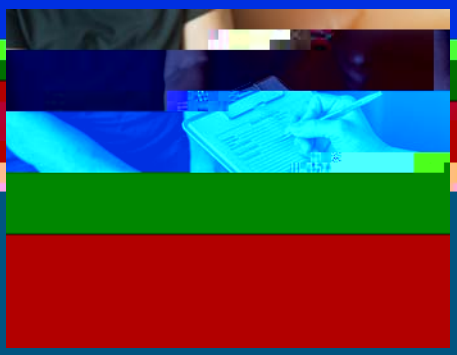


Jail-Based Medication-Assisted Treatment

Promising Practices, Guidelines, and Resources for the Field

October 2018

N

National Commission on Correctional Health Care

Foreword

As my colleague Jonathan Thompson notes, jails are on the front lines of the opioid epidemic in the United States.

Over the past 40 years, sheri□s and jail administrators across the country have sought to improve the quality of health services provided to the individuals in their care. In the mid-1970s, 30 jails served as the pilot sites for the □rst health services standards for correctional settings and an accompanying accreditation program. Today, the National Commission on Correctional Health Care (NCCHC) continues to help jails address the most complex problems in health services, including care for individuals su□ering from mental illness and substance use disorder. In addition to its standards for jail health services, NCCHC also o□ers standards and accreditation speci□cally for opioid treatment programs.

As this publication makes clear, pharmacotherapy—i.e., medication-assisted treatment (MAT)—is widely held to be a cornerstone of best practice for recovery from substance abuse. E□ective treatment, including MAT, particularly when coupled with evidence-based behavioral treatment, improves medical and mental health outcomes and reduces relapses and recidivism.

MAT provides a signi□cant opportunity to help individuals with substance use disorder, especially those who participate in a community-based opioid treatment program (OTP). OTPs are licensed facilities that provide methadone and often other MATs

Acknowledgments

So many people and organizations made the document *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* possible. Although it is not feasible to recognize each of these contributions individually, the National Sheri□s' Association (NSA) and the National Commission on Correctional Health Care (NCCHC) would like to highlight the distinctive roles of several people involved in this two-year e□ort.

First, the NSA and NCCHC sta□s would like to thank the co-chairs of the project: Ruby Qazilbash, Associate Deputy Director, Bureau of Justice Assistance, and Stephen Amos, Chief of the Jails Division, National Institute of Corrections. They initiated this e□ort and provided the leadership to realize a vision of consensus around issues that initially seemed to many as hopelessly complex and controversial.

An initiative of the scope and complexity of *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* never would have gotten beyond the concept phase without considerable funding and technical support. O□cials from the U.S. Department of Justice (speci□cally, the Bureau of Justice Assistance and the National Institute of Corrections), the O□ce of National Drug Control Policy, the National Institute on Drug Abuse, and the Substance Abuse and Mental Health Services Administration (SAMHSA) demonstrated how the federal government can e□ectively partner at the state and local levels.

The sta□s of the NSA and NCCHC are enormously indebted to Project Director and principal author Andrew Klein, PhD, of the Advocates for Human Potential, Inc. No other expert in the country knows more about the application of medication-assisted treatment (MAT) in correctional settings than Dr. Klein. He contributed his expertise, ideas, and suggestions about how to improve access to MAT and made substantial contributions to the design and early drafts of this document. Through his thoughtful engagement and input of the project partners, Dr. Klein brought to life a document that will be of signi□cant service to the □eld. In addition, special recognition goes to Jennie M. Simpson, PhD, O□ce of Policy, Planning, and Innovation, SAMHSA, who provided invaluable technical knowledge and input. A third crucial contributor is Kevin Fiscella, MD, MPH, an addiction medicine expert who serves on the NCCHC board of directors; he is a professor in the department of family medicine at University of Rochester, New York.

The NSA and NCCHC are grateful to the members and sta□ of the organizations that composed the roundtable discussion and provided a bedrock of strategic expertise: the American Probation and Parole Association, the National Association of Counties, the American Jail Association, the National Association of Drug Court Professionals, the Massachusetts Sheri□s' Association, the California State Sheri□s' Association, the Texas Sheri□s' Association, the Rhode Island Department of Corrections, the Kentucky Department of Corrections, the American Society of Addiction Medicine, the National Governors Association, the Council of State Governments Justice Center, The Pew Charitable Trusts, New York University School of Medicine, and Sam Houston State University.

Finally, the NSA and NCCHC sta□s and project partners thank the many correctional, addiction, and mental health professionals who strive daily to provide a better quality of life to people in their charge. Their devotion to providing the best possible services to people with substance use disorders can enhance the security and the well-being of our communities. It is for them that this document has been written.

What's in It for Me as a Criminal Justice Executive?

Medication-assisted treatment (MAT), utilizing the U.S. Food and Drug Administration (FDA)-approved medications methadone, buprenorphine, or naltrexone, is considered a central component of the contemporary standard of care for the treatment of individuals with opioid use disorders (OUDs).[1] It may also be used for individuals with co-occurring mental illnesses, in consultation with a physician.

Two-thirds of people in jail
as a tool in tsor8537 625 . 9997 TmjeData ic- a97 TN4 . 2 pl A925 . 9*[(18 Tmh .)12(m . ( )m

Evidence strongly supports that the use of MAT increases the likelihood of successful treatment for individuals with OUDs[2] and reduces morbidity and mortality. Research has begun to show that adding MAT to the treatment of those involved in the criminal justice system confers the same benefits and also reduces recidivism.[3]

These findings are particularly relevant for criminal justice decision makers—including sheriffs and corrections department officials—given that Bureau of Justice Statistics surveys found that nearly two-thirds (63 percent) of people in jail meet criteria for drug dependence or abuse. Many of these individuals have OUDs and could benefit from access to MAT, a combination of behavioral interventions and medications that have been shown to decrease opioid use, increase treatment retention, reduce overdose, and reduce criminal activity.[4]

By thoughtfully and carefully including MAT, when appropriate, as a tool in the range of jail-based treatment options, the value proposition to criminal justice executives may include:

- Stemming the cycle of arrest, incarceration, and release associated with substance use disorders (SUDs), as individuals with SUDs return to the community without connection to treatment.
- Contributing to the maintenance of a safe and secure facility for inmates and staff.
- Reducing costs: Comprehensive drug treatment programs in jails are associated with reduced system costs.[5] According to the 2018 Substance Abuse and Mental Health Services Administration (SAMHSA) TIP 63: Medications for Opioid Use Disorders, "Data indicate that medications for OUD are cost effective and cost beneficial."[6]

Explore In-Depth

Best Practices and Guidelines for Jail-Based Medication-Assisted Treatment

Client enrollment in a jail-based MAT program

All individuals entering a jail should be systematically screened for substance use disorders, including any history of alcohol/sedative or opioid withdrawal.

