WHAT IS THE ISSUE?

Across the U.S., opioid use and overdose deaths are at epidemic proportions. In 2017, 2.1 million people in the United States had an opioid use disorder (OUD)[h] and nearly 68 percent of overdose deaths involved opioids.[i] Individuals reporting opioid use are significantly more likely to be involved with the criminal justice system compared to people with no opioid use, and the level of justice involvement increases with the level of opioid use.[j] Within the criminal justice system, nearly 10 percent of justice-involved individuals self-report heroin use.[k] Estimates indicate that about half of drug courts serve groups where over 20 percent report an opioid dependency;[l] 22 percent of jails report that 10 percent or more of their jail populations have an opioid dependency.[m] Among individuals sentenced to jail and state prison, regular use of opioids was reported at 17 and 19 percent, respectively.[n]

Opioid overdose deaths have reduced the expected life span of justice-involved people in the U.S., largely due to the risks associated with community re-entry following incarceration. Justice-involved individuals are more likely to die of an opioid overdose compared to the general population;[o] and, drug overdose is among the leading causes of death for individuals re-entering the community, with a majority of these overdoses involving opioids.[p]

BENEFITS OF PROVIDING MAT TO JUSTICE-INVOLVED INDIVIDUALS

Studies show that MAT reduces drug use,[a] disease rates, and overdose events,[b] as well as, promotes recovery[c] among individuals with opioid use disorders. Across the criminal justice system, MAT has been found to reduce criminal activity,[d] arrests,[e] as well as probation revocations and re-incarcerations.[f]

Jail re-entry and treatment courts are two areas in criminal justice that are leading the uptake of MAT into criminal justice programs and facilities. Sheriffs and judges leading these efforts report fewer individuals with OUD cycling in and out of the local jails and individuals in treatment courts staying in treatment for longer periods of time.[g]

The field of criminal justice has been slow to incorporate FDA approved pharmacotherapy for opioid use disorder, also called medication-assisted treatment (MAT), into routine practice.[q] One study found that only 53 percent of drug court programs allowed MAT medications as part of their participants' treatment;[r] overall, treatment courts are reluctant for participants to begin MAT after they have detoxed during an incarceration.[s] Many jails require complete withdrawal from all opioids, including prescribed MAT medications. However, an estimated 77 percent of formerly incarcerated individuals with an OUD relapse to opioid use within three months of release even after participating in a counseling program while incarcerated.[t]

State governments have long been recognized as critical players in fostering the use of medication to treat substance use disorders (SUD) and increasing the availability of affordable, evidence-based treatments.[u] Now, in the midst of the opioid epidemic, states should consider the use of federal and state funding to create or expand evidence-based treatments, including MAT, in criminal justice settings.

SAMHSA
Substance Abuse and Mental Health Services Administration

PEP19-MATBRIEFCJS

CHALLENGES TO INCORPORATING MAT

SAMHSA'S DEFINITION OF MAT

Medication-assisted treatment is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. More information about MAT from SAMHSA is available at https://www.samhsa.gov/medication-assisted-treatment.

APPROVED MAT MEDICATIONS

Methadone blocks the symptoms of opiate withdrawal and reduces or eliminates craving for opiate drugs such as heroin, morphine, and codeine, as well as semi-synthetic opioids, such as oxycodone and hydrocodone. Methadone treatment must take place in a SAMHSA-certified opioid treatment program.

Buprenorphine blocks opioid withdrawal and reduces opioid craving. This medication may be prescribed or dispensed by qualified U.S. physicians in a number of settings, including physicians' offices, community hospitals, correctional facilities, and other locations. The preferred formulation of sublingual medication is buprenorphine combined with naloxone in a pill form, which reduces diversion to injected use because naloxone produces opiate withdrawal in those currently physically dependent on opioids.

Naltrexone is a non-narcotic, non-addictive opioid antagonist that blocks the euphoric and sedative effects of other opioids. It can be prescribed by any healthcare provider who is licensed to prescribe medications.

MISUNDERSTANDINGS ASSOCIATED WITH MAT

- The perception that MAT involves "substituting one drug for another" persists in the field of criminal justice and across communities.
- Incorrect perceptions about the functions of MAT medications and their side effects persist in the field of criminal justice, leading to an underutilization of this evidence-based treatment.

