Best Practices for Successful Reentry for People Who Have Opioid Addictions

The increasing number of people who have opioid addictions[1] continues to impact communities across the United States, from large urban areas to rural counties. Recent data show that 116 people die from an opioid overdose each day;[2] in 2016, overdoses fueled by opioid addictions were the leading cause of death for Americans under 50 years old, surpassing death by car accidents and guns.[3] The challenges associated with opioid addiction can also often have dangerous and life-altering consequences for people who are leaving incarceration and returning to the community. In fact, people who have opioid addictions and are released from prison or jail face a significantly higher risk of overdose and overdose-related death: in Washington State alone, opioids were detected in nearly 15 percent of all deaths over a 10-year period among people who were released from prison.[4] It was also found that the risk of death from all drug overdoses within the first two weeks after release from prison was 129 times that of other state residents.[5] And in Connecticut, 52 percent of people who died from a drug overdose in 2016 had at some point been incarcerated in jail or prison.[6]

In addition to these health and personal safety risks for people who have opioid addictions returning to the community, there can also be public safety concerns because people who have substance addictions tend to have higher risks for future criminal activity compared to people who do not have addictions.[7] Due to the increased risk of relapse, deaths by overdose, and recidivism, reentry is a critical period to provide rapid access to treatment pre- and post-release as well as supervision to people who have opioid addictions.

This fact sheet describes the best practices that correctional, community-based behavioral health, and probation and parole agencies can implement to ensure that reentry for people who have opioid addictions is safe and successful. These best practices fall under the following categories:

- Planning and coordination
- Behavioral health treatment and cognitive behavioral interventions
- Probation and parole supervision
- Recovery support services, housing, and other support services in the community

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1. Opioids are a class of drugs that include prescription painkillers, heroin, and fentanyl. Opioid addiction is a chronic, relapsing disease that alters the structure and function of the brain.
2. *Data Brief 294, Drug Overdose Deaths in the United States, 1999–2016*, (Atlanta: Centers for Disease Control, 2017), https://www.cdc.gov/nchs/data/databriefs/db294_table.pdf#page=4; Holy Hedegaard, Margaret Warner, and Arialdi Minino, *Drug Overdose Deaths in the United States, 1999–2016* (Atlanta: Centers for Disease Control and Prevention, 2017), https://www.cdc.gov/nchs/data/databriefs/db294.pdf; and "Data Brief 294, Drug Overdose Deaths in the United States, 1999–2016." (Atlanta: Centers for Disease Control, 2017).
3. Maya Salam, "The Opioid Epidemic: A Crisis Years in the Making," *The New York Times*, October 26, 2017, https://www.nytimes.com/2017/10/26/us/opioid-crisis-public-health-emergency.html.
4. Ingrid A. Binswanger et al., "Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends from 1999 to 2009," *Annals of Internal Medicine* 159 no. 9 (2013): 592-600.
5. Ingrid A. Binswanger et al., "Release from Prison—A High Risk of Death for Former Inmates," *The New England Journal of Medicine* 356 (2007): 157-165, https://www.nejm.org/doi/full/10.1056/NEJMsa064115.
6. Kathleen Maurer, "Medication for Addiction Treatment in the Justice System: Connecticut Experience," (PowerPoint presentation, American Association for the Treatment of Opioid Dependence [AATOD] Conference, New York, March 13, 2018).
7. Tyler N.A. Winkelman et al., "Health, Polysubstance Use, and Criminal Justice Involvement Among Adults with Varying Levels of Opioid Use." *Journal of the American Medical Association* 1 no. 3 (2018); Meredith H. Thanner and Faye S. Taxman, "Responsivity: the value of providing intensive services to high-risk offenders." Journal of Substance Abuse Treatment 24 (2003): 137-147; and Charles Summers and Tim Willis, *Pretrial Risk Assessment: Research Summary* (Arlington, Virginia: CSR, Incorporated, 2010).

PLANNING AND COORDINATION

Screen and assess for opioid addiction.

