Treatment of Substance Use Disorders Along the Criminal Justice Continuum

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Disclosure Information (Required)

- Presenter 1: Joshua Hammond MD
  - Disclosures: Gilead, Honorarium, Advisory Board
- Presenter 2: Dayna DeHerrera-Smith, MPH
  - Disclosures: No Disclosures
- Presenter 3: Karissa Gayosso, AGACNP-BC
  - Disclosures: No Disclosures

Learning Objectives (Suggested)

1. Upon completion, participants will be able to describe the scope of challenges facing the patient with SUD across the criminal justice continuum.
2. Upon completion, participants will be able to define and describe the current statistical trends and rationale to increase access to care to criminal justice involved patients.
3. Upon completion, participant will be able to list the types of interventions effective in supporting this population and define the key components of these interventions.

Background & Purpose

- Over 60% of incarcerated individuals **meet the criteria for SUD** [1]
- Increase risk of fatal overdose following incarceration due to change in tolerance while in custody & the lack of social & financial support [2]
- The highest risk of return to use (RTU) and overdose is the first 2 weeks after release from incarceration
- Over **60% decrease in fatal OD** in a Rhode Island correctional facility study where MOUD (all types) were offered [3]

1. NIDA. 2020, June 1. Criminal Justice DrugFacts. Retrieved from https://nida.nih.gov/publications/drugfacts/criminal-justice on 2025, Feb 17, 2025
2. Binswanger, I. A., Blatchford, P. J., Mueller, S. R., & Stern, M. F. (2013). 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(9), 592-600.
3. Mital, S., Wolff, J., & Carroll, J. J. (2020). The relationship between incarceration history and overdose in North America: A scoping review of the evidence. Drug and alcohol dependence, 213, 108088. https://doi.org/10.1016/j.drugalcdep.2020.108088

Introduction

- Legislative shifts have occurred that necessitate greater need for collaboration between criminal justice & SUD treatment
  - Medication for Addiction Treatment (MAT) Continuation and Induction in jail settings
  - More folks leaving incarceration in need of community based care
  - Re-entry programming
- Our clinic's mission is to provide low-barrier/high-access care
- A novel approach to access and continuity of care was necessary
  - Requires collaboration and understanding the medical/clinical limitations of carceral facilities

By the Numbers: MAT & Criminal Justice

65% of incarcerated individuals have a Substance Use Disorder (SUD).

17% have a co-occurring disorders: SUD + mental health disorder.

1000% more likely to die of overdose when released from prison.

570% higher risk of death in first two weeks after release.

61% of prisons do NOT offer any type of MAT.

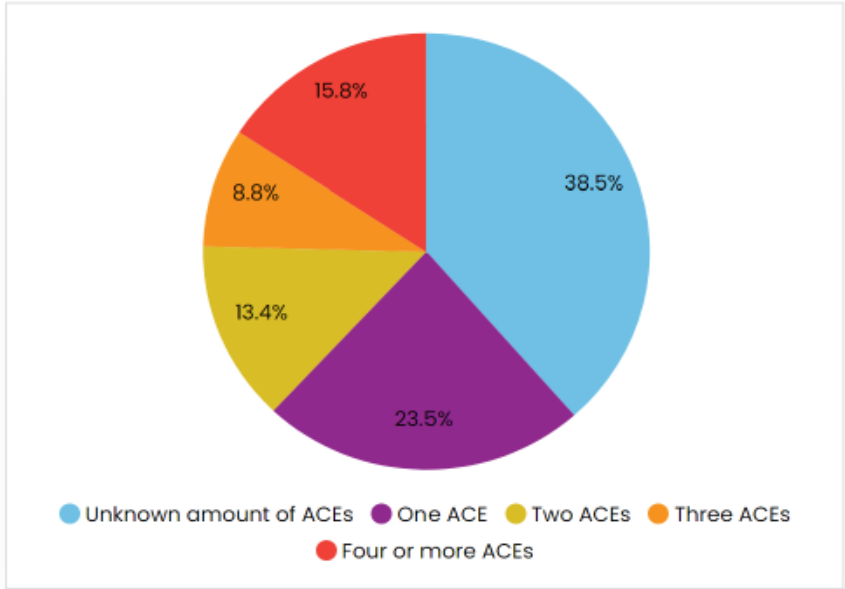
86% of Drug Courts allow MAT yet…

Only 14% of individuals with OUD were on MAT.

