

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



Executive Summary

Drug overdose deaths in the United States continue to hit staggering highs. Over 81,000 estimated overdose deaths were recorded in the 12-month period from May 2019 to May 2020.¹ Based on provisional data, over an estimated 72,000 Americans died from drug overdose death, and an estimated 50,000 Americans died from opioid overdoses in 2019.² And in previous years, the U.S. has seen astounding numbers, as over 67,000 drug overdose deaths occurred in 2018, and opioids were involved in roughly 46,800 of those overdose deaths.³ Additionally, in 2018, only an estimated 19.7 percent of individuals with opioid use disorder (OUD) received specialty treatment.⁴ This number has held relatively stable over the last five years and indicates a disconnect between need, access and uptake.⁵ While states made progress in addressing overdose deaths in 2018, especially by expanding access to evidence-based practices such as medications for opioid use disorder (MOUD), more work remains, especially among people in the justice system. According to the National Center on Addiction and Substance Abuse, 65 percent of the U.S. prison population meets the medical criteria for drug or alcohol use disorders, but less than 11 percent receives treatment for those illnesses.

As Governors and state officials continue to address the drivers of the overdose crisis, the high prevalence of substance use disorder (SUD) and OUD and the lack of access to treatment within and around correctional settings reveal the unique challenges facing people in the justice system. In addition, states face challenges brought on by the COVID-19 pandemic. The pandemic presented greater challenges for individuals who are dealing with SUD,⁶ created new health and safety risks to incarcerated individuals and staff working in correctional facilities and contributed to rising substance use and overdoses across communities. The evolving SUD and addiction landscape and continued challenges for people in, or impacted by, the criminal justice system underscore the need to increase treatment capacity.

For individuals with OUD, providing MOUD inside correctional facilities has a sizeable impact on overdose deaths,⁷ recidivism,⁸ and opioid use post incarceration.⁹ In 2019, the National Governors Association Center for Best Practices (NGA Center) and the American Correctional Association hosted a series of regional workshops to provide Governors' policy advisors, state health and public safety officials, and senior correctional administrators with best practices and training to build support for and increase access to evidence-based substance use treatment services in correctional settings and upon reentry to communities. Through these efforts, states began and continue to explore sustainable financing of these initiatives with state and federal funding, which includes leveraging Medicaid and other delivery and payment systems within communities to reach these populations.

This roadmap highlights existing state efforts and serves as a policy development tool for Governors and state officials seeking to improve coordination and bolster existing efforts across state agencies to address OUD among people involved in the justice system by expanding access to evidence-based medications. The following are key steps for supporting MOUD in corrections settings.

Gather the Key Players

Many entities, including state and local agencies and external stakeholder groups, play a role in the justice and health systems and are critical to ensuring access to treatment. Participating players may include those in leadership roles in relevant agencies (i.e., those with authority and resources to dedicate and align). Those leaders build consensus, garner stakeholder feedback and support, establish the plan, and direct implementation of the plan with designated staff support. In addition, legislative support can be critical to the ongoing stability of these programs. Strategic partnerships, such as collaborations with academic or other institutions, are key to completing baseline assessments of needs, gaps and opportunities and supporting program implementation and evaluation.

What Is Success?



Develop an Action Plan for Integrating MOUD into Correctional Policies and Procedures

State officials can develop a comprehensive and evidence-informed approach to reduce overdose deaths and improve outcomes for justice-involved people with OUD by writing policies, employing resources and modifying workflows to implement evidence-based interventions at each stage of the justice system. A key time for intervention is while individuals are incarcerated—from intake to reentry. Fundamental steps toward accomplishing that goal include:

- Conduct an environmental scan to inventory existing state and local efforts.
- Perform a gap analysis and identify opportunities for improvement.
- Set achievable goals to measure progress and ensure stakeholders are in agreement during implementation.
- Design infrastructure and models for providing treatment in correctional settings.
- Identify information-sharing needs to facilitate treatment and linkage to care.

Build Capacity

Raising awareness, dispelling myths, and facilitating a culture change about OUD among justice-involved populations is a key challenge for correctional leaders in implementing MOUD programs. Therefore, engaging, training and supporting correctional security and health staff, community supervision officers and incarcerated individuals and their families is an important component of capacity building.

Interagency and multidisciplinary efforts often require memoranda of understanding (MOUs), data-use agreements and other contracts or agreements to ensure common understanding and develop an institutionalized process for interagency actions. State officials can work with the Governor’s and agency legal counsel to develop such agreements. In fiscal year 2018, the federal government appropriated approximately \$7.4 billion to states to address the opioid overdose epidemic.¹⁰ At least 57 programs, distributed across multiple agencies, provided opioid-related funding to states.¹¹ Of these programs and funding opportunities, several can support MOUD programs. In addition, while there is a prohibition against using Medicaid funds for individuals who are incarcerated, Medicaid can be crucial to care coordination and access to services upon reentry. In states with Medicaid expansion, 80 to 90 percent of the prison population is eligible for Medicaid upon release.¹²

Implement and Evaluate

After engaging the right stakeholders, working across disciplines and entities to develop plans, state leaders will work to implement laws, policies and practices towards their goals. State leaders can require, establish or authorize treatment programs for incarcerated persons, and engage and support local jurisdictions to develop programs.

States can use a monitoring and evaluating process to assess success and effectiveness of MOUD programs. Monitoring and evaluating throughout the life cycle of the effort will highlight opportunities to employ strategies for quality improvement and adjust as needed.

Key Considerations

- 1.** Access to evidence-based medications is a priority. Medication alone can be effective, and experts note that medication should not be delayed in the absence of counseling or behavioral supports.
- 2.** Offering a choice among all forms of the U.S. Food and Drug Administration (FDA) approved medications for OUD treatment and providing behavioral health services and supports whenever possible represents the best practice for OUD treatment persons inside and outside correctional settings.
- 3.** Fully implementing evidence-based MOUD requires making multiple forms of medication available for shared decision-making between the physician and patient, and relies on thoughtful coordination among the justice system and health and behavioral health systems.
- 4.** Collaboration among the justice system and health, behavioral health and Medicaid systems at every touch point of the justice system ensures access and continuity of treatment. Existing frameworks may be leveraged, including opioid task forces and commissions.
- 5.** Needs, gaps and strengths assessments of policies and practices across agencies help state leaders identify a plan of action. Undertaking a justice system mapping exercises specific to OUD interventions across touch points, such as the sequential intercept model, can assist with these efforts.
- 6.** Treatment plans tailored to each individual prepare people and systems for continuity of treatment upon release. These plans include: determining health coverage whether Medicaid eligible, Social Security Disability eligible or private insurance; where the individual will be released for availability and coordination of treatment with community providers and services; risk and needs levels; and other individualized factors.

7. Addressing possible barriers to success in supervision systems, such as revocation policies that penalize or fail to support participation in MOUD, can improve outcomes and reduce recidivism upon release. Co-locating necessary health, behavioral health and social services with community supervision may reduce barriers for accessing services. Treatment and supervision philosophies must be proactively aligned and clearly communicated to supervision teams and patients.
8. Training on diversion of medications in corrections settings should be complemented with education and training aimed to reduce stigma and discrimination so that both are addressed equally.
9. Strategic use, alignment and braiding of state and federal funds is key to ongoing stability and success of programs and initiatives. Medicaid should be fully leveraged where applicable to support continuity of care by establishing automated data exchanges to facilitate suspension and reinstatement of Medicaid benefits upon reentry. This can be accomplished by collaboratively developing policies with Medicaid leadership and managed care partners to support timely reinstatement of benefits and funding community-based services for individuals returning to the community.
10. Develop a robust evaluation approach at the outset with clearly defined outcome metrics, data collection and analysis processes to inform implementation.

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Introduction

Framing the Issue

Drug overdose deaths in the United States hit a record high in 2017, with an estimated 72,000 deaths.¹⁷ Over two-thirds of those deaths, roughly 47,600, were due to opioids.¹⁸ These staggering numbers continued in 2018, as over 67,000 drug overdose deaths occurred, and opioids were involved in rough 46,800 of those overdose deaths.¹⁹ Based on provisional data, an estimated 50,000 American died of opioid overdose deaths in 2019.²⁰ Additionally, in 2018, an estimated 2.0 million people in the United States suffered from an opioid use disorder (OUD), with 1.7 million people reporting OUDs related to prescription pain relievers and 0.5 million people with heroin use disorders.²¹

While the number of people with OUDs has decreased since 2015,²² overdose deaths involving opioids continue to pose a significant public health challenge, in large part due to a rise in overdose deaths involving the synthetic opioid, fentanyl.²³ Only 19.7 percent of individuals with an OUD received evidence-based treatment in 2018.²⁴ Governors and senior state officials continue to grapple with mitigating contributing factors and tackling root causes associated with the crisis.

Individuals with OUD are more likely to have a history of involvement with the criminal justice system. Approximately 52 percent of individuals with a history of prescription opioid use and approximately 77 percent of individuals with a history of heroin use reported past involvement with the criminal justice system in 2015 and 2016.²⁵ With over 2 million people incarcerated in U.S. prisons and jails and an additional 4.5 million under community supervision, those figures represent a majority of individuals affected by the crisis and a clear opportunity for intervention.²⁶ As the nation continues to grapple with disproportionate criminal justice system involvement and disparities in access to treatment experienced by

Compounding Challenges

Although states are making strides in tackling this epidemic, opioids remain a leading cause of and contributor to overdose deaths.¹³ Many states are experiencing high rates of opioid use disorders coupled with the resurgence of stimulant drugs.¹⁴ Sixty-three percent of opioid deaths involved other drugs, spurred by the rise of fentanyl and poly-substance use, particularly involving cocaine and methamphetamine.¹⁵ In addition, in 2020 states faced new challenges brought on by the COVID-19 pandemic.

The impacts of the pandemic and the opioid overdose crisis may increase the risk of injury or death among individuals struggling with opioid use disorder (OUD), compounding health inequalities experienced in communities of color.¹⁶ This pandemic has also presented health and safety risks to incarcerated individuals and staff working in correctional facilities and addressing rising substance use and overdoses across communities. The evolving substance use disorder (SUD) and addiction landscape and continued challenges for people in, and impacted by, the criminal justice system underscores the need to increase treatment capacity.

communities of color, most notably Black and Latino Americans,³³ access to evidence-based interventions are limited for the justice-involved population at large, and seriously limited in corrections settings.³⁴

To limit negative outcomes and address racial disparities, states can implement evidence-based practices at different points in the continuum of contact with the criminal justice system. Current evidence indicates that the most effective intervention is to provide medications for opioid use disorder (MOUD) and that the decision to use any of the three Food and Drug Administration (FDA) approved medications should be made jointly by a patient and the treating provider.³⁵ Best practice is defined as access to all FDA-approved medications.³⁶ Therefore, fully implementing evidence-based MOUD requires making multiple forms of medication available for this type of shared decision-making and relies on thoughtful coordination among the justice system and health and behavioral health systems to do so at every touch point of the justice system.

Medicaid and Medicaid Expansion

Section 1905(a)(A) of the Social Security Act prohibits the use of Medicaid funds for individuals who are “inmates of a public institution,” with the exception of individuals who are incarcerated and receiving inpatient care lasting 24 hours or more.²⁷ This prohibition is commonly referred to as the inmate exclusion. In 2016 the Center for Medicare and Medicaid Services (CMS) clarified that individuals on parole, on probation or on home confinement are not included within this prohibition, and therefore services provided to these individuals are eligible for federal matching dollars on Medicaid services, referred to as Federal Financial Participation (FFP).²⁸ In addition, Medicaid may cover services provided in halfway houses, provided that individuals experience freedom of movement.²⁹ See information about upcoming guidance on providing in-reach services as required by the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) [below](#).

With Medicaid expansion, more individuals who were formerly incarcerated are eligible for Medicaid when they are released, prompting states to proactively plan coordination between corrections and Medicaid.³⁰ Expansion states have found 80 to 90 percent of their prison populations are eligible for Medicaid upon release.³¹ In addition, the Patient Protection and Affordable Care Act allowed individuals who are eligible for individual coverage through the marketplace and who are incarcerated and pending disposition of charges to be qualified to enroll in qualified health plans; however, those individuals are not eligible for Medicaid coverage.³²

While this roadmap primarily focuses on providing guidance on increasing access to MOUD inside correctional facilities, it also highlights important strategies to enhance access to MOUD and related best-practice interventions that reduce recidivism and improve outcomes at all points of intercept within the justice system—from entry to reentry—as outlined by the Sequential Intercept Model (SIM). (Modified version of the SIM included in the graphic below)



Originally authored by Policy Research Associates, Inc., the SIM is a strategic planning tool that policymakers, program administrators and other community stakeholders can use to align interventions and identify and fill gaps for people with mental illness and substance use disorders (SUDs) moving through the criminal justice system along six distinct intercept points.³⁷ Using the basic outline of this framing, this roadmap details the key players, resources, strategies and lessons learned along with case studies of successful approaches that Governors may consider adopting and adapting in their states. As a growing number of state and local leaders recognize the impact of SUD treatment, and specifically OUD treatment, increased attention is being paid to improving outcomes and promoting health equity for people in the justice system.

