or one month.

Also track the reason for discontinuation of MAT during incarceration. Programs with high rates of treatment discontinuation during or following incarceration may find it beneficial to monitor the average MAT maintenance dose of individuals in treatment. Subtherapeutic dosing of methadone and buprenorphine is associated with higher discontinuation rates among justice-involved individuals.[166, 167]

Question 4: How many correctional MAT program participants receive resources necessary to continue MAT upon release to the community?

Question 4 Relevant Monitoring Metrics

Of MAT program participants released to the community in a given time period:

viii. For programs that offer methadone or buprenorphine taper for the treatment of opioid withdrawal in addition to chronic therapy, take care to differentiate between first dose of MAT for chronic therapy versus withdrawal. When measuring MAT initiation, only count individuals initiated on MAT for chronic therapy.

- Number of individuals who have an appointment scheduled with a community MAT provider when released, by medication type.
- Number of buprenorphine recipients given a bridging supply or prescription for buprenorphine.
- Number of individuals insured at the time of release.

MAT provided in a correctional setting has the greatest impact when it is continued without interruption immediately following release, as this is a time when overdose risk is highest.[168] All programs should measure their process for ensuring continuity of treatment during this high-risk transition of care.

Referral Process and Capacity

When it is possible to schedule an appointment with a community MAT provider prior to an individual's release, this should be completed and documented. At a minimum, correctional MAT programs should establish referral processes with community MAT providers and track whether this process was completed at the time of release to the community.

Insurance Status

Insurance status at release is critical piece of data that should accompany reports of community MAT treatment referral as it strongly influences treatment participation.

DEVELOP AN EVALUATION PLAN

While all of these monitoring metrics previously discussed can be incorporated into evaluation plans to better understand impacts and outcomes of correctional MAT programs, there are additional metrics that should be considered for inclusion in an evaluation plan. Discussion of three impact questions follows, including potential metrics and considerations.

Impact Question 1: How has the MAT program affected the functioning of the correctional facility?

Impact Question 1 Relevant Metrics

During a given time period of MAT programming:

- Number of disciplinary reports.
- Incidence of contraband drug confiscation, by drug type.

In addition to measures that demonstrate improved health among MAT patients, discussed later in this section, it will be helpful to demonstrate the program's overall effects on the functioning of the jail. For example, some jail administrators have noted a marked decrease in the influx of contraband buprenorphine into the facility following MAT program implementation. Others have noted that patients are less likely to get into fights or break other facility rules when they receive appropriate medication. The following metrics reflect some possible methods to measure how the MAT program is affecting the overall functioning of the jail. Some specific considerations related to these metrics are discussed.

Data Sharing across Correctional Administration and Health Systems

While the process metrics already discussed are all obtainable within the correctional health system, some of the impact metrics require data sharing and data matching between the correctional administration and the correctional health system. For example, while the health care provider will be able to provide information about which individuals are on MAT, only the corrections staff will be able to provide information on disciplinary reports, confiscation of contraband and assaults. To share data across these systems, you may need to execute a data sharing agreement or data use agreement.

Sharing Data

SAMHSA provides guidance on how to collect, use, and share data for justice-involved populations, with examples of innovative initiatives.

Time Frame

For monitoring metrics, a short time frame such as a month can be illustrative, while when evaluating impacts, a longer time frame will likely be required. When outcomes of interest occur infrequently, totals may only be meaningful annually or by combining years of data together. When using longer time frames, it may be helpful to calculate rates (e.g., rate of death per person-year incarcerated) in order to account for changes in jail population.

Impact Question 2: How many correctional MAT participants continue treatment after release to the community?

Impact Question 2 Relevant Metrics

Of MAT program participants released in a given time period:

- Number of individuals who attend a community MAT appointment within 14 days or one month, by medication.
- Number of individuals who receive at least one dose of MAT in the community, by medication type.

Successful correctional MAT programs can impact individuals with OUD beyond the correctional setting by leading to participation in community MAT, reduced mortality and improved functioning.[169, 170, 171] To measure these effects, correctional MAT programs should collaborate and share data with stakeholders in the community, such as community-based OTPs and clinics.

Developing an infrastructure for data sharing often requires a leading government agency to direct resources and collaborate across government departments and community partners. Ideally, systems for data sharing are able to track individuals across settings and through time, but partnerships will need to match their data strategy to the resources available. Correctional programs must incorporate 42 CFR Part 2 requirements into any process for sharing substance use treatment data. With these considerations in mind, we recommend correctional MAT programs monitor and evaluate their impact on individuals released to the community when possible.

Appointment Attendance

Correctional health care providers and administrators can easily track appointments scheduled prior to release, but measuring appointment attendance in the community is more complex and requires cross-agency collaboration. We recommend that referral agreements between correctional MAT programs and community MAT providers include a process for reporting to the correctional program if referred individuals attend at least one community MAT visit. This will facilitate ongoing improvement in the referral process.

Post-release Medication Receipt

Alternative data sources for tracking receipt of medication after release may include payers or PDMPs. Specifically in the case of buprenorphine treatment, you can use PDMP data to determine if an individual filled a prescription for buprenorphine following release. In most states, naltrexone and methadone are not reported to PDMPs. For these medications, use other data sources such as treatment providers or payers. Also take into consideration that many data sources for post-release medication receipt have an expected lag time.

EXAMPLE FROM THE FIELD: PHILADELPHIA DEPARTMENT OF PRISONS

Philadelphia Department of Prisons (PDP) began offering buprenorphine treatment to incarcerated individuals with OUD in 2018. An estimated 90 percent of eligible women and 80 percent of eligible men participate in buprenorphine treatment.[172] Successful referral to community MAT providers is challenging, as 80 percent of program participants are in jail while awaiting trial and typically released with only a few hours' notice. In these instances, PDP cannot schedule a community MAT appointment prior to release. The program has used PDMP data to track continuation of treatment in the community and approximately 40 percent of women given a prescription for buprenorphine at release have it filled.[173]

Impact Question 3: What is the rate of unintentional fatal opioid overdose among incarcerated individuals recently released to the community?

Impact Question 3 Relevant Metrics

In the jurisdiction of the correctional facility, before and after MAT program implementation:

- The rate of opioid overdose mortality, before and after correctional MAT program implementation.
- The rate of opioid overdose mortality among individuals released from correctional settings within the past 12 months, before and after implementation.

Opioid overdose mortality rates are widely used to describe the scope and trajectory of the opioid epidem-

ic and it is a common metric for monitoring the impact of opioid-related response strategies. Use the rate of opioid overdose death in the community among recently incarcerated individuals before and after the implementation of a correctional MAT program to estimate program impact. Rhode Island's initial analysis of their correctional MAT program provides an example of this approach (see **Example from the Field: Rhode Island DOC**).

Communities may choose to link death and criminal justice data to determine the fatal overdose status of released incarcerated individuals. The key data elements for matching data sources are highly dependent on the linking method and how much of the identifying information (e.g., name, date of birth, sex, Social Security Administration number) is missing or inaccurate.

Data linkages can pave the way for a more rigorous comparison between groups if more data about the pre- and post-implementation population is shared. For example, correctional programs may choose to evaluate post-release opioid overdose mortality among correctional MAT program participants and individuals identified as having OUD but did not participate in MAT while incarcerated.

Despite their frequent use as a metric of the opioid epidemic, opioid overdose mortality rates have limitations as an outcome metric for correctional MAT programs. First, because the number of fatal overdoses proportional to the number of individuals with OUD is relatively small, short-term incremental improvements may not be detected in opioid overdose rates. In addition, there is significant delay in the reporting of overdose mortality rates. Finally, the outcome of opioid overdose is the culmination of many factors that are outside the influence of the corrections system.

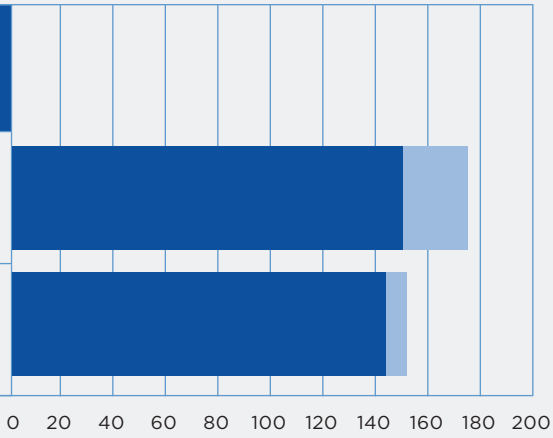
When evaluating the impact of a correctional MAT program on community overdose rates, analysts should carefully consider changes in the community during the time of program implementation. Events such as the influx of fentanyl in the drug supply or restriction or expansion of community naloxone distribution can impact overdose rates, but have little to do with a correctional MAT program. If changes are suspected that would differentially impact overdoses in the groups being compared, more complex statistical analyses may need to be pursued to remove the "noise" of these changes. Balancing the differences in the pre- and post-implementation groups can ensure the impact of the program is apparent.

