

EVIDENCE-BASED RESOURCE GUIDE SERIES

Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings



SAMHSA
Substance Abuse and Mental Health
Services Administration

Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS28320170006511/HHSS28342001T with SAMHSA, U.S. Department of Health and Human Services (HHS). Thomas Clarke served as contracting officer representative.

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Recommended Citation

Substance Abuse and Mental Health Services Administration: Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings. HHS Publication No. PEP19-MATUSECJS Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2019.

Originating Office

National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, HHS Publication No. PEP19-MATUSECJS.

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Evidence-Based Resource Guide

Series Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), and specifically, the National Mental Health and Substance Use Policy Laboratory, is pleased to fulfill the charge of the 21st Century Cures Act and disseminate information on evidence-based practices and service delivery models to prevent substance misuse and help individuals with substance use disorders (SUD), serious mental illnesses (SMI), and serious emotional disturbances (SED) get the treatment and support that they need.

Treatment and recovery of individuals with opioid use disorder (OUD) can vary. These individuals may have co-occurring disorders, live in diverse parts of the country, and face a variety of socio-economic factors that help or hinder their treatment. All these factors bring complexities to evaluating the effectiveness of services, treatments, and supports.

Despite variations, *substantial evidence is available* to understand the types of services, treatments, and supports that reduce substance use, lessen mental health symptoms, and improve individuals' quality of life. Communities are eager to take advantage of what has been learned to help individuals in need.

The Evidence-Based Resource Guide Series is a comprehensive and modular set of resources intended to support health care providers, health care system administrators, and community members to meet the

needs of individuals at risk for, experiencing, or recovering from substance use and mental health disorders.

An important area of concern for SAMHSA is promoting policies and practices to lower the risk of overdose for persons with OUD who are or have been in contact with criminal justice systems. This guide will review literature and science, examine emerging and best practices, determine key components of peer-reviewed models that affect policies and programs, and identify challenges and gaps in implementation.

Each guide in the series was developed through input from an expert panel made up of federal, state, and non-governmental participants. The expert panel for this Guide included accomplished scientists; practitioners and administrators from jails, prisons, and drug courts; law enforcement; community providers; and representatives from national corrections and OUD associations and organizations. They provided invaluable input based on their knowledge of criminal justice systems, evidence-based treatments and practices, and relevant experiences.

Identifying challenges and implementation strategies enhances organization and stakeholder readiness to change and encourages adoption of best practices, thus improving the care of individuals with OUD in criminal justice settings.

Content of the Guide

Each guide contains a foreword and five chapters. The chapters are modular and do not need to be read in chronological order. The chapters are short and accessible to individuals such as health care providers, law enforcement, court personnel, jail and prison administrators, state and community corrections personnel, and community members who are working to meet the needs of individuals at risk for, experiencing, or recovering from substance use disorders.

FW Evidence-Based Resource Guide Series Overview

Introduction to the series.

1 Issue Brief

Overview of what is happening in the field. This chapter covers challenges to implementing MAT programs. It provides descriptions of approaches being used in the field.

2 What Research Tells Us

Current evidence on effectiveness of programs and practices to address use of MAT in criminal justice settings.

3 Examples of Medication-Assisted Treatment Programs in Criminal Justice Settings

Descriptions of programs that use MAT in criminal justice settings.

4 Addressing Challenges to Implementing Evidence-Based Practices and Programs in Criminal Justice Settings

Practical information to consider when selecting and implementing programs and practices to address use of MAT in criminal justice settings.

5 Resources to Support Effective Use of Medication-Assisted Treatment in Criminal Justice Settings

Guidance and resources for implementing evidence-based programs and practices, monitoring outcomes, and improving quality.

Focus of the Guide

Following incarceration, individuals with OUD enter back into the environment where their substance use originated. Unfortunately, this puts the individual at high risk for relapse. Further, their tolerance for opioids is reduced while incarcerated. This puts the individual at high risk for overdose.

This guide focuses on policies and practices that can be implemented to intervene during an individual's time in the correctional system and upon release that moderate and mitigate the risk of overdose for persons with OUD after release.