Role of Governor and State Leadership

As states' chief executives, Governors play a critical leadership role in improving public safety and health of their residents. Governors are uniquely situated to set a statewide vision and lead system transformation toward these objectives. This includes building strategic partnerships and leveraging their roles as conveners, administrators or regulators, and purchasers to align best practices across health, behavioral health, social service, public safety and corrections systems. In the corrections and opioid use disorder space, this can take the form of leading collaborative efforts among state government officials, agencies and community partners to improve access to evidence-based interventions such as MOUD. Specifically, Governors can elevate and direct state correctional, health, behavioral health and social service leadership to use data to inform policy and target resources; build delivery and payment approaches to incentivize adoption of best practices; coordinate care across systems and upon reentry; and link returning citizens to wrap-around services and needed recovery supports (coaching, mentoring, educational services, transportation, housing and employment services). With funding and the support of state executives, corrections systems can create innovative evidence-based programs to save lives and deliver effective treatment and recovery programs for justice involved individuals.

Purpose of the Roadmap

Since NGA's 2016 roadmap on Finding Solutions to the Prescription Opioid and Heroin Crisis³⁸ and 2018 recommendations to Congress and the Administration calling for action to bolster the federal response to the opioid crisis,³⁹ Congress passed a series of bills to address the OUD treatment gap nationally. The Comprehensive Addiction and Recovery Act, 21st Century Cures Act and Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act enhanced policies and provided funding for state and local jurisdictions that are the catalysts for driving and supporting treatment in communities and in correctional settings. Additionally, the American Correctional Association was at the forefront in supporting state correctional leaders' development of strategies and solutions for SUD treatment, ratifying their Public Correctional Policy on Substance Use Disorder in 1992. The American Correctional Association issued the Public Correctional Policy on the Treatment of Opioid Use Disorders for Justice Involved Individuals in 2018 that recognized that OUD is a medical disorder, placed MOUD as a priority in effective treatment and set a higher standard for screening, assessment and treatment of OUD in nearly every justice-involved setting.

In addition to these efforts nationally, NGA and the American Correctional Association have also engaged directly with several states, and one common theme continues to emerge: Governors and other state leaders see reducing overdose deaths as a priority and recognize that addressing treatment needs among people in the justice system is a key part of that overall goal. From early adopter states demonstrating the significant outcomes that are possible by providing MOUD within correctional facilities, to states working across sectors and branches of government to align resources for sustainable programs, states have highlighted a bevy of pathways and solutions to make the aforementioned goal achievable.

Informed by lessons learned from states, this roadmap provides a step-by-step guide for Governors, state officials, and legislators who are pursuing initiatives to address OUD among individuals in the justice system by expanding access to MOUD and other needed supports with the goal of reducing recidivism, improving individual health public safety.

Roadmap components include:

- Convening a core team and gathering and engaging key stakeholders to identify priorities.
- Conducting an environmental scan to assess prevalence of OUD, treatment capacity and needs, existing initiatives and resources, and infrastructure, and identify gaps and opportunities to implement evidence-based policies and practices.
- Building capacity to share information and data to implement and evaluate programs, address resource and training needs, and inform policies and laws to support state goals.

Definitions

BJA, Bureau of Justice Assistance

BOP, Bureau of Prisons

CMS, Center for Medicare and Medicaid Services

COSSAP, Comprehensive Opioid, Stimulant, and Substance Abuse Program

DOC, Department of Correction(s)

DOJ, Department of Justice

EHR, Electronic Health Record

FDA, Food and Drug Administration

FFP, Federal Financial Participation

HIE, Health Information Exchange

MCO, Managed Care Organization

MAT, Medication Assisted Treatment

MOUD, Medications for Opioid Use Disorder

MOU, Memorandum of Understanding

ODU, Opioid Use Disorder

OTP, Opioid Treatment Program

RSAT, Residential Substance Abuse Treatment

SAA, State Administering Agency

SAMHSA, Substance Abuse and Mental Health Services Administration

SOR, State Opioid Response

SOTA, State Opioid Treatment Authority

STR, State Targeted Response

SUD, Substance Use Disorder

SIM, Sequential Intercept Model

Language

There are several ways to refer to misuse of substances in a manner that forms an addiction, people struggling with addiction and to the treatments and services that are used to help them. This document uses substance use disorder (SUD) as a broad term that refers to a disease that affects a person's brain and behavior such that he/she is unable to control use of substances and opioid use disorder when the disease is specific to misuse of opioids, consistent with Substance Abuse and Mental Health Services Administration (SAMHSA), American Society for Addiction Medicine (ASAM) and the Diagnostic Statistics Manual 5th Edition (DSM-5).

We also use medications for opioid use disorder (MOUD) to refer to the evidence-based practice to use FDA-approved medications to treat opioid use disorders. Another frequently used phrase is medication assisted treatment (MAT). States and the federal government are largely in the process of transitioning from using *MAT* to *MOUD* to avoid stigmatizing people in treatment and recovery. We also acknowledge that the professionals in this field may become used to simply using the word *medication* in the future, as is the convention for treatment of other chronic conditions.

Key Consideration

Access to evidence-based medications is a priority. Medication alone can be effective, and experts note that medication should not be delayed in the absence of counseling or behavioral supports.

Primer

This section will provide an overview of MOUD and highlight why it is important to provide treatment and reentry services for OUD for people in the criminal justice system.

What is MOUD and what are the different forms of medication?




Addiction is a chronic brain disease that, like many chronic conditions, often involves cycles of relapse and remission and may have long-term impacts on neurobiology.⁴⁰ In the case of opioid addiction, several evidence-based treatments are available that have been shown to reduce the risk of overdose death and can help support people with OUD into recovery.⁴¹ According to addiction specialists, the primary intervention for OUD is MOUD.⁴² This intervention includes the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUD.⁴³

Common misconceptions and stigma around the use of MOUD center on the sentiment that MOUD replaces one drug for another. In reality, when provided according to clinical guidelines, these medications relieve withdrawal symptoms and cravings and can support recovery. Evidence indicates that at proper doses, there are no adverse effects from MOUD on mental capability or physical functioning, or important occupational functioning, such as employability.⁴⁴ There is considerable evidence that these treatments reduce deaths and improve outcomes for those with OUD.⁴⁵

Key Consideration

Offering a choice among all forms of the FDA-approved medications for OUD treatment and providing behavioral health services and supports whenever possible represents the best practice for OUD treatment for persons inside and outside correctional settings.

There are three medications commonly used to treat OUD as part of the medication regimen: methadone, buprenorphine, and naltrexone.⁴⁶

 Methadone	 Buprenorphine	 Naltrexone
<p>Brand name: Diskets, Methadone Intensol, Methadose.</p> <p>Opioid agonist: Reduces craving and without producing euphoria and blunts the effects of other opioids if used concurrently.</p> <p>Offered in liquid, powder and wafer forms and is taken once per day at a specially regulated clinic, although some individuals may receive 'take home' doses for up to one week.</p>	<p>Brand name: Suboxone, Bunavail, Zubsolv, Sublocade.</p> <p>Opioid partial agonist: Reduces cravings and withdrawal symptoms by binding to opioid receptors in the brain with weaker activation than a full agonist and blocks the effects of other opioids if used concurrently, and reduces overdose potential.</p> <p>Offered in film and tablet form, or as a long-acting injectable, and must be prescribed by a provider with a special waiver from SAMHSA under the Drug Addiction Treatment Act of 2000 (commonly referred to as a DATA 2000 waiver).</p>	<p>Brand name: Vivitrol, ReVia, Depade.</p> <p>Opioid antagonist: Blocks the effects of opioids if taken concurrently by blocking activation of the opioid receptors in the brain and reduces cravings.</p> <p>Treatment with naltrexone is not begun unless the patient has abstained from opioid for 7-10 days.</p> <p>Prescribed by any physician and comes in pill or injectable extended-release form.</p>

Deciding which medication is the most appropriate for any individual depends on many factors and may change over time.⁴⁷ Best practice involves individualizing treatment plans based on considering multiple factors and revisiting patient needs routinely. Treatment decisions are that of a licensed health professional, in partnership with the patient. Shared decision-making is considered best practice.⁴⁸ For that reason, it is important that individuals seeking treatment work closely with providers to make an informed choice among all FDA-approved options.⁴⁹

Why should MOUD be provided in a correctional setting?

There is a high prevalence of OUD among justice-involved individuals. According to the most recent national data of the Bureau of Justice Statistics from 2007 to 2009, an estimated 58 percent of sentenced people in state prisons and 63 percent of sentenced people in jail met

the criteria for drug dependence or abuse.⁵⁰ While updated research is needed, corrections experts estimate SUD prevalence rates within correctional facilities are higher than prevalence rates in the community, based on intake screenings regarding substance use. In addition, it has been estimated that 18 percent of individuals in prison had the Hepatitis C virus (HCV) in 2015⁵¹ and 1.3 percent of individuals in federal custody had HIV in 2015.⁵²

Furthermore, evidence shows that individuals with OUD transitioning back into the community have disproportionately poor outcomes, including higher rates of recidivism; loss of employment and housing; breaks in social connectedness; transmission of infectious disease; and death.⁵³ State correctional agencies are also making efforts to update and improve screening procedures to more adequately capture the full picture of SUD and OUD among incarcerated populations. Despite state and local intervention efforts, more recent evidence shows that opioid overdose is one of the leading causes of death for individuals who were formerly incarcerated, with risks especially high in the first few weeks after reentry to the community.⁵⁴

Access to MOUD in correctional settings and facilitating access to services when reentering the community is an effective intervention for reducing overdoses among this high-risk population.

Furthermore, evidence shows several important benefits post incarceration from providing MOUD to incarcerated individuals with OUD.

1. Reduced illicit opioid use post-incarceration.⁵⁵
2. Reduced criminal behavior post-incarceration.⁵⁶
3. Reduced mortality and overdose risk post-incarceration.⁵⁷
4. Reduced HIV, Hepatitis C (HCV) risk behaviors (i.e., injection drug use) post-incarceration.⁵⁸
5. Improved rates of recidivism, when treatment is continued in the community.⁵⁹

In addition to reducing overdoses among people involved in the justice system, focusing MOUD efforts on people in correctional facilities can result in a meaningful return on investment through reduced or offset of costs to the health system. For example, in fiscal year 2017, **Kentucky** estimated that for every dollar spent on substance use treatment in correctional facilities there was a return of over \$4 in offset costs.⁶⁰ For MOUD treatment more broadly, states have found that treatment reduces overall health costs, due to avoided emergency department utilization and inpatient stays.⁶¹

Key Consideration

Fully implementing evidence-based MOUD requires making multiple forms of medication available for shared decision-making between the physician and patient, and relies on thoughtful coordination among the justice system and health and behavioral health systems.

State Spotlight: Rhode Island

Rhode Island is a leader on providing access to three forms of MOUD to incarcerated individuals and has demonstrated the benefits of doing so over a prolonged period of time.

In 2015, Rhode Island Governor Gina Raimondo issued an executive order establishing the Governor's Overdose Prevention and Intervention Task Force made up of a variety of representatives from public health, corrections, law enforcement, and communities. The group was tasked with recommending strategies to reduce overdose deaths by one-third in three years.

The task force created a four-point plan, including the recommendation to increase access to MOUD in prisons and across the state. In response to the task force's findings and recommendations, Governor Raimondo issued another executive order in 2017 to adopt and implement strategies around prevention, treatment, rescue and recovery.⁶² Through a budget request and support from the Governor, the Department of Corrections MOUD program is now funded by an annual \$2 million appropriation from the legislature.

Rhode Island Department of Corrections (DOC) screens all incarcerated persons for OUD and provides MOUD when appropriate. The DOC offers three forms of FDA-approved opioid medications, methadone, buprenorphine, and naltrexone. Continuity of care is prioritized at entry to corrections settings: anyone who enters the correction system with a doctor's prescription for MOUD is continued on the prescription. Individuals who are withdrawing from opiates go straight into a program where they are initiated on treatment through methadone or buprenorphine. Incarcerated people with histories of addiction can choose to begin methadone, buprenorphine, or naltrexone a few months before their release.