EXAMPLE FROM THE FIELD: RHODE ISLAND DOC

Rhode Island DOC began offering all three forms of MAT in all of its correctional settings in 2017. Preliminary assessment of the program's impact compared opioid overdose mortality deaths before and after program implementation among recently incarcerated individuals (released within the prior 12 months) and in the state as a whole. There was a 60 percent reduction in opioid overdoses among recently incarcerated individuals and a 12 percent reduction in opioid overdoses in the state overall (see Figure 1).[174] Although this cross-sectional data cannot specifi-cally assess if the reduction in overdose rates is attributable to the correctional MAT program, it does provide preliminary support for the use of MAT treatment in correctional settings as part of a successful state strategy to improve opioid overdose outcomes.

FIGURE 1. RHODE ISLAND OVERDOSE DEATHS BEFORE AND AFTER STATEWIDE CORRECTIONAL MAT PROGRAM IMPLEMENTATION [ix]

First 6 months of	Overdose decedents with recent incarceration	Overdose decedents without recent incarceration
2016	26	153
2017	9	143



Recidivism as a Measure of Success

Recidivism is a fundamental criminal justice outcome and is defined as the occurrence of re-arrest, reconviction or return to detention with or without a new sentence.[175] Recidivism is highly impacted by a number of factors not related to a correctional MAT program and is not a specific goal of MAT treatment. Therefore, recidivism has several limitations as a measure of MAT program success. However, given the importance of recidivism in the criminal justice setting, there are considerations for using it as an impact metric.

Local jurisdictions vary in their definitions of recidivism, and it is essential to clearly and consistently define recidivism metrics. New criminal acts should be distinguished from parole violations. Contextual information such as the time to re-offense, severity and category of re-offense and frequency of re-offense can be useful as well. Recidivism is typically measured in six-month, one-year and three-year intervals. Annual recidivism rates (the number of people released who re-offend within a given year) are regularly reported by correctional systems. Similar to measuring impact through overdose data, recidivism for incarcerated individuals can be examined before versus after program implementation or for comparable groups of incarcerated individuals with OUD who did versus did not receive MAT.

Assess recidivism rates in the context of evolving criminal justice approaches to drug-related activity. For example, pre-arrest interventions such as diversion to treatment may reduce recidivism, while stricter policing policies may increase recidivism. Factors like these can confound the evaluation of correctional MAT program impact on recidivism and may need to be addressed through more complex analyses. Individuals with high risk for frequent re-offense may skew recidivism rates, particularly if individuals with lower criminal risk are diverted to treatment. To account for this, tracking the recidivism rate among first offenders can be a helpful metric.

ix. Table source: Green, T. C., Clarke, J., Brinkley-Rubinstein, L., Marshall, B. D. L., Alexander-Scott, N., Boss, R., & Rich, J. D. (2018). Post-incarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system. JAMA Psychiatry, 75(4), 405-407. doi:10.1001/jamapsychiatry.2017.4614

COMPONENT 7
FUNDING AND SUSTAINABILITY

Funding and sustainability are often considered challenges to implementing any new program or services within correctional settings and other organizations; however, some level of MAT services can be implemented in any correctional facility with adequate support from leadership and staff. The funding structures of correctional MAT programs vary and funding needs for MAT programs correspond to the type of model a facility implements (see **Table 4. MAT Models in Correctional Settings**), the types of medications offered, the partners involved and the size of the patient population. This section provides an overview of key considerations, resources and existing finance structures related to supporting and sustaining correctional MAT programs.

ACTION STEPS

- [ ] Assess existing resources.
- [ ] Determine program needs.
- [ ] Identify funding sources.

IMPLEMENTATION TOOLS AND RESOURCES

- Franklin County Buprenorphine Budget Calculator
- Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose (SAMHSA)
- Benefits and Cost Savings of MAT Services in a Correctional Setting, Recorded Presentation (SAMHSA)

ASSESS EXISTING RESOURCES

Before applying for funding, first consider what model of treatment is most appropriate for your facility. This will help guide the process of assessing existing staff and services and identifying where additional staff, training or resources may be needed. When drafting the project narrative and budget, create a proposal that is cost-effective and sustainable. By utilizing and adapting existing resources, correctional

facilities can reduce excess costs and apply the appropriated funds to hiring or allocating staff, training and resource needs. Additionally, initial investments in MAT could result in longer-term cost savings. A 2016 study published by the Washington State Institute for Public Policy found methadone and buprenorphine MAT resulted in positive benefit to cost ratios of $2.22 and $1.76.[176] The study estimated that the chance benefits will exceed costs for providing methadone treatment is 89 percent and for buprenorphine, 86 percent.[177]

Correctional MAT Programs Benefits and Cost Savings

A SAMHSA recorded webinar features discussions by researchers and correctional administrators on the benefits and cost savings of correctional MAT programs.

"Some of our savings have been generated simply because four years ago we had 10,000 inmates and today we have 5,000. There's lots of savings from that. It could be expensive, if it's a very high-volume operation for a large jail. But I know from looking at jails across the country, that there are always ways to save money. And usually, when you do that, you improve the quality or the timeliness of the care as well. So we encourage people to not consider the financing as being a barrier until they're absolutely sure that there are better ways to do what they're doing."

Bruce Herdman, Chief of Medical Operations,
Philadelphia Department of Prisons, Pennsylvania

HOW SHOULD I BUDGET FOR A MAT PROGRAM?

When building a budget for a MAT program, conduct a thorough review of your specific funding options. This is important because you cannot bill Medicaid for medical services to individuals while incarcerated. Some states have separate funding or block grants to cover care for individuals with SUD or opioid-related needs in the criminal justice system and many cities and counties allocate funding for correctional health care. Explore state funding streams, city and county tax dollars as well as grants. Sometimes, medications or staff time can be donated or provided in-kind by community-based providers or pharmaceutical companies. Your budget will need to address staffing, medication and supplies (e.g., drug screens, medication storage).

EXAMPLE FROM THE FIELD: FUNDING SOURCES

Community Medical Services, a community-based SUD services provider that provides MAT in jails and prisons in several states, uses a variety of funding sources. In some locations it uses State Targeted Response/State Opioid Response funding, in others they use county funding. Grant funding can pay for staff time in some locations, while in others, medical staffing is pro bono or volunteer.

Hennepin County Jail in Minnesota funds both staff and medications out of the county sheriff's budget. It also received a grant to fund additional staff.

Franklin County Jail and House of Correction in Massachusetts was awarded a MAT Expansion Grant from SAMHSA, which enabled the hiring of two new staff. The first, a community health worker, works at the local community health center. The second, a social worker, works for a local behavioral health clinic. Both staff meet with pre-sentenced incarcerated individuals and continue working with them to provide wrap-around services post-release.

DETERMINE PROGRAM NEEDS

As mentioned, funding needs vary based on the type of MAT model implemented and the type of medications provided. To determine program needs and costs, Implementation Teams should consider the program implementation questions in **Component 2: Program Planning and Design** and **Component 4: Delivery of Treatment** related to estimating the size of the patient population, understanding which medications are the best fit for your facility and the staffing needs related to program model choice.

HOW SHOULD I BUDGET FOR MEDICATIONS?

Apart from staffing, unless donated, medication purchasing will probably be the biggest component of a program's budget. Medication costs can vary widely, from as low as $150 per week for methadone to as high as $1,580 for a monthly injection of Sublocade (extended-release injectable buprenorphine). More information about the cost of medications can be found in **Component 2: Program Planning and Design**.

Medications may be purchased directly from the drug makers as part of the state or other entity's bulk prescription purchases. Consider discount and rebate programs. If an external community-based medical provider staffs and dispenses medications, identify which entity will pay for the medication. Franklin County Jail and House of Correction created a useful calculator to determine the cost of providing buprenorphine to their patient population.

IDENTIFY FUNDING SOURCES

Correctional facilities should identify funding sources to help implement and sustain a MAT program and support the recovery efforts of individuals with OUD. Funding is allocated through a number of federal initiatives and state block grants focused on implementing evidence-based strategies for OUD, increasing access to treatment for OUD and reducing the number of opioid overdose-related deaths in the population. These funding mechanisms come from various health and judicial agencies, including SAMHSA, CDC and DOJ. Local health departments, departments of corrections and medical universities may offer small grant opportunities as well.