One Piece of a Multipronged Approach

Research shows that implementing evidence-based practices requires a multipronged approach. This guide is one piece of an overall approach to implement and sustain change. Users are encouraged to review the [SAMHSA website](#) for additional tools and technical assistance opportunities.

ISSUE BRIEF

Use of Medication-Assisted Treatment in Criminal Justice Settings

“For people with OUD involved with the criminal justice system, a lack of access to medication-based treatment leads to a greater risk of returning to use and overdose after they are released from incarceration.”

— *Medications for Opioid Use Disorders Save Lives*,
The National Academies of Sciences,
Engineering, and Medicine (2019, p. 99)

In 2017, the opioid crisis was declared a national public health emergency. At the time, over 2.1 million people in the United States suffered from an opioid use disorder (OUD)¹, and two out of three drug overdose deaths involved opioids.² Overdose deaths from opioids, including prescription opioids, heroin, and synthetic opioids like fentanyl, increased nearly six-fold since 1999.³

The criminal justice system has felt the impact of this epidemic.^{4,5} Based on the 2015-2016 National Survey on Drug Use and Health (NSDUH), the odds of being arrested and becoming involved in the criminal justice system increase greatly for persons using opioids, from approximately 16 percent for those with no past-year opioid use to 52 percent for those suffering from a prescription OUD and 77 percent for those using heroin.⁶

Twenty-four to thirty-six percent of individuals with a heroin use disorder (over 200,000 individuals) pass through American correctional facilities annually, and an estimated 17 percent of state prison inmates and 19 percent of jail inmates report regularly using opioids.⁷⁻⁹ Roughly 30 to 45 percent of inmates report suffering from serious withdrawal symptoms or an inability to control their use, indicative of severe symptoms of drug dependence.⁹

These prevalence estimates cannot be attributed merely to drug possession offenses. Nearly 15 percent of state prisoners and jail inmates convicted of violent crimes and 40 percent of those convicted of property crimes reported committing their offense to support a drug addiction.⁹ Approximately 7 percent of state prison and jail inmates were intoxicated on opioids at the time of their offense.⁹

The impact of opioid use on individuals transitioning from jail or prison back to the community is overwhelmingly negative. Outcomes include higher rates of returning to the criminal justice system, harm to families, negative public health effects such as the transmission of infectious diseases, and death. Within 3 months of release from custody, 75 percent of formerly incarcerated individuals with an OUD relapse to opioid use,^{10,11} and approximately 40 to 50 percent are arrested for a new crime within the first year.^{10,12}

Drug overdose is a leading cause of death among formerly incarcerated individuals.^{13,14} Prisoners and jail inmates released to the community are between 10 and 40 times more likely to die of an opioid overdose than the general population, especially within the first few weeks after reentering society.¹³⁻²³ Approximately 17 percent of persons living with HIV or AIDS (approximately 155,000 people) passed through U.S. correctional facilities in 2006 alone.²⁴

Key Definitions

Medication-Assisted Treatment*

Medication-assisted treatment (MAT) is the use of Food and Drug Administration (FDA)-approved medication for the treatment of a specific substance use disorder in combination with clinically indicated behavioral or cognitive-behavioral counseling and other indicated services. Currently, medications are available to treat tobacco, alcohol, and OUD, and research is underway to identify effective medications for other substances as well.

This Guide focuses on MAT for OUDs.

The term “medication-assisted treatment” in no way suggests medications are less important or less effective than behavioral interventions for treating OUDs. In the early stages of treatment, when persons are clinically unstable and experiencing withdrawal symptoms or drug cravings, evidence suggests medication alone may be adequate to enhance treatment retention and initiate abstinence from illicit opioids.⁴⁵⁻⁴⁷ No justification exists, therefore, for denying access to MAT because psychosocial services are unavailable or individuals are unwilling to avail themselves of those services. Over time, however, combining medication with psychosocial counseling appears to produce greater and more sustained improvements on important “secondary” or distal outcomes, such as reductions in crime and health risk behaviors.⁴⁸⁻⁵¹ Therefore, combining medication with psychosocial counseling is the recommended best practice for treating OUDs.

