Medication-Assisted Treatment in Jail

Jennifer Nobles

Abstract

The opioid crisis is having devastating consequences on our nation. Opioid Use Disorder does not discriminate and crosses all socio-economic boundaries. Communities struggle to provide substance abuse treatment resulting in individuals having negative encounters with law enforcement. County Jail facilities have a unique opportunity to initiate evidence-based drug treatment to increase addiction recovery chances, reduce recidivism rates, and reduce the financial impact on an already burdened criminal justice system. Florida jails were surveyed to determine if they are using Medication-Assisted Treatment, assess their program requirements, and evaluate outcomes.

Introduction

The opioid crisis is one of the top public health issues in the United States. Due to the overuse of prescription pain medications, and the accessibility to legal narcotics, there is a generation of opioid-dependent individuals turning to illegal drugs to sustain opioid addictions. According to the National Survey on Drug Use and Health statistics, in 2018, approximately 10.3 million people misused opioids in the past year, and two million people have an opioid use disorder. (SAMHSA, 2019) Most communities in our nation have felt the financial and moral impact of the opioid crisis. Opioid use disorder affects all demographics of our society and does not discriminate. With limited national resources available, the criminal justice system has endured the consequences for individuals dealing with an opioid use disorder. Our society can no longer arrest its way out of the opioid crisis. Robust initiatives dealing with the science of addiction and recovery are paramount to affecting change.

There is overwhelming evidence to support the reciprocal relationship between substance abuse and criminality. More often, people who have an opioid use disorder are more likely to have an adverse interaction with law enforcement resulting in them entering into the revolving criminal justice system. To reduce the recidivism rates of those with an opioid use disorder, the criminal justice system must be prepared to treat the root cause of addiction and provide evidence-based treatment.

Nationally, jails are underfunded and lack the resources needed to provide evidence-based treatment for those suffering from an opioid use disorder. Aging infrastructure, overcrowding, and incarceration costs are among the few top priorities for our criminal justice leaders. Absorbing the cost of addiction recovery and co-occurring mental health services makes the cost of incarceration rises expediently.

Since jails have become de facto drug detox facilities, drug screenings usually are conducted during the intake process and are used to determine if a person needs to be detoxed. The forced detox process is often dangerous for the individual, and if not

properly managed, can be life-threatening. Once detoxed, abstinence from opioid use is only maintained during incarceration and is typically not sustained.

Another challenge for jail facilities trying to deal with the opioid crisis is the average length of stay of an individual in jail. Since jail inmates are overwhelmingly pre-sentenced detainees, they have reasonable access to bond or pre-trial release, making it challenging to provide evidence-based drug treatment or connect them to sustainable services in such a short period. Once released from custody, someone with opioid addiction has a high probability of relapse and death. There is also a greater risk for HIV, Hepatitis, and other infectious diseases due to needle sharing.

Can Medication-Assisted Treatment provide individuals with an opioid use disorder a pathway to recovery? Since opioid use disorders are widespread among justice-involved individuals, should jails and prisons consider a different approach to sustainable, evidence-based treatment? Do Medication-Assisted Treatment Programs help to prevent relapse, death, and recidivism? Agencies must evaluate the efficacy of Medication-Assisted Treatment, or the arrest and incarceration cycle of those addicted to opioids will continue.

This research will examine the benefits, legal considerations, and ethical reasons to consider a Medication- Assisted Treatment Program in a county jail.

Literature Review

How did we get here?

Although there have been medications to assist with opioid addictions symptoms since the early 1970s, Medication-Assisted Treatment (MAT) is an emerging solution to deal with individuals with opioid use disorders. The opioid crisis originated from two very perspicuous issues. The first issue was the overuse of opioid analgesic prescriptions in the late 1990s. Many well-intended physicians used opioids to treat pain and were unaware of the susceptibility for addiction, overdose, or death. Addictions evolved as a result of harmless visits to the doctor to manage chronic pain. Physicians today recognize the likelihood of addiction when prescribing opioids for pain relief and the propensity for abuse, addiction, overdose, and death. The second issue is the lack of the healthcare system to provide evidence-based opioid addiction treatment. Nationally, people with opioid addictions do not receive opioid treatment. In cases where treatment is provided, it is not an evidenced-based program, such as MAT. (Collins, 2017)

Despite substantial evidence, Medication-Assisted Treatment Programs are highly underutilized in the correctional environment. In 2017, less than one percent of the 5,000 plus prisons and jails in the United States allow access to FDA approved medications for opioid use disorders. Some of the reasons agencies suggest are barriers to implementing Medication-Assisted Treatment Programs in their facilities are liability, excessive financial obligations, lack of trained providers, agency policies, challenges to aftercare, and leadership's reluctance to understand how the medications work. (SAMHSA, 2019)

The opioid crisis also had a substantial financial impact on our nation, states, and communities. According to the Council of Economic Advisors, the estimated annual cost of the opioid crisis is $504 billion. The average annual cost to incarcerate an individual

is $24,000 per year. Comparatively, the average price of a medication-assisted treatment program is $4,700.00. (SAMSHSA, 2019)