As an initiative of the Governor's Task Force, the state created a website to provide data and resources to stakeholders. A preliminary evaluation study published in the *Journal of the American Medical Association* demonstrated that comprehensive MOUD treatment in correctional settings, with linkage to treatment in the community upon release, is a promising strategy for addressing the opioid epidemic.⁶³ The study demonstrated a decrease in post-incarceration overdose deaths, going down from 26 in 2016 to 9 in 2017 after the program's implementation.⁶⁴

State Policy Developments

MOUD is not new to corrections: several correctional facilities have offered at least one form of MOUD since the late 1980s and mid-1990s.⁶⁵ More recently, state correctional MOUD programs are moving toward providing all forms of FDA-approved medications as a best practice in a sustainable manner through executive branch action and legislation. In 2017, Governor Raimondo of **Rhode Island** issued an executive order which led to its DOC becoming the first state system in the country to offer MOUD with all forms of FDA-approved medications in state correctional facilities. Similarly, in states such as **Connecticut, Delaware, New Jersey, and Pennsylvania**, Governors, corrections directors, and correctional health directors advanced initiatives to offer MOUD with all three forms of medications in corrections settings.⁶⁶ In states such as **Vermont, Maryland, and Massachusetts**, legislation signed by the Governors has ushered in a new era of medication initiation and maintenance programs for all forms of MOUD medications in state correctional facilities.⁶⁷

In addition to executive branch and legislative actions, several recent federal court cases address MOUD as the standard of care, with policies and practices that support patient freedom of choice and access to the various forms of MOUD medications.⁶⁸ To date, there are roughly a dozen lawsuits that have been filed against correctional facilities, including state prisons, county jails and the Federal Bureau of Prisons for allegedly failing to provide incarcerated individuals with access to MOUD. [See Appendix C.](#)

To ensure that the benefits of treatment and recovery are sustained when individuals return to their communities, state officials are also prioritizing continuity of care and linkage to community-based treatment and support services. State officials are strengthening partnerships between corrections and the health and behavioral health systems and leveraging Medicaid, state block grants and other funding options to incentivize increased access treatment options, wrap-around supports and care coordination. Additionally, this includes considering the important role that community corrections agencies, reentry and supervision teams can play in coordinating with community treatment providers to increase access to treatment, decrease revocations and re-incarceration, and support recovery.

GATHER THE KEY PLAYERS



- Designate the opioid task force lead, drug czar, corrections, or health lead to convene a core team responsible for developing and executing a plan.
- Gather the key players to gain buy-in and identify priorities, including those with authorities and funding streams relevant to a comprehensive response.
- Engage stakeholders, system actors, and community leaders to learn of needs and priorities in corrections and in the community around OUD, and linkage to care and treatment.

DEVELOP AN ACTION PLAN



- Complete an environmental scan with with state and county correctional health directors, wardens and key service delivery players.
- Determine data and information needs across agencies in correctional settings and in communities to facilitate treatment and linkage to care.
- Identify gaps and opportunities in access to screening, evidence-based interventions and implementation readiness.
- Set goals, action steps and timelines and develop an evaluation plan.
- Determine infrastructure and model for providing treatment in correctional settings.

BUILD CAPACITY



- Reassess data frameworks and governance to ensure necessary data is available, reliable and accessible for implementation.
- Fill resource and training needs.
- Obtain treatment licensure and contracts.
- Enact or amend policies, regulations and laws to support state goals.

IMPLEMENT & EVALUATE



- Collect and analyze a set of core metrics, including number of incarcerated persons with OUD and receiving treatment, recidivism, treatment retention and number of overdose deaths.
- Evaluate for ongoing buy-in, needed course corrections and sustainability.

Gather the Key Players

GATHER THE KEY PLAYERS



- Designate the opioid task force lead, drug czar, corrections, or health lead to convene a core team responsible for developing and executing a plan.
- Gather the key players to gain buy-in and identify priorities, including those with authorities and funding streams relevant to a comprehensive response.
- Engage stakeholders, system actors, and community leaders to learn of needs and priorities in corrections and in the community around OUD, and linkage to care and treatment.

Many entities, including state and local agencies and external stakeholder groups, play roles in the justice and health systems and are critical to ensuring access to treatment. Governors exercise their leadership in setting and implementing a vision for expanding treatment access, convening stakeholders and empowering a lead entity to take ownership of statewide coordination and streamlining of the state's efforts towards achieving success.

What Is Success?

Providing MOUD and quality Medical treatment during Incarceration

Ensuring successful reentry with warm hand offs, continuity of care, and recovery support services

Reducing recidivism

Decreasing overdoses and reducing hospitalizations post incarceration

Decreasing infectious disease for people in the justice system

Increasing connections to care and services



Key Consideration

Coordination among the justice system and health, behavioral health and Medicaid systems at every touch point of the justice system ensures access and continuity of treatment. Existing frameworks may be leveraged, including opioid task forces and commissions.

Participating state officials and personnel may include those in leadership roles in relevant agencies, that is those with authority and resources to dedicate and align. Those leaders build buy-in, garner stakeholder feedback and support, establish the plan and direct implementation of the plan with designated staff support. Legislative support can also be critical to the ongoing stability of these programs. In addition, strategic partnerships, such as with academic institutions, can be instrumental in completing baseline assessment of needs, gaps and opportunities and collaborating in program implementation and evaluation.

For example, the state behavioral health or Governor's opioid response lead can partner with senior correctional leaders to convene a core team of state and external stakeholder partners to conduct an environmental scan, as well as coordinate and organize the state's interagency efforts to expand access to MOUD for currently incarcerated and other justice-involved persons.

Notably, health care is provided in correctional settings using various approaches. Care provided onsite typically includes primary care and common outpatient services, and offsite services are used to supplement care. Onsite care is delivered using four systems: by state-employed clinicians directly; by clinicians who are contracted through a private company; through the state's academic medical institution or affiliated organization; or through a combination of the other three models.⁶⁹ Contracted services are typically paid for through a capitated, per person, per month payment; often with a subset of services carved out of the capitation payment, especially those services that are provided offsite.⁷⁰ Additionally, inside of correctional agencies, staff are encouraged to utilize

Core Team

The core team may look different in each state, but will likely include:

- Governor's policy advisor(s) for criminal justice and health.
- State correctional administrator, secretary, or director.
- State opioid lead/drug czar.
- State Opioid Treatment Authority (SOTA).
- Health, behavioral health, and public safety cabinet officials and key health services contractors as indicated.
- State Medicaid director.
- State and local correctional health directors.
- State Administering Agency for Criminal Justice.
- State Alcohol and Drug Abuse Directors.
- Other state, local and community organizations supporting reentry efforts.

a multidisciplinary service team (MDST) model. An MDST provides integrated services by assessing an individual's needs, developing an individualized plan and ensuring that services are delivered in an effective manner to assist the individual in transition to general population or the community. As states begin to gather the relevant players, consideration may be given to the current model of health care provision and coordination.

State Spotlight: Ohio

In **Ohio**, Governor Mike DeWine designated the RecoveryOhio office to lead the state's opioid and substance use treatment efforts in the state. The office coordinates the state's overall opioid treatment and response efforts, including a committee that addresses treatment for justice-involved populations. This committee works directly with the Ohio Department of Rehabilitation and Corrections to address OUD among the justice-involved population. Over the course of the 12 months following the National Governors Association (NGA) and American Correctional Association regional workshops on MOUD in correctional settings, Ohio, with leadership from the RecoveryOhio office, pursued cross-agency efforts to expand and fully implement its MOUD program within state prisons. The initiative also featured support for local jails in their efforts to set up similar programs, capacity building within the community to support returning citizens, and exchanging data and information across agencies.

Stakeholders, system actors, and community leaders

Stakeholders that may be engaged during the intake process:

- Corrections administrators and staff.
- Clinical coordinator and clinicians, care coordinator, social workers, peers, counselors, and other direct care staff.
- Medicaid agency and managed care organizations (MCOs), and entities involved with eligibility and enrollment and data sharing.
- Behavioral health agency, mental health agency and local agencies responsible for block grants for uninsured and safety net providers, including entities involved in eligibility and coverage, continuity of care and connection to community providers.
- Community-based providers, such as health, behavioral health, social support, and peer recovery services.
- Infectious disease specialist and department of public health lead.
- Probation and pretrial services.

Stakeholders that may be engaged during incarceration:

- Corrections administrators, wardens and officers.
- Clinical coordinator and clinicians, care coordinator, social workers, peers, counselors and other direct care staff.
- Medicaid agency and managed care organizations (MCOs), and entities involved with eligibility and enrollment and data sharing.
- Behavioral health agency, mental health agency and local agencies responsible for block grants for uninsured and safety net providers, including entities involved in eligibility and coverage, continuity of care and connection to community providers.
- Community-based providers, such as health, behavioral health, social support, and peer recovery services.
- Infectious disease specialist and department of public health lead.
- Health care administrator.
- Application assistants and Medicaid eligibility office representatives.
- Correctional health service provider.
- Corrections reentry specialists, case managers, and persons coordinating wrap-around services.

Stakeholders that may be engaged during reentry planning:

- Corrections administrators, wardens, and officers.
- Clinical Coordinator and clinicians, care coordinator, social workers, peers, counselors, and other direct care staff.
- Medicaid agency and Managed Care Organizations (MCOs), and entities involved with eligibility and enrollment and data sharing.
- Behavioral health agency, mental health agency and local agencies responsible for block grants for uninsured and safety net providers, including entities involved in eligibility, coverage, continuity of care and connection to community providers.
- Community-based providers, such as health, behavioral health, social support, and peer recovery services.
- Infectious disease specialist and department of public health lead.
- Parole board and parole supervising authority.
- Health Care Administrator.
- Correctional health service provider.
- Corrections reentry specialists, case managers, and persons coordinating wrap-around services.
- State and local reentry councils.

State Spotlight: Pennsylvania

Pennsylvania has weekly meetings on planning for reentry from corrections settings into the community. These meetings include the relevant corrections staff as well as behavioral health and Medicaid representatives.

Stakeholders that may be engaged in post release interventions.

- Corrections administrators, wardens, and officers.
- Medicaid agency and Managed Care Organizations (MCOs), and entities involved with eligibility and enrollment and data sharing.
- Behavioral health agency, mental health agency and local agencies responsible for block grants for uninsured and safety net providers, including entities involved in eligibility, coverage, continuity of care and connection to community providers.
- Community based providers, such as health, MOUD and behavioral health, social supports, peer recovery services.
- Infectious disease specialist and department of public health lead.
- Parole board and parole supervising authority.
- Corrections reentry specialists, case managers, and persons coordinating wrap-around services.
- State and local reentry councils.

Develop an Action Plan for Integrating MOUD into Correctional Policies and Procedures

DEVELOP AN ACTION PLAN



- Complete an environmental scan with with state and county correctional health directors, wardens and key service delivery players.
- Determine data and information needs across agencies in correctional settings and in communities to facilitate treatment and linkage to care.
- Identify gaps and opportunities in access to screening, evidence-based interventions and implementation readiness.
- Set goals, action steps and timelines and develop an evaluation plan.
- Determine infrastructure and model for providing treatment in correctional settings.

State officials can develop a comprehensive and evidence-informed approach to reduce overdose deaths, improve outcomes and promote equity for justice-involved people with OUD by developing policies, resources and workflows and by gaining stakeholder buy-in toward increased access to evidence-based interventions at each intercept of the justice system. A critical time for intervention is while individuals are incarcerated, from intake to reentry.

Environmental Scan

As the first step of a comprehensive approach, a designated core team can conduct an environmental scan to take an inventory of existing state and local efforts and identify successful and promising efforts.