Criminal Justice

Criminal justice is a process typically beginning with an initial encounter with law enforcement and potentially ending with the release of a convicted individual from correctional supervision. The criminal justice system includes all public entities and government-contracted service providers involved in the criminal justice process, including police, judges, prosecutors, defense attorneys, jail and prison staff, probation and parole officers, and contracted service providers such as substance use counselors or mental health practitioners.

Probation

A criminal sentence enabling an individual to be supervised in the community rather than being incarcerated in jail or prison.

Parole

A conditional release from jail or prison allowing an inmate to serve the remainder of his or her sentence under community supervision.

Prison

A correctional institution run by a state or federal government agency or government-contracted provider that typically houses individuals serving sentences of longer than one year.

Jail

A correctional institution run by a county or state government that houses individuals being held in pretrial detention or sentenced to less than one year.

Treatment Court

A special court docket or calendar serving persons charged with crimes caused or influenced by a mental health or substance use disorder or other serious social service needs. Participants may enter the program as a condition of pretrial supervision, probation, or parole, and successful completion of treatment typically leads to the criminal charge(s) being dropped or a reduced sentence. Common examples include drug courts, mental health courts, and veterans’ treatment courts.

Medically Supported Withdrawal (Medical Detoxification)

Medically supported withdrawal is a medical procedure designed to alleviate acute physiological effects of opioids or other substances while minimizing withdrawal discomfort, cravings, and other symptoms. Individuals may be administered methadone or buprenorphine in steadily decreasing doses over roughly 1 to 3 weeks. Other medications, such as clonidine, trazodone, or ibuprofen may also be prescribed for associated symptoms of autonomic hyperarousal (e.g., anxiety, heart palpitations), insomnia, or pain, respectively. Relapse rates are extremely high after medically supported withdrawal alone; therefore, medically supported withdrawal should always be followed by a formal course of substance use treatment.^{47, 52, 53}

Maintenance Treatment

Maintenance treatment refers to one type of MAT in which people are treated with methadone or buprenorphine for several months, for years, or indefinitely. Individuals are administered gradually increasing doses of the medication until they lack withdrawal symptoms and cravings without experiencing intoxication or sedation. Properly treated individuals can engage safely and effectively in employment, childcare, and other daily living activities. According to the U.S. Surgeon General, successful maintenance regimens typically last for at least 3 years.⁵²

**It is important to note that the terminology used in reference to this approach to treatment has been evolving over time. For example, the [National Academies of Sciences, Engineering and Medicine report](#) uses the term “medication-based treatment.” For the purposes of this document, the term “medication-assisted treatment” is used throughout.*

Medication-assisted treatment (MAT) has been carefully studied and shown to be effective in treating OUDs.^{25, 26, 53} As is discussed in the next chapter, numerous studies support the use of MAT for effectively addressing OUDs and its negative consequences among criminal justice involved persons.²⁷⁻³⁰

Yet, despite the overwhelming evidence of effectiveness, few jails or prisons offer this treatment.^{9, 25, 31} A national study in 2009 found that 86 percent of state and federal prisons in the U.S. failed to provide buprenorphine, and 45 percent failed to provide methadone.³² Of those that did provide methadone or buprenorphine, more than half offered it exclusively for pregnant women or for chronic pain management.^{5, 32} From 2007 to 2009, less than 1 percent of state prison and jail inmates with moderate to severe substance use disorders received any medically supported withdrawal or maintenance services while in custody.⁹

