TREATMENT OF OPIOID USE DISORDER IN LOS ANGELES COUNTY JAILS

INCREASING ACCESS TO BUPRENORPHINE FOR MEDICATION-ASSISTED TREATMENT

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EXECUTIVE SUMMARY

Opioid use disorder is a chronic condition that can manifest as the inability to control or limit one's opioid use. One devastating outcome of opioid use disorder if left untreated is death by overdose. This terrible outcome is unfortunately common across the United States where 130 individuals die each day due to an opioid-related overdose. Individuals in correctional facilities such as prisons and jails are disproportionately at risk for dying from an opioid overdose upon release because of decreased opioid tolerance following a period of forced abstinence. Correctional health providers are on the frontline of the opioid crisis and play an important role in preventing overdose deaths within justice-involved populations. The treatments that have been shown to most effectively treat opioid use disorder are methadone and buprenorphine. Nevertheless, less than one percent of correctional facilities across the United States provide access to these medications for the treatment of opioid use disorder.

Our client, the Drug Policy Alliance, is a drug policy advocacy organization that seeks to increase access to evidence-based treatments such as methadone and buprenorphine for the treatment of opioid use disorder throughout the United States. Drug Policy Alliance is particularly interested in advocating for increased treatment access to marginalized populations including justice-involved individuals. Therefore, the Drug Policy Alliance has asked us to answer the following policy question: *What are the significant barriers to buprenorphine treatment in LA County jails, and what policy strategies can Drug Policy Alliance utilize to overcome these barriers?*

To answer this question, we reviewed relevant literature, conducted an evidence synthesis to rank the quality of the reviewed literature, and interviewed 20 stakeholders within the correctional health system. Our analysis yielded five major barriers to buprenorphine treatment within the LA County jail system:

1. The LA County jail system does not track opioid use disorder data within the jails,
2. There is a lack of access to accurate information about opioid use disorder and buprenorphine treatment,
3. There is stigma against opioid users and buprenorphine treatment among correctional health and substance use disorder treatment staff,
4. There is a lack of funding to support buprenorphine treatment in the jails, and
5. There needs to be sufficient access to buprenorphine treatment in the community for justice-involved individuals upon release.

We then created a four-step framework of policy advocacy to address the existing barriers to buprenorphine treatment in LA County jails:

Step 1 – utilize data to understand the magnitude of the problem,
Step 2 – provide education about opioid use disorder and buprenorphine treatment to increase buy-in and address stigma,
Step 3 – increase funding for a buprenorphine treatment program in the jail, and
Step 4 – launch a pilot buprenorphine treatment program targeted to individuals at high risk for overdose.

Using this stepwise framework as a guide, we then provide Drug Policy Alliance with a comprehensive list of local, state, and federal policy recommendations and advocacy strategies for increasing access to buprenorphine treatment. Among these recommendations include: piloting a study to estimate the prevalence of opioid use disorder in LA County jails, providing accurate and non-judgmental education about opioid use disorder and buprenorphine maintenance treatment to all jail staff, increasing oversight of how LA County medication-assisted treatment funding is allocated in the jails, and pushing for the creation of a LA County jail system buprenorphine implementation plan with a clear timeline for when buprenorphine will be available to all who could benefit from treatment. We provide analysis of these recommendations using the criteria of political and administrative feasibility for Drug Policy Alliance to consider when developing their advocacy efforts. We hope that our recommendations will be a valuable roadmap to guide Drug Policy Alliance's advocacy and that our findings support both the LA County jail system and jail systems throughout the United States to increase access to buprenorphine treatment.

GLOSSARY

12-Step Programs: A peer-led substance use disorder treatment program that follows a set of guiding principles including support, service, and abstinence-focused recovery.[1]

Abstinence: Abstinence-based treatment refers to a recovery model that emphasizes for individuals to stop all drug and alcohol use.[2] Arguments for abstinence-based treatments are sometimes used to discourage the use of medications for the treatment of opioid use disorder.[3]

Addiction: "A chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain."[4]

Correctional Settings: "Jails and detention centers, prisons, and community supervised settings."[5]

Dependence: "A condition that can occur with the regular use of illicit or some prescription drugs, even if taken as prescribed. Dependence is characterized by withdrawal symptoms when drug use is stopped. A person can be dependent on a substance without being addicted, but dependence sometimes leads to addiction."[6]

Detoxification: "A process in which the body rids itself of a drug, or its metabolites. Medically assisted detoxification may be needed to help manage a person's withdrawal symptoms. Detoxification alone is not a treatment for substance use disorders, but this is often the first step in a drug treatment program."[7]

Diversion: "The transfer of a legally prescribed controlled substance, including medications for opioid use disorder (OUD), from the person for whom it was prescribed to another person for any illicit use."[8]

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1. Providers Clinical Support System. 2017. "Benefits of 12-step programs for opioid addiction." https://pcssnow.org/resource/benefits-12-step-programs-opioid-addiction/.
2. Yngvild Olsen, "Ask the PCSS-MAT Experts: Addressing Challenging Issues in Addiction Medicine: "Abstinence Based" Treatment Centers," last modified April 10, 2015, https://www.asam.org/Quality-Science/publications/magazine/read/article/2015/04/10/abstinence-based-treatment-centers.
3. Olsen.
4. National Institute on Drug Abuse. 2018. "Glossary." https://www.drugabuse.gov/publications/media-guide/glossary.
5. Center for Substance Abuse Treatment. 2005. Treatment Improvement Protocol (TIP) Series 44. Substance Abuse and Mental Health Services Administration (Rockville, MD).
6. National Institute on Drug Abuse, "Glossary".
7. National Institute on Drug Abuse, "Glossary".
8. Office of the Surgeon General. 2016. Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. U.S. Department of Health and Human Services (Washington, DC).

Drug Addiction Treatment Act of 2000 (DATA 2000) Waiver: Also referred to as the DATA 2000 waiver or the X-waiver. Eligible practitioners must receive this waiver in order to be able to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000.[9]

Drug Court: The Drug Court program is a 6-9 months, court monitored, "comprehensive treatment and rehabilitation program" that involves individual and group psychosocial substance use treatment services and case management services.[10]

Evidence-based Practice: "The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[11]

Harm Reduction: "A set of ideas and interventions that seek to reduce the harms associated with both drug use and ineffective, racialized drug policies."[12]

Jail: "A place for holding a person in lawful custody, usually while he or she is awaiting trial. In some jurisdictions, jails are used punitively for offenders serving short-term sentences or those involving work release or weekends in incarceration. Jails range in size from small rural ones with a dozen or so cells to urban settings with thousands of cells. Jails usually are operated by cities or counties."[13]

Justice-involved: "This descriptor indicates past or current involvement in the criminal justice system, typically indicating the person has experienced one or more of the following: an arrest, prosecution, incarceration in a jail or prison, and/or community supervision."[14]

Level I Evidence: "An experiment study, randomized controlled trial (RCT), explanatory mixed methods with only level I quantitative study, or systematic review of RCTs, with or without meta-analysis."[15]

Level II Evidence: "A quasi-experimental study, explanatory mixed methods with only level II quantitative study, or systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without

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9. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 100.
10. County of Los Angeles Probation, "Drug Court Program," accessed January 10, 2020, https://probation.lacounty.gov/drug-court-program/.
11. Substance Abuse and Mental Health Services Administration (SAMHSA). 2019. Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide. SAMHSA (Rockville, MD: Planning Office of Policy, and Innovation.).
12. Drug Policy Alliance. 2020. "Harm Reduction." http://www.drugpolicy.org/issues/harm-reduction.
13. Center for Substance Abuse Treatment. TIP Series 44.
14. SAMHSA. Principles of Community-based Behavioral Health Services for Justice-involved Individuals
15. Dang, D., & Dearholt, S. L. (2017). Johns Hopkins nursing evidence-based practice: Model and guidelines. Sigma Theta Tau, 130.

meta-analysis."[16]

Level III Evidence: "A quantitative nonexperimental study; explanatory mixed methods with only level III quantitative study; exploratory, convergent, or multiphasic mixed methods studies; systematic review of a combination of RCTs, quasi-experimental, and nonexperimental studies, or nonexperimental studies only; or qualitative study or systematic review of qualitative studies, with or without a meta-analysis."[17]

Level IV Evidence: "Opinion of respected authorities and/or nationally recognized expert committees or consensus panels based on scientific evidence."[18]

Level V Evidence: Evidence based on experiential and non-research including integrative reviews, literature reviews, quality improvement efforts, case reports, or the opinion of recognized experts based on experiential evidence.[19]

Maintenance Therapy/Treatment: "Providing medications to achieve and sustain clinical remission of signs and symptoms of OUD and support the individual process of recovery without a specific endpoint."[20]

Medication-Assisted Treatment: "US Food and Drug Administration (FDA)-approved medications for the treatment of a specific substance use disorder, typically used in combination with clinically indicated behavioral or cognitive behavioral counseling and other indicated services."[21]

Opioid: "All natural, synthetic and semi-synthetic substances that have effects similar to morphine."[22]

Opioid Agonist Medication: A medication that binds to and activates opioid receptors in the body.[23] Examples of opioid agonist medications include methadone and buprenorphine.

Opioid Antagonist Medication: "A substance that has affinity for opioid receptors in the central nervous system and prevents a physiological response."[24]

Opioid Treatment Programs: "An accredited treatment program with Substance Abuse and Mental Health Services Administration (SAMHSA) certification and Drug Enforcement Administration (DEA) registration to administer and dispense

16. Dang, 130.
17. Dang, 130.
18. Dang, Appendix D.
19. Dang, Appendix D.
20. SAMHSA. TIP Series 63.
21. Substance Abuse and Mental Health Services Administration (SAMHSA). 2019. Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings. Substance Abuse and Mental Health Services Administration (Rockville,MD: National Mental Health and Substance Use Policy Laboratory).
22. SAMHSA. TIP Series 63.
23. National Institute on Drug Abuse, "Glossary".
24. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 101.

opioid agonist medications approved by the FDA to treat opioid addiction. Opioid treatment programs must provide adequate medical, counseling, vocational, educational and other assessment and treatment services either onsite or by referral to an outside agency or practitioner through a formal agreement."[25]

Opioid Use Disorder: "A disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance and withdrawal."[26]

Prison: "A secured institution (Federal or State) in which convicted felons are confined after sentencing for crimes. Prisons are classified as minimum-, medium-, or maximum-security facilities, based on the need for internal institutional fortification. Inmates are similarly classified, according to severity of offense and/or other behavior and are usually assigned to prisons having a corresponding level of security."[27]

Probation: "A criminal sentence enabling an individual supervised in the community rather than incarcerated in jail or prison."[28]

Psychosocial Treatments: "Services that support and enhance a patient's overall functioning and well-being, including services related to recovery support, case management, housing, education and employment."[29]

Recidivism: "Criminal acts that resulted in re-arrest, reconviction or return to prison with or without a new sentence during a three-year period following the prisoner's release."[30]

Schedule I Drug: "No currently accepted medical use and a high potential for abuse"[31]

Schedule II Drug: "High potential for abuse, with use potentially leading to severe psychological or physical dependence."[32]

Schedule III Drug: "Moderate to low potential for physical and psychological dependence"[33]

Schedule IV Drug: "Low potential for abuse and low risk of dependence"[34]

Schedule V Drug: "Lower potential for abuse than Schedule IV and consist of

25. SAMHSA. TIP Series 63.
26. SAMHSA. TIP Series 63.
27. Center for Substance Abuse Treatment. TIP Series 44.
28. Center for Substance Abuse Treatment. TIP Series 44.
29. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 102.
30. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 103.
31. United States Drug Enforcement Administration (DEA). "Drug Scheduling". https://www.dea.gov/drug-scheduling
32. DEA.
33. DEA.
34. DEA.

preparations containing limited quantities of certain narcotics."[35]

Service Planning Area: "A specific geographic region within Los Angeles County" as defined by the Department of Public Health.[36] "These distinct regions allow the Department of Public Health to develop and provide more relevant public health and clinical services targeted to the specific health needs of the residents in these different areas."[37]

Substance Use Disorder: "A medical condition involving a physical and/or psychological dependence on one or more substances, such as a drug or alcohol. "Polysubstance use" is often used to describe use of more than one type of drug by a person with SUD."[38]

Withdrawal: "Symptoms experienced after discontinuing the use of a substance to which a person has become addicted. These symptoms can have both physical and emotional effects, ranging from nausea and vomiting to anxiety and depression. Withdrawal symptoms may lead a person to use the substance again."[39]

35. DEA.
36. Los Angeles County Department of Public Health. 2020. "Service Planning Areas." http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm.
37. Los Angeles County Department of Public Health, "Service Planning Areas."
38. Center for Substance Abuse Treatment. TIP Series 44.
39. SAMHSA. TIP Series 63.

