NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

JAIL GUIDELINES FOR THE MEDICAL TREATMENT OF SUBSTANCE USE DISORDERS 2025

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NATIONAL SHERIFFS' ASSOCIATION

AMERICAN JAIL ASSOCIATION

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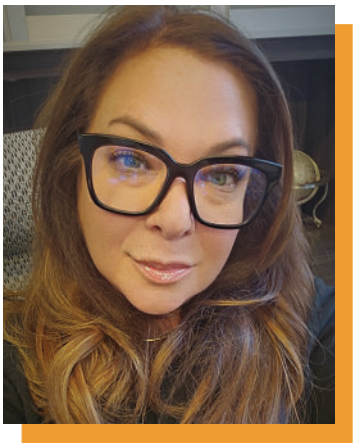

In 2018, NCCHC collaborated with the National Sheriffs' Association to create *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field,* providing much-needed evidence-based guidance on treating substance use disorders in jails. Since then, the landscape of SUD treatment in jails and the broader community has evolved significantly.

Although progress has been made, challenges remain. The drug supply has grown increasingly lethal, and opioid-related overdose deaths remain alarmingly high. Individuals with SUDs are disproportionately represented in U.S. jails, and the devastating impact of these issues extends to families and communities. Despite a growing legal imperative to provide medications for addiction treatment, many agencies still lack the expertise needed to implement these programs effectively.

Recognizing the ongoing need for updated guidance, NCCHC has revisited and expanded on this vital resource. This new publication builds on the groundwork established in 2018, incorporating the latest research, evidence-based recommendations for MAT program implementation and evaluation, and updates on the regulatory environment.

I believe that this publication will empower you in the crucial and often challenging work you do each day, offering practical insights to help lighten your load and enhance your efforts.

Thank you for your dedication to addressing this critical issue. Together, we can continue to make meaningful strides in improving the lives of those we serve.

Deborah Ross, CCHP
Chief Executive Officer
National Commission on Correctional Health Care

Foreword

The National Sheriffs' Association proudly partnered with NCCHC in 2018 to develop *Jail-Based MAT: Promising Practices, Guidelines, and Resources for the Field*. This collaboration underscored our shared commitment to addressing the critical challenges posed by substance use disorders in our nation's jails. There is still much to be done.

As sheriffs, we witness firsthand how SUDs affect individuals, families, communities, and public safety. The impacts reach far beyond the walls of correctional facilities, creating ripple effects that demand a thoughtful and informed response.

The guidelines provided in this resource are essential, up-to-date, evidence-based strategies for implementing effective MAT programs. My hope is that these guidelines serve as a trusted resource, giving correctional leaders the tools and knowledge needed to drive meaningful change within facilities and across the communities they serve.

Jonathan Thompson
Executive Director and CEO
National Sheriffs' Association

As jail administrators and staff, we are on the front lines of addressing the substance use crisis gripping our country. A shortage of community-based treatment options, coupled with an increasingly dangerous and addictive drug supply, has left jails shouldering much of the burden of managing substance use disorders.

This reality makes it essential for jail leadership and medical staff to have the expertise, resources, and tools necessary to address these challenges effectively. Doing so not only helps mitigate legal risks, but also provides individuals with the foundation they need to rebuild their lives and pursue a self-directed future upon release.

The guidelines outlined in this document serve as a critical resource for planning, implementing, and sustaining an effective medications for addiction treatment program. Such programs save lives, promote well-being, and support positive outcomes for everyone involved.

Although this work is undeniably complex and ongoing, our role in tackling substance use disorders within the correctional system is vital and cannot be overstated. Together, we have the opportunity to make a meaningful difference.

Chris Daniels, MPA, CAE
Executive Director
American Jail Association

Acknowledgements

The 2025 *Jail Guidelines for the Medical Treatment of Substance Use Disorders* represent a significant advancement in ensuring evidence-based, patient-centered care for individuals with substance use disorders in correctional settings. This update would not have been possible without the dedication, expertise, and collaboration of numerous individuals and organizations committed to improving health care in jails.

Special recognition is due to the working group members who generously contributed their expertise and time to this publication:

Andrew Angelino, MD, chair of psychiatry at Johns Hopkins Howard County Medical Center and professor of clinical psychiatry at Johns Hopkins University School of Medicine

Kevin Fiscella, MD, MPH, CCHP, addiction medicine expert and professor of family medicine at the University of Rochester

Anthony Tamburello, MD, CCHP, associate director of psychiatry at Rutgers University Correctional Health Care and clinical professor of psychiatry at Rutgers Robert Wood Johnson Medical School

Robert Simon, MEd, LPC-S, CCHP-MH, director of accreditation, Opioid Treatment Programs and mental health services for the National Commission on Correctional Health Care.

In addition, we extend our sincere appreciation to Claire Wolfe, MPH, MA, CCHP, program manager for NCCHC Resources, Inc., for her administrative and project management support throughout this process.

We also acknowledge the valuable contributions of the American Society of Addiction Medicine, National Sheriffs' Association, American Jail Association, and the International Association of Addictions and Offender Counselors, who provided thoughtful feedback on a draft of these guidelines. Their insights helped ensure that these guidelines reflect both the latest research and practical applications in correctional health settings.

Furthermore, this update builds upon the foundational work of those who contributed to *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* (2018). NCCHC recognizes and appreciates all individuals involved in that publication, whose efforts laid the groundwork for continued advancements in the treatment of substance use disorders in jails.

We sincerely thank the diverse community of subject matter experts, clinicians, researchers, policymakers, and correctional health professionals whose valuable insights and recommendations were essential throughout the revision process. Their commitment to enhancing substance use disorder treatment in jails has played a crucial role in shaping these guidelines.

Finally, we recognize the voices and lived experiences of individuals affected by substance use disorder, including those who have navigated treatment within the justice system. Their experiences serve as a powerful reminder of the importance of compassionate, effective, and comprehensive care.

Together, this collective effort ensures that the 2025 *Jail Guidelines for the Medical Treatment of Substance Use Disorders* serve as a vital resource for health care providers, correctional administrators, and policymakers striving to improve care for individuals with substance use disorders. We are confident that these guidelines will support better health outcomes, reduce recidivism, and promote recovery for those impacted by substance use disorder in jail settings.

Thank you to all who contributed to this important work. Your dedication makes a difference.

Perspective for Jail Leadership

Jails are the largest providers of substance use and mental health treatment in many communities across the country. From initial arrest to booking, through incarceration, and upon return to the community, our detention facilities are responsible for the safety, security, and health of justice-involved people. Over the past several years, programs that provide access to medications for addiction treatment have been implemented in many jurisdictions. In my role as the managing director of NCCHC's consulting arm, NCCHC Resources, Inc., I have traveled across the country and heard firsthand from many jail leaders about the benefits they have witnessed:

- Reduce adverse events: Providing evidence-based treatment may reduce emergency department transports and in-custody deaths.
- Improve behavioral management: Eliminating or minimizing withdrawal symptoms may reduce individuals' agitation and encourage cooperation.
- Enhance staff environment: With fewer people experiencing withdrawal symptoms, staff working conditions may improve.
- Reduce overdoses upon community reentry: MAT during incarceration and a connection to community resources upon release reduce the risk of overdose and death.
- Prevent legal liability: There is an increasing legal mandate to provide MAT under the Americans with Disabilities Act.

Although there may be concerns about medication misuse and diversion (i.e., contraband), facilities with appropriate policies, training, oversight, and continuous quality improvement programs have managed this risk effectively. To do so, it is crucial that custody staff and leadership work in tandem with health services. Use this guide to plan, implement, and monitor an effective MAT program in your facility.

Fred W. Meyer, MA, CJM, CCHP
Managing Director
NCCHC Resources, Inc.

Jail-based treatment for substance use disorders has evolved since 2018, when *Jail-Based Medication-Assisted Treatment* was originally published. Now, more jails offer access to methadone, buprenorphine, and/or naltrexone.[1] In addition, the legal landscape has evolved to elevate the standard of care that jails are required to meet.[2] Meanwhile, increasingly lethal drugs have become common, and the number of overdoses remains high in the United States.[3]

With this update, NCCHC seeks to capture this evolution while maintaining the goals of the original publication. This version includes a change in structure, updated research, and new resources, as well as changes to specific content that our working group deemed necessary to accurately reflect the current landscape of jail-based MAT treatment.

Notable updates include the following:

Terminology

Humanizing language and a nonstigmatizing approach to addiction elevates the understanding of substance use disorders as chronic diseases. Furthermore, justice-involved individuals often face stigma during and after incarceration that can lead to dehumanizing treatment and adverse outcomes. NCCHC promotes the use of humanizing, person-first language to describe people who are incarcerated.[4] The authors intended to avoid stigmatizing language. However, preferred language changes over time and differs by perspective. We acknowledge that the language used here may not be considered correct by all.

"Medication-assisted treatment" (MAT) and "medications for opioid use disorder" (MOUD) are commonly used to describe buprenorphine, methadone, and naltrexone, the three medications for the treatment of opioid use disorder (OUD) approved by the Food and Drug Administration (FDA). However, MOUD excludes medications for the treatment of alcohol use disorder (AUD), a condition that is highly prevalent among jail and prison populations.[5,6] The term MAT is commonly used and understood by jail administrators, custody staff, and health staff in correctional facilities to refer to addiction treatment that encompasses both OUD and AUD treatments. For these reasons, we have chosen to continue using the acronym MAT but intend for it to mean medications for addiction treatment, to include treatment for both OUD and AUD.

Regulatory Changes

Buprenorphine

Since 2023, prescribers no longer need to obtain an X-waiver to prescribe buprenorphine. Instead, all clinicians must complete educational requirements prior to applying for or renewing a Drug Enforcement Administration (DEA) registration regardless of whether they intend to prescribe buprenorphine or not. Furthermore, there is no longer a cap on the number of patients that practitioners are allowed to treat with buprenorphine. Thus, any physician, nurse practitioner, physician assistant, or nurse midwife with an active, unrestricted DEA license can prescribe buprenorphine in the absence of state restrictions.[7]

Methadone

In 2024, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced regulatory updates expanding the definition of long-term care facilities, with implications for methadone prescribing for correctional facilities that register with the DEA as a hospital/clinic (see the methadone section on page 12 for more information). States may also apply for a Medicaid reentry Section 1115 waiver demonstration project to benefit those leaving jails and prisons.[8]

Over-the-Counter Naloxone

Naloxone is a medication that rapidly reverses the effects of opioid overdose. In 2023, the FDA approved naloxone for over-the-counter, nonprescription use.[9]

Opioid Treatment Programs (OTPs)

In 2024, SAMHSA announced regulatory updates regarding OTPs. This document reflects the status of OTP regulations at the time of publishing.

[1] Flanagan Balawajder, E., Ducharme, L., Taylor, BG., et al. (2024). Factors associated with the availability of medications for opioid use disorder in US jails. *JAMA Netw Open*, 7(9):e2434704. doi:10.1001/jamanetworkopen.2024.34704

[2] Legal Action Center. (2024). Smith v. Aroostook Cty. In *Cases involving discrimination based on treatment with medication for opioid use disorder* (MOUD). https://www.lac.org/assets/files/Cases-involving-denial-of-access-to-MOUD.pdf

[3] National Center for Health Statistics. (2024). *Drug overdose deaths in the United States*, 2002–2022. https://www.cdc.gov/nchs/products/databriefs/db491.htm

[4] National Commission on Correctional Health Care. (2021). *Use of humanizing language in correctional health care* (position statement). https://www.ncchc.org/position-statements/use-of-humanizin g-language-in-correctional-health-care-2021/

[5] Fazel, S., Yoon, I. A., & Hayes, A. J. (2017). Substance use disorders in prisoners: An updated systematic review and meta-regression analysis in recently incarcerated men and women. Addiction, 112(10), 1725-1739. https://www.doi.org/10.1111/add.13877

[6] Bureau of Justice Assistance. (2022). *Managing substance withdrawal in jails: A legal brief*. https://bja.ojp.gov/doc/managing-substance-withdrawal-in-jails.pdf

[7] Substance Abuse and Mental Health Services Administration. (2024). *Waiver elimination* (MAT Act). https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act

[8] Health and Human Services Department. (2024). Medications for the treatment of opioid use disorder. *Federal Register*. https://www.federalregister.gov/documents/2024/02/02/2024-01693/medications-for-the-treatment-of-opioid-use-disorder

[9] U.S. Food and Drug Administration. (2023). *FDA approves first over-the-counter naloxone nasal spray*. https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray

Goal of This Resource

The main goal of this resource is to build on the original document's efforts to support and inform correctional leaders and personnel with up-to-date information when implementing and sustaining a MAT program. This document recommends evidence-based practices for providing MAT with the understanding that not every jail will have the resources to implement every practice described.