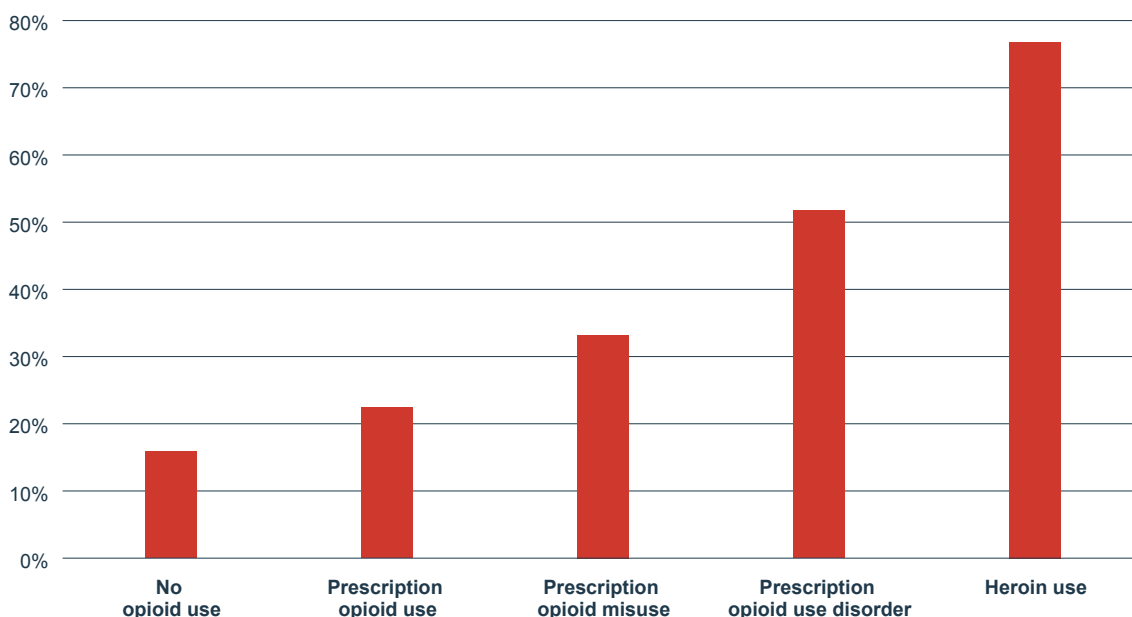
Research conducted more recently in 2018 by the Pew Charitable Trusts determined that only 14 states or territories in the U.S. (27 percent of jurisdictions) offered methadone or buprenorphine maintenance in any of their jail or prison facilities, 39 (76 percent) offered

injectable naltrexone as a preventative measure prior to release, and only one state (Rhode Island) offered all three FDA-approved medications for OUDs.³³ Studies have similarly reported gross underutilization of MAT in community corrections programs, such as probation, parole, and treatment courts,³⁴⁻³⁶ as well as non-criminal justice treatment programs.³⁷⁻⁴⁰ Several studies found that only about 2 to 10 percent of persons with OUDs on probation or parole received MAT.⁴¹⁻⁴⁴

Efforts are rarely made to ensure that returning jail or prison inmates have access to this evidence-based treatment when they transition back into the community.^{41,44} Less than half of state and federal prisons in 2009 referred inmates for methadone maintenance after release, and less than one-third provided referrals for buprenorphine.³²

This Guide focuses on the use of MAT in jails, prisons, and the reentry process, when justice-involved individuals return to the community. Reentry may occur through the parole system or other mechanisms for releasing individuals from custody with ongoing conditions for supervision and treatment.

Criminal Justice Involvement Among Adults in the United States with Varying Levels of Opioid Use, 2015-2016



Source: Winkelman et al. (2018). All pairwise comparisons significant at $p < .05$.

The Opioid Epidemic

Historians have tied the opioid epidemic in the U.S. to three primary causes:

- 1** A significant rise in opioid analgesic prescriptions that began in the 1990s, and subsequent increase in demand due to widespread diversion, misuse, and addiction.
- 2** A lack of healthcare provider capacity to provide individuals with high quality, evidence-based opioid use treatment.⁵⁴
- 3** A significant increase in the potency of illicit opioids, including infiltration of fentanyl and other potent synthetic compounds into heroin.

Wave 1

1999

Prescription opioid overdose deaths began to rise as a result of over-prescribing in the 1990's.

Wave 2

2010

A rapid increase in overdose deaths involving heroin began. Deaths from prescription opioids reached a new peak.