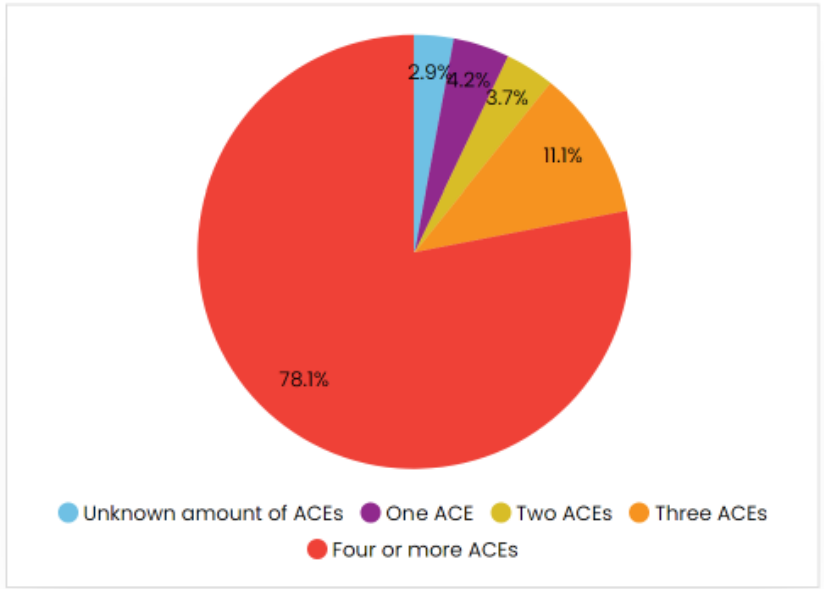
National Institute of Health

ACE's & Justice Involved Individuals

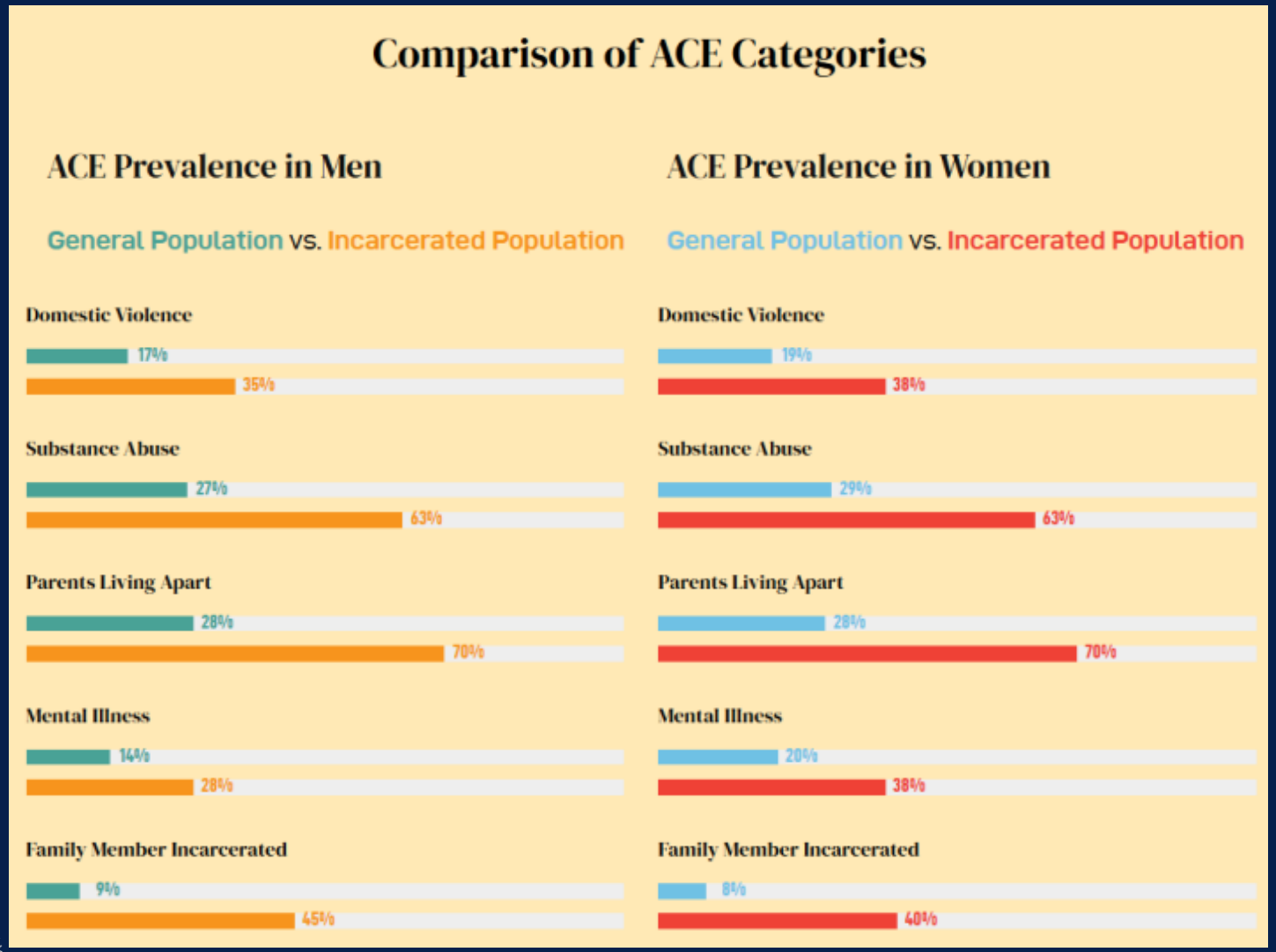
64% of the U.S. population has at least one ACE.