- **Understand the extent of the problem and pinpoint potential intervention targets.** Determine the extent to which state and local corrections facilities and community supervision entities are collecting data on OUD prevalence, current treatment and other demographic data demonstrating access and capacity to treatment across communities. Gather any available data from state and local corrections for a quick high-level scan of prevalence of OUD in the justice-involved population by location, for instance in which facilities and into which counties individuals return. Consider prioritizing the disaggregation of racial and ethnic breakdowns of overdose fatalities, as well as other outcome metrics. Doing so would help to provide a mechanism to identify and examine disparities in overdose deaths across the state.
- **Compare existing state plans and strategies addressing MOUD and corrections that may be leveraged.** Check relevant sources, including: statewide opioid response plans; statewide behavioral health intervention plans, for example those based on the SAMHSA block grants; State Health Improvement Plans (SHIPs); infectious and chronic disease plans; and criminal justice strategic plans. Other sources that may contemplate strategies for providing MOUD for people in the justice system include Medicaid waivers and managed care contracts, initiatives to understand and address racial disparities in justice-system involvement and access to treatment to support. Identify areas of overlap and opportunities to leverage specific actions for the justice-involved population with OUD and align where indicated to avoid duplication of effort and support common goals.
- **Determine what programs or pilot initiatives may already exist in state and local correctional partners and determine areas of alignment.** Identify any MOUD programs operational in the state correctional facilities and whether there are innovative approaches to linking individuals to community-based MOUD upon release. Successful or promising programs could be

State Spotlight: Massachusetts

The Franklin County Sheriff's Office in **Massachusetts** reported that in 2018, 40 percent of people incarcerated in the Franklin County jails self-reported opioid use. Franklin County currently offers all forms of FDA-approved medications for the treatment of OUD to incarcerated individuals. The program includes screening upon incarceration, treatment during incarceration, reentry planning and reentry care management. Franklin County also offers trauma-informed behavioral health support for individuals with mental illnesses and vocational and educational training.⁷¹

replicated or scaled and modified as indicated for different locations. For state officials seeking opportunities to align with or support local jurisdictions and jails, the core team can work with partners to survey local jails to determine what programs may already exist in county jails and communities.⁷² Once identified, the state can support effective and innovative local jail programs through funding, training and technical assistance, and partnerships to leverage community resources. Perhaps most importantly, they can build the relationships and connections with these entities who often are sending and receiving data on justice-involved individuals with state involvement.

- **Consider the whole justice system.** While this roadmap focuses largely on intake, incarceration and planning for reentry, it is also important to consider all junctures at which individuals with OUD could be successfully diverted from incarceration and linked with MOUD and other supports and services for success outside of the justice system. These periods include: pre-intake; during the reentry process; and while in community supervision. As referenced in this document, the SIM is a strategic planning tool that communities and stakeholders use to develop a comprehensive picture of how people with mental disorders and SUDs flow through the criminal justice system⁷³ and may be a useful tool as a reference for the core team and other stakeholders as they develop plans for expanding access to MOUD in the correctional setting while also proactively linking to MOUD and other supports at other touch points in the SIM. Similar to any model, the individual steps of the SIM may need to be re-visited many times during the life of an initiative. At times, the flow between the different points may not be smooth and continuous as challenges arise and adjustments are made. These efforts also allow states and local jurisdictions to identify various decision times where practitioners have the ability to steer eligible individuals away from the justice system and utilize disaggregated data to show demographic trends and improve outcomes, with a focus on promoting equitable opportunities for treatment and diversion.⁷⁴ For more information on diversion approaches and promising examples, [see Appendix D](#).

Identify gaps in policies, programs and resources and identify opportunities for advancement.

Assess capacity within DOC and across state agencies to implement MOUD in corrections. In addition to within the institutional setting, reentry planning and linkages to services and supports within the community upon reentry are critical to the success of MOUD treatment.

Key Consideration

Needs, gaps and strengths assessment of policies and practices across agencies help state leaders identify a plan of action. Undertaking a justice system mapping exercise specific to OUD interventions across touch points, such as the sequential intercept model, can assist with this effort.

Checklist of Resources, Tools and Policies for Implementation

These checklists are intended to assist state leaders with identifying the resources, tools and policies that should be compiled prior to starting this work. They include state examples and may be used to develop a similar checklist that is specific to a state's context and goals.

Intake



Validated risk and needs assessment tools.

[Pennsylvania DOC Risk Screen Tool, Ohio Risk Assessment System.](#)



Processes for screening for SUD, mental health conditions, infectious disease, other co-occurring conditions, and health care coverage.

[Rhode Island DOC MOUD standard operating procedures.](#)



Screening tools that include SUD, mental health conditions, infectious disease, health care coverage.



Mechanism to collect and utilize screening data, including electronic health records (EHRs) and health information exchange (HIE) system communications, and retrieve data from correctional health vendor, where applicable.



Processes and policies to suspend and reinstate Medicaid and enrollment with MCOs. Considerations for private insurance and uninsured.

[See Medicaid State Plan, Waiver, and Managed Care Options.](#)



Educational information to provide individuals with SUD on MOUD treatment for shared decision making with providers. Vermont's informed consent form for [buprenorphine](#), [methadone](#), and [naltrexone](#).



Clinical protocols for maintenance dosing for individuals detained pretrial.



Processes and agreements for sharing clinical information between corrections and community-based providers.



Process and agreements for sharing clinical information between jails and prisons if relevant.

During Incarceration

- Processes for determining treatment capacity and provider availability in DOC. Texas Christian University Organizational Readiness for Change [survey link](#) and [scoring guide](#).

- Clinical guidelines to administer medications and follow-up care as indicated. [Rhode Island DOC MOUD standard operating procedures](#); [Vermont MOUD Policies](#) ; [Kentucky DOC MOUD Treatment Protocol](#).

- Protocols to manage diversion of treatment medication. [Rhode Island DOC MOUD standard operating procedures](#); [Vermont Medication Control Procedure](#).

Reentry Planning

- Mechanism to determine MOUD treatment capacity in the community, including awareness of the number and location of treatment providers available in the community.

- Mechanism to determine the number and location of other key services in the community including primary care, mental health, supportive or recovery housing, recovery coaching/counseling, supported employment, other social support services.

- Processes to coordinate linkage and follow up to services in the community, beginning with an in-reach plan. [Massachusetts DOC MOUD Re-entry Initiative Clinical Guidelines](#).

- Processes to coordinate care with community supports across corrections, community systems, and the larger justice systems.

- Processes and policies to reinstate or apply for Medicaid and enrollment with MCOs. Considerations for private insurance and uninsured.

- Processes and agreements for sharing clinical information between corrections and community-based providers. [FAQs on HIPAA](#), [FAQ on 42 CFR Part 2](#), [SAMHSA Issue Brief on Improving the Health of Justice Involved People through Information Technology](#), [Arizona Universal Release of Information](#).

Post-Release



Mechanism to track access to MOUD in the community and required supervision and address gaps.



Processes to evaluate access to other essential services and address gaps, including transportation, employment and other reentry support services within the community.



Processes for DOC/community supervision entities to coordinate housing connections.

Reentry and Community Supervision

Upon release from incarceration, many individuals are placed on some form of community supervision through parole or probation. To help people succeed in the community, a robust reentry infrastructure is critical for individuals with OUD reentering the community. When designing a MOUD program, it is important to coordinate community supervision entities, access to health coverage, and community-based health, behavioral health and social service providers upon reentry to ensure successful reintegration in the community.

- **Addressing Barriers to Reentry and Reintegration in the Community.**

Individuals with OUD face several challenges upon reentry and during community supervision. Access to treatment providers, medication, housing, employment and transportation, as well as maintaining compliance with various supervision conditions, present challenges to individuals leaving incarceration and those on probation and parole—especially in rural areas. Revocations from community supervision are a major contributor to incarceration, and the high number of individuals under supervision for drug-related offenses correlates with the high rate of technical violations for drug-related reasons.⁷⁵ Parole and probation officers are in the unique role of balancing holding individuals accountable while also motivating them for success, and revocations may occur when other interventions are absent. Public safety and health officials have an opportunity to collaboratively address these challenges when planning for reentry.

- **Reentry Planning.**

During incarceration, individuals will create a reentry plan which includes that person's goals and the services and programs he or she should access. Reentry planning should discuss wrap-around services—such as childcare, vocational, educational, housing and transportation services—that are designed to improve an individual's access to and retention in primary supportive services, such as MOUD or other substance use and mental health treatment. Reentry planning and preparation may also include peer recovery specialists, which have shown reductions in substance use, more engagement in medical services, and increased social support and social functioning.⁷⁶ Successful reentry planning leverages all services and supports options, which includes collaborative planning with Medicaid (and contracted Medicaid managed care partners) and state and local behavioral health entities to ensure health insurance coverage upon release, to provide in-reach services and to make linkages to treatment providers and services in the community. In-reach services are often provided by a combination of MCO care managers, community-based providers, and peer support specialists. For example, **Arizona** requires its MCOs to provide in-reach services to assist with the reentry planning process and establish linkages to care coordination and treatment services in the community, prior to release. [For additional information see Medicaid State Plan, Waiver, and Managed Care Options chart.](#)

Key Consideration

Treatment plans tailored to each individual prepare people and systems for continuity of treatment upon release. These plans include: determining health coverage whether Medicaid eligible, Social Security Disability eligible or private insurance; where the individual will be released for availability and coordination of treatment with community providers and services; risk and needs levels; and other individualized factors.

- **Access to Community Services.**

Developing relationships with individuals while they are incarcerated and making services and supports accessible will increase the likelihood that they will engage in services after release. To better ensure the continuum of care, some counties in **Maryland** utilize release hubs. Through this process, a person is transferred to a facility near where they will ultimately be released as they get closer to the end of their sentence to facilitate easier connection with resources in the community. Individuals also meet their parole officers while incarcerated to establish relationships prior to release. **Arizona** co-locates integrated health, behavioral health, and social service clinics with their community supervision entities allowing individuals to access a variety of needed services during meetings with their parole or probation officers. [For more information see Medicaid State Plan, Waiver, and Managed Care Options chart.](#)

This continuum of care is an essential part of a successful transition from jail or prison to the community, and coordination between corrections administrators and community-based partners is important to ensure access to community services. Building relationships across state and local criminal justice agencies and health and behavioral health agencies and service providers and understanding the flow of information throughout each is crucial for setting up a successful reentry process. Individuals with OUD need community support to develop pro-social behavior patterns, maintain employment and avoid relapse.

State Spotlight: Louisiana

The **Louisiana** Department of Health and Department of Corrections partnered to ensure that individuals released from incarceration had Medicaid coverage. The program created an automated enrollment process that shares information, with the state Medicaid program, on individuals who will be released, allowing individuals to be enrolled and connected with a managed care organization (MCO) prior to release. In addition, DOC identifies individuals with a high need for health care services and connects with Medicaid managed-care plans to perform case management upon release.⁷⁷

State Spotlight: North Dakota

North Dakota's Department of Corrections and Rehabilitation partners with the Department of Human Services Behavioral Health Division to create the Free Through Recovery program which provides care coordination and peer support to individuals on community supervision with a substance use disorder (SUD) or mental health diagnosis. Savings from strategies to reduce the prison population were used to invest in the Free Through Recovery program (\$7 million initially with an additional \$7 million in the second biennium).

State Spotlight: Ohio

The Returning Home pilot program linked individuals leaving incarceration with supportive housing upon release. The program targeted individuals with disabilities who are at risk of homelessness. The program was funded largely through state general funds flowing from the **Ohio** Department of Rehabilitation and Correction (ODRC) and included a public/private partnership with the Corporation for Supportive Housing. The program was shown to reduce the probability of rearrest at the one-year follow up.⁷⁸

Key Consideration

Addressing possible barriers to success in supervision systems, such as revocation policies that penalize, or fail to support, participation in MOUD, can improve outcomes and reduce recidivism upon release. Co-locating necessary health, behavioral health and social services with community supervision may reduce barriers for accessing services. Treatment and supervision philosophies must be proactively aligned and clearly communicated to supervision teams and patients.

Ensuring Medicaid Coverage Upon Release

Historically, states have terminated Medicaid coverage when an enrollee is incarcerated in order to comply with CMS rules that FFP is not available for incarcerated individuals, often referred to as the inmate exclusion. However, other mechanisms exist to comply with the inmate exclusion, and terminating coverage creates delays in reapproval after release and interrupts access to services, which may lead to increases in recidivism.⁷⁹ It also complicates receiving Medicaid reimbursement for inpatient stays during incarceration, which are exempt from the inmate exclusion.⁸⁰

CMS released guidance in 2004⁸¹ and again in 2016⁸² recommending that states not terminate Medicaid coverage for individuals who are incarcerated, but rather, place them on suspended status or prevent payments until they are released through claims edits. Suspending benefits and reinstating them upon release means that individuals do not need to reapply for Medicaid upon their release, which can be a major barrier to coverage. In state fiscal year 2019, 43 states used suspensions rather than terminations, and 23 states have automated data exchanges to facilitate suspension and reinstatement.⁸³ Another approach besides suspension is preventing payments through claims edits. This approach requires data sharing from corrections to the Medicaid agency and a certain amount of flexibility within the states' Medicaid Management Information System (MMIS); however, the process is typically less onerous than using a suspension and it has the added benefit of seamlessly allowing reimbursement for inpatient services during incarceration. One of the major challenges to setting up an automated process to suspend or prevent payment is the limitations of technology, especially for outdated state data systems; however, those barriers can be overcome. These approaches require a significant amount of coordination between corrections and Medicaid agencies and are substantially strengthened by support of the Governor.⁸⁴ Either approach may require states to consider how to work with MCOs to ensure accurate capitation payments; efficiently utilize potentially antiquated MMISs; meet the requirement that coverage be renewed annually, even while the individual is incarcerated; respond to discharge dates; submit applications from jails and prisons; and adapt to changing placements from one jail or prison to another.⁸⁵ However, states may use

federal funding for new or updated health information systems to solve some of these problems.⁸⁶

Suspending Medicaid coverage rather than terminating it upon incarceration is an important step towards adequate linkage and coordination for re-entry; however, it does not help those who were not enrolled at the time of incarceration. More than half of all states facilitate applying for Medicaid upon entry to a prison or jail or at a specific time prior to release, usually between 30 and 90 days.⁸⁷ Some states use presumptive eligibility determinations to ensure immediate access to health care. However, these determinations are temporary, and the individual must complete a full application to maintain coverage beyond the presumptive eligibility period.⁸⁸ States have an incentive to enroll individuals upon incarceration to collect FFP for inpatient services during incarceration.⁸⁹ Some states use assistors to help individuals with the application process.⁹⁰ States that are especially effective at linking individuals to care after incarceration also closely monitor Medicaid status, facilitate MCO selection and consent to share medical information, and connect with MCOs to share reentry status and health needs.⁹¹

Set Statewide Goals

After determining the resources necessary for implementation, state officials can set achievable goals to measure progress and ensure stakeholders are on the same page during implementation.