Wave 3

2013

Illicitly-manufactured fentanyl and other synthetic opioids led to another significant rise in overdose deaths.

Source: Centers for Disease Control and Prevention. (2018). Understanding the epidemic. <https://www.cdc.gov/drugoverdose/epidemic/index.html>

Medications Used in Medication-Assisted Treatment

Three generic medications have been approved by the U.S. FDA to treat OUDs: methadone, buprenorphine, and naltrexone.⁵³

Methadone

Methadone is a full agonist medication that binds preferentially to mu opioid receptors in the brain, thus substantially blocking the effects of illicit opioids like heroin.⁵⁵ It reduces withdrawal symptoms and cravings for opioids by stimulating the receptors, but the effects are gradual and slow acting and elicit rapid tolerance to intoxication. Delivered in the proper dosage to a person who is physiologically tolerant to opioids, there is no experience of intoxication, euphoria or sedation, and most people can perform daily tasks safely and effectively, including childcare, many types of employment, and other nonhazardous activities.

Because methadone is an opioid, it causes physiological dependence, can be intoxicating in nontolerant individuals, and can cause serious side effects including respiratory suppression. Most serious side effects will occur, if at all, within the first 2 weeks of methadone treatment, after which the risk of overdose is significantly lower than for untreated individuals.⁴⁷

When used to treat OUDs, methadone must be prescribed and dispensed from a federally regulated opioid treatment program (OTP); however, individuals may receive limited take-home doses after meeting specified requirements for treatment attendance, clinical stability, and drug abstinence. Methadone is typically dispensed in liquid form mixed with juice but is also available as a pill.

Naltrexone

Naltrexone is a full antagonist medication that binds preferentially to opioid receptors in the brain but does not stimulate those receptors. As such, it does not cause physiological dependence, intoxication, or serious side effects such as respiratory suppression.⁵⁶

Naltrexone in pill form is commonly marketed under the brand names Revia or Depade. An extended-release injectable version, Vivitrol, is FDA-approved for treating opioid and alcohol use disorders, and the effects last for approximately 28 days. It is also available as a subdermal (under the skin) implant; however, the implant is not FDA-approved in the United States.

Naltrexone does not alleviate withdrawal symptoms; in fact, administration of naltrexone will precipitate withdrawal in persons who are not already detoxified from opioids. Although the oral formulation has no proven effects for reducing opioid cravings, Vivitrol was reported to reduce cravings in randomized trials conducted outside of the criminal justice system.⁵⁷⁻⁵⁹ Naltrexone does not require special licensure or certification to administer and may be prescribed or dispensed by any licensed medical practitioner or pharmacist.

Buprenorphine

Buprenorphine is referred to as a partial agonist or mixed agonist-antagonist because it partially stimulates opioid receptors in the brain while also producing some blockade effects.⁶⁰ It effectively treats withdrawal symptoms and cravings but is less likely than methadone to cause intoxication or dangerous side effects such as respiratory suppression. Buprenorphine is an opioid that elicits physiological dependence and can be intoxicating in nontolerant individuals.

Buprenorphine is marketed under the brand names Subutex, Suboxone, Zubsolv, Bunavail, Butrans, Buprenex, Probuphine, or Sublocade. It is commonly administered as a pill or buccal film that must be dissolved sublingually (under the tongue) or attached to the cheek. It may be combined with another medication, naloxone, which is pharmacologically comparable to naltrexone but far shorter acting. If a person tries to inject the medication to experience an intoxicating effect, the naloxone will be released and precipitate withdrawal. This combination has been proven to significantly reduce the likelihood of inappropriate usage.⁴⁷ Buprenorphine is also available as a monthly injection or subdermal implant that lasts for approximately 6 months, and the effects appear to be comparable or superior to the oral formulations.^{61, 62}

Buprenorphine may be prescribed and dispensed outside of a licensed OTP by physicians or other qualified medical practitioners (nurse practitioners, physician assistants) who have completed a requisite training course and received accreditation referred to as a DATA-2000 Waiver.