ACRONYMS

AB 109: Assembly Bill 109

ADA: Americans with Disabilities Act

ASAM: American Society of Addiction Medicine

BOS: Los Angeles County Board of Supervisors

CBT: Cognitive Behavioral Therapy

CDC: United States Centers for Disease Control and Prevention

CDCR: California Department of Corrections and Rehabilitation

CHS: Los Angeles County Correctional Health Services

CRDC: Century Regional Detention Center

DATA 2000: Drug Addiction Treatment Act of 2000

DEA: Drug Enforcement Administration

DHS: Los Angeles County Department of Health Services

DOC: Department of Corrections

DPA: Drug Policy Alliance

DPH: Los Angeles County Department of Public Health

EBP: Evidence-Based Practice

FDA: United States Food and Drug Administration

HHS: United States Department of Health and Human Services

HIV: Human Immunodeficiency Virus

ICRP: In Custody to Community Re-entry Program

IV: Intravenous

JHEBP: Johns Hopkins Nursing Evidence-Based Practice Model

LASD: Los Angeles Sheriff's Department

MAT: Medication-Assisted Treatment

MCJ: Men's Central Jail

NCCHC: National Commission on Correctional Health Care

NCCF: North County Correctional Facility

NIDA: National Institute on Drug Abuse

OAT: Opioid Agonist Therapy

ODR: Los Angeles County Office of Diversion and Reentry

OUD: Opioid Use Disorder

PDC-E: Pitchess Detention Center – East

PDC-N: Pitchess Detention Center – North

PDC-S: Pitchess Detention Center – South

RIDOC: Rhode Island Department of Corrections

SAMHSA: Substance Abuse and Mental Health Services Administration

SAPC: Substance Abuse Prevention and Control Division, Los Angeles County Department of Public Health

SPA: Service Planning Area

START: Substance Treatment and Re-entry Transition Program

SUD: Substance Use Disorder

TTCF: Twin Towers Correctional Facility

WPC-LA: Whole Person Care Los Angeles

XR-NTX: Extended release injectable naltrexone

INTRODUCTION

Opioid use disorder (OUD) refers to a pattern of opioid use that results in "clinically significant impairment or distress" in an individual over a 12-month period.[40] One manifestation of OUD is the inability to decrease or control one's opioid use, which can lead to the devastating outcome of death by overdose.[41] In 2017, the U.S. Department of Health and Human Services (HHS) declared a public health emergency (also referred to as the "Opioid Epidemic" or "Opioid Crisis") in response to the growing number of opioid overdose deaths throughout the country.[42] It is estimated that over 130 individuals die every day in the U.S. from an opioid-related overdose.[43] Justice-involved individuals, including individuals in jails and prisons, are disproportionately at risk for suffering from OUD and dying from an opioid-related overdose.[44] This puts correctional health providers on the frontline of the crisis, and offers an opportunity to intervene with a vulnerable and at-risk population.[45]

The most effective treatment modality for OUD is commonly referred to as medication-assisted treatment (MAT).[46] MAT includes the use of U.S. Food and Drug Administration (FDA)-approved medications including buprenorphine, methadone, and extended release injectable naltrexone (XR-NTX) for OUD treatment.[47] There is consensus in the literature that buprenorphine and methadone are the most effective treatment options for OUD, while naltrexone is effective for opioid relapse prevention in those who have undergone opioid withdrawal.[48] Despite the urgent need for MAT and the evidence that supports its effectiveness, less than one percent of prisons and jails in the United States provide access to these medications.[49] The California Department of Health Care

40. American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub, 2013; Opioid use disorder replaced terminology in the DSM-IV such as "Opioid Abuse" and "Opioid Dependence."
41. APA. DSM-5.
42. United States Department of Health and Human Services (HHS). 2019. "What is the U.S. Opioid Epidemic?" https://www.hhs.gov/opioids/about-the-epidemic/index.html
43. HHS. "Opioid Epidemic".
44. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 8; SAMHSA. Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings, 8.
45. National Council for Behavioral Health, 8.
46. Schuckit, Marc A. "Treatment of opioid-use disorders." New England Journal of Medicine 375, no. 4 (2016): 361; Center for Substance Abuse Treatment. 2005. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs (TIP) Series 43. Substance Abuse and Mental Health Services Administration (Rockville, MD), 3-4; National Council for Behavioral Health, 8.
47. United States Food and Drug Administration (FDA). 2019. "Information about medication-assisted treatment (MAT)". https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat.
48. Allen, Bennett, Michelle L. Nolan, and Denise Paone. "Underutilization of medications to treat opioid use disorder: What role does stigma play?." Substance abuse 40, no. 4 (2019): 459; Comer, Sandra, Chinazo Cunningham, Marc J. Fishman, FASAM Adam Gordon, FASAM Kyle Kampman, Daniel Langleben, Ben Nordstrom et al. "National practice guideline for the use of medications in the treatment of addiction involving opioid use." American Society for Addiction Medicine. 66 (2015), 23.
49. Brezel, Emma R., Tia Powell, and Aaron D. Fox. "An ethical analysis of medication treatment for

Services has worked to address this need through the implementation of the California Medications for Addiction Treatment Expansion Project.[50] One component of this project is the MAT in County Criminal Justice Systems Learning Collaborative.[51] The collaborative has provided 29 California counties, including Los Angeles (LA) County, with funding and technical support to expand access to at least two MAT medications in their jails and drug court systems.[52] LA County, however, has yet to expand access to MAT within their jail system.[53]

Among the FDA-approved medication options, buprenorphine has been underutilized in community and correctional treatment settings despite federal laws that were intended to make the medication more accessible.[54] Buprenorphine, unlike methadone, can be prescribed in outpatient settings and in correctional facilities by practitioners who have received a federal waiver (referred to as the "X-waiver") demonstrating that they have received specialized training on buprenorphine.[55] Our client, the Drug Policy Alliance (DPA), has been advocating for policies that will increase access to buprenorphine for all individuals who can benefit from the treatment.[56] In this report, we seek to identify barriers to buprenorphine treatment in the LA County jail system and provide policy recommendations to inform our client's advocacy efforts.

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opioid use disorder (MOUD) for persons who are incarcerated." Substance Abuse (2019): 1-5.
50. Health Management Associates. (2020). Addiction Free California: A MAT Expansion Website. https://addictionfreeca.org/
51. Health Management Associates. (2020). "Expanding Access to MAT in County Criminal Justice Setting". Addiction Free California: A MAT Expansion Website. https://addictionfreeca.org/California-MAT-Expansion-Project/Expanding-Access-to-MAT-in-County-Criminal-Justice-Settings.
52. Health Management Associates, "Expanding MAT".
53. California Health Care Foundation. 2018. "Closing the Loop in Treating Opioid Addiction: Integrating MAT into Prison and Jail Health Systems". https://www.chcf.org/wp-content/uploads/2018/05/WebinarClosingLoopMATCorrections05092018.pdf.
54. Allen, Bennett, Michelle L. Nolan, and Denise Paone. "Underutilization of medications to treat opioid use disorder: What role does stigma play?." Substance abuse 40, no. 4 (2019): 459-465; Valenstein-Mah, Helen, Hildi Hagedorn, Chad L. Kay, Melissa L. Christopher, and Adam J. Gordon. "Underutilization of the current clinical capacity to provide buprenorphine treatment for opioid use disorders within the Veterans Health Administration." Substance abuse 39, no. 3 (2018): 286-288.
55. Substance Abuse and Mental Health Services Administration (SAMHSA). 2019. "Buprenorphine". https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine; Methadone can only be prescribed and dispensed in federally regulated clinics called opioid treatment programs.
56.Drug Policy Alliance. (2020). "Drug Replacement and Maintenance Therapy." https://www.drugpolicy.org/issues/drug-replacement-and-maintenance-therapy.

CLIENT

Our client is Sheila P. Vakharia, PhD, the Deputy Director of the Department of Research and Academic Engagement at DPA.[57] DPA is a 501(c)(3) nonprofit drug policy advocacy organization whose advocacy initiatives span the local, state, and federal levels across the U.S.[58] The Department of Research and Academic Engagement is located in New York City where DPA's headquarters is located.[59] DPA seeks to advance drug policies that reduce criminalization, promote health and well-being, empower communities, and ensure access to accurate and non-judgmental drug treatment and education.[60] DPA's Department of Research and Academic Engagement utilizes innovative and evidence-based research to advance advocacy, shape policy platforms, and develop relationships with scholars and advocates in the field.[61] DPA believes that evidence-based treatments such as buprenorphine save lives by reducing drug use and overdose deaths.[62] DPA has asked us to identify the most significant barriers to buprenorphine treatment in LA County jails and to provide a comprehensive list of policy recommendations and advocacy strategies that they can deploy to increase access to buprenorphine in jail settings and to reduce disparities in treatment access among justice-involved individuals.

57. Drug Policy Alliance. (2020). "Sheila P Vakharia, PhD". https://www.drugpolicy.org/sheila-p-vakharia-phd.
58. Drug Policy Alliance. 2018 Annual Report. Drug Policy Alliance (New York, NY). https://www.drugpolicy.org/sites/default/files/dpa-annual-report-2018_0.pdf, 3.
59. Drug Policy Alliance. (2020). "Departments & State Offices". http://www.drugpolicy.org/about-us#departments-state-offices.
60. Drug Policy Alliance. 2020. "Vision & Mission." http://www.drugpolicy.org/about-us#vision-mission.
61. Drug Policy Alliance. 2020. "Staff & Board." http://www.drugpolicy.org/about-us#staff-board.
62. Drug Policy Alliance. 2020. "Drug Overdose." http://www.drugpolicy.org/issues/drug-overdose.

POLICY QUESTION

What are the significant barriers to buprenorphine treatment in LA County jails, and what policy strategies can Drug Policy Alliance utilize to overcome these barriers?

OVERVIEW OF REPORT

In this report, we first provide background information on OUD, the opioid crisis and its effects in criminal justice settings, treatments for OUD, and access to evidence-based treatments within jail settings. We will then present the methodology for our data collection and analysis and provide a detailed summary of our findings, including the main barriers to buprenorphine treatment in the LA County jail system. Finally, we will present our policy recommendations and policy analysis for how DPA can advocate for increasing access to buprenorphine in jail settings throughout the U.S.

BACKGROUND

Public health officials rely on non-fatal and fatal overdose data to estimate the burden of the opioid crisis in the U.S. According to the Centers for Disease Control and Prevention (CDC), from 1999 to 2017 the total number of opioid overdose deaths across the U.S. was approximately 400,000.[63] From 2016 to 2017, opioid overdoses increased by 30%, with the majority of these deaths attributed to more potent synthetic opioids such as fentanyl (frequently illicitly manufactured).[64] The CDC estimates that an average of 130 people die each day in the U.S. from an opioid-related overdose.[65]

The increase in opioid overdose deaths in the U.S. has taken place in a series of three distinct waves (see Figure 1).[66] The first wave started in the 1990s with an increase in prescription opioids.[67] During this time prescription opioids were misrepresented by pharmaceutical companies as non-addictive.[68] The second wave began in 2010 with a rise in heroin overdose deaths.[69] The third, present-day wave commenced in 2013 with a significant rise in overdose deaths related to synthetic opioids including illicitly-manufactured fentanyl.[70] The current wave has been increasingly fatal because of the extraordinary potency of synthetic opioids. Fentanyl is up to 100 times more potent than morphine and illicitly-manufactured fentanyl is often mixed with other drugs, including cocaine, heroin, and counterfeit pills, sometimes without a user's knowledge.[71]

63. United States Center for Disease Control and Prevention (CDC). 2018. "Opioid Overdose Basics". https://www.cdc.gov/drugoverdose/epidemic/index.html
64. National Institute on Drug Abuse. 2020. "Opioid Overdose Crisis". https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis; Wenger, Lynn D, David Showalter, Eliza Wheeler, Jennie Harris, Ingrid Binswanger, Barrot H. Lambdin, and Alex H. Kral. 2019. A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons. RTI International.
65. NIDA, "Opioid Overdose Crisis"; Wenger, Overdose Education.
66. CDC, "Opioid Overdose"; SafeMed LA: Prescription Drug Abuse Coalition Los Angeles County. (n.d.). "Drug Overdose Deaths". https://insight.livestories.com/s/v2/overdose-deaths-opioid-abuse-in-la-county/1dad2eb7-0134-4a55-9a3b-5a41720d8af9.
67. CDC ,"Opioid Overdose"
68. Jones, Greg H., Eduardo Bruera, Salahadin Abdi, and Hagop M. Kantarjian. "The opioid epidemic in the United States—Overview, origins, and potential solutions." Cancer 124, no. 22 (2018): 4279-4286.
69. CDC, "Opioid Overdose"
70. CDC, "Opioid Overdose"
71. CDC, "Opioid Overdose"; CDC National Center for Injury Prevention and Control. 2017. Prescription Behavior Surveillance System (PBSS) Issue Brief: Increase in overdose deaths involving synthetic opioids other than methadone linked to increase in supply of fentanyl in PBSS states. (Brandeis University).

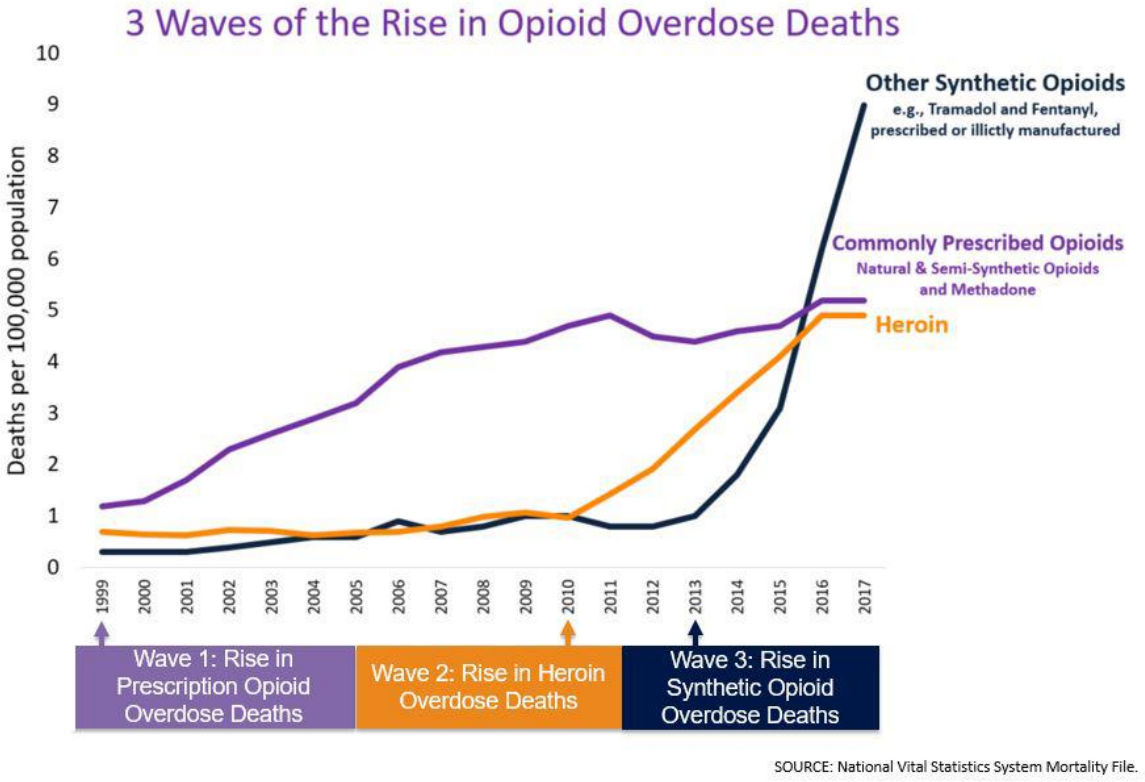

Figure 1.Three waves of opioid overdose deaths in the United States[72]

72. CDC, "Opioid Overdose".

THE OPIOID OVERDOSE CRISIS IN CALIFORNIA AND LOS ANGELES COUNTY

California and LA County have seen similar opioid overdose death trends as illustrated in the three waves above, but on a smaller scale (see Figures 2 and 3).[73] Although opioid overdose deaths slightly decreased in the U.S. from 2017 to 2018, LA County saw a continued increase during that time.[74] Since 2015, LA County has also experienced stark increases in the number of opioid overdose deaths related to synthetic opioids.[75]

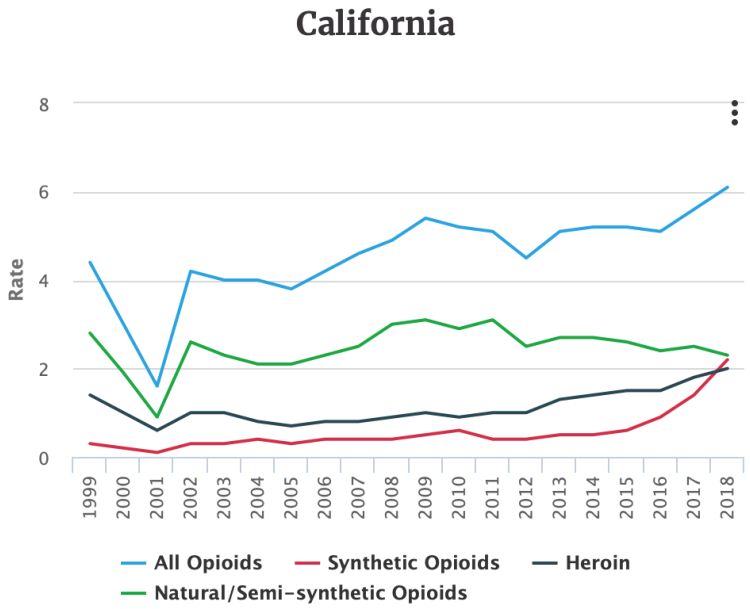

Figure 2. Rate of opioid overdose deaths per 100,000 by opioid type,1999-2018 in California [76]

73. SafeMed LA, "Drug Overdose Deaths".
74. SafeMed LA, "Drug Overdose Deaths".
75. SafeMed LA, "Drug Overdose Deaths".
76. SafeMed LA, "Drug Overdose Deaths".

