Guidelines for Implementing Medications for Opioid Use Disorder Treatment in State Prisons

June 2025

SAMHSA
Substance Abuse and Mental Health Services Administration

Acknowledgments

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Introduction

The prevalence of opioid use disorder (OUD) is greater among people involved with the criminal justice system than in the general population.[1] Greater intensity of opioid use is associated with a higher likelihood of incarceration and about one third of people who pass through the criminal justice system would benefit from treatment for this health condition.[2] Medications for opioid use disorder (MOUD) are a critical part of effective treatment, as they decrease cravings, lessen withdrawal symptoms, and reduce opioid-related mortality by more than 50 percent.[3] However, few prisons provide access to all three MOUD medications (i.e., methadone, buprenorphine, and naltrexone).[4,5]

The rates of overdose death are high among residents of correctional facilities who have not been treated with MOUD during incarceration and among individuals who have been released without a connection to continuing MOUD upon release.[6] These individuals are at significantly elevated risk of fatal opioid overdoses in the weeks following release.[7] MOUD can prevent overdose and mortality following reentry, and it can break the cycle of rearrest and reincarceration associated with OUD. Moreover, MOUD contributes to the maintenance of a safe and secure facility for both residents and staff.[8,9]

As a result, the U.S. Department of Justice (DOJ) and the U.S. Department of Health and Human Services (HHS) are focusing on reducing overdose deaths during and after incarceration and reducing recidivism by establishing effective treatment during residence and maintaining continuity of medication treatment for substance use disorder (SUD) and recovery services for residents upon return to their community. The Substance Abuse and Mental Health Services Administration (SAMHSA), an Operating Division within HHS, in close collaboration with DOJ and the Drug Enforcement Administration (DEA), is spearheading expansion of MOUD in correctional settings to focus on this critical effort.

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[1] Winkelman, T. N. A., Chang, V. W., & Binswanger, I. A. (2018). Health, polysubstance use, and criminal justice involvement among adults with varying levels of opioid use. *JAMA Network Open, 1*(3), e180558. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2687053

[2] Maruschak, L. M., Minton, T., Zeng, Z. (2023). *Opioid use disorder screening and treatment in local jails, 2019*. https://bjs.ojp.gov/document/oudstlj19.pdf

[3] Martin, R. A., Alexander-Scott, N., Berk, J., Carpenter, R. W., Kang, A., Hoadley, A., Kaplowitz, E., Hurley, L., Rich, J. D., & Clarke, J. G. (2023). Post-incarceration outcomes of a comprehensive statewide correctional MOUD program: A retrospective cohort study. *The Lancet Regional Health – Americas, 18*, 100419. https://doi.org/10.1016/j.lana.2022.100419

[4] Sharma, A., O'Grady, K. E., Kelly, S. M., Gryczynski, J., Mitchell, S. G., & Schwartz, R. P. (2016). Pharmacotherapy for opioid dependence in jails and prisons: Research review update and future directions. *Substance Abuse Rehabilitation, 7*, 27–40. https://doi.org/10.2147/SAR.S81602

[5] Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990). https://www.congress.gov/bill/101st-congress/senate-bill/933

[6] Bukten, A., Stavseth, M. R., Skurtveit, S., Tverdal, A., Strang, J., & Clausen, T. (2017). High risk of overdose death following release from prison: Variations in mortality during a 15-year observation period. *Addiction, 112*(8), 1432–1439. https://doi.org/10.1111/add.13803

[7] Chang, Z., Lichtenstein, P., Larsson, H., & Fazel, S. (2015). Substance use disorders, psychiatric disorders, and mortality after release from prison: A nationwide longitudinal cohort study. *The Lancet Psychiatry, 2*(5), 422–430. https://doi.org/10.1016/S2215-0366(15)00088-7

[8] Substance Abuse and Mental Health Services Administration. (2019). *Use of medication-assisted treatment for opioid use disorder in criminal justice settings* (HHS Publication No. PEP19-MATUSECJS). National Mental Health and Substance Use Policy Laboratory. https://library.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

[9] Longley, J., Weizman, S., Brown, S., & LaBelle, R. (2023, February). *A national snapshot update: Access to medications for opioid use disorder in U.S. jails and prisons*. O'Neill Institute for National and Global Health Law at Georgetown Law Center. https://oneill.law.georgetown.edu/publications/a-national-snapshot-update-access-to-medications-for-opioid-use-disorder-in-u-s-jails-and-prisons/

This document provides guidance for implementing MOUD in state correctional settings. It assumes that state and local agencies and external stakeholder groups concur about expanding access to MOUD. It provides practical information about medications, service delivery models, and regulatory requirements and processes related to MOUD. Additionally, this guidance includes suggestions for staff training to support implementation, highlights cultural issues that may affect the uptake and integration of MOUD, and suggests actions to ensure continuity of MOUD for residents returning to the community.

In this way, these guidelines directly support President Trump's Make America Healthy Again (MAHA) initiative's fundamental commitment to addressing chronic disease epidemics through evidence-based, transparent healthcare approaches. By expanding access to all three FDA-approved medications for OUD treatment in state prisons, the Guidelines align with MAHA's vision of ensuring that every American, regardless of their circumstances, has access to proven treatments that save lives. The evidence is clear: MOUD reduces mortality by more than 50 percent and breaks the devastating cycle of addiction, incarceration, and overdose that impacts millions of American families.

Furthermore, implementing MOUD in correctional facilities removes institutional barriers that prevent Americans from accessing life-saving treatments, a MAHA principle. The systematic approach outlined in these guidelines—from screening and assessment to medication management and community reentry coordination—embodies the transparency and evidence-based practices that MAHA champions. By treating OUD as the chronic medical condition it is, and by ensuring continuity of care from incarceration through community reentry, the recommendations prioritizes healing and recovery. These guidelines represent a critical step toward reducing the burden of chronic disease on American individuals and families by ensuring the provision of comprehensive, whole-person care - ultimately contributing to a healthier, more resilient nation where every individual has the opportunity to achieve wellness and reach their full potential.

Background

Many studies and resources are available to explain the types of services, treatments, and recovery supports that reduce substance use, lessen mental and physical health symptoms, and improve individuals' quality of life. The mission of SAMHSA's Center for Substance Abuse Treatment (CSAT) is to promote effective SUD treatment and recovery support services for individuals and families in every community. SAMHSA defines MOUD as the Food and Drug Administration (FDA)-approved medications typically provided to individuals with OUD in combination with counseling, behavioral therapies, and recovery support services. In this way, MOUD—in combination with other services—provides a whole-person approach to the treatment of OUD, which seeks to help individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Extensive studies demonstrate that MOUD is particularly valuable for the treatment of criminal justice-involved persons. It is important to acknowledge that for many individuals, MOUD alone may be enough to reduce opioid-related mortality and begin them on the road to recovery. However, combining MOUD with counseling services is known to have a greater impact on recovery outcomes than medication only.[10]

[10] Substance Abuse and Mental Health Services Administration. (2019). *Use of medication-assisted treatment for opioid use disorder in criminal justice settings* (HHS Publication No. PEP19-MATUSECJS). National Mental Health and Substance Use Policy Laboratory. https://library.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

There are three FDA-approved medications used to treat OUD—methadone, buprenorphine, and naltrexone. The recognized gold-standard, evidence-based treatments for OUD are the long-acting opioid agonist medications methadone or buprenorphine.[11] Methadone, buprenorphine, and naltrexone have been shown to reliably increase entry into, and retention in, treatment during incarceration. After release to the community, their use is associated with reduced arrests when compared to no treatment post-release.[12]