Overdose Reversal

The FDA has approved another medication, naloxone (Narcan), to reverse opioid overdoses and prevent overdose death.⁶³ Naloxone is pharmacologically comparable to naltrexone; however, its effects are far shorter-lasting. It begins to work within 2 to 5 minutes and lasts for approximately 30 to 60 minutes. For some people, multiple doses may be required because the duration of action is so much shorter than that of opioids. The short duration of action makes it unsuitable as a treatment option for addiction, but it can have lifesaving effects in medical emergencies.

Naloxone may be delivered via injection by trained professionals or intranasally by nonmedically trained laypersons. Studies confirm that educating at-risk persons, their significant others, and other first responders about naloxone and other overdose countermeasures significantly reduces overdose deaths.^{64, 65} Virtually all states shield professional first responders from criminal or civil liability if they administer naloxone or render comparable medical aid in the event of a drug overdose, and many shield nonprofessional Good Samaritans as well.⁶⁶ Implementing naloxone access laws and protections for Good Samaritans has been associated with a 15 percent decrease in overdose mortality rates.⁶⁷

Economic Costs

The Council of Economic Advisors to the White House estimated that the economic cost of the opioid crisis is \$504.0 billion.⁶⁸

The average annual cost per person of incarceration in U.S. prisons dwarfs the per-person cost of methadone maintenance treatment—approximately \$24,000 versus \$4,700 annually per person.⁶⁹

Availability of Medication-Assisted Treatment within the Criminal Justice System

Despite the substantial evidence supporting MAT for the treatment of OUDs, few jails or prisons offer this treatment. Moreover, upon release or diversion from the criminal justice system, most individuals with severe OUDs are not connected with MAT services in the community.

In Jails and Prisons



30 out of **5,100**

prisons and jails in the U.S. offered methadone or buprenorphine in 2017.⁷⁰



14

states offered methadone or buprenorphine maintenance for jail or prison inmates in 2018.³³

In Drug Courts



80%

In a 2018 study, participants with OUDs were 80% less likely to graduate from drug court.⁷¹



50%

Approximately 50% of drug courts required participants to discontinue methadone or buprenorphine within 30 days in a 2017 study.⁷²



50%

< 50% of drug court participants with OUDs received MAT in a 2018 study.⁷³

Upon Reentry or Community Corrections



45%

of state and federal prisons in the U.S. referred inmates for methadone maintenance after release in 2009.³²



29%

of state and federal prisons in the U.S. provided referrals for community buprenorphine providers in 2009.³²



Without MAT, there was a
10-40x higher
RISK OF DEATH

from overdose within two weeks of release from prison in a 2018 study.²³

<5%



of persons with OUDs referred to treatment in 2014 by probation, parole or court authorities received methadone or buprenorphine compared to 41% referred by non-criminal justice sources.⁷⁴



Methadone

Buprenorphine

Naltrexone

Extended-release Naltrexone (Vivitrol)

How it's taken	Tablet or liquid	Tablet, film, or extended-release injection or implant	Tablet	Injection, usually in the buttocks
What it does	Relieves withdrawal symptoms and cravings by stimulating opioid receptors in the brain. Methadone binds preferentially to <i>mu</i> opioid receptors and may reduce the effects of other illicit opioids such as heroin. Delivered in the right dose to a person tolerant to opioids, it does not cause intoxication, euphoria, or sedation, and most people can perform most daily tasks. Because methadone is an opioid, it is addictive and can cause serious side effects including respiratory depression and death. Because it can cause intoxication in nontolerant individuals, it may also be sold or traded illegally.	Like methadone, buprenorphine relieves withdrawal symptoms and cravings by stimulating <i>mu</i> opioid receptors in the brain. It, too, binds preferentially to these receptors, and may diminish the effects of illicit opioids. It is referred to as a <i>mu</i> opioid partial-agonist because it exhibits a ceiling effect such that dangerous side effects of full <i>mu</i> opioid agonists, for example methadone, such as respiratory depression do not occur.	If a person taking naltrexone uses opioids, naltrexone blocks the euphoric and sedative effects of the drug. Naltrexone binds preferentially to opioid receptors in the brain but does not stimulate the receptors. It is not an opioid and is neither intoxicating nor addictive. It does not have demonstrated effects on withdrawal symptoms or cravings.	Binds preferentially to opioid receptors in the brain but does not stimulate the receptors. The effects last for approximately 28 days. It is not an opioid and is neither intoxicating nor addictive. Although oral naltrexone has no proven effects for reducing opioid cravings, the injectable extended-release version has been shown to reduce cravings significantly.
Who can prescribe or administer it	When used to treat substance use disorders, methadone may only be administered by qualified medical providers in certified OTPs. Prisons and jails can become certified OTPs or contract with community- based OTPs.	Qualified providers who meet all requirements as defined by the United States Code, Code of Federal Regulations, and other relevant legislation.*	Physicians, nurses, physician assistants, or pharmacists.	Physicians, nurses, physician assistants, or pharmacists.