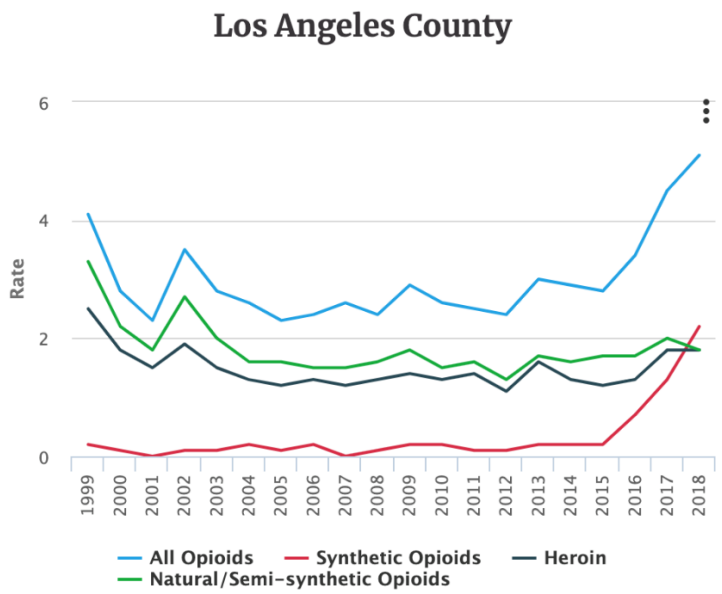

Figure 3. Rate of opioid overdose deaths per 100,000 by opioid type 1999-2018 in Los Angeles County [77]

The LA County Coroner reported 587 opioid-related deaths in 2018.[78] The areas of the County most impacted by the crisis have been the Antelope Valley region (designated by LA County as Service Planning Area (SPA) 1) with an opioid overdose death rate of 6.4 per 100,000 and the Metro region (SPA 4) with an opioid overdose death rate of 6.0 per 100,000 (see Figure 4).[79]

77. SafeMed LA, "Drug Overdose Deaths".
78. SafeMed LA, "Drug Overdose Deaths".
79. SafeMed LA, "Drug Overdose Deaths".

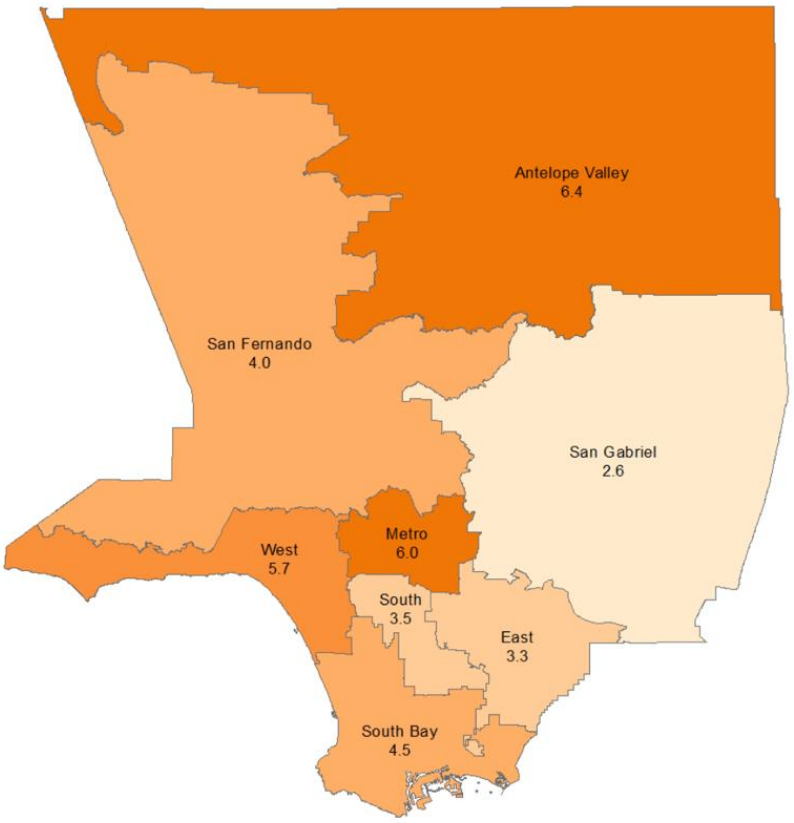

Figure 4. Opioid overdose death rate per 100,000 by Service Planning Area in Los Angeles County, 2018 [80]

80. SafeMed LA, "Drug Overdose Deaths".

CRIMINALIZATION OR COMPASSION? RESPONSES TO THE OPIOID CRISIS IN COMMUNITIES BY RACE

Much of the media attention and academic discourse related to the opioid crisis has focused on its impact in White, rural, and suburban communities and ignored its impact in non-White and other marginalized populations, including justice-involved individuals.[81] Although White populations have seen the most significant increases in opioid-related deaths in the US, the opioid crisis currently and historically has had devastating effects in communities of color.[82] Within California, Native American populations have the highest age-adjusted opioid overdose death rate per 100,000 residents at 13.54, followed by White (9.81) and Black (7.11) populations.[83] In LA County, White populations have the highest death rate at 9.68, followed by Native American (7.09) and Black (5.00) populations.[84]

In 2017, the US Department of Health & Human Services (HHS), under the guidance of President Trump, declared the opioid crisis as a public health emergency.[85] The federal government's response to the current opioid crisis, which has predominantly focused on White communities throughout the US, stands in stark contrast to federal responses to prior drug epidemics in communities of color.[86] Instead of framing drug use and overdose deaths through the lens of public health, as is occurring now, the heroin epidemic of the 1960s – 1970s and the crack-cocaine epidemic of the 1980s – 1990s were framed as crime epidemics and met with harsh drug laws and criminalization targeted in low-income Black communities.[87] The severe drug laws during this time period, known as the War on Drugs, disproportionately devastated communities of color and its impacts are still apparent today.[88]

In 2000, Black individuals were incarcerated for drug-related offenses at 15 times the rate of White individuals.[89] Though the disparity ratio has decreased to

81. James, Keturah, and Ayana Jordan. "The opioid crisis in black communities." The Journal of Law, Medicine & Ethics 46, no. 2 (2018): 404; Netherland, Julie, and Helena Hansen. "White opioids: Pharmaceutical race and the war on drugs that wasn't." BioSocieties 12, no. 2 (2017): 217-238.
82. James, "Opioid Crisis in Black Communities", 404.
83. California Opioid Overdose Surveillance Dashboard. https://skylab.cdph.ca.gov/ODdash/
84. California Opioid Overdose Surveillance Dashboard.
85. United States Department of Health & Human Services. 2017. "HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis". https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html
86. James, "Opioid Crisis in Black Communities", 410-411; Griffith, Clairmont, Bernice La France, Clayton Bacchus, and Gezzer Ortega. "The effects of opioid addiction on the black community." International Journal of Collaborative Research on Internal Medicine & Public Health 10, no. 2 (2018): 843-850.
87. Gostin, Lawrence O., James G. Hodge, and Sarah A. Noe. "Reframing the opioid epidemic as a national emergency." JAMA 318, no. 16 (2017): 1539-1540; James, 410; Griffiths, "Effects of opioid addiction on the black community", 846; Netherland. "White Opioids".
88. James, "Opioid Crisis in Black Communities", 411; Netherland, "White Opioids".
89. Sabol, William J., Thaddeus L. Johnson, and Alexander Caccavale. 2019. Trends in Correctional Control by Race and Sex. Washington, D.C.: Council on Criminal Justice, 8.

4.7 times the rate of White individuals in 2016, racial disparities in the criminalization of drug use continue to persist.[90] When considering policies related to MAT access in jail settings, it is essential to consider the history of drug policies in the U.S. that have punished rather than humanized and uplifted marginalized communities. Increasing access to buprenorphine in jails will decrease unnecessary suffering and save lives.[91]

THE OPIOID CRISIS IN JUSTICE-INVOLVED POPULATIONS

Individuals recently released from jail or prison are approximately 10 to 40 times more likely than the general population to overdose, and 12.7 times more likely to die from a drug-related overdose.[92] In a study conducted in Washington State, drug overdose was the leading cause of death among individuals released from prison, and within the first two weeks of release, the adjusted relative risk of overdose death was 129.[93] Among individuals recently released from North Carolina prisons, the risk of opioid-related overdose death was 40 times higher than other North Carolina residents at 2-weeks post release and 11 times higher at 1-year post release.[94] Risk factors for post-release opioid overdose death during incarceration include forced abstinence from opioid use and lack of access to opioid agonist therapies such as buprenorphine in prisons and jails.[95] Upon release after a period of abstinence, individuals have a reduced tolerance to opioids and disproportionately face individual and environmental stressors such as mental health disorders, poverty, and a lack of access to care.[96] Together these factors contribute to the tragically high rates of opioid overdose deaths among formerly incarcerated populations and highlight systemic failures in our society's ability to care for our most vulnerable populations.

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90. Sabol, 8.
91. Woodruff, Alex E., Mary Tomanovich, Leo Beletsky, Elizabeth Salisbury-Afshar, Sarah Wakeman, and Andrey Ostrovsky. "Dismantling Buprenorphine Policy Can Provide More Comprehensive Addiction Treatment." NAM Perspectives (2019).
92. Pizzicato, Lia N., Rebecca Drake, Reed Domer-Shank, Caroline C. Johnson, and Kendra M. Viner. "Beyond the walls: Risk factors for overdose mortality following release from the Philadelphia Department of Prisons." *Drug and alcohol dependence* 189 (2018): 108-115; Binswanger, Ingrid A., Carolyn Nowels, Karen F. Corsi, Jason Glanz, Jeremy Long, Robert E. Booth, and John F. Steiner. "Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors." *Addiction science & clinical practice* 7, no. 1 (2012): 1.
93. Binswanger, "Return to drug use and overdose". 161.
94. Ranapurwala, Shabbar I., Meghan E. Shanahan, Apostolos A. Alexandridis, Scott K. Proescholdbell, Rebecca B. Naumann, Daniel Edwards Jr, and Stephen W. Marshall. "Opioid overdose mortality among former North Carolina inmates: 2000–2015." *American journal of public health* 108, no. 9 (2018): 1209.
95. Joudrey, Paul J., Maria R. Khan, Emily A. Wang, Joy D. Scheidell, E. Jennifer Edelman, D. Keith McInnes, and Aaron D. Fox. "A conceptual model for understanding post-release opioid-related overdose risk." *Addiction science & clinical practice* 14, no. 1 (2019): 2.
96. Joudrey, 4-6; Wenger, *Overdose Education*, 1.

OVERVIEW OF MEDICATION-ASSISTED TREATMENT

Research, including randomized controlled trials and meta-analyses, shows that MAT is the most effective treatment for opioid use disorder.[97] The three FDA-approved medications for MAT are methadone, buprenorphine, and extended-release injectable naltrexone (XR-NTX).[98] Below is a table comparing the three medications, which are discussed in further detail below.

Medication	Medication Type	How often it is used	How it works
Buprenorphine	Implant	Every 6 months	**Partial opioid agonist, meaning that it binds to the opioid receptor and only produces a partial effect.**
	Injection	Monthly	
	Tablet	Daily	
	Films	Daily	
	Buprenorphine with Naltrexone	Daily	**Combination of a partial opioid agonist and an antagonist.**
Methadone	Liquid Concentrate	Daily	**Full opioid agonist, meaning that it binds to and activates the opioid receptor, but in a safer and controlled fashion.**
	Tablet	Daily	
Naltrexone	Injection	Monthly	**Opioid antagonist, meaning that it blocks activation of the opioid receptor, which prevents a response.**
	Tablets (not FDA Approved)	Daily	
Tablet: Pill that is taken orally **Film**: A film that is taken orally and dissolves under the tongue **Implant:** Placed under the skin in the arm			

Table 1. Medications for the Treatment of Opioid Use Disorder[99]

While we will provide policy strategies that are specific to increasing access to buprenorphine within LA County jails, we support recommendations that all MAT medication options should be available within jail settings so that individuals can make informed treatment decisions in partnership with their healthcare provider.[100]

97. National Academies of Sciences, Engineering, and Medicine. 2018. *Medication-assisted treatment for opioid use disorder: Proceedings of a workshop—in brief.* Washington, DC: The National Academies Press, 1; National Council for Behavioral Health, *MAT in Jails and Prison Toolkit*; Comer, "National Practice Guidelines"; Office of Surgeon General, *Facing Addiction in America,* 21-24.
98. FDA, "Information about MAT".
99. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 12.
100. National Sheriffs' Association (NSA) and National Commission on Correctional Health Care (NCCHC). 2018. *Jail-Based Medication Assisted Treatment*: *Promising Practices, Guidelines and*

METHADONE

Approved by the FDA for MAT in 1972, methadone has historically been the primary form of MAT and remains the most studied and frequently used medication for this purpose. Methadone can be used for the treatment of opioid use disorder (referred to as maintenance therapy) and for the management of opioid withdrawal symptoms.[101] When used for maintenance therapy at a proper dose, methadone reduces opioid cravings, decreases illicit opioid use, and increases substance use treatment retention.[102] FDA regulations require that methadone be dispensed only at specialized treatment centers known as opioid treatment programs (OTPs) because of its designation as a Schedule II drug and concerns about the risk of overdose if taken in an unsupervised environment.[103] OTPs must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), accredited by the National Commission on Correctional Health Care (NCCHC), licensed in their state, and registered with the Drug Enforcement Administration (DEA).[104] In addition to providing medications for OUD, OTPs are required to provide clients with counseling and other behavioral health services.[105]