The contents of this resource are based on the currently available research on MAT in correctional settings, resources from leading health care organizations and governmental agencies, relevant NCCHC standards, and the expertise of correctional health professionals who shared their guidance on this update.

To advance informed consideration and support for evidence-based practices related to the provision of jail-based MAT, this document offers:

- Information on the various stages of a MAT program, organized clearly with an intent to be concise without sacrificing information and quality
- Current understanding of the regulations related to the provision of MAT
- Citation of resources that delve deeply into specific topics not discussed in depth here
- Case studies of existing programs, presenting real-world examples from which readers can learn

Commonly Used Acronyms

ACOG	American College of Obstetricians and Gynecologists
ASAM	American Society of Addiction Medicine
AUD	alcohol use disorder
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CQI	continuous quality improvement
DEA	Drug Enforcement Administration
FDA	Food and Drug Administration
MAT	medications for addiction treatment/medication-assisted treatment
MAUD	medications for alcohol use disorder
MOUD	medications for opioid use disorder
NCCHC	National Commission on Correctional Health Care
OTP	opioid treatment program
OUD	opioid use disorder
PDMP	prescription drug monitoring program
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	substance use disorder
XR-NTX	extended release naltrexone

Screening Upon Intake

All individuals entering a jail should be systematically screened for substance use disorders upon intake.

Receiving screening should be conducted Immediately upon acceptance into jail custody. Screeners should explain the reason for the questions (e.g., "We ask these questions to ensure you receive appropriate treatment while you are here"). Questions should address physical and mental health, prescribed medications, including MAT, previous drug or alcohol treatment, recent drug or alcohol use including types and amount, and current or past history of drug or alcohol withdrawal. Individuals showing evidence of intoxication or who report MAT or past or current drug or alcohol use should be immediately referred to medical personnel for further evaluation.

Clinical assessments begin with a general screening and assessment for SUDs, allowing treatment to be tailored to a person's problem substances and often helping to reduce the amount of medication needed. People who acknowledge that they have used opioids should be asked about frequency, amount, route, concomitant use of other substances, and history of withdrawal and overdose. Validated tools have been developed for such purposes:[1]

- The Texas Christian University (TCU) Drug Screen 5 is based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. It screens for mild to severe SUD and is particularly useful when determining an individual's placement and level of care in treatment. The TCU Drug Screen 5 also has an opioid supplement to identify the needs of people with OUD and the specific risk for overdose.[2]
- The Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) Tool is a validated nine-item screening and brief assessment for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past 3 months.[3] It screens for SUD in general populations and is available in the public domain. Some jails may elect not to screen for tobacco use.

Medically Managed Withdrawal

Protocols to support timely screening for, and evidence-based management of, active withdrawal syndromes should be in place.

In custody settings, especially jails, substance withdrawal must be addressed early in the intake process (ideally, within 4 hours of admission) to reduce the risk of medical complications and fatalities. Acute withdrawal symptoms may begin within 8 to 48 hours of the last opioid use and last up to 4 to 10 days for short-acting opioids or 10 to 12 days for long-acting opioids.[4] Jails should have protocols in place to identify people who might require medically managed withdrawal services. Medically managing withdrawal reduces the risk of postrelease overdose and use of opioids in jails.

For an individual with OUD, withdrawal is typically avoidable by either continuation of previously prescribed MAT or by initiation of buprenorphine or methadone. There are several potential exceptions to initiation, however, including patient refusal, a preference for injectable naltrexone, transfer to a facility that has confirmed they prohibit MAT, or known unavailability of, or patient unwillingness to participate in, long-term treatment upon release.

Medically managed withdrawal is not only humane but also necessary to reduce the risk of severe medical consequences, including death. However, it is not, by itself, treatment for SUD. In June 2023, the Bureau of Justice Assistance published comprehensive *Guidelines for Managing Substance Withdrawal in Jail,*[5] which state:

- Regular and active observation by custody and health care staff is the foundation for an effective withdrawal management process, which begins with screening upon an individual's arrival to the jail. Diligent observation and structured screening help identify individuals who may be at risk for substance withdrawal.
- Individuals who appear unwell are referred for immediate clinical assessment conducted by a qualified health care professional. Broadly defined, "appears unwell" encompasses observed signs and symptoms obvious to a layperson that:
    - An individual may be sick (physically or psychologically), which includes signs of or self-reported intoxication or substance withdrawal. Symptoms of the latter may present at any time (including upon arrival to the facility); typically, they emerge within 72 hours of arrival.
    - The condition of a patient who has already been assessed by a qualified health care professional is worsening, becoming unstable, or becoming a danger to the patient or others.

People who use opioids often use other substances, too. It is a risk to assume that an individual who reports a history of opioid use is exempt from the potentially life-threatening consequences of alcohol or benzodiazepine

withdrawal. Opioid-dependent individuals may increase their alcohol consumption when they attempt to curtail opioid use. Universal withdrawal severity screening of all people entering corrections with an established or suspected history of substance use is widely recommended.[3,6,7]

Trained staff should use the following instruments to identify and quantify the severity of withdrawal symptoms from opioids, alcohol, and benzodiazepines:

- The Clinical Opiate Withdrawal Scale (COWS), an 11-item scale, is used to reproducibly rate common signs and symptoms of opioid withdrawal and monitor these symptoms over time.[8,9]
- The Clinical Institute Withdrawal Assessment for Alcohol–Revised (CIWA-Ar) is a 10-item scale used to measure symptoms of alcohol withdrawal.[9]
- The Clinical Institute Withdrawal Assessment for Benzodiazepines (CIWA-B) is a 22-item scale used to measure symptoms of benzodiazepine withdrawal.

The use of a standardized brief withdrawal severity assessment can help to stratify risk levels: [5,10]

- Low: should be monitored but does not require medical attention
- Medium: requires immediate medical attention but does not have complicating medical conditions
- High: requires immediate medical attention and intensive monitoring because of other medical conditions that elevate risk.

Even people who do not require medical attention should have easy access to ample drinkable fluids.

Symptoms of opioid withdrawal should be treated in accordance with correctional health care guidelines. Inadequately treated withdrawal increases risk for suicide, disruptive behavior, and illicit use of opioids in jails.[6,11-15] Deaths from withdrawal in jails have been documented.[6,16] Adverse events from poorly managed withdrawal pose a significant legal and financial risk.[6,17]

For opioid withdrawal, methadone and buprenorphine are generally more effective in reducing symptoms and retaining patients in, and in supporting completion of, withdrawal management than alpha-2 adrenergic agonists (e.g., FDA-approved lofexidine and off-label clonidine).[18] Additional medications may be offered as needed to manage specific withdrawal symptoms (e.g., diarrhea or abdominal cramping) but are typically not required when buprenorphine or methadone is given in adequate doses.

Common factors that can elevate risk levels for a complicated alcohol withdrawal include a history of delirium tremens or withdrawal-associated seizures, a history of traumatic brain injury, advanced age, major medical or psychiatric comorbidity, and pregnancy.[5] Patients at high risk may require transfer to a higher level of care.

Medications combined with psychological support are the standard for medical practice and improve recovery outcomes. Outpatient medically managed withdrawal treatment may be appropriate for individuals with mild to moderate opioid withdrawal.[19] To get the best results from medically managed withdrawal, an individual should be immediately connected with medication and counseling.

In custody settings, the medical consequences of acute withdrawal from alcohol or chemically related sedative/hypnotic drugs (for example, benzodiazepines or barbiturates) can be reduced or eliminated when sound protocols are implemented and followed.[5]

Alcohol and sedative withdrawal is usually treated with short-term, gradually tapered doses of long-acting benzodiazepines (e.g., chlordiazepoxide, diazepam, or lorazepam). Alternative protocols may include clonidine. Intravenous fluids, electrolytes, and thiamine (vitamin B1) are recommended. All medications should be ordered by a licensed prescriber and administered under the supervision of trained medical personnel, particularly considering that many individuals entering corrections may suffer from liver disease, a condition that contraindicates the use of certain medications. Vital signs should be monitored.

ASAM criteria, endorsed by SAMHSA in its *TIP 45: Detoxification and Substance Abuse Treatment*, suggests:

> For alcohol, sedative-hypnotic, and opioid withdrawal syndromes, hospitalization (or some form of 24-hour medical care) is often the preferred setting for medically managed withdrawal, based on principles of safety and humanitarian concerns. When hospitalization cannot be provided, then a setting that provides a high level of nursing and medical backup 24 hours a day, 7 days a week is desirable.

If adequate medical monitoring and treatment for moderate to severe withdrawal is not possible within the jail setting, a transfer for emergency medical management is needed.[10]

Continuity of Care

Jails should establish systems to ensure that patients who had been receiving MAT, particularly methadone and buprenorphine, before their arrest have MAT continued in a timely manner.

Withdrawal from prescribed MAT after an arrest is predictable and avoidable by continuing the individual on their prescription. Given the frequency of unexpected releases and transfers from jails, a decision to stop clinically appropriate MAT is high risk. Withdrawal from methadone or buprenorphine increases the risk for adverse consequences. Research has found that forced detoxification (medically supervised withdrawal) of prescribed opioid medication, such as methadone, can undermine an individual's willingness to engage in MAT in the future, compromising the likelihood of long-term recovery.[20,21]

Furthermore, patients in treatment for OUD, including those who are prescribed MAT, are protected from discrimination under the Americans with Disabilities Act. The court in a federal appellate case, *Smith v. Aroostook County* (2019), held that a county jail needed to continue MAT for an arrested individual who had been taking it in the community.[22,23]

MAT continuity can be ensured through appropriate policies and procedures, memoranda of understanding with community programs, established lines of communication with community prescribers, and systems for obtaining MAT and for supervised administration of MAT.

Communication with the person upon jail entry is necessary to confirm dosing with the community program, pharmacy, or prescriber. States with an operational prescription drug monitoring program (PDMP) collect most Schedule II, III, and IV (and, in some states, Schedule V) controlled substance prescription data that can be accessed by authorized users, including physicians and pharmacists. The PDMP can aid in continuity of care when communication with a community prescriber is delayed. Every state and the District of Columbia now have an operational PDMP.[24] Methadone administered through OTPs, however, is generally not reported in PDMPs, although exceptions exist.[25] Systems for obtaining MAT must comply with federal and state regulations.

Enrollment in MAT

Individuals should be assessed by a qualified treatment provider to determine whether MAT is clinically indicated.

If indicated, medication for addiction treatment, and the specific medication chosen, should be based on a medical recommendation and an individual's decision, not imposed by facility policy.

FDA-approved MAT medications are not interchangeable between drug classes (e.g., methadone and buprenorphine). Treatment must be individualized, as some MAT medications work better for a given patient.

People enrolling in MAT often have multiple sources of motivation. These may include internal factors (e.g., a desire for recovery) and external factors (e.g., a desire to impress families, attorneys, and judges). However, research has shown that successful treatment is not dependent on initial internal motivation, and court-mandated treatment may be successful.[26]

When the results of an appropriate health care assessment indicate that someone needs treatment, the health professional's authority to order MAT should not be infringed upon by law enforcement officers, probation and parole agents, judges, facility administrators, or custody staff. The choice of the medication should be a shared decision between the clinician and patient. Adherence is poor when patients are not involved in the decision. Considerations include the patient's prior experience with MAT, the level of structure and supervision required postrelease, cardiac considerations, expected duration of incarceration, prior history of overdose, and availability of the medications for continuity in the community. The most effective MAT medication is the one that the patient takes regularly.

