Medication for Opioid Use Disorder (MOUD):

Correctional Health Implementation Toolkit

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We at the NYSDOH AI, OASAS and DOCCS would like to commend all stakeholders that have worked to promote the utilization of evidence-based medications for this particularly vulnerable population. We hope this toolkit will provide readers with useful information to learn and work towards improving the outcomes for individuals and communities affected by the opioid epidemic.

Table of Contents

Introduction

Opioid use disorder (OUD) is highly prevalent among justice-involved individuals. Detainment in correctional settings can pose treatment challenges for individuals with OUD. Those who are receiving medications for opioid use disorder (MOUD), also known as medication for addiction treatment (MAT), prior to incarceration may be forced to discontinue such treatment, and those with untreated OUD are often not offered evidence-based and lifesaving treatment upon entering jail.

In New York State (NYS), through continued collaboration, state partners have worked diligently to improve access to all three forms of MOUD within the correctional health system. Specifically, the NYSDOH AI's ODUH has continued to augment these efforts by increasing the practice of low-barrier buprenorphine provision. This is a new and growing model of care for OUD that seeks to reduce opioid overdose deaths and improve health and quality of life for all people with OUD. "Low-threshold treatment" is a term used to describe an alternative approach that attempts to remove as many barriers to treatment as possible. This toolkit provides a framework derived from a low-threshold ideology and guided by the following principles: same-day treatment entry; harm reduction (HR) approach; program flexibility; and increased accessibility for individuals with OUD.

NYS Legislation

On October 7, 2021, S1795/A.533 was signed into law. This law mandates the establishment of a program offering all forms of MOUD in correctional facilities in NYS. Such programs shall also include conditions for a reentry strategy for inmates who have participated in MOUD programming. Reentry planning and community supervision should include a collaborative relationship between clinical and parole staff, including sharing of accurate information regarding the inmate's participation in MOUD treatment, and a bridge prescription provided for those transitioning into the community.

Purpose and Audience

The purpose of this toolkit is to serve as a guide to assist with designing, developing, and implementing a program that would allow MOUD inside the tightly controlled correctional setting. It highlights the multiple components necessary to ensure quality services are provided to individuals with OUD. Many correctional facilities in NYS have expanded their MOUD programs, including Albany, Monroe, Niagara, Ontario, Saratoga, Seneca, and Tompkins counties. This document details examples and lessons learned from recent MOUD expansion efforts in Albany County Correctional and Rehabilitative Services facility (ACCRS) in Albany, NY. The experience of ACCRS has served as a model for other facilities' MOUD expansion efforts, and has been featured by the US Department of Justice Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program (BJA COSSAP).[i]

Although we cannot fully quantify the outcomes (both positive and negative) of the newly implemented programs in the state of NY, similar programs are showing positive results in other states. The goal is to provide a standard of care that will improve the health of those who face the greatest barriers to achieving optimal health, as well as have an impact on the opioid epidemic. Reducing the risk of overdose and death in this, the highest risk group, will ensure they have the opportunity to lead healthy and productive lives upon reentry to the community.

The content in this toolkit is designed to resonate with all levels of personnel that work within these facilities (i.e., sheriffs, jail administrators, medical staff, mental health providers, correctional officers, discharge planners, peer supports, social workers, and other support staff).

How To Use This Toolkit

This toolkit is organized by core key elements essential in developing and implementing an MOUD corrections-based program. Each element has its own section to provide a guiding framework for the toolkit. Each section includes:

- Key Considerations
- Comprehensive descriptions
- Checklists
- Resources
- Lessons, highlights, and examples from the field where applicable

These key elements were derived from the experience of various MOUD expansion efforts in multiple correctional facilities throughout NYS, and from the feedback of SMEs. These elements are critical for the successful implementation of MOUD programs in jails and provide a guiding framework for the toolkit. The key elements do not need to be followed in the order they are presented; however, it is recommended to begin with ***Key Element 1: Understanding the Resources in the Community and Correctional Facility***.

The Appendix contains protocols and tools that are provided as "real world" examples providers may adopt wholesale or tailor to their individual circumstances.

While it is recognized that county facilities differ from one another, particularly with regard to resources, this toolkit provides examples from the field of innovative models of care to help guide newer facilities toward integrating MOUD using a "phased-in" approach; this approach allows for a greater level of consistency in MOUD provision than would otherwise be possible.

Background/Rationale

Overall, drug overdose deaths in the United States (U.S.) rose from 2019 to 2020 with 91,799 drug overdose deaths reported in 2020, the highest number of overdose deaths ever recorded in a 12-month period, according to data from the Centers for Disease Control and Prevention (CDC). Deaths involving synthetic opioids other than methadone (primarily fentanyl) continued to rise with 56,516 overdose deaths reported in 2020. New York State, similar to the rest of the country, has seen a rise in overdose deaths during the COVID-19 pandemic. From 2018 to 2020, New York State had a 35.3 percent increase in overdose deaths.[ii]

As the prevalence of OUD continues to rise in NY and the U.S., there is a corresponding increase of those diagnosed with OUD entering the criminal justice system. According to data from the U.S. Department of Justice (DOJ), approximately half of state and federal prisoners meet criteria for having substance use disorder (SUD),[iii] including OUD. Even with this population representing a large portion of the incarcerated census, most correctional facilities do not continue or initiate MOUD,[iv] which clinical research supports as the standard of care for individuals with OUD despite high rates of opioid overdose immediately after release from incarceration.[v]

Current approaches to OUD treatment during incarceration have been unable to reduce the high rates of recidivism and reincarceration. In order to "break the cycle" of incarceration, release, relapse and recidivism, and most importantly to save lives, better collaboration between correctional facilities and community treatment providers is necessary. MOUD has shown that it is an effective intervention in breaking the cycle.[vi]

Reducing the number of people with substance use and mental health (MH) disorders in local jails and state prisons depends on further developing community capacity to treat these conditions. Until that capacity is fully developed, correctional facilities will continue to remain a vital intercept for treating people with these chronic illnesses. Correctional health care equals community health care because most people passing through the criminal justice system will ultimately return to their community. Recently, corrections-based MOUD programs have expanded and are providing evidence and experience regarding what works and what does not. Innovative models of care can help guide newer facilities toward integrating MOUD.

The NYSDOH AI's ODUH and NYS OASAS commend the various correctional facilities for programs that properly serve individuals with OUD entering their facility. The state also recognizes their effort to coordinate robust transitional services. It is important to note that these efforts exemplify the state's overarching goal to help those with OUD rehabilitate while they are in custody and aid reintegration into their communities.

Medications to Treat OUD

What is OUD?

OUD is a chronic condition characterized by compulsive opioid use, craving, ongoing use despite negative consequences, and loss of control. Studies show that individuals with OUD who follow detoxification with complete abstinence are likely to relapse or return to using at a time that is very high risk as mentioned previously.[vii] While relapse is a normal step over the course of someone's recovery, for this population it can be alarmingly life threatening. MOUDs reduce craving, increase engagement in treatment, and reduce the chances of opioid overdose. Thus, OUD treatment should focus on engagement, improving well-being, and reducing harms associated with illicit opioid use – there are no "quick fixes."

FDA-Approved MOUD:

There are three FDA-approved medications used to treat OUD:

Methadone	Buprenorphine	Naltrexone

Methadone (Full Agonist): Methadone is a synthetic opioid agonist that acts on opioid receptors in the brain—the same receptors that other opioids such as heroin, morphine, and opioid pain medications activate. Methadone occupies these opioid receptors which helps opioid-dependent persons by reducing opioid craving and preventing withdrawal without producing euphoria. The liquid formulation has been used successfully for more than 40 years to treat OUD and must be dispensed through a specialized opioid treatment program.[viii] Ingestion is done under direct visual observation.

Buprenorphine (Partial Agonist): Buprenorphine is a partial opioid agonist, meaning that it binds tightly to the above mentioned opioid receptors; however, buprenorphine activates the receptors less than full agonists do. Like methadone, it can reduce cravings and withdrawal symptoms in a person with OUD without producing euphoria. Research has found buprenorphine to be similarly effective as methadone for treating OUD, as long as it is given at a sufficient dose and for sufficient duration.[ix] Due to the medication binding tightly to opioid receptors, additional protection and the risk of overdose is much lower than with full opioid agonists. Initiation of buprenorphine is done when the person is in **mild-moderate** opioid withdrawal – can use Clinical Opiate Withdrawal Scale (COWS) or simplified checklist. This often occurs within a day after last use of a short-acting opioid such as heroin. Ingestion is done under direct visual observation.

Sublocade, approved for use in 2017, is a brand (trade) name for an extended release **buprenorphine subcutaneous (SC) injection formulation**. As it is a long-acting formulation, it only needs to be administered by a health care provider once a month, with a minimum of 26 days between doses. It is administered subcutaneously (shallowly under the skin) into the abdomen. It is a depot injection, which means that the medication is released slowly over time. Patients must first be initiated and stabilized by a transmucosal buprenorphine-containing product, delivering the equivalent of 8-24 mg/day of buprenorphine for a minimum of 7 days. Following initiation and stabilization, patients can be transitioned to Sublocade. The Sublocade SC injection must be stored in a secure refrigerator, but may be removed from the refrigerator up to 7 days prior to administration as long as it is stored at room temperature, and discarded if not used within 7 days. For more information view the NYS OASAS XR buprenorphine guidance.

Note: If an individual is on sublocade while incarcerated it is important to find community providers that prescribe sublocade for linkage to care post release.

Naltrexone (Antagonist): Naltrexone is an opioid antagonist, which means that it works by blocking the activation of opioid receptors. Instead of controlling withdrawal, it treats OUD by preventing any opioid drug from producing euphoria, opioid antagonists do not produce any responses at the receptor, so no physical dependence is associated with their use, it also can increase risk of overdose if person returns to use due to decreased tolerance for opioids. It cannot be initiated until the person has been fully withdrawn from opioids, which can take from 5-10 days, depending on the opioid. The pill form does not have proven efficacy and is not considered safe for OUD. The injectable formulation, currently sold under the brand name Vivitrol, is administered by a health care provider as an intramuscular gluteal injection in the buttocks every month. This medication requires special storage and handling. Its use for ongoing OUD treatment has been somewhat limited because of poor adherence to monthly injections, particularly in real world studies.[x]

> The immediate goal of MOUD is to prevent deaths and reduce individual and societal harms. The long-term goal is to promote full OUD recovery and restore functioning. Only opioid agonists have been definitively proven to prevent deaths long term; the data is more preliminary and less consistent for antagonist treatment. Ideally, correctional facilities should offer all three medications. However, if only one medication is offered, that medication should be either methadone or buprenorphine based upon current evidence that these medications prevent deaths, there is a higher documented dropout rate with naltrexone, and the 5-10 day withdrawal period required for naltrexone makes initiation more difficult

Addressing Stigma

A history of pervasive stigma and discrimination exists against persons with SUD across the U.S. Many myths about substance misuse and SUD, including OUD, are perpetuated daily through popular culture and media. Furthermore, stigma and misperceptions exist related to MOUD as a treatment modality.[xi]

Unfortunately, many communities often view these lifesaving medications in stigmatizing ways. The *Facing Addiction in America* report, the Surgeon General's spotlight on opioids, combats these stigmatizing perceptions by defining OUD as a chronic disease rather than a moral imperfection.[xii] Persons who use OUD medications are not "trading one addiction for another," but instead are choosing a safe and effective treatment for a chronic disease.

Understanding OUD in this way is a first step in reducing stigma. Like many other chronic medical conditions, OUD is both treatable, and in many cases, preventable. It is also a disease that must be addressed with compassion. Stigma prevents many people from speaking about their struggles and from seeking help. The way we view and address OUD must change—individual lives and the health of our nation depend on it.

Common language related to SUD and OUD can perpetuate stigma and discrimination against persons who use drugs (PWUD). Evidence demonstrates that stigmatizing language can lead to increased negative attributions about patients and negative perceptions among patients.[xiii] Although some language that may be considered stigmatizing is commonly used within social communities of people who struggle with SUD, correctional staff, stakeholders, and community partners can show leadership in how language can destigmatize SUD/OUD. Below are tips for using "Person-First" language, as well as terms to avoid to reduce stigma and negative bias.

Instead of this...	Say this...
Addiction	Substance Use Disorder/Opioid Use Disorder
Drug Addict, Abuser	A person who uses drugs
"Clean" or "Dirty" toxicology	Test was "Negative" or "Positive"
Got clean	A person who formerly used drugs
Junkie, Crackhead, Tweaker, etc.	A person who uses... (specify drug/s)

Essential Elements for MOUD Integration

Eight elements. The following eight elements, identified through lessons learned from MOUD expansion efforts in correctional facilities in NYS, and from SMEs, are critical for the successful implementation of MOUD programs in jails:

I. Assessing Readiness: Understanding the Resources in the Community and Correctional Facility

II. Developing Key Partnerships

III. Establishing Buy-In and Organizational Culture Shift

IV. Identifying Goals and Objectives

V. Developing Service Delivery

VI. Training and Workforce Development

VII. Program Implementation

VIII. Program Evaluation

I. Assessing Readiness: Resources in the Community and Correctional Facility

Key Considerations:

- ✔ Correctional staff awareness of the resources available in the community
- ✔ Understanding of the current infrastructure that exists within the facility
- ✔ Identification of internal and external staff that can be utilized during programming
- ✔ Building upon existing policies and procedures (P&P) and existing memorandum of understanding (MOU) with community-based opioid treatment providers

Prior to program implementation, it is recommended that correctional staff become aware of the resources available in the community as well as have an in-depth understanding of the current infrastructure that exists within these facilities. Infrastructure can include identification of internal and external staff that can be utilized during programming, existing P&P that can be built upon, and existing MOUs with community-based opioid treatment providers to facilitate exchange of information and coordination of care upon a person's entry and release from the correctional facility.