Receiving screening should be conducted immediately upon acceptance into jail custody. Screeners should explain the reason for the questions, e.g., "We ask these questions to ensure you receive appropriate treatment while you are here." Questions should address physical and mental health, prescribed medications including MAT, previous drug or alcohol treatment, recent drug or alcohol use including types and amount, and current or past history of drug or alcohol withdrawal. Individuals showing evidence of intoxication77(T)60(,58s including M)10(A8so(ec)6(ep5(y o4(t(A)77(T)60(,ast hist)st 10(ent or p

This is particularly important when it comes to prescribing medications, including those for alcohol and OUDs. All medications carry di□erent risks and bene□ts for di□erent individuals; treatment decisions, including medication, should be based on what has been proven to work and what is most likely to bene□t the individual patient.

Clinical assessments for MAT begin with a general assessment for SUDs. Such assessments allow tailoring of treatment to a person's withdrawal symptoms, often helping to reduce the amount of medication needed. Several instruments have been

After the assessment, the physician and the patient should discuss the best course of treatment, including which medication the patient should take and what dosage may be appropriate. Substance abuse counselors, or, with permission, close family members or friends may be valuable participants in treatment planning, monitoring, and support. Because the number of MAT providers is limited, especially in rural communities, not all FDA-approved medications may be available to all individuals in the community.

Oral naltrexone for the treatment of OUDs is often adversely a□ected by poor medication adherence. Clinicians should reserve its use for patients who are able to comply with special strategies to enhance their adherence (for example, observed dosing). Extended-release injectable naltrexone reduces, but does not eliminate, issues with medication adherence. It should be noted that individuals may be provided with oral naltrexone for several days prior to injections of naltrexone to ensure that there are no negative reactions to the medication, although this practice is not advised or required by the FDA. Of the medications on the market, the least amount of research is available for naltrexone. Two recent studies have found that once individuals have their □rst injection of naltrexone, their retention and relapse rates are the same as those taking buprenorphine with naloxone; however, they are more likely to initially balk at the treatment than those who sign up for buprenorphine,[19] in part because of the need for a 7- to 14-day medically supervised withdrawal before starting naltrexone.

Certain widely agreed-upon considerations should be discussed and considered prior to determining the appropriate medication (or switching medications), dosages, and

Switching from Methadone to Buprenorphine

Some correctional institutions may not be equipped to provide methadone, which may require switching individuals from methadone to buprenorphine with or without naloxone. Individuals with OUDs can safely be switched from methadone to buprenorphine maintenance. According to SAMHSA's *Quick Guide for Physicians: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*:

> Induction of patients from long-acting opioids (e.g., methadone) onto buprenorphine should be managed by physicians experienced with the procedure. Patients taking methadone should have their dose tapered to 30 mg or less per day for at least 1 week before buprenorphine induction. Twenty-four hours must elapse between the final dose of methadone and the first dose of buprenorphine. The first dose of buprenorphine should be 2 mg of monotherapy. A second 2 mg dose can be given and repeated up to 8 mg per day if signs of withdrawal appear.

The guide goes on to chart the steps in the induction from Day 2 and forward. When an individual has no withdrawal symptoms, minimal side effects, and no uncontrollable cravings, he or she is considered stabilized. During stabilization (1 to 2 months), adjustments in the dose and frequent physician–patient contact help establish the proper level of medication. Until full stabilization is achieved, weekly assessments are indicated. Doses of buprenorphine/naloxone may be increased in 2/0.5–4/1 mg increments until stabilization is achieved. Nearly all patients stabilize on daily doses of 16/4–24/6 mg; some may require up to 32/8 mg daily. The maintenance phase follows.

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

The *ASAM Practice Guidelines* highlights the following:

> "Patients switching from methadone to buprenorphine in the treatment of opioid use disorder should be on low doses of methadone before switching medications. Patients on low doses of methadone (30 to 40 mg per day or less) generally tolerate transition to buprenorphine with minimal discomfort, whereas patients on higher doses of methadone may experience significant discomfort when switching medications. Generally, buprenorphine initiation should occur at least 6 to 12 hours after the last use of heroin or other short-acting opioids or 24 to 72 hours after their last use of long-acting opioids such as methadone. Buprenorphine doses after induction and titration should be, on average, at least 8 mg per day. The FDA approves dosing to a limit of 24 mg per day, and there is limited evidence regarding the relative efficacy of higher doses. In addition, the use of higher doses may increase the risk of diversion."[22]

Naltrexone

Naltrexone is a recommended treatment for preventing the relapse of OUDs. Naltrexone does not require a special license to prescribe. Oral formula naltrexone may be considered for patients where adherence can be supervised or enforced. Extended-release injectable naltrexone may be more suitable for patients who cannot be observed or supported when taking their medication daily.

There is no recommended length of treatment with oral naltrexone or extended-release injectable naltrexone. The duration depends on clinical judgment and the patient's circumstances. Because there is no physical dependence associated with naltrexone, it can be stopped abruptly without withdrawal symptoms. Importantly, patients should be informed that discontinuation of naltrexone is associated with enhanced sensitivity to opioids and heightened risk of overdose. The FDA warning label for extended release naltrexone states: "It is important that patients inform family members and the people closest to the patient of this increased sensitivity to opioids and the risk of overdose."[23]

Switching from naltrexone to methadone or buprenorphine should be planned, considered, and monitored. Switching from an antagonist such as naltrexone to a full agonist (methadone) or a partial agonist (buprenorphine) is generally less complicated than switching from a full or partial agonist to an antagonist, because there is no physical dependence associated with antagonist treatment and, thus, no possibility of precipitated withdrawal. Patients being switched from naltrexone to buprenorphine or methadone will not have a physical dependence on opioids; therefore, the initial doses of methadone or buprenorphine should be low.

A patient should not be switched until a significant amount of naltrexone is no longer in his or her system. This requires a 1-day wait for oral naltrexone and a 30-day wait after a naltrexone injection.