Resources in the Field, 7.
101. Comer, "National Practice Guidelines", 24.
102. Center for Substance Abuse Treatment, Tip Series 43, 17-18; Substance Abuse and Mental Health Services Administration (SAMHSA). 2020. "Methadone". https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone; Drug Policy Alliance. "About methadone and buprenorphine", 8-9; Brennan, Lawrence V. "Medication for opioid use disorder after nonfatal opioid overdose and mortality." Annals of internal medicine 170, no. 6 (2019); National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 13.
103. DEA, "Drug Scheduling"; Comer, "National Practice Guidelines"; SAMHSA TIP Series 63, 5.
104. Substance Abuse and Mental Health Services Administration (SAMHSA). 2015. "Certification of Opioid Treatment Programs (OTPs)". https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs; National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 30.
105. Substance Abuse and Mental Health Services Administration (SAMHSA). 2020. "Medication and Counseling Treatment". https://www.samhsa.gov/medication-assisted-treatment/treatment

BUPRENORPHINE

Buprenorphine is the first and only Schedule III opioid agonist medication approved for the treatment of OUD.[106] Buprenorphine is a partial opioid agonist, meaning that it activates opioid receptors less intensely than a full agonist and has a plateau effect at higher doses, making it safer than methadone if misused.[107] Like methadone, buprenorphine can be used for maintenance therapy or withdrawal management. Buprenorphine has been shown to reduce illicit opioid use, retain patients in treatment, and have minimal negative side effects.[108] Buprenorphine is available on its own and in combination with naloxone, which works to block the partial opioid agonist effects if misused.[109]

The prescribing and dispensing of buprenorphine are strictly regulated by enacted legislation. The Drug Addiction Treatment Act of 2000 (DATA 2000) established a waiver program designed to increase access to MAT for the treatment of OUD.[110] The waiver (commonly referred to as the X-waiver and overseen by SAMHSA) allows qualifying addiction medicine and non-addiction medicine healthcare providers to dispense or prescribe Schedule III, IV, and V medications for the treatment of OUD in non-OTP settings, including physician offices and correctional facilities.[111] In order to be eligible to apply for the waiver, non-addiction medicine physicians must complete 8 hours of training and qualified nursing and physician assistant practitioners must complete 24 hours of training.[112] Approved by the FDA for the treatment of OUD in 2002, buprenorphine became the first medication regulated by the DATA 2000 waiver program.[113]

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106. Center for Substance Abuse Treatment, TIP Series 40, 2.
107. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 12; Center for Substance Abuse Treatment, TIP Series 40, 7; Office of Surgeon General, Facing Addiction in America, 4; Drug Policy Alliance. "About methadone and buprenorphine: Revised." (2006), 10.
108. Center for Substance Abuse Treatment, *TIP Series 40*, 8; National Council for Behavioral Health, *MAT in Jails and Prison Toolkit*, 13; Mattick, Richard P., Courtney Breen, Jo Kimber, and Marina Davoli. "Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence." *Cochrane database of systematic reviews* 2 (2014).
109. Comer, "National Practice Guidelines", 32. If used as prescribed, the naloxone (which is an opioid antagonist) will have no effect. If an individual attempts to inject the medication, the naloxone will activate and block the opioid agonist effect and induce withdrawal.
110. Center for Substance Abuse Treatment, *TIP Series 40*, 79; Stanton, A. "The SAMHSA Evaluation of the impact of the DATA waiver".
111. Substance Abuse and Mental Health Services Administration (SAMHSA). 2019. "Buprenorphine". https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine; Center for Substance Abuse Treatment, *TIP Series 40*, 2; U.S. Congress House, Drug Addiction (DATA 2000) Act of 2000, HR 6026, 106th Congress, 2nd Sess. https://www.congress.gov/106/bills/hr2634/BILLS-106hr2634pcs.pdf; American Society of Addiction Medicine (ASAM). "Buprenorphine Waiver Management". *Advocacy*. https://www.asam.org/advocacy/practice-resources/buprenorphine-waiver-management; Physicians, nurse practitioners, physician assistants, certified nurse specialists, certified nurse midwives, and certified registered nurse anesthetists are all currently eligible to apply for the X-waiver.
112. ASAM, "Buprenorphine Waiver Management".
113. Center for Substance Abuse Treatment, *TIP Series 40*, 79-80; SAMHSA, 2006, 1.

In its original form, DATA 2000 only allowed individual and group providers to treat a maximum of 30 patients at any one time.[114] There have since been several changes to the X-waiver program that have sought to increase access to buprenorphine. The Office of National Drug Control Policy Reauthorization Act of 2006 permitted physicians to increase their patient limits from 30 to 100 after their first year with a waiver.[115] In 2016, eligible practitioners with a 100-patient waiver limit were allowed to re-apply to treat 275 patients at any one time.[116] Most recently, the enacted federal SUPPORT for Patients and Communities Act of 2018 now allows qualifying providers to treat up to 100 patients in their first year with the ability to increase their patient limit to 275 in year two (see Figure 5).[117] If administered in OTP settings, buprenorphine can be dispensed without a waiver and providers are not restricted by patient limits.[118]

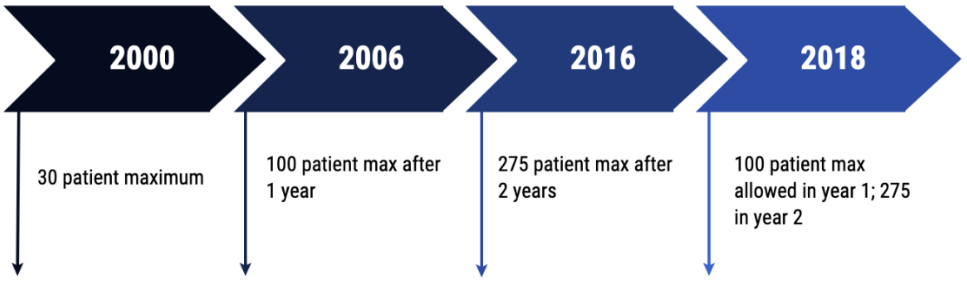

Figure 5. Federal Buprenorphine Prescribing Patient Maximums 2000 – 2018

114. DATA 2000; Center for Substance Abuse Treatment, *TIP Series 40*, 80.
115. U.S. Congress House. Office of National Drug Control Policy Reauthorization (ONDCPRA) Act of 2006, HR 6344, 109th Congress, Public Law 109-469. https://www.congress.gov/109/plaws/publ469/PLAW-109publ469.pdf.
116. Office of Surgeon General, Facing Addiction in America, 4.23-4.24.
117. U.S. Congress House. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018, HR 6, 115th Congress, Public Law 115-271. https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf; Substance Abuse and Mental Health Services Administration (SAMHSA). 2020. "Statutes, Regulations, and Guidelines". https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines.
118. SAMHSA. TIP Series 63, 1-7. This is because OTPs already have to meet strict federal certifications and guidelines.

NALTREXONE

Naltrexone is an opioid receptor antagonist, meaning that it will block the effect of opioids if used.[119] Because naltrexone does not activate the opioid receptor, it is not considered a controlled substance and therefore can be prescribed by all practitioners with prescribing privileges.[120] Naltrexone is used to prevent opioid use in those who have already detoxed from opioids and to decrease opioid cravings.[121] Naltrexone was previously FDA-approved for the treatment of OUD as a daily oral pill, but poor treatment compliance and low treatment retention rates significantly diminished the effectiveness of the oral formulation and it is no longer recommended.[122] XR-NTX is a monthly injection that is now the only FDA-approved formulation of naltrexone approved for the treatment of OUD.[123] Despite advice from the HHS to increase access to all MAT medications, the Trump administration has responded to the opioid crisis by only providing federal funding for naltrexone programs,[124] which has already increased naltrexone use across the U.S. by 55 percent.[125] Analysts suspect this funding and endorsement from Trump is connected to significant lobbying efforts by Alkermes Pharmaceutical Manufacturing, the producers of XR-NTX (brand name Vivitrol ®).[126]

119. Comer, "National Practice Guidelines", 35.
120. Substance Abuse and Mental Health Services Administration (SAMHSA). 2020. "Naltrexone". https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone; Office of Surgeon General, Facing Addiction in America, 4-24.
121. SAMHSA, "Naltrexone"; Comer, "National Practice Guidelines", 36.
122. National Institute on Drug Abuse (NIDA). 2019. Medications to Treat Opioid Use Disorder. https://www.drugabuse.gov/node/pdf/21349/medications-to-treat-opioid-use-disorder, 11; Comer, "National Practice Guidelines", 36; National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 13; Minozzi, Silvia, Laura Amato, Simona Vecchi, Marina Davoli, Ursula Kirchmayer, and Annette Verster. "Oral naltrexone maintenance treatment for opioid dependence." Cochrane Database of Systematic Reviews 4 (2011), 12; NIDA, Medications to Treat OUD, 11; National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 13.
123. FDA, "Information about MAT".
124. Dyer, Owen. "Trump and health department diverge on how to deal with opioid crisis." BMJ: British Medical Journal (Online) 360 (2018).
125. United States Department of Health & Human Services. 2019. "Trump Administration Announces $1.8 Billion in Funding to States to Continue Combating Opioid Crisis". https://www.hhs.gov/about/news/2019/09/04/trump-administration-announces-1-8-billion-funding-states-combating-opioid.html.
126. "Untangling the web of opioid addictions in the USA." Lancet (London, England) 389, no. 10088 (2017): 2443.

MEDICATION-ASSISTED TREATMENT IN JAIL SETTINGS

Despite ample evidence illustrating the effectiveness of MAT for OUD treatment and demonstrated support for MAT access in jails by national correctional and addiction medicine professional organizations, less than one percent of individuals in U.S. prisons and jails with OUD receive access to these medications while in custody.[127] In 2017, only 30 out of 5,100 jails and prisons in the U.S. offered buprenorphine or methadone treatment.[128] The Rhode Island Department of Corrections (DOC) operates a combined jail and prison system and was the first in the nation to offer all three FDA-approved medications for the treatment of OUD.[129] Other correctional departments in the U.S. that offer buprenorphine treatment in their jails include the Vermont DOC, Franklin County Jail and House of Correction in Massachusetts, New York City Health + Hospitals/Correctional Health Services, and Snohomish County Jail in Washington.[130]

127. Bronson, Jennifer, Jessica Stroop, Stephanie Zimmer, and Marcus Berzofsky. "Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009." Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention (2017), 13; Vestal, Christine. "New Momentum for Addiction Treatment Behind Bars". Pew Trusts: Stateline. (2018). https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars; SAMHSA. Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings, 5.
128. SAMHSA. Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings, 8.
129. NSA, Jail-Based Medication Assisted Treatment, 29; National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 34.
130. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 34-35; NSA, Jail-Based Medication Assisted Treatment, 28.

METHODOLOGY OF DATA COLLECTION AND ANALYSIS

In order to inform their advocacy for increasing access to buprenorphine treatment in jail settings, DPA has asked us to evaluate the significant barriers to buprenorphine treatment in LA County jails and to provide a comprehensive list of policy recommendations to help overcome these barriers at the local, state, and federal levels. We first conducted semi-structured interviews with key correctional health and substance use treatment stakeholders to understand barriers to buprenorphine and potential policy options that may be applicable to the LA County jail system. We then conducted an evidence synthesis to review relevant literature, appraise the quality of available literature, and understand barriers and promising practices to implementing buprenorphine in criminal justice settings more broadly.

SEMI-STRUCTURED INTERVIEWS

We conducted 20 semi-structured interviews with correctional health administrators, correctional physicians, correctional officers, drug court judges, substance use treatment providers and program administrators, and correctional health policy makers and researchers (see Figure 6; see Appendix A for our de-identified interview list). All interviews were conducted by phone. We utilized purposive and snowball sampling techniques with the goal of reaching professionals who work directly with individuals with OUD in the jails or who have influence on policies related to buprenorphine in correctional settings.[131]

131. Palinkas, Lawrence A., Sarah M. Horwitz, Carla A. Green, Jennifer P. Wisdom, Naihua Duan, and Kimberly Hoagwood. "Purposeful sampling for qualitative data collection and analysis in mixed method implementation research." *Administration and policy in mental health and mental health services research* 42, no. 5 (2015): 2.

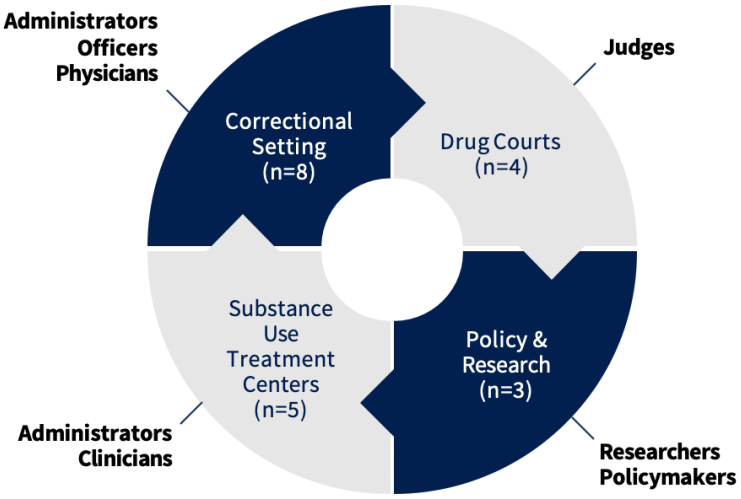

Figure 6. Interview Participants by Profession

We first researched and developed a list of Los Angeles subject experts whom we thought would be knowledgeable about the implementation of MAT in criminal justice settings.[132] Concurrently, we reached out to personal contacts who work in criminal justice, mental health, or addiction medicine settings for additional recommendations and connections to professionals in the field. At the end of each interview, we also asked interviewees for the contact information of other colleagues whom they felt would be appropriate to interview. Using this snowball sampling technique, each connection generated several additional outreach contacts.

Our interview guide explored the interviewee's professional role, experience working with justice-involved individuals with OUD, perspective on OUD treatment and MAT, knowledge of buprenorphine access for justice-involved individuals, and thoughts on policies needed to increase buprenorphine access (see Appendix B for complete interview guides). We coded our interviews using NVivo 12 qualitative data analysis software and analyzed the data for major themes related to barriers to buprenorphine in jail settings and policy recommendations to increase access to the medication.

132. Palinkas et al., 2015, 6.

EVIDENCE SYNTHESIS

Evidence-based practice is the outcome of a movement to promote the use of evidence to improve patient outcomes. The Johns Hopkins Nursing Evidence-Based Practice (JHEBP) model provides a problem-solving approach to clinical decision-making that integrates the best available scientific evidence with the best available experiential (patient and practitioner) evidence.[133] The model guides researchers and healthcare teams through a three-step process consisting of developing a practice question, gathering and appraising relevant literature, and translating the findings into best practices that can be quickly and appropriately incorporated into patient care.[134] We felt that the JHEBP model was appropriate for our policy question because we sought to combine the knowledge of correctional health and substance use professionals with the highest quality research available on our topic in order to generate well-informed policy recommendations for how to implement buprenorphine (an evidence-based treatment) in criminal justice settings. The two questions that we sought to answer using our evidence synthesis were:

1. Among justice-involved adults, does buprenorphine safely and effectively treat opioid use disorders by reducing overdoses, illicit drug use, and recidivism?
2. Among justice-involved adults, what are the known barriers to receiving buprenorphine treatment for opioid use disorder?