CONCERNS AROUND MAT MEDICATION DIVERSION

- Criminal justice programs and facilities may need to alter policies, procedures, and training in order to ensure MAT is administered in a way that reduces medication diversion. A number of strategies can reduce the risk of diversion, including: assign dedicated staff who participate in multidisciplinary teams of medical and correctional staff, monitor dispensing of medications, conduct drug testing, implement spot audits and incident reports, and ensure the safe, secure storage of the medications.

CONCERNS ABOUT COST OF MAT

- Criminal justice programs may assume they cannot afford to provide MAT due to costs of medication, staffing, training, additional certifications, storage requirements, etc. Often, MAT medications are not on correctional facilities' formularies.
- Criminal justice programs may serve a large population that does not qualify for Medicaid in states that did not expand Medicaid coverage. This can limit individuals' ongoing treatment if they were to start MAT during incarceration.

STATE REGULATIONS

Some states' licensing, credentialing, and regulations processes may pose hindrances to efficient and effective use of MAT. These can deter correctional facilities from becoming a provider of MAT or may limit the number of community-based providers available. Some states' scope of practice laws prohibit nurse practitioners (NPs) or physician assistants from prescribing one or more MAT medication for opioid use disorders without the oversight of a physician; three states prohibit NPs from prescribing buprenorphine at all.[v] These issues can limit the delivery of MAT to criminal justice-involved populations.

LACKING COMMUNITY-BASED MAT PROVIDERS

The availability of community-based providers is critical to the delivery of MAT to justice-involved people. Many jurisdictions face barriers in identifying community-based treatment providers willing or having capacity to serve people who are under criminal justice oversight. A majority of jurisdictions do not have sufficient provider capacity to serve the number of people with OUD.[w] Community-based providers may be unprepared to establish partnerships and provide services in correctional settings, face complexities of providing services to individuals for which they cannot bill for reimbursements, lack skill sets to effectively serve criminal justice populations, or lack capacity to serve individuals with complex substance use treatment needs.

MAT AND THE CRIMINAL JUSTICE SYSTEM

MAT is relevant at each point of contact across the justice system. At first contact between a law enforcement officer and individuals with an opioid use disorder (OUD), opportunities may exist to divert people directly to MAT treatment or services rather than arresting them and taking them to jail. Upon intake and booking into jail, correctional staff can provide screenings to identify individuals appropriate for further assessment and consideration for MAT. Agencies involved in the court process, such as drug courts, district attorney's offices, and public defenders' offices, may also have staff and programs in place to assess individuals for OUD in order to provide MAT or refer them to a community-based MAT provider. During incarceration in a jail or prison, individuals may begin MAT and establish the relationships and plans needed to continue treatment after release. Once back in the community, community corrections officers can support an individual's continued participation in MAT.

By including the criminal justice system as another "door" to treatment, states may see an increase in access to and retention in treatment, reduced use of the justice system by individuals with opioid use disorders, and options to move funds from punitive criminal justice practices to supporting the recovery of individuals with OUD throughout the state.

KEY CONSIDERATIONS

LEGISLATION & REGULATIONS

Many states already have plans in place to address the opioid epidemic through various strategies, including Medicaid 1115 demonstration waivers, increasing the provision of MAT to individuals in the justice system, enabling the diversion of individuals with OUD away from the justice system, and creating state-level positions/offices to focus specifically on the opioid epidemic.

PROTECTIONS FOR MAT PARTICIPANTS UNDER CRIMINAL JUSTICE SUPERVISION: In 2015, the state of New York passed legislation to allow individuals on MAT to participate in judicial diversion programs and to ensure those participants would not inadvertently face probation violation charges due to the presence of MAT medications in drug screens.[x]

Some jurisdictions have policies/programs in place that allow an individual seeking treatment to contact criminal justice partners for help without the threat of arrest or criminal justice involvement. States can help promote these approaches by implementing them with state law enforcement agencies and disseminating information about them.

WORKFORCE ISSUES

MULTI-DISCIPLINARY TEAMS: MAT in criminal justice settings should involve multi-disciplinary teams of behavioral health and criminal justice professionals. Approaching justice-involved individuals with OUD using a medical model of addiction may require a paradigm shift among professionals accustomed to "abstinence-only" approaches to substance use treatment. By incorporating multidisciplinary teams into MAT programs for justice-involved individuals, collaborative and informed decisions about the person's treatment can be made.