Funding mechanisms exist not only for overall MAT program implementation, but also for specific programmatic components. Some states operating under a Section 1115 Medicaid demonstration waiver have some flexibility in their operations and can provide specific services that are generally not allowed under federal rules, such as peer services, wraparound case management and re-entry support. Table 15 provides a description of grant opportunities that support MAT in correctional settings.

TABLE 15. EXAMPLE FUNDING SOURCES USED TO SUPPORT MAT IN CORRECTIONAL SETTINGS

Source	Eligibility	Description
State Opioid Response Grants (SOR)	States and territories	Provides supplemental funding to support existing evidence-based opioid-related activities undertaken by state agencies.
SAMHSA MAT Expansion Grant (MAT-PDOA)	States and territories, political subdivisions in states, public and private nonprofit organizations, tribes	Provides funding to state and tribal organizations with high rates of primary treatment admissions for opioids to expand and enhance MAT for people with OUD.
SAMHSA State Targeted Response to the Opioid Crisis Grant (Opioid STR)	States	Funding allocated to states based on unmet needs for OUD treatment and drug poisoning deaths to increase access to treatment and reduce opioid overdose deaths.
Department of Justice (DOJ) RSAT for State Prisoners Program Grant	States and territories	Provides funding to develop and implement substance use treatment programs in correctional facilities and create and maintain community reintegration services post-release.
SAMHSA Substance Abuse and Treatment Block Grant (SABG)	States and territories, tribes	Provides funding to plan, implement and evaluate activities that prevent and treat substance abuse, with a focus on pregnant women, intravenous drug users, tuberculosis services, early intervention for HIV/AIDS and primary prevention services.

Source	Eligibility	Description
CMS Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act	States	Provides funding to increase the capacity of state Medicaid providers to deliver SUD treatment, provide training and technical assistance for Medicaid providers offering SUD treatment or recovery services and improve reimbursement for Medicaid providers.
DOJ Comprehensive Opioid Abuse Program (COAP)	Local governments and tribes, State Administering Agencies (SAA) directing criminal justice planning or State Alcohol and Substance Abuse Agencies, states and territories required to submit controlled substance prescription data to an authorized state agency	Provides funding and technical assistance to develop and implement comprehensive efforts to treat and support those impacted by the opioid epidemic.
DOJ Improving Re-entry for Adults with Co-occurring Substance Abuse and Mental Illness	States, local governments and tribes	Provides funding to improve provision of services for individuals who are reentering the community after incarceration and reduce recidivism.
DOJ Justice and Mental Health Collaboration Program (JMHCP)	States, local governments and tribes	Provides funding to support cross-system collaboration to improve responses and outcomes for individuals with mental illness or co-occurring mental illness and SUD who are justice-involved.

LIST OF APPENDICES

APPENDIX A: Resources and Tools Guide

Topic	Target Audience(s)	Title	Source	Description
INTRODUCTION				
Substance use, misuse and substance use disorder (SUD)	Professional care providers, public health professionals, correctional administrators, family and advocates, parents and caregivers, people with SUD and policymakers	Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health	U.S. Department of Health and Human Services (HHS), Office of the Surgeon General	Provides an overview of substance use, substance misuse, SUD and treatment in America.
FDA-approved medications for opioid use disorder (OUD)	Professional care providers, public health professionals, correctional administrators, family and advocates, parents and caregivers, people with SUD and policymakers	Treatment Improvement Protocol 63, Medications for Opioid Use Disorder	Substance Abuse and Mental Health Services Administration (SAMHSA)	Reviews the use of the three Food and Drug Administration (FDA)-approved medications used to treat OUD and other strategies and services needed to support recovery for people with OUD.
Medication First model for OUD	Health care providers, health care administrators	Provider Implementation Guide Using a Medication First Model	Missouri Department of Mental Health, Division of Behavioral Health	Provides guidance on implementing the Medication First model to deliver treatment and supportive services to individuals with OUD.
COMPONENT 1: PREPARING FOR CHANGE				
OUD and medication-assisted treatment (MAT) in the criminal justice system	Correctional administrators, community health organizations and providers, family and advocates and policymakers	Medication-assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States	SAMHSA	Provides an overview of substance use, substance misuse, SUD and treatment in America.
Planning and implementation considerations for correctional MAT programs	Correctional administrators and health care providers, health care administrators, policymakers and public health professionals	Video series on Implementing Medication Assisted Treatment in Corrections	Rhode Island Department of Corrections (DOC)	Provides an overview of OUD and MAT in criminal justice settings in the US and key considerations in increasing access to treatment and improving continuity of care.

Topic	Target Audience(s)	Title	Source	Description
Myths about MAT	Professional care providers, public health professionals, correctional administrators and health care providers, family and advocates, parents and caregivers, people with SUD and policymakers	Medication-assisted Treatment for Opioid Addiction: Myths & Facts	Legal Action Center	A series of 12 videos produced by the Rhode Island DOC that provides information on establishing a MAT program in a correctional setting.
	Professional care providers, public health professionals, correctional administrators, correctional health care administrators, family and advocates, parents and caregivers, people with SUD and policymakers	Myths and Misconceptions: Medication-Assisted Treatment for Opioid Addiction	Providers Clinical Support System	Reviews and corrects common myths and misconceptions about MAT.
Language and stigma	Health care providers and administrators, correctional administrators, correctional health care administrators, family and advocates, parents and caregivers and policymakers	Words Matter: How Language Choice Can Reduce Stigma	Education Development Center	Provides guidance on implementing the Medication First model to deliver treatment and supportive services to individuals with OUD.
COMPONENT 2: PROGRAM PLANNING AND DESIGN				
Becoming an opioid treatment program (OTP)	Health care providers and administrators, correctional administrators and health care providers	Federal Guidelines for Opioid Treatment Programs	SAMHSA	Provides guidance on operating an OTP, including patient assessment, treatment and recovery planning; key considerations for methadone and buprenorphine; and overdose prevention.
	Correctional administrators and health care providers	Becoming a Correctional OTP Flowchart	Franklin County, Massachusetts Sheriff's Office	Provides guidance on how correctional facilities can apply to become an OTP.
	Correctional administrators and health care providers	Standards for OTP Accreditation	National Commission on Correctional Health Care (NCCHC)	Provides an overview of federal regulations around OTPs and guidance on the unique nature of care provided in correctional facilities.

Topic	Target Audience(s)	Title	Source	Description
Applying for a buprenorphine waiver	Health care professionals, correctional health care professionals	Apply for a Practitioner Waiver	SAMHSA	Provides guidance on how physicians, physician assistants and nurse practitioners can apply for a buprenorphine waiver.
SAMHSA directories	Health care providers and administrators, correctional administrators and health care providers	Buprenorphine Practitioner Locator	SAMHSA	Directory of practitioners authorized to prescribe buprenorphine (only includes prescribers who have provided information).
	Health care providers and administrators, correctional administrators and health care providers	OTP Directory	SAMHSA	Directory of OTPs in all 50 states, Washington, DC, and U.S. territories.
Addressing medication diversion in correctional settings	Correctional administrators and health care providers	Medication-assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion	SAMHSA	Provides an overview of diversion of MAT in correctional settings and strategies to prevent and decrease diversion.
COMPONENT 3: WORKFORCE DEVELOPMENT AND CAPACITY				
Training tools	Professional care providers, public health professionals, correctional administrators, family and advocates, parents and caregivers, people with SUD and policymakers	Providers Clinical Support System (PCSS) SUD 101 Core Curriculum	Providers Clinical Support System	A series of 22 training modules that provide an overview of evidence-based practices in the prevention, identification and treatment of SUD and co-occurring mental disorders, including the provision of MAT.
Requesting training and technical assistance	Health care providers and administrators, correctional administrators and health care providers	Residential Substance Abuse Treatment (RSAT) Training and Technical Assistance Request Form	Residential Substance Abuse Treatment Training and Technical Assistance (RSAT)	A form for agencies to request training and technical assistance related to their residential substance abuse treatment program.
Staffing tools	Correctional administrators and health care providers	Role of Correctional Officers in Jail/Prison Substance Use Disorder Treatment Programs	RSAT	Provides an overview of substance use disorder treatment programs and the role of correctional officers in these programs.