One reason for this review is to assess a facility's readiness to engage in programming. For example, the presence of existing P&P for OUD during pregnancy may provide some indication of the facilities' readiness.

Jails may already have developed clear policies surrounding pregnant patients currently enrolled in Opioid Treatment Programs (OTPs). This might include transport to the OTP for the initial visit after incarceration followed by pickup of guest doses by a correctional officer. This policy might also address careful tracking of doses and returning of unused doses to the OTP. It is important to note that not every county has an OTP. Many facilities are located in rural areas where there are currently no operating OTPs. In order to obtain the medications, county jails should enter into agreements with the nearest OTPs to maintain incarcerated individuals on their medication.

Other jails might have policies that address initiation of methadone (or buprenorphine) during pregnancy. The existence of successful policies for pregnant people suggests greater readiness and potential for scaling relevant policies to the general population.

I. Assessing Readiness: Resources in the Community and Correctional Facility

To analyze a facility's readiness, we have developed the following checklist of key factors to assess prior to implementation.

Community and Correctional Assessment Checklist:

- ☐ Identify Key Stakeholders that can Contribute to Various Portions of the Program
- ☐ Assess Current OUD Management/Processes within the Facility
- ☐ Identify Internal and External Staff (that can be utilized during programming, existing P&P that can be built upon)
- ☐ Assess Staff Resources, Knowledge and Attitudes (perceived acceptability, feasibility, and appropriateness)
- ☐ Assess Incarcerated Population Knowledge and Attitudes
- ☐ Assess Staffing Capacity/Infrastructure (Clinical, Medical, Support and Correctional)
- ☐ Identify Existing Partnerships with Community-Based providers (see *Important MOUD Program Community Resources* checklist)
- ☐ Assess Existing MOUs/Linkage Agreements (see *Important MOUD Program Community Resources* checklist)
- ☐ Identify Useful Entities (see *Important MOUD Program Community Resources* checklist)
- ☐ Create a Community Description and Record Findings

I. Assessing Readiness: Resources in the Community and Correctional Facility

The following checklist includes specific resources within the community that may be leveraged; it is important to engage with these partnerships early in the process.

Important MOUD Program Community Resources:

- ☐ Office-based opioid treatment prescribers e.g., community clinicians with a DEA x-waiver to prescribe buprenorphine
- ☐ OTPs, i.e., methadone programs
- ☐ Drug User Health Hubs (DUHHs)
- ☐ Centers of Treatment Innovation (COTIs)
- ☐ Syringe Service Exchange Programs (SSPs)
- ☐ Pharmacies
- ☐ Opioid Overdose Prevention (OOP) Programs
- ☐ Behavioral Health Programs
- ☐ Other additional resources that can support someone's transition into the community

Current protocols and agreements with already established partnerships provide some indication of readiness.

Protocols: Examples From the Field

- Confirmation of prescribing and doses
- Guest dosing for people enrolled in OTPs
- Bridge dosing upon release
- Confirmation of appointments
- Potential contracts/payments for specific services delivered by community providers

Section Resources

Understanding the Resources in the Community and Correctional Facility

- Building Effective Correctional Facility–Community Provider Partnerships for the Benefit of Justice Involved Women: Lessons Learned (National Resource Center on Justice-Involved Women)
- Jail-Based MAT: Promising Practices, Guidelines and Resources (NCCHC)
- MAT Inside Correctional Facilities: Addressing Medication Diversion

II. Developing Key Partnerships

Key Considerations:

- ✔ Foster collaboration
- ✔ Develop accountability and communication strategies with the collaboration
- ✔ Clarify roles
- ✔ Create implementation team

This section details the importance of fostering collaboration and building relationships with administrators and internal staff, system partners, Drug Courts, Department of Corrections and Community Supervision (DOCCS), and Local Community Providers (e.g., DUHHs and COTIs). It is important to ensure that various departments, agencies, organizations, and individuals involved in these programs have influence in the program.

Key Collaboration Steps:

- Identify type and scope of the program
- Build strategic partnerships with a broad array of partners
- Agree on general goals
- Build trust
- Agree on specifics
- Clarify roles and schedule regular meeting times to monitor progress and make adjustments
- Set regular times to debrief on the partnership

Foster Collaboration

Building on existing partnerships and/or establishing new collaborations among resources in the community can foster new insights into service delivery (improve and expand the reach of your service delivery model) and more effective use of targeted resources.

Lessons From the Field: ACCRS MAT Program

ACCRS began collaborative efforts by building on existing partnerships or establishing new collaborations among resources in the community. The stakeholders involved in this collaborative effort realized each entity was serving many of the same individuals across their agencies and, as a result, aimed to improve services to this shared population.

Communication Strategies and Role Clarification

When care coordination for OUD is the main focal point, it is important to *clarify roles* and how information will be communicated between the individuals filling those roles. In many counties, corrections staff, medical staff in the facility, and community-based organizations (CBOs) provide most of the program components. Due to this structure, a clear line of communication between these three entities is essential.

For example, CBO staff members must rely on the jail staff to confirm when a participant is enrolled in the program, communicate the release date, get clearances for in-house visitation, adjust schedules for visitation and medication administration, and secure space for program delivery. Thus, facilities will need to determine everyone's role in program delivery, including who will oversee program administration and provide specific services.

For some of the counties, these connections may never have existed prior to the program which is why having a good working relationship is critical and those involved must **build trust and strive for a common goal**. Close collaboration with jail staff can help program staff members implement measures to make the programs effective and still ensure they do not compromise the safety and security of the jail or disrupt other correctional operations.

Strategic Partnerships

As you determine roles and build mutually beneficial relationships, consider **thinking broadly about partners** and including stakeholders who are not directly involved in service delivery or program administration/implementation. Partnerships and relationships with external organizations, including hospitals, social service providers, community-based programs, criminal justice agencies, court systems, and other waived providers are helpful for referrals, retention, and continuity of care.

Community-based providers may enable correctional facilities to provide treatment at a lower cost or subsidized rate in order to maintain individuals in care, thus increasing the likelihood that an individual will return to the clinic and reducing the significant risk of fatal overdose following release.

For example, working with local drug courts is essential as those in drug courts have the potential of being connected to MOUD treatment options and increasing the number of individuals on these lifesaving medications. Even though this expansion is desired, it can create an unintended consequence if the individual starts one of these medications (especially buprenorphine or methadone) and is remanded to a facility or residential program that doesn't offer continuation of the medications.

All NYS OASAS certified and/or funded residential services are not allowed to exclude based on MOUD, since it is against NYS regulations.

Creating Multidisciplinary Implementation Team

When implementing a program that requires coordination from multiple internal and external partners, it is beneficial to create a specific program team that includes individuals from all the partnering agencies. This multidisciplinary team can include medical staff, MH providers, CASACs, CPRAs, Department of Social Services (DSS), discharge planners, correctional facility representatives, and additional support staff. For these programs, there needs to be:

- A program manager
- Cross-staff trainings
- Establishment of points of contact
- Performance measures/benchmarks
- Collaborative problem-solving around workflow issues/challenges
- Scheduling of ongoing meetings to discuss project status
- Refinement of Policy & Protocols (P&Ps), trainings
- Continuously expanding partnerships

III. Establishing Buy-In and Organizational Culture Shift

Key Considerations:

- ✔ Obtaining Buy-in from Leadership and Staff
- ✔ Working to Address Stigma
- ✔ Communicating Evidence-Based Strategies for Organizational Culture Shift

Cultivating Champions

Leadership within correctional and community settings has the ability to change the general perception of MOUD among all staff. One of the ways to facilitate this change is by instituting a new cultural norm within medical and correctional staff around MOUD and the recovery process.

One of the biggest challenges of having a MOUD program inside correctional facilities is the concern of introducing a medication that has historically been regarded as contraband in this setting – and concerns of how to address instances of diversion.

Shifting this belief may require a significant change in attitudes and behavior toward incarcerated persons with SUD and their need for effective treatment. For those that have significant objections and actively oppose the implementation of MOUD in correctional settings, it is useful to apply a number of strategies, including a fellow peer to convey their support of the program, and information sharing around program success. For example, inviting sheriffs and other correctional leaders to discuss their experiences implementing MOUD can be effective for gaining buy-in, especially if they address key areas of concern, including staffing, program costs, and preventing medication diversion. It can also be beneficial to allow corrections personnel currently involved in MOUD programming to have dialogue with other corrections staff whose facility has yet to integrate services.

Leadership plays a vital role in facilitating change and creating a healthy environment for change to occur.

Significant progress in this area will not be made without the buy-in and support of the executive team. Lower level internal champions can also be critical for successful implementation. The issues involved with integrated MOUD services are complex, requiring sustained effort and engagement of leadership at all levels.

Addressing MOUD Stigma

Challenges exist regarding stigma associated with opioid use and with MOUD agonist medications. It is useful to identify leadership, staff, and patients who support abstinence-only norms. These individuals should receive education, resources and support to increase their understanding of the need for access to these medications, and the lack of evidence supporting abstinence-only approaches. Studies show detoxification followed by abstinence carries the risk of a very high relapse rate and increased overdose risk.[xiv]

Lessons From the Field: Albany County Corrections & Rehabilitative Services Center (ACCRS)

Challenge: Stakeholders indicated that a challenge in implementing MOUD in correctional settings is preexisting stigma and lack of buy-in. MOUD remains stigmatized and under-resourced in correctional settings.

Strategies for Implementation: It is essential for leadership to make it known consistently to staff that MOUD accessibility is a necessity for the incarcerated population with OUD. NYSDOH also provided additional education and technical assistance regarding the efficacy of MOUD and additional destigmatizing information for staff.

Communicating effectively to create buy-in for change requires clear, consistent messaging. Because there are many myths and misconceptions associated with MOUD, it is important to prepare staff by providing the facts to help people understand how these medications work and dispel the myths and misperceptions about MOUD.

Addressing stigma, including implicit bias, is critical in helping to develop a shared understanding and language related to the implementation of MOUD. Training is discussed in more depth in ***Section VI. Training and Workforce Development***.

Communicating for Buy-in

Effectively communicating the evidence-based rationale for MOUD integration is critical in gaining buy-in from leadership, staff, and other stakeholders. Understanding the priorities of the leadership team and other stakeholders, such as patients, staff, and community partners, will help develop a tailored approach for this communication. Below are some additional rationale and talking points:

Rationale and Talking Points for Corrections-Based MOUD Integration

- The criminal justice system is the largest source of organizational referrals to SUD treatment. Justice leaders, drug court commissioners, and jail administrators have a unique opportunity to reduce the negative impacts of substance use and facilitate safer transition into the community for persons with SUD and OUD.
- Research has shown the risk of fatal overdoses among persons recently released from prison is 12 times greater than the rest of the population. Overdoses are more common when a person relapses to drug use after a period of abstinence due to loss of tolerance to the drug.
- Limiting MOUD accessibility during incarceration creates missed opportunities for engagement, interruptions and lapses in treatment and difficulties in initiating or resuming medications upon reentry.
- Costs for incarcerated persons receiving MAT post release were half those of incarcerated persons who did not receive MAT post release.[xv]
- Research indicates that lack of continued care throughout the course of incarceration puts these persons at risk for reincarceration, emergency department (EDs), and hospital admission. If left untreated, OUD can also lead to risky behavior contributing to the spread of HIV and Hepatitis B and C infections.[xvi]
- Corrections-based MOUD programs have resulted in health care cost savings, and reduced crime and recidivism.[xvii]
- MOUD is recommended by the American Academy of Addiction Psychiatry (AAAP), American Medical Association (AMA), The National Institute on Drug Abuse (NIDA), Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Centers for Disease Control and Prevention (CDC), and World Health Organization (WHO).
- Individuals who received buprenorphine or methadone treatment prior to release are more likely to engage in treatment after their release than inmates who only participate in counseling.[xviii]

Section Resources

Establishing Buy-In and Organizational Culture Shift

- Evidence-Based Resource Guide Series: Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings (SAMSHA)
- Jail-Based MAT: Promising Practices, Guidelines and Resources (NCCHC)
- MAT for Opioid Use Disorder: Overcoming Objections (California Health Care Foundation)
- Engaging People Who Use Drugs in Prevention Efforts: Strategies for Reducing Stigma (Prevention Collaboration in Action)
- MAT Myths and Facts (Legal Action Center)

IV. Identify Goals and Objectives

Key Considerations:

- ✔ Identify Overall Design of the Program
- ✔ Identify What Program Staff Hope to Accomplish
- ✔ Whom should the program benefit
- ✔ How might those benefits be realized
- ✔ Are the goals in line with current practice

When initial development is underway, it is important to identify common goals shared by the entire group. Regardless of the role these partners play, understanding shared goals increases collaboration and buy-in.

Those goals may include, but are not limited to; **preventing deaths, reducing overdoses, reducing recidivism, preventing the spread of communicable diseases, increasing engagement in treatment, and improving community safety**. Coinciding with these overarching goals are key objectives that will assist in accomplishing these goals.

Key Objectives for MOUD Program Implementation

- Screening for OUD and comorbid conditions
- Building a comprehensive plan for initiating or expanding a MOUD continuum of care model from jail/prison to the community
- Initiating and/or maintaining incarcerated persons on medications for OUD
- Developing effective partnerships between correctional settings and community-based treatment providers for continuity and coordination of MOUD accessibility
- Utilizing clinically-indicated courses of treatment and prevention services

Screening for OUD and comorbid conditions.