The foundation for starting to plan for reentry when it comes to people who have opioid addictions is first knowing whether someone has an addiction. Screening for opioid use should take place upon intake into correctional facilities to identify whether a person has signs of opioid use (prescribed drugs) or misuse (illicit drugs), addiction, dependence, or is experiencing withdrawal. Correctional agencies should establish processes to refer people who screen positive to receive a full substance addiction assessment,[8] which determines the scope and nature of the respondent's behavioral health needs, including psychosocial problems, substances used (which would include opioids such as prescription drugs, heroin, and fentanyl), and substance addictions. Assessment results form the basis of the person's reentry plan and inform addiction treatment services that should be continued upon the person's return to the community. Because of high rates of co-occurring substance addictions and mental illnesses among people who are incarcerated, correctional facilities should also ensure that screening and assessment for mental illness take place before release.

Establish a process to determine whether people who have recently used opioids need withdrawal management or detoxification.

Withdrawal symptoms need to be monitored to ensure the person's own safety and health as well as the safety of staff and other people who are incarcerated in the facility. In addition to being monitored for withdrawal, people who have opioid addictions should continue receiving previously prescribed medications or, if needed, start taking prescribed or over-the counter medications as they prepare for reentry and upon their return into the community to ease the withdrawal process. When indicated, medically managed withdrawal should include medical supervision of detoxification from physical dependency on a substance and be followed by continued addiction treatment services.[9] Because of the potential for increased risk of suicide during withdrawal from substances, correctional facilities should also develop a screening process to identify people at heightened risk for suicide.

Sharing information from drug screenings, assessments, and treatment

Instrumental to improving treatment outcomes is the sharing of information about screening, assessments, and treatment, as well as the use of naloxone,[10] with the appropriate people involved in a person's recovery process. Data collected by anyone involved in the person's recovery must be shared

8. Roger Peters, Elizabeth Rojas, and Marla G. Bartoi, *Screening and Assessment of Co-Occurring Disorders in the Justice System* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015), http://www.qualishealth.org/sites/default/files/SMA15-4930.pdf.

9. David Mee-Lee, "Understanding and Utilizing the ASAM Placement Criteria" (webinar, The Association for Addiction Professionals [NAADAC], March 14, 2012), http://www.naadac.org/assets/1959/2012-03-14_understanding_and_utilizing_asam_webinarslides.pdf.

10. Naloxone is a medication that reverses the effects of overdose from opioids. It can be administered by anyone. After receiving naloxone, the person should get medical attention and be referred to or re-engaged in treatment for opioid addiction. See, "Opioid Overdose Reversal with Naloxone (Narcan, Evzio)," *National Institute on Drug Abuse*, accessed July 18, 2018, https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio.

with the others who are involved, as appropriate, to ensure the person's medical needs are addressed; for example, it is important for behavioral health, correctional health, and residential substance abuse treatment (RSAT) programs in a correctional facility to share information with community-based behavioral health providers to avoid gaps in health care coverage and treatment.[11] Federal laws and regulations are in place to protect the confidentiality of sensitive information relating to opioid use and other health issues. The Health Insurance Portability and Accountability Act (HIPAA) and Title 42 of the Code of Federal Regulations (CFR) Part 2 provide guidance about the conditions under which protected health information can be shared.[12] It is important that agencies and entities involved in a person's reentry understand these guidelines and work collaboratively to share relevant information with each other to reduce duplicative efforts of gathering information.

Develop a Collaborative Comprehensive Case Plan (CC Case Plan) for reentry.

People who have opioid addictions who are returning to their community should have comprehensive, tailored plans to guide their successful reentry. Reentry plans[13] may be developed by staff from the correctional facility, community-based behavioral health treatment providers, or the probation and parole agency and should follow the CC Case Plan[14] model to address criminogenic risk and behavioral health needs based on screening and assessment results. These plans should include referrals and connections to ongoing treatment and recovery support services as well as ensure that all entities involved in the person's reentry have access to pertinent information.

Facilitate in-reach by community-based behavioral health treatment providers and probation and parole agency staff into the correctional facility.

When developing the reentry plan, staff from community-based behavioral health treatment providers and probation and parole agencies should begin to engage people who have opioid addictions as they approach their release date from jail or prison. This in-reach is useful in building a rapport with people leaving incarceration and helps ensure that treatment continues seamlessly as they move from the correctional facility to the community. Ideally, in-reach entails an in-person connection of the person to staff from the community-based treatment provider (i.e., peer recovery support specialist, case manager, or therapist) for treatment upon their release from corrections and making sure that they attend their first appointment for treatment in the community soon after release.