Topic	Target Audience(s)	Title	Source	Description
Integrating recovery supports	Health care providers and administrators, correctional administrators and health care providers	Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)	SAMHSA	Provides resources, tools and training and technical assistance opportunities around recovery supports and services for people with mental or substance use disorders.
COMPONENT 4: DELIVERY OF TREATMENT				
Screening tools	Health care providers, correctional health care providers	Screening and Assessment of Co-Occurring Disorders in the Justice System	SAMHSA	Provides guidance on implementing evidence-based practices for screening and assessment of co-occurring mental and substance use disorders among justice-involved individuals.
	Health care providers, correctional health care providers	DSM-5 Criteria for Diagnosis of Opioid Use Disorder	IT MATTTRs Colorado	DSM-5 criteria for diagnosing OUD among individuals.
	Health care providers, correctional health care providers	Screening Tools and Prevention Resources	National Institute on Drug Abuse (NIDA)	Provides resources to increase awareness of the impact of substance use on patients' health and help identify drug use early and prevent it from escalating to misuse or SUD.
	Health care providers, correctional health care providers	Screening Tools and Prevention Chart	NIDA	Provides a catalog of evidence-based screening tools and assessment resource materials.
	Health care providers, correctional health care providers	TCU Core Forms Matrix	Texas Christian University (TCU)	Provides a catalog of screening and assessment tools for use across a treatment continuum for behavioral health needs.
Safe storage of medications in OTPs	Health care providers and administrators, correctional administrators and health care providers	Narcotic Treatment Programs Best Practice Guideline	Drug Enforcement Agency (DEA), Diversion Control Division	Provides guidance on safe storage of controlled substances in OTPs.

Topic	Target Audience(s)	Title	Source	Description
Treatment decision-making resources	Health care providers and administrators, correctional administrators, patients and families	Decisions in Recovery: Treatment for Opioid Use Disorder	SAMHSA	Provides guidance and tools around decision-making in seeking treatment for OUD.
Health information privacy and confidentiality	Health care providers and administrators, correctional health care providers and administrators	Substance Abuse Confidentiality Regulations	SAMHSA	Provides an overview of substance abuse confidentiality regulations and guidance on applying the regulations in practice.
	Health care providers and administrators, correctional administrators, compliance officers, legal counsel and program evaluators	Basics of 42 CFR Part 2	Justice and Health Connect	Provides an overview of 42 CFR Part 2 and its application to the criminal justice system.
Implementing MAT for pregnant women	Health care providers and administrators, correctional administrators and health care administrators	Vermont Guidelines for Medication Assisted Treatment (MAT) for Pregnant Women	Vermont DOC	Provides guidance on managing opioid dependence during pregnancy.
	Health care providers and administrators and correctional administrators	Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants	SAMHSA	Provides guidance on managing OUD for pregnant and parenting women and their infants.
	Health care providers and administrators and correctional administrators	ACOG Committee Opinion on Opioid Use and Opioid Use Disorder in Pregnancy	American College of Obstetricians and Gynecologists (ACOG)	Provides guidance and recommendations on screening, assessing and treating OUD for pregnant women and their infants.
	Health care providers and administrators and correctional administrators	Improving care for pregnant people with opioid use disorder in U.S. jails: Research to implement medication assisted treatment	Johns Hopkins Medicine	Provides an overview of OUD among pregnant women in jail and guidance on implementing MAT in jails for pregnant women.

Topic	Target Audience(s)	Title	Source	Description
COMPONENT 5: LINKAGES TO CARE AND SERVICES UPON RELEASE				
Resources for identifying community-based MAT providers	Health care providers and administrators, correctional administrators, re-entry coordinators and navigators	Behavioral Health Treatment Services Locator	SAMHSA	Directory of behavioral health providers in all 50 states, Washington, DC, and U.S. territories.
	Health care providers and administrators, correctional administrators, re-entry coordinators and navigators	Opioid Treatment Program Directory	SAMHSA	Directory of OTPs in all 50 states, Washington, DC, and U.S. territories.
	Health care providers and administrators, correctional administrators, re-entry coordinators and navigators	Buprenorphine Practitioner Locator	SAMHSA	Directory of practitioners authorized to prescribe buprenorphine (only includes prescribers who have provided information).
	Health care providers and administrators, correctional administrators, re-entry coordinators, navigators, patients and families	FindTreatment.gov	SAMHSA	Searchable database for mental health and SUD treatment providers. Also provides information on paying for treatment and behavioral health conditions.
	Health care providers and administrators, correctional administrators, re-entry coordinators, navigators	AAAP Find a Specialist	American Academy of Addiction Psychiatry (AAAP)	Directory of addiction psychiatrist specialists by state (only includes members who have permitted their practice information to be released publicly).
	Health care providers and administrators and correctional administrators	ABAM Physician Locator	American Board of Addiction Medicine (ABAM)	Directory of board-certified addiction specialists by state.
	Health care providers and administrators and correctional administrators	AAAP Physician Locator	ABAM	Directory of board-certified addiction and addiction psychiatrist specialists by state.

Topic	Target Audience(s)	Title	Source	Description
Re-entry for individuals with behavioral health conditions	Health care providers and administrators, correctional administrators, re-entry coordinators and navigators	Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison	Policy Research Associates	Provides guidance on building community partnerships and implementing effective re-entry plans for individuals with behavioral health conditions.
Staffing tools	Health care providers and administrators, correctional administrators, re-entry coordinators and navigators	States Reporting Corrections-Related Medicaid Enrollment Policies In Place for Prisons or Jails	Kaiser Family Foundation	Table and interactive map of states' policies around Medicaid suspension, termination, reinstatement and enrollment.
Naloxone distribution in correctional settings	Correctional administrators, health care administrators and providers	A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons	RTI International	Provides guidance on implementing overdose education and naloxone distribution programs in jails and prisons.
COMPONENT 6: DATA MONITORING AND EVALUATION				
Data collection	Health care administrators, correctional administrators and program evaluators	Data Collection Across the Sequential Intercept Model: Essential Measures	SAMHSA	Provides guidance on data collection and evaluation measures across the six intercepts with the criminal justice system.
	Correctional administrators, program evaluators	How to Collect and Analyze Data: A Manual for Sheriffs and Jail Administrators	National Institute of Corrections	Provides guidance on data collection, analysis and dissemination.
	Health care administrators, correctional administrators and program evaluators	The Busy Person's Guide to Measuring and Improving Program Performance	Bloomberg American Health Initiative, Johns Hopkins Bloomberg School of Public Health	Provides guidance on identifying performance measures, collecting and analyzing data and improving program performance.
	Health care administrators, correctional administrators, program evaluators	A Framework for Program Evaluation	Centers for Disease Control and Prevention (CDC)	Provides an overview of the CDC's framework for public health program evaluation.

Topic	Target Audience(s)	Title	Source	Description
	Health care administrators, correctional administrators and program evaluators	Data Collection Across the Sequential Intercept Model: Essential Measures	SAMHSA	Provides guidance on collecting and sharing data across the continuum of the criminal justice system.
Data sharing	Program evaluators, compliance officer, attorneys, health care administrators and correctional administrators	Checklist of Information Needed to Address Proposed Data Collection, Access and Sharing	The Network for Public Health Law	A checklist of considerations related to data collection and sharing.
COMPONENT 7: FUNDING AND SUSTAINABILITY				
Buprenorphine budget calculator	Health care administrators and correctional administrators	Franklin County Jail Buprenorphine/ Naloxone MAT Program Budget Calculator	Franklin County, Massachusetts Sheriff Office	Provides an example of budget allocations for Franklin County Sheriff's Office buprenorphine/ naloxone MAT program.
Medicaid coverage of MAT	Health care administrators and correctional administrators	Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose	RSAT	Provides an overview of Medicaid coverage and financing of medications for alcohol use disorder and OUD.
Example funding sources for MAT in correctional settings	Health care providers and administrators and correctional administrators	State Opioid Response Grants (SOR)	HHS	Provides supplemental funding to support existing evidence-based opioid-related activities undertaken by state agencies.
	Correctional administrators and health care administrators	SAMHSA MAT Expansion Grant (MAT-PDOA)	SAMHSA	Provides funding to state and tribal organizations with high rates of primary treatment admissions for opioids to expand and enhance MAT for people with OUD.

Topic	Target Audience(s)	Title	Source	Description
Example funding sources for MAT in correctional settings	Health care providers and administrators and correctional administrators	SAMHSA State Targeted Response to the Opioid Crisis Grant (Opioid STR)	SAMHSA	Funding allocated to states based on unmet needs for OUD treatment and drug poisoning deaths to increase access to treatment and reduce opioid overdose deaths.
	Health care providers and administrators and correctional administrators	Department of Justice (DOJ) RSAT for State Prisoners Program Grant	U.S. Department of Justice (DOJ)	Provides funding to develop and implement substance use treatment programs in correctional facilities and create and maintain community reintegration services post-release.
	Health care providers and administrators and correctional administrators	SAMHSA Substance Abuse and Treatment Block Grant (SABG)	SAMHSA	Provides funding to plan, implement and evaluate activities that prevent and treat substance abuse with a focus on pregnant women, intravenous drug users, tuberculosis services, early intervention for HIV/AIDS and primary prevention services.
	Health care providers and administrators and correctional administrators	CMS Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act	Centers for Medicare and Medicaid Services (CMS)	Provides funding to increase the capacity of state Medicaid providers to deliver SUD treatment, provide training and technical assistance for Medicaid providers offering SUD treatment or recovery services and improve reimbursement for Medicaid providers.
	Health care providers and administrators and correctional administrators	DOJ Comprehensive Opioid Abuse Program (COAP)	DOJ	Provides funding and technical assistance to states, local governments and tribes to develop and implement comprehensive efforts to treat and support those impacted by the opioid epidemic.