98% of the prison population has at least one ACE.



ACE's & Justice Involved Individuals



Notice the significant prevalence of ACEs for all incarcerated populations vs. the general population.

Messina and Burdon 2020, BRFSS data 2011-2014 and ncbi.nim.nih.gov

Case 1: Introduction

John
57 yr old Male
AUD

- Arrested for DUI
- Drinking heavily since early 20s
- Currently drinking 1.75 L vodka every 2 days
- Living in a van & Working day labor
- Currently on pre-trial
- Attempts to decrease or cessate alcohol use limited by severity of w/d.

Case 1: Discussion

What barriers to care do you anticipate for John?

Case 1: Discussion

How could effective treatment be introduced earlier as John navigates the criminal justice system?

Case 1: Discussion

How can **treatment be integrated** into the criminal justice process, while still **maintaining a trusting relationship** and keeping John engaged in treatment during and after court proceedings?

Medical Guided Treatment Supervision (MGTS)

- *Who*: Individuals w/ non-violent substance-related charges
- *Where*: Larimer County, CO
- *What*: Individuals are given the **OPTION to schedule a MAT clinic intake** and follow prescribed treatment plan as an alternative to pretrial supervision with UDS which is the default
- *How*: The judge introduces the program and interested defendants connect with an on-site care coordinator

MGTS Continued

At MAT clinic intake, it is explained to the patient that they will be treated like any other patient in our clinic except that a form will be faxed to the court that indicates engagement in the treatment plan

While the form provides information related to their attendance, UDS, and treatment compliance the overall reporting takes a ***compliance*** or ***non-compliance*** format.

MGTS Compliance Form

Patient is compliant with the treatment plan as of today:

☐ Patient attended office visits as scheduled and planned. _____

Date

_____

Date

☐ Patient is taking all medication(s) as prescribed.

☐ Patient is complying with monitoring as required.

Patient has made the following progress towards the goals of treatment: _____

_____

UDS results are **NOT** shared with the courts!

MGTS Compliance Form

Patient has struggled to comply with the following elements of treatment:

☐ Patient missed office visits as scheduled and planned on: _____

Date

_____

Date

☐ Patient has not taken all medication(s) as prescribed.

☐ Patient has not complied with all monitoring as required.

☐ Despite multiple attempts to reach patient, we have not been able to establish a successful treatment regimen or office visit schedule.

Other comments on Patient's compliance: _____

UDS results are **NOT** shared with the courts!

Medical Guided Treatment Supervision

If a patient determines they are not interested in treatment or is non-compliant, they will simply revert to default of pretrial supervision as determined by the court.

When the case is closed, the patient may voluntarily continue or terminate treatment.

The patient may also agree to continue MGTS as part of their sentencing.

Case 1: What Happened to John?