For individuals involved in the criminal justice system, who have a companion opioid use disorder, transitioning back into the community can be problematic for many reasons. According to research, 75% of those released from custody with an opioid use disorder experienced a relapsed within three months. Furthermore, that same justice-involved individual with a relapse is between 10 and 40 times more likely to die from an opioid overdose. Several factors that increase the probability of death is lower tolerance, different forms of synthetic opioids available (such as fentanyl and carfentanyl), and availability. The recidivism rate for an individual released with an untreated opioid use disorder is 40 to 50 percent within the first year. (SAMHSA, 2019)

Opioid use disorder is covered under the Americans With Disability Act (ADA), which prevents the discrimination of people in recovery. Consequently, there has been successful litigation across the country, requiring jails and prisons to allow individuals to either maintain their medication while incarcerated or provide Medication-Assisted Treatment as a viable treatment option for opioid addiction. Judgments suggest that correctional facilities violate a person's Eighth Amendment when preventing medical intervention for treating their opioid use disorder. Arguably, courts and legal opinions debate the meaning of deliberate indifference and what qualifies as medically necessary. Nevertheless, court judgments against correctional facilities continue to rise. (ACLU, 2019 + Linden, 2018)

Since the criminal justice system is the largest source of organizational referrals to substance abuse treatment, jails have a unique opportunity to initiate medication-assisted treatment. The treatment pathway might not exist outside of the criminal justice system. Evidence shows that addiction is a treatable disease of the brain, yet criminal justice agencies are slow to incorporate sustainable, evidence-based treatment programs. (Chandler, 2009 and SAMHSA 2019)

What is Medication-Assisted Treatment?

Medication-Assisted Treatment is the combination of behavioral therapy and the use of the Food and Drug Administration (FDA) approved medications to treat substance abuse disorders. Medication-Assisted Treatment is currently used to treat opioid use disorder, alcohol use disorder, and smoking cessation. Although pharmaceuticals continue to evolve, three medications are approved by the FDA to treat opioid use disorders: Methadone, Buprenorphine, and Naltrexone. A common misconception of Medication-Assisted Treatment is that the medicines substitute one drug for another. However, the medications used reduce the physical and psychological withdrawal symptoms while dealing with the brain's chemical imbalance. (SAMHSA, 2020)

Methadone is a synthetic opioid agonist (a substance that creates a feeling of satisfaction) to treat chronic pain, relieve drug cravings, and eliminate withdrawal symptoms in people addicted to opioids. Research indicates that methadone reduces drug cravings by acting on opioid receptors in the brain. Since the release is slower, methadone does not produce euphoria. Methadone is required to be dispensed through a licensed opiate treatment program. (NIDA, 2018)

Buprenorphine is considered a partial opioid agonist. Similar to methadone, it binds to the same opioid receptors but in a slower manner. Buprenorphine also reduces cravings and withdrawal symptoms without producing euphoria. This medication was approved by the U.S. Food and Drug Administration in 2002. Unlike methadone, Buprenorphine was the first medication approved to be dispensed by certified physicians through the Drug Treatment Act, which expanded access to those in need without the rigorous restrictions. Buprenorphine-based drugs are available in several different forms, such as tablets, sublingual film, implants, and monthly injections. (NIDA, 2018)

Naltrexone is an opioid antagonist medication. It does not stimulate the activation of opioid receptors. It does not control withdrawal symptoms and cravings, rather it prevents any opioid drug from producing rewarding effects, like euphoria. In 2010, The FDA approved Vivitrol as a Naltrexone based medication to treat opioid use disorder. Naltrexone is a long-acting, injectable used initially to treat alcohol use disorder. Since the drug lasts for weeks, it is a good option for individuals with commitment issues to taking daily medications or who have limited access to healthcare providers. (NIDA, 2018)

Challenges to Implementing a MAT Program

Lack of Providers

One of the obstacles to creating and sustaining a Medication-Assisted Treatment program is the lack of providers who can dispense medications to treat opioid use disorders. Federal statutes, regulations, and guidelines strictly regulate how FDA approved medications are prescribed and dispensed. The Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for regulating opioid treatment programs. SAMHSA works with the Drug Enforcement Administration (DEA), states, and territories to assess all opioid treatment program applications to ensure they adhere to evidence-based treatment practices and have sound risk management. Annual reporting requirements are required to ensure physicians are providing the standard of care established by SAMHSA. SAMHSA also regulates physicians, physicians' assistants, and nurse practitioners who prescribe Buprenorphine from office-based treatment settings. (Collins, 2017)

Funding

Seeking long-term funding to initiate and sustain a Medication-Assisted Treatment program poses another barrier for agencies. Without financial assistance, agencies have to absorb a substantial financial burden to implement and maintain the program. Since federal courts have ruled that preventing access to Medication-Assisted Treatment violates the Americans With Disabilities Act and the Eighth Amendment, research suggests that jails with budgetary challenges should seek grant funding. Another way suggested to traverse budget shortfalls would be to create partnerships with community-based opioid treatment programs. Community-based substance abuse treatment programs often have providers on staff that meet the requirements for dispensing medications. There are also opportunities to enroll justice-involved individuals in Medicaid for post-release coverage of MAT medications. Lastly, there are discount

programs that offer substance abuse programs significant discounts for MAT medications. (Purington + Kukka, 2019)