Systematically screening and identifying all patients for OUD and signs of withdrawal using validated screening instruments is an important part of building a comprehensive plan for initiating or expanding a MOUD continuum of care model from jail/prison to the community.

Building a comprehensive plan for initiating or expanding a MOUD continuum of care model from jail/prison to the community.

Striving to integrate a system that includes early identification of those with OUD, providing evidence-based treatment; such as MOUD without tapering or discontinuation, and establishing a linkage to ensure continuity in medication and supportive care after release from incarceration.

Initiating and/or maintaining incarcerated persons on medications for OUD.

Beyond screening and discharge planning, one of the main goals of the program is to initiate and/or maintain incarcerated persons on MOUD that are proven to prevent death. Individuals who are maintained or commence on MOUD prior to their release are more likely to continue their treatment in the community.[xix]

Developing effective partnerships between correctional settings and community-based treatment providers for continuity and coordination of MOUD accessibility.

In order to build a plan to initiate MOUD services, it is essential for communication to be disseminated from leadership through all sections of the correctional facility that have a role. It is also important to develop effective partnerships and coordination of care and services between corrections and community-based treatment providers that ensure continuity in MOUD without interruption in medication treatment and access to supportive community services, e.g., housing, health care, MH, etc. Regardless of setting, seamless engagement into care and access to medications is critical for persons with SUDs returning to their community.

Correctional health programs that have relationships established with community-based MOUD providers can help ensure continuity of care once individuals are no longer under criminal justice oversight. Administratively, jails or prisons should establish MOUs or contracts with their community-based providers to clearly establish the expectations, boundaries, and other details around the MOUD program. These should be reviewed annually with the provider to ensure all parties remain informed through staffing changes, program expansions, or other developments.

Highlight From the Field: NYS agency-supported programs that increase access to community-based SUD services in a flexible way.

NYSDOH has 12 Drug User Health Hubs (DUHH) and NYS OASAS Center for Treatment Innovations (COTIs) has 23 COTIs across the state. These programs provide increased access to community-based SUD services in a flexible way, to improve the availability and accessibility of culturally competent health care and MOUD for persons who use drugs (PWUD), especially those who have not yet engaged in care or services and are at greatest risk for opioid overdose.

Utilizing clinically-indicated courses of treatment and prevention services.

Another goal is to **utilize clinically-indicated courses of treatment and prevention services**. Facilities should include evidence-based practices in screening, interventions, treatment, and prevention services (e.g., HR practices, person-centered care, appropriate dosing of medications).

It is important to prudently apply the evidence gathered over the years to guide reasonable and impartial treatment for persons with OUD in the justice system.

Creating consistency in care among these correctional entities can be fostered by aligning admission, screening, assessment, and treatment practices with these evidence-based standards.

> *Buprenorphine, a commonly used evidence-based treatment of an OUD in the U.S., is a realistic step to reduce mortality. Patient safety depends on care that is evidence-based, emphasizes harm reduction, and has a low barrier to entry.*
>
> SAMSHA TIP 63

Program Evaluation

Evaluation should be discussed in the initial phase of program planning and preliminary evaluation should start at program inception. Data monitoring and program evaluation plans are important tools to regularly track MOUD program activities and understand the program's outcomes and impact. (Refer to ***Section VIII. of this document Program Evaluation***)

Section Resources

Identify Goals and Objectives

- Implementing Transmucosal Buprenorphine for Treatment of Opioid Use Disorder, Best Practices from New York State Department of Health and Office of Alcoholism and Substance Abuse Services
- Treatment of OUD – AIDS Institute Clinical Guidelines
- Medications for Opioid Use Disorder TIP 63 For Healthcare and Addiction Professionals, Policymakers, Patients, and Families (SAMSHA)

V. Developing Service Delivery and Workflow

Key Considerations:

- ✔ Developing P&P
- ✔ Eligibility requirements for program participants
- ✔ Guidance on medication administration and observation
- ✔ Safeguards to prevent diversion of medications
- ✔ Support service engagement and additional systems to ensure continuation and/or initiation of medications

It is critical to think through the services that will be offered to the participants and how each component will look from initial assessment to release. This includes development of appropriate P&P to ensure delivery of MOUD services that achieve the goals and objectives of the program.

To ensure their success, program components should address the identified goals and ensure a collaborative process among individuals involved to help achieve goals.

Lessons From The Field: **ACCRS**

Challenge: Stakeholders and jail administrators indicated that facility workflow and logistical planning was an initial challenge. Some facilities in the planning phase expressed concerns and difficulties implementing services due to infrastructure and lack of established P&P. Space must be big enough to accommodate the various program components, such as medication initiation and maintenance, and process for individuals to receive the medication outside of usual medication rounds.

Strategies for Implementation: Staff converting preexisting spaces within the facility into areas where individuals can go for buprenorphine administration (i.e., gymnasiums, extra evaluation rooms, dosing time adjustments, etc.).

Policy and Procedures

It is important for facilities to develop a protocol that allows for the utilization of all three of the approved medications for persons with OUD.

Regardless of whether medical services are provided by a contracted provider or internal staff, the developed policies and procedures should correlate to the program. These documents can provide further guidance around medication administration as well in assisting to prevent potential diversion among program participants.

Establishing P&P that correlate with the various components of the MOUD program is a critical step in the planning and implementation process. These P&P can pertain to eligibility requirements for program participants, guidance on medication administration and observation, safeguards to prevent diversion of medications, support service engagement, and additional systems to ensure continuation and/or induction of medications. (See ***Appendix A: Sample of Buprenorphine Distribution Protocol***)

Some facilities may only offer one or two of the approved medications. Staff may not necessarily be knowledgeable about all three medications.

Some staff may harbor misconceptions. Developing general education and fact sheets for the correctional staff, clinical, and support staff may assist in streamlining implementation.

Lessons From The Field: ACCRS

Challenge: Stakeholders indicated that a challenge in implementing MOUD is the **Concern of Diversion of Medication**. Most of the correctional health stakeholders and administrators view buprenorphine as a medication that is commonly diverted in the jail, rather than evidence-based treatment.

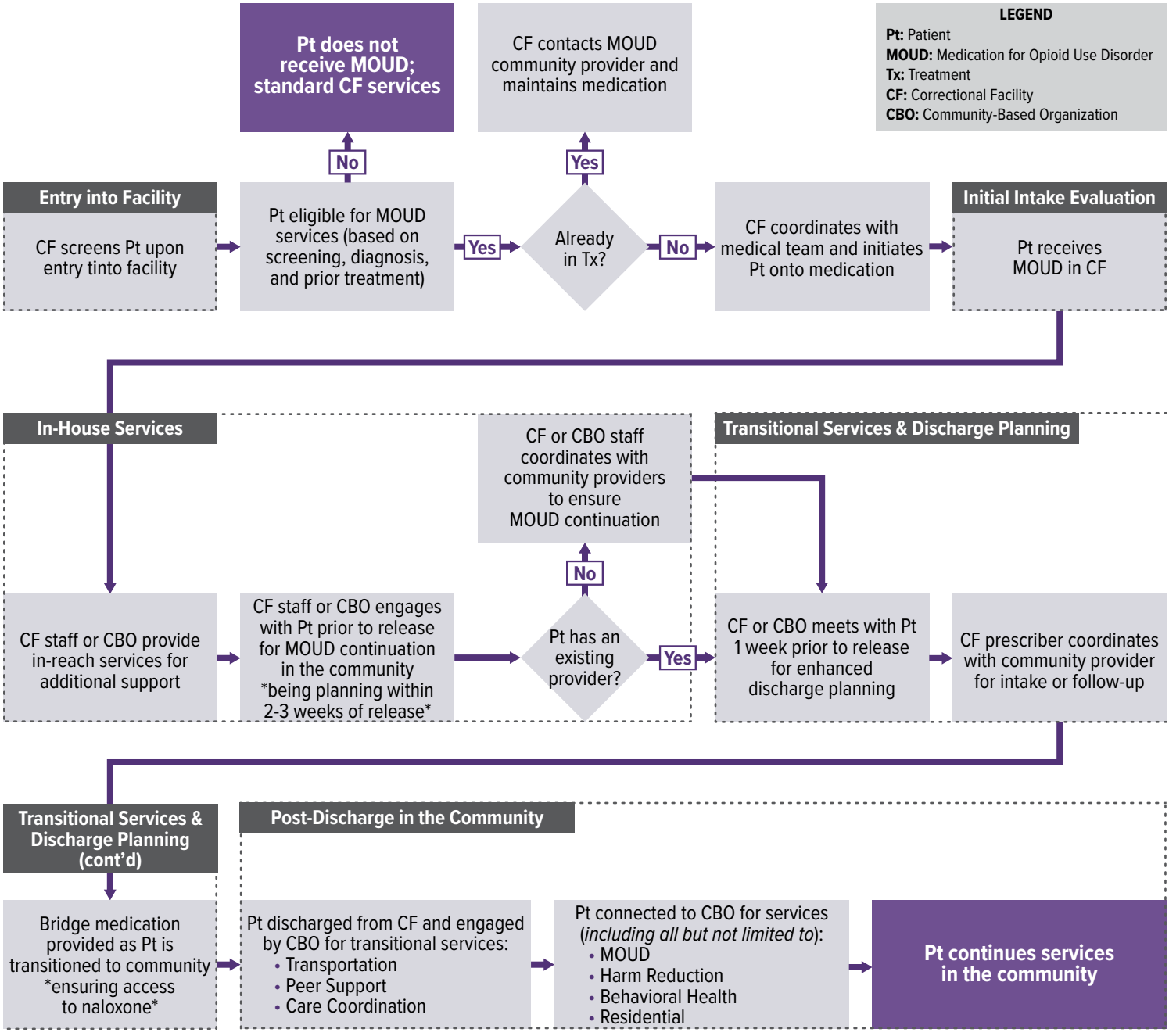
Strategies for Implementation: Due to this concern, correctional facilities developed standardized protocols that provide detailed guidance around buprenorphine distribution (pre- and post-administration) for medical and correctional staff, as well as patients. Diversion attempts should include consultation with the multidisciplinary team for further evaluation that lead to standardized responses in the event there are further diversion attempts.

Service Delivery

To further assist the layout of the service delivery, flowcharts offer a visual representation of the sequence of steps and decisions needed to perform the process. These visual representations detail a service delivery flow chart for both:

- Initial intake evaluation and in-house treatment
- Discharge planning and post discharge into the community

Service Delivery Flow Chart



Key Implementation Considerations

It is important to review key implementation considerations related to program service delivery and workflow design. The following highlights the critical components of corrections-based programs being utilized in county and state correctional facilities. These components include:

- Screening and Assessments
- Selection of Appropriate Medications
- Program Implementation Approaches
- In-House Programming
- Streamlined Reentry Support/MOUD continuity

Screening and Assessments

Correctional facilities and criminal justice agencies should have policies and procedures in place to screen and assess persons for OUD and other potential co-occurring disorders. Screening refers to identification of persons who might have OUD or additional relevant conditions, e.g., pregnancy or psychosis.

Screening questions often focus on regular use of any opioids, both licit and illicit. Assessment refers to a medical and MH assessment including confirmation of diagnoses, e.g., OUD, pregnancy, psychosis, current treatment, medications prescribed, doses, etc. It often includes urine toxicology screening and pregnancy tests.

Screening Tools

Examples of screening tools include all but not limited to:

- Rapid Opioid Dependence Screen (RODS)
- Drug Abuse Screening Tool (DAST)
- Car, Relax, Alone, Forget, Friends/Family, Trouble (CRAFFT)
- Screening, Brief Intervention Referral to Treatment (SBIRT)

Selection of Appropriate Medications

Correctional facilities and criminal justice agencies should be encouraged to assess the capability of their staff and facility in planning to provide these medications to incarcerated persons. Availability of all three FDA-approved medications to treat OUD based on individual need is encouraged.

Proper assessment mechanisms should be in place and medications should not be predetermined for individuals. Generally, existing MOUD should be continued.

Best Practice:

For patients not receiving treatment, opioid agonists should generally be considered first-line based on evidence showing they reduce deaths. However, patients should be involved in the selection of the medications they will be receiving after discussion of the advantages and disadvantages of available options. Informed patient decision-making is important for ethical reasons, i.e., the principle of patient autonomy, but also for practical reasons patients are more likely to continue with a medication that they have selected.

Program Implementation Approaches

When initial program planning begins, the thought of implementing all components of initiation, maintenance, and post-release services may seem overwhelming, especially to staff that are new to medication provision. Due to this, facilities may benefit from the use of "phases" or "tiers" to distinguish between different stages of the program.

Lessons From The Field: ACCRS MAT Program

ACCRS structured their programs in a way that allows for jail staff to gradually work out the service delivery of the program without being overwhelmed from the start. Through this "phased-in" approach, there is a greater level of consistency in MOUD provision than would otherwise be possible.

Phase 1: Continuation of MAT
- Patients arriving to facility already on prescribed MOUD will have MOUD maintained while in facility.

Phase 2: Sentenced with OUD
- Induction of patients reporting OUD upon admission that are now sentenced, have a release date, and will be housed in facility for sentence.

Phase 3: All with OUD
- Offered buprenorphine for detox and/or inducing new patients reporting OUD and maintaining while in facility, regardless of release date.

Flexibility remains important as county facilities differ from one another. Facilities that have already implemented successful, evidence-based programs for treatment of OUD during pregnancy may consider building on this experience in order to expand OUD services to the general population. Facilities that are not providing guideline-concordant care during pregnancy may want to start by providing opioid agonists during pregnancy (naltrexone is not recommended during pregnancy).