John - 57
AUD

- Entered MGTS, underwent treatment for alcohol withdrawals in inpatient setting after 4th outpatient visit.
- Engaged in MAT treatment plan, taking naltrexone, acamprosate and gabapentin in the outpatient setting.

Case 1: What Happened to John?

John - 57
AUD

- Resumed MGTS as part of sentencing, along with additional probation requirements; return to use prevention groups and DBT.
- Remained in remission from AUD, with only brief return to use over the holidays.
- Engaged in care total of 10 months!

Case 1: What Happened to John?

John - 57
AUD

- A year after initial intake, patient was driving by and “thought I should stop in”
- No longer court ordered to continue but wanted to have naltrexone on hand for the future and wanted to check on his blood pressure.

Case 1: Successes

- Earlier introduction to treatment.
- Allowance of harm reduction approach early in the process, as UDS results are not shared with the court system.
- Preventing likelihood of patient withdrawing in jail setting.
- Ability to form therapeutic relationship prior to sentencing, increasing likelihood of follow up afterwards.
- 58% (18/31) of patients followed up in clinic after they were through with the pre-trial period!

Case 1: Limitations

- Requires a judge and court system willing to forgo UDS.
- Bolstered by regional care coordinators.
- Requires patients to be insured or able to pay sliding scale.
- Some patients are presenting solely because they think it will help improve their outcome in court, and are not ready to engage meaningfully in discussion surrounding substance use.
- Patients are more likely to falsify UDSs.
- If a patient understands that their UDSs are not shared with the courts there is the potential for heavier substance use.

Case 2: Introduction

- Presents from Denver Reception & Diagnostic Center (DRDC) to continue MOUD.
- Hx OUD since 23yo, IVDU heroin and inhalation of fentanyl “blues” with history of overdose.
- Hx comorbid methamphetamine use
- Incarcerated since 2021, started on MOUD in Nov. 2024: taking buprenorphine/naloxone 8/2mg SL daily, reports high cravings nearing release date, nighttime withdrawal symptoms: sweats, restless leg, insomnia.
- Will be released to Aurora, CO in 2 weeks. Accepted into Sober Living.
- Parole x 2 years.

Jane

35 yr old Female

Poly Substance

Case 2: Discussion

What barriers to care might Jane experience after release?

Case 2: Discussion

How could a medical provider improve access to care and likelihood of patient follow-up?

Case 2: Discussion

If Jane ***had not yet started MOUD*** during incarceration, how could a medical provider help "bridge the gap" and decrease risk of return to use or overdose?

Department of Corrections In-Reach

- Colorado Department of Corrections (DOC) MAT In-Reach Program
- DOC partners with treatment providers to enable patients to establish care with an outpatient clinic prior to release from incarceration
- Goals:
  - Improve continuity of care
  - Decrease risk of return to use or overdose
  - Impact recidivism

Case 2: What Happened to Jane?

Jane
35 yr old Female
Poly Substance

- Jane was released from DOC and received a 30 day Rx for buprenorphine/naloxone 8/2mg SL daily. She increased her dose to 16mg daily due to high cravings before follow up.

- She followed up in clinic 1 week later after getting a pass from sober living, where MOUD was continued. Jane did not experience any return to use after release.

Case 2: Successes

- Continuity of MOUD and establishment of a relationship prior to release
- Jane has contact information & a date/time for community based follow-up
- Opportunity to decrease risk of RTU and OD
- Schedule appointment for the day after release to support transition
- Using a virtual platform improves access to care

Case 2: Outcomes

DOC InReach Partnership Outcomes

DOC InReach Pts seen 2023 - 2024

Total # DOC InReach Pts seen	% of Pts engaged Prior to DOC InReach	% of Pts attending Community F/U Appt
261	17%	55%

Service Line Engagement of Pts attending Community F/U Appts after DOC InReach

MAT			Psych			BH		
# of Pts	% of Pts	# of Visits	# of Pts	% of Pts	# of Visits	# of Pts	% of Pts	# of Visits
142	99%	974	34	24%	112	52	36%	110

Case 2: Testimony

"...DOC In-Reach provides **continuity of care** for clients with Opioid Use Disorder (OUD)... Our goal was to **ensure that clients leaving prison had connected with a community agency** and had treatment appointments scheduled and prescriptions available to them upon release…

The clients are provided with **an appointment within 7 days after they are released from prison**… We have gotten very positive feedback from our DOC clients and our DOC staff. This endeavor has been a great partnership and has **enabled us to serve hundreds of clients in need of community care for OUD**."