The use of MOUD is not a commonly known or understood topic by the general public. Many have heard myths about MOUD or hold a strong bias against its use for treatment of OUD. While concerns about security, liability, and the risk of diversion may deter some from incorporating MOUD into their facilities, MOUD can be safely provided in carceral settings.[13]

Long-term treatment with MOUD is often necessary for some people to continue in recovery. Tapering off methadone or buprenorphine is generally not recommended because premature or unwarranted discontinuation of the medications puts people at risk of returning to use. The risk of recurrence of opioid use falls significantly when individuals have been treated with MOUD for at least 3 years.[14]

Federal laws protect people with OUD who are incarcerated in jails or prisons. The ADA of 1990 and the Rehabilitation Act (RA) of 1973 are important federal statutes designed to protect individuals with disabilities from discrimination. The ADA explicitly includes "drug addiction" as a "physical or mental impairment."[15] Not treating OUD as any other medical condition could pose a violation of both the ADA and the RA. Providing individualized evaluations for OUD and access to MOUD ensures that these laws are upheld. Essentially, a correctional facility, its personnel, and contractors who are involved in healthcare delivery are obliged to provide MOUD to people who are incarcerated. Numerous states have enacted laws requiring their correctional facilities to make MOUD available to residents in their care.[16]

MOUD: Options, Benefits, and Considerations

Providing access to MOUD in correctional settings and facilitating access to services when residents are reentering the community are effective interventions for reducing overdoses among this high-risk

[11] National Academies of Sciences, Engineering, and Medicine. (2019). *Medications for opioid use disorder save lives*. The National Academies Press. https://doi.org/10.17226/25310

[12] Substance Abuse and Mental Health Services Administration. (2019). *Use of medication-assisted treatment for opioid use disorder in criminal justice settings* (HHS Publication No. PEP19-MATUSECJS). National Mental Health and Substance Use Policy Laboratory. https://library.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

[13] National Governors Association & American Correctional Association. (2021, January). *Expanding access to medications for opioid use disorder in corrections and community settings: A roadmap for states to reduce opioid use disorder for people in the justice system*. https://www.nga.org/publications/expanding-access-medications-oud-corrections-community-settings/

[14] Substance Abuse and Mental Health Services Administration. (2019). *Use of medication-assisted treatment for opioid use disorder in criminal justice settings* (HHS Publication No. PEP19-MATUSECJS). National Mental Health and Substance Use Policy Laboratory. https://library.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

[15] Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990). https://www.ada.gov/

[16] Longley, J., Weizman, S., Brown, S., & LaBelle, R. (2023, February). *A national snapshot update: Access to medications for opioid use disorder in U.S. jails and prisons*. O'Neill Institute for National and Global Health Law at Georgetown Law Center. https://oneill.law.georgetown.edu/publications/a-national-snapshot-update-access-to-medications-for-opioid-use-disorder-in-u-s-jails-and-prisons/

population. Evidence shows several important benefits post-incarceration when providing MOUD to incarcerated individuals with OUD, such as[17]:

- Reduced illicit opioid use post-incarceration.
- Reduced criminal behavior post-incarceration.
- Reduced mortality and overdose risk post-incarceration.
- Reduced HIV, hepatitis C (HCV) risk behaviors (i.e., injection drug use) post-incarceration.
- Increased engagement with healthcare professionals, reducing costs associated with untreated physical and behavioral health issues.
- Improved rates of recidivism when treatment is continued in the community.

Withdrawal symptoms for individuals with OUD can be quite severe and are often a reason why individuals have difficulty stopping their use of opioids. Some withdrawal symptoms include anxiety, depressed mood, extreme restlessness, sweating, fatigue, irritability, vomiting, fever, increased sensitivity to pain, trouble sleeping, nausea, abdominal cramps, and diarrhea.[18] The diagnostic criteria for OUD, however, rely less on the presence of withdrawal symptoms and more on the presence of intense cravings and continued use despite the risk and/or presence of adverse consequences.[19]

Methadone

Methadone has been considered the gold standard for treatment of OUD since the 1960s. It reduces craving and withdrawal symptoms and lessens the effects of other opioids if used concurrently, thereby reducing overdose potential. Methadone does not cause euphoria or drowsiness when it is dosed appropriately for a patient with OUD. An important advantage of methadone is that it can be started even before a patient is in severe withdrawal, without risk of precipitated withdrawal. The medication is usually offered in liquid form and is taken by mouth once per day at a federally regulated clinic (i.e., an opioid treatment program [OTP]).

Methadone is long-acting and fills the same opioid receptors in the brain as other opioids. As a result, people who take methadone as part of an SUD treatment/recovery program will not experience opioid cravings or intense withdrawal symptoms. This establishes a strong basis for recovery and allows individuals to fully focus on other priorities, such as therapy, work, and other recovery-related activities.

Other advantages of methadone include[20,21]:

- Reduced risk of infectious disease, such as HIV or HCV.

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[17] Substance Abuse and Mental Health Services Administration. (2019). *Use of medication-assisted treatment for opioid use disorder in criminal justice settings* (HHS Publication No. PEP19-MATUSECJS). National Mental Health and Substance Use Policy Laboratory. https://library.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

[18] Pergolizzi, J. V., Jr., Raffa, R. B., & Rosenblatt, M. H. (2020). Opioid withdrawal symptoms, a consequence of chronic opioid use and opioid use disorder: Current understanding and approaches to management. *Journal of Clinical Pharmacy and Therapeutics, 45*(5), 892–903. https://doi.org/10.1111/jcpt.13114

[19] American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

[20] Substance Abuse and Mental Health Services Administration. (2019). *Use of medication-assisted treatment for opioid use disorder in criminal justice settings* (HHS Publication No. PEP19-MATUSECJS). National Mental Health and Substance Use Policy Laboratory. https://library.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

[21] Substance Abuse and Mental Health Services Administration. (2021). *Medications for opioid use disorder* (Treatment Improvement Protocol [TIP] Series 63, Publication No. PEP21-02-01-002). Rockville, MD: Substance Abuse and Mental Health Services Administration. https://library.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002

- Overall improvement in quality of life (e.g., achieving self-sufficiency).
- Better chance at long-term recovery success.
- Improved social functioning.
- Improved participation and retention in addiction treatment and recovery services.
- Safe for use with pregnant people.

Buprenorphine

Like methadone, buprenorphine binds to opioid receptors in the brain, reducing cravings and withdrawal symptoms. Buprenorphine also does not produce euphoria and lessens the effects of other opioids if used concurrently, thereby reducing overdose potential. When buprenorphine is prescribed to treat OUD as an oral medication, the formulation typically also contains naloxone. Oral buprenorphine is taken sublingually (under the tongue). While buprenorphine is well absorbed this way, naloxone is not. If the medicine is injected, inhaled, or misused, the naloxone is absorbed and may block the effects of buprenorphine. This may reduce the risk of misuse and of diversion.

As previously noted, buprenorphine has similar benefits to methadone. However, it is easier to access because it can be prescribed by outpatient providers in the community, picked up from a pharmacy, and taken at home. In contrast, methadone can be accessed only through OTPs, although there are some exceptions, including correctional facilities, hospitals, and long-term care facilities.

Naltrexone

Naltrexone is an opioid antagonist medication, which means it blocks the effects of opioids by occupying the opioid receptor without activating it, preventing opioids from producing euphoria. It reduces cravings in some people and makes opioid use less appealing because the opioids do not have an effect.

Naltrexone is administered once every 28 days via intramuscular injection. In order to avoid precipitated withdrawal, treatment with naltrexone is not started unless the individual has abstained from all opioids for 7 to 10 days. Individuals who discontinue naltrexone treatment and return to use may have a reduced tolerance to opioids.[22] As a result, if they use opioids at the same or even lower doses than they have in the past, it can cause an overdose. Patients need to be informed of this risk as part of informed consent. Naltrexone is also available in pill form for the treatment of alcohol use disorder, but the pill form is not indicated for treating OUD.