Since SAMSHA and the DEA strictly regulate Medication-Assisted Programs, jails that do not have physicians on staff need to consider how they can facilitate their program. It is particularly challenging for rural and semi-rural counties with limited or no access to a physician who can prescribe MAT medications or provide behavioral therapy. Jail administrators should then focus on solutions such as telemedicine and mobile medical units. Research suggests that medication alone will not work. (Westervelt, 2019)

Another significant barrier to implementing a Medication-Assisted Treatment Program is the cost of the medications. The cost of opioid treatment varies and is based on many factors. The National Institute on Drug Abuse states that the national average for treatment in a certified opioid treatment program is:

TABLE 1: Cost of MAT Medications

Medication	Frequency of Visits	Weekly Costs	Annual Cost
Methadone	Daily	$126.00	$6,552.00
Buprenorphine	2x weekly	$115.00	$5,980.00
Naltrexone	Monthly	$1,176.50	$14,112.00

(NIDA, 2018)

Although there are significant financial obligations for implementing and sustaining a Medication-Assisted Treatment program, research suggests that its value could eventually pay for itself by reducing incarceration rates. Addressing the high-risk population by providing sustainable, evidence-based treatment will reduce overdose rates and recidivism. According to data, 77% of inmates with an opioid use disorder relapse without the help of a Medication-Assisted Treatment program, implying a high return on investment for jails to provide a treatment program. (Purington + Kukka, 2019)

Research indicates that prescription medication without counseling and behavioral therapy still improves outcomes; however, the best practice is to combine medicine with counseling and behavioral therapy and, when appropriate, offer wraparound services. Since a correctional setting is different from non-forensic treatment programs, jails must tailor cognitive treatment to meet the facility's operational needs and include group and individual counseling. (AHP, 2018)

Diversion

The reduction of contraband is a top priority in a correctional setting. Once facilities begin to dispense medications for Medication-Assisted Treatment, the potential for diversion rises expediently. Since the drugs used in MAT can cause euphoria, there is contraband value. To mitigate diversion, facilities must create stringent security protocols for administering MAT medications. Research suggests that security staff should receive training tailored to identifying agonist medications and reducing the likelihood of diversion. Some facilities take additional security precautions and use medication lines, mouth checks, and dispersal windows to minimize diversion potential. Other facilitates created

specialized housing units for those individuals participating in a Medication-Assisted Treatment Program. By limiting contact with other inmates, the risk for diversion reduces. However, some research suggests that segregating individuals involved in a Medication-Assisted Treatment Program creates a stigma that may make some individuals reluctant to participate. The critical component of reducing diversion in a correctional environment is mitigating risk, training, and robust medication protocols. (SAMSH, 2019)

Methods

This research aimed to identify Florida county jail facilities that offer Medication-Assisted Treatment Programs and assess its effectiveness at reducing recidivism and relapse. The survey will also garner data from those facilities not using MAT to evaluate their implementation challenges.

Data was gathered through surveys provided to the Orange County Corrections, Seminole County Sheriff's Office Department of Corrections, Polk County Sheriff's Office Department of Detention, Miami-Dade Corrections and Rehabilitation, Hillsborough County Sheriff's Office Detention Services, Pasco County Sheriff's Office Jail, Osceola County Corrections, Sarasota County Jail, Broward County Jail, and the Volusia County Division of Corrections. The agencies selected are county correctional facilities and are similar in size and operations to the Pinellas County Sheriff's Office Department of Detention and Corrections.

The eleven survey questions were developed to determine if facilities offer Medication-Assisted Treatment, assess their program requirements, identify which medication they use, and provide any lessons they have learned. The survey also provided an open text field to allow the respondents to share any additional information.

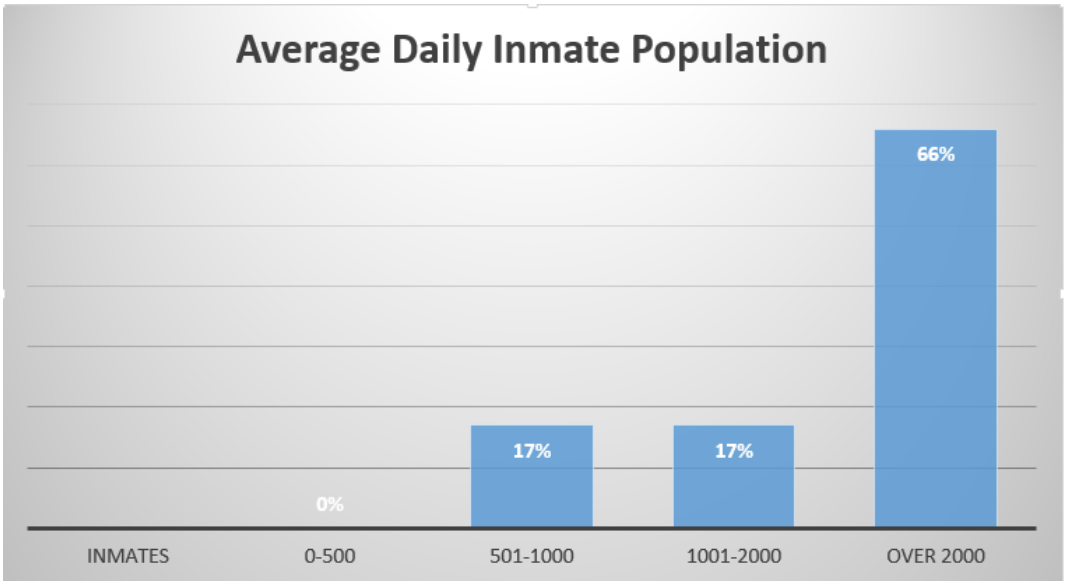
A weakness in the data collection instrument was the surveys requested that the respondents identify their agency. Since there has been successful litigation against agencies for not offering Medication-Assisted Treatment Programs, agencies may be reluctant to share their information.