Informed consent and shared decision-making are essential steps before prescribing MAT. Before someone is enrolled into a jail's MAT program, they should be educated about the medications offered with enough information to make an informed decision (see Appendix for a sample educational document).

All available FDA-approved medication options and the rules that govern how each is obtained and used should be discussed, as well as the need for accompanying treatment, support, appropriate services, and postrelease continuation of treatment.[27] All potential adverse reactions to the medications should be disclosed.

Agonist medications (buprenorphine and methadone) cannot be abruptly discontinued without risking withdrawal and relapse. Discontinuation of extended-release naltrexone also increases risk of relapse and overdose due to

decreased opioid tolerance. Thus, patients taking MAT should be warned that discontinuation of the medication should be done only under medical supervision.

Access to care in the community is also part of the informed consent discussion as the number of MAT providers available may be limited, especially in rural communities.

The potential adverse consequences should be presented in a manner and with a vocabulary that the patient can understand. Substance use counselors or, if permitted and available, family members, or close friends may be valuable participants in treatment planning, monitoring, and support.

Professional language interpretation services, whether in-person or telephonic, should be provided if the patient has limited English proficiency. Use of other incarcerated people, family, or custody staff to interpret is a violation of privacy and dangerous given the potential for miscommunication or exploitation.

A physical examination to determine general health is part of the assessment.[28] It should include a drug test and screening bloodwork for medical conditions, including hepatitis, HIV, and other diseases common in people who use substances. When considering methadone, an electrocardiogram should be performed for patients with specific risk factors, such as patient age, heart disease, a history of cardiac arrhythmia, a prolonged QT interval (required time for ventricular repolarization), or taking medications known to prolong the QT interval.[29]

Although a complete assessment is medically necessary for the safe treatment of patients with MAT, initiation of MAT, when clinically indicated, should not be delayed pending full completion of the assessment.

[1] For more information, see *Screening for Substance Use Disorders in Jails (Bureau of Justice Assistance*, 2019). https://www.cossup.org/Content/Documents/Articles/AHP_Screening_for_ Substance_Use_Disorders_in_Jails.pdf

[2] Find the tool here: https://ibr.tcu.edu/wp-content/uploads/2020/09/TCU-Drug-Screen-5-PLUS-Opioid-Supplement-v.Sept20.pdf

[3] Find the tool here: https://cde.nida.nih.gov/sites/nida_cde/files/TAPS Tool Parts I and II V2.pdf

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[6] Bureau of Justice Assistance. (2022). *Managing substance withdrawal in jails: A legal brief*. https://bja.ojp.gov/doc/managing-substance-withdrawal-in-jails.pdf

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[13] Favril, L., Yu, R., Geddes, J. R., & Fazel, S. (2023). Individual-level risk factors for suicide mortality in the general population: An umbrella review. The Lancet Public Health, 8(11), e868–e877. https://doi.org/10.1016/S2468-2667(23)00207-4

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MAT for Opioid Use Disorder

People receiving prescribed MAT should be allowed to continue their medication when this is the patient's wish and is clinically appropriate.

This means that jails need to provide access to all three FDA-approved medications. ASAM gives this advice to physicians treating patients with OUD:

> The choice among available treatment options should be a shared decision between the clinician and the patient. A number of factors should be considered in deciding what treatment(s) to choose. Among the first considerations are the priorities of the patient, for instance: Is the patient open to pharmacotherapy? ... A patient's past experiences with treatment for opioid use disorder should be considered as well. Of course, above all, evidence supporting the potential efficacy and safety of the various treatments is critically important.[1]

Uncertainty regarding the length of detention should not necessarily deter initiation of buprenorphine or methadone since the induction could be continued following release. XR-NTX requires an opioid-free period (i.e., withdrawal) of 7 to 10 days from short-acting opioids and 10 to 14 days from long-acting opioids. Therefore, people opting for this treatment should be informed of the risk of overdose if they are released before the drug can be given.

Choice of Medication

The selected medication must be matched to the needs of the individual.

Table 1 provides further details on each medication.

Methadone

Methadone for OUD is prescribed by OTPs, commonly referred to as "methadone programs." Methadone is a full-opioid agonist (i.e., it stimulates opioid receptors). Clinicians often recommend methadone when a patient may benefit from the structure of an OTP, including daily dosing. Patient preference should also be considered. Retention in treatment is higher for methadone compared to buprenorphine or naltrexone.[2]

Methadone has been widely used during pregnancy, is typically administered in liquid or tablet formulations, and is FDA approved for maintenance and withdrawal management. There is a risk of overdose from methadone when starting this medicine.[3]

The FDA does not permit administering/dispensing methadone for OUD outside of OTPs. However, there are several options and important exceptions under which jails can continue or initiate methadone treatment (see Table 2):

- **Registration as a hospital/clinic.** Under SAMHSA's 2024 final rule, if a correctional facility has registered as a hospital/clinic, a physician or authorized staff may administer or dispense narcotic drugs to maintain or manage withdrawal for an incarcerated individual as an incidental adjunct to medical or surgical treatment of conditions other than addiction. Jails, prisons, and other carceral facilities registered with the DEA as a hospital/clinic are permitted to dispense methadone to patients who are being treated for other medical or surgical conditions. It is recommended that jails ensure that this "incidental adjunct use" conforms with state laws and regulations and coordinate with the local DEA office concerning their registration.
- **OTP accreditation and certification.** Jails may elect to obtain SAMHSA certification as an OTP. NCCHC is designated by SAMHSA as the accrediting body for carceral facilities. The certification process involves a partnership with the DEA, SAMHSA, State Opioid Treatment Authority, and the accrediting body and takes at least a year. Once certified, the jail can dispense methadone for either withdrawal or maintenance. OTP certification is recommended to ensure timely and long-term access to methadone for patients.
- **Partnership with community-based OTP.** Most jails should have memoranda of understanding with local OTPs that include respective roles, relevant processes, and payment terms. Such partnerships should include exchange of information to facilitate care coordination, timely medication continuation, the means for administering methadone to patients (e.g., transport of patients to the OTP or transport of methadone to the jail and telehealth), take-home dosing, and guest dosing services. Under take-home dosing, the OTP will provide up to 28 days of doses for dispensing at the jail. Guest dosing is a process that enables a patient to receive methadone for a short duration at a clinic other than their home clinic. If available, an OTP may use a mobile unit to facilitate methadone dosing. Correctional leaders should be aware of their specific state regulatory environment.[4]

Under an exception to federal regulations known as the 3-day rule, jails can dispense methadone for up to 3 days to a person entering the jail. This is especially pertinent on weekends, when community-based OTPs may be closed, to prevent withdrawal in patients who require methadone. Similarly, a practitioner may dispense a 3-day supply for

Table 1. Maintenance Medications for Addiction Treatment			
	Buprenorphine	**Methadone**	**Naltrexone**
Mechanism of effect	Partially activates the same areas of the brain as opioids; may block higher risk opioids	Activates the same areas of the brain as opioids but longer lasting to stabilize activity	Blocks both external (e.g., heroin) and internal (e.g., endorphins) opioids
FDA indications	Opioid use disorder	Opioid use disorder	Opioid use disorder Alcohol use disorder
Route of administration	Sublingual, buccal, subcutaneous extended-release injection	Oral	Oral, intramuscular extended-release injection
Dosage	≥ 8 mg per day (sublingual) ≥ 5.7 mg per day (buccal) 300 mg monthly x 2 months, then 100 mg monthly (subcutaneous)	Typically 60 to 120 mg per day (oral)	50 mg per day (oral) 380 mg per month (intramuscular)
Pregnancy/lactation	Widely used during pregnancy and lactation. Neonatal abstinence syndrome is common but treatable and may be less severe than with methadone.	Widely used during pregnancy and lacation. Neonatal abstinence syndrome is frequent but treatable.	Controversial, though postinduction risk is comparable to buprenorphine and methadone. Induction requires opioid withdrawal during pregnancy. May be used during lactation.
Considerations	Conversion from methadone to buprenorphine should be performed by experienced clinicians to avoid precipitated wtihdrawal. A patient using fentanyl may require higher doses.	Conversion from buprenorphine to methadone is uncomplicated.	Initiation requires an opioid-free period of 7–10 days before starting long-acting injectable treatment. Unexpected release to the community may thus interrupt treatment initiation.
Possible adverse effects	Sedation, intoxication, dependence, withdrawal, hepatic impairment, constipation, edema, dental complications, adrenal insufficiency, respiratory depression, and death (usually when combined with other sedating medications)	Sedation, intoxication, dependence, withdrawal, itching, QT prolongation and cardiac arrhythmia, neonatal opioid withdrawal syndrome, sperm abnormalities, adrenal insufficiency, respiratory depression, and death (especially when combined with other sedating medications)	Nausea, hepatic impairment, withdrawal if given around the same time as an opioid, mood changes, suicidality, and pain and bleeding on injection. Higher risk of overdose on opioids after long-acting injectable treatment is discontinued.
Retention in treatment	Medium	Highest	Lowest
Mortality risk	Shown to reduce mortality from opioid use disorder; shown to reduce suicide	Shown to reduce mortality from opioid use disorder; higher risk of mortality during treatment compared to buprenorphine	Not shown to reduce mortality from opioid use disorder

Source Notes

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Table 2. Models for Providing Methadone
Model 1: Health care practitioners within the jail provide methadone
Medication administered on-site by facility health staff. Methadone may be dispensed for up to 3 days. A facility may alternatively register with the DEA as a hospital/clinic to provide methadone "to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction."
Facility becomes a licensed OTP. Under this approach, a facility must become certified by SAMHSA, accredited by a nationally approved body (only NCCHC is recognized as such for correctional facilities), licensed by the state in which they operate, and registered with the DEA. It must also comply with applicable state laws and regulations.
Model 2: Community OTP provides methadone to incarcerated patients
Community partner administers medication on-site. A community OTP, under its license, administers MAT in the jail through establishing a brick-and-mortar medication unit within the correctional facility or through the use of a mobile unit (e.g., a van) that travels from the OTP onto the grounds of the jail, where medication is administered.
Community partner provides "take-home" doses to patients under auspices of custody for "self-administration." Patient-specific medication is prescribed by an OTP and taken by facility staff to dose on-site. OTP guidelines allow flexibility in the number of take-home doses and allow for methadone induction through audiovisual telehealth through the OTP.
Patients are transported from the jail to the OTP daily. This model is resource intensive.
Source Notes: Electronic Code of Federal Regulations. (n.d.). *21 CFR § 1306.07—Administering or dispensing of narcotic drugs.* U.S. Government Publishing Office. https://www.ecfr.gov/current/title-21/chapter-II/part-1306/subject-group-ECFR1eb5bb3a23fddd0/section-1306.07#p-1306.07(b). Retrieved February 7, 2025 and National Commission on Correctional Health Care. (n.d.). *Opioid treatment programs.* https://www.ncchc.org/accreditation/programs/opioid-treatment-programs-accredition.

bridging, for example when a patient is being released from jail on a Friday and arrangements have been made for the patient to be seen on Monday at a community-based OTP.

Methadone is recommended for patients who may benefit from additional supervision in the community (i.e., with daily dosing from an OTP) or those who did not maintain buprenorphine adherence.[5] Hypersensitivity to methadone is an absolute contraindication in outpatient or correctional facility settings.[5] If the patient has a prolonged QT interval on electrocardiogram, buprenorphine and naltrexone may be safer considerations.[6]

The usual daily dose of methadone ranges from 60 to 120 mg, but higher doses may be clinically indicated. The starting dose may range from 20 to 40 mg, with 3 hours of observation and consideration of additional dosing depending on severity of withdrawal. Some patients may respond to lower doses and some may need higher doses, especially those with fentanyl dependence.