Topic	Target Audience(s)	Title	Source	Description
Example funding sources for MAT in correctional settings	Health care providers and administrators and correctional administrators	DOJ Improving Re-entry for Adults with Co-Occurring Substance Abuse and Mental Illness	DOJ	Provides funding to improve provision of services for individuals who are re-entering the community after incarceration and reduce recidivism.
	Health care providers and administrators and correctional administrators	DOJ Justice and Mental Health Collaboration Program (JMHCP)	DOJ	Provides funding to support cross-system collaboration to improve responses and outcomes for individuals with mental illness or co-occurring mental illness and SUD who are justice-involved.

APPENDIX B: Glossary of Terms

Term	Definition	Source
Addiction	A primary, chronic disease of brain reward, motivation, memory and related circuitry, characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships and a dysfunctional emotional response.	Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings (SAMHSA)
DATA 2000 waiver	Also known as the "x-waiver." Refers to the waiver practitioners must obtain to prescribe or buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000).	Apply for a Practitioner Waiver (SAMHSA)
Drug diversion	The transfer of a legally prescribed controlled substance, including medications for opioid use disorder (OUD), from the person for whom it was prescribed to another person for any illicit use.	Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health (HHS)
Induction	A process of initial dosing with medication for OUD treatment until the patient reaches a state of stability; also called initiation.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Maintenance treatment	Providing medications to achieve and sustain clinical remission of signs and symptoms of OUD and support the individual process of recovery without a specific endpoint.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Medical management	A process where health care professionals provide medication, counseling, monitoring of drug use and medication adherence and, when necessary, referrals to addiction counseling and other services to address the patient's medical, mental health, comorbid addiction and psychosocial needs.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Medically-supervised withdrawal	Using an opioid agonist in tapering doses or other medications to help a patient discontinue illicit or prescription opioids; formerly called detoxification.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Medication-assisted treatment	US Food and Drug Administration (FDA)-approved medications for the treatment of a specific substance use disorder, typically used in combination with clinically indicated behavioral or cognitive-behavioral counseling and other indicated services.	Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings (SAMHSA)

Term	Definition	Source
Opioid agonist	A substance that has an affinity for opioid receptors in the central nervous system and stimulates a physiological response similar to that of an opioid (e.g., methadone, buprenorphine) • Full agonist: Binds to the opioid receptor and produces a physiological response similar to that of an opioid (e.g., methadone). Increasing the dose increases the effect. • Partial agonist: Binds to the opioid receptor a produces a physiological response similar to that of a full agonist (e.g., buprenorphine). Unlike full agonists, increasing the dose will not produce additional effects after reaching the maximum threshold.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Opioid agonist treatment (OAT)	Treatment for OUD using evidence-based opioid agonist and partial agonist medications which include methadone and buprenorphine.	Medications to Treat Opioid Use Disorder (National Institute on Drug Abuse)
Opioid antagonist	A substance that has an affinity for opioid receptors in the central nervous system and prevents a physiological response (e.g. XR-NTX).	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Opioid blockade	The blunting or blocking of the euphoric effects of an opioid through opioid receptor occupancy by an opioid agonist or antagonist.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Opioid misuse	The use of prescription opioids in any way other than as directed by a prescriber; the use of any opioid in a manner, situation, amount or frequency that can cause harm to self or others.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Opioid treatment program (OTP)	An accredited treatment program with Substance Abuse and Mental Health Services Administration (SAMHSA) certification and Drug Enforcement Administration (DEA) registration to administer and dispense opioid agonist medications approved by the FDA to treat opioid addiction. Opioid treatment programs must provide adequate medical, counseling, vocational, educational and other assessment and treatment services either onsite or by referral to an outside agency or practitioner through a formal agreement.	Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings (SAMHSA)

Term	Definition	Source
Opioid use disorder (OUD)	A disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance and withdrawal. According to the DSM-5, an OUD diagnosis is applicable to a person who uses opioids and experiences at least two of the 11 symptoms in a 12-month period.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Opioids	All natural, synthetic and semi-synthetic substances that have effects similar to morphine.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Parole	A conditional release from jail or prison allowing an inmate to serve the remainder of his or her sentence under community supervision.	Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings (SAMHSA)
Peer support	Using peer support specialists in recovery to provide nonclinical support services to individuals in recovery from addiction and to their families.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Peer support specialist	A person in recovery with lived experience in addiction and who has skills learned in formal training. Peer support specialists offer experiential knowledge that treatment staff typically lack and they differ from members of mutual-help groups in that they maintain contact with treatment staff.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Probation	A criminal sentence enabling an individual supervised in the community rather than incarcerated in jail or prison.	Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings (SAMHSA)
Psychosocial support	Services that support and enhance a patient's overall functioning and well-being, including services related to recovery support, case management, housing, education and employment.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Psychosocial treatment	Interventions to enhance a patient's social and mental functioning, including addiction counseling, contingency management and mental health services.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Receptor affinity	The strength of the bond between a medication and its receptor. A medication with high receptor affinity requires lower concentrations to occupy the same number of receptors as a medication with low receptor affinity.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)

Term	Definition	Source
Recidivism	Criminal acts that resulted in re-arrest, reconviction or return to prison with or without a new sentence during a three-year period following the prisoner's release.	Recidivism (National Institute of Justice)
Recovery	A process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential. Although abstinence from all substance misuse is a fundamental feature of a recovery lifestyle, it is not the only path to leading a healthy prosocial life.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Recovery-oriented care	A service orientation that supports individuals with behavioral health conditions in a process of change through which they can improve their health and wellness, live self-directed lives and strive to reach their full potential.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Remission	A medical term meaning a disappearance of signs and symptoms of the disease. Remission is an essential element of recovery.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Return to opioid use	One or more instances of opioid misuse without a return of symptoms of OUD.	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Tolerance	A change in the body's responsiveness to a substance, including opioids, that requires higher doses to produce the same effect as achieved during initial use. • Cross-tolerance: the potential for people who have tolerance to one opioid (e.g., heroin) to have tolerance to another opioid (e.g., methadone).	TIP 63: Medications for Opioid Use Disorder (SAMHSA)
Withdrawal	Symptoms experienced after discontinuing the use of a substance to which a person has become addicted. These symptoms can have both physical and emotional effects, ranging from nausea and vomiting to anxiety and depression. Withdrawal symptoms may lead a person to use the substance again.	Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health (HHS)
Wrap-around services	Non-clinical services that promote engagement and retention in a patient's treatment and recovery. These include services related to transportation, employment, housing and legal concerns, among others.	Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health (HHS)

APPENDIX C: Staff Training Resources

Term	Source	Content	Learning Objectives
Opioid overdose response	Narcan Class Video (Rhode Island DOC)	Recorded training on how to administer naloxone (Narcan) during an overdose (33 minutes in length).	Understand the basics of administering naloxone to an individual experiencing an opioid overdose.
Stigma and discrimination	Module 2: Changing Language to Change Care: Stigma and Substance Use Disorder (PCSS)	Self-guided online module, including a video presentation and pre- and post-tests. Continuing education credits for health care professionals are available.	1. Describe three examples of stigma in the way the medical system approaches substance use disorder (SUD). 2. Explain the importance of using medically appropriate language for SUD. 3. Utilize effective terminology when discussing SUD.
Overview of SUD	Module 1: Overview of Substance Use Disorders (PCSS)	Self-guided online module, including a video presentation and pre- and post-tests. Continuing education credits for health care professionals are available.	1. Identify the spectrum of substance use. 2. Describe neurobiological responses to substances. 3. Assess existing theories regarding SUD. 4. Use accurate clinical terminology. 5. Describe the basic epidemiology and public health impact of the disorder. 6. List common comorbidities in people with SUD. 7. Describe how chronic disease treatment applies to addiction.
Understanding SUD	Understanding Substance Use Disorders (HealtheKnowledge)	A two-hour self-guided course on SUD and SUD treatment. Continuing education credits for health care and social work professionals are available.	1. Understand the basic science of SUD. 2. Understand the basics of SUD treatments.