ONGOING TRAINING AND EDUCATION: It is essential for criminal justice staff and behavioral health providers delivering MAT in justice settings to receive on-going cross-trainings regarding various aspects of MAT, the criminal justice system, reducing medication diversion, and effectively providing MAT within the criminal justice setting. States are encouraged to support the adoption of a medical model of addiction and recovery across state and local behavioral health and justice system partners.

COMMUNITY PARTNERSHIPS

WORKING WITH COMMUNITY-BASED PROVIDERS – Criminal justice agencies may choose to provide MAT in-house or may partner with community-based providers to deliver the treatment to voluntary participants under criminal justice oversight. This component of MAT programming is essential for continuity of care as individuals transition in and out of the criminal justice system. Criminal justice programs that have relationships established with community-based MAT providers can help ensure continuity of care once individuals are no longer under criminal justice oversight. Community-based providers should be encouraged to develop the appropriate patient-provider relationships as they provide MAT services during or after the person's incarceration.

SPOTLIGHT: The Middlesex Sheriff's Office established the Medication-Assisted Treatment and Directed Opioid Recovery (MATADOR) program in 2015. The program is partnered with 35 community-based providers, that accept and continue MAT with individuals released from the jail. Peer recovery navigators are an essential element of the program, providing resources, advocacy, and support throughout the re-entry process. While the program educates participants on all of the MAT medications, currently it only provide extended-release injectable naltrexone, with plans to explore the inclusion of all MAT medications in the program. This would enable individuals who were previously started on MAT in the community to continue their treatment during their incarceration. In 2019, the Middlesex Jail and House of Correction will be one of five jails participating in a statewide pilot to provide MAT to individuals with OUD in county correctional facilities across Massachusetts.

DATA AND INFORMATION SHARING

PRACTICES AND PROCEDURES: Criminal justice agencies should have the capacity to store and share data and information regarding individuals involved in MAT with a variety of partners, including other criminal justice stakeholders, community-based social service providers, and community-based treatment providers. States should ensure that agencies that provide or link individuals to MAT are able to track and share information across state and local information systems. A State Medicaid Director letter issued in 2018 by the Centers for Medicare & Medicaid Services (CMS) provides guidance around the use of Medicaid supported technology (e.g., prescription drug monitoring programs, telehealth, electronic health records, etc.) to enhance information sharing and service delivery in addressing the opioid epidemic.

It is important that criminal justice agencies and community-based treatment providers adhere to HIPAA and 42 CFR Part 2 legislation when sharing information regarding individuals with OUD. However, states should review their own privacy laws to ensure that they are not overly restrictive and inhibit necessary and meaningful information sharing that can expedite and enhance an individual's involvement in treatment and services.

FUNDING FOR MAT PROGRAMMING

SUPPORTING CORRECTIONS-BASED MAT PROGRAMS: Local jurisdictions may need financial support to implement or sustain MAT programming for individuals in need of continuing or starting MAT during their incarceration. State block grants, federal dollars disbursed to the states for opioid-related needs, or other sources should be allocated for comprehensive MAT programming across state and local criminal justice systems. In some states, criminal justice agencies may participate in group purchasing organizations in order to negotiate more affordable rates for MAT medications on their formulary.

ENSURING CONTINUED TREATMENT IN THE COMMUNITY: Criminal justice agencies that provide MAT or oversee clients on MAT should ensure seamless continuity of care once the individual is back in the community or no longer under criminal justice supervision. Some criminal justice programs establish affiliations directly with community-based agencies or Federally Qualified Health Centers (FQHCs) to create a pathway for continued care. Some states are exploring the concept of opioid health homes and health homes designed for justice-involved individuals, where integrated primary care and substance use treatment may be delivered to individuals re-entering the community.

States that expanded Medicaid show higher rates of coverage among justice-involved populations, and thus, are better able to ensure that participants will be able to afford and continue MAT once in the community.[v] If not already provided in the state, Medicaid coverage and/or other sources of funding should be made available to cover re-entry support services, peer services, outreach services, and wrap around case management services for people with opioid use disorders.

As states consider financing strategies to respond to the opioid epidemic, some are experimenting with 1115 waivers to pilot innovative ways to more effectively use Medicaid funds to support individuals with OUD. For example, some states are piloting the use of Medicaid funds to cover substance use disorder case management for individuals with qualifying SUD/OUD diagnoses who are diverted from the criminal justice system into treatment. A State Medicaid Director letter issued in 2017 by CMS provides information on 1115(a) demonstrations to improve OUD treatment to Medicaid beneficiaries.