Buprenorphine

Buprenorphine is a partial opioid agonist, meaning it has some stimulation of opioid receptors. It is FDA approved for OUD treatment and withdrawal management. In 2023, Congress removed certain requirements, including mandatory "X-waivers," to prescribe buprenorphine. It may be prescribed by any practitioner with a current DEA registration that includes Schedule III authority as long as they have completed at least 8 hours of training on OUD or other SUDs. As of June 2023, all new or renewal applications for DEA registration require this training regardless of the provider's intent to prescribe buprenorphine.

Buprenorphine's effectiveness is similar to that of methadone in treating OUD and preventing death from overdose. It does not affect the QT interval and has a significantly lower risk of overdose death than methadone. It may be used during pregnancy. It is also effective for withdrawal management and is available in film, tablet, or long-acting injectable form.

Telehealth prescribing for buprenorphine inductions and dosing is temporarily permitted at the time this document was written. This provision allows licensed clinicians off-site from the jail to order it after evaluating the patient through a video visit. SAMHSA announced permanent rules allowing OTPs to initiate buprenorphine via telehealth (including by phone only) in early 2024, although state regulations may vary.[7]

For patients who have recently used opioids, clinicians should wait until patients are experiencing moderate opioid withdrawal (i.e., COWS score > 12) before administering the first dose to reduce the risk of precipitated withdrawal. Generally, buprenorphine initiation should occur at least 6 to 12 hours after the last use of heroin or other short-acting opioids or 24 to 72 hours after the last use of long-acting opioids such as methadone.

Buprenorphine doses after induction and titration should be ≥ 8 mg per day, although some studies have shown

improved retention at doses of 16 mg daily or higher.[8,9] Specific dosing should be left to clinical judgment. Dosing strategies involving multiple films may present a higher risk of diversion because of "stacking."[10]

Buprenorphine tapering and discontinuation is a slow process, and close monitoring is recommended.[11] Buprenorphine tapering is generally accomplished over weeks to months. The *ASAM National Practice Guideline for the Treatment of Opioid Use Disorder (*2020) provides further guidance on tapering.[1]

When a switch from buprenorphine to naltrexone is being considered, 7 to 14 days should elapse between the last dose of buprenorphine and the start of naltrexone to ensure that the patient is not physically dependent on opioids before starting naltrexone.

Long-acting injectable forms of buprenorphine (e.g., Sublocade, Brixadi) are available. These medications are costly, though the risk of diversion is virtually eliminated and the risk of postrelease interruption of treatment is reduced. Sublocade requires refrigeration and must be used within 12 weeks after being warmed to room temperature. Brixadi can be stored at room temperature.[12] Both medications should be administered as directed by the manufacturer and approved by the FDA.

Naltrexone

Naltrexone is FDA approved for treatment of both AUD and OUD. Naltrexone is a full opioid antagonist (i.e., it blocks the opioid receptors, minimizing any effects from opioids) and can be prescribed by any licensed health care provider. It has been shown to reduce opioid use. However, it has not been shown to prevent overdose death, possibly because patients can stop taking it without experiencing withdrawal symptoms. It is available in a daily tablet and a monthly long-acting injectable form. The injectable form is recommended for treatment of OUD given lower adherence with the tablet.

There is no physical dependence associated with naltrexone, and it can be stopped abruptly without withdrawal symptoms. There is no risk of overdose from taking naltrexone. Importantly, however, patients should be informed that discontinuation of naltrexone is associated with enhanced sensitivity to opioids and a heightened risk of overdose.[13] Patients who have been taking opioids or who are being switched from buprenorphine or methadone to naltrexone must be off all opioids for 7 to 14 days,[14] depending on the half-life of the drug. This is a limitation to use of naltrexone for unsentenced individuals since they may be released during withdrawal and before they are eligible to receive naltrexone, leaving them at high risk for opioid use and overdose.

Patients being switched from naltrexone to buprenorphine or methadone will not have a physical dependence on opioids; therefore, the initial doses of methadone or buprenorphine should be low. A patient should not be switched until a significant amount of naltrexone is no longer in his or her system. This requires at least a 1-day wait after oral naltrexone and a 30-day wait after a naltrexone injection.

Of the medications on the market, the least amount of research is available for naltrexone. In a jail-based study, XR-NTX was shown to reduce opioid use.[15] However, initiation and retention in treatment with naltrexone is more challenging, and patients often do not prefer it. Nevertheless, evidence suggests that providing XR-NTX before release, ideally over several months,[16] results in a higher proportion of patients adhering to the treatment in the community relative to those who receive their first dose postrelease.[17]

Switching Methadone and Buprenorphine

When a switch from buprenorphine to methadone is considered, no time delay is required because this switch does not typically result in any type of adverse reaction.

Switching from long-acting opioids (i.e., methadone) to buprenorphine should be managed by physicians experienced with the procedure and typically requires gradual reduction of the methadone.[18] For a complete discussion on this topic, consult the ASAM guidelines.[1]

Duration of Treatment

Expert consensus supports long-term or even lifelong prescription of MAT.

OUD is a chronic condition with alterations in brain function.[19] Relapse rates are high and relapse is often fatal.[20] Long-term MAT is often required in the same way that long-term medications are needed for other chronic conditions such as diabetes or high blood pressure.[21]

Research indicates that the length of time an individual should spend on medication varies and needs to be reassessed with the medical staff, considering the patient's medical history and situation. The long-term goal of MAT is not necessarily to stop the medication but rather to allow the patient to live a self-directed life.[22]

In summary, there should be no arbitrary restriction on how long a person may remain on MAT during incarceration. Those who undergo forced withdrawal are less likely to reengage in treatment, despite the high risk of relapse and overdose death immediately following release.[23,24] Patient refusal, a preference for injectable naltrexone, transfer to

a facility that has confirmed it prohibits MAT, or known unavailability of, or patient unwillingness to participate in, long-term treatment upon release may be factors in determining treatment duration.

MAT for Alcohol Use Disorder

The FDA has approved three drugs to treat AUD: naltrexone, disulfiram, and acamprosate.

A 2023 systematic review and meta-analysis of pharmacotherapy for AUD in outpatient settings found evidence to support the use of naltrexone and acamprosate but insufficient evidence to support the use of disulfiram.[25] Specific to incarcerated populations, there is less research available on the use of MAT for AUD except for a few older studies on the use of disulfiram during community supervision.

- **Naltrexone:** A 2022 systematic review of pharmacological interventions for AUD in criminal justice-involved populations found that XR-NTX is effective in reducing alcohol consumption and may reduce recidivism.
- **Disulfiram:** This is not a first-line treatment choice, and evidence of its effectiveness among justice-involved people is limited. Its action interferes with the breakdown of alcohol by the liver, resulting in adverse physical responses to any intake of alcohol. Its use is limited to highly motivated patients and those who can be directly observed while they take the medication. It is contraindicated for patients who are still drinking.
- **Acamprosate:** Research among justice-involved people has not supported the use of acamprosate.[26,27] In the community, although not all patients respond to acamprosate, research suggests it is more likely to be effective for patients who are abstinent from alcohol before acamprosate is initiated, and it is more likely to benefit patients who intend to abstain from alcohol completely rather than for those who plan to reduce their alcohol use.

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[12] For more information, see the Brixadi drug label: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/210136Orig1s000lbl.pdf

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Models of Medication Delivery

Collaborative relationships, both within the facility and with outside community-based organizations, benefit patients and staff.

The ways in which jails provide access to MAT will vary depending on the facility's resources, location, community resources, health services vendor, and leadership, among other factors. Evidence-based practice dictates that all three FDA-approved medications be available and that medication choice is not influenced or directed by correctional administrators.

Facility Staff

Health and custody staff should receive education and training on OUD and AUD, nonstigmatizing language, MAT, and facility policies and procedures related to the treatment. It is important to provide opportunities for staff to communicate feedback and concerns regarding the MAT program in order to garner buy-in from those involved in ensuring high quality care, continuously improve program delivery, and ensure ongoing success. Interdisciplinary coordination between health and custody staff is crucial. For example, administration of oral buprenorphine commonly includes a nurse to administer the medication and conduct mouth checks to ensure the medication has dissolved and a custody staff member to monitor for attempts at diversion.[1]

Community-Based Partnerships

Community partners are essential to a successful MAT program, and it is important to build strong relationships with them. When jails lack the resources to provide comprehensive MAT, community partners may fill the gap in care.

Community-based treatment and medication providers must be carefully selected. Correctional facility collaboration may be required to encourage providers to meet the needs of referred individuals.

In October 2024, revisions to Part 8 of Title 42 of the Code of Federal Regulations that guide OTPs went into effect. The final rule was released in February 2024.[2] Notable changes include increased flexibility for take-home doses and increased access to telehealth services. Per SAMHSA:

> The prior criteria for take-home doses were significantly revised, including prior requirements for lengthy periods in treatment before take-home doses can be considered and strict reliance on toxicology testing results. Now, based on the clinical judgment of the treating practitioner, patients may receive take-home doses upon entry into treatment. This recognizes the importance of the practitioner–patient relationship and is consistent with evidence-based treatment standards that include shared decision-making and individualized person-centered treatment.
>
> The final rule also expands telehealth services for people seeking care from OTPs. It makes permanent the ability of OTPs to initiate buprenorphine via telehealth, both audiovisual and audio-only, and adds initiation of treatment with methadone through audiovisual telehealth platforms.[3]

Correctional leaders should be aware of the services that OTPs are required to provide, according to SAMHSA:

- OTPs shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. These services must be available at the primary facility, except where the program sponsor has entered into a formal, documented agreement with a private or public agency, organization, practitioner, or institution to provide these services to patients enrolled in the OTP. The program sponsor, in any event, must be able to document that these services are fully and reasonably available to patients.
- OTPs must provide adequate substance abuse counseling to each patient as clinically necessary. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients, contribute to the appropriate treatment plan for patients, and monitor patient progress.
- OTPs must provide counseling on the prevention of exposure to and the transmission of HIV disease for each patient admitted or readmitted to maintenance or medically managed withdrawal treatment.
- OTPs must provide directly, or through referral to adequate and reasonably accessible community resources, vocational rehabilitation, education, and employment services for patients who either request such services or who have been determined by the program staff to need such services.[4]

Correctional personnel should refer clients to prescribing providers and other treatment providers who are knowledgeable about SUDs and comprehensive treatment. Policies, procedures, and agreements with community providers should ensure that there is no interruption of MAT between release from the jail and an appointment with a receiving community MAT provider. A formal understanding

between a correctional facility and community partner is crucial in easing the transition for released individuals with OUDs, ensuring continuity of care, and reducing the risk of overdose.

Many licensed SUD treatment programs complete an assessment that includes whether MAT may be indicated. If a program does not have a physician on staff, clients may be referred to a physician or a certified OTP that can prescribe, dispense, and/or administer the appropriate medication. This underscores the need to exercise care in making referrals to SUD treatment programs that can conduct proper pharmacotherapy assessments, directly provide the most appropriate medication, and deliver counseling and recovery support services.

The *ASAM National Practice Guideline for the Treatment of Opioid Use Disorder* (2020) advises:

> Behavior change is an important part of recovery, that may be facilitated by psychosocial treatment. However, these treatments take time to be effective. Medications work quickly to reduce the risk for overdose and overdose death. Thus, the combination of pharmacotherapy and psychosocial treatments, tailored to the individual's needs, is the recommended standard of care. Medications work rapidly to restore balance to the brain circuits impacted by addiction, reducing cravings and withdrawal symptoms and enabling patients to address the psychosocial factors that contribute to their disease and establish healthier patterns of behavior to support long-term recovery.[5]

A "whole-person" approach, or a combination of medication and behavioral health interventions, is the most effective way to treat SUDs;[6] however, jails may lack the staff and funding necessary to provide robust services to individuals receiving MAT. In these cases, medication alone can be effective in reducing overdose deaths postrelease, and access to medication should not be limited due to a lack of psychosocial support services.