State goals may include, but are not limited to, the following:

- Reducing overdose deaths among justice-involved individuals.
- Increasing access to all forms of evidence-based SUD and OUD treatment.
- Strengthening reentry approaches and facilitating engagement with services in the community to support people with OUD/SUD.
- Strengthening SUD and OUD treatment protocols within the state's correctional facilities.
- Increasing collaboration among state and community health and behavioral health, corrections and public safety officials to use data to assess gaps and target resources and track outcomes to improve outcomes for justice involved individuals with OUD/SUD.

To reach these broader goals, state officials should consider setting and working towards action steps towards the broader aims, such as:

- Introducing a pilot MOUD program offering more than one form of MOUD medication inside a correctional facility.
- Increasing existing MOUD offerings to include two or three types of MOUD medication within an entire correctional system.
- Creating in-reach and linkages to care partnerships with MCOs where indicated and community-based providers that can provide MOUD upon reentry.
- Implementing processes for Medicaid and behavioral health authorities to activate benefits and fund services for reentry purposes.
- Supporting increased distribution of naloxone to justice-involved persons and their family members.
- Strengthening coordination among community corrections, community-based treatment and safety net providers, and state agencies responsible for OUD/SUD care.
- Partnering with local jails for further piloting of MOUD or bolstering reentry and health care and social support linkages.
- Considering legislation and executive administration action to launch such activities.

In addition to focusing goals on expanding MOUD access for incarcerated individuals and strengthening linkages to care in the community, state officials can also include and consider pursuing goals that limit interactions of individuals with OUD with the justice system. See examples of goals for diversion in [Appendix D](#).

Determine infrastructure and model for providing treatment in correctional settings

There are several models that are available for creating a systemwide MOUD initiative. Individual correctional systems or jails can choose the treatment model that meets the needs of their institutions and the needs of their populations. Some jurisdictions utilize a variety of different structural models to dispense medications most effectively in their systems.

- **Opioid Treatment Program Model.** Correctional facilities may become an Opioid Treatment Program (OTP) by obtaining a license from the U.S. Drug Enforcement Administration, accreditation by a SAMHSA-approved accrediting body and certification by SAMHSA.⁹² Through an OTP, MOUD practitioners can provide treatment in a range of settings, including correctional facilities. OTPs must meet all federal regulatory requirements under 42 Code of Federal Regulations (CFR) 8. Receiving an OTP license can provide facilities with the flexibility to treat and provide other services to patients, as needed. Correctional leaders have noted that seeking an OTP license can be an arduous process with greater costs on the front end, but challenges may be lessened by coordinating and communicating with federal partners.

- **Contract Service Provider Model.** Correctional facilities may contract with community-based MOUD providers to bring medications to the facility on a daily basis for dispensing, operate within individual correctional facilities, transport individuals to receive medications and treatment, or provide treatment through telehealth services. States may also choose to contract with universities, private health care or other providers for such services for additional capacity. Include a sample or the ideal contract within the RFP to providers so that potential service providers will be writing to the state's needs.
- **Hybrid or Combination.** There are several combinations of these service models available, and state and facility leaders may determine which model may be best based on the facility and population.

State Spotlight: Connecticut

In **Connecticut**, the Department of Correction (DOC) provides an example of a hybrid using two different models in their prisons and jails. Connecticut is a unified system where all the jails and prisons belong to a single agency. Connecticut has MOUD programs in six of its 14 facilities: three jails, two prison-jail combinations and one mid-security level prison.

The system treats more than 300 patients daily, and in 2018 treated 900 patients. In its women's facility, which is a combination jail-prison, methadone, buprenorphine and naltrexone are provided through an internal fully licensed CT DOC-managed opioid treatment program (OTP). The DOC is the Drug Enforcement Administration (DEA) licensee for this program and is responsible for its management. There is a substantial regulatory burden associated with managing an internal OTP. Connecticut leverages its state opioid treatment authority (SOTA)⁹³ to manage the grant funds and development of the OTP.

Connecticut's other programs provide MOUD services through contracts with community-based opioid treatment programs. These can be structured so that contracted providers bring medications to the correctional facilities on a daily basis, dispense the medications in a licensed area and then return to their clinics. This is effective for smaller treatment numbers of 50 or fewer patients. For larger numbers of patients, community OTPs can be contracted to operate their own licensed OTPs within individual correctional facilities. This provides the benefits of an OTP to the correctional system without the regulatory and management burden that accompanies an in-house OTP.

Considerations for operating within a pandemic context

The COVID-19 pandemic brought significant and unprecedented challenges, including health and safety risks to incarcerated individuals and staff working in correctional facilities, as correctional institutions are particularly vulnerable to infectious disease outbreaks and were hit particularly hard with COVID-19 related infections and deaths. As part of state and local COVID-19 response efforts, there are several emergency planning efforts and actions that state leaders can take to mitigate the spread of virus and protect criminal justice-involved

populations and correctional staff. These efforts, however, may impact previous operating procedures and present the need for additional considerations to operate treatment and programming, and prepare individuals for life in the community upon release. The following includes considerations for state officials and correctional leaders for operating within a pandemic context:

- **Consider changes to treatment protocols for inside facilities.** States may face added challenges with contracts and vendors providing medications and scheduling or coordinating dispensing, so officials may consider changes to protocols to align with any new facility physical distancing, grouping, or other mitigation procedures in accordance with local, state and federal guidelines. This is particularly pertinent to issues such as diversion control and behavioral health interventions, including group therapy.
- **Consider early release.** As part of broader pandemic response efforts, state prisons and local jails released some individuals from correctional facilities prior to the completion of their sentences.⁹⁴ Evaluating the ability and capacity to supervise individuals within the community and access and availability of supports may also be considered, including treatment and housing upon release.
- **Continue reentry planning.** Coordination among community corrections, community-based treatment and safety net services remains key to continuing treatment and preparing individuals for release into their communities. Given the challenges of shortened release timelines and potential limitations in capacity among community service providers, correctional facilities may consider contingency plans and dedicated staff to develop mechanisms to continue this coordination.

Determine information-sharing needs to facilitate treatment and linkage to care

Achieving a state's goals of expanding access to MOUD for incarcerated and justice-involved populations requires not only buy-in from multiple stakeholders, but also coordinated implementation of comprehensive public safety and health strategies. Coordinated efforts among state and local governments and community stakeholders allow states to implement innovative and effective programs and initiatives to treat individuals while incarcerated and provide linkages to care post release.

The following charts include the data and data sources needed to identify OUD and associated treatment options for determining health coverage, payment and delivery capabilities; for coordinating care; and for facilitating reentry and reintegration for individuals moving through the corrections system. Core teams could align these information-sharing needs with the state's broader substance use and opioid response efforts. Additionally, collaboration with university partners creates opportunities to expand capacity to compile evidence-based outcome metrics and to collect and analyze data for evaluation.

Charts: Information sharing to facilitate treatment and linkage to care

Behavioral Health Screening

What information should be collected?	Information gathered from individuals upon intake about substance use and cooccurring conditions.
Who owns the information?	DOC clinicians or intake personnel
When are they needed?	Intake through reentry
How are they used?	<p>At intake, corrections staff will conduct streamlined screening of individuals to determine substance use treatment needs across the state’s prisons and plan the interventions and programming needed to prepare the individual for release.⁹⁵</p> <p>To the extent possible, DOC can match information received from local jails and community-based behavioral health providers for more comprehensive information on the individual.</p> <p>Screening may also consider pregnancy status which has important ramifications for treatment. See Appendix A for additional resources.</p>

Community Treatment Plans and Health Records

What information should be collected?	Information gathered from community-based providers upon intake.
Who owns the information?	Community providers
When are they needed?	Intake through reentry
How are they used?	Clinicians within the corrections facility can utilize treatment plans and health records from community clinicians to ensure continuity of care.

Individual Health Coverage

What information should be collected?	Information gathered from the Medicaid agency, local jail, drug court, or from individuals upon intake about current Medicaid or other health care coverage and potential eligibility for coverage.
Who owns the information?	Medicaid agency, DOC clinicians or intake personnel
When are they needed?	Intake through reentry
How are they used?	DOC, Medicaid agencies, health plans, and behavioral health agencies can establish a process to communicate between agencies regarding individual health care coverage and Medicaid eligibility. This will allow agencies to identify persons that need to be enrolled, suspended, or reinstated for Medicaid coverage, who may be eligible to apply for Medicaid, or who may be uninsured and eligible for services under block grants. ⁹⁶

Individual Release Dates

What information should be collected?	Information of the incarcerated person's anticipated date to be released from DOC into the community.
Who owns the information?	DOC/parole board
When are they needed?	During incarceration and reentry planning
How are they used?	<p>Disseminate information about an individual's release to exchange between Medicaid agency and health plans, behavioral health agency, community-based and safety net providers, DOC, parole authority, and community supervision agencies. These agencies can use MOUs or established systems for transfer and communication of this information.⁹⁷</p> <p>In many states, release dates can change or vary during an individual's term of incarceration, which requires increased communication and coordination between corrections, parole, community supervision, and any relevant health entities. This is especially important for entities working together to conduct in-reach services and reentry planning. Release from jails can be especially difficult to predict.</p> <p>This information is used to: (1) facilitate and prioritize programming needs and reentry planning within DOC; (2) determine when to initiate reentry services and connections in the community, including in-reach programs to initiate connections;⁹⁸ and (3) prioritize Medicaid and other health insurance coverage efforts.</p>

Individual Treatment and Case Plans

What information should be collected?	Individualized programming and transition plans developed during incarceration and adapted post-release.
Who owns the information?	DOC/parole or community supervision agency
When are they needed?	Reentry planning and post-release
How are they used?	<p>For a coordinated effort to facilitate transition from incarceration into the community, states have established processes to share information and plans developed for programming treatment. This information exchange includes DOC, community supervision agencies, community-based providers, primary care, mental and behavioral health specialists.</p> <p>To provide comprehensive planning from incarceration to the community, states have developed individualized transition plans that are modified as the individual moves through the entire correctional process to reflect both progress and changes in risk and need.⁹⁹</p>

Additionally, states may partner with universities or other institutions to identify additional data needs to support program implementation and monitor and track progress and outcomes. For examples of outcome measures, see [below](#).

Build Capacity



- Reassess data frameworks and governance to ensure necessary data is available, reliable and accessible for implementation.
- Fill resource and training needs.
- Obtain treatment licensure and contracts.
- Enact or amend policies, regulations and laws to support state goals.

Fill training and education needs

State leaders note that raising awareness, dispelling myths and facilitating a culture change about OUD among justice-involved populations through education is necessary to address public safety and public health issues. Therefore, engaging, training and supporting correctional security and health staff, community supervision officers, and incarcerated individuals and their families are important components of capacity building.¹⁰⁰

States may provide resources, technical assistance and training supports around OUD and substance use, and procedures for implementation of MOUD and substance use treatment programs. Training and supports include explaining MOUD and what it is used for, breaking down myths and combatting stigma,¹⁰¹ standardizing language related to OUD and treatment, utilizing naloxone, incorporating infectious disease awareness and prevention, addressing challenges with implementation, administering treatment, and addressing security concerns to support initiatives and reinforce concepts and purpose. While the language and terminology can be standardized, correctional leaders may contemplate and make policies and procedures specific to the agency, state, and local regulations and guidelines.