What the Research Suggests Regarding Different Opioid Medications

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

> Buprenorphine is an effective medication in the maintenance treatment of heroin dependence, retaining people in treatment at any dose above 2 mg, and suppressing illicit opioid use (at doses of 16 mg or greater) based on placebo-controlled trials.
>
> However, compared with methadone, buprenorphine retains fewer people when doses are flexibly delivered and at low fixed doses. If fixed medium or high doses are used, buprenorphine and methadone appear no different in effectiveness (retention in treatment and suppression of illicit opioid use); however, fixed doses are rarely used in clinical practice so the flexible dose

results are more relevant to patient care. Methadone is superior to buprenorphine in retaining people in treatment, and methadone equally suppresses illicit opioid use.[24]

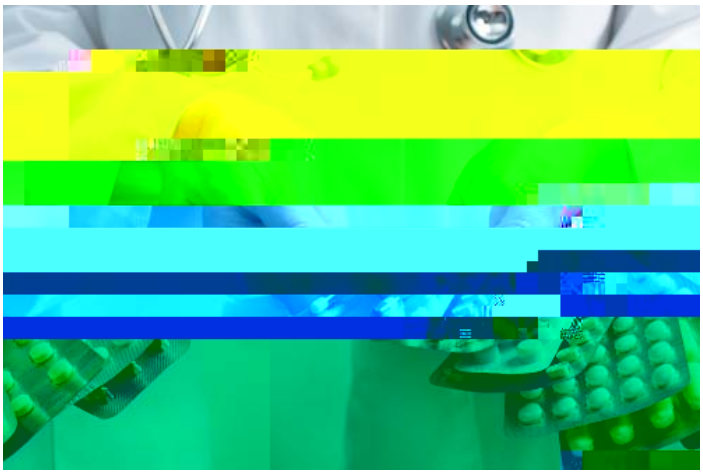
Studies have also compared the mortality risk in and out of treatment with methadone and buprenorphine. Researchers examined 19 eligible cohorts, following 122,885 people treated with methadone over 1.3 to 13.9 years and 15,831 people treated with buprenorphine over 1.1 to 4.5 years.

> Overdose mortality evolved similarly, with pooled overdose mortality rates of 2.6 and 12.7 per 1,000-person years in and out of methadone treatment (unadjusted out-to-in rate ratio 4.80, 2.90 to 7.96) and 1.4 and 4.6 in and out of buprenorphine treatment.

The authors concluded:

> Retention in methadone and buprenorphine treatment is associated with substantial reductions in the risk of all cause and overdose mortality in people dependent on opioids. The induction phase onto methadone treatment and the time immediately after leaving treatment with both drugs are periods of particularly increased mortality risk . . . .[25]

There have been far fewer studies of naltrexone use. One national study found that use of oral naltrexone was associated with higher risk of mortality than methadone.[26] A 2017 study was conducted to evaluate the long-term safety, tolerability, and treatment outcomes of injectable naltrexone. The small study of fewer than 49 screened opioid-dependent individuals screened by health care professionals concluded that "(l)ong-term (2 years) (of injections) was associated with no new safety concerns . . . ." The NIDA study described above of a larger sample found that "(a)ll recorded overdose events, fatal or nonfatal, occurred among participants assigned to usual treatment (0 events in the extended-release naltrexone group vs. 5 in the usual-treatment group from week 0 to 25, p=0.10; 0 vs. 7 events from week 0 to 78, p=0.02); no overdoses occurred in the extended-release naltrexone group after discontinuation of the agent."[27] A recent study compared use of methadone, buprenorphine, and extended-release naltrexone among patients who had previously survived an overdose.[28] Findings showed that use of methadone or buprenorphine was associated with reduction in death, but the use of naltrexone was not. Small numbers and inclusion of both oral and injectable naltrexone limit firm conclusions regarding this drug's effect on mortality.



Only two studies have compared buprenorphine and injectable naltrexone, as mentioned previously. Both found that, once begun, the medications were equally effective in terms of retention over 6 months. The larger NIDA study found that "a monthly shot of naltrexone (sold as Vivitrol) is as effective as its main competitor, the daily pill of buprenorphine and naloxone (sold as Suboxone)." Researchers found that about half of the people with opioid addiction who took either drug remained free from relapse 6 months later. However, because naltrexone required abstinence for 7 to 10 days, 28 percent of those assigned naltrexone did not follow through and receive their first injections. For those who did, 52 percent subsequently relapsed, as opposed to 56 percent who relapsed on buprenorphine with naloxone.[29] As previously noted, the ASAM National Practice Guideline states:

> Oral naltrexone for the treatment of opioid use disorder is often adversely affected by poor medication adherence. Clinicians should reserve its use for patients who would be able to comply with special techniques to enhance their adherence, for example, observed dosing. Extended release injectable naltrexone reduces, but does not eliminate, issues with medication adherence.

Length of Treatment

Research indicates that the length of time an individual should spend on medication varies and needs to be reassessed with the medical staff, considering the individual's medical history and situation. Opioid use disorder is a chronic condition representing alterations in brain function.[30] Relapse rates are common and often fatal. Long-term MAT is often required in the same way that long-term medications are needed for other chronic conditions such as diabetes or high blood pressure.

Both SAMHSA[31] and ASAM[32] have suggested guidelines for determining when and how medication should be discontinued. The latter, for example, concludes that there is no recommended time limit for treatment with buprenorphine, methadone, or naltrexone. It advises, however, that "buprenorphine taper and discontinuation is a slow process and close monitoring is recommended." Further, discontinuation is generally accomplished over several months and "patients and clinicians should not take the decision to terminate treatment with buprenorphine lightly" (p. 34). Similarly, ASAM holds that "the optimal duration of treatment with methadone has not been established; however, it is known that relapse rates are high for most patients who drop out; thus, long-term treatment is often needed" (p. 30). For both oral and injectable naltrexone, ASAM concludes that the duration of treatment should depend on the response of the individual patient, the patient's individual circumstances, and clinical judgment (p. 37).

Related Federal Guidelines

Federal Guidelines for Agonist Maintenance in Opioid Treatment Program (OTP) Settings

1. **Maintenance treatment**. An OTP shall maintain current procedures designed to ensure that patients are admitted to maintenance treatment by quali□ed personnel who have determined, using accepted medical criteria such as those listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), that a person is currently addicted to an opioid drug and that the person became addicted at least 1 year before admission for treatment. In addition, a program physician shall ensure that each patient voluntarily chooses maintenance treatment, that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient, and that each patient provides informed written consent to treatment.

2. **Maintenance treatment for persons under age 18**. A person under 18 years of age is required to have had two documented unsuccessful attempts at short-term medical withdrawal (detoxi□cation) or drug-free treatment within a 12-month period to be eligible for methadone maintenance treatment. No person under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment.

3. **Maintenance treatment admission exceptions**. If clinically appropriate, the program physician may waive the requirement of a 1-year history of addiction . . . for patients released from penal institutions with a documented history of opioid use disorder (within 6 months after release), for pregnant patients (program physician must certify pregnancy), and for previously treated patients (up to 2 years after discharge).

4. **Medically managed withdrawal treatment**. An OTP shall maintain current procedures that are designed to ensure that patients are admitted to short- or long-term medically managed withdrawal by quali□ed personnel, such as a program physician, who determines that such treatment is appropriate for the speci□c patient by applying established diagnostic criteria. Patients with two or more unsuccessful medically managed withdrawal episodes within a 12-month period must be assessed by the OTP physician for other forms of treatment. A program shall not admit a patient for more than two medically managed withdrawal treatment episodes in one year.