Diversion of Agonist Medications

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

Prior research has found that diversion is often cited as a barrier to providing MAT.[7] Although fears of medication diversion are not unfounded, research has demonstrated that a MAT program can disrupt illegal buprenorphine markets in jail and lead to a more favorable environment for both jail staff and incarcerated individuals.[8,9]

Nevertheless, the incorporation of MAT programming can raise challenges based on the medication options available. Dispensing OUD medications in facilities that have no previous experience handling and storing them requires preparation and education. Protocols must be in place to guard against the illicit use of agonist medications. CQI studies should be thoughtfully conducted to quantify and monitor diversion and to guide any corrective action.

A study published in 2023 that consisted of semi-structured interviews and focus groups with administrative, custody, behavioral health, and clinical staff in seven Massachusetts jails recommended the following diversion prevention strategies:[8]

- Distinguish between reasons for diversion so that staff are able to respond effectively
- Use dosing protocols that are routine but not so rigid that staff are unable to adapt to specific patient needs
- Educate patients on the potential adverse health impacts of diverting medication and that effective security measures are in place to intercept diverted medication
- Ensure effective supervision of medication administration by custody staff
- Develop formal responses to actual and suspected diversion that give patients an opportunity to continue treatment

Reported reasons for diversion include coercion or "strong-arming" from individuals not prescribed MAT; managing one's own withdrawal symptoms (e.g., by stockpiling); to experience euphoria (i.e., to get "high"); and to cope with the emotional toll of incarceration.[7,8,10]

Medication discontinuation due to diversion should always be a clinical decision that may be informed by custody staff input. If there is a reasonable and documented rationale for discontinuing MAT, the medication should be tapered, not discontinued abruptly, and documented in the patient's health record.

Doses must always be documented in the medication administration record. Any missed dose must be documented and returned to a locked cabinet. Before initiating administration of the medications, staff members must be trained and a protocol must be developed to accommodate the additional responsibilities entailed.

When buprenorphine tablets are administered by health staff in crushed form, they retain properties similar to those of whole forms and are an option to consider for patients who both have an OUD and are at risk for diversion.[11,12] The

use of long-acting injectable buprenorphine (e.g., Sublocade, Brixadi) virtually eliminates diversion.

Alcohol and drug use during treatment should be carefully monitored as outlined in the National Institute on Drug Abuse's *Principles of Drug Abuse Treatment for Criminal Justice Populations* (2014).[13] Individuals trying to recover from SUD may experience a relapse and return to drug use. Those on MAT, like others in SUD treatment, may relapse, take other drugs, or misuse prescription medication. Individuals on antagonist drugs such as naltrexone may switch to cocaine or other drugs that are not blocked by naltrexone.

Relapse is considered a part of the recovery process for people with SUDs. Different people have different triggers for relapse, and treatment providers work to identify such triggers. Common triggers include mental stress (e.g., a death, divorce, job termination, and other losses) and associations with peers and social situations linked with drug use. An undetected relapse can progress to serious alcohol and drug misuse and potential overdose.

When detected, relapses can present opportunities for therapeutic intervention. Monitoring alcohol and substance use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the patient's treatment progress.

When ordered by a health care provider, the confidentiality of such testing and test results should be respected. Open communication between a person with SUD and their health care providers allows for the delivery of effective services. According to ASAM, "Drug testing should be used as a tool for supporting recovery rather than exacting punishment. Every effort should be made to persuade patients that drug testing is a therapeutic, rather than punitive, component of treatment."[14] Drug testing also provides opportunities to intervene to change unconstructive behavior and to facilitate change by modifying treatment plans as needed.

SAMHSA's *Federal Guidelines for Opioid Treatment Programs* (2015)[4] require certified OTP programs to conduct adequate testing or analysis for drug use, including at least eight random drug screens annually in accordance with generally accepted clinical practice for those on maintenance treatment.[4] Patients receiving medically managed withdrawal treatment must have an initial drug screen; those receiving long-term treatment must also have monthly random screens.

Health care authorities should be aware of what tests are available on-site and via outside laboratory services. Unless the facility is certified as a laboratory, tests used on-site should be Clinical Laboratory Improvement Amendments (CLIA)-waived,[15] and the facility should maintain a certificate of waiver.[16] Instant urine drug screens that are CLIA-waived may detect the presence of buprenorphine, methadone, and common recreationally used substances like cocaine, heroin, and marijuana.

Whether positive or negative, results should be interpreted with caution to consider what substances the test was for, the recency and frequency of use or nonuse of a substance, and other factors that may cause inaccurate or unexpected results.[14]

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[1] For advice on program planning and implementation, see Getting buy in from the Rhode Island Department of Corrections. https://vimeo.com/335954007

[2] At the time this document was published, SAMHSA had not released formal guidance on the final rule. Check samhsa.gov for important updates.

[3] Substance Abuse and Mental Health Services Administration. (n.d.). *42 CFR Part 8 final rule — Frequently asked questions*. https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/42-cfr-part-8/faqs

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[5] The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update. (2020). *Journal of Addiction Medicine*, 14(2S), 1–91. https://doi.org/10.1097/ADM.0000000000000633

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[13] National Institute on Drug Abuse. (2014). Principles of drug abuse treatment for criminal justice populations – A research-based guide. https://nida.nih.gov/sites/default/files/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide_508.pdf

[14] American Society of Addiction Medicine. (2017). *Appropriate use of drug testing in clinical addiction medicine* (Consensus statement). https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/guidelines/the-asam-appropriate-use-of-drug-testing-in-clinical-addiction-medicine-full-document.pdf Centers for Disease Control and Prevention. (n.d.). Waived tests. https://www.cdc.gov/labquality/waived-tests.html

[15] Centers for Disease Control and Prevention. (n.d.). *Waived tests*. https://www.cdc.gov/labquality/waived-tests.html

[16] Centers for Medicare and Medicaid Services. (2019). *How to obtain a CLIA certificate*. https://www.cms.gov/regulations-and-guidance/legislation/clia/downloads/howobtaincliacertificate.pdf

Discharge Planning

Facilities should strive to employ a designated discharge planner who is responsible for ensuring continuity of care postrelease and can assist with other practical needs.

Time of release from jail can be difficult to predict. Thus, discharge planning must begin at intake and continue throughout incarceration. At the very least, the facility should ensure that a newly released individual has an appointment with, or a warm handoff to, a community provider to continue MAT. When possible, patients should go directly from the correctional facility to the community-based treatment center.[1]

If receiving buprenorphine, individuals should leave the facility with a prescription or a bridge dose of medication to avoid any disruption in treatment. Methadone may also be provided upon release through an OTP, or by the facility, in accordance with federal and state laws and regulations.

Not everyone receiving MAT will be ready for long-term recovery; therefore, education on risk of overdose postrelease and access to FDA-approved opioid reversal drugs (e.g., naloxone, nalmefene) is crucial. In May 2023, the FDA approved the first nalmefene hydrochloride nasal spray to treat acute opioid overdose (available with a prescription).[2,3]

All individuals with OUD and, if feasible, everyone being released should leave the facility with an opioid reversal drug. To prevent a fatal overdose, they should be educated on when and how to administer these lifesaving drugs. To enhance family preparedness, some jails provide opioid reversal drugs and education on use to family members during visitation.[4]

Understanding community resources and cultivating relationships with staff is important in guiding individuals directly upon release. The staff member in the discharge planning role should also assist with enrollment in, or activation of, Medicaid; obtaining identification, transportation, and housing; and addressing other social determinants of health. Those released without the resources to meet their housing, transportation, and other financial needs face daunting circumstances. Community organizations may be willing to come into the facility to meet with incarcerated people before their release.

Jails facilitating MAT should engage their state Medicaid agencies and other public payers to facilitate health care coverage postrelease. Lack of insurance or gaps in coverage inhibit the use of MAT postrelease. From October 2020 to September 2025, state Medicaid programs are generally required to cover all three of the FDA-approved OUD medications when prescribed in the community. However, states may apply prior authorization requirements governing the coverage of MOUD.[5]

To ensure the continuity of medication after release, it is essential that funding be arranged. If medication is to be paid for through a state Medicaid program, individuals should be enrolled or have their coverage reactivated before release so there is no gap between release and eligibility to access the medication. If health coverage requires prior approval for certain medications, it should be arranged before release for the same reason.

Beginning in January 2026, states will be required to suspend, rather than terminate, Medicaid enrollment when an individual is incarcerated. A suspension must be lifted when this exclusion no longer applies—for example, upon a person's release, or when they are admitted to a medical institution for treatment that falls within the inpatient exception.[6] Dedicated discharge planners or dedicated jail staff should be trained on Medicaid enrollment and policies. If an individual is eligible for Medicaid, it is important to refer them to a covered community-based treatment provider for postrelease care.

The 2018 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act allows states to apply to the federal government for matching Medicaid funding to strengthen reentry services.[7] Services are restricted to individuals who would otherwise qualify for Medicaid if they were not incarcerated. In 2024, these efforts were implemented in individual states through experimental or pilot projects.[8] States must provide, at a minimum, case management, MAT (i.e., buprenorphine, methadone, and naltrexone), and a 30-day supply of medications upon release, but have the flexibility to determine who receives services and what facilities offer them.

Beginning in 2025, states are required to cover various services for postadjudicated youth under the age of 21 who are eligible for Medicaid or CHIP and youth who were formerly in foster care and are under the age of 26. These services include case management and some diagnostic and behavioral health screenings. States will also have the option to offer Medicaid-covered services to youth who are incarcerated pending disposition of charges.[9]

Although such policy changes present a tremendous opportunity to improve transitions of care, systemic changes and ongoing efforts will be required by all stakeholders to ensure optimal implementation. The Health and Reentry Project (HARP) recommends that state and local governments address the following:[10]

1. Build active, ongoing collaboration across sectors and stakeholders
2. Invest in data and systems
3. Navigate operational issues to strengthen health services in criminal justice settings
4. Assess and resolve differences in health care quality and access standards
5. Tackle the challenges of unpredictable release dates and short stays
6. Prioritize building community capacity to provide services after release
7. Prepare the corrections and community workforce
8. Build accountability for service provision across sectors

Individuals who obtain employment after release and no longer qualify for Medicaid may not be able to afford the subsidized premiums or copays. Those individuals may need additional assistance such as pharmaceutical company coupons (e.g., from GoodRx).

Programs for reduced-price medications are available from federal and state governments as well as the pharmaceutical industry itself. Congress established the 340B Drug Pricing Program to allow certain covered entities that serve large numbers of uninsured patients to obtain drugs from pharmaceutical suppliers at the same discounted rates that Medicaid pay (i.e., 25% to 50% less).[11]

In addition, more than 1,200 Federally Qualified Health Centers are located in inner cities and rural areas and serve uninsured and low-income individuals. Many offer buprenorphine based on discounted fees.[12]

The Centers for Medicare & Medicaid Services (CMS) makes several types of in-person assistance available:[13]

- **Navigators –** Navigators receive extensive training from CMS and are responsible for providing unbiased information about public and private health insurance programs in a culturally competent manner. They help individuals determine whether they qualify for Medicaid and assist with the enrollment process. A list of funded navigator organizations and key contacts is available on the CMS website.
- **Non-navigator assistance personnel** – Non-navigator assistance personnel are similar to navigators. These individuals complete specific training and inform consumers about coverage options but are funded through grants or contracts administered by the federal government or an individual state.
- **Certified application counselors –** CMS designates organizations to certify counselors who perform these functions. The counselors complete pre-service training and receive ongoing in-service training via CMS webinars and newsletters. They comply with privacy and security standards but have fewer reporting requirements.
- **Brokers, agents, and contracted assistors** – Brokers usually act on behalf of the consumer and are compensated by insurers or consumers. Agents are compensated by insurers. Some states contract with brokers or agents to act as navigators. They may be required to forgo compensation or abide by other guidelines that mitigate potential conflicts of interest.