COMPONENTS OF MAT

SCREENING AND ASSESSMENTS: Criminal justice agencies should have policies and procedures in place to screen and assess individuals for opioid use disorders, and appropriateness for MAT.

APPROPRIATE MEDICATIONS: Criminal justice agencies should be encouraged to assess the capability of their staff and facility in planning to provide MAT. Consideration of making available all FDA-approved pharmacotherapy based on individual need is encouraged. SAMHSA can provide TA to help facilities in the planning process.

SPOTLIGHT: The state of Rhode Island is unique in that its unified correctional system has implemented a MAT program that offers all three of the approved MAT medications to individuals who are screened and placed on appropriate medication based on clinical criteria. Through screening, provision of appropriate MAT medication and comprehensive treatment, and linkage to community-based treatment upon release, the state has documented a decrease in overdose deaths by 60 percent. The MAT program, established by the Department of Corrections, provides seamless transition to community MAT upon release from incarceration.

MEDICATION ASSISTED TREATMENT APPROACHES: States and local jurisdictions should determine the parameters under which medication assisted treatment will be provided. For example, MAT could be considered as an ongoing therapy during sentences of 1 year or less. For those screened and found to have an active opioid use disorder but not currently receiving treatment, MAT initiation could be considered. For those with longer (> 1 year) sentences, medical withdrawal including comfort medications for specific withdrawal symptoms should be offered. MAT would then be considered prior to release according to protocols put in place at the facility.

THERAPEUTIC PROGRAMMING: Criminal justice agencies should be supported in providing therapeutic programming (such as relapse prevention counseling, cognitive-behavioral therapy, etc.) in addition to MAT medications, either through in-house services or by partnering with community-based agencies. States can support this by providing community-based agencies a way to bill for therapeutic services conducted with individuals during their incarceration; in a Medicaid-expansion state, many of these services will be reimbursable by Medicaid when delivered after the person's release.

COMPREHENSIVE RE-ENTRY SUPPORT

PRIOR TO RELEASE: Jail-based MAT programs should have comprehensive re-entry planning in place to ensure individuals are able to access affordable MAT and other health care treatments upon release. Services and supports are also critical to address recidivism risk factors, such as lack of stable housing, employment, meaningful daily activities, and supportive peers, as individuals with OUD return to the community.

POST RELEASE: Individuals with opioid use disorders are at high risk of overdose and other adverse outcomes following release from incarceration. It is important that state and local jurisdictions provide re-entry support in the days and months following transition back into the community.

BENEFITS AND HEALTH CARE COVERAGE SUPPORT

MEDICAID SUSPENSION VS. TERMINATION: States are not required to terminate or suspend Medicaid coverage during a person's incarceration; however, most states discontinue a person's enrollment during incarceration. If a person's coverage must be stopped, states are encouraged to suspend rather than terminate Medicaid coverage so that coverage may be more quickly reinstated for individuals with opioid use disorders upon release back into the community. However, even suspension is not working well in some states where reinstating coverage is a tedious and/or paper-based process; and, in practice, many people's coverage is actually terminated. It is important for states to develop mechanisms to efficiently suspend then re-activate an individuals' Medicaid coverage. This would significantly improve the continuity of care for individuals receiving MAT as they move between the justice system and the community.

ENROLLMENT/RE-ENROLLMENT SUPPORT: Local and state jurisdictions with the electronic infrastructure to submit a person's information and start or resume their Medicaid coverage can significantly reduce the time to effective coverage and receipt of community-

based health care services. Jail-based MAT programs should designate a staff member or partner with another criminal justice or community-based agency to ensure that MAT participants are signed up for health care coverage prior to release from jail. Allowing individuals to sign up for services prior to release may require a change in legislation or regulations in some states.

COVERAGE & FORMULARIES: Many state Medicaid agencies do not provide coverage for all three medications approved for MAT.[z] However, inclusion of these medications on Medicaid formularies is a significant predictor of their availability in the community[aa] and, correspondingly, in criminal justice settings. State Medicaid offices can take steps to ensure that all three medications approved for opioid use disorder treatment are included on the formulary for the purpose of treating opioid use disorder. States can also ensure that private insurance plans cover the three MAT medications. This will enable individuals in the community but under criminal justice oversight or those reentering the community from jail or prison to access the medication in a timely manner. Even if MAT is covered, reimbursement rates for some state Medicaid programs are not sufficient to fully cover the cost of MAT medications and/or services. This should be remedied as part of states' efforts to reduce OUD and justice involvement.