Results

The survey was sent via an email link using an agency survey platform to ten jails throughout Florida. Each participating agency was given two weeks to complete the survey. Of the ten sent surveys, I received six responses for a return rate of 60%.

The first question ascertained the average daily population of the jail facility. Of the six who responded, 17% averaged between 501 to 1000 inmates daily, 17% averaged between 1001-2000 inmates daily, and 66% had over 2000 inmates per day.

TABLE 2: Average Daily Population of Inmates

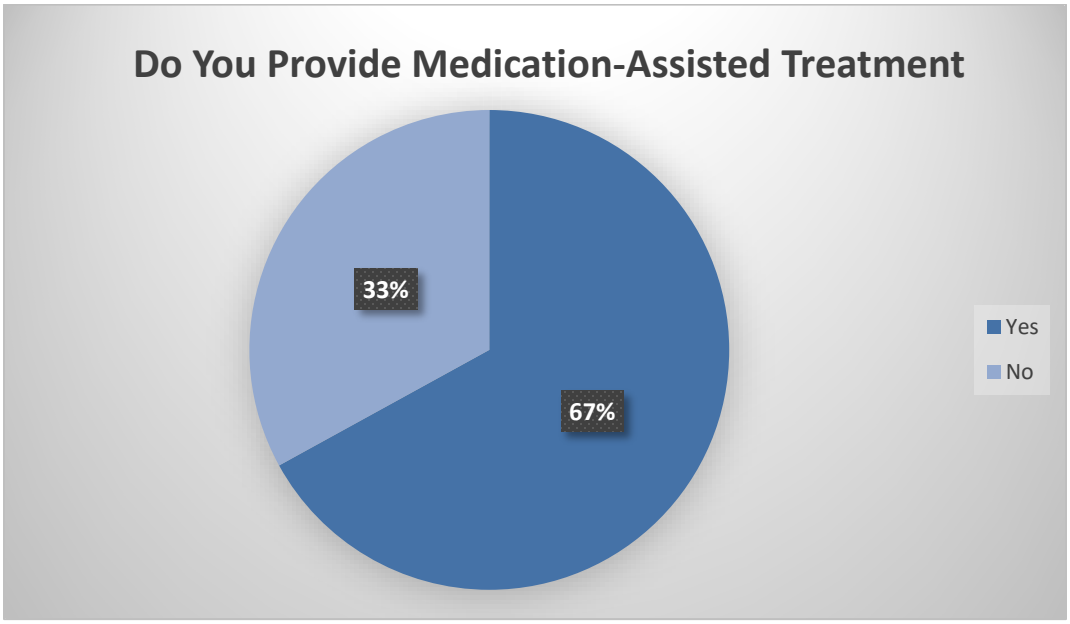


Question two asked participants to indicate their average length of stay of an inmate in their facility. Fifty percent (50%) of respondents said the average length of stay was between 16 and 30 days, and another 50 % were between 31 to 45 days.

TABLE 3: Average Length of Stay

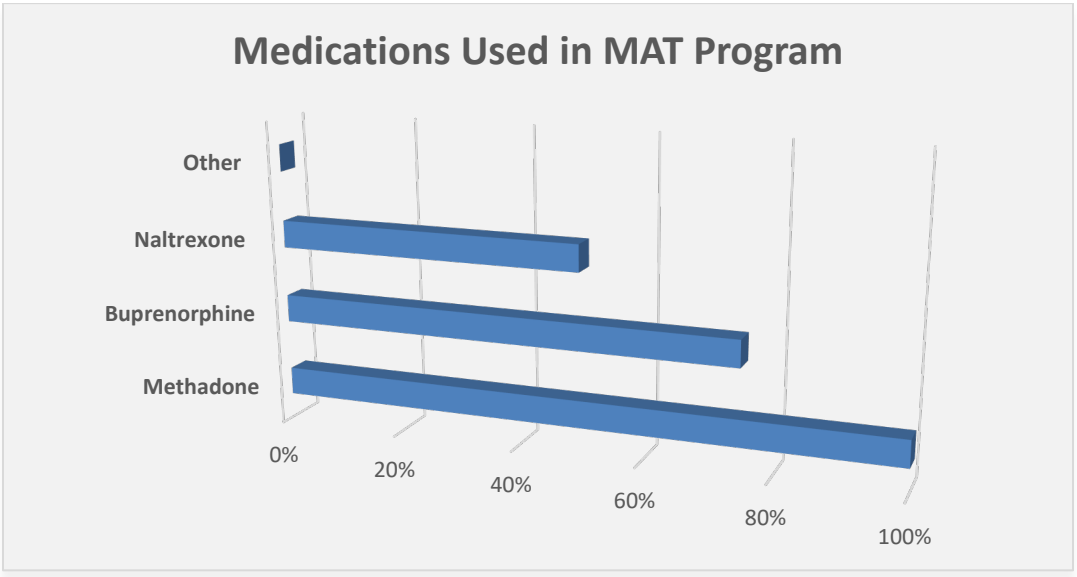
Question three asked if their jail provided a Medication-Assisted Treatment program. Of the six respondents, 67% offered a Medication Assisted Treatment program, and 33% did not offer a program. Those who did not provide a Medication-Assisted Treatment program in their jail were asked to skip to question #11.