Naltrexone helps reduce the severity of ongoing opioid cravings but does not have any effect on opioid withdrawal symptoms. There are no regulatory restrictions in the use of naltrexone to treat OUD. There is no misuse and diversion potential with naltrexone. Unlike the opioid agonist medications, stopping naltrexone does not require tapering to avoid withdrawal symptoms. Unlike buprenorphine and methadone, naltrexone has not been shown to have a strong impact on reducing mortality.[23]

The duration of treatment with any medication for OUD should be individualized and patients should be informed that stopping the medications too soon may increase their risk of return to use.

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[22] Substance Abuse and Mental Health Services Administration. (2021). *Medications for opioid use disorder* (Treatment Improvement Protocol [TIP] Series 63, Publication No. PEP21-02-01-002). Rockville, MD: Substance Abuse and Mental Health Services Administration. https://library.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002

[23] Substance Abuse and Mental Health Services Administration. (n.d.). *Naltrexone*. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone

Bringing MOUD Options to Residents—Models for Care

Correctional facilities may provide forms of MOUD directly or in collaboration with a community-based provider. Buprenorphine can be prescribed by any licensed practitioner who holds a DEA registration for Schedule III–V controlled medications while prescribing naltrexone does not require any specific DEA registration. To provide all three MOUD medications directly, a correctional facility will either need to register as an OTP to provide methadone, in addition to buprenorphine and naltrexone, or partner with a local OTP. Alternatively, a facility may provide all three MOUD medications if it holds a DEA hospital/clinic registration. A DEA hospital/clinic registration allows a facility to administer methadone to patients with OUD "to maintain or detoxify a patient as an incidental adjunct to medical or surgical treatment of conditions other than addiction." (21 CFR 13.07(c)).

For correctional settings that are not eligible to hold a DEA hospital/clinic registration and where it is not possible to become certified and registered as an OTP, relying on partnerships with community OTPs is an excellent alternative. In this scenario, the facility would partner with a local OTP to provide medication, and with a memorandum of understanding (MOU) or by contract, the two entities would determine whether the OTP will establish a medication unit in the facility, arrange for the OTP to deliver medication to the facility, or arrange for the correctional facility to pick up the medication from the OTP. An MOU between the facility and the OTP can formalize procedures by establishing a general understanding or conditional agreement among parties. Implementation requires planning for storing and administering medication. The following section offers details on these different options.

Correctional Facility Registration and Certification as an OTP

In the United States, methadone used for the treatment of OUD must be provided by an OTP. OTPs are governed by the regulations at Medications for the Treatment of Opioid Use Disorder, 42 Code of Federal Regulations (CFR) Part 8 (hereafter, referred to as 42 CFR Part 8). The regulation created a system to certify and accredit OTPs, allowing them to administer and dispense FDA-approved MOUD. In addition to accessing MOUD, individuals must also be provided with access to counseling and other behavioral therapies to provide a whole-person, comprehensive approach to SUD care.

Directly providing MOUD in the facility requires being the owner/operator of the OTP. The OTP must be certified by SAMHSA, registered as a Narcotic Treatment Program (NTP) with DEA, and licensed by the state in which it operates. This requires identifying a space to operate the OTP and establishing policies and procedures to guide it. The correctional facility assumes full control of the services delivered and regulatory operation. OTPs are required to provide counseling (including counseling on the prevention of HIV and other communicable diseases) and drug testing. This model promotes collaboration between the OTP, the facility's other health services, and the correctional staff. Explanation of how a facility can become an OTP is provided later in this document.

Partner With a Local OTP to Provide Medication Onsite

A correctional facility can contract or establish an MOU with a local OTP to establish a medication unit within the correctional facility or to bring medication to the facility via a mobile medication unit. In either case, the OTP manages all aspects of its services. Residents are assessed and participate in the OTP's services, and the resident's care is continued as part of the established community reentry plan Staffing and service coordination of care, which ensures ongoing access of residents to MOUD, are critical to the success of the model. A correctional facility partnering with an OTP to deliver OTP services

onsite or via a mobile medication unit can provide induction/initiation of agonist MOUD for residents who would benefit from MOUD treatment.

Transport Residents to OTP

The correctional facility can enter into an agreement with an OTP located near the correctional facility to bring residents to the community-based OTP to receive their dose of medication and to receive medication to bring back to the correctional facility. This model requires significant correctional staff time to transport residents to and from the OTP. In addition to these related costs, transporting persons in custody can increase stigma and safety risks for both the residents and staff.[24] It is important to consider whom at the correctional facility can transport the methadone under a chain-of-custody record. Please see DEA's Narcotic Treatment Program Manual for further details about this option.

Transport Medication to Correctional Facility

A local OTP may deliver medication to the correctional facility by entering into an agreement with the correctional facility to coordinate the MOUD needs of its resident population. To reduce medication diversion risks, it is important to document the frequency of medication deliveries, protocols for the transfer of medication from OTP staff to identified correctional facility staff, and chain of custody for the medication.

Another option is for correctional facility staff to travel to the OTP to collect the medications and transport them back to the correctional facility using a documented chain of custody. It should be noted, however, that specific procedures for correctional facilities may vary by jurisdiction. Consulting local regulations and coordinating with community OTPs is recommended to ensure compliance with all legal and safety requirements.[25]

Summary of Models

The clinical and administrative arrangement best suited to each correctional facility will vary based on the respective facility, average length of stay, proximity of community OTPs, staffing resources, and other considerations. Regardless of options, each presents different challenges and benefits.

Transporting residents to an OTP or bringing medications into the correctional facility may pose challenges for initiating MOUD, due to the need for close monitoring of the patient during induction. However, these approaches can reduce the need for correctional facilities to invest in OTP infrastructure and staffing. Additionally, both the OTP and the correctional facility can avoid navigating each other's regulatory requirements, which simplifies operations for both systems.[26]

Becoming an OTP—or partnering with one—ensures that correctional facilities can provide residents with comprehensive treatment, access to MOUD, and other essential services. These collaborative models are particularly beneficial for residents who are already receiving MOUD and those who are newly screened and identified as people who could benefit from MOUD. These collaborative models

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[24] A Guide to DEA Narcotic Treatment Program Regulations DEA-DC-056, EO-DEA169 June 15, 2022. https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-056)(EO-DEA169)_NTP_manual_Final.pdf

[25] Substance Abuse and Mental Health Services Administration. (2024). *Federal guidelines for opioid treatment programs (HHS Publication No. PEP24-02-011).* U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/federal-guidelines-opioid-treatment-pep24-02-011.pdf

[26] Substance Abuse and Mental Health Services Administration. (2024). *Federal guidelines for opioid treatment programs (HHS Publication No. PEP24-02-011).* U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/federal-guidelines-opioid-treatment-pep24-02-011.pdf

also facilitate the development of a relationship between residents and the OTP that can support continuity of care and enhance the resident's reentry to the community.

Providing MOUD Within State Prisons

A state may decide to provide MOUD directly by using buprenorphine or naltrexone or in collaboration with a local OTP for methadone, or it may decide to provide all three medications in-house, by integrating an OTP within their facility. In any of these scenarios, consideration must be given to the following areas:

Screening for MOUD

Regardless of the model used to provide MOUD to residents, screening residents for recent opioid use, withdrawal symptoms, and MOUD history will inform the decision on whether MOUD should be a component in the safe management of the individual's OUD. How screening and subsequent management strategies are implemented will vary depending on the size of the institution, access to medical services, and available resources. This variability has implications for those who potentially screen positive for opioid use, and the provision of comprehensive and ongoing care.