Term	Source	Content	Learning Objectives
Introduction to the criminal justice system	Module 21: Introduction to the Criminal Justice System and MAT (PCSS)	Self-guided online module, including a 50-minute video presentation and pre- and post-tests. Continuing education credits for health care professionals are available.	1. Describe police lock-ups, jails, prisons, court systems, probation and parole. 2. Discuss pathways for people with OUD who encounter the criminal justice system and importance of medication-assisted treatment (MAT) across systems of care. 3. Describe opportunities for the MAT provider working with justice-involved individuals to enhance treatment outcomes.
Preventing opioid overdose with naloxone	Module 22: Preventing Opioid Overdose with Education and Naloxone Rescue Kits – Revised (PCSS)	Training slides, train the trainer video and pre- and post-tests	1. Review the epidemiology of opioid overdose. 2. Describe the rationale for and scope of overdose education and naloxone distribution (OEND) programs. 3. Implement OEND in settings that offer medication for OUD. 4. Educate patients about overdose risk reduction. 5. Prescribe naloxone rescue kits.
Trauma-informed care	Training Tool: Trauma-Informed Approaches in Correctional Setting (RSAT)	Training manual	1. Introduction to trauma-informed approaches. 2. Understand how trauma relates to the criminal justice system. 3. Identify strategies to implement trauma-informed approaches in correctional settings.

APPENDIX D: DSM-5 Criteria for Opioid Use Disorder[178]

Present	Criteria
	Opioids are often taken in larger amounts or over a longer period than was intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects.
	Craving or a strong desire or urge to use opioids.
	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous.
	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
	Exhibits tolerance, defined by either of the following: A. A need for markedly increased amounts of opioids to achieve intoxication or desired effect. B. Markedly diminished effect with continued use of the same amount of an opioid.
	Exhibits withdrawal, as manifested by either of the following: A. The characteristic opioid withdrawal syndrome. B. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
Total number present =	
Severity Scale **2-3 = Mild, 4-5 = Moderate, 6 or more = Severe**	

APPENDIX E: National Commission on Correctional Health Care (NCCHC) Principles for Care of Adults and Adolescents with Substance Use Disorders in Correctional Facilities[179]

Care Component	Principles
Screening, evaluation and care coordination	1. Conduct universal screening of all inmates for risk factors and symptoms of withdrawal upon entry into the facility from the community. Use valid screening instruments for alcohol, benzodiazepine and opioid withdrawal, which are available from a variety of sources (e.g., National Institute on Drug Abuse; see also NCCHC standard E-02 Receiving Screening).
	2. All inmates who screen positive should receive a medical evaluation that includes the following: a) Evaluation of current use and status, including current enrollment in a substance use disorder treatment program (e.g., opioid treatment program [OTP]), primary care-based buprenorphine treatment or alcohol treatment program. b) Pregnancy test, at minimum for all females reporting opioid use and, conversely, opiate use history for all pregnant females. Facilities should follow national medical standards of care in providing appropriate medication-assisted treatment (MAT) (methadone or buprenorphine), and not withdrawal, to pregnant women with opiate dependence. c) Assessment for comorbidity and confirmation of medications and dosing, including those used to treat substance use disorders (e.g., naltrexone, acamprosate, methadone and buprenorphine). d) Formal assessment for withdrawal severity using validated, standardized instruments such as the Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar), Clinical Institute Withdrawal Assessment for Benzodiazepines (CIWA-B) and the Clinical Opiate Withdrawal Scale (COWS).
Medication-assisted treatment	3. Continuation of prescribed medications for substance use disorders: Continuation of opioid agonist treatment treats the physiological and psychological symptoms of dependence and minimizes risk from opioid withdrawal, failure to reinitiate treatment and relapse due to unexpected inmate release. As with many ongoing medical conditions, stability of treatment and medical condition is important. Continuation of maintenance medications and therapies for substance use disorders in incarcerations of less than six months has proven beneficial to the patient in medical evidence based on randomized controlled studies (Rich et al., 2015). Longer-term stays (when expected confinement is more than six months) have less evidence and the treatment plan, including decisions about continuation, should be evaluated on a case-by-case basis. MAT offers the potential to reduce illicit opioid use inside correctional facilities, which may benefit the individual and the facility.

Care Component	Principles
Medication-assisted treatment	4. Inmates not receiving MAT prior to entry, or whose MAT is discontinued while incarcerated (which is not preferred), should be offered MAT pre-release when post-release continuity can be arranged (Kampman & Jarvis, 2015). Use of methadone or buprenorphine avoids medication-assisted withdrawal and improves engagement in treatment upon release (Rich et al., 2015). Some facilities may opt to withdraw inmates with expected confinements that exceed six months. In these cases, opioid agonist treatment should be initiated 30 days prior to release to prevent post-release death from overdose and promote engagement in treatment. Use of naltrexone (an opioid antagonist) requires complete withdrawal before initiation.
	5. Appropriate pre-release planning with community OTPs and community buprenorphine prescribers is critical to ensure there is no interruption of treatment. Where there are no community programs, inmates should undergo medication-assisted withdrawal prior to release.
	6. Correctional facilities should have several strategies for providing buprenorphine or methadone to inmates, including during pregnancy. These strategies differ in the level of planning and licensing required. a) Transport inmates to community OTPs or a hospital (this is sometimes used during pregnancy). OTPs may obtain waivers for use of takeout doses under the custody of the jail or prison in order to minimize the number of transports. b) Partner with community OTPs for dosing inmates within the facility. In this case, the dosing is done under the license of the community OTP. c) Have correctional physicians obtain buprenorphine licenses. This license permits use of buprenorphine for MAT as well as for medication-assisted withdrawal. d) Obtain an OTP license for the facility. This permits use of methadone and buprenorphine for both treatment and withdrawal. (Note: NCCHC accredits facilities for OTP.) e) Obtain state and Drug Enforcement Administration (DEA) licensing as a health care facility. This entitles the facility to the same exemptions as hospitals for use of methadone or buprenorphine during pregnancy or to ensure treatment of other conditions (e.g., HIV, mental illness).
	7. Attention to the needs of pregnant women with substance use disorders, including following national standard of care[2] to provide MAT, and not withdrawal, to pregnant women with opiate dependence, is essential. Treatment should be provided by clinicians with expertise in this area. Initiation of MAT may require inpatient hospitalization. Other opioid medications, such as acetaminophen with codeine, hydrocodone or oxycodone, should not be substituted for appropriate medication-assisted treatments because of risk to mother and fetus.

Care Component	Principles
Psychosocial treatment	8. Correctional facilities should provide non-medication-based therapies as part of a comprehensive substance use disorder treatment plan.
Medication-assisted withdrawal when indicated	9. Inmates with clinically significant alcohol, opiate or other drug withdrawal should be treated with evidence-based effective medications, including opioid agonists for severe withdrawal.
	10. Inmates should be evaluated and appropriately treated for physical and mental health comorbidity, including concurrent mental health disorders, by qualified health care professionals trained and experienced in managing comorbid disorders.
	11. If a patient is on pharmacotherapy for substance use disorders while incarcerated, provide referral and coordination of community resources for continued treatment for substance use and mental health disorders after release.
	12. For individuals who screen positive for substance abuse and are not already involved in a community treatment program, a pre-release evaluation should occur to determine referral and coordination of community resources for treatment for substance use and mental health disorders.
	13. Facilities ensure the availability of naloxone and personnel trained to use it when opioid overdoses occur. Consideration may be given to providing naloxone to high-risk inmates upon release.
	14. NCCHC supports high-quality research regarding best practices related to treatment of substance use disorders in corrections. Although a substantial evidence base exists for such treatment, there is a high need for research to determine the best practices for provision of treatment in different types of correctional facilities. Such research is needed to inform optimal treatment type, intensity, timing and post-release coordination for different populations (e.g., adolescents, those with chronic persistent mental illness, those with different types of substance use disorders). Research should also address issues related to risk stratification as well as composition and training of substance use disorder teams.

APPENDIX F: Research and Information on MAT Medication Effectiveness

Year published	Title and weblink
2019	Effectiveness of medication assisted treatment for opioid use in prison and jail settings: A meta-analysis and systematic review
2018	Extended-release injectable naltrexone for opioid use disorder: A systematic review
2018	Medications for Opioid Use Disorder, Treatment Improvement Protocol 63
2017	Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial
2017	Extended-release naltrexone for opioid use disorder started during or following incarceration
2016	Pharmacotherapy for opioid dependence in jails and prisons: Research review update and future directions
2015	Pharmacological interventions for drug-using offenders
2014	A systematic review and meta-analysis of naltrexone implants for the treatment of opioid dependence
2014	Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence
2012	The effectiveness of opioid maintenance treatment in prison settings: A systematic review
2011	Oral naltrexone maintenance treatment for opioid dependence
2009	Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence
2007	The impact of substitution treatment in prisons: A literature review

APPENDIX G: Sample Policies and Forms

The following list contains weblinks to sample policies and forms for establishing MAT programs in correctional settings. Policies and forms were provided by key informants and identified through an environmental scan of existing resources. Please note that these policies may have been revised, updated or no longer used and should be viewed as examples only. Correctional MAT programs should always consult compliance and legal staff when crafting policies, procedures or agreements.