TABLE 4: Does Your Agency Provide Medication-Assisted Treatment



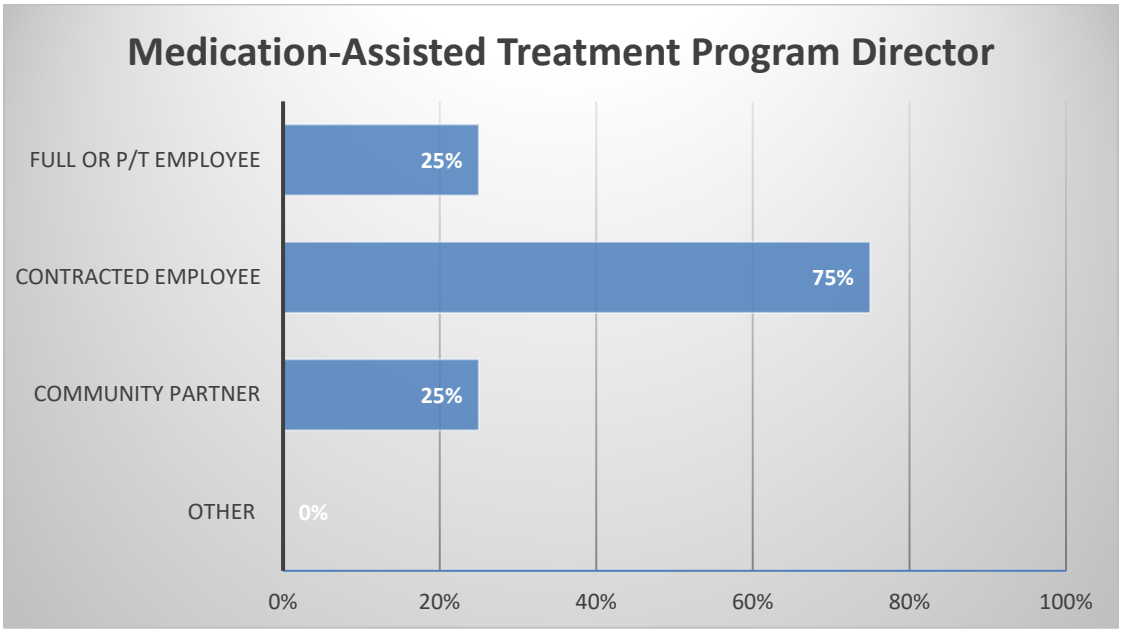
Question four asked respondents with a Medication-Assisted Treatment Program to identify which medications they use in their program. Of the four respondents, 100% used a combination of medicines. One hundred percent (100 %) of respondents used methadone. In addition to methadone, 75% also used Buprenorphine, and 50% also used Naltrexone. Additionally, there was a blank field for respondents to share any other medications they used besides those listed in the survey. None of the agencies used any other drugs in their program.

TABLE 5: Medications Used in a MAT Program



Question five focused on identifying the provider who oversees the Medication-Assisted Treatment Program. Respondents could select more than one option. Of the four respondents, 25% reported using multiple providers. Twenty-five percent (25%) of the total responses used a full or part-time member of their agency, 75% used a contracted employee, and 25% used a community partner.

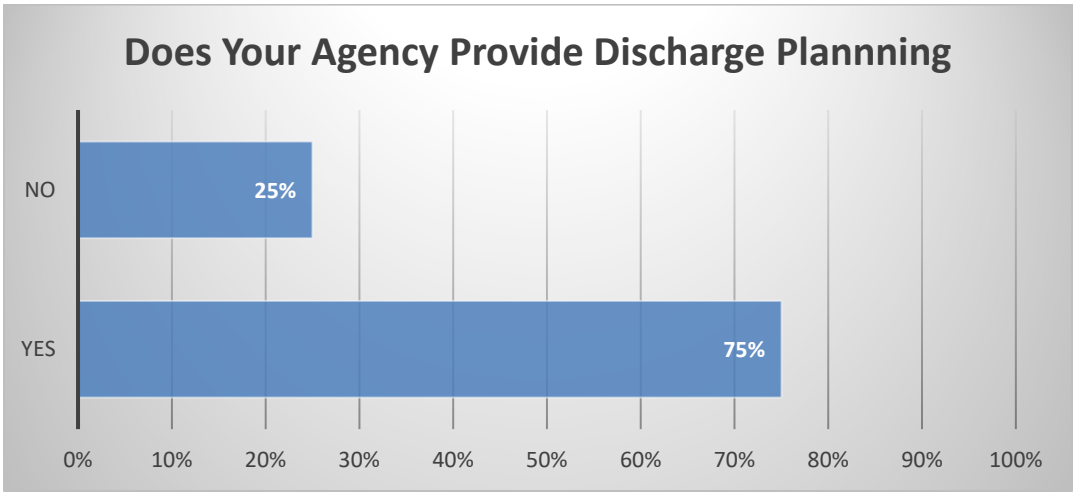
TABLE 6: Program Director



Question six evaluated the funding sources for agencies Medication-Assisted Treatment Programs. Of the four programs, no one (0%) received any type of funding to support their treatment program to include staff, licensing, or medications.