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11. Martha R. Plotkin and Alex Blandford, *Critical Connections: Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need* (New York: The Council of State Governments Justice Center, 2017), https://files.csgjusticecenter.org/critical-connections/Critical-Connections-Full-Report.pdf.

12. (1) John Petrila and Hallie Fader-Towe, *Information Sharing in Criminal Justice-Mental Health Collaborations* (New York: The Council of State Governments Justice Center, 2010), https://www.bja.gov/Publications/CSG_CJMH_Info_Sharing.pdf; and (2) "New Health Policy Materials for the Criminal Justice System," Legal Action Center, accessed July 9, 2018, https://lac.org/resources/state-profiles-healthcare-information-for-criminal-justice-system/.

13. Reentry plans may also be referred to as case plans, supervision plans, service plans, or treatment plans.

14. "Collaborative Comprehensive Case Plans," The Council of State Governments Justice Center, accessed May 15, 2018, https://csgjusticecenter.org/nrrc/collaborative-comprehensive-case-plans/.

Create a relapse prevention plan and distribute materials on overdose prevention, and provide naloxone upon release when possible.

Due to the increased risk of overdose death after release from a correctional facility for people who have opioid addictions, the staff involved in a person's reentry and recovery should develop a relapse prevention plan prior to release. The plan should include identification of the person's triggers for relapse, how to avoid these triggers, and how to manage impulses. Depending on the jurisdiction's procedures, this plan will be part of the CC Case Plan for reentry. In addition, the person's family and/or support system should be engaged in the development of the relapse prevention plan to ensure that they are aware of the person's triggers, impulses, and cues,[15] and know how to help if the person relapses or overdoses after release from a correctional facility. They should also receive materials on overdose prevention, and when possible, be provided with naloxone kits to help reverse the effects of a potential overdose.

BEHAVIORAL HEALTH TREATMENT AND COGNITIVE INTERVENTIONS

Ensure treatment, including Medication-Assisted Treatment (MAT) and counseling, is delivered in the correctional facility and upon release in the community.

Once opioid addiction is identified, there are treatment options available to address a person's specific needs. These treatment options can include Medication-Assisted Treatment (MAT)[16] for alcohol and opioid addiction, counseling, and behavioral therapy, which are designed to address thinking and actions that may lead to relapse. Because opioid addiction alters the structure and function of the brain,[17] MAT is often used to help treat the brain changes that occur.[18] MAT's purpose is to reduce the cravings people have to use opioids again, which is an especially important consideration when people are reentering the community. The medication options approved by the Food and Drug Administration (FDA) for people who have opioid addictions are buprenorphine, methadone, and naltrexone.[19] Because some people may respond differently to one medication than another, it is important that people who have opioid addictions have access to all three medication options. If a person has received MAT while incarcerated, access to MAT should remain uninterrupted throughout the reentry process. Additionally, because research has not yet established timelines for the appropriate duration of MAT, criminal justice professionals should not associate the length of time a person is on MAT with success or failure. The

15. Cues for relapse vary from person to person but may include stress, experiencing emotions that relate to substance use, being in physical locations where the person previously used drugs, or seeing paraphernalia associated with drug use.
16. "Medication-Assisted Treatment Overview," Substance Abuse and Mental Health Services Administration, accessed May 15th, 2018, https://www.samhsa.gov/medication-assisted-treatment.
17. "The Science of Drug Abuse and Addiction: The Basics," National Institute on Drug Abuse, accessed June 11, 2018, https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics.
18. "Effective Treatments for Opioid Addiction," National Institute on Drug Abuse, accessed June 11, 2018, https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics.
19. Substance Abuse and Mental Health Services Administration, *Medications for Opioid Use Disorder: Treatment Improvement Protocol (TIP) 63* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018).

decision to place a person on or remove a person from MAT is one to be made only by the person who has an opioid addiction in conjunction with a licensed medical practitioner.