In-House Programming

It is recommended for correctional facilities and criminal justice agencies to offer supportive services in addition to MOUD, either through in-house services or by partnering with community-based agencies. In the facilities that are currently implementing these programs, supportive services will continue to be available through the facility's Offender Rehabilitation Coordinators (ORC) and other counselors and care coordinators.

Example From The Field: ACCRS MAT Program

Key ACCRS partners include:

- CFG Health Systems
- NYSDOH AI
- NYS OASAS
- Catholic Charities Care Coordination Services (CCCCS)
- Katal Center for Health, Equity, and Justice
- Conifer Park
- Whitney M. Young, Jr. Health Services

In facilities with existing partnerships, discharge planning prior to release by the support staff will include case management and linkage and referral services provided by the regional DUHH or COTI, to ensure continuity of treatment while also securing housing, health insurance, medical and MH care, and other needs using the full array of services offered from organizations available.

Streamlined Reentry Support

Corrections-based MOUD programs should have comprehensive reentry planning to ensure individuals are able to access appropriate medications and other health care treatments upon release. Services and supports are also important in addressing recidivism risk factors, such as lack of stable housing, employment, meaningful daily activities, and supportive peers, as persons with OUD return to the community. Coordinating reentry includes dispensing naloxone and relevant instructions to the patient and/or friends/family before discharge, and mechanisms in place for bridging medications.

Another essential component to reentry includes insurance navigation and reinstatement prior to release. This will assure services are not delayed due to lapse in coverage. As individuals are released back to the community, persons with OUD are at high risk of overdose and other adverse outcomes following release from incarceration. Research provides overall support for the dictum that legally referred clients do as well or better than voluntary clients in and after treatment.[xxi]

Lessons From The Field: ACCRS

Challenge: Limited staffing and resources was seen as a barrier for these facilities as it relates to correctional officers, medical staff, discharge planners, and additional support staff.

Strategies for Implementation: Facilities need to identify where additional staff are needed and explore with collaborating stakeholders whether there are resources to add additional staff to support the program. In the ACCRS, the hiring of staff included one full-time and one part-time counselor, a 20-hour a week prescriber, and a Reentry Coordinator. Another way the lack of staffing has been addressed is through the utilization of community providers to provide additional support throughout the program process. Telemedicine has also assisted correctional facilities with filling gaps in available staff.

Overdose Education and Naloxone Distribution (OEND)

Naloxone is an important tool to reverse opioid overdose and correctional facilities should be prepared to respond to opioid overdose by administering naloxone. All NYS prisons provide overdose training. Persons upon release are offered naloxone. Similar efforts are taking place in a growing number of county jails.

Realizing this notable shift toward jail or prison culture, additional training may be geared towards attitudes and perceptions to incarcerated persons with SUDs and their need for effective treatment among both correctional and medical staff.

Overdose Education and Naloxone Distribution (OEND) Programs in Jails and Prisons

It is clear that persons exiting incarceration are at the highest risk of opioid-related overdose and that OEND programs, including those located in jails and prisons, save lives.

Section Resources

Developing Service Delivery and Workflow

- Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison (Policy Research Associates)
- A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons (RTI International)
- Corrections-Based Responses to the Opioid Epidemic: Lessons from New York State's Overdose Education and Naloxone Distribution Program (Vera Institute of Justice)

VI. Training and Workforce Development

Key Considerations:

- ✔ Trainings should be delivered to staff at the outset of the MOUD program and when new staff are onboarded, as well as delivered periodically as refresher courses
- ✔ All health care and correctional staff should receive basic training; correctional health care staff and security staff directly involved with the provision of MAT services should receive more extensive training on a range of topics
- ✔ For facilities that work with external providers to administer MOUD within the correctional facility, the external provider should receive training related to facility security protocols

The delivery of structured trainings is a core component of implementation models and can help correctional staff and clinical and support staff at all levels understand the ways in which MOUD is compatible with the goals of their profession.

As more states are being encouraged by governing bodies to offer MOUD as the standard of care, it is suggested that proper training and clinical guidelines be developed and ingrained in the standardized practice among those working within these systems (See ***Appendix B: MOUD Clinical Guidance and Protocol***).

Prior to MOUD becoming a part of standard operations, it is necessary for medical practitioners to become DATA-waivered (Drug Addiction Treatment Act), i.e., licensed to prescribe buprenorphine. Other corrections personnel should receive general training on MOUD. Some facilities may also benefit from TA around reentry planning.

Ongoing Training

Ongoing training for all involved parties is critical to the safe implementation of MOUD and the reduction of medication diversion. All jail and prison staff should receive training regarding MOUD, and should be given an overview of the facility's proposed program (whether it is run by jail staff or a community-based provider).

The training should be provided to correctional officers, medical staff, clinical staff, and additional support units (i.e., group facilitators, discharge planners, etc.).

Training Topics Checklist

Training Topics Checklist
☐ Overview and Science of OUD
☐ Science of MOUD and approved FDA medications
☐ Efficacy of MOUD and Common Misconceptions
☐ Science of Opioid Withdrawal
☐ Facility MOUD Program P&P
☐ HR and Stigma
☐ Medication Diversion
☐ Federal, State, Local and Accreditation Bodies' Rules and Regulations Related to Storage, Mixing, Administration, Disposal, and Ordering of MOUD
☐ Telehealth for MOUD
☐ Opioid Overdose Response Training

Training should be evidence-based, person-centered, HR-focused, and pertain to various departments. Training should emphasize education on the three FDA-approved medications for OUD, the efficacy of MOUD, and common misconceptions. The science of opioid withdrawal, and medication diversion prevention techniques, and where applicable, state, local, and accreditation bodies' rules and regulations on the storage, mixing, administration, disposal, and ordering of medications.

Lessons From The Field: ACCRS

Challenge: Absence of specialty training for internal medical and clinical staff is seen as a challenge because those working in the correctional facilities do not feel equipped to provide services under the structure of this program.

Strategies for Implementation: To address this, the coordinating facilities and NYSDOH AI ODUH have integrated additional training geared toward medical, clinical, behavioral health, and correctional staff. It is essential for correctional staff to receive ongoing trainings regarding various aspects of MOUD and effectively provide these medications within correctional health.

It is essential for correctional health staff and behavioral health providers delivering MOUD in justice settings to receive ongoing cross-disciplinary trainings regarding various aspects of MOUD, the criminal justice system, reducing medication diversion, and effectively providing MOUD within the correctional health setting.

Buprenorphine-Prescribing HHS Guidelines

HHS Released Buprenorphine Practice Guidelines, Expanding Access to Treatment for Opioid Use Disorder. Effective 4/28/21, providers no longer need to complete the 8- or 24-hour training in order to apply for a waiver to prescribe buprenorphine for opioid use disorder if they intend to prescribe to 30 patients or less.

To prescribe buprenorphine, a Drug Enforcement Agency (DEA) x-waiver is required.

- MDs, DOs, NPs, PAs, and eligible Advanced Nurse Specialists still need to submit a Notice of Intent before using buprenorphine to treat patients with OUD, and obtain a waiver number from the DEA, but no longer need to complete the 8 (MD/DO) or 24 (NP/PA/Nurse Specialists) hours of training in order to do so.
- The Notice of Intent requires a simple, online application, submission of documentation of a valid DEA registration and state license, followed by approval. Information about this process can be found at: https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner.
- This applies only to treating up to 30 patients; in order for a provider to treat up to 100 or 275 patients, they will still need to complete the 8 or 24 hours of training. For further information visit: SAMSHA FAQs About the New Buprenorphine Practice Guidelines.

NYSDOH has collaborated with the NYS Clinical Education Initiative HCV and Drug User Health Center of Excellence, to develop a one-hour course ***X-Express: Buprenorphine Prescribing for Beginners***. This training reviews best practices for initiation, dose stabilization, maintenance and discontinuation, and discusses clinical cases that demonstrate how buprenorphine treatment can be delivered in various clinical settings (i.e., Correctional Settings).

X-Express: Buprenorphine Prescribing for Beginners

According to the DEA dataset, as of July 2021, there are a total of 8,279 active waived buprenorphine providers in NYS. All communication pertaining to requests and/or questions around *X-Express: Buprenorphine Prescribing for Beginners* trainings can contact buprenorphine@health.ny.gov.

Further information can also be found at: https://ceitraining.org/resources/drug_user_health/.

VII. Program Implementation

Key Considerations:

- ✔ Program structure and sequence
- ✔ Staff training
- ✔ Creating a multi-disciplinary team
- ✔ Troubleshooting and TA
- ✔ Budget

Once you have identified your goals, collaborated with necessary partners, and decided which components to include in the program, you are ready for implementation. This section will review the operational aspects of program implementation, such as eligibility requirements to consider for program participants, training for program staff, logistical flow of service delivery, and clinical resolution procedures.

This section highlights how the MOUD program was implemented in Albany County (AC) at ACCRS, based on a phased-in approach model. While the examples are illustrative, they are not the only ways to implement a MOUD program in a correctional setting.

Program Structure and Sequence

Phasing in various stages of the program allows more time for staff to acclimate to the nuances of the program while still serving a portion of the population. The facilities should attempt to build upon current programming around MOUD provision (i.e., continuation for pregnant population, adjusting withdrawal management with buprenorphine to initiation, etc.).

Expanding current mechanisms that are part of current operations is one way to increase comfort among staff.

MOUD programs, like all other programs, work best when program staff members are supportive and in constant communication as various components of the program overlap with one another. Each program component is part of the more comprehensive program and staff members are typically involved in multiple components.

Below is summary of the phased-in approach model from ACCRS.

Lessons From The Field: ACCRS MOUD Program

Through collaborative efforts that began in 2018 between state and local entities, the AC Sheriff's Office introduced a robust, multiphase MOUD program to operate within the ACCRS.

Phase 1: Maintenance

- Patients arriving to facility already on prescribed MOUD will have MOUD maintained while in facility.

The initial phase of implementation is for all individuals entering the facility, who are currently under treatment with one of the three forms of MOUD in the community, to be continued on these medications for the duration of their time in the facility and upon discharge. At full implementation, all persons entering the facility who are receiving treatment with these medications, will continue treatment with them through release, thus avoiding the dangerous practice of stopping treatment upon entry, which exposes the person to overdose and possibly death upon release.

Phase 2: Initiation-Sentenced

- Initiation of patients reporting OUD upon admission that are now sentenced, have a release date and will be housed in facility for sentence.

The second phase of the program includes buprenorphine initiation for persons with OUD who are sentenced and have an expected release date. The correctional staff and outside provider continue to connect the individual to an identified provider upon release for continuation of care and medication maintenance.

*If not started on buprenorphine, those that are sentenced will be initiated on other MOUD (i.e., Methadone or Naltrexone) based on further assessment, evaluation, and coordination with internal and external staff.

Phase 3: All with OUD

- Offered buprenorphine for detox and/or inducing new patients reporting OUD and maintaining while in facility regardless of release date.

In the final phase, individuals who have not begun treatment with buprenorphine or naltrexone but desire to, will have the opportunity to initiate their treatment while in custody in preparation for release to the community.

*If not started on buprenorphine, those that are sentenced will be initiated on other MOUD (i.e., Methadone or Naltrexone) based on further assessment, evaluation, and coordination with internal and external staff.

Staff Training:

As noted in the previous section, all correctional setting staff should receive training regarding MOUD, including an overview of the facility's MOUD program, whether internally operated or through a community provider. It is important for these connections to be made with providers who have the ability to prescribe and are knowledgeable about OUD, SUD, and/or are familiar with the role medication plays in substance use treatment.

Telehealth:

Telehealth offers the criminal justice system an innovative strategy for intervention and treatment of OUD for persons who have been incarcerated.

Telehealth can be used to serve persons during incarceration and reentry in a number of ways, including by enabling peer counseling, increasing access to specialty services, and smoothing transitions upon reentry. Telehealth can improve access to care and care coordination, and it can reduce costs of providing care to persons who are incarcerated. For programs providing buprenorphine with limited clinical staff, telehealth may be a valuable option to allow for more timely dose adjustments.

Successful implementation includes changes to P&P, preparation of staff and patients, and analysis of costs and benefits implementing telehealth.

Lessons From The Field: Niagara County Correctional and Dutchess County Correctional

Challenge: Linkage to care to MOUD providers post release.

Strategies for Implementation: Niagara and Dutchess County Jails have partnered with NY MATTERS, a referral system that connects community providers, emergency departments, and correctional facilities to treat patients via telemedicine. This online referral mechanism serves as a linkage to care and connects persons being discharged from these correctional facilities to ensure access to MOUD. Persons are able to select the location and time that best suits them for follow-up MOUD care. Referrals to peer support, drug user health hubs, and insurance programs, as well as pharmacy vouchers, are also made available as needed.

Troubleshooting and Technical Assistance (TA):

An essential part of program implementation is ongoing TA and guidance. Regardless of whether the program is in development or ongoing, there will be instances where challenges are posed and TA is required. To support facilities when barriers occur (***Appendix VII Challenges and Strategies for Implementation***), it is helpful to learn how and what other facilities are doing when it comes to OUD treatment.

Section Resources

Program Implementation

- Screening and Assessment of Co-Occuring Disorders in the Justice System (SAMSHA)
- Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison (Policy Research Associates)
- Partnering with Jails to Improve Reentry (Urban Institute)

VIII. Program Evaluation

Key Considerations:

- ✔ Program sustainability and quality improvement
- ✔ Number of patients with OUD participating in MOUD program
- ✔ Retention in services pre and post discharge
- ✔ Long-term outcomes among those treated with MOUD

Knowing whether the program is working is necessary for program sustainability and quality improvement. An effective and sustainable program takes evaluation seriously and builds it into program design. Evaluation should be discussed in the initial phase of program planning and preliminary evaluation should start at program inception. Regardless of the evaluation intensity, evaluation helps identify which elements of the program work effectively and efficiently, and which should be modified. It also allows project managers to better tell their stories, prove the value of their projects, and justify the modifications that need to be made.