- *CO Department of Corrections Representative*

Case 2: Limitations

- Patients' parole location may impact access to care
- Transportation to follow up visit due to housing status & support
- Some re-entry plans having restrictions, emphasizing importance of bridge prescription
- A DOC Social Worker must chaperone the visit
- Cannot do inductions while incarcerated, medication must be received from external pharmacy

Case 3: Introduction

Dave
36 yr old Male
OUD

- Frequently lost to follow up in outpatient MAT setting
- Frequent positive UDS results with parole/probation, primarily using fentanyl “blues”
- Hx OUD since 17 with IVDU of opioids and stimulants periodically for greater than 15 years
- hx comorbid methamphetamine use
- Lengthy hx of criminal justice involvement with incarceration, parole, and probation.
- Mandated to 90-day Intensive Residential Treatment (IRT) program in rural CO

Case 3: Discussion

Patients are only seen via telehealth.

How can the provider build a trusting relationship with Dave during treatment & encourage follow-up upon discharge?

Case 3: Discussion

Keeping in mind the rural nature of the facility & his discharge location, what barriers to care do you anticipate for Dave?

Case 3: Discussion

How do Dave & his cohort benefit from the accessibility of MAT/MOUD in IRT & transitional programs?

Case 3: Advantage Treatment Centers (ATC)

- An intensive residential treatment (IRT) program that provides intensive short-term treatment for 90 days
  - Also offers a long term residential side (Halfway House) for longer court ordered sentences, and a sober living facility.
- Clients are admitted through the criminal justice system.
  - Intake process must be initiated by probation or parole
  - Clients cannot volunteer to enroll in the program.
- Sterling facility has 128 beds, co-ed
  - Additional facilities in Alamosa & Lamar (both rural communities)

Case 3: What happened to Dave?

Dave
36 yr old Male
OUD

- Upon graduation from IRT, Dave transitioned to the facility's sober living. Dave lived in sober living and worked in the rural area for ten months until marrying a local resident.

Case 3: What happened to Dave?

Dave
36 yr old Male
OUD

- After marriage, he moved to a further remote area until problems with the criminal justice system placed him back into treatment in the urban area.
- With the exception of two RTU, Dave's MOUD remained stable for 23 months with long acting injectable (LAI) and oral combination buprenorphine/naloxone product.

Case 3: Successes

- Collaborative team with a primary facility POC and use of one local pharmacy
- Pharmacy is aware of facility prescribing restrictions
- Collaboration between medical provider, psych provider, and lead case manager encourages engagement while enrolled in the program
- Supported transition to community based clinic upon completion, utilizing pop-up clinics in rural area.

Case 3: Partner Testimony

“This seamless service **responds directly to the transitional needs of clients** entering and leaving our inpatient and Community Corrections programs.”

“The ability for clients to begin MAT services in jail and transition smoothly into our IRT program without interrupting medication management has been crucial. This **eliminates withdrawal or post-acute withdrawal symptoms during early, intensive programming phases.** Similarly, clients entering our programs directly from the community can establish MAT services immediately and experience the same benefits”

Case 3: Partner Testimony

"This **removal of barriers to program engagement improves positive outcomes** after graduation. When MAT services continue after discharge, and clients remain connected to psychosocial care, their **long-term sobriety is more secure, and recidivism risk is reduced**."

Their understanding of criminal behavior and timely, tailored services have been essential to **maintaining policies that protect both our clients and communities** by reinforcing prosocial lifestyles and beliefs. Other specific benefits we have observed include facilitating use of **[long acting buprenorphine] injectables which eases overall medication management needs**, and more immediate psychiatric stabilization which also **improves early and ongoing effective engagement**."

- *ATC Director of Treatment Operations*

Case 3: Limitations

- The facility has prescribing limitations
- Gaps in care after graduation from the inpatient program:
  - Transportation limitations in rural areas
  - Substance use in the rural community they are discharged to
  - Lack of support system in rural area if most of their support system remains in the urban areas

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Final Takeaways/Summary

Partnerships along the criminal justice continuum can be leveraged to successfully:

- decrease time to treatment access
- optimize continuity of care and minimize disruption of access
- practice harm reduction
- optimize transitions of care

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