Counseling and behavioral therapy are other important parts of addiction treatment. These treatments enable people to identify and address the thinking and behavior that contribute to substance addictions by encouraging self-awareness and behavioral change. Counseling, which can be offered either in a group format or individually, is also a vital component of treatment for substance addictions and mental illnesses and should be part of the treatment for people who have opioid addictions and co-occurring mental illness. Many organizations provide resources to guide reentry professionals through the MAT process, but it is best practice to offer people who have opioid addictions MAT and counseling together; interventions that do not involve MAT, such as abstinence-only treatment, are not considered evidence-based practices and should not be used for treatment.[20]

MAT partnerships prove successful in Rhode Island

Uninterrupted connection to MAT treatment is fundamental to its efficacy. In 2014, 60 percent of fatal overdoses in Rhode Island were among people who had been incarcerated, highlighting the need to provide treatment to people who have opioid addictions both during and after incarceration.[21] In July 2016, the Rhode Island Department of Corrections began offering the three MAT options to people who have opioid addictions in their facilities in partnership with a community-based provider, who offered MAT to the same people post-release. Between January 1, 2017, and June 30, 2017, after the full implementation of the MAT model, there was a 12.3 percent decrease in the number of overdose deaths among people who were released from correctional facilities as compared to the same period in 2016, from 179 deaths to 157.[22]

Provide cognitive behavioral interventions in the correctional facility and in the community to address criminogenic risk and need factors.

Cognitive behavioral interventions (CBI) are designed to reduce people's risk of recidivating by addressing criminogenic risk factors such as criminal thinking, antisocial peers, and antisocial personality patterns.[23]

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20. American Society of Addiction Medicine, *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (Chevy Chase, MD: American Society of Addiction Medicine, 2015); "Buprenorphine Treatment Practitioner Locator," Substance Abuse and Mental Health Services Administration, accessed July 16, 2018, https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator; "Opioid Treatment Program Directory," Substance Abuse and Mental Health Services Administration Division of Pharmacologic Therapies, accessed July 16, 2018, http://dpt2.samhsa.gov/treatment/directory.aspx; "Search Membership Directory," American Society of Addiction Medicine, accessed July 16, 2018, https://asam.ps.membersuite.com/directory/SearchDirectory_Criteria.aspx; and Substance Abuse and Mental Health Services Administration, *Medications for Opioid Use Disorder* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018).

21. Jennifer Clarke, Linda Hurley, and Rosemarie Martin, "Medication for Opioid Use Disorder Expansion in RI Department of Corrections. Needs Assessments, Clinical Intervention, Reentry and Outcomes" (PowerPoint presentation, ATTOD Conference, New York, March 2018).

22. Traci C. Green et al., "Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System." *JAMA Psychiatry* 75, no. 4 (2018): 405-407.

23. Harvey Milkman and Kenneth Wanberg, *Cognitive-Behavioral Treatment: A Review and Discussion for Corrections Professionals* (Washington, DC: National Institute of Corrections, 2007); and Edward J. Latessa, "What Works in Reducing Recidivism?" University of St. Thomas Law Journal no. 3: 521-535.

CBI programs help participants address these risk factors by improving critical thinking skills, problem-solving, moral reasoning, self-control, and impulse management.[24] People who have opioid addictions often have several criminogenic risk factors which, if left unaddressed, can contribute to the likelihood of recidivating.[25] Paired with addiction treatment, CBI play a critical role in decreasing the likelihood of recidivism. CBI should be offered in correctional facilities as well as in the community to address criminal thinking throughout the reentry process and reduce the likelihood of further criminal behavior.

Connect people who have opioid addictions to health care coverage.

Staff from correctional facilities, community-based behavioral health treatment providers, and other social service agencies should ensure that people who have opioid addictions either are enrolled in health care coverage or will have their coverage reinstated immediately upon release from the facility. Doing so reduces the likelihood of interruptions in treatment. Many states have processes in place for corrections and reentry staff to assist people with filling out appropriate applications for health care coverage and policies that turn on Medicaid benefits immediately upon their release. In other cases, arrangements are made for time-limited coverage for people who are poised to leave prison or jail but have not received final eligibility determination at the time of their release.[26] Ensuring people have health care coverage immediately upon release can reduce gaps in access to addiction treatment, thereby also reducing the acute risk of relapse[27] and increasing their chances of sustained recovery.

PROBATION AND PAROLE SUPERVISION

Train probation and parole officers on how to work with people who have opioid addictions, and when possible, create specialized caseloads for those individuals who have co-occurring substance addictions and mental illnesses.