Screening for recent opioid use and MOUD history should occur as the individual is taken into custody, and it should be conducted by trained staff using a brief, standardized and validated instrument to identify recent problematic substance use.[27] There are several SUD screening tools that could be considered, such as the Screening to Brief Intervention (S2BI).[28] Screening should take place in a confidential and nonjudgmental manner and used as an opportunity to discuss potential interventions for short- and long-term management. Screening should include the type of substance(s) used, the route of administration, quantity used, and frequency of use. Note that standardized screening tools do not assess signs and symptoms of substance-specific withdrawal syndromes, but they may identify individuals who should be monitored or who need clinical assessment of withdrawal symptoms.[29]

Opioid withdrawal syndrome can be medically complex and often coincides with withdrawal from other substances. In the absence of appropriate management, withdrawal can be life-threatening. By the time a patient is admitted to a facility, they may have been in custody for hours to days. Therefore, screening and assessment upon a resident's entry or planned transfer is recommended.[30]

Any individual who screens positive for recent opioid use should receive a timely medical assessment/evaluation, which should include:

- Patterns of substance use.
- Current or recent enrollment in an SUD treatment program.
- Co-occurring conditions.

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[27] National Commission on Correctional Health Care. (2021). *Opioid use disorder treatment in correctional settings*. https://www.ncchc.org/position-statements/opioid-use-disorder-treatment-in-correctional-settings-2021/

[28] National Institute on Drug Abuse. (n.d.). *Screening and assessment tools chart*. National Institute on Drug Abuse. Retrieved January 13, 2025, from https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

[29] Substance Abuse and Mental Health Services Administration. (2024). *Federal guidelines for opioid treatment programs* (HHS Publication No. PEP24-02-011). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/federal-guidelines-opioid-treatment-pep24-02-011.pdf

[30] Bureau of Justice Assistance, & National Institute of Corrections. (2023). *Guidelines for managing substance withdrawal in jails* (NCJ 306491). U.S. Department of Justice. https://bja.ojp.gov/library/publications/guidelines-managing-substance-withdrawal-jails

- Confirmation of medications and dosing, including those used to treat SUD (e.g., naltrexone, acamprosate, methadone, buprenorphine).
- Withdrawal severity, using validated, standardized instruments.
- A pregnancy test for all people of childbearing age and capacity.

The Clinical Opiate Withdrawal Scale is an 11-item tool designed to systematically assess and monitor the severity of common opioid withdrawal signs and symptoms over time.[31] Toxicology testing may help further evaluate people who have positive screening for substance use.

Facilities-Related Issues

In preparation for service delivery, correctional settings should consider the physical layout of their campus and facilities. For example, consideration should be given to whether services will be located at one site or at each site, or whether there are spacing challenges at the respective site considered. DEA guidelines and federal and state regulations should drive planning and development for each of the following areas:

- MOUD secure storage (e.g., secure safe, automated medication dispensing unit, security system to protect medication storage and dispensing area, when in use).
- Medication administration (e.g., adequate space for patients taking medication and waiting specific MOUD dosing times, decentralized dosing).
- Designated area(s) for medication administration.
- Designated area(s) for individual and group treatment.
- Designated area(s) for toxicology collection.

Medication Management/Diversion Control

Staff and resident safety require consideration of the possibility that controlled medications will be transferred or used by those to whom they were not dispensed. Consideration for both resident and staff diversion should be included in this plan. Federal regulation 42 CFR Part 8 requires that an OTP have a diversion control plan (DCP)—a set of documented policies and procedures that reduce the OTP's risk of medication diversion and would work collaboratively with their accreditation bodies to ensure successful outcome of this requirement. Facilities that are not OTPs are required to comply with DEA regulations under 21 CFR Part 1306. Appropriately licensed staff for medication administration should be maintained as specified in state and federal regulations.

Staffing

Effective MOUD programs in correctional settings require attention to detail and high levels of coordination among team members, particularly among operations and medical staff. Having designated staff assigned to this service enables those employees to learn MOUD program processes, know the residents they work with, and share the responsibility for the success of the program. Additionally, it is important to employ staff with the experience, qualifications, expertise, and orientation toward providing treatment within the correctional setting. These staff members should be supported with a variety of ongoing trainings (e.g., MOUD training, SUD information) and system structures to ensure they have the foundational knowledge and skills to safely address the risk of medication diversion. Dedicated staff include adequate medical coverage for:

[31] Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *Journal of Psychoactive Drugs, 35*(2), 253–259. https://doi.org/10.1080/02791072.2003.10400007

- Assessment and treatment planning services.
- Prescribing and dispensing medications.
- General medical oversight.

Multidisciplinary Teams

Successful MOUD programs require a multidisciplinary team of correctional staff, regardless of MOUD model. As such, this may incorporate both internal and external staffing, in order to safely dispense, administer, or deliver medications and prevent their diversion. Although these teams may differ across correctional facilities, the relationships fostered through a multidisciplinary approach help create the necessary program environment and trust to reduce mistakes, increase transparency, ensure treatment care quality, and minimize the opportunities for medication diversion. Strong relationships are needed between medical/health and correctional/enforcement staff so communication is clear, the needed conversations happen when staff recognize red flags related to diversion, or an individual is not responding to or adhering to treatment as expected.[32]

Integrating an OTP Within the Correctional Facility

Overall Responsibilities

To operate its own OTP or to have a community-based OTP establish a medication unit within the correctional facility, the facility must understand the requirements for applying to SAMHSA/CSAT and DEA and the responsibilities involved in implementing and maintaining OTP operations.[33]

42 CFR Part 8 requires an OTP to have a designated Program Sponsor and Medical Director. A Program Sponsor is the person named in the application for certification described in §8.11(b) as responsible for the operation of the OTP and who assumes responsibility for its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any of its medication units. The Program Sponsor need not be a licensed physician but the program must employ a licensed physician for the position of Medical Director.

The Medical Director must be a physician, licensed to practice medicine in the jurisdiction in which the OTP is located, who is responsible for administering all medical services performed by the program—either by performing them directly or by delegating specific responsibility to authorized program physicians and healthcare professionals functioning under the Medical Director's direct supervision. One staff member can fulfill the roles of both the Program Sponsor and the Medical Director.

Provision of ongoing routine medical services, counseling and peer support services is expected, in addition to the provision of MOUD. Federal regulation 42 CFR §8.12(f) specifies that OTPs must offer adequate medical, counseling, vocational, educational, and other assessment and treatment services. Counseling may occur on an individual and group basis, either virtually or in-person, based on the needs of the individual. These services must be available at the facility, unless the Program Sponsor enters into a formal, documented agreement with a private or public agency, organization, practitioner, or

[32] Substance Abuse and Mental Health Services Administration, & Bureau of Justice Assistance. (2019). *Medication-assisted treatment inside correctional facilities: Addressing medication diversion* (PEP19-MAT-CORRECTIONS). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/pep19-mat-corrections.pdf

[33] Substance Abuse and Mental Health Services Administration, & Bureau of Justice Assistance. (2019). *Medication-assisted treatment inside correctional facilities: Addressing medication diversion* (PEP19-MAT-CORRECTIONS). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/pep19-mat-corrections.pdf

institution to provide these services to individuals enrolled in the OTP. The Program Sponsor must be able to document that these services are fully and reasonably available to patients. Managing medical and behavioral health comorbidities should be integrated as part of all OTP services provided.

The Division of Pharmacologic Therapies, SAMHSA/CSAT OTP Certification

The Division of Pharmacologic Therapies (DPT), part of SAMHSA's CSAT, is responsible for certifying that an OTP complies with federal regulations governing treatment for SUDs.