Data show that treatment retention is reduced when patients are tapered o□ MAT prematurely.[33] For some patients, MAT could be inde□nite.[34] NIDA describes addiction medication as an "essential component of an ongoing treatment plan" to enable individuals to "take control of their health and their lives."[35] For methadone maintenance, 12 months of treatment is the minimum, according to NIDA.[36]

The □rst long-term follow-up of patients treated with buprenorphine/naloxone for addiction to opioid pain relievers found that half were abstinent at 18 months after starting therapy. After 3 ½ years, the number reporting abstinence rose to 61 percent. At each follow-up interview, patients who were currently receiving the medication were much more likely to report abstinence compared with those not taking medication. Only 6.6 percent of the patients maintained abstinence after a brief course of medication (2 weeks of medication, 2 weeks to taper o□, and 2 months follow-up). Those who relapsed during this phase were provided with 12 weeks of medication followed by 4-week tapering and 2-month follow-up. Nearly half of these patients achieved abstinence during their last 4 weeks; however, fewer than 10 percent were still doing well at the end of the 2-month follow-up. At 18 months, 30 months, and 42 months, patients who were engaged in MAT had markedly higher odds of positive outcomes. At 42 months, the advantage associated with MAT had narrowed but was still large, 79.6 percent abstinence versus 50.8 percent abstinence. During the study, patients reported abstinence only for the prior 30-day period. Many who relapsed reentered MAT and then were able to remain abstinent for at least the 30 days at reporting periods.[37]

After piloting the use of injected naltrexone, the Pennsylvania Department of Corrections' MAT program, which initially recommended 6 months of injections, now recommends a full year of injections. A study of individuals involved in the criminal justice system provided with injected naltrexone for 6 months found that those receiving the injections had signi□cantly fewer relapse events, a higher rate of opioid-negative urines, and less-serious adverse events, including fatal and nonfatal overdoses, than those engaged in abstinence-only treatment. However, those treated with 6 months of naltrexone injections had outcomes similar to those not treated after a year. This suggests that more than 6 months of injections may be indicated for longer-term abstinence.[38]

Alcohol Use Disorder

Three drugs are approved by the FDA to treat alcohol use disorder (AUD): disul□ram, acamprosate, and naltrexone. An Agency for Healthcare Research and Quality review of 167 studies of medical treatment of AUD in outpatient settings found evidence to support the use of naltrexone and acamprosate, but insu□cient evidence to support the use of disul□ram.[39] Speci□c to incarcerated populations, there is less research available on the use of MAT for alcohol use disorder, except for a few older studies on the use of disul□ram during community supervision.

- **Disul□ram:** Although disul□ram has been in use for many years, it is no longer considered a □rst-line treatment choice. Its action interferes with the breakdown of alcohol by the liver, resulting in adverse physical responses to any intake of alcohol. The National Institute on Alcohol Abuse and Alcoholism clinical guidelines state: "The utility and e□ectiveness of disul□ram are considered limited because compliance is generally poor when patients are given it to take at their own discretion."[40] Its use is limited to highly motivated patients and those who can be directly observed while they take the medication. It is contraindicated for patients who are still drinking. Disul□ram is available only with a prescription.
- **Acamprosate:** Acamprosate can be prescribed by physicians or nurse practitioners and, in some states, by physician assistants and psychologists. Although not all patients respond to acamprosate, research suggests it is more likely to be e□ective for patients who are abstinent from alcohol before acamprosate is initiated, and it is more likely to bene□t patients who intend to abstain from alcohol completely rather than for those who plan to reduce their alcohol use. Acamprosate has been successful in European studies at increasing abstinence rates. It works by relieving some of the anxiety and dysphoria associated with postacute withdrawal from alcohol.
- **Naltrexone:** Systematic reviews show that naltrexone is e□ective for treating alcohol use disorder. It appears to be comparable to acamprosate.[41]

Medication Dosages

Appropriate doses vary for these medications, except for naltrexone and disul□ram, where the dose is standard. Dosing is an individualized medical decision. In some instances, low doses of methadone, for example, have been found less e□ective for keeping users in treatment than higher doses.[42]

Clients should be routinely tested to ensure receipt of the appropriate prescribed dosage of medications.

SAMHSA's *Federal Guidelines for Opioid Treatment Programs*[43] requires programs to "provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient, in maintenance treatment, in accordance with generally accepted clinical practice."

There are several di□erent ways to test for drugs, including alcohol. As described by ASAM, "Drug tests do not detect drug use in general." Instead, drug tests identify speci□c drugs or drug classes as well as drug metabolites in biological matrices that are represented in particular test panels. Drugs can be identi□ed in any matrix; the most common matrices for typical testing purposes include urine, blood, and oral □uid."[44]

Because of the risk of overdose, it is important to ensure that individuals not try to circumvent the stabilizing or blocking e□ects of their medication, whether it be an agonist, a partial agonist, or an antagonist, by taking other drugs or increasing doses of prescribed medications. If persons try to overcome the blocking e□ects of naltrexone by ingesting increasing amounts of opioid medications or heroin, they are at a high risk of overdosing. The utilization of drug testing also can

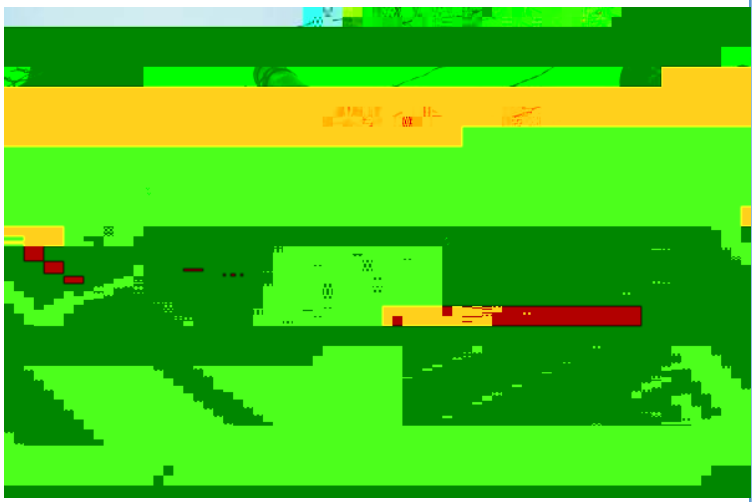
This condition is known as neonatal abstinence syndrome (NAS). Infants born to mothers treated with methadone or buprenorphine are also at risk of NAS but are less likely to be preterm or have low birth weight. Opioid-exposed infants can be monitored and managed in most hospitals. Women receiving medications are usually encouraged to breastfeed because the bene□ts greatly outweigh the very small trace amounts of medication that may be found in breast milk.[48]

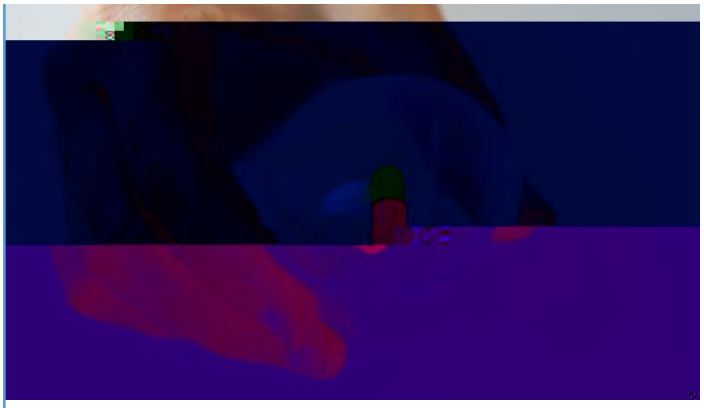
There are fewer long-term studies of safety and e□ectiveness of buprenorphine during pregnancy, but some suggest that buprenorphine reduces NAS.[49] ACOG supports treating pregnant women with buprenorphine if they are already on it or prefer it.[50] Pregnant women should generally receive only the single-drug formula, without added naloxone.