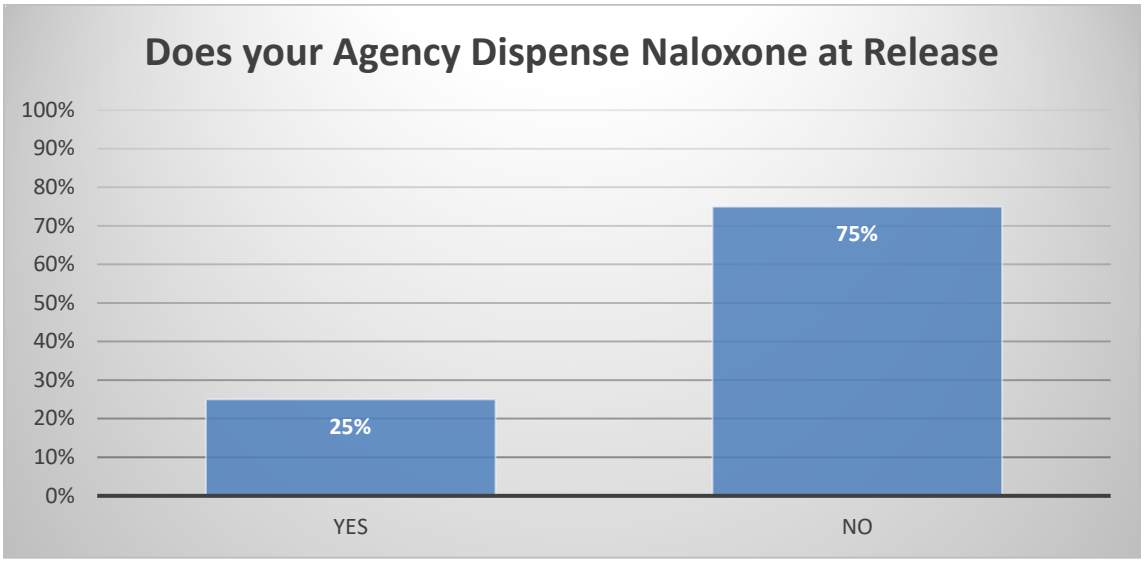
Question Seven asked if their agency provided discharge planning for participants enrolled in a MAT Program. Of the four respondents, 75% indicated they offered discharge planning, and 25% did not.

TABLE 7: Does Your Agency Provide Discharge Planning

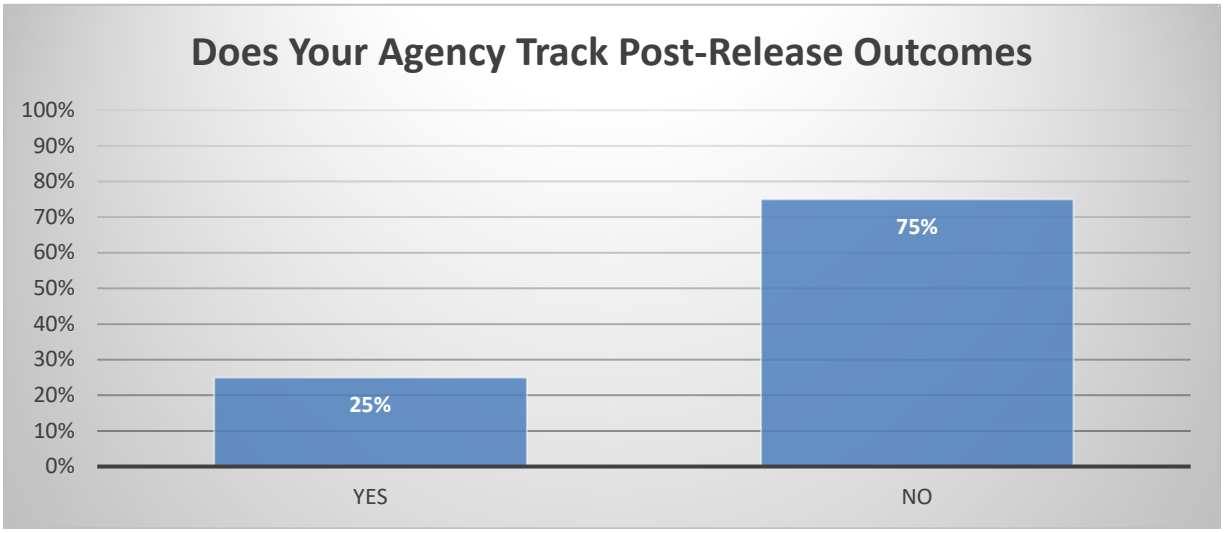


Question eight requested to see if the participating agencies dispensed Naloxone to detainees with an opioid use disorder upon release. Of the four respondents, 25% responded that they do provide Naloxone at the time of release, and 75 % said they did not.