Conducting a JHEBP evidence synthesis allowed us to obtain and summarize literature relevant to our policy question, assess the level of evidence used in the analysis, and determine the quality of the study design and methodology. Our complete evidence synthesis methodology and tabular synthesis can be found in Appendix D and E respectively.

133. Dang, D., & Dearholt, S. L. (2017). Johns Hopkins nursing evidence-based practice: Model and guidelines. Sigma Theta Tau.
134. Dang, 4-5.

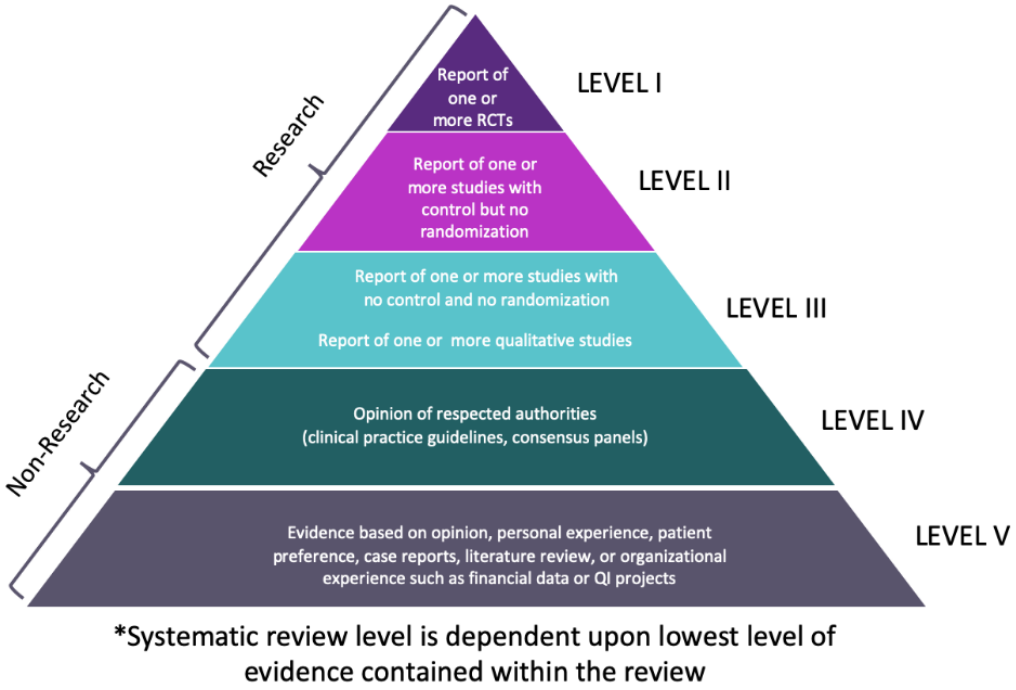

Figure 7. JHEBP Levels of Evidence Modified into Pyramid Framework[135]

LIMITATIONS

While we believe that our findings and policy recommendations will offer valuable insights and guidance for DPA, we also recognize that our report is limited by the lack of available data on opioid use disorder in LA County jails, the lack of representation of key stakeholders in the jail setting including correctional officers and correctional nurses in our interview pool, and the lack of representation from the individuals with OUD in the jails who experience the barriers to buprenorphine treatment every day. We hope that future research will include the voice of this vulnerable population and further add to the findings and recommendations presented in this report.

135. Dang, 4-5.

INTERVIEW AND EVIDENCE-SYNTHESIS FINDINGS

Below we provide a summary of the findings from our semi-structured interviews and evidence synthesis starting with an overview of the landscape of opioid use and MAT in LA County jails and ending with the presentation of the five main barriers to buprenorphine treatment in the LA County jail system.

LANDSCAPE AND SEVERITY OF OPIOID USE IN LA COUNTY

Opioid use among individuals in Los Angeles varies by location in the County. For example, community substance use disorder (SUD) treatment staff working in Downtown, Long Beach, Inglewood, Lancaster, and Pasadena noted that they regularly work with individuals who use opioids, while drug court judges working in El Monte and Compton drug courts rarely see opioid users.[136] Some SUD treatment providers noted that heroin use was declining for several years, but has recently made a reappearance among clients in their programs.[137] Although methamphetamine is often the most commonly used drug among justice-involved clients in drug court and community SUD treatment programs, treatment providers stated that they now see many clients who are using methamphetamine as their primary drug and heroin or prescription opioid pills as a secondary drug.[138] In some cases, a client's opioid use was not discovered until later in treatment because it was not the client's primary drug of choice, the client did not see their opioid use as an issue, or the opioid use was not related to their criminal case.[139] One SUD treatment program director noted that with the increase in fentanyl in the community, the severity of clients with OUD has increased and the age of individuals using opioids has decreased.[140]

136. Interviews SUD1, SUD2, SUD3, SUD4, SUD5, DCJ1, DCJ2, DCJ3, DCJ4.
137. Interviews SUD2, SUD3, SUD4, SUD5, DCJ1, DCJ2.
138. Interviews SUD1, SUD2, SUD3, SUD4, SUD5, DCJ1, DCJ2.
139. Interviews SUD2, SUD3, SUD4, SUD5.
140. Interview SUD1.

AN OVERVIEW OF THE LA COUNTY JAIL SYSTEM

With an average daily population between 17,000 – 22,000 individuals across seven jail sites, the LA County jail system is the largest in the world.[141] The LA County jail system is operated by the LA County Sheriff's Department (LASD) with an annual budget of $890 million in 2020.[142] Prior to 2015, medical and addiction health services were overseen by LASD's Medical Services Bureau and mental health services were overseen by the LA County Department of Mental Health.[143] In 2015, the Board of Supervisors (BOS) approved a motion to transfer oversight of jail medical, addiction, and mental health services to the LA County Department of Health Services (DHS).[144] The goal of this motion was to better coordinate the delivery of these services under a newly formed Integrated Correctional Health Services (ICHS) department.[145] In LA County's 2020-2021 recommended budget, ICHS' net appropriations is approximately $386 million: $316 million for salaries and employee benefits, $69 million for services and supplies, and $1 million for other charges.[146]

The per person cost of incarceration in the LA County jail system is approximately $50,000.[147] This costs increases to approximately $65,000 if an individual has a mental health condition.[148] The breakdown of the types of services covered by this cost is not available for LA County, but is available for California prisons. The average per person cost to incarceration an individual in California prisons is $81,203.[149] The majority of this funding goes toward security

141. Interview CPA5, Correctional Physicians and Administrators, conducted January 23, 2020; Los Angeles Almanac. 2020. "Los Angeles County Jail System by the Numbers." http://www.laalmanac.com/crime/cr25b.php; American Civil Liberties Union (ACLU), "LA County Jails," accessed May 4, 2020, https://www.aclu.org/issues/prisoners-rights/cruel-inhuman-and-degrading-conditions/la-county-jails?redirect=la-county-jails; The seven jail facilities include Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Center (CRDC, the only women's jail), Pitchess Detention Center-East (PDC-E, only used as a fire camp site for inmate firefighters), Pitchess Detention Center-North (PDC-N), Pitchess Detention Center-South (PDC-S), and North County Correctional Facility (NCCF).
142. Los Angeles Almanac http://www.laalmanac.com/crime/cr25b.php; All of the jail facilities are grossly overpopulated holding more individuals than their capacity: MCJ (129% occupied), TTCF (138%), CRDC (126%), PDC-N (172%), PDC-S (187%), NCCF (177%).
143. Department of Health Services County of Los Angeles. 2018. Annual Report 2016-2017: Department of Health Services. http://file.lacounty.gov/SDSInter/dhs/1032798_DHSAnnualreport1-16AM_96dpi.pdf, 71; Interview CPA4.
144. Department of Health Services County of Los Angeles. 2018. Annual Report 2016-2017, 71; Interview CPA4.
145. Wilson, Michael. "DHS Expands Role in Correctional Health". Fast Facts with Dr. Katz. (2015): 1; Department of Health Services County of Los Angeles. 2018. Annual Report 2016-2017, 71; Interview CPA4.
146. Sachi A. Hamai and Arlene Barrera, "County of Los Angeles 2020-21 Recommended Budget," County of Los Angeles Chief Executive Office, April 28, 2020, 4.13, https://ceo.lacounty.gov/wp-content/uploads/2020/04/2.-2020-21-Recommended-Budget-Volume-One-Online.pdf
147. "About L.A. County's Jail Expansion Plan," JusticeLA Coalition, accessed May 4, 2020, https://justicelanow.org/jailplan/
148. JusticeLA, "About L.A. County's Jail."
149. "How much does it cost to incarcerate an inmate?," Legislative Analyst's Office (LAO), last modified January 2019, https://lao.ca.gov/PolicyAreas/CJ/6_cj_inmatecost

and medical and dental costs.[150] Pharmaceuticals only account for 4% of the per person incarceration costs (see Figure 8).[151]

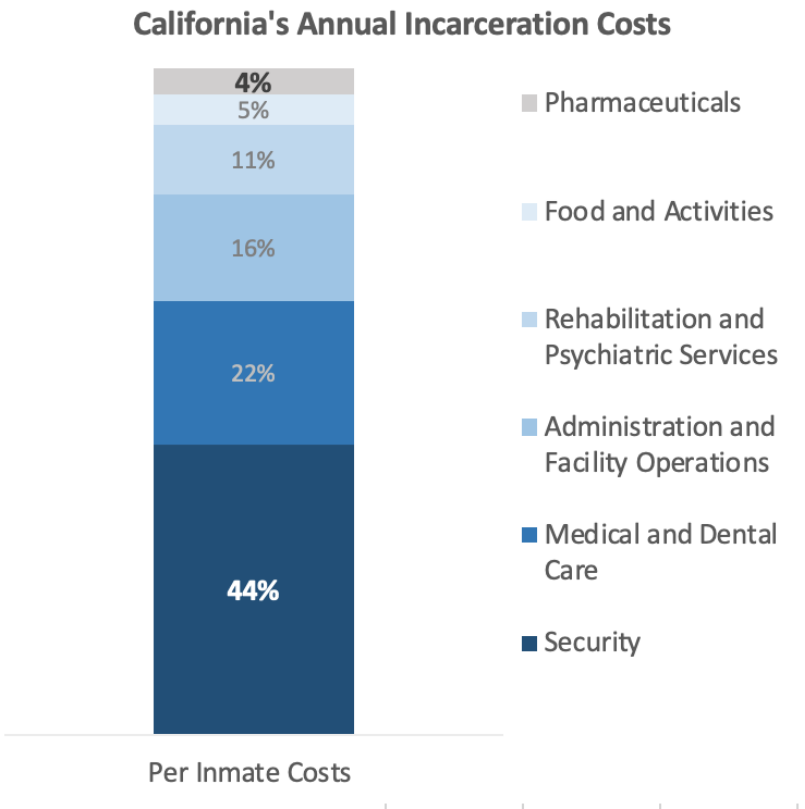

Figure 8. California's Annual Per Person Prison Incarceration Costs by Type of Expenditure[152]

The majority of individuals in the jail system have a diagnosable substance use disorder, and many also have a co-occurring mental health condition (see Figure 9).[153] The racial and ethnic demographics within the jail in 2019 was 53% Latino, 29% African American, 15% white, and 3% other.[154] Black individuals, comprising only 9% of LA County's population, are the most overrepresented group in the jails.[155] In 2017, the average length of stay for individuals held in custody was 165 days and for those that were released was 60 days.[156]

150. LAO, "How much does it cost."
151. LAO, "How much does it cost."
152. LAO, "How much does it cost."
153. California Health Care Foundation.
154. Los Angeles Almanac.
155. United States Census Bureau. Quick Facts: Los Angeles County, California and Los Angeles City, California. https://www.census.gov/quickfacts/fact/table/losangelescountycalifornia,losangelescitycalifornia/PST045219.
156. Davidson, Peter J., Karla D. Wagner, Paula L. Tokar, and Shoshanna Scholar. "Documenting need for naloxone distribution in the Los Angeles County jail system." Addictive behaviors 92 (2019): 21.

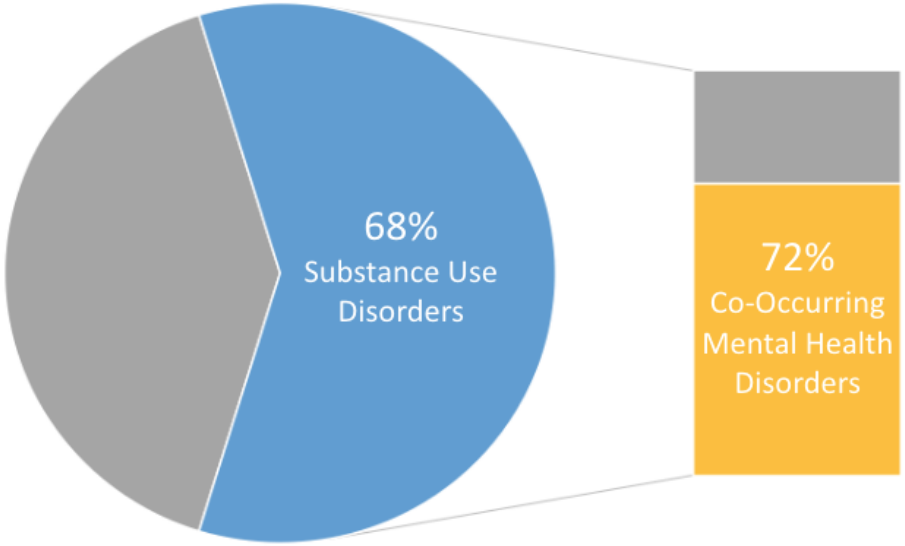

Figure 9. Substance Use Disorders and Co-Morbidities in LA County Jails[157]

CURRENT STATE OF OPIOID USE DISORDER TREATMENT IN LA COUNTY JAILS

The only MAT medication option currently available to all individuals with OUD in the LA County jail system is naltrexone tablets.[158] Buprenorphine sublingual tablets (Subutex ®) are only available to pregnant women with OUD because of the risk of serious pregnancy complications including miscarriage or premature delivery associated with opioid withdrawal during pregnancy.[159] Individuals who enter the jail physically dependent on opioids undergo withdrawal, which is managed with supportive measures such as fluids, muscle relaxers, acetaminophen, and anti-diarrheal medications.[160] Buprenorphine and methadone can both be used to manage painful withdrawal symptoms, but they are also not available within the jails for this purpose despite efforts to get buprenorphine withdrawal management protocols approved.[161] Our interviews with correctional physicians suggested a lack of urgency to provide buprenorphine for withdrawal management or maintenance therapy because, unlike alcohol withdrawal, opioid withdrawal is rarely fatal.[162] Other interviewees commented on the need to amplify the inaccuracy of this perception given the high post-release overdose mortality rates.[163]

157. California Health Care Foundation.
158. Interviews CPA2, CPA5; This medication option is only used after someone has gone through withdrawal as a way to reduce opioid cravings and to block the effect of opioids if someone were to use. As previously noted, because of poor treatment adherence, the naltrexone tablet formulation is no longer FDA-approved.
159. Interviews CPA1, CPA2, CPA3, CPA5.
160. Interviews CPA2, CPA3, CPA6.
161. Interviews CPA2, CPA6.
162. Interviews CPA2, CPA6.
163. Interviews CPA7, CHR2, CHR3; Joudrey, "Post-Release Opioid-Related Overdose Risk", 2.