This section emphasizes the overarching themes of evaluation that can be captured in the correctional health facility, and will highlight the more intricate evaluation procedures currently underway in Albany, NY at the ACCRS.

Indicating Measures of Success

In order to address OUD, it must first be assessed and identified, therefore some measures of success include:

- The percentage of incarcerated persons with OUD who are identified
- Percentage of incarcerated persons with OUD who are provided with continuation or initiation of MOUD
- Percentage of the incarcerated persons with OUD who are successfully linked to care in the community post release
- Percentage of reentrants with OUD who continue care six months post release.

Lessons From The Field: ACCRS MOUD Program

The evaluation and tools being conducted at the ACCRS are currently being used by other county facilities. There are several commonly used approaches to program evaluation and continuous quality improvement.

In the Albany program, evaluation focused on care continuation, recidivism, mortality, and quality of life improvement for the individuals. Four separate reporting tools were designed to collect data from ACCRS and the regional DUHH (community-based provider) that assumed responsibility as the main provider, Catholic Charities AIDS Services (CCAS), at both individual and facility levels. Ideally, data collection should start concurrent with the beginning of the program. The data collected from ACCRS was extracted from the jail management system, medical records, and the medical staff's internal MOUD-specific data log. The CCCCS reporting tool is completed for each patient by a reentry specialist who is mainly responsible for the reach-ins, warm handoffs, the post-release linkages to other care providers, and the specific outcomes that pertain to an individual's social determinants of health (SDOH) in the community.

Research has already established that provision of MOUD for incarcerated individuals is evidence-based.[xxii] Successful correctional MOUD programs can impact individuals with OUD beyond the correctional setting by leading to participation in community MOUD, reduced mortality, and improved functioning. To measure these long-term effects, correctional MOUD programs should collaborate and share data with stakeholders in the community, such as community-based OTPs and clinics.

Note: Data Sharing Regulations and Restrictions

It is critical when developing a program evaluation, it's important to understand and consider the data sharing limitations and policies of the particular correctional agency and to establish any data sharing or research agreements in advance. For example, DOCCS Directive 0403 governs all research activities that involve outside entities, including the sharing of administrative data, surveys, interviews, or focus groups. At DOCCS, an NDA is also required for any data sharing between agencies.

Consistent with DOCCS' requirements for any research activities involving incarcerated individuals or parolees. Program participants should be provided an informed consent of program outlining that their data is being included in a program evaluation and the purpose of the research study/program evaluation.

Community providers planning to conduct focus groups, surveys or interviews of parolees who were released from jail, any of those research activities must be approved through DOCCS, Division of Program Planning, Research & Evaluation in advance, per this directive: https://doccs.ny.gov/system/files/documents/2022/01/0403.pdf.

Pursuant to 42 U.S.C. 290dd-2(g), the regulations impose restrictions upon the disclosure and use of substance use disorder patient records which are maintained in connection with the performance of any part 2 program. Therefore, it may be necessary for substance use treatment agencies to analyze data internally and share only blinded, aggregate data with partners, or to explore other creative data-sharing mechanisms that comply with federal regulations.

Research shows that the benefits of collaboration between public health agencies and public safety personnel goes far beyond the scope of the specific programs, and can address major societal issues such as stigma. Additionally, the findings will provide further insight as it relates to staff perceptions of the acceptability and effectiveness of MOUD. Due to the patient base and secure environment, administering MOUD in the correctional health system has different layers of complexity, but with the use of evaluation, these issues can be captured and help structure a targeted response from state partners.

ACCRS Evaluation

The current evaluation efforts at ACCRS and other NYS county jails aim to empirically assess the impact of MOUD integration for the individuals they serve, their county, and the facility itself. To measure this, developing a comprehensive data collection process that focuses on various points in the program is beneficial to have better tracking efficacy in place.

The various points of catchment include:

- The individual's initial entry at the correctional facility
- Time during incarceration
- Approaching discharge and follow-up in the community for up to six months post release

Evaluation is best conducted at two levels:

- Individual
- Facility

Example From The Field: ACCRS MOUD Program

Individual and Facility Assessment

Two Sites: ACCRS (during incarceration) and Catholic Charities (CCAS) (post-release)

Individual Level (ACCRS)

- Sociodemographic factors (Jail Management System)
- Medical records (including mental health): EMR Intake assessments
- Psychological services
- Drug court status
- Knowledge, attitudes, and beliefs about MOUD (Interviews and focus groups)

Individual Level (CCAS)

- Linkage to care and community support
- Housing and employment
- Social support
- History of overdose
- Recidivism
- Knowledge, attitudes, beliefs around MOUD (Interviews and focus groups)

Facility Level (ACCRS)

- Facility's readiness for implementing the MAT program
- Successes and challenges

Facility Level (CCAS)

- Facility's readiness for connecting reentrants to community providers
- Successes and challenges

Individual-Level Assessment

The individual-level assessment includes a list of wide-ranging indicators that could help evaluate the impact of the program on care continuation, recidivism, and quality of life improvement for various groups of patients.

The individual-level assessment at the jail can include various levels of information such as:

- Sociodemographic factors,
- MOUD (initiation or maintenance, type of medication, name of the outside provider if applicable, etc.),
- Patients' medical records such as health insurance coverage and history of overdose,
- MH and counseling services,
- Drug court status, as well as disciplinary tickets issued by the jail in relation to the program (i.e., diversion)

It is recommended for the individual-level assessment to be complemented with more in-depth qualitative components, such as focus group discussions and semi-structured interviews with staff and patients to evaluate their knowledge, attitudes, and beliefs around MOUD. (***Appendix D: Evaluation Forms***)

The individual-level assessment at the main care provider (DUHH, COTI, etc.) captures items including:

- Success of the linkages and referrals to community care providers
- Risk of overdose
- Quality of life measures (such as health status, housing, income, and social support) after release
- Drug court status and recidivism

Individual-level assessment forms are completed on a rolling basis as individuals enter the correctional settings and start the MOUD program at the jail.

It is important to revisit the forms for each patient once new information is obtained; for instance, information such as the bridge script is usually not available prior to release date.

It is recommended for the post-release individual assessment to be complemented with semi-structured interviews conducted with a random sampling of 25-35 reentrants at two stages of reentrance:

1) Two to four weeks, and
2) Six months after their release

Facility-level assessment

The facility-level assessments measure the key organizations' capacity-building in preparation for the MOUD program. Particularly crucial in the early phase of the program, the facility-level assessment at the county jail should include:

- Questions about the essential trainings for the staff and patients
- Number and capacity of trained staff
- Procedures and arrangements for enabling close collaboration among various stakeholders in the MOUD program

It is recommend that facilities complete this form no less frequently than monthly, especially at the beginning of the program. It is also recommended that the data in this category is complemented with more in-depth content such as semi-structured interviews and focus group discussions with the staff. (***Appendix E: Qualitative Evaluation Tools***)

The facility's capacity will depend on the expected number of persons entering the facility every day who meet OUD criteria in addition to the daily census of persons with OUD.

These data should be further disaggregated by continuation of existing medications versus initiations which typically require frequent dose adjustment and greater prerelease care coordination. Determining the expected number of eligible patients (and the number of patients who agree to treatment) is important in estimating the resource requirements.

The facility-level assessment for the regional DUHH (or the main MOUD facilitator post-release) should include indicators that capture the current level of involvement their staff has in preparing an individual for discharge and community reentry, with an emphasis on connections to MOUD.

These indicators include all but are not limited to:

- Number of in-reach visits and warm handoffs provided
- Naloxone trainings prerelease and post release

It is recommended for the facility assessment to be complemented with more in-depth data such as semi-structured interviews and focus group discussions with the staff. Key questions can address attitudes and beliefs about MOUD, including perceived acceptability, appropriateness, and feasibility of implementing it within this jail. (***Appendix F: Issue to Consider for Designing Evaluation Forms***)

Section Resources

Program Evaluation

- How to Collect and Analyze Data: A Manual for Sheriffs and Jail Administrators (National Institute of Corrections)
- Data Collection Across the Sequential Intercept Model: Essential Measures (SAMSHA)
- A Framework for Program Evaluation (CDC)

Appendices

- **Appendix A:** **Sample of Buprenorphine Distribution Protocol**
- **Appendix B:** **MOUD Clinical Guidance and Protocol**
- **Appendix C:** **Buprenorphine Initiation Protocol**
- **Appendix D:** **Evaluation Forms**
- **Appendix E:** **Qualitative Evaluation Tools**
- **Appendix F:** **Issues to Consider for Designing Evaluation Forms**

Appendix A: Sample of Buprenorphine Distribution

Buprenorphine Continuation Protocols

I. PURPOSE:

To provide a procedure that both the Nursing and Correctional Staff can adhere to for the administration of buprenorphine.

II. POLICY:

The (Insert Name of County Facility) provides for the continuation of treatment of OUD for patients prescribed buprenorphine.

III. PROCEDURES:

A. Buprenorphine/Naloxone Maintenance Protocol

a) Medical staff will conduct an assessment at intake utilizing validated screening and assessment tools.

b) Patient signs Release of Information (ROI) to coordinate with community prescriber and verify medication dosage. If dose is not verified, screen for OUD and consult with MD. Medical practitioners or their designee check the Prescription Drug Monitoring Program (PDMP) to access a snapshot and history of controlled substances prescribed to the patient, and to check medication and dosage. https://www.nyacp.org/i4a/pages/Index.cfm?pageID=3799.

c) Urine drug screen consent form needs to be completed, signed, and witnessed. The urine test performed to verify buprenorphine metabolite. If no buprenorphine metabolite is detected, screen for OUD and consult with the MD or other prescriber.

d) Patient consent for treatment is obtained.

e) Patient consent is obtained for communication between clinical and supportive staff to coordinate care.

f) Obtain order for current dosage of buprenorphine from provider; clinical assessments and other pertinent medical history are received from patient with the provider.

g) Continue the order of buprenorphine as prescribed, from the previous prescriber.

h) Notify correctional staff so patient can be escorted to _____ for administration of buprenorphine.

i) Administer buprenorphine. (See instruction sheet #)

j) Document the referral in medical records and communicate to the supportive staff involved in patients care (CASAC, MH, etc.) to ensure continued coordination throughout term of incarceration for patient.

k) Provide patient education via materials that details MOUD and opioid overdose prevention (OOP).

l) Provide linkage via internal support staff to recovery coaches, community providers, and counseling services and coordinate with community buprenorphine providers to ensure medication maintenance and continuation.

m) Upon discharge, 3-7 day prescription of buprenorphine will be transmitted to local pharmacy for the patient.

n) Naloxone kit will be disseminated to the patient upon release (in property on release).

Buprenorphine Administration

I. PURPOSE:

To provide a procedure that both Nursing and Correctional Staff can adhere to for the orderly and secure issuance of buprenorphine.

II. POLICY:

The (*Insert Name of County Facility*) provides for the maintenance and prerelease treatment for patients prescribed buprenorphine.

III. PROCEDURES:

1. The unit of buprenorphine to be administered will be in the form of a sublingual (under the tongue) dissolvable tablet or buccal (inside cheek) dissolvable film.
2. The time of issuance will be determined by Medical Staff in consultation with the Shift Commander.
3. Patients who are prescribed buprenorphine will be called to the (designated location) by a Correctional Officer at a designated time.
4. A Nurse will administer the buprenorphine from the area where medications are regularly administered.
5. Buprenorphine shall be left in its original packaging until nursing staff is ready to administer to the patient.

Prior to Administration

The following procedures below discuss the step by step instructions prior to the administration of buprenorphine.

6. The Nurse will verify each inmate by their departmental identification protocol, administer the buprenorphine and document in each patient's record.
7. Prior to the issuance of buprenorphine, a nurse and/or assigned staff will conduct a thorough check of the patient's mouth. (Patients shall open their mouths, lift their tongues and roll each lip for the Nurse and/or assigned staff to view.)
8. Patients are instructed to untuck uniform shirts to avoid diversion attempts. (Patients are not allowed to wear shirts under uniform shirt).
9. A Nurse/Correctional Officer will require the patient(s) to drink a small cup of water prior to buprenorphine being given to them.
10. The nurse is to make sure the patient's hands are dry and if the patient needs to handle the medication, the medication is to remain visible. They should hold the buprenorphine between two fingers.

If medication needs to be handled by the nurse or the patient, the facility should ensure appropriate hygiene.

Buprenorphine Administration

The following procedures below discuss the step by step instructions for the administration of buprenorphine.

11. The Nurse will direct the patient to place sublingual buprenorphine tablet under their tongue or buccal film inside cheek and leave it there until it has fully dissolved.
12. The Nurse will verify the patient placed the buprenorphine under their tongue or inner cheek. (The Nurse will administer the buprenorphine the same way each time to ensure consistency in medication absorption).
13. After the patient(s) have received buprenorphine, the patients(s) will be observed by designated staff while the medication is being absorbed/dissolved.
14. Patients will be directed to keep their hands visible to the correctional officers while in the designated area.

Post-Administration

The following procedures below discuss the step by step instructions that occur after the administration of buprenorphine.