To provide methadone, as well as the other MOUD options, the facility must successfully complete the certification and accreditation process and meet other requirements outlined in 42 CFR Part 8. Requirements include:

- Certification as an OTP by CSAT and federal accreditation from one of the SAMHSA-approved accreditation entities.
- Licensure as an OTP by the state in which it operates.
- Registration with DEA, through its local DEA office, as an NTP (a term that is functionally equivalent to OTP).

Programs applying for accreditation, certification, and registration must also comply with the applicable laws and regulations in their states. More information is available from the State Opioid Treatment Authorities (SOTA), which oversee state and federal requirements related to the provision of OTP services.

To help OTPs achieve regulatory compliance for both certification and accreditation, SAMHSA updated the *Federal Guidelines for Opioid Treatment Programs (2024)*.

SAMHSA also offers resources to learn more about medications used and counseling treatment for SUDs.

Provisional Certification

The provisional certification is an initial, temporary certification granted to a new OTP for up to 1 year, during which time it must become accredited. OTPs applying to SAMHSA for provisional certification are required to apply to a SAMHSA-approved accrediting body for accreditation. OTPs may seek provisional certification while working to gain state and DEA approvals. However, SAMHSA will not grant provisional certification without both state and DEA approval.

Steps in the SAMHSA/CSAT Application Process

Programs seeking provisional certification as an OTP must use SAMHSA Form SMA-162: Application for Certification to Use Opioid Drugs in a Treatment Program. Each application requires different supporting documentation. This documentation can be uploaded along with Form SMA-162. New applicants should prepare the following supporting documents:

- Copy of the certification application, including the date applied for accreditation, dates of any previously held or scheduled accreditation surveys, and the expected schedule for completing the accreditation process.
- Program organizational structure description and chart indicating key OTP personnel, including their position and title, and the name and complete address of any central administration or larger organization structure to which the program is responsible. This includes identifying the OTP Program Sponsor—the individual who will assume the executive leadership responsibilities of the OTP.
- Facilities description and diagram and description demonstrating the adequacy of the facilities for drug dispensing and individual and group counseling. The description shall specify how the OTP will provide

adequate medical, counseling, vocational, educational, and assessment services at the primary facility, unless the Program Sponsor has entered into a formal documented agreement with another entity.

- The name, address, and description of each hospital, institution, clinical laboratory, or other facility used by the OTP to provide the necessary medical and rehabilitative services.
- The name and address of any facility other than the primary dispensing site where methadone will be dispensed either on a regular basis or on weekends, and as a service to the treatment program.
- A copy of the Medical Director's DEA registration, state license, and *curriculum vitae*. If the Medical Director is also the Medical Director for another treatment program, enclose a written justification for the feasibility of such an arrangement. This feasibility shall address the portion of the Medical Director's time spent in the treatment of unrelated medical patients and memberships on boards and committees that compete for time allocated to the treatment programs.
- The name and state license number of all OTP personnel (other than program physicians) licensed by law to dispense controlled medications even if they are not, at present, responsible for administering or dispensing methadone at the program. These would include pharmacists, registered nurses, and licensed practical nurses.
- A tentative schedule showing dispensing hours, counseling hours, and hours to be worked by physicians, nurses, and counselors. Also, describe how the dispensing hours are adequate and will ensure quality of patient care, per 42 CFR §8.12 (b).
- A budget with indication of the funding sources, including the name and address of each governmental agency providing funds.
- A description of the number of patients to be treated at operating capacity.
- A Diversion Control Plan (DCP).
- Acknowledgment that the Medical Director and/or program physician must register for an account via the SAMHSA OTP Extranet to submit federal patient exception requests (Form SMA-168) online. Applicants may register for an extranet account at the SAMHSA OTP Extranet. After the request is verified, the applicant will receive an email with a username and password to access the website.

DEA Narcotic Treatment Program Registration

In addition to applying to SAMHSA to become a certified OTP, a separate DEA registration is required to administer or dispense (but not prescribe) methadone or buprenorphine products to residents with OUD, per 21 CFR 1306.07(a). It should be noted that DEA uses the term *narcotic treatment program* (NTP), which is functionally equivalent to *opioid treatment program* (OTP).

The DEA application is limited to Schedule II- (methadone) and Schedule III- (buprenorphine) controlled medications approved by FDA specifically for the treatment of OUD.

The DEA Application and Approval Process

To register with DEA as an NTP, the correctional facility must apply using DEA Form 363 (Application for Registration Under the Narcotic Addict Treatment Act of 1974), which must be completed online at www.DEAdiversion.usdoj.gov, per 21 CFR 1301.13(e)(1)(vii). The form includes complete instructions and the cost of the application fee.

The following are required for a successful NTP application and approval process[34]:

- Security and alarm system for medication dispensing and medication storage.
- An approved safe.
- Recordkeeping practices.

Each DEA-registered NTP must maintain patient records in a dispensing log, in accordance with 21 CFR 1304.24, containing the following information:

- Name, strength, and dosage form of controlled medication.
- Date dispensed.
- Adequate identification of patient (consumer).
- Amount consumed.
- Amount and dosage form taken home by patient.
- Dispenser's initials.

Once DEA receives a new NTP application, the local DEA Diversion Field Office contacts the correctional facility/NTP to schedule an onsite pre-registration investigation. During the investigation, DEA personnel explain recordkeeping and security requirements. The NTP's security systems are tested and evaluated for compliance. This pre-registrant investigation includes verification of state licensure with SOTA and certification by SAMHSA. Upon approval, a DEA Form 223 is issued and sent to the mailing address indicated on the application. The DEA Form 223 must be maintained at the NTP's registered location in a readily retrievable manner and available for official inspection, per 21 CFR 1301.35(c). An NTP may not order, store, or dispense any controlled medications until an application is approved a DEA registration number assigned, per 21 CFR 1301.13(a). A separate registration is required for each principal place of business or professional practice where controlled medications are manufactured, distributed, or dispensed, per 21 CFR 1301.12(a).

Medications dispensed or administered at an NTP must be dispensed or administered directly to residents by only the following NTP staff (also known as authorized dispensers):

- Licensed practitioner.
- Registered nurse under the direction of the licensed practitioner.
- Licensed practical nurse under the direction of the licensed practitioner.
- Pharmacist under the direction of the licensed practitioner.

As per DEA, the correctional setting OTP/NTP must provide effective controls and procedures to guard against theft and diversion of controlled medications. Standards requirements are set forth in 21 CFR 1301.71-1301.76 and should be referred to in designing the facility's security system and ensuring its compliance.

Before making expenditures for a new or modified security system, the correctional facility is encouraged to contact the local DEA Diversion Field Office to determine whether the proposed system complies with DEA regulations. In determining whether the NTP's overall security system is in

[34] A Guide to DEA Narcotic Treatment Program Regulations DEA-DC-056, EO-DEA169 June 15, 2022. https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-056)(EO-DEA169)_NTP_manual_Final.pdf.

compliance, DEA considers several factors, including but not limited to, the following factors under 21 CFR 1301.71(b):

- Type and form of controlled medication handled (e.g., bulk powder, liquid, tablets).
- Quantity of controlled medications handled.
- Location of the NTP in the correctional facility.
- Type of building construction (e.g., brick or frame).
- Type of safe or vault used.
- Adequacy of electronic detection and alarm systems.
- Availability of security/enforcement staffing at the NTP.

DEA needs records of the number of physicians, staff members, and security/enforcement staffing, as well as the number of patients enrolled in the NTP when evaluating existing security or requiring new security at an NTP.

It is important to consider the state-to-state variances associated with DEA recommendations and decisions made when seeking registration as an NTP. The SOTA should be contacted if consultation is needed and to ensure that there are no additional requirements. In addition to the SOTA, the state Board of Pharmacy, other state licensing authorities, and SAMHSA should also be consulted, as applicable.