Topic	Sample form or policy	Source
Medication-assisted treatment (MAT) clinical guidelines	Centurion Clinical Guidelines Medication Assisted Treatment (MAT)	Vermont Corrections-Based Medication-Assisted Treatment Program, Centurion
	Medication Assisted Treatment Re-Entry Initiative Clinical Guidelines	Massachusetts Department of Corrections (DOC)
MAT program policies (admission criteria, treatment requirements, impairment, non-adherence, care coordination, urine drug screening)	Policy and Procedure Directive: Medication Assisted Treatment Program-Substance Use Disorders	New Hampshire DOC[x]
	Policy: Medication-Assisted Treatment Program	Vermont DOC
Patient agreements	Medication Assisted Treatment Patient Agreement	Vermont DOC
	Buprenorphine Patient Agreement	Hennepin County Adult Detention Center
	Informed consent to treat with buprenorphine	Vermont DOC
Buprenorphine correctional health care policies	Buprenorphine Policy	Hennepin Healthcare
	Distribution of Suboxone Protocol Standard Operating Procedure (SOP)	Rhode Island DOC[x]
	Distribution of Suboxone (Women's Facility)	Rhode Island DOC[x]
Diversion control	Diversion Control Plan	Community Medical Services

x. Source: Residential Substance Abuse Treatment (RSAT) Training and Technical Assistance. (2019). Retrieved from www.rsat-tta.com/Home

Topic	Sample form or policy	Source
Correctional opioid treatment program (OTP) policies	Clinical Practice Guidelines — Methadone OTP	Maricopa County Correctional Health Services
Behavioral health services policies	Opioid Treatment Program: Mental Health Workflow	Community Medical Services
Extended-release injectable naltrexone (XR-NTX) MAT protocols	Substance Abuse Medication Assisted Treatment Protocol	Kentucky DOC[x]
	Vivitrol Relapse Prevention Protocol Program Manual	Rhode Island DOC[x]
Naloxone protocols	Naloxone Protocol	La Frontera Center, Inc.
Standard operating procedures (SOP) for individuals with SUD	SOP Patients with Alcohol and Other Drug Problems	Maricopa County Correctional Health Services
Observed medication withdrawal	Observed Medication Withdrawal-Methadone (Prison)	Corizon Health Inc.
Nursing protocols for MAT	Nursing Protocol for Medication Assisted Treatment (MAT) of Opioid Use Disorders Policy	Vermont DOC

APPENDIX H: Data Elements for MAT Programs in Correctional Settings

To facilitate the reporting of metrics related to treatment initiation, referral and continuation, the following data elements should be established for every incarcerated individual. Length of detention may be particularly important information for programs implemented in jails due to the short duration of contact.

Data Element	Description
Individual level data	
Detention type	Pre-trial, sentenced
Demographics	Age, gender, race/ethnicity
Date of detention entry	mm/dd/yyyy
Date of OUD screening	mm/dd/yyyy
Result of OUD screening	positive/negative
Date of OUD assessment	mm/dd/yyyy
Result of OUD assessment	OUD diagnosis yes/no
Date of MAT assessment	mm/dd/yyyy
Result of MAT assessment	MAT recommended (yes/no and type of MAT)
Receiving MAT at time of arrest	yes/no and type of MAT
Date offered MAT	mm/dd/yyyy
MAT accepted by patient	yes/no
Date initiated MAT	mm/dd/yyyy
Form of MAT initiated	Methadone, buprenorphine/naloxone, buprenorphine, XR-NTX
Dose of MAT at time of discharge from treatment or detention release	Methadone (mg)/buprenorphine/naloxone (mg)
Date of discharge from treatment	mm/dd/yyyy
Reason for discharge from treatment	Released from incarceration/facility transfer/patient request/medically advised (describe)/non-medically advised/death (cause)/other (describe)
Participation in behavioral OUD treatment	For example, residential substance abuse treatment (RSAT), counseling, peer support, etc.
Date of detention release	mm/dd/yyyy

Data Element	Description
Location to which released	Other correctional facility/community
Legal status at release	Pretrial/post-trial
If released to community, form of release	Pretrial: bond/citation, post-trial: "time served"/charges dismissed
Referral to community MAT provider made prior to release	yes/no
Appointment with community MAT provider made prior to release	yes (date)/no
Insurance status at time of release	Medicaid/Medicaid eligible and uninsured privately insured/Medicare/Medicaid ineligible and uninsured
Date seen by community MAT provider	mm/dd/yyyy
Date first post-release MAT prescription filled/methadone dose received/XR-NTX received	mm/dd/yyyy
Unintentional opioid overdose death post-release	Yes (mm/dd/yyyy)/no
Correctional system level data *(Measured among entire correctional facility population during identified time period)*	
Deaths due to suicide	#
Deaths due to opioid overdose	#
Incidence of contraband drugs confiscated within facility	Non-prescribed buprenorphine/illicit opioids/all illicit drugs
Assaults	# assaults on staff/inmates/visitors
Disciplinary reports	#, type
Annual recidivism rate	Rate of people who are released and re-offend within a given year, by type of re-offense (new offense/parole violation)
Community level data *(Measured among correctional facility catchment area over the identified time period)*	
Annual deaths due to opioid overdose among total population	# deaths, by gender
Annual deaths due to opioid overdose among individuals released from correctional setting within 12 months	# total post-release overdose deaths/post-release MAT participant deaths

APPENDIX I: Formulas for Monitoring and Evaluating MAT Programs in Correctional Settings

Question 1: How many incarcerated individuals have an opioid use disorder (OUD)?

Relevant Monitoring Metrics

1a. Percent of individuals screened for OUD:

$$\frac{\text{\# of individuals screened between Time 1 and Time 2}}{\text{Total \# of individuals who entered facility between Time 1 and Time 2}}$$

1b. Percent of positive OUD screens:

$$\frac{\text{\# of individuals who screen positive between Time 1 and Time 2}}{\text{Total \# of individuals screened between Time 1 and Time 2}}$$

1c. Percent of individuals assessed for OUD:

$$\frac{\text{\# of individuals assessed for OUD between Time 1 and Time 2}}{\text{Total \# of individuals who screened positive}}$$

1d. Percent of OUD among new intakes:

$$\frac{\text{\# of individuals diagnosed with OUD between Time 1 and Time 2}}{\text{Total \# individuals screened between Time 1 and Time 2}}$$

Question 2: How many patients with OUD participate in the correctional medication-assisted treatment (MAT) program?

Relevant Monitoring Metrics

2a. Percent of individuals with OUD offered MAT:

$$\frac{\text{\# of individuals offered MAT between Time 1 and Time 2}}{\text{Total \# of individuals diagnosed with OUD between Time 1 and Time 2}}$$

2b. Percent of individuals initiated on MAT:

$$\frac{\text{\# of individuals initiating MAT treatment between Time 1 and Time 2}}{\text{Total \# of individuals offered MAT between Time 1 and Time 2}}$$

Among individuals initiating MAT treatment between Time 1 and Time 2:

- Percent of individuals continued on treatment from community:

$$\frac{\text{\# of individuals who initiated MAT treatment between Time 1 and Time 2 AND were on MAT treatment at time of arrest}}{\text{Total \# of individuals initiating MAT treatment between Time 1 and Time 2}}$$

- Percent of new treatment inductees:

$$\frac{\text{\# of individuals who initiated MAT treatment between Time 1 and Time 2 AND were NOT on MAT treatment at time of arrest}}{\text{Total \# of individuals initiating MAT treatment between Time 1 and Time 2}}$$

Question 3: What percent of correctional MAT program participants are retained in treatment while incarcerated?

Relevant Monitoring Metrics

3a. Percent of MAT patients dosed daily:

Average daily number of patients dosed

Total # of patients prescribed daily MAT (substitute monthly for XR-NTX)

3b. Percent of MAT patients retained:

# of MAT patients who remain on MAT through the length of their incarceration
---
Total census of people initiated on MAT released during time frame

- By medication type

3c. Percent of MAT patients MAT discontinued:

# of MAT program participants who are no longer in MAT treatment at time of release to the community
---
Total # of patients initiated on MAT

- By medication type
- By cause of treatment cessation

3d. Average maintenance dose of buprenorphine or methadone:

Question 4: How many correctional MAT program participants receive resources necessary to continue MAT upon release to the community?