15. Once buprenorphine has been administered, the patient(s) are not allowed to have their hands in or around their mouth.
16. The patient will remain in the designated area for the entire 10-20 minute period or longer if necessary (buprenorphine has not dissolved).
17. If patient is having difficulty dissolving the buprenorphine, the correctional staff should instruct the patient to tip head forward to increase the production of saliva in their mouth.
18. Once the buprenorphine has completely dissolved, a nurse/designated staff will conduct a thorough check of the patient's mouth. (Patients shall open their mouths, lift their tongues and roll each lip for the Officer to view).
19. The patient will be required to drink a small cup of water prior to being allowed to leave the area. The patient will then be instructed to open hands with fingers spread before leaving the area.
20. If at any time, correctional staff suspects or observes a patient putting their hands around their mouth, a mouth check will be performed to determine the presence of the buprenorphine. *If facilities administer film form of medication, staff should also check fingers and hands post administration.*
21. Upon conclusion of the procedure, the patients(s) will return to their assigned living area.
22. If at any time, the patient reports an adverse reaction to buprenorphine, the correctional staff is to immediately refer the patient to the nursing staff for medical observation. (Adverse side effects can include difficult or troubled breathing, dizziness, faintness, lightheadedness, drowsiness, irregular, fast, slow or shallow breathing, sleepiness, unusual tiredness or weakness, blurred vision).
23. If there are any questions or concerns around medication (dosage, late-onset side effects, etc.), these will be reported to the prescribing practitioner for follow-up medical consultation.
24. Any identified attempt at diversion of buprenorphine should be documented and the patient should be referred to medical for evaluation.

Appendix B: MOUD Clinical Guidance and Protocol

What Do We Want to Achieve Through the Use of this Protocol?

This clinical guidance and protocol focuses on medical providers working within correctional facilities and prescribing MOUD for persons who have OUD who are incarcerated. The information below describes diagnostic requirements, prescribing and dosing strategies, recommendations and physical assessment prior to dosing recommendations. Guidance is provided on patient identification recommendations, opioid withdrawal assessment protocols and issues relevant to special populations.

Target Audience:

Medical providers working within correctional facilities.

Target Population:

Persons with an OUD that are currently incarcerated in correctional facilities that enter the facility on buprenorphine and/or to be inducted on buprenorphine within the facility prior to release.

Recommended Process/Procedures:

A. Diagnostic Requirements

Common opioids

1. Diacetylmorphine (Heroin);
2. Fentanyl (Duragesic)
3. Hydromorphine (Dilaudid),
4. Oxycodone (OxyContin, Percodan, Percocet, and Tylox);
5. Meperidine (Demerol);
6. Hydrocodone (Lortab, Vicodin);
7. Morphine (MS Contin, Oramorph),
8. Codeine
9. Methadone
10. Tramadol (Ultram)

1. Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association page 541.

Diagnosis of OUD (DSM-V Criteria[1]):

3 criteria in the same 12-month period:

- ☐ Opioids are taken in larger amounts or over a longer period of time than intended.
- ☐ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- ☐ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- ☐ Craving, or a strong desire to use opioids.
- ☐ Recurrent opioid use resulting in failure to fulfill major obligations at work, school or home.
- ☐ Continues opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- ☐ Important social, occupational or recreational activities are given up or reduced because of opioid use.
- ☐ Recurrent opioid use situations in which it is physically hazardous.
- ☐ Continues use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
- ☐ Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of opioids to achieve intoxication or desired effect
  - Markedly diminished effect with continued use of the same amount of an opioid
- ☐ Withdrawal, as manifested by either of the following:
  - The characteristic opioid withdrawal syndrome
  - The same (or closely related) substance are taken to relieve or avoid withdrawal symptoms.

Total Number Boxes Checked: _____

Severity: **Mild:** 2-3 symptoms **Moderate:** 4-5 symptoms **Severe:** 6 or more symptoms

B. Prescribing Requirements:

Under federal law, methadone for addiction treatment may only be lawfully dispensed by federally-authorized treatment centers, or OTPs. Buprenorphine may be prescribed in many outpatient settings, but only by clinicians who have completed an approved training and received authorization to prescribe it from SAMHSA. Authorized or "waivered" prescribers are permitted to dispense or prescribe specifically approved Schedule III, IV, and V narcotic medications, including buprenorphine. Naltrexone may be prescribed by anyone who prescribes medications. DATA 2000 enables qualifying physicians to receive a waiver from the special registration requirements in the Controlled Substances Act for the provision of medication for opioid use disorder. This waiver allows qualifying practitioners to prescribe Schedule III, IV, or V narcotic medications specifically approved by the FDA for MAT.

Buprenorphine Prescribing Requirements:

The DEA assigns the practitioner an identification (ID) number to prescribe buprenorphine. DEA regulations require this ID number to be included on all buprenorphine prescriptions for opioid addiction treatment, along with the practitioner's regular DEA registration number.

Prescribing requirements:

- Licensed provider with DEA Registration
- Registration with SAMHSA and DEA
- With respect to the prescription of certain medications that are covered under applicable provisions of the CSA, such as buprenorphine, practitioners, defined as physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives, who are licensed under state law, and who possesses a valid DEA registration, may be exempt from the certification requirements related to training, counseling and other ancillary services.
- Practitioners utilizing the exemption are limited to treating no more than 30 patients at any one time. Time spent practicing under the exemption will not qualify the practitioner for a higher patient limit.
- Must adhere to patient panel size limitations
  - — Practitioners who do not wish to practice under the exemption and its attendant 30 patient limit may seek a waiver per established protocols.
  - — Eligible to apply for increase to 100 after the first year
  - — May apply to increase to 275 after being at 100 for a year and meeting specific criteria

*The limit is "rolling". Once the medical practitioner is no longer prescribing to a patient, that individual is no longer an active patient under that provider's DEA X number.

Prescribers in Correctional Facilities:

Medical personnel in correctional facilities serving incarcerated patients may obtain a DATA 2000 waiver to provide MAT for OUD by submitting a Notice of Intent before using buprenorphine to treat patients with OUD and obtain a waiver number from the DEA. The Notice of Intent requires a simple, on-line application, submission of documentation of a valid DEA registration and state license, followed by approval. Information about this process, can be found at: https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner.

C. Opioid Withdrawal Protocols:

Clinical assessments for MOUD begin with a general assessment for SUDs, which includes alcohol and benzodiazepines. Such assessments allow tailoring of treatment to a person's withdrawal symptoms, often helping to identify the appropriate amount of medication needed and when the medication should be initiated. The physician should consider the use of objective opiate withdrawal assessment instruments when initiating treatment to an individual who is currently dependent (e.g., Clinical Opiate Withdrawal Scale (COWS).

D. History and Physical Assessment Prior to Initiation:

In the correctional setting the physical assessment should include obtaining the clinical history of the individual. The history should encompass the types of opioids used and the history of usage. The provider should review first use, illicit vs. licit use, frequency and amounts, routes of administration, and recent use. The provider should consider tolerance and withdrawal, relapse frequency and history of non-opioid SUDs. Treatment history including MOUD and details of recently prescribed buprenorphine can be verified in the PDMP. Psychiatric and medical histories should be components of the overall history.

E. Initiation Protocol:

The goal of the initiation phase is to transfer the patient from an opioid to a form of FDA approved MOUD and make initiation the first step to assist the patient in diminishing use of other opioids. Having structured initiation procedures in the correctional setting is intended to ensure monitoring during the initial phases of treatment.

Buprenorphine: Opioid-dependent individuals should wait until they are experiencing mild to moderate opioid withdrawal before taking the first dose of buprenorphine to reduce the risk of precipitated withdrawal. Generally, buprenorphine initiation should occur at least 6-12 hours after the last use of heroin or other short-acting opioids, or 24-72 hours after their last use of long-acting opioids such as methadone. Initiation of buprenorphine should start with a dose of 4-8 milligrams (mg). Dosages may be increased in increments of 4-8 mg, and clinicians should observe individuals during medication administration.

If individuals are continuing to report opioid withdrawal symptoms and/or crave opioids, consideration should be given to increasing the dose by 4-8 mg (daily doses of 12-24 mg or higher in some cases).

Methadone: Methadone is a treatment option recommended for persons who are physiologically dependent on opioids, able to give informed consent, and who have no specific contraindications for agonist treatment when it is prescribed in the context of an appropriate plan that includes psychosocial intervention. The recommended initial dose for methadone ranges from 10 to 30 mg, with reassessment in 3-4 hours, and a second dose not to exceed 10 mg on the first day if withdrawal symptoms are persisting.

The usual daily dosage of methadone ranges from 60 to 120 mg. Some individuals may respond to lower doses and some individuals may need higher doses. Dosage increases in 5-10 mg increments applied no more frequently than every 7 days (depending on clinical response) are necessary to avoid over sedation. Doses are to be individualized based upon the patient's subjective feelings of craving opioids and with attention to other medications that may cause rapid metabolism of methadone. It is imperative for correctional facilities to have a ongoing care coordination with local OTPs to ensure medication maintenance and oversight.

Naltrexone: Extended-release injectable naltrexone may be more suitable for individuals who have issues with adherence. Extended-release injectable naltrexone should be administered every 4 weeks by deep Intramuscular (IM) injection in the gluteal muscle at a set dosage of 380 mg per injection.

Special Considerations for Naltrexone

- Contraindicated with concurrent use of opioid analgesics, including methadone or buprenorphine.
- Need to stop all opioids for at least 7-10 days before starting treatment to avoid precipitated withdrawal.
- Will precipitate acute opioid withdrawal if administered to a person dependent on opioids.
- Blocks reinforcing effects of opioids.
- No tolerance or withdrawal symptoms upon discontinuation.
- May be useful in stable patients with strong motivation and established recovery programs, or in patients who are required to discontinue methadone or buprenorphine.
- Has been found to be useful in treatment of alcohol use disorder.
- Increased potential for overdose after discontinuation.[xxiv]

For patients who are actively using opioids other than prescribed buprenorphine or methadone, the medical staff should assess symptoms with COWS, Subjective Opioid Withdrawal Scale (SOWS) or other validated screening tools. (***Appendix C for Buprenorphine Initiation Protocol***).

F. Discussing Goals of Treatment:

Inform the individual that the use of these medications does not "substitute one substance for another" and that these medications are best practice to treating persons with OUD. The provider should also inform the individual that medications such as buprenorphine and methadone help stabilize the brain chemistry, alter the euphoric effects of opioids and prevent cravings, and protect against overdose: all of which can assist the individual in addressing areas of their life that affect their health and well-being.

G. Length of Time:

Length of time in MOUD is a clinical decision. Studies show that longer-term MOUD participation increases abstention from illicit opioid use. Treatment with medications should continue for as long as the patient is benefiting. Risks of return to illicit opioid use and mortality are high when treatment is discontinued.

H. Dose Titration/Transitioning/Tapering Protocol:

If the individual is to be tapered off buprenorphine (either by choice or outside factors such as transferring to a facility that does not offer MOUD), it is recommended to decrease the individual's maintenance dose by no more than 4 mg every 3 days, and more slowly if time allows. Once the individual's dose is lowered to 4 mg for 3 days, medical staff can give 2 mg for an additional 3 days while offering ancillary withdrawal medications (ibuprofen, promethazine, loperamide, etc.)

If switching medications (suboxone to methadone or methadone to suboxone), it is recommended to consult with an outside addiction specialist for ordering guidance. Consultation should also be included for individuals choosing to switch to naltrexone.

Methadone: Individuals switching from methadone to buprenorphine in the treatment of OUD should be on low doses of methadone before switching medications. Individuals on low doses of methadone (30-40 mg per day or less) generally tolerate transition to buprenorphine with minimal discomfort, whereas individuals on higher doses of methadone may experience significant discomfort in switching medications[2].

Individuals switching from methadone to extended-release injectable naltrexone must be completely withdrawn from methadone and other opioids before they can receive naltrexone.

Buprenorphine: When considering a switch from buprenorphine to naltrexone, 7-14 days should elapse between the last dose of buprenorphine and the start of naltrexone to ensure that the individual is not physically dependent on opioids before starting naltrexone. When considering a switch from buprenorphine to methadone, there is no required waiting period because the addition of a full opioid agonist to a partial agonist does not typically result in any type of adverse reaction.

Naltrexone: Switching from naltrexone to methadone or buprenorphine should be planned, considered, and monitored. Individuals being switched from naltrexone to buprenorphine or methadone will not have physical dependence on opioids and thus the initial doses of methadone or buprenorphine used should be low. Individuals should not be switched until a significant amount of the naltrexone is no longer in their system, generally about 21 days for extended-release injectable naltrexone.

2. Kampman & Jarvis. ASAM National Practice Guideline for Medications in OUD, JAM 2015.

I. Pregnancy Population:

Medical provider, when evaluating pregnant person for OUD, should first identify emergent or urgent medical conditions that require immediate referral for clinical evaluation. Pregnant people who are physically dependent on opioids should receive treatment using methadone or buprenorphine rather than withdrawal management or abstinence. Release of information forms may need to be completed to ensure communication among healthcare providers. **Treatment with methadone or buprenorphine should be initiated and/or maintained as early as possible during pregnancy**.

J. Patient's Rights:

Each program participant has the right to engage in decisions regarding their treatment, including the right to refuse treatment. Informed consent requires clinician to discuss likelihood of developing physical dependence to agonist medications and withdrawal syndromes if these medications are not continued. It is important for persons seeking these services to agree to those identified services and be made aware of the options and alternatives available to them as well as specific risks and benefits associated with these services.