OTP Accreditation

Accreditation is a peer-review process that evaluates an OTP against SAMHSA's opioid treatment standards and the accreditation standards of SAMHSA-approved accrediting bodies. The accreditation process includes onsite visits by specialists with experience in OUD treatment medications and related treatment activities. The purpose of site visits is to ensure that OTPs meet specific, nationally accepted standards for MOUD.[35]

Federal Guidelines for Opioid Treatment Programs (2024) provides details on all required treatment services.

For correctional facilities that are applying to operate their own OTP, the National Commission on Correctional Health Care (NCCHC) is the accreditation body that they would apply to and participate in as part of implementation and ongoing service delivery. The first step would be to review the NCCHC Jail and Prison Standards that pertain to specific correctional settings or programs and assess the facility's compliance with them. These are the guidelines used for OTPs in correctional facilities. Next, the facility will need to provide basic information to begin the application process and establish an accreditation portal for the facility. NCCHC provides a self-assessment instrument that will help the correctional facility assess readiness for and compliance with the accreditation standards.[36]

After a provisionally certified program becomes accredited, it applies to SAMHSA for full certification via Form SMA-162, the same form used to become an OTP (also available via the SAMHSA Extranet at

[35] Substance Abuse and Mental Health Services Administration. (2024). *Federal guidelines for opioid treatment programs* (HHS Publication No. PEP24-02-011). U.S. Department of Health and Human Services. https://library.samhsa.gov/product/federal-guidelines-opioid-treatment-programs-2024/pep24-02-011

[36] National Commission on Correctional Health Care. (n.d.). *Applying for accreditation*. Retrieved January 13, 2025, from https://www.ncchc.org/accreditation/applying-for-accreditation/

https://otp-extranet.samhsa.gov). Once fully certified, OTPs must renew certification annually or every 3 years, depending on the accreditation timeframe awarded.

Collaborate With a Community-Based OTP to Provide OTP Services in the Facility

There are several benefits for both the correctional facility and a community-based OTP to partner in the delivery of MOUD services. For the correctional facility, the front-end challenges associated with delivering MOUD in the correctional facility can be shared with the OTP, with the OTP providing expertise in MOUD and other services. These partnerships also may enable a correctional facility to provide treatment for lower cost. Community-based providers are often interested in delivering services in correctional facilities, sometimes for subsidized rates, to maintain continuity of care among their patients, thus increasing the likelihood that a resident will return to the OTP post-release and reducing the significant risk of fatal overdose following release. To maximize the benefits of these partnerships, correctional leaders should have clear processes and plans in place for MOUD delivery.[37] Linking with community-based OTPs requires the establishment of collaborative relationships among the justice system and health and behavioral health systems to ensure access and continuity of treatment.

In partnering with a community-based OTP, the OTP takes the lead in applying to become an OTP. As part of the application, coordination is needed to determine staffing (i.e., identifying staff needed by the OTP and staffing allocation from the correctional facility, including prescribing staff, case management/counseling support staff, and peer support specialists who have lived experience and can help residents in understanding MOUD from the resident's perspective). Space identification (e.g., determination of space to dispense MOUD, storage of medication) and resources needed at the correctional facility (e.g., medical and storage equipment) will need to be coordinated, as well as means of sharing patient and treatment information (e.g., case conferences). Correctional facilities should be a part of all aspects of the OTP certification, registration, and accreditation process (see Integrating an OTP Within the Correctional Facility section of this document for specific details and guidance documents).[38]

Continuing Care—Coordinating Reentry Services Upon Resident Release

Coordination with community-based providers is an essential part of ensuring seamless continuity of treatment, supporting individuals in their recovery, and preventing overdose among individuals reentering the community following incarceration. The community-based provider will need to be an OTP if the resident has been receiving methadone, or if dispensing buprenorphine would benefit the resident upon release. Implementation strategies to support continuing care upon reentry include the following:

- Partnerships with community-based providers/OTPs.
- Mechanisms to support in-reach services, including services provided by peer support specialists or people with lived experience.

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[37] Substance Abuse and Mental Health Services Administration. (2024). *Federal guidelines for opioid treatment programs* (HHS Publication No. PEP24-02-011). U.S. Department of Health and Human Services. https://library.samhsa.gov/product/federal-guidelines-opioid-treatment-programs-2024/pep24-02-011

[38] Substance Abuse and Mental Health Services Administration. (2021). *Medications for opioid use disorder* (Treatment Improvement Protocol [TIP] Series 63, Publication No. PEP21-02-01-002). Rockville, MD: Substance Abuse and Mental Health Services Administration. https://library.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002

- Healthcare coverage and benefits applications or reinstatement.
- Identification materials.
- Release support.[39]

Effective partnerships require the establishment of collaborative relationships between correctional facilities and local treatment and service providers. Correctional facility leadership and staff should meet with community-based OTPs and/or providers to foster relationships of trust, share information, co-create policies and procedures, and cross-train staff so that everyone is on the same page regarding the services to be provided, security concerns, healthcare and recovery concerns, and other issues that may arise. Ongoing meetings and regular reporting are recommended as routine procedures so that all partners remain informed and engaged in supporting individuals in reentry.

Prior to a resident's release, it is critical that treatment and service providers can provide in-reach services to establish relationships, as well as begin planning for the person's care post-release. Addressing potential barriers to continuity of medication and treatment services is paramount to preventing overdoses upon return to the community. Treatment providers may offer in-reach services to create a therapeutic relationship and increase the likelihood that the resident will follow up on their treatment upon release. Social service providers and peer support specialists may reach in to create rapport and plan for immediate needs, such as pick-up and transportation and housing upon release. Correctional facilities will need to provide private space and develop a plan for movement of incarcerated individuals to meet with community-based providers to compete intake forms, screenings, and assessments; set up appointments; begin case management or transition planning; and other important activities to ensure a smooth transition from incarceration to the community.

It is important that the correctional facility develop policies and practices that enable peer support specialists with the lived experience of incarceration, past conviction, SUD, or mental disorder to come into the facility and provide direct services. If in-reach services do not take place, correctional staff, including medical staff, should work with residents to set up appointments with the community-based providers that they will follow up with after their release. Correctional facilities should also provide a sufficient supply of current medications so that a patient does not experience any lapse in treatment before they are able to see a community-based provider following release.

Ensuring that a person has the healthcare coverage to continue treatments started during incarceration is essential. Correctional facilities can best support reentry and continuity of care by providing staff that can help residents complete the necessary paperwork to obtain or reinstate healthcare coverage following release. If it is not possible to staff such a position, there are often community-based organizations that provide these services and might be open to a partnership with a correctional facility to provide these services to residents as an in-reach service. Ensuring insurance coverage/leveraging Medicaid and other delivery and payment systems within communities to reach these populations is essential.

Historically, many states have terminated Medicaid coverage when an enrollee is incarcerated in order to comply with Centers for Medicare & Medicaid Services (CMS) rules that federal financial participation is not available for incarcerated individuals (often referred to as "the inmate exclusion"). At the time of publication, there are 12 states that suspend but do not terminate Medicaid coverage when an enrollee

[39] National Reentry Resource Center. (n.d.). *Implementing evidence-based strategies to reduce overdose risk during reentry: A primer for reentry professionals*. https://nationalreentryresourcecenter.org/sites/default/files/inline-files/Implementing%20Evidence-Based%20Strategies%20to%20Reduce%20Overdose%20Risk%20During%20Reentry_v3_508.pdf

is incarcerated. CMS has issued letters (the first in 2004 and the second in 2016) encouraging suspension rather than termination of benefits; however, there remain states that continue to terminate. Upon reentry, reapplying for Medicaid can be difficult, which leaves people medically vulnerable and disconnected from healthcare services in the community.