*As defined in [21 U.S.C. § 823\(g\)](#), as amended by the Drug Addiction Treatment Act of 2000., nurse practitioners, or physician assistants who satisfy the definition of a “qualifying other practitioner” under [21 U.S.C. § 823\(g\)\(2\)\(G\)\(iv\)](#), as amended by the Comprehensive Addiction and Recovery Act of 2016 and who have completed an 8 to 24-hour training course and received a waiver pursuant to the Drug Addiction Treatment Act of 2000 (DATA-2000) and Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, or Certified Nurse Midwife who satisfy the definition of a “qualifying other practitioner” under [21 U.S.C. § 823\(g\)\(2\)\(G\)\(iv\)](#), as amended by the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018, until October 1, 2023. Implementation of this provision of the SUPPORT for Patients and Communities Act is in process. For more information, please go to SAMHSA’s website.

Why Is It So Difficult to Incorporate Medication-Assisted Treatment into the Criminal Justice System?

Despite the overwhelming evidence in support of MAT, as discussed in the next chapter, there are various reasons it is underutilized within the criminal justice system.^{25, 31, 35, 36, 38, 39, 44, 47, 52, 70, 73, 75} Understanding these challenges is essential for overcoming the barriers.

1 **Misunderstanding or Lack of Information**

Some of the reluctance of criminal justice leadership to adopt MAT comes from a misunderstanding of MAT and the mechanisms by which the medications work. Some officials and practitioners view these medications as replacing one addictive drug for another.⁷⁵ Others believe that forced withdrawal from opioids is part of living “a clean lifestyle.”^{32, 44}

2 **Current Policies Do Not Support MAT**

Some jails and prisons have policies that prohibit the use of controlled substances (including the medications used in MAT).⁷ Some drug courts may require detoxification from methadone or buprenorphine treatment as a condition of participation.⁷

3 **No Trained Providers**

Some jails and prisons do not have the capacity to treat substance use disorders in their facilities.⁷⁶ Individuals already on MAT may be forced to disrupt treatment upon incarceration, leading to physiological and psychological problems.⁷ Some jails and prisons will arrange for a community-based provider to provide MAT. However, many facilities do not have trained medical personnel available.^{31, 77, 78}

4 **Medically Supported Withdrawal Services Available, but No Maintenance Therapy**

Some criminal justice facilities will offer short-term MAT to detoxify individuals from opioids. However, when only medically supported withdrawal is provided to incarcerated individuals, rates of post-release overdose and

death are high.⁷ Jails and prisons may only provide methadone maintenance therapy if they are registered with the U.S. Drug Enforcement Agency as an OTP.⁷⁹ SAMHSA and state opioid treatment authorities may also certify jails and prisons as OTPs.

Many correctional facilities do not have the personnel, capacity, or desire to register as an OTP.⁷ Jails and prisons may also make methadone accessible to inmates without having to become certified as OTPs through agreements with community-based OTPs. This would allow methadone to be securely transported to a facility from an OTP or enable inmates to be transported to a community-based OTP for dosing. More information about these options can be found in the Federal Guidelines for Opioid Treatment Programs.