K. Care Coordination (Warm-Hand Off):

Encouraging coordination between entities as one person transfers from the correctional facility to a community provider is particularly important as release from incarceration is among the highest risk factors for fatal overdose. The term "warm hand-off" is often used to imply that the individual never loses contact with the referring provider until contact with the new provider is established. While a "warm hand-off" is conceptually ideal, organizing systems and programs for successful and consistent implementation can be challenging and complex. Warm hand offs are comprised of several core components. These include:

- Sharing medical records as necessary.
- Medicaid activation or reactivation.
- Providing needed prescription drugs and other treatment regimens continuously after release from or upon return to jail or prison (e.g., 7 to 10-day buprenorphine bridge prescription to allow for medication maintenance until connection to a community provider).
- Providing individuals the information they need to actively participate in managing their health problems as they cycle between systems.
- Ensuring naloxone is made accessible when the individual is being discharged into the community (**Ideally in their possessions upon release**).

Appendix C: Buprenorphine Initiation Protocol

Purpose: The initiation steps listed below are guidelines intended to ensure close monitoring during the initial phases of treatment. For patients who are actively using opioids other than prescribed buprenorphine or methadone, the medical staff should assess symptoms with COWS, SOWS or other validated screening tools.

a) Nursing assessment on intake

b) Urine drug screen consent form needs to be completed, signed, and witnessed. The urine test needs to be performed. Patients should not be discontinued and/or not treated based on the use of prescribed or unprescribed substances including, but not limited to, cannabis, and benzodiazepines.

- **If poly-substance is indicated, refer to the** New York State Buprenorphine Best Practices or the NYSDOH Clinical Guidelines for Substance Use Disorder for further guidance.

c) Patient consent for treatment is obtained.

d) If patient is not currently opioid dependent but diagnosed with OUD, the patient is still eligible for buprenorphine induction.

e) Check NYS Prescription Monitoring Program (PMP) Registry and have patient sign ROI for prescriber or pharmacy to verify medication dosage and fill dates.

f) Review screening, assessments and other pertinent medical history from patient with the provider.

g) Medical staff need to ensure the patient is not on long-acting opioids as buprenorphine may precipitate withdrawal if started too soon following the use of long-acting opioids (i.e., methadone).

If patient is currently on a long-acting opioid, they will not be inducted and/or transitioned to buprenorphine medication until a clinical decision and a plan of care/transition is determined between the community OTP and jail medical provider.

h) Once you have verified that the patient's last reported opioid has been at least 12 hours prior to initiation and the patient's COWS rating is 8-10, begin administration (**per facility's administration policy**).

i) Assess patient's withdrawal symptoms, alleviate cravings and other potential side effects before the next scheduled dose. (Refer to SOWS or COWS for assessing withdrawal symptoms before each subsequent dose throughout the initiation period).

j) Day 1: Initial dose 4-8 mg buprenorphine/naloxone mucosal formulation (or buprenorphine mono-product for pregnant individuals).

k) Provider should monitor patient around response per post administration protocols indicated in policy (**per facility's post administration policy**).

l) Target buprenorphine dose range should be 8 mg to 16 mg per day, with a recommended maximum of 16 mg daily.

Medical staff can increase dosage up to 24 mg for special circumstances such as individuals who have been maintained on that dosage in the community, pregnant population and/or other situations deemed necessary by the medical provider

m) If more than an 8 mg dose is needed, gradually increase the dose in 4 mg increments over the next several days.

Appendix D: Evaluation Forms

Note: Please refer to Appendix F for additional information about Patient ID as well as other issues to consider in evaluation.

A. Individual-Level Reporting Form: MOUD Program for Reentrants

Please complete this form for each reentrant that accessed MOUD services

Patient ID[3] [See *Appendix F*]: _____

Date Patient started reentry services for this case: _____

The goal of this form is to capture information for patients who were enrolled in the MOUD program at this correctional facility, specifically demographic information, arrest history, medical records, psychological services, and enrollment on MOUD.

This form should be completed by the main reentry care provider, 2-4 weeks after the patient is released from the jail. Please note that you should complete a separate form each time an individual is arrested.

Section 1. General Questions

No.	Question	Response Options
1.	Patient's age?	*Please write in*.
2.	Patient's gender?	☐ Female ☐ Male ☐ Non-binary ☐ Other (specify): _____
3.	Patient's race? (Check all that apply.)	☐ African American/ Black ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other (specify): _____
4.	Patient's marital status?	☐ Single ☐ Married/Domestic Partnership ☐ Divorced/Separated ☐ Widow ☐ Other (specify): _____

3. Make sure to introduce a commonly used Patient ID that securely deidentifies patient information. Do not use patient identifier information in your evaluation data set. More information in ***Appendix F***.

5.	Date patient entered facility?	*Please write in the format of* MM/DD/YYYY.
6.	Date patient was enrolled in the MOUD program?	*Please write in the format of* MM/DD/YYYY.
7.	Date patient was discharged?	*Please write in the format of* MM/DD/YYYY.
8.	Is this patient sentenced?	☐ Yes ☐ No ☐ Unknown ☐ Other (specify): _____
9.	How many times was the patient arrested in this facility in total (including the current booking)?	*Please write in*.
10.	How many times was the patient arrested in this facility since program inception (including the current booking)?	*Please write in*.
11.	Which county was this patient committed in?	*Please write in*.

Section 2. Medication for Opioid Use Disorder (MOUD) Program

No.	Question	Response Options
12.	Which of the following phases of the MOUD is the patient participating in? (Categories are specific to MOUD program in Albany)	☐ **Phase 1:** On MOUD prior to incarceration; maintained (on either buprenorphine, naltrexone or methadone) while in the facility ☐ **Phase 2:** Sentenced, OUD indicated and inducted onto buprenorphine at the facility ☐ **Phase 3:** OUD indicated and inducted onto buprenorphine at the facility (regardless of sentencing status) ☐ Other (specify): _____
13.	Which of the following applies to the patient?	☐ Patient had been linked to MOUD care prior to arrest, and currently continues receiving the services at the facility ☐ Patient had never received MOUD by a medical provider prior to arrest. Patient was inducted on MOUD at the facility. ☐ Other (specify): _____
14.	If this was the first time the patient received MOUD, which of the following medications were used for initiation?	☐ Methadone ☐ Buprenorphine (SUBOXONE) ☐ Naltrexone (VIVITROL) ☐ Other (specify): _____ ☐ Does not apply (not the 1st time)

15.	Which provider will continue MOUD care for the patient post-release? (Responses specific to the MOUD program in Albany)	☐ Conifer Park ☐ Whitney Young ☐ Camino Nuevo ☐ Catholic Charities ☐ Addictions Care Center of Albany ☐ St. Peter's Addiction Recovery Center ☐ Patient's Primary Medical Doctor (specify): _____ ☐ Unknown ☐ Other (specify): _____
16.	If on buprenorphine, was a bridge script written for the patient to ensure uninterrupted MOUD upon release from the facility?	☐ Yes ☐ No, patient didn't need a bridge script (i.e., the patient already connected to outside provider or had an open script at home) ☐ No, patient declined a bridge script regardless of medical determination ☐ No, however, the patient most likely needed a bridge script ☐ Unknown ☐ Other (specify): _____
16A.	If a bridge script was written for the patient, how many days of medication were covered? Please provide a numerical number.	Provide responses? ☐ 1 ☐ 2 ☐ 3, etc.

Section 3. Other Medical and MH Records

No.	Question	Response Options
17.	Does the patient have health insurance?	☐ Yes ☐ No ☐ Unknown ☐ Other (specify): _____ If yes, please specify the name of the insurance company: _____
18.	If yes to previous question: Does the patient have Medicaid?	☐ Yes ☐ No ☐ Unknown ☐ Other (specify): _____
19.	Select all items that apply to the patient:	☐ Dependency on alcohol ☐ Dependency on benzos (define?) ☐ Currently pregnant ☐ History of opioid overdose ☐ History of injection drug use (IDU) ☐ History of suicide ☐ Major MH issues/ history of MH hospitalization ☐ Other major health issues (specify): ☐ Unknown
20.	Did the patient participate in any counseling?	☐ Yes ☐ No ☐ Unknown ☐ Other (specify): _____
21.	Which of the following counseling groups did the patient participate in? (Select all that apply)	☐ MOUD ☐ AA ☐ NA ☐ Women's Recovery Group ☐ MH ☐ Counseling ☐ Peer Support ☐ Unknown ☐ None ☐ Other (specify): _____
22.	Did the patient receive any other MH care in addition to counseling?	☐ Yes ☐ No ☐ Unknown ☐ Other (specify): _____

Section 4. Additional Questions

No.	Question	Response Options
23.	Is the patient currently on drug court probation?	☐ Yes ☐ No ☐ Unknown ☐ Other (specify): _____
24.	Has the patient received any disciplinary tickets since program inception at the facility?	☐ Yes ☐ No ☐ Unknown
25.	If yes to the previous question: If known, explain the reason why the disciplinary tickets were issued at the jail for this patient and include the dates	*Please write in*.
26.	Did the patient decline any of the services offered? This may include discontinuing MOUD, declining bridge script, declining warm hand off to [*X DUHH*], etc.	☐ Yes ☐ No ☐ Unknown ☐ Other (specify): _____
27.	(If yes to question 26) Which service/services did they decline?	*Please write in*.
28.	(If yes to question 26) Why did the patient decline services?	*Please write in*.
29.	Please include any other relevant information about the patient's case here.	*Please write in*.

B. Facility Level Monthly Reporting Form: MOUD Program for Correctional Facility

Please complete this form each month to capture facility data specific to the MOUD program and send your completed forms to the program evaluator [*include contact information*]. Should you have any questions, please reach out to *firstname@email.com*. (*000-000-0000*)

Section 1. General Questions

<table>
<tr><th>No.</th><th>Question</th><th>Response Options</th></tr>
<tr><td>1.</td><td>Reporting period month/year:</td><td>Please write in the format of MM/YYYY.</td></tr>
<tr><td>2.</td><td>How many individuals participating in the MOUD program were discharged during the reporting period?</td><td>Please write in.</td></tr>
<tr><td>3.</td><td>Number of providers prescribing MOUD and their current patient limits:</td><td>Please write in.</td></tr>
<tr><td>4.</td><td>Please provide any additional information about MOUD-related staffing (successes, issues that have arisen, etc.)</td><td>Please write in.</td></tr>
<tr><td>5.</td><td>What trainings were offered at your facility?
Please refer to Section VI. Training and Workforce Development for training topics.</td><td>
<table>
<tr><th></th><th>Targeted Group</th><th>Topic</th><th>Pre/Post assessment conducted?</th></tr>
<tr><td>Training 1</td><td></td><td></td><td></td></tr>
<tr><td>Training 2</td><td></td><td></td><td></td></tr>
<tr><td>Training 3</td><td></td><td></td><td></td></tr>
<tr><td>Other (specify):</td><td colspan="3"></td></tr>
</table>
</td></tr>
<tr><td>6.</td><td>How many two-week care follow up meetings were conducted during the reporting period?</td><td>Please write in.</td></tr>
<tr><td>7.</td><td>Please use this space to record any successes for the reporting period:</td><td>Please write in.</td></tr>
<tr><td>8.</td><td>Please use this space to record any challenges for the reporting period:</td><td>Please write in.</td></tr>
<tr><td>9.</td><td>Additional comments/recommendations:</td><td>Please write in.</td></tr>
</table>

Section 2. Discharge and Linkage to Regional Health Hubs

No.	Question	Response Options
1.	Reporting period month/year:	*Please write in the format of* MM/YYYY.
2.	How many reentrants in the MOUD program were discharged from the correctional facility?	*Please write in*.
3.	How many reentrants were included in the warm hand-off program by [*X DUHH*]?	*Please write in*.
4.	How many reentrants were successfully linked to [*X DUHH*] (i.e., attended their first appointment within a month post release)?	*Please write in*.
5.	How many naloxone kits were distributed to reentrants upon release?	*Please write in*.

Section 3. Trainings

No.	Question	Response Options
1.	Please provide information on the training sessions offered at [*X DUHH*] during this reporting period:	

	Targeted Group	Topic	Pre/Post assessment conducted?
Training 1			
Training 2			
Training 3			
Other (specify)**:**			

Section 4. Care Coordination

No.	Question	Response Options
1.	How many two-week progress (program update) meetings were conducted during the reporting period?	*Please write in*.

Section 5. Feedback/Comments

No.	Question	Response Options
1.	Please use this space to record any successes for the reporting period:	*Please write in*.
2.	Please use this space to record any challenges for the reporting period:	*Please write in*.
3.	Additional comments/recommendations:	*Please write in*.

Appendix E: Qualitative Evaluation Tools

Note: Please refer to ***Appendix F*** for additional information about Patient ID as well as other issues to consider in evaluation.

A. Sample interview/survey questions for correctional staff

Sample Description: This goal of this survey/interview is to learn about your experiences with the MOUD program (medication provided for the treatment of OUD) in this correctional facility. Your participation will help us learn more about the MOUD program and will be very useful in helping us expand similar programs throughout the state. We would like to let you know that any information you share with us will remain confidential. Please feel free to skip any questions that you are not comfortable responding to. We appreciate your participation and thank you for your time.