TABLE 8: Does your Agency Dispense Naloxone at Release



Question nine requested to know if agencies tracked post-release outcomes for those participating in Medication-Assisted Treatment Programs? Of the four respondents, only 25% of the respondents reported tracking results post-release.



Question ten was an open text field that allowed respondents to share the lessons learned from initiating a Medication-Assisted Treatment Program in their agency. Three people chose to leave comments. Comments left by these individuals reflected the challenges of procuring a licensed provider to facilitate the program, medication protocols, program requirements, and average success rates post-incarceration.

Question eleven was an open text field that offered respondents an opportunity to share any obstacles preventing their agency from implementing a Medication-Assisted Treatment Program in their agency. Four participants chose to leave comments. Comments left by these individuals suggest there are challenges in finding adequate aftercare, lack of transitional housing, and co-occurring disorders such as mental health.

Discussion

The survey results suggest that the use of Medication-Assisted Treatment in jails is an emerging solution to deal with the opioid crisis. Of the agencies surveyed, 67% have a program tailored specifically to individuals with an opioid use disorder. The prevalence of opioid addiction appears to affect counties state-wide and is not isolated to a specific region.

There was also commonality between the research and survey results regarding an inmates' average length of stay. Fifty percent of respondents indicated their average length of stay was between 16-30 days, and the other 50% said their average length of stay was between 31-45 days in jail. Short-term detention is a barrier to implementing a robust program. Stabilizing an individual from opioids, initiating MAT medications, providing meaningful cognitive therapy, and discharge planning can be challenging for jails in such a short time.

Interestingly, not all agencies that had a Medication-Assisted Treatment Program used all three FDA approved medications in their program. Only 25% of participating respondents used all three drugs. This data suggests that although MAT programs must

follow strict SAMHSA requirements, agencies have some autonomy to tailor a program that meets their needs. Specifically, when deciding whether to employ a physician to oversee the program or create a community partnership with an existing program. The ability to tailor your program may help those agencies who struggle with funding or agencies in rural areas.

The desire to assist those most vulnerable to relapse and death was indicative of how many agencies provided Naloxone at release. Sixty-seven percent (67%) of respondents offered Naloxone to those with opioid addiction at release from jail. In the absence of discharge planning or MAT medications, Naloxone does reduce deaths post-release from jail. This data suggests that counties are trying to reduce opioid deaths.

The comments left by respondents suggest there is a gap between incarceration and aftercare. Some agencies have limited community resources making it challenging to comply with MAT medications and cognitive therapy post-incarceration. When there are gaps in services between incarceration and aftercare, relapse increases, recidivism rises, and it is difficult to track outcomes. Agencies may be reluctant to fund a Medication-Assisted Treatment Program when they can't provide program efficacy.

Recommendations

The survey results and literature review indicate that the use of Medication-Assisted Treatment Programs improves the chance for addiction recovery. Opioid Use Disorder is a treatable disease of the brain. With the help of FDA approved medications coupled with cogitative therapy, individuals with an opioid use disorder can achieve long term recovery.

Opioid Use Disorder affects public safety, public health, and places a significant financial burden on correctional facilities. County jails are the best way to engage justice-involved individuals that are opioid-dependent to provide the opportunity to obtain evidence-based opioid treatment.

The following are high-level recommendations for agencies to begin the framework for implementing a Medication-Assisted Treatment Program in their facility.

Create a Steering Committee

The Steering Committee should contain internal and external stakeholders who will create a strategic plan which identifies a Medication-Assisted Treatment Program's assets and liabilities. Facility Administrators play a significant role in this committee. They have to share the program's vision and also commit staffing, funding, and agency resources. Agency Administrators have to assess the impact of a Medication-Assisted Treatment Program on the jail's daily operations.

Security Staff should be a fundamental part of the steering committee. Since security staff will have the most interaction with participants, they must receive robust training on the types of medications used in a MAT program and their diversion potential. Security Staff should also be involved in making housing recommendations and identifying the program participants to reduce diversion.

The facility's medical team is a critical part of the steering committee. The medical team has to outline how they intend to meet the stringent requirements to become licensed by the DEA to dispense MAT medications. The medical team should also discuss which MAT medications the agency wants to use. Although the pinnacle would offer all three drugs, agencies have the flexibility to tailor a program that fits their facility and community's needs. Once that challenge is overcome, the team can move onto program requirements.

Considerations for program requirements should include screening individuals into the program, medication protocols, providing cognitive therapy, conducting on-going medical assessments, and discharge planning. Mental health services should also be offered since research indicates that a high percentage of participants have co-occurring disorders.

Program Services staff provides the social service's advocacy that is needed with this vulnerable population. Once there is a projected release date, Program Services staff can help individuals traverse some of the challenges to post-release life such as homelessness, transportation to aftercare, cost of medications, and employment.

Community partners are also critical to the success of a Medication-Assisted Treatment Program. The continuity of care post-release can make the difference between compliance and relapse. Community partners should work closely with correctional staff to bridge services post-release. Community partners may also supplement group substance abuse classes in jail for those enrolled in MAT. There are also opportunities for agencies to receive grants and funding that may not exist exclusively in the criminal justice setting.