Optimally, staff would also be available to help individuals who may be eligible for disability to apply for income benefits. Many individuals experiencing serious mental illness qualify for disability benefits, which could help with obtaining housing and other necessities in the community. Furthermore, in most states, Medicaid coverage is also available to people receiving disability benefits. Correctional facilities might consider hiring or setting up a partnership with benefits specialists who are trained in the Supplemental Security Income/Social Security Disability Insurance Outreach, Access, and Recovery (SOAR) model.

The correctional facility can enhance reentry success by ensuring that, at the time of release, each person is picked up by a support person who can provide transportation to housing or a service provider. This will require coordination and communication between release staff and the community-based peer support specialist or service provider. Release times should be limited to hours when a safe, supportive person is available to provide transportation and when service providers are open for business.

Facilitating Change

Implementing a change in any organization, including within a correctional facility, can seem daunting when that change may potentially involve challenging existing organizational culture or staff beliefs. Collaborative and thoughtful planning can help prepare correctional facility staff and leadership for changes related to implementing MOUD.[40]

Some preliminary action steps that should be considered in successful organizational culture change include:

- Identify a project champion.
- Develop an implementation team.
- Obtain buy-in from leadership and staff.
- Develop goals and action steps.
- Monitor progress.[41]

Challenges to Implementation Planning

Gaining Buy-In

Despite the medical evidence supporting MOUD and the legal implications of not treating OUD like any other medical problem, correctional facilities planning MOUD implementation may encounter

[40] Mace, S., Siegler, A., Wu, K., Latimore, A., & Flynn, H. (2020). *Medication-assisted treatment for opioid use disorder in jails and prisons: A planning and implementation toolkit*. National Council for Behavioral Health and Vital Strategies. https://www.thenationalcouncil.org/resources/medication-assisted-treatment-mat-for-opioid-use-disorder-in-jails-and-prisons-a-planning-and-implementation-toolkit/

[41] Mace, S., Siegler, A., Wu, K., Latimore, A., & Flynn, H. (2020). *Medication-assisted treatment for opioid use disorder in jails and prisons: A planning and implementation toolkit*. National Council for Behavioral Health and Vital Strategies. https://www.thenationalcouncil.org/resources/medication-assisted-treatment-mat-for-opioid-use-disorder-in-jails-and-prisons-a-planning-and-implementation-toolkit/

challenges, myths, and biases that need to be addressed.[42] Stigma and discrimination are considered primary barriers to MOUD implementation in any setting but may be impediments to improving the correctional treatment system.[43] Addressing misperceptions and misinformation regarding MOUD will help dispel stigma. Facilitating a culture change in correctional treatment services may be needed to ensure the development of high-quality, efficient, and person-centered SUD treatment services and residents' access to MOUD. Buy-in from a correctional facility's medical and enforcement staff team will yield a more positive view of the services provided. The implementation team should include staff who are fully dedicated to integrating the program across all levels of the correctional facility. When the facility hosts open discussions that allow staff to express their reservations about MOUD, buy-in is fostered and active support for MOUD is achieved.[44]

Workforce Development

Training is critical to the safe integration of MOUD. Lack of information has been shown to foster negative attitudes toward the provision of MOUD.[45,46,47] Training can encourage medical and corrections staff's openness to the effectiveness of SUD and MOUD treatment, help staff learn that caring for people with SUD/OUD can be rewarding, improve perceptions about individuals with SUD, and reduce fears about MOUD treatment. As of June 2023, all DEA-registered practitioners are required to have received at least 8 hours of training on SUD prior to either renewing or newly applying for their DEA registration.[48]

At a minimum, all medical/health and correctional staff should receive training on MOUD, including an overview of the facility's MOUD program, basic information about MOUD options and benefits, potential side effects of medications, and medication diversion. Staff training that highlights the efficacy of medications and portrays SUD and OUD as treatable medical conditions will facilitate implementation of MOUD. Overall, the goal of these staff trainings is to ensure the successful implementation of the MOUD program, which involves a shift in the correctional setting's attitudes and behavior toward residents with SUD and OUD and their need for effective treatment from both correctional and medical/health staff.[49]

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[42] Substance Abuse and Mental Health Services Administration. (2019). *Use of medication-assisted treatment for opioid use disorder in criminal justice settings* (HHS Publication No. PEP19-MATUSECJS). National Mental Health and Substance Use Policy Laboratory. https://library.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

[43] Substance Abuse and Mental Health Services Administration, & Bureau of Justice Assistance. (2019). *Medication-assisted treatment inside correctional facilities: Addressing medication diversion* (PEP19-MAT-CORRECTIONS). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/pep19-mat-corrections.pdf

[44] Substance Abuse and Mental Health Services Administration, & Bureau of Justice Assistance. (2019). *Medication-assisted treatment inside correctional facilities: Addressing medication diversion* (PEP19-MAT-CORRECTIONS). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/pep19-mat-corrections.pdf

[45] Ober, A. J., Watkins, K. E., Hunter, S. B., Ewing, B., Lamp, K., Lind, M., Becker, K., Heinzerling, K., Osilla, K. C., Diamant, A. L., & Setodji, C. M. (2017). Assessing and improving organizational readiness to implement substance use disorder treatment in primary care: Findings from the SUMMIT study. *BMC Family Practice, 18*(1), 107. https://doi.org/10.1186/s12875-017-0673-6

[46] Alanis-Hirsch, K., Croff, R., Ford, J. H. II, Johnson, K., Chalk, M., Schmidt, L., & McCarty, D. (2016). Extended-release naltrexone: A qualitative analysis of barriers to routine use. *Journal of Substance Abuse Treatment, 62*, 68–73. https://doi.org/10.1016/j.jsat.2015.10.003

[47] Louie, D. L., Assefa, M. T., & McGovern, M. P. (2019). Attitudes of primary care physicians toward prescribing buprenorphine: A narrative review. *BMC Family Practice, 20*, Article 157. https://doi.org/10.1186/s12875-019-1047-z

[48] Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, § 1263, 136 Stat. 4459. https://www.congress.gov/bill/117th-congress/house-bill/2617/text

[49] Mace, S., Siegler, A., Wu, K., Latimore, A., & Flynn, H. (2020). *Medication-assisted treatment for opioid use disorder in jails and prisons: A planning and implementation toolkit*. The National Council for Behavioral Health and Vital Strategies. https://www.vitalstrategies.org/wp-content/uploads/MAT_in_Jails_Prisons_Toolkit.pdf

Additionally, concerns about security, liability, and the risk of diversion sometimes arise in planning for MOUD implementation. Ensuring conversations about planning and engaging staff in the development of policies regarding medication management and diversion risk management will mitigate these concerns and ensure the safety of residents and staff.

Outcomes Management/Continuous Quality Improvement Evaluation

> *When this program started, methadone was completely new to me… Once I started to see our inmates being treated, I realized that not only was it important from a medical perspective, but it made my job of running the jail easier.*
>
> —Warden Joseph Feliciano, New Haven Correctional Center[50]

Outcomes management tracks progress over time and looks at the effectiveness of service delivery through the achievement of both facility and resident successes/changes as outcomes. Planning for MOUD outcomes management is best conducted during the initial planning and implementation stages, so outcome measures are incorporated into regular operations and provides a framework for prospective activities and services.