BENEFITS OF BUPRENORPHINE IN CRIMINAL JUSTICE SETTINGS

In the first year after implementing all FDA-approved medications in their jails and prisons, Rhode Island DOC saw a 61 percent decrease in the rate of post-release overdose deaths.[164] One study in Australia of more than 16,000 individuals with OUD in prison found that individuals who received methadone or buprenorphine had a 94 percent reduction in risk of death in the first four weeks of incarceration, primarily driven by a decrease in suicide deaths.[165] Other benefits of initiating buprenorphine treatment in correctional settings include increasing adherence to SUD treatment, facilitating long-term recovery, lowering opioid relapse rates, decreasing recidivism, increasing rates of employment, and promoting safe jail and prison environments.[166]

In addition to saving lives and promoting long-term well-being and recovery, providing buprenorphine for the treatment of OUD has been shown to be cost effective and is associated with several cost benefits.[167] Cost effectiveness analyses have also found methadone and buprenorphine to be more cost effective than OUD treatment without use of the medications.[168] One study conducted by the Washington State Institute for Public Policy found that buprenorphine treatment resulted in a positive benefit to cost ratio of $1.76 with an 86 percent chance that benefits will exceed costs.[169] Other cost benefits of OUD treatment include decreased criminal justice expenditures and healthcare costs.[170]

164. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 9.
165. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 9.
166. Crowley, Des, and Marie Claire Van Hout. "Effectiveness of pharmacotherapies in increasing treatment retention and reducing opioid overdose death in individuals recently released from prison: a systematic review." Heroin Addiction and Related Clinical Problems 19, no. 2 (2017); Malta, Monica, Thepikaa Varatharajan, Cayley Russell, Michelle Pang, Sarah Bonato, and Benedikt Fischer. "Opioid-related treatment, interventions, and outcomes among incarcerated persons: A systematic review." PLoS Medicine 16, no. 12 (2019); National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 9-10; NSA, 5; SAMHSA. Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings, 42.
167. SAMHSA TIP Series 63, 1-7.
168. SAMHSA TIP Series 63, 1-7.
169. Nafziger, M. 2016. Long-Acting Injectable Medications for Alcohol and Opioid Use Disorders: Benefit-Cost Findings. (Document Number 16-12-3901). Olympia: Washington State Institute for Public Policy, 7; National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 85.
170. SAMHSA TIP Series 63, 1-7.

BARRIERS TO BUPRENORPHINE IN LOS ANGELES COUNTY JAILS

Barrier 1: LA County does not track prevalence of opioid use disorder and opioid overdoses among justice-involved individuals.

The prevalence of OUD and opioid withdrawal among individuals in the LA County jail system is not currently known or tracked.[171] When an individual enters the jail system, they go through a centralized intake process that consists of an intake survey and interview to determine their initial housing assignment.[172] At this time, an individual can self-disclose prior opioid use but this information is not tracked at the system level.[173] Based on their experience providing or coordinating SUD treatment services in the jails, some of our interviewees estimated the prevalence of OUD to be between 15% to 20%.[174] One interviewee cited the prevalence as 17% based on a two-week survey implemented in the jail as part of a study that asked individuals at intake if they have used opioids in the past year.[175] They acknowledged, however, that these percentages are likely underestimates because the information is self-reported and individuals may be concerned about potential legal repercussions associated with disclosing prior opioid use in the jail setting.[176] Another way that someone with presumed OUD can be identified is if they go into withdrawal once they are housed in the jail.[177] Once an individual is released from jail, drug overdose is one of the leading causes of death and opioid-related overdoses constitute the majority of these deaths.[178] Despite this elevated risk, LA County does not currently track opioid overdose mortality rates among individuals recently released from the jails.[179]

Barrier 2: Criminal justice and substance use disorder treatment settings lack access to accurate information about opioid use disorder and buprenorphine.

Although all interviewees had a general understanding of MAT, we noticed varied understandings among SUD treatment providers and drug court judges about the action and effectiveness of buprenorphine.[180] Some common myths about buprenorphine in these settings are that the medication is substituting one drug for another, represents another form of addiction, and will leave clients

171. Interviews CPA2, CPA3, CPA4, CPA5, CPA6.
172. Davidson, "Naloxone Distribution", 21; The intake process for all incoming men takes place at the Inmate Reception Center, while intake for women takes place on site at the women's jail (CRDF).
173. Interviews CPA2, CPA4.
174. Interviews CPA2, CPA3, CPA4, CPA6.
175. Davidson, "Naloxone Distribution", 21-22; Interview CPA5.
176. Interviews CPA2, CPA3, CPA4, CPA5, CPA6.
177. Interview CPA2.
178. Joudrey, "Post-Release Opioid-Related Overdose Risk", 2.
179. Interview CPA7; County of Los Angeles Public Health: Substance Abuse Prevention and Control (SAPC). (2019). *SAPC Data Brief: Prescription (Rx) Opioid Misuse/Abuse and Consequences.* http://publichealth.lacounty.gov/sapc/MDU/MDBrief/OpioidBriefFinal.pdf.
180. Interviews SUD2, SUD3, SUD4, SUD5, DCJ1, DCJ2.

feeling high or sedated.[181] There was also uncertainty about how the effectiveness of buprenorphine compared to that of abstinence-only treatments such as 12-step groups and psychosocial treatments alone despite having received some form of training on MAT.[182]

Because only a limited number of SUD treatment programs (approximately 10%) and drug courts in LA County offer buprenorphine treatment to clients, most interviewees had limited professional experience with buprenorphine and mostly relied on personal experiences (either their own lived experience or stories from friends and clients) to inform their judgment about buprenorphine.[183] The effect of personal experiences were both positive and negative; when someone has had or heard of a positive experience with buprenorphine they were in favor of increasing access to the medication and the opposite for negative experiences.[184] One interviewee shared that relying on lived experience to inform clinical practice is common in the SUD treatment world because many providers are in predominately abstinence-based recovery themselves.[185] The LA County Department of Public Health (DPH) has now integrated this point into their education about MAT to emphasize that while personal experience is meaningful to the work, it should not be used to dictate the treatment options available to others.[186]

Our conversations with correctional health administrators and physicians highlighted the need for additional buprenorphine education for physicians and other important stakeholders in the jail system including correctional officers and nurses.[187] Correctional officers and nurses play an essential role in buprenorphine protocols in the jail because the officers bring individuals to the treatment area and nurses administer the medication.[188] Among correctional healthcare providers, they stated that physicians receive minimal to no training on MAT in medical school or residency depending on their specialty and that this training should be mandated for all future physicians.[189] These interviewees also discussed the need for more X-waivered providers in the LA County jail setting.[190]

181. Interviews SUD2, SUD3, SUD4, SUD5, DCJ1.
182. Interviews SUD2, SUD3, SUD4, SUD5, DCJ1, DCJ2, DCJ4; Only one out of the nine substance use disorder treatment providers and drug court judges interviewed offers buprenorphine treatment in their program.
183. Interviews SUD2, SUD3, SUD4, SUD5, DCJ1, DCJ2.
184. Interviews SUD2, SUD3, SUD4, SUD5, DCJ1, DCJ2, CHR1.
185. Interview SUD1.
186. Tsai, Gary, and Brian Hurley. "Medication-Assisted Treatment in Integrated Care Settings." Los Angeles County Department of Public Health: Substance Abuse Prevention and Control. http://publichealth.lacounty.gov/sapc/mat/docs/Tsai-Hurley-MAT-ICC.pdf, 5; Interview SUD1.
187. Interviews CPA1, CPA2, CPA3, CPA4, CPA5, CPA6, CPA7.
188. Interviews CPA1, CPA2, CPA3, CPA4, CPA5, CPA6, CPA7.
189. Interviews CPA3, CPA7.
190. Interviews CPA1, CPA3, CPA4.

Barrier 3: Stigma against buprenorphine treatment and opioid users is prevalent among substance use disorder treatment providers and criminal justice leadership, healthcare providers, and staff.

Many interviewees working within the LA County jail system shared that there is a stigma against opioid users and buprenorphine present in the jails that is likely more exaggerated than in community settings due to a culture of punishment within the jail.[191] There is a perception in the jail, particularly among correctional officers and nurses, that providing buprenorphine would be rewarding an individual for bad behavior.[192] Two interviewees discussed attempts within the jail to address the stigma and use of stigmatizing language among correctional nursing staff, but both felt that the trainings have been ineffective.[193] One interviewee suggested that this stigma is potentially being fueled by the stigma among correctional officers who are more focused on punishment than treatment and who work closely with nurses when they bring individuals from their housing units to receive treatment.[194] Another interviewee compared the stigma against opioid users and MAT in the jails to the HIV epidemic in the 1980s when marginalized populations such as intravenous (IV) drug users were dying in large numbers and being largely ignored by the medical system.[195]

Factors that contribute to stigma against medications for addiction treatment include the belief that addiction is a choice rather than a chronic disease, the separation of addiction services from other medical services, language on addiction that minimizes its biological nature, and a criminal justice system that does not incorporate medical expertise in its approach to individuals with addiction.[196] One contributing factor specifically to buprenorphine treatment stigma is around the issue of diversion. Buprenorphine diversion refers to the passing of buprenorphine from the person for whom it was prescribed to another person without a prescription who may potentially misuse the medication.[197] A correctional health expert we interviewed stated that there is really no such thing as too much buprenorphine in a jail because those who are diverting the medication are likely forced to do so because they need the medication and are unable to access it by other means.[198] Factors shown to reduce stigma against MAT include providing accurate education and providing testimonials from real justice-involved patients who have benefitted from MAT in the jail setting.[199] One interviewee stated that sharing testimonials from correctional health departments that previously did not want to implement MAT but have since successfully implemented the medications and have seen the benefits has been effective at

191. Interviews CPA1, CPA2, CPA3, CPA4, CPA5, CPA6, CHR2.
192. Interviews CPA1, CPA4, CPA6.
193. Interviews CPA1, CPA6.
194. Interview CPA6.
195. Interview CPA5; Avert. (2019). HIV Stigma and Discrimination. https://www.avert.org/professionals/hiv-social-issues/stigma-discrimination.
196. Wakeman, Sarah E., and Josiah D. Rich. "Barriers to medications for addiction treatment: How stigma kills." Substance use & misuse 53, no. 2 (2018): 330-333.
197. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 100.
198. Interview CHR2.
199. Turban, Joseph W. "Can Parole Officers' Attitudes Regarding Opioid Replacement Therapy be Changed?." Addictive Disorders & Their Treatment 11, no. 3 (2012): 165-170; Interview CHR2.

reducing stigma among correctional health leadership.[200]

Barrier 4: Paying for buprenorphine treatment in the LA County jail system will be challenging given the already stretched correctional health services budget.

County jails are not able to bill to Medicaid for treatment services provided while an individual is in jail due to the federal law known as the Medicaid Inmate Exclusion Policy.[201] Unable to use federal dollars, the LA County jail system must rely on general county funds in order to pay for SUD treatment services in the jail including MAT.[202] Because the LA County jail system is the largest in the nation, it is difficult to find the county funds needed to consistently cover buprenorphine costs at this scale.[203] Correctional health leadership stated that the jails have a small pharmacy budget and that they are already spending millions over budget on medications without offering buprenorphine to the general population.[204] Nevertheless, the BOS are supportive of MAT in the jails and approved a $5.8 million one-time funding allocation in the 2019-2020 LA County budget for 31 staff positions in the jails to help expand access to these services.[205] One interviewee expressed concern about the lack of funding specifically for the purchase of MAT medications, and felt that the BOS may not understand the primary role of medications to OUD treatment even without psychosocial services.[206] This interviewee also shared that LA County correctional health leadership likely support MAT, but are holding MAT "politically hostage" to increase the corrections budget overall.[207]

The precise cost of providing buprenorphine treatment in jail is difficult to estimate because it will vary depending on the number of individuals eligible for treatment, the duration of treatment, the formulation of buprenorphine purchased, the jail's procurement process, and the staffing required to implement the program.[20]

In OTP settings, the annual per person treatment cost varies by medication: $6,552 for methadone, $5,980 for buprenorphine, and $14,112 for naltrexone.[209] In

200. Interview CHR2.
201. National Association of Counties and National Sheriffs' Association. Reinstate Federal Health Care Benefits for Non-Convicted Justice-Involved Individuals. https://www.sheriffs.org/sites/default/files/NACo%20Medicaid%20and%20Jails%20One-Pager_wNSA.pdf; Interview CHR1.
202. Interviews CPA5, CHR1.
203. Interview CHR1.
204. Interviews CPA1, CPA5.
205. Los Angeles County Board of Supervisors, Recommended Adjustments to the 2019-20 Adopted County Budget to Reflect the Various Changes and Authorization to Execute Funding Agreements. (2019). p. 42; Interview CHR1.
206. Interview CPA4; This approach is referred to as a "medication-first" model, meaning that individuals in the jails should be able to access MAT medications even without participation in psychosocial services such as 12-step groups.
207. Interview CPA4.
208. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 56-57, 86; For example, buprenorphine tablets and films cost less but must be administered daily which requires staff time to administer and observe while the medication dissolves in a patient's mouth. Conversely, the buprenorphine injection or implant is more expensive to purchase but is administered less frequently and requires less staff time.
209. National Institute on Drug Abuse. (2018). "How Much Does Opioid Treatment Cost?".

jail settings, however, the per person costs will likely be cheaper due to shorter lengths of stay. In one large jail in New Mexico, the average length of stay is six weeks and the average total cost of methadone treatment per person was $689.[210] Rhode Island DOC allocates $2 million per year to their MAT program and purchased buprenorphine tablets for $4 each and buprenorphine films for $8 each in 2018.[211] Franklin County Jail and House of Correction in Massachusetts estimates the cost per dose of buprenorphine/naloxone at $2.70 (see Appendix E for their buprenorphine/naloxone treatment program cost calculator).[212] Buprenorphine per dose costs are typically more expensive than methadone but cheaper than XR-NTX.[213]

Using LA County jail system data, we estimate the per person cost of providing buprenorphine tablets in LA County jails to individuals with OUD to be $660 per person and a total of $1.9 million per year.[214]

Barrier 5: LA County correctional health providers want to know that there is sufficient access to buprenorphine in community treatment settings to ensure continuity of care for individuals recently released from the jails.