Lastly, an analyst should be a founding member of the steering committee. The analyst will provide input for data collection and can track post-release outcomes. The aggregate data will assist the Steering Committee in the Evaluation Phase.

Create an Implementation Plan

After the Steering Committee convenes, copious assessments should be conducted to mitigate the risks of implementation. Since there are multiple stakeholders involved, the steering committee must ensure everyone uses the same language and that the program's goals are shared. A plan is developed during the implementation phase, including program requirements, policies, training, and aftercare requirements. Once the implementation plan is complete, a go-live date can be selected.

Evaluation

The last component of a successful MAT Program is to evaluate outcomes. Agencies should assess relapse rates, recidivism rates, and death rates for individuals participating in a MAT Program. A critical review of how MAT impacted jail operations should be included in the evaluation. Administrators must evaluate incident reports, disciplinary reports, diversion issues, and any other concerns that would affect the program's longevity. Annual reports should be submitted to all participating stakeholders.

TABLE 9: How to Start a Medication-Assisted Treatment Program

1. Create a Steering Committee
    a. Stakeholders
        i. Facility Administrators
            1. Vision/Direction for the Program
            2. Buy-In
            3. Budget
            4. Staffing Requirments
            5. Impact on facility
        ii. Security Staff
            1. Training
                a. What is MAT
                b. MAT Medications
                c. Diversion/Risk Mitigation
            2. Housing
        iii. Medical Department
            1. Licensing Requirements
            2. Medications
            3. Cognitive Treatment Service
            4. Co-occurring Disorders
            5. Continuity of Care post-release
        iv. Program Services
            1. Wraparound services
                a. Housing
                b. Transportation
                c. Medicaid
        v. Community Partners (Substance Abuse and Mental Health)
            1. Post-release services
            2. Grant opportunities
        vi. Agency Analyst
            1. Data Collection
2. Implementation Plan
    a. Program Requirements
    b. Develop Protocols, Policies, and Practices
    c. Training
    d. Go-Live
3. Evaluation
    a. MAT Efficacy
        i. Relapse Rates
        ii. Recidivism Rates
        iii. Death Rates
    b. Sustainability

A robust Medication-Assisted Treatment Program in the county jail will provide an opportunity to strengthen our understanding of addiction and how brain function

contributes to long-term addiction recovery. By providing Medication-Assisted Treatment, our community can begin to confront the challenges of the opioid crisis.

Captain Jennifer Nobles has been with the Pinellas County Sheriff's Office since 1999. She has served in many different capacities during her tenure. Captain Nobles is currently a Division Commander within the Department of Detention and Corrections, where she oversees a medical and psychiatric facility with a full complement of staff. Captain Nobles has a Bachelor of Arts degree in Criminology from the University of South Florida and holds a Certified Public Manager certification from the Florida Center for Public Management at the Florida State University. She is a 2017 graduate of Leadership Pinellas and is a volunteer with Big Brothers Big Sisters.

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Appendix A

Survey Introduction

Good Afternoon,

My name is Captain Jennifer Nobles, and I am with the Pinellas County Sheriff's Office Department of Detention and Corrections. I am reaching out for assistance with research on Medication-Assisted Treatment Programs in jail.

The following survey will take approximately ten minutes to complete. The data collected will provide useful information regarding the impact of Medication-Assisted Treatments in jail. I will be publishing this data in my research project for my Senior Leadership Program. Participation in this survey is highly valued but voluntary.

I respectfully request that the questionnaire is completed by August 28, 2020. Please follow the following link to access the survey.

https://www.pcsoweb.com/surveynet2/TakeSurvey.aspx?SurveyID=n4LM8l3

If you have any questions, please do not hesitate to contact me. I appreciate your assistance.

Regards,

Captain Jennifer Nobles
Pinellas County Sheriff's Office
Department of Detention and Corrections
727-464-8184

Survey Questions

1. What is your average daily inmate population?
    a. 0 - 500
    b. 501 – 1000
    c. 1001 – 2000
    d. Over 2001

2. What is the average length of stay of an inmate?
    a. 0 to 15 days
    b. 16 to 30 days
    c. 31 to 45 days
    d. Over 45 days

3. Does your jail provide a Medication-Assisted Treatment Program (MAT)?
    a. Yes
    b. No (skip to question # 11)

4. If yes, what medications do you use (select all that apply)?
    a. Methadone
    b. Buprenorphine
    c. Naltrexone
    d. Other, please specify _____

5. The prescribing physician who oversees your MAT program is a:
    a. Full or part-time member of your agency
    b. Contracted employee
    c. Community partner
    d. Other, please describe _____

6. Does your agency receive any funding for your MAT program (including staff, medication, or practitioners)?
    a. Yes
    b. No

7. Does your agency provide discharge planning for participants enrolled in a MAT program?
    a. Yes
    b. No

8. Do you dispense Naloxone kits to detainees with a diagnosed Opioid Use Disorder?
    a. Yes
    b. No

9. Does your agency track post-release outcomes for participants enrolled in a MAT program?
    a. Yes
    b. No

10. Please share any lessons learned after implementing your MAT program.

_____
_____
_____
_____
_____

11. Please share any obstacles preventing your agency from implementing a MAT program?

_____
_____
_____
_____
_____