Women with opioid use disorders who are under community supervision should be referred to treatment providers that o□er specialized services for pregnant and postpartum women. They require an intensive level of support after delivery to prevent relapse, and many will bene□t from additional services, including parenting skills training and supports or family reuni□cation planning.[51]

Pregnant women with alcohol use disorders should receive medically managed withdrawal treatment from alcohol as soon as possible. Fetal alcohol spectrum disorders and fetal alcohol e□ects occur in a small but signi□cant proportion of babies born to women who drink heavily during pregnancy. Alcohol consumption during the □rst trimester is a particularly high risk. Because some women who drink heavily during the □rst trimester may not know they are pregnant, treatment providers should include pregnancy tests if clients are unsure.

In custody settings, women are usually screened for pregnancy on intake, but women with a history of substance use should also be screened for pregnancy in community corrections. All women who come in contact with the criminal justice system should be educated about the risks of substance use during pregnancy, including the provision of tobacco cessation support and services (which all public and private health insurance plans are now required to cover).[52]





Existing Standards and Guidelines

- *A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders.* SAMHSA, 2016. https://store.samhsa.gov/shin/content//SMA16-4978/SMA16-4978.pdf
- *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. SAMHSA, 2018. https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf
- *Advancing the Care of Pregnant and Parenting Women With Opioid Use Disorder and Their Infants: A Foundation for Clinical Guidance.* SAMHSA, 2016. https://www.regulations.gov/document?D=SAMHSA-2016-0002-0001
- *Opioid Use Disorders and Medication-Assisted Treatment in Pregnancy*. National Center on Substance Abuse and Child Welfare, n.d. https://ncsacw.samhsa.gov/resources/opioid-use-disorders-and-medication-assisted-treatment/default.aspx
- *Pregnancy and Postpartum Care in Correctional Settings*. Carolyn Sufrin, MD, PhD. Endorsed by the American College of Obstetricians and Gynecologists and should be construed as ACOG clinical guidance. https://www.ncchc.org/□lebin/Resources/Pregnancy-and-Postpartum-Care-2018.pdf
- *Standards for Health Services in Jails.* National Commission on Correctional Health Care, 2018. https://www.ncchc.org/jail-prison-standards
- *Standards for Opioid Treatment Programs in Correctional Facilities.* National Commission on Correctional Health Care, 2016. https://www.ncchc.org/opioid-treatment-programs-2
- *State Standards for Pregnancy-related Health Care and Abortion for Women in Prison*. American Civil Liberties Union, 2016. https://www.aclu.org/state-standards-pregnancy-related-health-care-and-abortion-women-prison-0

Medication alone is not the answer: The force multiplier of partnerships and support services

For maximum benefits in the treatment of opioid and alcohol use disorders, couple MAT with counseling and the appropriate wraparound services.

Example from the Field

A New York jail relies on a state treatment court where

Agonist medications must be counted, recorded, and stored in locked cabinets. Administering each dose takes a few minutes, and patients must be closely observed to lessen the possibility of diversion. Any missed dose must be documented and returned to the locked cabinet. Prior to initiating administration of the medications, sta members must be trained and a protocol must be developed to accommodate the additional responsibilities entailed. The FDA approved a monthly injectable form of buprenorphine sold under the brand name Sublocade. Use of injectable buprenorphine avoids diversion and minimizes postrelease interruption of treatment. It requires refrigeration and must be used within 7 days after being warmed to room temperature.

Special care must be taken in the storage of medications, both for security and to make sure that the medications are used before their expiration dates. For example, injectable naltrexone must be refrigerated and then allowed to warm to room temperature before mixing, followed by intramuscular injection. Once at room temperature, the drug must be used within 7 days or discarded. Medical sta members must be reassured about potentially increased liability for the prescription and dissemination of these medications and informed about the possibility of increased workloads.

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

To limit the potential for diversion of opioid agonist treatment medications to the illicit market, opioid agonist treatment medications dispensed to patients for unsupervised use shall be subject to the following requirements.

1. Any patient in comprehensive maintenance treatment may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and state and federal holidays.

2. Treatment program decisions on dispensing opioid treatment medications to patients for unsupervised use, beyond that set forth in paragraph (i)(1) of this section, shall be determined by the medical director. In determining which patients may be permitted unsupervised use, the medical director shall consider the following take-home criteria in determining whether a patient is responsible in handling MAT for unsupervised use.

   - No recent abuse of drugs (opioid or nonnarcotic), 68(An)13(ydr of drugspic),)]TJ 0 Tc 0 Tw 0.9 -1.2 Td [(68(An)13(ydr of dru4 f)13(or)-24(th in 3tes rl)]TJ 0 Tc 0 Tw 0J 0 0 Tw 0ineRa

     An2. th in 3tes rl

     2. th in 3tes rl

     and for unsl c2.13,

Community-based treatment and medication providers should be carefully selected. Correctional BE

Once individuals have gone through medically managed withdrawal, many jails are in a unique position to initiate treatment for these individuals, launching them on the path to long-term recovery. An increasing number of jails have begun to establish treatment programs for these individuals. In addition to medically managed withdrawal services, these jails have established medical screening for MAT as well as in-jail provision of these medications to promote continued abstinence from illicit opioids upon release. To ensure continuity of treatment, these jails link released individuals to treatment, support, and medical providers in the community. However, medically managed withdrawal is not treatment. In fact, withdrawal is associated with high risk for overdose and death following release, underscoring the need for MAT.

There is a dual incentive for incarcerated individuals to take advantage of these programs: Not only can their participation lead to recovery in the long term, but in the short term, their participation can in□uence prosecutors and courts to consider noncustodial treatment alternatives once they return to court for further hearings. In many jurisdictions, prosecutors and courts let defendants know at arraignment that they will take into consideration the defendants' participation in a jail pretrial program to resolve their criminal cases. Although many defendants may be more concerned with avoiding custodial sentences than long-term abstinence and recovery, research has shown that successful treatment is not dependent on voluntary entry into treatment.[76]

However, if it is likely that a prosecutor and a court will not consider a noncustodial sentence, beginning agonist treatment pretrial may not be indicated if the individual is expected to return to jail for a long period of time or be sentenced to prison.