Several jail-based MAT programs have created recovery support case manager positions to bridge the gap between institutions and communities. Case managers meet with individuals before release and remain available for support and assistance for up to a year after release. Among other duties, recovery support case managers may accompany released individuals when they first enter treatment programs, meet with medical providers, or engage in other recovery-related activities. Unlike probation or parole officers, the case managers' function is solely to provide support, and their engagement by the released individuals is voluntary.

Community Corrections

Once a patient is released from jail, the method and extent of monitoring depends on the type of medication. Patients prescribed buprenorphine typically take home a prescription for a month's worth of medication. Methadone patients, on the other hand, typically take their doses in liquid form under observation by clinic medical staff and do not self-administer medication at home until they are well stabilized to safeguard against misuse. Exceptions apply when OTPs are closed on weekends and/or holidays. Consequently, arrangements must be made with the OTP to ensure continuity of methadone dosing. Long-acting injectable medication (e.g., buprenorphine or naltrexone) cannot be easily diverted, and oral naltrexone has no abuse potential.

States with an operational PDMP[14] collect all Schedule II, III, and IV (and, in some states, Schedule V) controlled substance prescription data that can be accessed by authorized users, including physicians and pharmacists. By regularly checking the PDMP, providers can become aware of whether a patient receives a controlled substance from another prescriber and address the possible return to drug use. Every state and the District of Columbia now has an operational PDMP.[15] Generally, however, methadone administered through OTPs is not reported in PDMPs, although exceptions exist.

[1] For more information, see *Best practices for successful reentry from criminal justice settings for people living with mental health conditions and/or substance use disorders* (SAMHSA, 2023). https://store.samhsa.gov/sites/default/files/pep23-06-06-001.pdf

[2] For more information, see the FDA letter approving Opvee (nalmefene) nasal spray: https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2023/217470Orig1s000ltr.pdf

[3] For more information, see the Opvee prescribing information: https://opvee.com/wp-content/uploads/2023/07/Combined-USPI_Patient-Info_IFU_Clean_05July2023.pdf

[4] For more information, see the *SAMHSA opioid overdose prevention toolkit* (SAMHSA, 2018). https://www.dea.gov/sites/default/files/2021-09/SAMHSA Opioid Overdose Toolkit.pdf

[5] Centers for Medicare and Medicaid Services. (2020). RE: *Mandatory Medicaid state plan coverage of medication-assisted treatment*. https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf

[6] For more information, see Critical connections: *Getting people leaving prison and jail the mental health care and substance use treatment they need* (Plotkin & Blandford, Council of State Governments Justice Center, 2017) https://bja.ojp.gov/sites/g/files/xyckuh186/files/publications/Critical-Connections-Full-Report.pdf and Medicaid and incarcerated individuals (Congressional Research Service, 2024) https://crsreports.congress.gov/product/pdf/IF/IF11830.

[7] The SUPPORT Act required the Secretary of Health and Human Services to convene a stakeholder group to discuss best practices for reentry; see *Health care transitions for individuals returning to the community from a public institution: promising practices identified by the Medicaid Reentry Stakeholder Group* (2023). https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf

[8] For the most up-to-date information, see *Reentry Section 1115 demonstration opportunity* (CMS). https://www.medicaid.gov/medicaid/section-1115-demonstrations/reentry-section-1115-demonstration-opportunity/index.html

[9] For more information, see the *Why Does This Matter section in Medicaid opportunities to support youth transitioning from incarceration* (Buck & Goyal-Carkeek, Center for Health Care Strategies, 2024). https://www.chcs.org/media/Medicaid-Opportunities-to-Support-Youth-Transitioning-from-Incarceration-August-Update.pdf

[10] The Health and Reentry Project. (2024). *Eight key considerations for successful implementation of new Medicaid reentry policies*. https://healthandreentryproject.org/wp-content/uploads/2024/06/Harp-Successful-Implementation-Medicaid-Reentry-2024-Final.pdf

[11] For more information, see HRSA Office of Pharmacy Affairs 340B OPAIS. https://340bopais.hrsa.gov/CoveredEntitySearch/000006615

[12] For more information, see HRSA Data *Warehouse Find a health center.* https://findahealthcenter.hrsa.gov/

[13] For more information, see *In-person assistance in the health insurance marketplaces (CMS)* https://www.cms.gov/marketplace/in-person-assisters/programs-procedures/in-person-assistance and Find local help (Healthcare.gov) https://localhelp.healthcare.gov.

[14] For more information, see American Association for the Treatment of Opioid Dependence, AATOD PDMP policy guidance statement for OTPs at https://www.aatod.org/advocacy/policy-statements/aatod-pdmp-policy-guidance-statement-for-otps.

[15] For a list of each PDMP's capabilities, see (Prescription Drug Monitoring Program Training and Technical Assistance Center). https://www.pdmpassist.org/Policies/Maps

CQI Programs

A continuous quality improvement program enables staff to identify health care aspects to be monitored, to implement corrective action plans when necessary, and to study the effectiveness of corrective action plans.

A CQI program is an important aspect of health services in jails and, when applied to a MAT program, will offer insights that may otherwise go unnoticed. This allows for improvements to be made to processes and outcomes.

The basic steps to conducting a structured CQI study are as follows:

1. **Establish a quality improvement committee:** Form a multidisciplinary team comprising representatives from major program areas to guide and oversee the CQI process. CQI programs are more effective if they are inclusive.
2. **Ensure that custody staff are present when relevant information is discussed.**
3. I**dentify the area of focus**: Observation, preexisting data, staff feedback, and patient grievances are all mechanisms for identifying the need for a CQI study.
4. **Define the type of study to be conducted:** A *process study* examines the effectiveness of health care delivery; examples include delays in access to care, medication refusals, and discontinuity of medication. Process studies begin by identifying a component of care delivery to study. An *outcome study* identifies a clinical care area of focus, such as emergency department transfers, and explores the outcome of processes on patients' health and well-being.[1]

   Examples: Based on data indicating potential concerns, one program might want to improve OUD screening upon booking (a process study), and another might assess complications among pregnant patients with OUD (an outcome study).
5. **Define quality indicators:** Identify key performance indicators and a threshold (goal) for which, if met, corrective action is not necessary. Thresholds should be established by the CQI committee and reflect expected levels of performance and may be informed by a baseline study.

In its *Standards for Opioid Treatment Programs in Correctional Facilities (2025),* NCCHC recommends use of the following quality performance measures in evaluating MAT programs:

1. Accessibility
2. Appropriateness of clinical decision making
3. Continuity
4. Timeliness
5. Effectiveness (outcomes)
6. Efficiency
7. Quality of clinician–patient interaction
8. Safety

Examples:

- Percentage of all people booked who are screened for OUD using a validated screening tool
- Percentage of OUD assessments that are done clinically appropriately
- Percentage who screen positive and are then assessed for OUD within a specified time frame
- Percentage with AUD who are sent to the emergency department
- Percentage linked to community treatment on release

6. **Understand the cause of the problem:** This will likely require interdisciplinary collaboration, including provider, nursing, behavioral health, and custody staff. Each individual will have a unique perspective that is informed by their daily work and experience. Quality improvement tools, such as root cause analysis, can be used in this step to provide a structure to investigate the likely cause of the problem.[2]
7. **Collect data:** Implement a system for collecting, analyzing, and reporting data on identified quality indicators. Determine the methods, including data source and time frame, that will be used to conduct the study. Review health records, patient satisfaction surveys, clinical performance enhancement, and other data collection tools to gather relevant information about the identified concern. Ensure that the sample size is large enough to draw meaningful conclusions.
8. **Create a corrective action plan:** Implement changes based on the agreed-upon corrective action plan. Provide staff with the necessary resources to implement and support new policies, procedures, and

practices. For example, one program might find that dosing information is missing for patients receiving buprenorphine in the community. The committee would identify the community OTP that is involved, arrange a meeting with OTP representatives, and develop a written process for bidirectional exchange of dosing information on entry and release.

The corrective action plan should follow the SMART goals structure. Goals should be designed to be:

Specific

Measurable

Attainable

Relevant

Time-bound

Example: The committee develops a SMART goal: Dosing information will be available within 24 hours for 100% of patients entering who have been receiving buprenorphine or methadone, according to communication documented in the health records. This goal will be achieved within 30 days of policy implementation.

9. **Evaluate effectiveness:** Conduct the study again and refine improvement methods if the threshold is not met. Monitor for any unintended consequences. Consider using qualitative and quantitative methods in evaluating effectiveness.

   Example: Designate a staff clinician to review the health records of all people who were receiving these medications in the community and, using a chart abstraction form, compile data on date/time of entry and date the dosing information was provided by any means (e.g., fax, secure email, phone). The data will then be analyzed to determine whether the SMART goal is met.

10. **Monitor:** Continuously monitor the process or outcome over time (e.g., monthly) and adapt improvement methods based on lessons learned and evolving needs.

    Example: To monitor progress, the committee creates a nursing log to document when dosing information was absent.

11. **Adapt and repeat:** If the threshold has not been achieved, the committee reconvenes to discuss strategies to achieve the goal or establish a more achievable one.

    Example: The committee adjusts the threshold to 95% of dosing information available within 24 hours, having determined the original goal of 100% is not feasible due to factors outside staff control.

12. **Report and recognize successes:** When the threshold has been achieved, disseminate relevant information about the CQI process to stakeholders and recognize and celebrate meaningful improvements.

If these steps have been taken and the problem persists, it is prudent to go back and analyze the potential cause using different methods or including voices that were not involved originally but may have a unique perspective on the problem.

Information related to volume, such as the monthly number of patients on each medication, should be monitored to guide resource allocation, staffing, and long-term funding for the program. NCCHC recommends collecting and analyzing the following data:

1. Service delivery patterns
2. Referrals to OTP services
3. Number of patients admitted to OTP services
4. Number of patients declining OTP services
5. Number of patients receiving OTP services by category of care
6. Referrals to health staff and/or specialists
7. Adverse health events or deaths
8. Emergency services provided to patients
9. Referrals to community OTPs
10. Number of grievances

Common challenges in implementing MAT, such as medication diversion or long medication lines, may arise. Solutions will vary based on unique facility factors. These concerns, and others not identified here, should be included in CQI studies. The NCCHC standards provide additional information on CQI.

[1] For more information, see *Types of Health Care Quality Measures (Agency for Healthcare Research and Quality* (2015). https://www.ahrq.gov/talkingquality/measures/types.html

[2] For more information, see the *Quality Improvement Essentials Toolkit* (Institute for Healthcare Improvement, 2017). https://www.ihi.org/resources/tools/quality-improvement-essentials-toolkit

Pregnant women with opioid and alcohol use disorders require specialized services to prevent and reduce health risks during pregnancy.

Opioid withdrawal during pregnancy is associated with high risk of relapse, overdose, premature delivery, stillbirth, low birth weight, and other serious complications. Opioid overdose is also a significant contributor to maternal mortality. ACOG therefore recommends against opioid withdrawal and supports MAT with methadone or buprenorphine during pregnancy.[1] The NCCHC *Standards for Opioid Treatment Programs* require that pregnant patients and their fetuses be provided every opportunity for healthy outcomes. That includes having MAT readily available to stabilize pregnant women with OUDs during pregnancy.

Studies find that women who use substances during pregnancy have elevated risk of early birth, babies with lower birth weights, and more complications during labor and delivery.[2-4] However, withdrawal from opioids during pregnancy is also risky. Opioids cross the placenta to the developing fetus. If the pregnant woman discontinues opioid use, the fetus experiences withdrawal, and dangerous complications can result. The most significant risk of opioid withdrawal in pregnancy is the documented high risk of relapse, which is associated with overdose and can be fatal for the pregnant person and the fetus. Infants of women treated for OUDs with MAT during pregnancy have overall improved birth outcomes.[5]

Maintenance therapy with methadone or buprenorphine for pregnant patients is a long-established, evidence-based practice. As with any treatment, there are some risks, but they are weighed against the consequences of untreated OUD, including withdrawal and relapse.