Given the prevalence of opioid addiction in the U.S., all probation and parole officers should receive training on supervising people who have opioid addictions so they can effectively supervise and connect people to treatment. Some jurisdictions have developed specialized caseloads for supervising this population, with specific protocols for drug testing when someone has been receiving MAT and close monitoring of people within the first two weeks of release from the correctional facility for signs of overdose. Because many people who have opioid addictions may also have co-occurring mental illnesses, probation and parole agencies should, when possible, implement specialized caseloads for people with co-occurring mental illnesses and substance addictions so that supervision and programming can effectively address their unique criminogenic risk factors and needs.

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24. Milkman and Wanberg, *Cognitive-Behavioral Treatment.*

25. Charles Summers and Tim Willis, *Pretrial Risk Assessment: Research Summary* (Arlington, Virginia: CSR, Incorporated, 2010); Faye S. Taxman and Michael S. Caudy, "Risk Tells Us Who, But Not What or How," *Criminology and Public Policy* 14 no. 1: 71-103; and Faye S. Taxman, "Second Generation of RNR: The Importance of Systemic Responsivity in Expanding Core Principles of Responsivity," *Federal Probation* 78 no. 2: 32-40.

26. Plotkin and Blandford, *Critical Connections.*

27. Ibid.

RECOVERY SUPPORT SERVICES, HOUSING, AND OTHER SUPPORTS IN THE COMMUNITY

Provide recovery support services immediately upon release.

Recovery support services are a range of programs and resources that help people access systems of care and remain engaged in their treatment and recovery process. These services may include supported employment, education, and housing; illness management; and peer-led services.[28] The services that are provided will vary from person to person because recovery is an individualized process,[29] but all people who have opioid addictions and are reentering the community should be connected to these services as soon as possible as part of their reentry plan so their needs can be addressed and recovery can be sustained.

Provide safe and stable housing in the community. Secure housing is critical for any person reentering the community from correctional facilities but particularly for people who have opioid addictions and are navigating behavioral health treatment and other interventions in their reentry process. Some community-based housing facilities, including some sober living recovery houses or halfway houses, may not accept people who are receiving MAT, so it is important that the person reentering the community has housing accommodations that will let him or her continue with MAT, if applicable. If appropriate and available, supportive housing (i.e., affordable housing that also offers recovery support and other services) may be helpful for people who have opioid addictions.[30] Community-based specialized housing providers should also facilitate connections to health care coverage and other benefits for people who are reentering the community. Identifying whether a person is eligible for health care coverage and other benefits should be part of the intake and follow-up process at specialized housing providers.

Implement rapid response teams (RRT). Closely monitoring people who have opioid addictions—especially following times of transition such as release from a correctional facility, detoxification center, and completion of treatment—is critical to successful recovery. RRTs typically consist of a probation or parole officer and clinical staff who check in daily on the well-being of people who have opioid addictions who are reentering the community, starting from the hours after release through the first two weeks. These well-being checks become less frequent the longer someone has been in the community. Multidisciplinary RRTs are organized and deployed not to respond to overdoses but to stay in touch with this high-risk population on top of existing treatment and supervision.

Use peer recovery support to assist with the reentry process. Increasingly, peer recovery support specialists[31] are an integral part of the reentry and recovery process. Generally, peer recovery support specialists have histories of substance addiction and/or mental illnesses, and forensic peer specialists have previously been involved in the

28. "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, accessed June 11, 2018, https://www.samhsa.gov/recovery.

29. Ibid.

30. "Supportive Housing," United States Interagency Council on Homelessness, accessed July 9, 2018, https://www.usich.gov/solutions/housing/supportive-housing.

31. Many states have a process to certify people to be peer recovery coaches.

criminal justice system. In some cases, peer specialists may have histories of both. Because of their histories of behavioral health conditions and prior incarceration, peer specialists can share their experiences with people who have substance addictions and mental illnesses and are currently transitioning from correctional facilities to the community and help them navigate various services upon their release.[32] Peer specialists can play an important role in motivating people who have opioid addictions to make their first treatment appointment in the community upon release and, in some cases, even take them to the appointment to minimize the risk of relapse and overdose.

Special considerations

Because reentry and recovery are individualized processes, there should be special considerations for cultural competence and gender-responsivity across the reentry processes. These considerations should be taken for people of different races, ethnicities, and cultures; women; lesbian, gay, bisexual, and transgender people; family and children of people who have opioid addictions; veterans; and people who live in rural areas.

32. Larry Davidson and Michael Rowe, *Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists* (Delmar, New York: The CMHS National GAINS Center, 2008).

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