For example, states have offered training and technical assistance around alternative forms of MOUD in response to challenges with using buprenorphine medications. Suboxone may be more susceptible to diversion within the correctional system due to its pill and sublingual form and the method in which it is dispensed. In response, prison administrators have worked with security and medical staff to develop a number of steps to train and educate personnel and develop policies and procedures to address diversion.¹⁰² For example, **Rhode Island** DOC worked with Brown University to develop and provide training to staff, including training on detecting diversion and implemented a graduated response protocol for identified and discovered diversion.¹⁰³ The protocol involves security and treatment staff working together to counsel patients for suspected diversion, offer change in medication for documented first time diversion, reevaluate if the change is not accepted or if there is

Key Consideration

Training on diversion of medications in corrections settings should be complemented with education and training aimed to reduce stigma and discrimination so that both are addressed equally.

subsequent diversion, and if necessary, implement removal from the program.¹⁰⁴ Based on the needs of the population and security staff, states may also consider different application of medication, for example oral film strips versus pills, depending on challenges expressed by security and medical staff.

State correctional leaders can partner with public health and behavioral health officials to create education and training materials, hold staff trainings and workshops, and provide ongoing support to staff and other groups throughout the implementation process.¹⁰⁵ These education and training initiatives should seek to gain support from all levels of correctional staff by including staff early in the planning and implementation process; informing staff on why providing this treatment is important and how it can help correctional officers in their day-to-day duties; and by using credible messengers to deliver the trainings. **Rhode Island** DOC provided trainings presented by security corrections staff and produced education and informational videos available to the public to continue to relay the message of the program's importance and the state's approach to implementation.¹⁰⁶ Trainings can also be supplemented with onsite technical assistance to help work through initial issues, challenges, and details to reinforce the purpose of programming.

State leaders may also consider supporting training and education on MOUD treatment and programs for other justice-system stakeholders, including judges, attorneys, legislators, and community corrections staff. For example, the National Judicial Opioid Task Force provides resources and tools for judges to help them identify strategies to work with health and public safety officials when they encounter individuals with OUD, or other drug addictions.¹⁰⁷

Develop contracts for delivery of services and MOUs for interagency operations

Interagency and multidisciplinary efforts often require MOUs, data-use agreements and other contracts or agreements to ensure common understanding and develop an institutionalized process for interagency coordination. State officials can work with the Governor's office and legal counsel to develop such agreements. Below is a checklist of common contracts and agreements used in implementation efforts, with references to examples.

Intake



MOU between Medicaid and DOC to share health data. Behavioral Health agencies for the uninsured.



Processes and agreements for sharing clinical information between corrections and community-based providers.

During



Health care service delivery agreements, if not the state.



Certification and licensure for OTP and buprenorphine or contract for MAT service provider, if not the state.

Reentry Planning



Medicaid agency and/ or Medicaid MCOs. Behavioral Health agencies for the uninsured.



MOUs or initiatives with transportation services, such as [Arizona's transportation initiative](#).



Community based and safety net providers for behavioral health services and human services

Post-Release



Agreements or processes between DOC and parole agency to ensure access to case plan and relevant treatment information.



Contracts and relationships with community-based and safety net providers.



Medicaid agency and Medicaid MCOs. Behavioral Health agencies for the uninsured.



Service locators, such as [Washington's Recovery Helpline MOUD Locator](#).

Key Consideration

Strategic use, alignment and braiding of state and federal dollars is critical to ongoing stability and success of programs and initiatives. Fully leverage Medicaid where applicable to support continuity of care by establishing automated data exchanges to facilitate suspension and reinstatement of Medicaid benefits upon reentry, by collaboratively developing policies with Medicaid leadership and managed care partners to support timely reinstatement of benefits, and by funding community-based services for individuals returning to their communities.

Funding, Delivery and Payment

Federal and State Funding Opportunities

In fiscal year 2018, the federal government appropriated approximately \$7.4 billion that states could use to address the opioid overdose epidemic.¹⁰⁸ At least 57 programs, distributed across multiple agencies, provided opioid-related funding to states.¹⁰⁹ Of these programs and funding opportunities there are several that may be used to support MOUD programs and initiatives. States may consider these funding opportunities and state options, such as line-item budgeting, to ensure proper delivery of services and continued support to achieve the state's goals.

- **CDC Overdose Data to Action:** The Overdose Data to Action cooperative agreement provides funding to state and local jurisdictions and health departments to support public health surveillance activities.¹¹⁰ States and localities use the funding to assist with obtaining high-quality, comprehensive and timely data on overdose morbidity and mortality and use those data to inform prevention and response efforts. Surveillance activities may include:
 - Collecting and disseminating emergency department data on suspected overdoses categorized as all-drug, all-opioid, heroin and all-stimulant.
 - Collecting and disseminating descriptions of drug overdose death circumstances using death certificates, toxicology reports and medical examiner or coroner reports.
 - Implementing innovative surveillance activities to support interventions. These activities help increase the comprehensiveness of surveillance data and allow jurisdictions to tailor their surveillance efforts to specific needs.
- **SAMHSA State Targeted Response to the Opioid Crisis Grants (STR):** STR was authorized in the 21st Century Cures Act and is intended to close the treatment gap between those who seek treatment and those who receive it. The grant application specifies that no less than 80 percent of the award must fund treatment services. Funds

were awarded to states based on a formula, and \$500 million was awarded to states in fiscal year 2017 and \$500 million was awarded in fiscal year 2018. The ten states with the highest rate of overdose deaths were eligible to apply for this supplemental funding. STR funding made up 15 percent of total appropriations to address the opioid epidemic in fiscal year 2017. STR grants may be used for services in corrections settings and for reentry.

- **SAMHSA State Opioid Response Grants**

(SOR): The SOR grant program was awarded to states in fiscal year 2018. The SOR is a \$1 billion grant program with a 15 percent set-aside for states with the highest rate of drug overdose deaths. The SOR program is intended to build on the STR program. The funding opportunity announcement requires that applications for funding include the entire continuum of care, prevention, treatment and recovery. In addition, programs receiving funds under the SOR grant are required to make treatment medications such as methadone, naltrexone and buprenorphine available. The STR and SOR programs combined made up 21 percent of total opioid-related appropriations in fiscal year 2018. SOR grants may be used for services including treatment and trainings for staff in corrections settings and for reentry.

Strategic Use of Funding Sources

States may choose to pool multiple funding streams, often referred to as braiding, to create more robust programs. For example, **Washington** has an agreement with Medicaid to allow enrollment to begin prior to release with the coverage activated on the day of release. The department of corrections has grant-funded release planners that schedule appointments within 24 hours and provide a video conference warm hand off. In addition, the correctional facilities ensure that individuals are released with at least several days of medication. This approach highlights the need for multiple agencies to coordinate with one another to support successful transitions to the community.

- **Department of Justice (DOJ), Bureau of Justice Assistance (BJA) Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP):**

The COSSAP grant program is awarded to state, local and tribal entities to support responses to the opioid epidemic to reduce overdose deaths, promote public safety and support access to treatment and recovery services in the criminal justice system, including in correctional facilities. In fiscal year 2018, BJA awarded \$330 million in COSSAP funding to jurisdictions.

- **DOJ, BJA Residential Substance Abuse Treatment (RSAT):** The RSAT for State Prisoners Program assists states, local and tribal governments in the development and implementation of substance abuse treatment programs in state, local and tribal correctional and detention facilities. Funds are also available to create and maintain

community reintegration services for individuals after they are released from incarceration.¹¹³ In fiscal year 2018, BJA awarded \$30 million to jurisdictions.

- **State Funds:** In addition to utilizing federal grant funding, Governors and state leaders are utilizing state funding to support MOUD-expansion efforts. Some states have sought to use general state funds appropriated to DOCs. For example, in fiscal year 2020, several Governors proposed more funding to expand MOUD programs, including **Connecticut** and **New York**.¹¹⁴ Other states have found innovative funding sources to support expansion of treatment, such as funding received from the Tobacco Master Settlement Agreement. Also, states have developed some grant funding programs to support expanding MOUD in local jails. For example, Pennsylvania enacted legislation to create a pilot grant program for counties to provide MOUD to individuals upon release from jail.¹¹⁵
- **SAMHSA Block Grants:** Block grants are used to supplement Medicaid, Medicare, and private insurance to provide access to prevention, treatment, recovery supports and other services. Grant funds are awarded to the state behavioral health authority, substance abuse authority, and/or mental health authority, depending on how the state agencies are arranged. SAMHSA funds states and territories through the following grants:
 - Substance Abuse Prevention and Treatment Block Grants (SABG)
 - Community Mental Health Services Block Grant (MHBG)

Increased Flexibility for Reentry with Section 1115 Waivers

Section 5032 of the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 requires the federal government to issue a state Medicaid director letter with opportunities for demonstration programs related to care transitions up to 30 days prior to release for individuals who would otherwise be eligible for Medicaid.¹¹¹ The letter will be based on recommendations developed by a working group of stakeholders. The working group has not yet been formalized, delaying the release of the letter. As part of COVID-19 relief, the Reentry Act on Health Care and the Criminal Justice System was proposed to allow Medicaid to cover services during the 30 days prior to release.¹¹²

Medicaid State Plan, Waiver, and Managed Care Options

While there is a prohibition against using Medicaid funds for individuals who are incarcerated, Medicaid can be crucial to care coordination and access to services and other social services upon reentry. In states with Medicaid expansion, 80 to 90 percent of the prison populations are eligible for Medicaid upon release.¹¹⁶

The charts below review various Medicaid mechanisms and authorities that can be leveraged specific to justice-involved populations, with relevant state examples and references to useful resources. Please refer to [Appendix B](#) for additional reading on the connections between Medicaid and justice-involved populations.

Authority	Eligibility and enrollment process
Eligibility¹¹⁷	All beneficiaries are eligible. States do not need special authority to allow for ongoing eligibility during incarceration.
Services	CMS released guidance in 2016 recommending that states not terminate Medicaid coverage for individuals who are incarcerated, but rather, place them on a suspended status or prevent payments until they are released through claims edits. ¹¹⁸ This approach allows for easier initiation of coverage upon an individual’s release. In state fiscal year 2019, 43 states used suspensions rather than terminations, and only 23 states have automated data exchanges to facilitate suspension and reinstatement. ¹¹⁹
Examples and resources	<p>Arizona uses an automated data exchange with jails and prisons to suspend and reinstate Medicaid upon incarceration release. Correctional facilities send bookings and releases to the Medicaid agency daily. The Medicaid agency then automatically identifies any individuals enrolled with Medicaid and suspends coverage. This information is transmitted back to the correctional facility and to the individual’s health plan. When notified of an individual’s release, the Medicaid agency automatically reinstates benefits and auto assigns beneficiaries to the same managed care plan they were engaged with prior to incarceration.¹²⁰ Individuals who were not enrolled in Medicaid upon incarceration, may apply up to 30 days prior to release. Maricopa County also placed health insurance navigators in the probation centers to assist with enrollment.¹²¹</p> <p>Louisiana shares data on Medicaid eligibility through a centralized state correctional agency to assist with eligibility determinations. The state suspends Medicaid upon incarceration and begins the Medicaid application process pre-release with transition specialists and reentry staff assisting with the application.¹²²</p> <p>Ohio, upon incarceration, limits Medicaid to in-patient stays only and begins the Medicaid application process 105 days pre-release with trained individuals serving life sentences assisting with the application. Peers provide information to individuals in the prisons 90 days prior to release and assist with Medicaid enrollment. DOC screens for high needs individuals 30 to 60 days prior to release. As required in the managed care contracts, a health-plan care manager is assigned, and they develop a transition plan for once the individual is released.¹²³</p>

Expanding Access to Medications for Opioid Use Disorder in Corrections and Community Settings