Relevant Monitoring Metrics

4a. Percent of individuals referred to a community provider:

# of MAT program participants referred to a MAT provider upon release to the community
---
Total # of patients initiated on MAT

- By medication type

4b. Percent of individuals with community appointments scheduled:

# of MAT program participants who have an appointment scheduled with a MAT provider when released to the community
---
Total # of MAT patients released to the community

- By medication type

4c. Percent of buprenorphine patients receiving a bridge prescription or bridge medication:

# of buprenorphine program participants who receive bridge prescriptions or bridge medications upon release to the community
---
Total # of buprenorphine patients released to community

4c. Percent insured, by type:

Insurance status of MAT program recipients when released to the community
---
Total # of MAT patients released to the community

Impact Question 1: How has the MAT program affected the functioning of the correctional facility?

Relevant Monitoring Metrics

1a. Number of deaths inside jail due to suicide

1b. Number of deaths inside jail due to opioid overdose

1c. Number of contraband drug confiscations

- Nonprescribed buprenorphine
- Illicit opioids
- All illicit drugs

1d. Number of assaults on inmates, staff and visitors

1e. Number of disciplinary reports

Impact Question 2: How many correctional MAT participants continue treatment after release to the community?

Relevant Monitoring Metrics

2a. Percent of individuals who attend follow-up:

$$\frac{\text{\# of MAT program participants who attend community MAT appointment within xx days of release}}{\text{Total \# of MAT participants released to the community}}$$

2b. Percent of bridge prescriptions filled:

$$\frac{\text{\# of buprenorphine program participants who fill a prescription for buprenorphine within 14 days following release}}{\text{Total \# of buprenorphine participants released with a prescription}}$$

2c. Percent of methadone patients who enter community treatment:

$$\frac{\text{\# of methadone program participants who receive treatment at an outpatient treatment program within 14 days following release}}{\text{Total \# of methadone participants released}}$$

2d. Percent of XR-NTX patients who receive injection in community:

$$\frac{\text{\# of XR-NTX program participants who receive a XR-NTX injection within 30 days following release}}{\text{Total \# of XR-NTX participants released}}$$

Impact Question 3: What is the rate of unintentional fatal opioid overdose among incarcerated individuals recently released to the community?

Relevant Monitoring Metrics

3a. Opioid overdose rate:

$$\frac{\text{\# unintentional opioid overdose deaths}}{\text{Total population per year (total and stratified by demographic features)}}$$

2b. Percent of opioid overdoses among formerly incarcerated:

$$\frac{\text{\# unintentional opioid overdose deaths among individuals released from incarceration within last 12 months}^{xi}}{\text{\# unintentional opioid overdose deaths among entire population}}$$

xi. Programs may consider a shorter cut-off time period, such as released within past 30 days.

APPENDIX J: Sample Tables for Collecting MAT Data in Correctional Settings

Sample Table 1a. Number of people diagnosed with opioid use disorder (OUD) between dd/mm/yyyy and dd/mm/yyyy.

Measure	Number	Percent
Total # of new intakes		
# of OUD screenings		(out of total # of new intakes)
# of positive OUD screens		(out of total # of individuals screened)
# of individuals assessed for OUD		(out of total # screened positive)
# of positive OUD assessments		(out of total # of individuals assessed)

Sample Table 1b. Characteristics of individuals diagnosed with OUD between dd/mm/yyyy and dd/mm/yyyy.

Measure	Number	Percent
Total # of positive OUD assessments		
Sex (male, female)		
Age group (18-29; 30-39; 40-49; 50-59; 60+)		
Race/ethnicity (American Indian/Alaskan Native; Asian, Black/African American, Latino/Hispanic, Native Hawaiian/Other Pacific Islander, White, Other, More than one race)		
Insurance status		
Insurance type (public, private)		
Location of residence		
Pre-trial, sentenced		
In methadone program in community at time of arrest		
Prescribed buprenorphine in community at time of arrest		
Taking XR-NTX in community at time of arrest		
Facility or housing area		

Sample Table 2. Medication-assisted treatment (MAT) initiation from dd/mm/yyyy to dd/mm/yyyy.

Measure	Number	Percent
Total # of positive OUD assessments		
# offered MAT		(out of total diagnosed with OUD)
# offered methadone		(out of total offered MAT)
# offered buprenorphine		(out of total offered MAT)
# offered XR-NTX		(out of total offered MAT)
# initiated on MAT		(out of total offered MAT)
# initiated methadone		(out of total initiated MAT)
# initiated buprenorphine		(out of total initiated MAT)
# initiated XR-NTX		(out of total initiated MAT)
# of MAT patients continued on MAT from community		(out of total initiated MAT)
# of methadone initiates continued on methadone from community		(out of total MAT patients continued on MAT from community)
# of buprenorphine initiates continued on buprenorphine from community		(out of total MAT patients continued on MAT from community)
# of XR-NTX initiates continued on XR-NTX from community		(out of total MAT patients continued on MAT from community)
# of MAT patients started who were not on MAT in community		(out of total initiated MAT)
# of methadone initiates who were not on methadone in the community		(out of total MAT patients started who were not on MAT in community)
# of buprenorphine initiates who were not on buprenorphine in the community		(out of total MAT patients started who were not on MAT in community)
# of XR-NTX initiates who were not on XR-NTX in the community		(out of total MAT patients started who were not on MAT in community)

Sample Table 3. MAT treatment retention from mm/dd/yyyy to mm/dd/yyyy.

Measure	Number	Percent
Average daily # of MAT patients dosed		(out of average daily total number of patients prescribed MAT during time frame)
Average daily # of methadone patients dosed		(out of average daily total number of patients prescribed methadone during time frame)
Average daily # of buprenorphine patients dosed		(out of average daily total number of patients prescribed buprenorphine during time frame)
# of MAT patients who remain in treatment for entire incarceration		(out of total census of people initiated on MAT who were released during time frame)
# of methadone patients who remain in treatment for entire incarceration		(out of total census of people initiated on methadone who were released during time frame)
# of buprenorphine patients who remain in treatment for entire incarceration		(out of total census of people initiated on buprenorphine who were released during time frame)
# of MAT patients who are no longer in treatment at time of release		(out of total census of people initiated on MAT who were released during time frame)
# of methadone patients who are no longer in treatment at time of release		(out of total census of people initiated on methadone who were released during time frame)
# of buprenorphine patients who are no longer in treatment at time of release		(out of total census of people initiated on buprenorphine who were released during time frame)
Causes of treatment cessation (voluntary, discharged for medical reasons, discharged for non-medical reasons)		(out of total census of people initiated on MAT who discontinued treatment during time frame)
Average daily methadone dose, range		(among all patients prescribed methadone for chronic therapy during time frame)
Average daily buprenorphine dose, range		(among all patients prescribed buprenorphine for chronic therapy during time frame)

Sample Table 4. MAT among those released to the community between mm/dd/yyyy and mm/dd/yyyy.

Measure	Number	Percent
Total # of MAT patients released during time frame		
# of MAT patients referred to a community-based MAT provider at release		(out of total # of MAT patients released)
# of methadone patients referred to a community OTP at release		(out of total # of methadone patients released)
# of buprenorphine patients referred to a community buprenorphine prescriber at release		(out of total # of buprenorphine patients released)
# of XR-NTX patients referred to a community prescriber at release		(out of total # of XR-NTX patients released)
# of MAT patients who have an appointment scheduled at a community-based MAT provider at release		(out of total # of MAT patients released)
# of methadone patients who have an appointment scheduled at a community OTP at release		(out of total # of methadone patients released)
# of buprenorphine patients who have an appointment with a community buprenorphine prescriber at release		(out of total # of buprenorphine patients released)
# of XR-NTX patients who have an appointment with a community prescriber at release		(out of total # of XR-NTX patients released)
# of buprenorphine patients leaving with a bridge prescription		(out of total # of buprenorphine patients released)
# of buprenorphine patients leaving with bridge medications		(out of total # of buprenorphine patients released)
Insurance status at time of release (Medicaid eligible and reinstated, Medicaid eligible not reinstated, privately insured, Medicaid ineligible and uninsured)		(out of total # of MAT patients released)

APPENDIX K: Key Informants

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Bruce Herdman, PhD, MA, MBA Chief of Medical Operations Philadelphia Prison System (PA)	Peter Koutoujian, JD Sheriff Middlesex Sheriff's Office (MA)
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APPENDIX L: References

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