Both methadone and buprenorphine (including the monoproduct and in combination with naloxone) are safe in pregnancy. Naltrexone, however, is not recommended in pregnancy.[6] Some studies have shown decreased risk of neonatal withdrawal symptoms for infants exposed to buprenorphine compared to methadone. However, the choice of treatment should be based on what works best for the patient and what will be available to them in the community upon release.

If pregnant patients are transported off-site for MAT initiation, routine dosing, or other care, facilities should be aware of state laws and evidence-based practices for nonuse of restraints in pregnancy.[7]

Pregnant patients who enter custody on MAT should be continued on the same medication. This is especially important if they are on methadone, as switching from methadone to buprenorphine can precipitate withdrawal, which should be avoided in pregnancy. Due to the physiology of pregnancy, MAT doses usually need to be increased as pregnancy progresses, and sometimes split dosing is needed. Pregnant patients who decline MAT should, after thoughtful counseling as part of an informed refusal process, undergo medically supervised withdrawal using only medications that are safe in pregnancy and under the supervision of providers experienced with this population.

Counseling is an essential part of recovery for pregnant patients with OUD. However, as with all MAT, medications should not be withheld if a patient declines counseling.

The postpartum period is a very high-risk time for opioid overdose.[8] Postpartum patients should be continued on their MAT, as stabilization and recovery are both necessary to ensure a healthy mother and baby. MAT doses may need to be adjusted postpartum but should not be discontinued. Furthermore, postpartum patients in custody should also have access to a method of reversible contraception but should not be pressured into starting one.

Some infants exposed to opioids in utero, whether through illicit use or MAT, may experience withdrawal symptoms at birth, sometimes severe enough to require medication and delay discharge from the hospital. This condition is known as neonatal opioid withdrawal syndrome (NOWS, sometimes called neonatal abstinence syndrome or NAS). Infants born to mothers treated with methadone or buprenorphine may experience NOWS but are less likely to be preterm or have low birth weight than babies born to mothers who have withdrawn from opioids and subsequently relapsed. NOWS is an expected, treatable, short-term consequence of evidence-based treatment for the pregnant person.[9] Opioid-exposed infants can be monitored and managed in most hospitals.

Women receiving medications are usually encouraged to breastfeed because studies have shown that this decreases NOWS symptoms. The benefits of breastfeeding greatly outweigh the potential risks of trace amounts of medication that may be found in breast milk.[10]

Upon release, women should be referred to treatment providers who offer specialized services for pregnant and postpartum patients. They require an intensive level of support after delivery to prevent relapse, and many will benefit from additional services, including parenting skills and supports or family reunification planning.[11]

Pregnant women with alcohol use disorder should receive medically managed alcohol withdrawal treatment using

standard protocols, as alcohol withdrawal can be fatal. Benzodiazepines for this purpose are safe in pregnancy.[12] Fetal alcohol spectrum disorders and fetal alcohol effects caused by alcohol use during pregnancy include cognitive and behavioral deficits, facial abnormalities, and growth impairments.[13] Alcohol consumption during the first trimester is a particularly high-risk behavior, and women who drink heavily during this time may not know they are pregnant. In custody settings, women are usually screened for pregnancy on intake, but women with a history of substance use should also be screened for pregnancy in community corrections.

All women who come in contact with the criminal justice system should be educated about the risks of substance use during pregnancy, including the provision of tobacco cessation support and services (which all public and private health insurance plans are required to cover).[14]

Standards and Guidelines

- ACOG and ASAM: *Opioid Use and Opioid Use Disorder in Pregnancy* (2021), acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy
- ACOG: *Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals* (2024), acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/07/reproductive-health-care-for-incarcerated-pregnant-postpartum-and-nonpregnant-individuals
- SAMHSA: *A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders* (2016), store.samhsa.gov/sites/default/files/sma16-4978.pdf
- SAMHSA: *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* (2018), store.samhsa.gov/sites/default/files/sma18-5054.pdf
- NCCHC: *Standards for Health Services in Jails* (2025) and *Standards for Opioid Treatment Programs in Correctional Facilities* (2025)[15]

[1] American College of Obstetricians and Gynecologists. (2017). *Opioid use and opioid use disorder in pregnancy* (Committee opinion). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

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[7] For more information, see the NCCHC position statement *Nonuse of restraints for pregnant and postpartum incarcerated individuals* (2020). https://www.ncchc.org/position-statements/nonuse-of-restraints-for-pregnant-and-postpartum-incarcerated-individuals-2020.

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[12] American Society of Addiction Medicine. (2020). *The ASAM clinical practice guideline on alcohol withdrawal management*. https://www.asam.org/docs/default-source/quality-science/the_asam_clinical_practice_guideline_on_alcohol-1.pdf

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[14] Agency for Healthcare Research and Quality. (2008). *Treating tobacco use and dependence: 2008 update*. https://www.ahrq.gov/prevention/guidelines/tobacco/index.html

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Interaction with the criminal legal system may provide an early opportunity to address adolescent SUD, minimize negative impacts on development, and reduce the severity of disease over the lifespan.

Although MAT for adolescents is understudied relative to adult populations, expert consensus is that methadone, buprenorphine, and naltrexone may be considered when treating adolescents with OUD.[1-3] The Society for Adolescent Health and Medicine recommends:

> All adolescents and young adults with opioid use disorder (OUD) should be offered medication for OUD as a critical component of an integrated treatment approach that includes pharmacologic and nonpharmacologic strategies.[2]

The NCCHC *Standards for Health Services in Juvenile Detention and Confinement Facilities* (2022) address the use of MAT for youth who are intoxicated, at risk of withdrawal, undergoing withdrawal, or entering the facility on MAT.

A commonly used framework in adolescent health care is the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. All youth should be screened for SUD upon intake to the facility and receive a comprehensive assessment if they screen positive for SUD.[4] Initial screening provides an important opportunity to define the adolescent's experience with substance use and to guide intervention.

The following validated tools to screen for substance use and guide assessment for use-related problems in adolescents are recommended:[5-7]

- Screening to Brief Intervention (S2BI)[8]
- Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD)[8]
- CRAFFT[9] (also used as an assessment tool)

Comprehensive biopsychosocial screening should be conducted. Screeners may begin to address risky behaviors, including substance use, through a brief intervention, which is a conversation to promote healthy behaviors and prevent future unhealthy behaviors. If moderate or severe substance use is identified during this process, the adolescent may be referred to a provider to consider enrollment in an MAT program.[10]

Buprenorphine monoproduct and buprenorphine/naloxone are FDA approved for use for youth over 16 years of age and are frequently used off-label for those under 16.[11-13] Oral and long-acting injectable naltrexone are FDA approved for those over 18 years and may be used to treat OUD and AUD.[14]

Unless contraindicated, youth receiving MAT in the community should have their MAT continued. Before initiating treatment, written informed consent must be obtained, either from the patient, parent(s), or legal guardian(s), depending on the age and emancipation of the patient and as applicable in the local jurisdiction. As with adults receiving MAT, co-occurring mental and physical illness must also be identified and treated.

The NCCHC position statement *Opioid Use Disorder Treatment in Correctional Settings*[3] suggests that facilities:

> Ensure that adolescents with OUD have access to providers with experience in MOUD as well as psychosocial interventions that are developmentally appropriate, take into consideration relevant concerns about confidentiality and consent, and include family whenever possible.

Although MAT should not be withheld if psychosocial services are unavailable, this is an especially important aspect of treatment for adolescents. When possible, developmentally appropriate, evidence-based psychosocial interventions should be provided. Evidence-based practice models for treating adolescent OUD include cognitive behavioral therapy and motivational enhancement therapy. Therapeutic intervention should focus on repairing and building relationships and developing adaptive coping strategies, and, if patients are returning home, should include family when possible.[15-18]

Medicaid and Children's Health Insurance Program Services for Incarcerated Youth

In July 2024, CMS issued guidance on the Consolidated Appropriations Act, 2023, as it relates to the provision of health care for incarcerated youth (i.e., CHIP-eligible youth under age 19 and Medicaid-eligible youth under age 21 or under age 26 for former foster care children). Beginning January 1, 2025, states are mandated to provide targeted case management services and screening and diagnostic services for children and youth following adjudication.

The guidance clarifies that targeted case management for Medicaid enrollees includes the following:

- Comprehensive assessment and periodic reassessment of individual needs, including medical, educational, social, or other services
- An individualized, person-centered care plan
- Referrals and related activities (e.g., scheduling appointments for the youth, warm handoffs) to help the youth obtain needed services per the care plan

- Monitoring and follow-up activities to ensure the care plan is implemented effectively

These services must be provided for 30 days before release and 30 days following release. When this is not possible, services must be provided no later than 1 week following release. CHIP Targeted Case Management services are not defined in the regulations, but CMS encourages states to align offerings with Medicaid case management services.

Medicaid screening and diagnostic services include, at a minimum, comprehensive health and development history, comprehensive unclothed physical examination, appropriate vision and hearing testing, appropriate laboratory testing, dental screening services, and diagnostic services, including those related to hearing and vision, dental care, and immunizations. States may have different requirements under the CHIP plan and should align these services accordingly.

It is imperative that correctional facilities work with their state government to ensure a smooth and effective implementation of these requirements. Correctional health care providers will need to ensure that they comply with Medicaid and CHIP provider participation and enrollment and data sharing requirements if they are to provide these services.

States also have the option to provide the full scope of Medicaid and CHIP benefits to incarcerated youth who are pending a conviction but are otherwise eligible for these services.[19]

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[9] For more information on CRAFFT, see www.crafft.org.

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[11] For more information, see the Suboxone drug label: https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022410s000lbl.pdf

[12] For more information, see the FDA letter approving Subutex and Suboxone: https://www.accessdata.fda.gov/drugsatfda_docs/nda/2002/20-733_Subutex_Approv.pdf

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[19] For more information on mandatory and optional services, see the letter to state health officials RE: Provision of Medicaid and CHIP services to incarcerated youth (CMS, 2024). https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf

Central Valley Juvenile Detention and Assessment Center

California

Program Overview

The Central Valley Juvenile Detention and Assessment Center began offering MAT in 2019 to address a growing need for evidence-based treatment for youth with opioid use disorder in the carceral system. This program is part of the San Bernardino County Youth Opioid Response (SBCYOR) program, which provides not only medication but also counseling and community resources to support lasting recovery.

All individuals are screened and assessed for OUD within 4 hours of intake. Those identified to have OUD are then referred for medication continuation or buprenorphine induction and monitored through chronic care visits with a provider at a frequency determined by the severity of their disorder and the level of stabilization. Those who were prescribed methadone in the community before arrest have their medication continued in consultation with a provider. Discharge planning includes referrals to community providers and behavioral health support.

Program planning involves interdisciplinary consultation and coordination, including between leaders in law enforcement, a local hospital, behavioral health professionals, emergency medical services, public health, and public education. Robust policies and procedures that guide the provision of care and discharge planning are integral to the success of the program and enable uninterrupted treatment upon discharge. Education on naloxone and risk of overdose is provided to patients and family members.

Lessons Learned

Despite planning and coordination, stigma among custody personnel, health staff, and community members can lead to various barriers in day-to-day implementation. Training for health and custody staff is necessary to combat stigma and overcome logistical and regulatory challenges that arise when providing this medication in a correctional setting. An integral part of this program includes warm connections within a community network to provide ongoing support postrelease. The level of external coordination that the program requires is time intensive. Adequate and thorough planning can help to alleviate obstacles before they arise. In addition, a member of leadership must champion this work to overcome barriers.

Outcomes

Facility staff report positive qualitative outcomes, including overall environmental changes due to increased patient satisfaction and well-being. An internal research unit collects and analyzes program data, including information related to recidivism, diversion, and contraband, that was not available at the time this report was published.