If the LA County jail system offers buprenorphine to individuals with OUD, they will likely become the largest buprenorphine provider in LA County and possibly in the nation.[215] The scale of the county jail system has contributed to concerns among correctional health leadership, physicians, and researchers about the availability of buprenorphine providers in the community to continue maintenance therapy upon release.[216] One interviewee shared the example of the Rhode Island DOC who started offering buprenorphine in the jails, but then realized that there were not a sufficient number of buprenorphine providers in the community to meet the demand upon release.[217] Others, in contrast, believe that this deficiency would not be replicated in LA County, and felt that these concerns should not delay providing MAT access in the jail.[218] One correctional physician stated that the issue is not the availability of buprenorphine providers in the community, but rather the lack of pipelines available to connect individuals with OUD to existing LA

Medications to Treat Opioid Use Disorder. https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-much-does-opioid-treatment-cost; These estimates include costs for psychosocial services, regular visits, and associated medical support services.

210. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 33.
211. SAMHSA. Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings, 41; National Council for Behavioral Health, 33.
212. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 84-86.
213. National Council for Behavioral Health, 33.
214. LA County buprenorphine treatment cost calculation: 17,000 individuals on average in the jail system, approximately 17% have an OUD, average length of stay for individuals held in custody of 165 days , buprenorphine tablets $4 per pill – 17,000 * 0.17 = 2,890 individuals with OUD * 165 days = 476,850 * $4 per pill = $1,907,400. Per person cost = $1,907,400/2890 = $660. Note: this cost calculation does not take into account staffing costs (e.g., nurse to administer buprenorphine and security guard to transport and observe individual).
215. Interview CPA5.
216. Interview CPA2, CPA4, CPA5, CPA7.
217. Interview CPA5.
218. Interviews CPA2, CPA3, CPA4, CPA7.

County MAT providers upon release.[219] This interviewee stated that current county MAT services are underutilized, possibly because of a lack of awareness of these services and a need to support justice-involved populations in accessing these treatment centers.[220] While LA County pharmacies will provide access to buprenorphine, other local pharmacies may be apprehensive to provide buprenorphine in the community due to increased DEA oversight, additional security requirements for storing buprenorphine, and perceived stigma associated with serving MAT clients.[221]

Our interviews and evidence synthesis illustrated the importance of developing a coordinated jail-to-community referral system and a comprehensive network of buprenorphine treatment providers who will serve justice-involved populations in the community.[222] In 2014, only 4.6% of justice-involved individuals in the U.S. received referrals for methadone or buprenorphine treatment compared to 40.6% of their general population counterparts.[223] Incarceration interrupts an individual's insurance coverage and post-release many individuals face compounding stressors such as poverty, mental health conditions, and disrupted social supports that make it difficult to access buprenorphine treatment and increases the risk of post-release opioid overdose.[224] California has already been working to address this issue through the California Hub and Spoke MAT Expansion Program.[225] The California Department of Health Care Services (DHCS) received funding from SAMHSA to develop a Hub and Spoke system, modeled by Vermont, to identify SUD treatment agencies (Hubs) that can partner with community health clinics (Spokes) to develop a MAT treatment network that will reach individuals who otherwise may not engage with or be able to access specialty SUD treatment services.[226] In LA County there are two Hub sites (Clare I Matrix and Tarzana Treatment Centers) that are partnered with 38 clinic sites.[227] The Substance Abuse Prevention and Control (SAPC) Division of DPH has also been working in LA County to increase the number of X-waivered providers and move community clinics from the contemplative phase into implementing MAT services.[228]

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219. Interview CPA4.
220. Interview CPA4.
221. Interviews CPA5, CHR3.
222. Interviews CPA4, CPA5, CPA7, CHR3.
223. Krawczyk, Noa, Caroline E. Picher, Kenneth A. Feder, and Brendan Saloner. "Only one in twenty justice-referred adults in specialty treatment for opioid use receive methadone or buprenorphine." Health Affairs 36, no. 12 (2017): 2050.
224. Joudrey, "Post-Release Opioid-Related Overdose Risk", 2-8.
225. Darfler, K., Urada, D., Antonini, V., Padwa, H., Joshi, V., & Sandoval, J. (2018). California State Targeted Response to the Opioid Crisis: Year 1 Evaluation Report. Los Angeles, CA: UCLA Integrated Substance Abuse Programs, 13.
226. Darfler, 12-14.
227. Darfler 14-15; California Hub and Spoke System: MAT Expansion Project. 2020. Find a Treatment Center Near You. http://www.uclaisap.org/ca-hubandspoke/html/find-treatment-center.html
228. Interview CPA7

POLICY RECOMMENDATIONS AND ANALYSIS

DPA's goal is to advance drug policies that promote equitable access to buprenorphine treatment for OUD in jail settings and to eliminate treatment disparities that keep marginalized populations such as justice-involved individuals with OUD from accessing evidence-based, standard of care treatments. With these goals in mind, we utilized the information gained from our qualitative research to develop a stepwise framework of policy advocacy for increasing buprenorphine access in LA County jails (see Figure 10). We only considered policy options that would increase access to buprenorphine treatment and directly address one of the five main barriers identified. Within each step of the framework we provide local, state, and federal recommendations with associated strategies for DPA's policy advocacy. We did not analyze policy recommendations for increasing community access to buprenorphine because they do not directly increase buprenorphine access within the jails, but we provide these recommendations in Appendix F. Although our project focused on the LA County jail system context, we believe that our policy recommendations will support DPA's efforts to expand access to buprenorphine in criminal justice settings nationally.

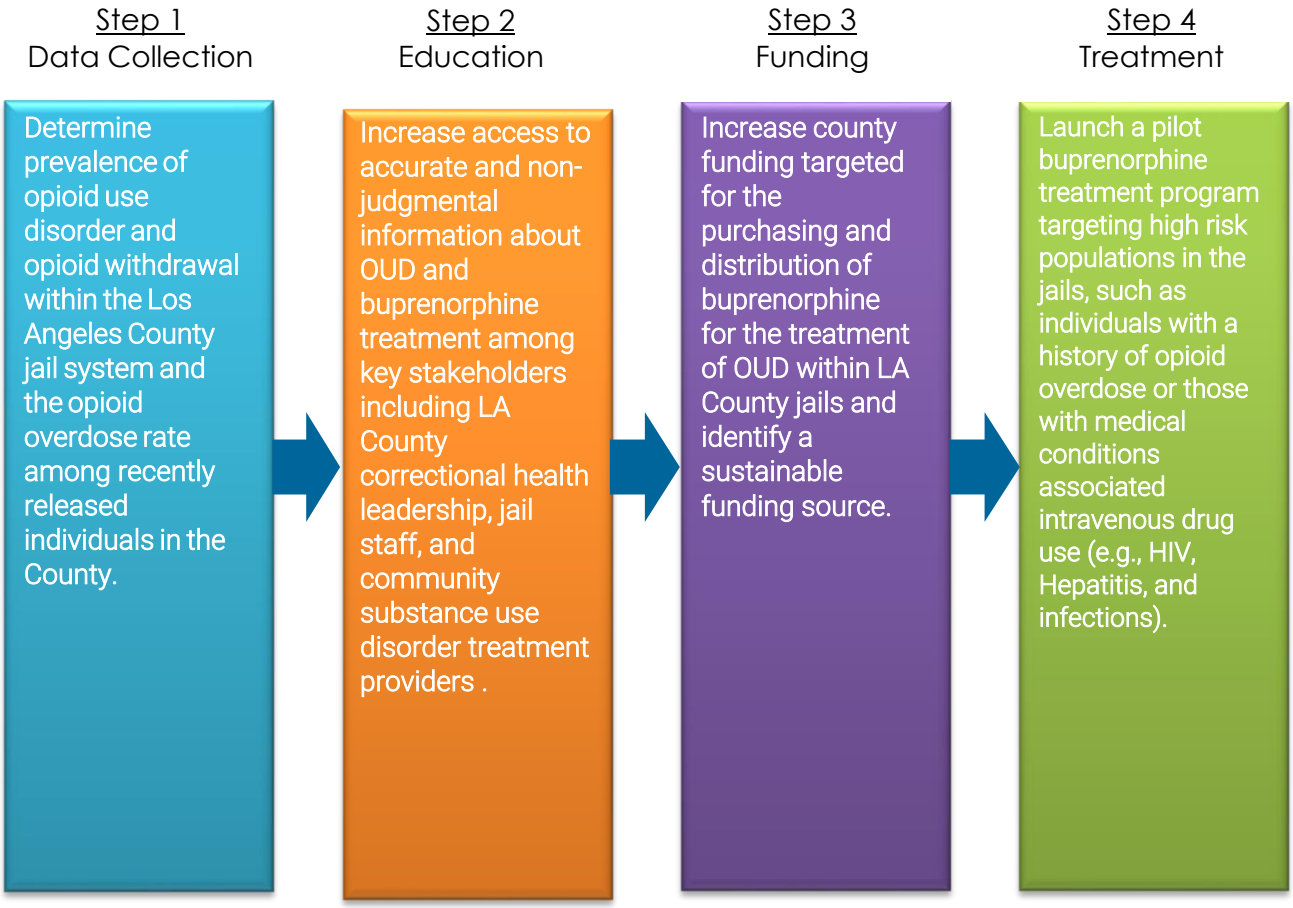

Figure 10. Stepwise framework of policy advocacy for increasing buprenorphine access in LA County jails

LOGIC OF THE FRAMEWORK

In order for correctional health leadership to make informed decisions about MAT access in jails, they must first understand the scale of the problem to better assess the level of need and the resources that will be required to address this issue. Once the problem is better understood, the LA County jail system will have to address the rampant misinformation and stigma against OUD and the medications used to treat it through the expansion of education initiatives. After key stakeholders within the jail system better understand the need for buprenorphine treatment and the positive benefits it will bring to individuals with OUD and to the jail system at large, LA County leaders are more likely to provide long-term MAT funding support. Finally, with a better understanding of the needs within their jail populations, an educated workforce, and sufficient funding, the LA County jail system can then launch a small buprenorphine program so that they can test and make adjustments to their implementation model before expanding buprenorphine access to all individuals with OUD in the jail who would benefit from treatment.

CRITERIA FOR POLICY ANALYSIS

We evaluated our policy recommendations based on the criteria of political feasibility and administrative feasibility. We selected these criteria because while all of our policy recommendations seek to increase access to buprenorphine and address identified barriers to the medication, we learned that the political context and capacity of existing jail infrastructure will likely influence the type of advocacy and mobilization required to implement the policy recommendations within each step. We discuss each criterion in detail below.

POLITICAL FEASIBILITY

Our interviews with key correctional health stakeholders revealed that increasing access to buprenorphine in the LA County jail system is a politically divisive issue. When analyzing our local policy recommendations, political feasibility refers to DPA's ability to obtain buy-in from critical LA County jail system stakeholders including the Department of Health Services, the Sheriff's Department, the Department of Public Health, the Board of Supervisors, and correctional and SUD treatment staff. DPA's advocacy strategies will require engagement with these various stakeholders making it essential for them to understand the political landscape in LA County. Our interviews revealed that the ability to obtain buy-in from essential stakeholders will likely be the determining factor for whether or not and how quickly buprenorphine treatment will be offered in the jails.[229] When analyzing state and federal policy recommendations, political feasibility also refers to the current political climate related to MAT in California and at the federal level. In addition, we examined existing laws and pending legislation that may facilitate our policy recommendations.

ADMINISTRATIVE FEASIBILITY

Our key stakeholder interviews also revealed that there are significant administrative challenges associated with expanding buprenorphine access in the LA County jail system. This criterion assesses the ability for a policy recommendation to be implemented within the existing jail system infrastructure. We consider issues such as existing correctional health resources, space within the jail, staffing considerations, funding, and oversight of medical and SUD treatment in the jails.

229. Interviews CPA1, CPA2, CPA3, CPA4, CPA5, CPA6, CPA7, CHR2, CHR3.

POLICY RECOMMENDATIONS

Because of our client's national reach and engagement in policy advocacy across all levels of government, we were asked to develop a comprehensive set of policy recommendations to increase access to buprenorphine in correctional settings with a focus on the LA County jail system. We were also asked to include state and federal recommendations that could inform advocacy strategies to increase access to buprenorphine in jails throughout the U.S. We based our policy recommendations on our review of relevant literature, evidence synthesis, and interviews with key LA County correctional health informants. With the information gained, we were able to identify five major barriers to buprenorphine access in jail settings and develop a set of local, state, and federal policy recommendations utilizing a stepwise framework.

Our analysis predominately focused on our local policy recommendations given that the majority of our informant interviews were with LA County stakeholders. For our local policy recommendations, we divide our recommendations into short-term and long-term recommendations. Based on information gathered from our interviews, we define short-term as recommendations that can be implemented in 0 to 3 years and long-term as recommendations that can be implemented in 3 to 5 years.[230]

STEP 1: DATA COLLECTION

LA County jails currently do not track data regarding individuals with OUD in the jail system.[231] This means that LA County correctional health leadership and staff do not know the prevalence of OUD and opioid withdrawal symptoms among individuals in the jails.[232] Because LA County also does not track post-release opioid overdose data, the opioid overdose risk among individuals recently released from the jails is unknown.[233] Data collection and analysis within the jails and on the county level will allow decision makers to better understand the scope and severity of the situation, which populations are at highest risk for overdose, how to target OUD treatment services, and assess the effectiveness of any MAT policy changes moving forward. We have seen in Rhode Island[234] and New Mexico[235] that data collection was an important first step to increase access to MAT among their justice-involved populations. With data, DPA can make a case for action, create comprehensive plans, and measure progress toward the goal of increasing access to gold standard treatments such as buprenorphine.

230. Interviews CPA1, CPA3, CPA4, CPA5, CPA6, CPA7, CHR1, CHR2, CHR3.
231. Interviews CPA2, CPA3, CPA4, CPA5, CPA6.
232. Interviews CPA2, CPA3, CPA4, CPA5, CPA6.
233. SafeMedLA.; County of Los Angeles Public Health: SAPC, *Data Brief*, 1-2.
234. Clarke, Jennifer G., Rosemarie A. Martin, Shelley A. Gresko, and Josiah D. Rich. "The first comprehensive program for opioid use disorder in a US statewide correctional system." (2018): 1323-1325.
235. Trigg, Bruce G., and Samuel L. Dickman. "Medication-assisted therapy for opioid-dependent incarcerated populations in New Mexico: statewide efforts to increase access." *Substance abuse* 33, no. 1 (2012): 76-84.