Before an individual is enrolled into a jail's MAT program, he or she is educated about the medications o□ered and the associated choices to be made (as described earlier). The jail then introduces concurrent initial drug counseling and sets up referrals in the community for follow-up counseling as well as continued access to medication.

An increasing number of jails provid agonist medications for incoming individuals who are already prescribed these medications, especially if they are not expected to remain in jail for prolonged periods of time. While certi□ed medical personnel can dispense buprenorphine, methadone must be dispensed by a licensed methadone clinic. For this reason, most jails rely on community methadone clinics to come to their facilities daily to dispense medication under the supervision of the jail authorities rather than becoming licensed methadone providers in their own right.

Jail(ur)10(e amethad13nal12(, bex)15(Tw Tt)6(o a jail)-6(')72(s nA)77(

In addition, research makes it clear that receiving MAT in jail along with treatment is associated with better follow-up in the

medications should be administered under the supervision of trained medical personnel, particularly considering that many individuals entering corrections may su□er from liver disease, a condition that contraindicates the use of certain medications.

Jail MAT programs should include ongoing monitoring through drug screening and other diversion/risk mitigation strategies.

Alcohol and drug use during treatment should be carefully monitored as outlined in NIDA's *Principles of Drug Abuse for Criminal Justice Populations*.[99] Individuals trying to recover from alcohol and drug addiction may experience a relapse and

Correctional or treatment agency staff members can help ensure that individuals receive the coverage needed to utilize MAT programs, including available state-subsidized medications.

> Federal law and regulations do not require states to terminate Medicaid enrollment when a person is incarcerated, but the law does prohibit federal payments for that person's health care costs while he or she is in prison or jail (excluding the inpatient exception). Guidance from the Centers for Medicare & Medicaid Services (CMS) in April 2016 clarifies that states must accept applications from people who are incarcerated and enroll or reenroll them if determined eligible. It encourages states to suspend enrollment or coverage by using markers or other indicators in the claims processing system that help ensure that claims submitted by states are denied for disallowed services provided to people in prisons and jails. Whatever method is used, CMS states that a suspension must be lifted when this exclusion no longer applies—for example, upon a person's release, or when he or she is admitted to a medical institution for treatment that falls within the inpatient exception.[107]

In addition, if an individual obtains employment and no longer qualifies for Medicaid, he or she may not be able to afford the subsidized premiums or copays. Such an individual may need additional assistance, such as pharmaceutical company coupons or access to generic versions of buprenorphine.

There are programs for reduced-price medications, some from the pharmaceutical industry itself. There are also federal and state government programs. Congress established the 340B program to allow certain covered entities that serve large numbers of uninsured patients to obtain drugs from pharmaceutical suppliers at the same discounted rates that Medicaid pays (i.e., 25 to 50 percent less). The following website lists 340B-covered entities by state: http://datawarehouse.hrsa.gov/topics/HealthcareSystems/CE340BDataExplorer.aspx. Also, some states fund MAT medications for programs that serve correctional populations out of state block grant funding or state appropriations. More than 1,200 Federally Qualified Health Centers are located in inner cities and rural areas and serve uninsured and low-income individuals. Many offer buprenorphine based on discounted fees. The nearest center can be located via https://findahealthcenter.hrsa.gov.

The different types of assistors include the following:

- **Navigators**—Navigators receive extensive training from CMS and are responsible for providing unbiased information about public and private health insurance programs in a culturally competent manner. They regularly report on their outreach and consumer education activities and accomplishments. In plan year 2018, the Navigator Program is evolving: Navigators will be encouraged to leverage volunteers as well as strategic partnerships with public and private organizations to identify individuals who would benefit from Exchange coverage. These updates leverage practices from private sector-focused programs like those within Medicare Advantage.
- **Non-navigator assistors (in-person assisters)**—These serve a function similar to navigators, providing in-person assistance and informing consumers about coverage options, but funding for assistors is more flexible than navigator funding. Many states opt to train staff members of existing community-based agencies to carry out in-person assistor duties.
- **Certified application counselors (CACs)**—CMS designates organizations to certify counselors who perform these functions. CACs complete pre-service training and receive ongoing in-service training via CMS webinars and newsletters. They comply with privacy and security standards but have fewer reporting requirements.
- **Brokers, agents, and contracted assistors**—Brokers usually act on behalf of the consumer and are compensated by insurers or consumers. Agents are compensated by insurers. Some states contract with brokers or agents to act as "navigators." They may be required to forgo compensation or abide by other guidelines that mitigate potential conflicts of interest.

services, and health insurance plans. Communication between the health care provider and the program is initiated when the program navigator noti□es a provider of a new participant and schedules a medical follow-up appointment. If an appointment is missed, the MSO's research team is noti□ed via phone call. The health care provider attempts to reengage the participant; failure to do so results in a call to a navigator, who attempts to reach the individual separately.

MATADOR team meetings provide ongoing communication among the MSO's research sta□, executive sta□, and navigators to ensure program integrity. The MATADOR program navigator works in conjunction with nearly 90 community health care providers, support programs, and drug courts throughout Massachusetts. The engagement and collaboration of these critical health care and criminal justice stakeholders have made a key di□erence in the success of the program reboot.

Outcomes

Of the 370 individuals who have completed the program, 81% percent had not been rearrested for new crimes as of January 2018.

Louisville Metro Department of Corrections, Kentucky

Origin and Development of the Program

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

Implementation

In the spring of 2016, LMDC partnered with Correct Care Solutions (CCS), its contracted medical/mental health provider, to launch its MAT program. Flowcharts, consent-to-treat forms, and informational handouts were developed, and training for medical sta□ was provided. Originally, the program was designed to be provided only to inmates who were active participants in Enough is Enough, a 90-day voluntary drug treatment program. Shortly thereafter, sta□ members realized that the program would also bene□t inmates who could not be enrolled in Enough is Enough because of shorter incarceration periods. LMDC partnered with the cou11(orr)19 partnered w0001 d [(o(

Snohomish County Jail, Washington

Origin and Development of the Program

The Snohomish County Jail initiated its buprenorphine MAT program in January 2018, beginning with a buprenorphine/naloxone (marketed as Suboxone) detox program. The program became necessary because of a huge increase over the past few years in people being arrested who were addicted to opioids. The jail's 24-bed medical unit was overwhelmed with individuals in need of medically managed withdrawal.