Authority	Managed Care
Eligibility	Most individuals eligible under the state plan.
Services	<p>Managed care plans must cover state plan or waiver services where applicable.</p> <p>In addition, managed care plans may cover cost-effective alternative services not included in the state plan such as in-reach, reentry, care coordination, and recovery-related services. Managed care plans may also decide to offer additional services using administrative funding from the state.</p> <p>State Medicaid agencies may consider choosing performance and outcome measures that encourage health plans to support justice-involved populations.</p>
Examples and resources	<p>Arizona’s Medicaid managed care contracts require the plans to provide in-reach care coordination for people who are incarcerated and have chronic or complex physical or behavioral health needs. MCOs submit plans to the Medicaid agency that specify a justice liaison, parameters for identifying complex and chronic health needs, coordinating services, educating members on how to access services, and scheduling appointment within seven days of release.¹²⁴ Contract language found on page 96 here.¹²⁵</p> <p>Louisiana’s health plans are required in their contract to have at least one pre-release contact with high-needs individuals and must establish referrals, including for MOUD if appropriate. Medicaid pays a higher capitation rate for individuals designated as high need, a designation that lasts at least one year until they are reviewed again.¹²⁶</p> <p>Ohio has justice-involved individuals select their managed care plans prior to release. For those individuals with chronic conditions, the managed care plans are required to develop transition plans and provide reentry planning services through care managers during a video conference prior to release.¹²⁷</p> <p>Kentucky Department of Corrections (DOC), Department for Behavioral Health Developmental and Intellectual Disabilities (BHDID), local community-based providers, and Medicaid managed care organizations (MCOs) partner to provide quality care in DOC institutions and ensure continuity of care on release. DOC provides upcoming release information to the team and ensures the individual is released with any needed medications. BHDID facilitates coordination with community-based providers, treatment providers, and other community resources and ensures that all medical, mental health, and substance use disorder (SUD) needs are met. Community mental health centers assist individuals in selecting MCOs, applying for Medicaid, social security income, or social security disability income, identify and assist linking to treatment services, ensure all necessary medical authorizations are completed prior to release and schedule community appointment for post-release. MCOs monitor release dates, ensure pre-authorizations are obtained pre-release, identify resources and monitor utilization.</p>

<p>Authority</p>	<p>Section 1115 Demonstrations</p>
<p>Eligibility</p>	<p>States define qualifying criteria.</p>
<p>Services</p>	<p>States may define the benefit package. This option provides the most flexibility for states to pursue innovative demonstration initiatives.</p> <p>Additional guidance specific to reentry is expected in 2020 – 2021 (see sidebar/pop out on SUPPORT Act).</p>
<p>Examples and resources</p>	<p>California used a section 1115 demonstration to create Whole Person Care pilot programs focused on the local level to coordinate physical health, behavioral health and social services for individuals who are high users of health care and continue to have poor outcomes. Pilots are targeted to populations at risk of homelessness upon release from institutions, including prisons and jails.¹²⁸ Counties provide education to providers that individuals on parole and probation are eligible for services, counties also may allow extended lengths of stay for justice-involved populations and encourage the use of drug courts. See the approved waiver here.</p> <p>New Hampshire used its waiver to support in part a Community Reentry Program focused on justice-involved adults and youth with SUD or behavioral health issues. The overall program begins pre-discharge and continues 12 months post release. The program includes screening for behavioral health conditions prior to release, discharge assessments to identify needed services at least 30 days prior to release, a transitional care plan, and care management services. Participants receive integrated primary and behavioral health services, care coordination, and social and family supports.¹²⁹ See the approved waiver here.</p> <p>Arizona's 1115 demonstration includes a Targeted Investments Program which integrates services for individuals with significant behavioral health needs. One part of this program specifically targeted individuals on parole or probation by co-locating integrated care clinics with probation and parole offices to allow individuals to meet with their parole or probation officers and receive health care and wrap-around services simultaneously.¹³⁰</p> <p>New York and Utah have pending 1115 demonstration amendment requests to CMS to ask for federal Medicaid matching funds for services provided in the 30 days prior to release from incarceration for specific populations.</p> <ul style="list-style-type: none"> • See New York's proposed plan here.¹³¹ • See Utah's submission here.

Authority	1915(i) Home and Community-Based Services State Plan Option
Eligibility	<p>Individuals must meet the criteria for requiring institutional or lower level of care. Individuals must be at or below 150 percent of the federal poverty level.</p> <p>States may target specific populations, but services must be offered statewide.</p>
Services	<p>Broad flexibility in services including case management, community transition services, home health aides, habilitation, respite care, and environmental modifications for accessibility.</p>
Examples and resources	<p>Minnesota used a 1915(i) state plan amendment to create a housing stabilization services program to support individuals with disabilities including mental illness and substance use who are transitioning from institutions including corrections institutions and are at risk of homelessness. Services include housing transition services, housing sustaining services, and housing consultation.¹³²</p>

Authority	Targeted Case Management State Plan Option
Eligibility	<p>Most individuals eligible under the state plan. States must target certain populations.</p>
Services	<p>Case management services. Identification of needs and linking to services.</p>
Examples and resources	<p>States have flexibility to determine populations of focus for their targeted case management programs. Colorado's effort focuses on individuals leaving incarceration with high-risk chronic health care needs, serious mental illness, substance abuse, and conditions such as HIV.¹³³</p>

Authority	Health Homes State Plan Option
Eligibility	<p>Medicaid eligible individuals who:</p> <ul style="list-style-type: none"> • Have two or more chronic conditions; • Have one chronic condition and are at risk for a second; or • Have one serious and persistent mental health condition <p>States may choose to target specific populations.</p>
Services	<p>Comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow up, patient and family support, referral to community and social support services.</p> <p>Enhanced federal match is available for the first eight quarters, or ten quarters if the health home is targeted to SUD populations.</p>
Examples and resources	<p>New York developed a pilot program to test methods of connecting individuals involved with the criminal justice system with Medicaid health homes after release. The pilot uses the health home care management funding to cover the services in addition to grants, internal funds, and New York City funding. In addition, state officials are considering hiring staff to assist with making linkages between correctional staff and health home care managers prior to release. The involved health homes place particular emphasis on retaining engagement with services and delivering culturally appropriate services.¹³⁴</p> <p>Rhode Island¹³⁵ operates three health home programs, one for children and youth with severe mental illness or chronic physical or developmental conditions, one for adults with severe mental illness and one for adults with OUD. The DOC and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) share data on individuals who become incarcerated to trigger continuity of MOUD services. The Health Homes also offer reentry services when transitioning back into the community.</p> <p>Vermont's hub and spoke model creates links between MOUD providers and funds the enhanced health home services. Hubs are OTPs reimbursed through an enhanced bundled rate that also offer services under the Health Home state plan amendment. Hubs offer training and expert consultation to primary care providers and other clinicians in the community who are authorized to prescribe or dispense buprenorphine, referred to as spokes. Spokes also have access to one full-time equivalent nurse and licensed mental health or addiction counselor per 100 patients, funded by the Medicaid program at no cost to the spoke.^{136,137} Outcomes show that participants report reductions in opioid and other illicit drug use, increased housing stability, and improved family life and emotional health. In addition, the program is roughly cost neutral due to reduced inpatient and outpatient costs and slower growth in spending.^{138,139} Since the program launched the number of OTPs has grown from 5 to 9, wait lists at OTPs have been eliminated, and the number of buprenorphine prescribers has doubled from 114 to 235.¹⁴⁰</p>

Implement and Evaluate

IMPLEMENT & EVALUATE



- Collect and analyze a set of core metrics, including number of incarcerated persons with OUD and receiving treatment, recidivism, treatment retention and number of overdose deaths.
- Evaluate for ongoing buy-in, needed course corrections and sustainability.

Implement

After engaging the right stakeholders, working across disciplines and entities to develop plans, state leaders will work to implement laws, policies and practices towards their goals.

Enact Laws and Issue Executive Orders to Support State Goals

- **Require, establish, or authorize treatment programs for incarcerated person.**
 - Governor Janet Mills of **Maine** issued 2019 Executive Order 2 which directs state agencies to address the opioid epidemic in various ways.¹⁴¹ One of the mechanisms outlined is to expand effective treatment and recovery efforts by identifying how to integrate MOUD into the criminal justice system, including by having MOUD services available in all county jails and developing pilot programs to offer MOUD in prisons.
 - **Vermont** enacted S. 295 in 2013 to develop a pilot program for the use of MOUD within the DOC for detainees and sentenced individuals.¹⁴² It enacted subsequent legislation, Act 195 in 2014, requiring the DOC and Department of Health (VDH) to collaboratively continue the Medication-Assisted Treatment (MOUD) Work Group created in 2013 and evaluate the legislatively mandated demonstration project.¹⁴³ In 2018, additional legislation was signed into law, S.166/Act 176, to require the DOC to provide MOUD to all incarcerated individuals when medically necessary, which was intended to mirror community standards.

State Spotlight: Kentucky

Kentucky expanded on its existing naltrexone pilot program, by developing pilot programs within their state correctional facilities that would provide access to all forms of medications for opioid use disorder (MOUD) in corrections. This effort is in collaboration with the parole and probation entities to provide continuity of treatment upon reentry and includes developing protocols and procedures.

- **Massachusetts** enacted HB 4742 in 2018, which requires two DOC facilities, Framingham or South Middlesex, to provide MOUD with all forms of FDA-approved medications for OUD to incarcerated individuals upon the recommendation of a qualified addiction specialist.¹⁴⁴
- **Maryland** enacted HB 116 in 2019, which requires the state DOC to establish an MOUD program which offers each FDA-approved treatment medication.¹⁴⁵
- **Model Access to Medication for Addiction Treatment in Correctional Settings Act.** Written by the Legislative Analysis and Public Policy Association, in collaboration with the O'Neill Institute for National and Global Health Law at the Georgetown University Law Center, the Act sets forth a comprehensive, evidence-based framework for ensuring that all incarcerated individuals with SUD be provided access to FDA-approved medication for addiction treatment in state and local correctional settings.¹⁴⁶ This Act: (1) promotes the use of all FDA-approved treatment options, including MAT for OUD, in correctional settings; (2) ensures that all incarcerated people with SUD are provided access to MAT while incarcerated; and (3) ensures that, upon release from a correctional setting, individuals receiving MAT are provided with connections for continued care, including prescriptions, and the necessary contacts and tools to continue their treatment.¹⁴⁷
- **Engage and support local jurisdictions to develop programs.**
 - **Pennsylvania** enacted Act 80 in 2015 to create a pilot grant program for counties to provide MOUD to individuals upon release from jail.¹⁴⁸
 - **Colorado** enacted 2019 SB 8 that provided that its DOC must allow MOUD to any individual who was receiving such treatment in a local jail prior to being placed in DOC custody. It also provides grant funding to jails to provide MOUD.¹⁴⁹
 - **Maryland** enacted 2019 HB 116, which requires state and local correctional facilities to evaluate and offer methadone to pregnant women with an opioid use disorder and requires local correctional facilities to make at least one form of MOUD available.¹⁵⁰

Stepwise Implementation

Piloting of programs, or incremental implementation, can allow any initiative to be tested, adjusted as needed, and subsequently scaled to the appropriate costs, policies, and scope of needed training, treatment and staffing needs.

State Spotlight: Vermont

In 2013, **Vermont** established a one-year demonstration project in two Department of Correction (DOC) facilities to pilot the continued use of medication-assisted treatment (MAT) before expanding the program statewide. In 2018, legislation was signed into law, S.166/Act 176, to require the DOC to provide medications for opioid use disorder (MOUD) to all incarcerated individuals when medically necessary, which was intended to mirror community standards. After this requirement went into effect on July 1, 2018, the system was inundated with over 700 requests for buprenorphine. This high level of requests was unanticipated; however, the DOC used its five years of experience through its pilot program to scale the program to respond to these requests. The DOC classified categories of individuals to process these requests.

Upon release, Vermont uses the hub and spoke model in the community to facilitate treatment and reentry. The spokes are office-based opioid-treatment settings, and the hubs are regional Opioid Treatment Programs (OTPs). [See state example in Medicaid State Plan, Waiver, and Managed Care Options chart.](#) To evaluate effectiveness upon release, DOC tracks reduction in overdoses post-release for a period of months.

State Spotlight: Pennsylvania

In response to increasing rates of substance use and deaths in the state, **Pennsylvania** Governor Tom Wolf signed an opioid statewide disaster declaration in 2018.¹⁵¹ The declaration was a mechanism to foster collaboration among state agencies and other stakeholders to increase prevention and treatment across the state. The disaster declaration featured 13 initiatives split into three pillars of response: prevention, rescue, and treatment.

As part of the treatment pillar, the state expanded access to medications for opioid use disorder (MOUD), including expanding access in the state's prisons. Prior to expanded access in, people incarcerated in Pennsylvania's prisons had limited access to MOUD within its facilities. Programs included a methadone MOUD program for pregnant women and a Vivitrol pilot facility initiated in 2014. The state set a goal of increasing access to all forms of FDA-approved MOUD medications in all state institutions. By April of 2018, all 24 state prisons offered Vivitrol, 439 injections were administered throughout 2018. In 2019, the state began a buprenorphine pilot program at one institution, with plans to expand the program to other facilities. The state also utilized its full-time statewide MOUD coordinator, a position that was established in 2016, to provide technical assistance and coordinate with the Department of Corrections (DOC).