Identifying ways to evaluate the quality of care and possible areas of weakness--and then using this information to develop strategies for improvement—helps ensure quality and establishes a protocol for continuous improvement.[51] Some potential outcomes a correctional facility should consider include:

- Improved safety:
  - Reduced rate of incidences (e.g., confiscated contraband, resident-on-resident assaults, resident-on-staff assaults)
- Reduced rates of MOUD diversion and improved resident behavioral health:
  - Reduced overdoses
  - Reduced opioid and other substance misuse
  - Increased resident participation in OUD behavioral health services
  - Reduced use of emergency health services
  - Reduced suicide attempts
- Improved staff behavioral health:
  - Reduced rates of staff health issues, e.g., staff burnout
- Following reentry/post-release:
  - Increased rate of continued MOUD
  - Increased access to stable housing
  - Increased placement in employment
  - Decreased unintentional opioid overdose and mortality

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[50] Haas, E. J., Bart, G., & Fine, D. R. (2021). Post-incarceration outcomes for individuals who continued methadone treatment while in Connecticut jails, 2014–2018. *Drug and Alcohol Dependence, 228*, 109090. https://pubmed.ncbi.nlm.nih.gov/34371235/

[51] Mace, S., Siegler, A., Wu, K., Latimore, A., & Flynn, H. (2020). *Medication-assisted treatment for opioid use disorder in jails and prisons: A planning and implementation toolkit*. The National Council for Behavioral Health and Vital Strategies. https://www.vitalstrategies.org/wp-content/uploads/MAT_in_Jails_Prisons_Toolkit.pdf

Appendix A: Carceral Settings and MOUD

Questions and Answers

Why is it important to implement MOUD in prisons and jails?

MOUD implementation:

- Reduces unintentional overdose and overdose deaths during reentry.
- Improves safety within the facility.
- Prevents recidivism.

Why is it important to spend resources to keep a resident on MOUD for the duration of their incarceration?

OUD is a chronic condition that causes alterations in brain function.[52] High recurrence rates are common and often fatal. Long-term MOUD is often required in the same way that long-term medications are needed for other chronic conditions, such as diabetes or high blood pressure. Research indicates that the length of time an individual should spend on medication varies and should be informed by continual medical reassessment that considers the resident's medical history and current situation.[53]

Why can't we just taper a resident from their MOUD?

If a correctional setting does not provide MOUD and must taper a newly entering resident, this increases the chances the person will overdose following community release due to decreased opioid tolerance. For this reason, all residents with OUD should be considered for MOUD.

Why not only use naltrexone as the MOUD option?

While some people with OUD may respond to naltrexone, others may not. This is especially the case if someone has been taking either buprenorphine or methadone in the community or has used an opioid within the prior 7-10 days. In these situations, naltrexone, as an opioid antagonist, may actually cause withdrawal symptoms. In addition, patients using fentanyl may stabilize more quickly with methadone or buprenorphine because these opioid agonists treat opioid withdrawal and may more effectively address the high tolerance that can develop with prolonged fentanyl use.

Why not provide MOUD only during the final, reentry phase of the correctional stay?

Best practices are to provide MOUD access upon entry to the correctional facility and throughout the person's stay. Stabilization of a resident's OUD and engagement in SUD treatment services while incarcerated helps support the reentry process post-release and reduce the likelihood of recidivism once

[52] Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine, 374*(4), 363–371. https://doi.org/10.1056/NEJMra1511480

[53] American Society of Addiction Medicine. (2020). *The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update*. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline

the person is in the community. MOUD offered and continued during a resident's stay has been shown to reduce the likelihood of post-release unintentional overdose and overdose mortality.[54]

How do we protect against diversion of MOUD?

We can mitigate MOUD diversion by ensuring that:

- Only authorized medical or administrative staff have access to MOUD.
- Prior to initiating administration of the medications, staff members must be trained, and a protocol must be developed to accommodate the additional responsibilities entailed.
- Agonist medications must be counted, recorded, and stored in locked cabinets.
- Sufficient time is factored in when administering each medication dose. Note that dosing may take a few minutes, and residents must be closely observed during administration.
- A resident's missed dose is documented and the missed dose is returned to the locked storage cabinet.

What is withdrawal management?

Withdrawal management is the person-centered and evidence-based medical and psychological care of individuals who are experiencing opioid withdrawal symptoms as a result of ceasing or reducing use of a substance. People experience withdrawal symptoms (e.g., nausea, vomiting, insomnia, restlessness, muscle cramps, diarrhea) when they are physically dependent on opioids (i.e., heroin or prescription opioids) and abruptly stop or significantly reduce the amount they are taking.[55] The goal of opioid withdrawal management in a correctional setting is to link residents to SUD services by providing a transition to MOUD, thereby increasing motivation for change so that ongoing SUD recovery is possible.

[54] Substance Abuse and Mental Health Services Administration. (2023). *Best practices for successful reentry from criminal justice settings for people living with mental health conditions and/or substance use disorders* (Publication No. PEP23-06-06-001). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/pep23-06-06-002.pdf

[55] Substance Abuse and Mental Health Services Administration. (n.d.). *Medications for substance use disorders.* U.S. Department of Health and Human Services. https://www.samhsa.gov/substance-use/treatment/options/medications

Appendix B: Resources

SAMHSA

- ***Federal Guidelines for Opioid Treatment Programs (2024)*:** https://library.samhsa.gov/product/federal-guidelines-opioid-treatment-programs-2024/pep24-02-011
- **TIP 63, *Medications for Opioid Use Disorder*:** https://library.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002
- ***Practical Guide for Implementing a Trauma-Informed Approach*:** https://library.samhsa.gov/sites/default/files/pep23-06-05-005.pdf
- **SAMHSA's GAINS Center for Behavioral Health and Justice Transformation:** https://www.samhsa.gov/gains-center

Drug Enforcement Administration (DEA)

- **DEA Diversion Control Division Service Center:** https://www.deadiversion.usdoj.gov/
- ***DEA Narcotic Treatment Program Manual*:** https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-056)(EO-DEA169)_NTP_manual_Final.pdf

Department of Justice (DOJ), Bureau of Justice Assistance (BJA)

- ***Guidelines for Managing Substance Withdrawal in Jails*:** https://bja.ojp.gov/news/new-resource-guidelines-managing-substance-withdrawal-jails
- **National Reentry Resource Center (NRRC)**: https://nationalreentryresourcecenter.org/about-national-reentry-resource-center?utm_source=chatgpt.com

Federal Statutes and Regulations and Sub-Regulatory Guidance

- **42 CFR Part 8 (Final Rule)—Medications for the Treatment of Opioid Use Disorder:** https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8
- **Controlled Substance Act Regulations:**
  - **21 CFR 1301.71:** https://www.ecfr.gov/current/title-21/chapter-II/part-1301/subject-group-ECFRa7ff8142033a7a2/section-1301.71
  - **21 CFR 1306.07:** https://www.ecfr.gov/current/title-21/chapter-II/part-1306/subject-group-ECFR1eb5bb3a23fddd0/section-1306.07
- **Expanding Access to Medications for Opioid Use Disorder (MOUD) under 42 CFR Part 8:** https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/42-cfr-part-8/expanding-access-patients
- ***Federal Register* Notice—Opioid Treatment Program Rules and Updates:** https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8
- **Americans with Disabilities Act (ADA):** https://www.ada.gov/
- **Rehabilitation Act (RA), Section 504:** https://www.hhs.gov/civil-rights/for-individuals/disability/section-504-rehabilitation-act-of-1973/index.html

National Commission on Correctional Health Care (NCCHC)

- **Accreditation for Correctional Facilities:** https://www.ncchc.org/accreditation/programs/opioid-treatment-programs-accredition/

NCCHC Contact Information	
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Email: info@ncchc.org	

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SAMHSA

Substance Abuse and Mental Health Services Administration

SAMHSA envisions that people with, affected by, or at risk for mental health and substance use conditions receive care, achieve well-being, and thrive.

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