Program Development

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

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

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

Once through medically managed withdrawal, inmates who will be at the jail for at least 6 weeks (including those sentenced as well as those held pretrial) are offered Suboxone treatment 10 to 14 days before they are released. Three jail staff nurse practitioners and a physician at the jail prescribe the medication for both medically managed withdrawal and maintenance. The nurses carefully provide the medication each day under the supervision of correctional officers who provide direct supervision of inmates.

Rhode Island Correctional Facilities

Origin and Development of the Program

Appendix I: Substance Use Disorder Screening Tools

The National Institute on Drug Abuse (2015) o□ers a list of screening tools that have been found to be e□ective for adults and adolescents.

For Alcohol

- Alcohol Screening and Brief Intervention for Adolescent and Youth: A Practitioner's Guide
- Alcohol Use Disorders Identi□cation Test (AUDIT)
- Alcohol Use Disorders Identi□cation Test-C (AUDIT-C)
- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)
- Center for Adolescent Substance Abuse Research: CRAFFT
- CRAFFT (Part A)
- Helping Patients Who Drink Too Much: A Clinician's Guide
- NIDA Drug Use Screening Tool
- NIDA Drug Use Screening Tool: Quick Screen
- Screening to Brief Intervention (S2BI)

For Drugs

- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)
- CRAFFT
- CRAFFT (Part A)
- DAST 20: Adolescent Version
- Drug Abuse Screen Test (DAST-10)
- NIDA Drug Use Screening Tool
- NIDA Drug Use Screening Tool: Quick Screen
- Opioid Risk Tool
- S2BI

National Institute on Drug Abuse (NIDA)

NIDA lists the following substance use disorder treatment programs:

- Behavioral therapies, including multisystemic therapy (MST)[110]
- Cognitive behavioral therapy (CBT)
- Community reinforcement approach (CRA) plus vouchers
- Contingency management (CM) interventions/motivational incentives
- Family behavior therapy (FBT)
- The Matrix Model
- Motivational enhancement therapy (MET)
- Therapeutic communities (TC)
- Twelve-step facilitation therapy

Subst

1. National Institute on Drug Abuse. (2016). Advancing addiction science, e□ective treatment for opioid addiction. https://www.drugabuse.gov/publications/e□ective-treatments-opioid-addiction/e□ective-treatments-opioid-addiction

Substance Abuse and Mental Health Services Administration. (2018). Tip 63: Medications for opioid use disorders. (HHS Publication No. [SMA] 18-5063EXSUMM). Rockville, MD. https://store.samhsa.gov/product/SMA18-5063EXSUMM

2. Gelber, S., & Rinaldo, D. W. (2013, June). Report III: FDA-approved medications indicated for the treatment of opioid dependence: Literature reviews on e□ectiveness and cost-e□ectiveness, Treatment Research Institute (TRI), 2013. In American Society for Addiction ioid use ciety fn addictio addieminists 2(.sa3(tion)]TJ -0.0003 ns f)13(or opio)15(ubor)1(e)Tc 0.0732 Tw 12.8 use ciet.

5. National League of Cities and National Association of Counties. (2016). A Prescription for Action: Local Leadership in Ending the Opioid Epidemic. http://opioidaction.org/report

6. SAMHSA, op. cit. ES-3.

7. Smith, K., & Strashny, A. (2016, April 26). Characteristics of criminal justice system referrals discharged from substance abuse treatment and facilities with specially designed criminal justice programs. The CBHSQ Report. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. https://www.samhsa.gov/data/sites/default/files/report_2321/ShortReport-2321.html

8. An agonist is a drug that activates certain receptors in the brain. Full agonist opioids activate the opioid receptors in the brain fully, resulting in the full opioid effect. Examples of full agonists are heroin, oxycodone, methadone, hydrocodone, morphine, and opium. An antagonist is a drug that blocks opioids by attaching to the opioid receptors without activating them. Antagonists cause no opioid effect and block fully agonist opioids. Examples are naltrexone and naloxone. Naloxone is sometimes used to reverse a heroin overdose. Buprenorphine is a partial agonist, meaning that it activates the opioid receptors in the brain, but to a much lesser degree than a full agonist. https://www.naabt.org/faq_answers.cfm?ID=5

9. Wesson, D. R., & Ling, W. (2003). The clinical opiate withdrawal scale (COWS). Journal of Psychoactive Drugs, 35(2), 253–259.

10. Cunningham, C., & Fishman, M. The ASAM national practice

25. Sordo, L., Barrio, G., Bravo, M. J., Iciar Indave, B., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017, April 26). Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies, BMJ, 357, j1550.

26. Gibson, A. E., Degenhardt, L. J., (2007). Mortality related to pharmacotherapies for opioid dependence: a comparative analysis of coronial records. Drug and Alcohol Review, 26(4), 405-410.

27. Lee, J., Friedmann, P. D., Kinlock, T. W., Nunes, E. V., Boney, T. Y., Hoskinson, R. A., & O'Brien, C. P. (2016, March 31). Extended-release naltrexone to prevent opioid relapse in criminal justice o□enders. New England Journal of Medicine, 374, 1232–1242.

28. Larochelle, M. R., Bernson, D., Land, T., Stopka, T. J., Wang, N., Xuan, Z., & Walley, A. Y. (2018). Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: a cohort study. Annals of Internal Medicine, 169(3), 137-145.

29. Lee, J., Friedmann, P. D., Kinlock, T. W., Nunes, E. V., Boney, T. Y., Hoskinson, R. A., & O'Brien, C. P. (2016, March 31). Extended-release naltrexone to prevent opioid relapse in criminal justice o□enders. New England Journal of Medicine, 374, 1232–1242.

30. Volkow, N. D., Koob, G. F., & McLellan, A. T. (2018). Neurobiologic advances from the brain disease model of addiction. New England Journal of Medicine, 374(4), 363-371.

31. Substance Abuse and Mental Health Services Administration. (2016). Sublingual and transmucosal buprenorphine for opioid use disorder: Review and update. SAMHSA Advisory, 15(1), 1–12.3tic r31. enalth S asetalitl of Medicine. ≥hd use

46. Center for Substance Abuse Treatment. (2009). Substance abuse treatment: Addressing the speci□c needs of women. Treatment Improvement Protocol (TIP) Series, No. 51. (HHS Publication No. [SMA] 14-4426). http://store.samhsa.gov/shin/content/SMA14-4426/SMA14-4426.pdf

47. American College of Obstetricians and Gynecologists. (2012, May). ACOG Committee Opinion No. 524: Opioid abuse, dependence, and addiction in pregnancy. Obstetrics & Gynecology, 119(5), 1070–1076. https://www.ncbi.nlm.nih.gov/pubmed/22525931

48. National Institutes of Health, U.S. National Library of Medicine. (2015). Neonatal abstinence syndrome. www.nlm.nih.gov/medlineplus/ency/article/007313.htm