Cermak Health Services at Cook County Jail

Illinois

Program Overview

The Cermak Health Services opioid treatment program at Cook County Jail was established in 2008 in response to a recognized clinical need for treatment for substance use disorders. Today, all patients who self-report opioid use in the community are eligible for MAT treatment. Patients receiving MAT in the community are maintained after confirmation with their community OTP or through the Illinois Prescription Monitoring Program. Patients with OUD who are not on MAT in the community are induced and maintained after stabilization. Both oral naltrexone and extended-release naltrexone are available for AUD treatment. In 2023, the OTP expanded its offerings with long-acting injectable buprenorphine.

The care coordination team provides wraparound services, including linkage to community primary care and MAT services, as well as assistance with insurance and social services upon release. Patients are tracked for 1 month in the community and offered assistance with any challenges that arise in accessing care.

Lessons Learned

Securing buy-in from custody staff and fostering close collaboration among health care providers, custody personnel, and community providers is crucial. Cermak integrated a peer who is in long-term recovery and had experience in the criminal legal system into the care coordination team. This addition enhanced the credibility of the health services team among patients who come from historically disadvantaged communities, many of whom had had suspicions about and/or negative interactions with health care providers.

A primary challenge remains reducing the waitlist for MAT induction, as limited personnel and financial resources hinder the ability to initiate treatment immediately upon intake.

Outcomes

In the last year, Cook County Jail has seen a reduction in use-of-force incidents among individuals enrolled in the OTP, with such incidents accounting for 34.4% among those in the program versus 65.6% among those not enrolled. This reduction suggests that MAT and supportive services may contribute to improved behavior and reduced conflict, benefiting both patients and staff within the jail.

In collaboration with community partners, the OTP's care coordination team has facilitated stable housing for 88% of individuals referred to the Cook County Flexible Housing Pool. Housing is an often difficult, but critical, resource to provide.

Essex County Sheriff's Department

Massachusetts

Program Overview

The opioid treatment program of the Essex County Sheriff's Department (ECSD) has offered access to buprenorphine, methadone, and naltrexone since 2019. The origin of the program cannot be credited to one factor. Instead, it was spurred by state legislation, judicial mandates, and an ethical response from the correctional community after witnessing the devastating and ongoing impact of the opioid crisis.

Everyone is screened for substance use upon intake to the jail, and individuals receive a referral to the OTP when indicated. Patients on medication in the community have their prescriptions verified quickly, a process that ECSD leadership attributes to strong relationships with community organizations and the fact that the jail's OTP has trained, dedicated staff who are focused on this population.

Lessons Learned

ECSD takes a holistic perspective to recovery, including educating individuals on treatment modalities and providing a spectrum of treatment options. In addition to medication, self-help resources, a didactic curriculum, and individual counseling are available. ECSD emphasizes a progressive culture and a therapeutic environment that differs from traditional corrections. This is evident in the physical plant, which was designed and built in collaboration with local Drug Enforcement Administration officials to satisfy all mandated specifications and provides a modern, spacious, and welcoming environment that deviates from a typical jail design.

The logistical requirements that arose in running an OTP were major challenges. The jail saw a substantial increase in the movement of individuals for screening, assessment, medication administration, and discharge planning, in addition to other treatment programming. Collaboration, communication, open dialogue, and robust planning are continuously needed to achieve both the security needs and clinical goals of the OTP. This requires proactively seeking staff buy-in. One component of this is education on myriad topics to provide a foundational understanding of the evidence base and requirements for the OTP.

Outcomes

ECSD is collaborating with the University of Massachusetts and Tufts University to collect and analyze data on their MAT program, and the results will be submitted to an academic journal.

Hampden County Sheriff's Office

Massachusetts

Program Overview

Hampden County Sheriff's Office (HCSO) offered limited access to MOUD, including naltrexone and buprenorphine prerelease and methadone for pregnant women, before becoming a certified and accredited opioid treatment program in 2019. This expansion was in response to state legislation that created a pilot program enabling correctional facilities to provide access to MOUD. HCSO was one of five counties in the state to participate. The legislation specified MOUD continuation and induction 3 months prior to a planned release. After starting with these populations, HCSO expanded coverage to include inductions near onset of incarceration, including for those with pretrial status.

Currently, individuals who arrive at the jail on MOUD have their prescription verified and medication continued. Everyone is screened for substance use disorders during intake and again during their physical health assessment. OTP services and AUD treatment can be requested then or via daily sick call or during a health care appointment. Health services and custody staff may also refer individuals to the OTP.

The project began by evaluating the facility's infrastructure to identify suitable locations for housing an OTP. HCSO held interdisciplinary meetings, ensuring participation from all facility departments. By involving everyone from the start, leadership created space for diverse ideas

and feedback during the development phase. This also facilitated the formation of subcommittees and cross-discipline education, helping to address and reduce stigma around supporting an OTP.

Lessons Learned

HCSO encountered challenges around COVID-19, staffing levels, and staff buy-in at the inception of the OTP. During program development, cross-disciplinary collaboration, where employees were given an opportunity to offer ideas and feedback, was an important component for success. Proactively soliciting staff buy-in through this strategy has led to enhanced communication, improved feedback, and increased strategic collaboration among those working on the program.

Today, recruiting for and maintaining adequate staffing, especially among nursing, remains a challenge. Creative solutions are necessary to successfully provide MOUD in the jail within the constraints of a controlled budget. It is imperative to provide details of staffing concerns, including key metrics, to administration on a consistent basis to effect change around employment incentives.

Outcomes

HCSO is undertaking a study to understand quantitative outcomes associated with the OTP. Qualitative data suggests that the overall environment among staff and those in custody has improved.

Hudson County Correctional Center

New Jersey

Program Overview

The Hudson County Correctional Center's MAT program emerged from a combination of legal, clinical, and legislative motivations. Although leadership recognized the value in and evidence behind providing MAT, the New Jersey Division of Mental Health and Addiction Services (NJDMHAS) established requirements for Medicaid-certified programs, mandating that any certified entity provide MAT for opioid use disorder. In 2017, Hudson County became the only correctional center in New Jersey to integrate a NJDMHAS-certified residential treatment program within its facility.

Individuals accepted into the facility are screened for a history of substance use and mental health issues. The MAT program is accessible to everyone housed in the facility who is assessed by a provider and determined to benefit from the treatment.

Lessons Learned

Implementing the MAT program required overcoming funding and logistical hurdles. A SAMHSA grant made the program more feasible by covering medication costs, which were initially a concern for county leadership.

Custody staff expressed concerns about introducing MAT, as buprenorphine and methadone were perceived to be susceptible to diversion. However, facility leadership recognized the program's value and accepted the change, addressing frontline staff concerns through training and adjustments to security protocols.

A significant takeaway from the program is that to serve incarcerated populations effectively, facilities must prioritize both security and health care in equal measure. Hudson County's experience suggests that a correctional center must embrace a role that combines public safety with public health to create a rehabilitative environment conducive to recovery.

Outcomes

Hudson County's MAT program has significantly impacted recidivism rates. The recidivism rate for those on MAT is 26%, a figure below the national average for those with substance use disorders.

The therapeutic environment created by the treatment has fostered noticeable improvements in behavior, and the MAT patients have fewer grievances and disciplinary issues compared to the jail's general population.

Medications for Addiction Treatment (MAT) Fact Sheet

Opioids like oxycodone, heroin, and fentanyl continue to cause overdoses, deaths, health problems, relationship problems, job loss, and arrests all over the country.

MAT saves and improves lives.

Buprenorphine (brand names include Suboxone, Subutex, Zubsolv, Sublocade, Brixadi)

- Buprenorphine partially activates the same part of the brain as opioids but is not as strong. It is not a "blocker," but it makes it harder for a drug like heroin to work.
- In the community, buprenorphine is usually taken by the patient at home.
- Various forms of buprenorphine are available, including buprenorphine/naloxone tablets and films that go under the tongue and buprenorphine extended-release long-acting injections.
- Buprenorphine is intended as a long-term treatment and can be taken as long as it is helpful.
- Risks and side effects: Buprenorphine can be misused. Missing doses may cause withdrawal. Common side effects include headache, dizziness, numbness or tingling, drowsiness, constipation, difficulty driving or using machinery, liver or dental problems, and leg swelling. If you mix it with alcohol or other drugs or medications, it may make it hard to breathe and may even cause death.
- Pregnant or breastfeeding individuals: Buprenorphine may be prescribed to women who are pregnant or breastfeeding and have an opioid use disorder.

Methadone

- Methadone fully activates the same part of the brain as illegal opioids but is long acting so reduces opioid craving and withdrawal and blunts or blocks the effects of opioids. It has been used to treat opioid use disorders for over 50 years.
- In the community, methadone is typically taken by the patient at a certified opioid treatment program (OTP), though take-home doses may be permitted.
- Methadone is taken daily by mouth, usually in liquid form.
- Methadone should be continued for as long as the individual finds it helpful. It must be stopped gradually with medical supervision to prevent severe withdrawal.
- Methadone may only be prescribed by an OTP. Ask your provider about an OTP near where you live so you can continue methadone.
- Risks and side effects: Common side effects include sedation, restlessness, nausea, slow breathing, itchy skin, sweating, constipation, and heart problems. When taken with other opioids, alcohol, benzodiazepines (like Xanax or Valium), or other medications (including Neurontin and Lyrica), this may cause overdose, low blood pressure, heart problems, respiratory failure, cardiac arrest, and death.
- Pregnant or breastfeeding individuals: Those who are pregnant or breastfeeding can safely take methadone. Research has shown that the benefits of breastfeeding can outweigh the effect of the small amount of methadone that enters breast milk. During withdrawal, the uterus can contract and bring on miscarriage or premature birth, but consistently taking methadone prevents withdrawal symptoms in the mother. It may cause some babies to experience opioid withdrawal after birth, but it does not mean that they have an addiction.

Naltrexone (brand names include Vivitrol, ReVia, Depade)

- Naltrexone is FDA approved for the treatment of both opioid and alcohol use disorders.
- Naltrexone is a nonaddictive "blocker" and not an opioid. It does not cause withdrawal symptoms when stopped. It may reduce cravings. Naltrexone blocks feelings of intoxication from alcohol and helps reduce drinking.
- This medication is available in pill form taken daily and as a monthly injection.
- If you use opioids, you must wait at least 7 days (longer if taking methadone) before you can comfortably start naltrexone.
- Risks and side effects: Use of long-acting naltrexone may "reset" your tolerance for opioids and may increase your risk of overdose if you start using opioids again. Common side effects include upset stomach, diarrhea, headache, mood changes, sleep problems/tiredness, liver problems, and joint or muscle pain.

If you are prescribed MAT, you will need to take the medication as instructed. Staff will follow a procedure to make sure that the medicine is taken safely. Testing may be necessary to check that the medication is being taken and is causing no new health problems.

The **National Commission on Correctional Health Care (NCCHC)** is a nonprofit 501(c)(3) organization working to improve the quality of care in our nation's jails, prisons, and juvenile detention and confinement facilities. NCCHC establishes standards for health services in correctional facilities, operates a voluntary accreditation program for institutions that meet these standards, produces and disseminates resource publications, offers a quality review program, conducts educational trainings and conferences, and offers a certification program for correctional health professionals. NCCHC is supported by the major national organizations representing the fields of health, mental health, law, and corrections.

ncchc.org

Chartered in 1940, the **National Sheriffs' Association (NSA)** is a professional association dedicated to serving the Office of Sheriff and its affiliates through law enforcement education and training, and through the provision of general law enforcement informational resources. NSA represents thousands of sheriffs, deputies and other law enforcement, public safety professionals, and concerned citizens nationwide.

sheriffs.org

The **American Jail Association (AJA)** is a national, nonprofit organization that supports the professionals who operate our nation's jails. It is the only national association that focuses exclusively on issues specific to the operations of local correctional facilities.

americanjail.org

NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

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NCCHC.org

Download this resource at ncchc.org/jail-based-MAT