1. Your position/job role _____
2. Years of experience in this role _____
3. In your opinion, what are the most effective strategies for responding to the opioid crisis?
4. What are your thoughts about MOUD as a response to OUD? Do you think that persons with OUD can maintain functional and healthy lives through access to MOUD? What are your thoughts on abstinence and/or detoxification oriented programs?
5. Has the program at the jail changed your perspective to MOUD? If yes, in what ways?
6. Do you think it's a good idea to implement the MOUD program in corrections? Please explain.
7. Do you think that MOUD can help in reducing recidivism and crime?
8. Do you have any particular preferences for certain treatments? Please elaborate.
9. What are the main challenges you encounter on a day to day basis that are related to OUD or the MOUD program?
10. Can you see any changes in the jail dynamics since the program has started? What are the major changes?
11. How do you feel about the jails taking a rehabilitation role for persons who are incarcerated? Do you think this facility is ready for the change?
12. How could the MOUD program be improved in this facility? What additional steps need to be taken to develop high quality programming?
13. Have you received any trainings about the OUD or MOUD in this facility? Please explain which trainings. How would you assess the quality of the trainings? Were the trainings helpful for you? Please explain. In your opinion, how could they be improved? Do you think that the trainings have been sufficient for you to be confident in addressing issues with patients and overcome the challenges?
14. What are the major successes of this program (if any)/What worked well?
    What are the major challenges in this program (if any)/What did not work well?
15. Overall, how successful is this program in your opinion? (From the scale of 1-10)

B. Sample interview questions for patients who are enrolled in the MOUD program while incarcerated

Sample Interview Opening: [*Introduce yourselves*]. We are here to learn about your experience with the MOUD program (medication provided for the treatment of OUD) at this jail. You were selected for this interview because you were enrolled in the MOUD program. Your participation in this group will help us learn more about the MOUD program and will be very useful in helping us expand these type of programs throughout the state. We would like to let you know that no one else can hear your voice at the moment; anything you tell us will be kept confidential, and we will keep all the information private. Please feel free to skip any questions that you are not comfortable responding to. Should this interview make you uncomfortable, you can stop the interview at any moment. This conversation will take approximately 45 minutes. Thank you for your time.

Background information:

- Gender _____
- Race/Ethnicity _____
- Age _____

1. Are you currently using any MOUD for substance use? If yes, which medication are you using? When did you start? Have you had any interruptions in your treatment?
2. Please tell us what you think about MOUD as a response to OUD? [*Follow up questions about the common perceptions about the MOUD program and the attitudinal components of "being clean" vs. "being treated for a chronic disease"*.]
3. What do your friends and family think about the MOUD program here at the jail, or in general? Are they happy that you are currently enrolled? If they have any concerns regarding the program or treatment, what are they?
4. How do you feel about the current MOUD program that is provided at the jail? What are some of the strengths and weaknesses of the program? How could the program be improved in your opinion?
5. *Specific for patients who were inducted on the medication at the jail*: How did you feel (physically and mentally) when you first started MOUD? How are you feeling now?
6. What has been the reaction/opinion of other individuals who are not enrolled regarding your treatments? Do they give you any advice on the treatments?
7. Tell us about the reactions/behavior of the correctional officers regarding the MOUD program and people who are enrolled in it.
8. Tell us about the reactions/behavior of medical staff regarding the MOUD program and people who are enrolled in it.
9. Do you have any comments about the way MOUD medication is being dispensed routinely? In your opinion, how could the process be improved?
10. Have you met with [*X outside provider*] staff? About how many times? Do you think the meetings are generally helpful for you? Please explain. Do you think they will help you be more prepared for reentry into the community? Do you know if you are going to be in touch with them [*X outside provider staff*] post release? Do you have any suggestions for improving these services?

11. Aside from addressing your substance use, what other services do you need to be connected to in the community after you are released (i.e., housing, employment, support services, etc.)?
12. What are your thoughts on continuing MOUD after release?
13. How do you think your family and friends feel about you continuing MOUD after you are released?
14. What do you know about Narcan or naloxone? Can you administer Narcan? Do you have access to it or know where to get it after release?
15. Have you ever experienced an overdose or been with someone that overdosed? If you are willing, can you describe what happened?
16. Is there anything else you would like to tell us about your experiences with MOUD that we have not asked?

C. Sample interview questions for patients who are enrolled in the MOUD program after they are released

Sample Interview Opening: [*Introduce yourselves*]. We are here to follow up on your experience with the MOUD program at [*X Correctional Facility*]. This is the medication provided for the treatment of OUD. Your participation in this group will help us learn more about the MOUD program and will be very useful in helping us expand these types of programs throughout the state. We would like to let you know that anything you tell us will be kept confidential, and we will keep all the information private. Please feel free to skip any questions that you are not comfortable responding to. Should this interview make you uncomfortable, you can stop it at any moment. This conversation will take approximately 45 minutes. We appreciate your participation and thank you for your time.

Background information:

- Gender _____
- Race/Ethnicity _____
- Age _____

1. I understand that you were enrolled in the MOUD program while you were incarcerated at [*X Correctional Facility*]. Please tell us about your experience when you first started MOUD. Were there any interruptions in your treatment since you enrolled? If yes, what happened? Did you receive any MOUD related trainings at the jail or any where else? Looking back, can you tell us more about what you liked or disliked about the MOUD program at [*X Correctional Facility*]?
2. When were you first contacted [*by X DUHH*]? How many times did you meet with them before release? Tell us about the meetings: Were they helpful for you? Which trainings or services were provided for you before release?
3. Were you in contact with [*X Correctional Facility*] after release? Please tell us if you accessed any trainings or referrals (for example, transportation upon release, referrals for MOUD, referrals for any testing or other medical issues, referrals for any psychological or MH services, referrals for housing or employment, or any other services). Were these referrals helpful for you? Were you able to access the services offered by these providers? Do you wish there were referrals for other services? If yes, please tell us which services? Do you have any suggestions for improving these services?

4. Where do you currently live? Do you think you will stay there permanently? Do you currently work? Do you have health insurance? What type of health insurance do you have? Are you obtaining any counseling or mental health services? Do you currently receive any medical services other than MOUD?
5. Have you been arrested since you were released in [*Date of the arrest*]?
6. We would like to learn about your current access to MOUD: Are you currently receiving MOUD services from a provider in the community?
   - If no, what are the main reasons/barriers?
   - If yes, which provider are you linked to? How long did it take to get linked to your current provider? Tell us about your experience with the provider so far.
7. If on buprenorphine or Suboxone, did you receive a bridge script upon release? If yes, how many days of treatment did the script cover? How was the process for receiving a bridge script? Has the script been helpful for you? If yes, please explain how.
8. Please tell us what you think about MOUD as a response to OUD? Had you ever used MOUD before? What do you like about it? What don't you like about it? If you feel it is beneficial, what types of benefits do you see in having a program like this? In your opinion, what are the positive and negative aspects of using MOUD? Do you think that MOUD could prevent future arrests for people with OUD? Would you recommend MOUD to your friends/family members? [*Ask follow up questions about the common perceptions about the MOUD program and the attitudinal components of treating MOUD as "substituting one drug with another" vs. treating OUD as a "chronic illness"*]
9. What do your friends and family think about the MOUD program? How do they feel that you are currently enrolled/not enrolled in MOUD? Do you have any concerns regarding the program or treatment? If yes, what are they? Do they give you any advice on the treatments? Please explain.
10. Do you know about naloxone or Narcan? Do you know how to use Narcan? Do your partner/family members/friends know about it? Do they know how to use it? Would you like to receive a Narcan kit? Have you ever administered Narcan for anyone else? Do your family/friends have a Narcan kit? Do you know where you can get Narcan kits and training in your community?
11. Have you ever experienced an overdose or observed someone having an overdose? If yes, and if you are willing, can you describe what happened?
12. Anything else you would like to tell us about your experiences with MOUD that we have not asked?

Appendix F: Issues to Consider for Designing Evaluation Forms

- Make sure to introduce a commonly used Patient ID that securely deidentifies patient information. Do not use patient identifier information in your evaluation data set. Instead of patient names or other identifying information, use a deidentified Patient ID to merge data from correctional facility and the post release care providers. This can potentially put research participants at risk. This ID will help protect patient confidentiality, while allowing the evaluator to put together various pieces of data at different stages of the program and provides room for more nuanced analysis by allowing for tracking individuals down the road.
- Organizations differ in terms of their preference for electronic or paper-based reporting tools. It is helpful to discuss data collection logistics with relevant stakeholders prior to designing the reporting forms.
- Establishing close communication among various care providers, program coordinators and evaluation specialists is key to effective evaluation.
- Data collectors should preferably be familiar with data analysis and research. If this is not feasible, make sure to organize a few training sessions on data collection techniques to ensure data quality.
- Using various data collection techniques including culturally competent reporting forms with multiple choice and open-ended questions. Forms should be reviewed for health literacy.
- One-on-one interviews and focus group discussions can provide more in-depth information about the program.
- Having an easy to maintain data log is helpful in collecting data and visualizing what processes need to be completed.

Glossary of Terms

ACOG: American College of Obstetricians and Gynecologists

The premier professional membership organization of obstetricians and gynecologists dedicated to the improvement of women's health. ACOG produces practice guidelines and other educational material, including guidelines on treating pregnant patients with opiate use disorder. acog.org/

ASAM: American Society of Addiction Medicine

A professional medical society representing over 6,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of SUD treatment by educating providers and the public, supporting research and prevention, and promoting physician care of patients with SUDs. asam.org/

BWG: Buprenorphine Working Group

This is a working group consisting of approximately 35 buprenorphine providers and SMEs on MOUD from around NY focused on buprenorphine expansion in the state.

COTI: Center for Treatment Innovation

NYS OASAS-certified providers who engage people in treatment through mobile service clinics and linkages to other appropriate levels of care. oasas.ny.gov/RegionalServices/COTI.cfm

CRAFFT: Car, Relax, Alone, Forget, Friends/Family, Trouble

A validated screening tool designed to identify substance use, substance related riding/driving risk, and SUD among adolescents ages 12-21. See SBIRT. crafft.org/

DEA: Drug Enforcement Administration

The agency that enforces the controlled substances laws and regulations of the U.S. through investigation and preparation for prosecution of those who traffic illicit drugs and enforcement of provisions pertaining to the manufacture, distribution, and dispensing of legally produced controlled substances. dea.gov/

DOCCS: Department of Corrections and Community Supervision

Also referred to as NYS DOCCS, this agency is responsible for the confinement and rehabilitation of individuals under custody at 54 state facilities and parolees supervised throughout seven regional offices.

ESAP: Expanded Syringe Access Program

A NYS program under which pharmacies and health care facilities registered in ESAP may sell or furnish up to 10 syringes at a time to adults, 18 years or older, without a prescription. health.ny.gov/diseases/aids/consumers/prevention/needles_syringes/esap/overview.htm

FDA: Food and Drug Administration

The U.S. public health agency that assures the safety, effectiveness, and security of human and veterinary drugs, vaccines, medical devices, food supply, cosmetics, dietary supplements, tobacco, and other biological products for human use. fda.gov/

HR: Harm Reduction

HR is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. It is built on a belief in and respect for the rights of persons who use drugs (PWUD) and incorporates a spectrum of strategies to meet drug users "where they are at," reflecting specific individual and community conditions. harmreduction.org/

MOUD: Medication for Opioid Use Disorder

Formerly Medication Assisted Treatment (MAT) is the use of FDA-approved medications, to treat patients with OUD.

Naloxone: *Not a form of MOUD*

Naloxone, which is administered when a patient is showing signs of opioid overdose, prevents overdose death by blocking opioid receptor sites, reversing the toxic effects of an overdose. It can be administered by intranasal spray under the brand name Narcan or by intramuscular, subcutaneous, or intravenous injection under the brand name Evzio. It can be administered by any person who has been trained to properly administer the spray or injection.

NYSDOH-ODUH: New York State Department of Health-Office of Drug User Health (ODUH)

Established in 2016, ODUH brings together NYSDOH AIDS Institute's Harm Reduction Unit (HRU), Opioid Overdose Initiative, ESAP & NYS Alternative Safe Sharps Collection Program, and the NYS Buprenorphine Access Initiative. ODUH facilitates access to quality, stigma free, culturally competent local health care, prevention, and HR services for all NY'ers who use drugs. health.ny.gov/diseases/aids/general/about/substance_user_health.htm

NYS OASAS: New York State Office of Addiction Services and Supports

NYS OASAS plans, develops, and regulates NYS's system of approximately 1600 chemical dependence prevention, treatment, and recovery programs with an average daily enrollment of nearly 100,000 people. NYS OASAS is the single state agency responsible for the coordination of state-federal relations in the area of addiction services. oasas.ny.gov/

OTP: Opioid Treatment Program

OTPs, which are certified by SAMHSA and accredited by a SAMHSA-approved accrediting body, provide MOUD and counseling for people diagnosed with OUD. OTPs must be licensed by the state in which they operate and register with the DEA.

OUD: Opioid Use Disorder

Physical and psychological reliance on opioids, a substance found in prescription pain medications and illegal drugs like heroin. Opioid dependence causes withdrawal symptoms. Also called opioid addiction.

RODS: Rapid Opioid Dependence Screen

RODS is an 8-item measure of opioid dependence designed for quick, targeted screening in clinical and research settings.

SBIRT: Screening, Brief Intervention, and Referral to Treatment

An evidence-based early intervention approach used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Providers screen patients for risky substance use behaviors using standardized assessment tools, engage patients showing risky substance use behaviors in a short conversation of up to five counseling sessions, and provide referrals to additional treatment for patients whose assessment shows this need.

SEP: Syringe Exchange Program

SEPs, also called Syringe Service Programs (SSPs) or Needle Exchange Programs (NEPs), are community-based prevention programs that protect the public and first responders by facilitating safe access to and disposal of sterile syringes and injection equipment, and can provide a range of services, including linkage to care for SUD and for infectious diseases.

SUD: Substance Use Disorder

SUD, also called substance abuse and addiction, occurs when the recurrent use of alcohol and/or other drugs causes health problems or failure to meet major responsibilities at work, school, or home.

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