49. Jones, H. E., Martin, P. R., Heil, S. H., Kaltenbach, K., Selby, P., Coyle, M. G., & Fischer, G. (2008, October). Treatment of opioid-dependent pregnant women: Clinical and research issues. Journal of Substance Abuse Treatment, 35(3), 245–259. doi: 10.1016/j.jsat.2007.10.007

50. American College of Obstetricians and Gynecologists. (2012, May). ACOG Committee Opinion No. 524: Opioid abuse, dependence, and addiction in pregnancy. Obstetrics & Gynecology, 119(5), 1070–1076. https://www.ncbi.nlm.nih.gov/pubmed/22525931

51. Unger, A., Metz, V., & Fischer, G. (2012). Opioid dependent and pregnant: What are the best options for mothers and neonates? Obstetrics and Gynecology International, Article ID 195954. doi: 10.1155/2012/195954

52. National Commission on Correctional Health Care. (2014, October 19). Women's health care in correctional settings (position statement). http://www.ncchc.org/womens-health-care

American College of Obstetricians and Gynecologists. (2011, November, rea□rmed 2016). Health care for pregnant and postpartum incarcerated women and adolescent females. Committee Opinion, Number 511. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Pregnant-and-Postpartum-Incarcerated-Women-and-Adolescent-Females

53. Sigmon, S. C., Ochalek, T. A., Meyer, A. C., Hruska, B., Heil, S. H., Badger, G. J., & Higgins, S. T. (2016, December 22). Interim buprenorphine vs. waiting list for opioid dependence. New England Journal of Medicine, 375, 2504–2505. doi: 10.1056/NEJMc1610047

54. Crime Solutions, the U.S. Justice Department National Institute of Justice registry of evidence-based programs. https://www.crimesolutions.gov/

55. Godley, S. H., White, W. L., Diamond, G., Passetti, L. L., & Titus, J. C. (2001). Therapist reactions to manual-guided therapies for the treatment of adolescent marijuana users. Clinical Psychology Scienti□c Practice, 8, 405–417. doi: 10.1093/clipsy.8.4.405

56. Dowden, C. & Andrews, D. A. (2004, April 1). The importance of sta□ practice in delivering e□ective correctional treatment: A meta-analytic review of core correctional practice. International Journal of O□ender Therapy and Comparative Criminology, 48 (2), 203–214. doi: 10.1177/0306624X03257765

57. Substance Abuse and Mental Health Services Administration. (2015, March). Federal guidelines for opioid treatment programs. (HHS Publication No. [SMA] PEP15-FEDGUIDEOTP). Rockville, MD. http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf

58. Taxman, F., Thanner, M., & Wesburd, D. (2006, January 1). Risk, need, and responsivity (RNR): It all depends. Crime & Delinquency, 61(9), 1.

59. Bonta, J., & Andrews, D. (2007). Risk-Need-Responsivity model for o□ender assessment and rehabilitation, 2007–06. Canada: Public Safety Canada & Carleton University.

60. Lowenkamp, C., & Latessa, E. (2005). Increasing the e□ectiveness of correctional programming through the risk principle: Identifying o□enders for residential placement. Criminology & Public Policy, 4(2), 263–290.

61. Andrews, D., Bonita, J., & Wormith, S. (2011, June). The Risk-Need-Responsivity (RNR) Model: Does adding the good lives model contribute to e□ective crime prevention? Criminal Justice Behavior,

66. Gordon, M. S., Kinlock, T. W., Schwartz, R. P., Fitzgerald, T. T., O'Grady, K. E., & Vocci, F. J. (2014, September 1). A randomized controlled trial of prison-initiated buprenorphine: Prison outcomes and community treatment entry. Journal of Drug and Alcohol Dependence, 142, 33–40. doi: 10.1016/j.drugalcdep.2014.05.011

67. Substance Abuse and Mental Health Services Administration. (2015, March). Federal guidelines for opioid treatment programs. (HHS Publication No. [SMA] PEP15-FEDGUIDEOTP). https://store.samhsa.gov/product/PEP15-FEDGUIDEOTP

68. Substance Abuse and Mental Health Services Administration. (2014). National Survey of Substance Abuse Treatment Services (N-SSATS): 2013. Data on Substance Abuse Treatment Facilities. (BHSIS Series S-73, HHS Publication No. [SMA] 14-489). Rockville, MD. Retrieved from https://www.samhsa.gov/data/sites/default/files/2013_N-SSATS/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services.pdf

69. Pennsylvania Department of Corrections. (2015, October). MAT expansion plan: PA DOC strategies for expanding the use of MAT for justice-involved individuals. http://www.cor.pa.gov/General%20Information/Documents/Medication%20Assisted%20Treatment/MAT%20Expansion%20Plan.pdf

70. Substance Abuse and Mental Health Services Administration. (2015, March). Federal guidelines for opioid treatment programs. (HHS Publication No. [SMA] PEP15-FEDGUIDEOTP). Rockville, MD. Available at http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf

71. Cognitive behavioral therapies should be considered specifically for correctional populations.

72. Substance Abuse and Mental Health Services Administration. (2015, March). Federal guidelines for opioid treatment programs. (HHS Publication No. [SMA] PEP15-FEDGUIDEOTP). Rockville, MD. http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf

73. For more information on these standards, visit https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs.

74. Gordon, A. J., Lo-Ciganic, W. H., Cochran, G., Gellad, W. F., Cathers, T., Kelley, D., & Donohue, J. M. (2015, November–December). Patterns and quality of buprenorphine opioid agonist treatment in a large Medicaid program. Journal of Addiction Medicine, 9(6), 470–477. doi: 10.1097/ADM.0000000000000164

75. Substance Abuse and Mental Health Services Administration. (2015). National Survey of Substance Abuse Treatment Services (N-SSATS): 2014. Data on Substance Abuse Treatment Facilities. (BHSIS Series S-79, HHS Publication No. [SMA] 16-4963). http://www.samhsa.gov/data/sites/default/files/2014_National_Survey_of_Substance_Abuse_Treatment_Services/2014_National_Survey_of_Substance_Abuse_Treatment_Services/2014_National_Survey_of_Substance_Abuse_Treatment_Services.pdf

76. Telepractice Standards for OASAS Designated Providers. New York State Office of Alcoholism and Substance Abuse Services. https://www.oasas.ny.gov/regs/documents/TelepracticeStandards.pdf

77. Coviello, D. M., Zanis, D. A., Wesnoski, S. A., Palman, N., Gur, A., Lynch, K. G., & McKay, J. R. (2013). Does mandating offenders to treatment improve completion rates? Journal of Substance Abuse Treatment, 44(4), 417–425. http://doi.org/10.1016/j.jsat.2012.10.003

78. Friedmann, P. D., Ducharme, L. J., Welsh, W., Frisman, L., Knight,

85. Alex, B., Weiss, D. B., Kaba, F., Rosner, Z., Lee, D., Lim, S., …

About the National Sheriffs' Association