Parity continues to be an important consideration in public and private health plans. Despite the passage of the Mental Health Parity and Addiction Equity Act of 2008, the Essential Health Benefits of many states' health plans still do not cover substance use disorder treatments the same way that other chronic diseases are covered.[bb] This can reduce the availability of MAT to justice-involved individuals participating in pretrial services, drug court, and community corrections programs.

Private and public health plans should reimburse for evidence-based substance use screening and intervention practices, such as the Screening, Brief Intervention, and Referral to Treatment (SBIRT), which is emerging as a promising practice in the criminal justice setting. All health plans should also promote and reimburse for peer recovery services, which can be critical for individuals reentering the community after incarceration, as well as other program components necessary for effective MAT programming, such as urine drug testing.

UTILIZATION MANAGEMENT PROTOCOLS: Many state Medicaid agencies, as well as private insurance plans, currently limit the use of MAT through policies and procedures that complicate providers' abilities to prescribe MAT medications.[cc] These may include prior authorization requirements, fail first policies (i.e., requiring patients to fail on other types of medication or other forms of a medication [pill versus injection]), dosing/quantity restrictions, or time limits. These policies inhibit the availability of MAT medications and can be disruptive to the patient's recovery process. Medicaid, managed care organizations, and private insurance agencies can facilitate and support the uptake of MAT by ensuring that policies do not excessively burden providers, disrupt patients' treatment, or require patients to undergo multiple therapies before being placed on the preferred or most appropriate treatment.

Some states are implementing state-approved criteria for making decisions regarding an individual's level of care. This can provide consistency in care across the state and ensure that people seeking services, including those in the criminal justice system, are evaluated against evidence-based standards when determining the treatment to meet their needs.

BENEFITS LINKAGE: States can ensure that procedures are in place to facilitate the enrollment of potentially qualifying individuals in benefits such as Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). While drug addiction is not a qualifying condition for Social Security Administration disability benefits, an individual with medical or mental health conditions resulting from a drug addiction may apply for these benefits. SAMHSA's SSI/SSDI Outreach Access and Recovery (SOAR) Center works with criminal justice officials in states to maximize successful applications for these benefits, including those from individuals with opioids use disorders involved in the justice system.

CONTINUITY OF CARE

TRANSITION TO AND FROM COMMUNITY-BASED CARE: Jails should make arrangements to allow individuals who already receive MAT through a community-based provider to continue that

treatment during the time of incarceration. Policies should ensure that incarceration does not disrupt or reduce compliance with MAT. Jail-based MAT programs should link participants with community-based MAT providers, prior to release, through "in-reach" services, where the provider may establish a relationship and schedule a follow-up appointment for the individual to attend immediately after release.

RECOVERY AS A PROGRAM OUTCOME: The state may need to lead conversations to foster changes in how jail-based MAT programs view their purpose and outcomes. Thinking about recovery as an outcome of a jail-based program is a shift from traditional approaches and will require correctional staff to embrace non-punitive responses to failures in treatment compliance.

DATA-INFORMED IMPROVEMENTS

States can leverage the power of data to understand and explain the impact of the opioid epidemic on its residents. Some states have passed legislation to enable a comprehensive data analysis to inform their strategies to address opioid use. Linking these analyses with jail-based information and data can inform planning for implementing MAT in criminal justice settings.

Few criminal justice MAT programs track the outcomes of individuals who started MAT during incarceration as criminal justice oversight often ends once those people are back in the community. This has resulted in correctional facility-based programs that provide one or two doses of medication prior to release, with little to no follow-up after release. States should consider leveraging partnerships, appropriate contractual or funding requirements, and resources to support tracking of program outcomes and continuous quality improvement.

CULTURAL RESPONSIVITY

States should provide leadership in ensuring cultural responsivity within all criminal justice programming, including MAT programs. This should involve holding agencies to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and ensuring equitable outcomes across different racial and ethnic groups.

EXISTING STANDARDS/GUIDELINES

- Standards for Opioid Treatment Programs in Correctional Facilities. National Commission on Correctional Health Care, 2016, available at https://ncchc.org/opioid-treatment-programs-accreditation.
- American Society of Addiction Medicine (ASAM), National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, available at https://www.asam.org/resources/guidelines-and-consensus-documents/npg/complete-guideline.

ADDITIONAL RESOURCES

- Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field
- Standards for Opioid Treatment Programs in Correctional Facilities

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