To continue to extend access to MOUD, Pennsylvania implemented a new policy in 2019 to continue MOUD for anyone within a state facility who was already receiving verified MOUD, including new inmate receptions and parole violators.¹⁵²

Evaluate

The success and effectiveness of MOUD programs in states can be determined by monitoring and evaluating progress. Monitoring and evaluating throughout the life cycle of the efforts will highlight opportunities to employ quality improvement strategies and make adjustments, as needed. To ensure that evaluation is built into efforts from the beginning, the core team can incorporate evaluations into the state plans. If capacity does not exist within state agencies to plan for and conduct evaluation, state officials can consider partnering with colleges and universities for assistance and support.

Key Consideration

Develop a robust evaluation approach at the outset with clearly defined outcome metrics, data collection and analysis processes to inform implementation.

An evaluation plan:

1. Determine a methodology and identify meaningful and measurable metrics to assess outcomes and progress aligned with the state's goals and desired outcomes;
2. Collect qualitative data from direct stakeholders, including program participants and corrections staff, either formally or informally to provide context; and
3. Consider capacity and resource needs and work with universities and other partners prior to implementation to assist with evaluation design, provide full-time equivalent support for data collection and analysis.

Consider identifying and utilizing the following measures to evaluate and monitor progress.

Process Data

- Ratio of staff--reentry planning, probation and parole--to individual.
- Intake time.
- Time to treatment, from intake to treatment.
- Number of counseling and behavioral health visits.
- Number of individuals screened.
- Number of individuals receiving MOUD.

Outcome and Impact Data

- *Short term measures:*
 - Recidivism and rate and type of revocation.
 - Connection to care rate, including time to first appointment; appointment kept, etc.
 - Receipt of housing and employment support services.
 - Demographic characteristics as modifying variables to measure any racial or ethnic disparities.

- *Long term outcomes and impacts:*
 - Reductions in drug-related harms to the justice-involved population, and overall state population, including overdoses and overdose deaths.
 - Recidivism.
 - Opioid use and other substance misuse.
 - Utilization and cost associated with health care services, for example emergency department utilization.
 - Demographic characteristics as modifying variables to measure any racial or ethnic disparities, including disparities in types of treatment available, access to treatment and supports, uptake of treatment and supports; contact with criminal law enforcement; overdose and overdose deaths.
 - Employment status, housing stability.

State Spotlight: Rhode Island

Partnering with Universities for Evaluation: Rhode Island and Brown University

In 2017, Brown University worked with the **Rhode Island** Department of Corrections (RIDOC) to design and conduct a preliminary evaluation of RIDOC's medications for opioid use disorder (MOUD) program.¹⁵³ The University conducted a retrospective cohort analysis linking data from the Rhode Island Office of State Medical Examiners for all overdose deaths to data from RIDOC releases. Through this evaluation, the state was able to show the preliminary effectiveness in reducing overdose deaths among recently incarcerated people. The report was released in the *Journal of the American Medical Association Psychiatry* in 2018.¹⁵⁴

Conclusion

Governors recognize and are taking steps to address the continuing impact of the opioid overdose epidemic. As high prevalence of OUD among justice-involved individuals remains a challenge, Governors, in partnership with state corrections administrators, embrace the evidence-based practices of providing MOUD during incarceration. By implementing evidence-based practices and using innovative strategies, state leaders can work collaboratively across health and criminal justice systems to have positive impact towards reducing overdoses and improving outcomes for the communities and people in their states.

Appendices

Appendix A – Additional Resources on Screening and Intake

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Appendix C – Key Access to MOUD Litigation

As of early 2020, multiple lawsuits have been filed against correctional facilities, including state prisons, county jails and the Federal Bureau of Prisons (BOP), for allegedly failing to provide incarcerated individuals with access to medications for opioid use disorder (MOUD) for opioid use disorder (OUD). In each case, the incarcerated individual was being treated with MOUD for OUD prior to incarceration. Upon incarceration the correctional facility refused to continue providing the treatment due to prohibiting policies or lack of an MOUD program, whether methadone, naltrexone or buprenorphine.

The plaintiffs in these lawsuits base their claims on Title II of the Americans with Disabilities Act, the Eighth Amendment of the U.S. Constitution, and the Rehabilitation Act.

- *Eighth Amendment of the U.S. Constitution.* This amendment prohibits the infliction of cruel and unusual punishment. Conditions of confinement can themselves rise to the level of cruel and unusual punishment and denial of proper medical care is a condition of confinement under the Eighth Amendment. In these cases, plaintiffs have argued that denial of MOUD is denial of proper medical treatment, as determined by the individual's medical provider, for SUD, and thus qualifies as cruel and unusual punishment.
- *The Americans with Disabilities Act (ADA).* Title II of the ADA protects individuals with disabilities from discrimination on the basis of disability in services, programs and activities provided by state and local entities. Under this claim, plaintiffs have argued that SUD is a qualifying medical condition under the ADA, such that persons are protected under the Act, and denial of proper treatment such as MOUD constitutes discrimination under the ADA.
- *The Rehabilitation Act.* Like the ADA, the Rehabilitation Act prohibits discrimination on the basis of disability in federal agency programs. Though this Act is not applicable to state entity programs, as such programs are addressed through the ADA, the claims brought under this Act incorporates the same standard as the Rehabilitation Act.

The relief sought may include a preliminary injunction, a permanent injunction, monetary damages or attorney's fees. So far, the results of litigation have produced successful outcomes for plaintiffs. For example, in two cases against county jails, the court granted a preliminary injunction requiring the facility to provide MOUD pending the resolution of the case.¹⁵⁵ Where the courts granted preliminary injunctions, they found a sufficient likelihood of success on the merits combined with both strong balance of harms and public interest in favor of the plaintiffs. Such courts also found that the plaintiffs have a high likelihood of prevailing on a claim for discrimination under Title II of the Americans with Disabilities Act. Additionally, in three cases brought against the federal government, the BOP agreed to a settlement with each individual plaintiff to provide access to MOUD.¹⁵⁶

Given these building lawsuits on these issues, refusal to provide MOUD to incarcerated persons with SUD is likely to provoke litigation.

Appendix D – Diversion Considerations and Examples

The following includes a brief overview of initiatives at the front end of the system that aim to treat individuals within the community and divert them from further justice-system involvement.

- **Diversion prior to law enforcement engagement.** Individuals who cannot access adequate community-based services may find themselves interacting with the criminal justice system more frequently. Arrest and incarceration are destabilizing factors to an individual's housing, employment, behavioral health treatment, and connections to family and the community. Upon incarceration, individuals with behavioral health conditions remain incarcerated longer, are at a higher risk of self-harm, receive more frequent punitive responses, and may experience lapses in treatment.¹⁵⁷

Strong community-based systems of care, adequate crisis response systems, and needed social services may serve to prevent individuals from becoming involved with the criminal justice system in the first place.¹⁵⁹ A comprehensive continuum of services in the community may include MOUD, medical management of withdrawal as needed, psychotherapies and counseling with such treatments as cognitive behavioral therapy, contingency management, individual, group, or family counseling, assertive community treatment (ACT) and forensic assertive community treatment (FACT), intensive case management, integrated mental health and substance use services, and key interventions that help the individual meaningfully connect with community such as supportive or recovery housing, supported employment or peer and recovery support services.

Treatment Alternatives for Safe Communities

TASC provides specialized case management services and various off ramps from the justice system into community-based services. TASC's justice programs target preventing unnecessary incarceration by stopping cycles of substance use and crime. At every point along the justice system, TASC provides screening assessment, client advocacy, service planning, outpatient and intensive outpatient treatment for substance use disorder (SUD), care coordination, case management, and related services.¹⁵⁸

State Spotlight: Nebraska

The Mental Health Association of **Nebraska** developed the Respond, Empower, Advocate, and Listen R.E.A.L. program with the goal of reducing emergency protective orders and involuntary treatment placement. Service providers link individuals to trained peer specialists who provide free, voluntary peer support. Participants were 44 percent less likely to engage with law enforcement.¹⁶⁰

- **Law enforcement-led diversion.** These efforts take place at the very front end of the criminal justice system and allow law enforcement the ability to either not arrest, defer arrest, or defer processing an arrest, and instead refer individuals to services in the community. The goal of these programs is to continue to promote public safety while also responding more effectively to substance use disorders and mental health.¹⁶² These solutions help reduce the reliance on incarceration for people with low-level offenses. These programs vary in design and depend on the state, local community needs and behavioral health capacity.
- **Prosecutor-led diversion.** These pretrial diversion programs provide prosecutors, in collaboration with judges, court professionals, pretrial services and probation officers, the discretion to divert individuals from incarceration or further involvement with the justice system. These programs take many forms and may intervene at different times in the adjudication process, including: before the prosecutor's office formally files charges or after the prosecutor's office has formally filed charges, but before the case is adjudicated.¹⁶³ A 2017 National Institute of Justice study by the Center for Court Innovation, RAND Corporation, Association of Prosecuting Attorneys, and Police Foundation, noted these programs as promising practices.
- **Treatment courts.** Treatment courts are regarded as a successful intervention to reduce recidivism and provide a sound return on investment. However, treatment courts that receive executive branch support should be using multiple forms of MOUD. Courts create specialty dockets that specify participant eligibility generally geared toward individuals with drug offenses and charged with low-level offenses. These courts may operate as drug courts, mental health courts or veterans' courts but each target individuals that demonstrate a high-need, generally due to substance use disorders, mental health or co-occurring disorders. Evaluations have examined these courts both at the individual program and state levels. Overall, these courts have been found to reduce recidivism and provide a sound return on investment. For drug courts in particular, the National Association of Drug Court Professionals released a best practice standards guide for states and jurisdictions looking to implement such these treatment courts.¹⁶⁴ These courts rely heavily on partnership and collaboration between judges, attorneys, court professions, health agencies,

Law Enforcement Assisted Diversion

LEAD is a program that gives police officers the discretion to refer qualifying individuals into the LEAD program to treat the underlying issue, which could be substance use disorder (SUD), mental health, homelessness or employment, diverting them away from the justice system. For example, in Seattle, **Washington** the LEAD program operates through a coalition of law enforcement agencies, behavioral health providers, prosecutors and community groups. The program provides low-barrier services through outreach in the community.¹⁶¹ Similarly, the Police Assisted Addiction and Recovery Initiative (PAARI) is an initiative that aims to create pathways to treatment and recovery through alternatives to arrest, to ultimately reduce overdose deaths and expand access to treatment. Other local law enforcement agencies have adopted the PAARI initiative, and in many states, governors have provided support to these local initiatives through funding and policy changes to support innovative programming. For example, in 2019, North Carolina utilized state opioid response (SOR) grant funding to support jurisdictions implementing PAARI and other pre-arrest diversion programs.

clinicians, social workers and the community. Additionally, the National Judicial Opioid Task Force report includes resources on best practices for court-initiated drug treatment programs and court diversion programs.¹⁶⁵

In addition to focusing goals on expanding MOUD access for incarcerated individuals and strengthening linkages to care in the community, state officials can also include and consider pursuing goals that limit interactions of individuals with OUD with the justice system. These goals include front-end diversion efforts, including but not limited to:

- Strengthening community-based interventions to reduce interactions with law enforcement and the criminal justice system;
- Supporting law enforcement agency, fire department, and prosecutor led efforts with state and local health departments and behavioral health service providers in communities to develop crisis intervention teams and craft pre-arrest, pre-booking and other related diversion and deflection programs, to reduce incarceration overall;
- Establishing linkages to care and social supports for persons who are on probation and reintegrating into the community; and
- Supporting training for state and local judicial officials, such as judges, administrative officers of the court, probation and parole officers on linkage to care.

State Spotlight: Tennessee

In **Tennessee**, the Tennessee Recovery Oriented Compliance Strategy (TN ROCS) serves individuals charged with drug offenses who have an urgent need for treatment. TN ROCS participants are partnered with criminal justice liaisons to perform clinical assessments and develop evidence-based behavioral health treatment plans.¹⁶⁶ Some of these treatment plans include medications for opioid use disorder (OUD). TN ROCS docket members--the judge, prosecutor, public defender, probation officers, and other criminal justice and health stakeholders--meet regularly with corrections officers who check that the participant is adhering to the standards of the behavioral health treatment plan, and make regular appearances before the judge for updates on progress. The more progress is made, and the longer a participant adheres to the requirements of the treatment plan, the less frequent these appearances become until the judge declares the participant finished with the program. This typically takes around two years. The 4th Judicial District court in Tennessee, along with other state courts partnered with the National Center for State Courts to develop guidelines for courts with dockets of persons with OUD. These guidelines include the basics of medications for opioid use disorder (MOUD) in court settings¹⁶⁷ and assessing quality treatment providers in the community.¹⁶⁸

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