5 **Concerns About Security and Liability**

Concerns about security and the risk of diversion cause some jails and drug courts to either limit or deny access to buprenorphine or methadone.^{7, 32, 35, 44} Diversion, misuse, and potential overdose are also liability concerns for some courts.⁴⁴ As discussed in Chapter 4, these concerns can be addressed safely and effectively in most programs.

6 **Costs of MAT**

Buprenorphine or methadone may not be offered in prisons and drug courts because of cost concerns and insufficient funding.^{35, 44} Strategies for obtaining funding are described in Chapter 4.

Promising Programs and Practices That Support the Use of Medication-Assisted Treatment

There are several promising practices that have been used within criminal justice settings and during transition into the community that can facilitate successful outcomes.

Partner with Community Providers

Correctional facilities can develop partnerships with registered opioid treatment programs and other providers of MAT. Incorporating jails and prisons into a system of care allows incarcerated individuals to continue MAT upon incarceration and/or to connect with MAT services once they reenter the community.

Support Police Officer-led Diversion Programs

Some police departments have engaged in training their officers to identify and divert non-violent opioid dependent individuals into MAT programs. One such program is the Law Enforcement Assisted Diversion (LEAD) Program in Seattle, Washington.⁸²

Embed MAT Within Drug Court Programs

Many drug courts do not recommend (or even allow) the use of MAT for opioid dependence.⁸⁰ Approximately half of drug courts surveyed in one study offered any form of MAT to participants.³⁵

Change Organizational Policies to Reflect the Science

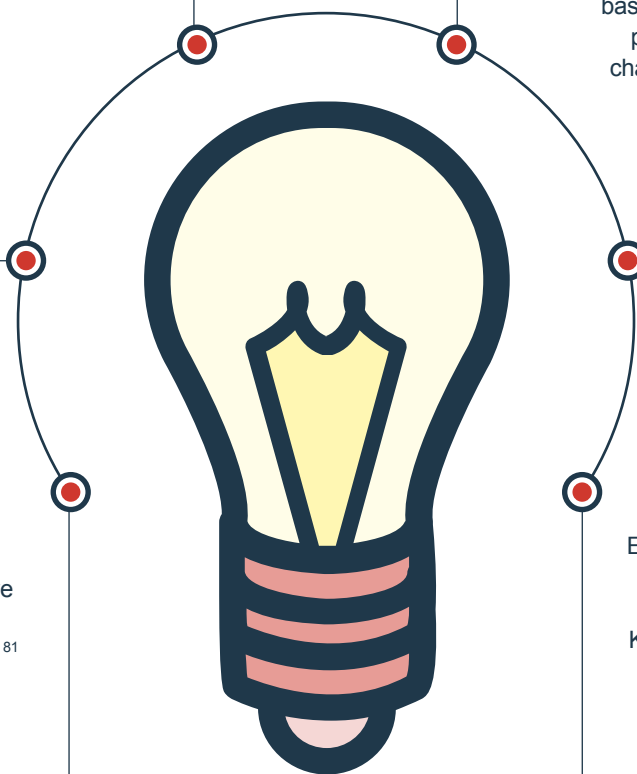
Based on the overwhelming evidence base for MAT, many jails, prisons, parole, probation, and diversion programs are changing policies that prohibit the use of MAT medications. A growing number of states have enacted legislation authorizing or requiring expansion of MAT in the criminal justice system.⁸³

Ensure Linkages to Treatment

According to a 2009 publication, only 45 percent of criminal justice facilities provided any community linkages to methadone treatment clinics.³² Treatment with MAT and brief drug counseling integrated into the probation and parole system have shown positive results in terms of opioid use and re-arrest rates.^{28, 30, 43, 81}

Register as a MAT Provider

Some jails and prisons have registered to become an opioid treatment program or have medical staff obtain buprenorphine waivers. For example, the Key Extended Entry Program (KEEP) is a methadone treatment program initiated in 1987 for incarcerated individuals. KEEP participants receive MAT behind bars, and when returning into the community, they are discharged to outpatient KEEP programs.⁸⁴



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