Level of Government	Data Collection Policy Recommendations	Short Term	Long Term
Local	1.1 Run a pilot study to estimate the prevalence of opioid use disorder and opioid withdrawal among individuals in L.A. County jails. Advocacy Strategies a. Encourage DHS to initiate the pilot study b. If no action taken within DHS, urge the Board of Supervisors to motion for a report from DHS with this information	●	
	1.2. Track fatal and non-fatal opioid overdoses among individuals recently released from jail. Advocacy Strategies a. Urge the LASD to provide DPH with jail release data so that post-release opioid overdoses can be estimated b. If no response from LASD, prompt the Board of Supervisors to request collaboration between LASD and DPH and motion for a report on post-release opioid overdoses c. If still no traction, explore the ability to collaborate with the Office of Inspector General or Sheriff Civilian Oversight Commission to obtain release data	●	
	1.3. Create a standardized system of documenting OUD and withdrawal symptoms within the LA County jail system.		●
	1.4. Foster collaboration between DHS, DPH, and LASD to implement a system for consistently tracking post-release overdoses.		●
State & Fed	1.5 Advocate for legislation in California requiring county jails to report the number of individuals with OUD, opioid withdrawal, and post-release opioid overdose deaths.		●
	1.6 Call for the U.S. HHS and CDC to provide state funding for post-release opioid overdose surveillance throughout the U.S.		●

Table 2. Data Collection Policy Recommendations

ANALYSIS OF DATA COLLECTION POLICY RECOMMENDATIONS

POLITICAL FEASIBILITY

Among our short-term policy recommendations, we first recommend for the LA County DHS, the department who oversees medical and addiction treatment services in the jails, to run a pilot study to estimate the current prevalence of OUD and opioid withdrawal symptoms among individuals in the jails. Our interviews suggest that this may be politically challenging because it will require the support and cooperation of DHS leadership, LASD leadership, and correctional staff to implement.[236] For this reason, we first recommend for DPA to advocate for DHS leadership to take the lead in initiating this pilot study given that the information is essential to their OUD treatment role in the jails. If this recommendation is stalled by a lack of support from stakeholders, we then recommend for DPA to urge the BOS to get involved and use their power to motion for a report from DHS with this information.[237] Because the LA County Office of Diversion and Reentry (ODR), which is housed within the DHS, was able to collaborate successfully with the LASD to conduct a study on individuals entering the jails, DPA can advocate for the Integrated Correctional Health Services department to foster a similar relationship and trust with the LASD by conducting a pilot study together focused on estimating the prevalence of OUD.[238] Highlighting the contentious nature of this issue, one interviewee speculated that DHS already has this information but does not want it released to the public.[239]

Our second short-term recommendation is for the LA County DPH to track fatal and non-fatal opioid overdoses among individuals recently released from LA County jails. SAPC already tracks the prevalence of opioid "misuse/abuse" and opioid overdose death rates in the county, and this recommendation would simply add post-release individuals to their ongoing data collection.[240] We believe that DPA may need to utilize a variety of advocacy strategies to advance this recommendation because of the need for LASD to provide SAPC with jail release data. The LASD has faced years of public controversy because of the lack of transparency about the conditions of the jails, the treatment of individuals in jail, and access to medical services.[241] The LA County BOS created an Office of

236. Interviews CPA1, CPA2, CPA3, CPA4, CPA5, CPA6, CPA7, CHR1, CHR2, CHR3.
237. Interview CHR1; Ridley-Thomas, Mark. 2018. AGN. No. 12: Amendment to Item #12.
238. Davidson, "Naloxone Distribution", 20-23.
239. Interview CHR2.
240. County of Los Angeles Public Health: Substance Abuse Prevention and Control (SAPC). (2019). SAPC Data Brief: Prescription (Rx) Opioid Misuse/Abuse and Consequences. http://publichealth.lacounty.gov/sapc/MDU/MDBrief/OpioidBriefFinal.pdf.
241. ACLU, "LA County Jails."; Gazzar, Brenda. "Men's Central Jail is 'falling apart.' LA County leaders weight spending $2.2 billion to replace it." 2019. Los Angeles Daily News; Public Media Group of Southern California. "Video from Men's Central Jail in L.A. Shows Violence Against Inmates". 2008. KCET: SoCal Connected; Liebowitz, Sarah, Peter Eliasberg, Margaret Winter, and Esther Lim. Cruel and Usual Punishment: How a Savage Gang of Deputies Controls LA County

Inspector General and the Sheriff Civilian Oversight Commission to monitor the LASD and their operation of the jail facilities.[242] With Measure R's recent passage in LA County, the Sheriff Civilian Oversight Commission now has the power to subpoena documents to investigate complaints against the LASD.[243] If needed, DPA may be able to work with the Commission to obtain release data that can then be analyzed by the DPH.

Our long-term recommendations speak to the need to create standardized systems for tracking OUD-related data in the jails and overdose data upon release.[244] We anticipate that implementing these recommendations will be a politically challenging process in the jails because of the divisions that exist between the Custody Division of the LASD and Integrated Correctional Health Services department of DHS.[245] The two stakeholders have 'dueling missions,' one prioritizing law and order and the other prioritizing health and well-being.[246] Nevertheless, we are hopeful that this recommendation can get implemented in a 5-year timeframe because DHS is already working with FUSE Corps to develop an inmate processing system that will assess the health and mental health needs of incoming individuals and provide an opportunity to standardize data collection.[247] We recommend that DPA advocates for this system to go beyond screening at intake to provide correctional physicians with a system to track opioid withdrawal symptoms and ensure timely access to treatment in those who may not self-disclose opioid use at intake.[248] Because the development of this system requires LASD partnership and collaboration, it may represent an opportunity to advocate for the creation of a jail release data sharing memorandum of understanding so that post-release overdoses can be consistently tracked in LA County.

Finally, within our state and federal policy recommendations we believe that the political environment in California is favorable to advocate for legislation that requires all county jails in California collect and track OUD-related data for justice-involved individuals. Governor Newsom has proposed $161.9 million in ongoing general funds starting in 2020 to expand MAT access in California prisons for high-risk populations such as those with prior overdose histories.[249] DPA can

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Jails. 2011. ACLU National Prison Project and the ACLU of Southern California; Gorman, Anna. "Health Care Revamp at the L.A. County Jails". 2018. California Healthline. https://californiahealthline.org/news/health-care-revamp-at-the-l-a-county-jails/.

242. County of Los Angeles. Office of Inspector General. https://oig.lacounty.gov/; County of Los Angeles Board of Supervisors. Los Angeles County Civilian Oversight Commission. https://coc.lacounty.gov/.

243. Ballotpedia. 2020. "Los Angeles County, California, Measure R Civilian Police Oversight Commission and Jail Plan Initiative. Local Ballot Measures.

244. Interviews CPA1, CPA2, CPA3, CPA4, CPA5, CPA6, DCJ1, DCJ2

245. O'Donnell, Erin. (2019). "Los Angeles County Works to Transform Criminal Justice Through Collaboration". Fuse Corps. https://fusecorps.org/2019/11/06/los-angeles-county-works-to-transform-criminal-justice-through-collaboration/; Interviews CPA1, CPA5, CHR2, CHR3.

246. O'Donnell, "LA County Transforms Criminal Justice".

247. Barseghian, Tina. (2018). "Designing a Patient-Centered Approach in the L.A. County Jail System". Fuse Corps. https://fusecorps.org/2018/07/11/designing-a-patient-centered-approach-in-the-l-a-county-jail-system/.

248. Interviews CPA2, CPA3, CPA6.

249. California Department of Finance. (2019). California General Budget May Revision, 19-20. http://www.ebudget.ca.gov/2019-20/pdf/Revised/BudgetSummary/FullBudgetSummary.pdf, 63;

emphasize the need for systems of data collection in the prisons and jails throughout California to better understand the magnitude of need for MAT services and to track long-term outcomes before and after the implementation of MAT services in jails and prisons. Having this data available throughout the nation is essential to ensuring that the needs of justice-involved individuals with OUD are truly being met.

ADMINISTRATIVE FEASIBILITY

As discussed above, the ODR demonstrated that it is administratively feasible to implement a pilot study related to opioid use during the LA County jail intake process.[250] The ODR did so by administering a brief survey that asked incoming individuals questions such as if they had used opioids in the past year and if they have ever received MAT.[251] Therefore, the DHS can again use this survey method to determine how many individuals coming into the jail meet OUD criteria. Tracking opioid overdoses upon release, however, will be more administratively challenging. Correctional health physicians within the jail do not have access to LASD data and often do not have the information on an individual's release date needed to coordinate treatment planning and ensure continuity of care in the community.[252] Obtaining records from the LASD has been a point of contention in the county that if often associated with long wait times, incomplete data, and potential fees.[253] Asking for release data within a specific timeframe (e.g., within the last year) will likely be more administratively feasible for the LASD than asking for several years of data.[254] At the state level, some counties in California have taken the lead on collecting OUD-related data in their jails which can serve as models for other counties to support a statewide mandate.[255]

League of California Cities. "Gov. Gavin Newsom Releases May Revise Budget with More Funding for Disaster Response and Homelessness". 2019. News. https://www.cacities.org/Top/News/News-Articles/2019/May/Gov-Gavin-Newsom-Releases-May-Revise-Budget-with.

250. Davidson, "Naloxone Distribution", 20-23.

251. Davidson, 21.

252. Interview CPA1.

253. Gilbertson, Annie. "The Fight to Get Public Records from LA County's Sheriff". 2019. LAist News. https://laist.com/2019/03/11/public_records_los_angeles_sheriff_department.php.

254. Interview CHR3.

255. Interview CHR2.

STEP 2: EDUCATION FOR KEY STAKEHOLDERS

We learned from our interviews that there is a range of understanding about OUD and perceptions about MAT among LA County correctional health leadership, correctional staff, and community substance use disorder treatment providers who serve justice-involved populations. A major theme in the interviews was a lack of understanding about the neurobiology of OUD and the chronic nature of the disease which requires medical treatment just like other chronic conditions such as diabetes or hypertension. We also found that MAT myths, including the idea that MAT is addictive and substituting one drug for another, perpetuates negative attitudes and biases against an effective, evidence-based therapy. These misconceptions about OUD and buprenorphine contribute to the stigmatization of justice-involved individuals with OUD, unnecessarily increases the suffering of individuals with OUD in the jails, and keep these individuals at higher risk of opioid overdose death upon release.

Level of Government	Education Policy Recommendations	Short Term	Long Term
Local	2.1 Provide L.A. County correctional leadership and decision makers with targeted education and resources focused on the neurobiology of OUD, the effectiveness of buprenorphine treatment, and buprenorphine implementation strategies in jail settings. <u>Advocacy Strategies</u> a. Collaborate with organizations who offer jail MAT educational resources b. Call on DHS and the LASD to make educational materials mandatory for all individuals making decisions about OUD treatment in the jails	●	
	2.2 Support the expansion of X-Waiver trainings in L.A. County for all eligible clinicians in both jail and community settings.	●	
	2. 3 Require all staff working with individuals in the jails to receive education about OUD, MAT, patient experiences, and language that does not stigmatize opioid users. <u>Advocacy Strategies</u> a. Call on DHS and LASD leadership to implement required OUD and MAT staff trainings	●	

	2.4 Once buprenorphine treatment protocols are created, require all staff members assisting with treatment to receive training on these protocols prior to implementation.		●
	2.5 Require education on OUD, MAT, and de-stigmatizing language related to substance use to be included in the onboarding process of new staff with required annual refresher trainings.		●
State & Fed	2.6 Advocate for increasing state funding for educational efforts regarding OUD and MAT in criminal justice settings.		●

Table 3. Education Policy Recommendations

ANALYSIS OF EDUCATION POLICY RECOMMENDATIONS

POLITICAL FEASIBILITY

LA County has a number of opioid-related learning collaboratives that include representatives from LASD, DHS, and DPH.[256] Nevertheless, it is still unclear how many key correctional health stakeholders and decision makers have access to accurate information about OUD and buprenorphine treatment and how the information is received.[257] Our interviews suggest that the LASD leadership may not be supportive of making buprenorphine trainings mandatory because of stigma against the medication.[258] Prior LA County Sheriff Jim McDonnell, however, led an initiative to address the opioid crisis by providing sheriff deputies with Narcan ®, a medication used to reverse the effects of an opioid overdose.[259] DPA can call on current Sheriff Alex Villanueva to expand on this initiative by providing education on buprenorphine, a medication that represents a more upstream solution to preventing opioid overdoses long before they occur.

Although X-waiver training previously did not appear to be a priority within LA County jail system according to one interviewee, there has since been a noticeable increase in the number of eligible healthcare providers attending county X-waiver

256. Bobrowsky, Joshua. Opioid Abuse Prevention and Treatment in Los Angeles County. Los Angeles County Department of Public Health. http://publichealth.lacounty.gov/sapc/MDU/DE/OpioidBriefFactSheet.pdf, 1; Solis, Hilda L and Janice Hahn. "Expanding Timely Access to Comprehensive Substance Use Disorder Treatment for Opioid Users in Los Angeles County." 2018.
257. Interviews CPA1, CPA4, CPA5, CHR2, CHR3.
258. Interviews CPA1, CPA4, CPA5, CHR2, CHR3.
259. Los Angeles County Sheriff's Department. 2017. Opioids. https://lasd.org/opioids.html.

trainings.[260] This likely reflects a positive outcome of LA County's Hub and Spoke system, opioid learning collaboratives, and interagency coordination between DPH and DHS.[261] We recommend that DPA supports efforts to increase X-waiver training among eligible jail and community SUD treatment staff. One interviewee, however, stated that X-waiver trainings alone are not sufficient to increasing access to buprenorphine, which speaks to our third short-term policy recommendation.[262] This interviewee shared that despite having X-waivered providers in the jail setting, some physicians will refuse to prescribe buprenorphine, will not increase the number of patients they can see under their waiver, or will prescribe lower doses of buprenorphine than recommended so that the medication effectively has no action.[263] Education on OUD and buprenorphine in the jail setting, therefore, must address stigma against opioid users and MAT, and should include all staff that work with individuals with OUD including physicians, nurses, and correctional officers.[264]

Our first long-term policy recommendation calls for DHS leadership to create, finalize, and train treatment staff on buprenorphine treatment protocols in the jail. We learned that some correctional healthcare providers feel frustrated about the lack of transparency from correctional health leadership about why buprenorphine treatment protocols are not being approved and implemented.[265] One interviewee stated that the providers are ready to implement buprenorphine and that protocols have been drafted, but that the protocols are being delayed for unknown reasons.[266] Requiring mandatory OUD and MAT training for all new staff will also likely receive pushback from correctional officers and jail nursing staff.[267] One interviewee stated that implementing buprenorphine trainings and protocols may require sheriff and nursing union involvement to negotiate the details of the requirements.[268]

260. Interviews CPA4, CPA5.
261. Interviews CPA4, CPA5, CPA7, CHR2.
262. Interview CPA3.
263. Interview CPA3.
264. Interviews CPA1, CPA2, CPA3, CPA4, CPA5, CPA6, CHR1, CHR2, CHR3.
265. Interviews CPA1, CPA2, CPA4, CPA6.
266. Interview CPA6.
267. Interview CPA1, CPA2, CPA3, CPA6.
268. Interview CPA3.

ADMINISTRATIVE FEASIBILITY

Because of the many opioid learning collaboratives in LA County, there is a wide variety of easily accessible MAT informational resources that can be distributed within DHS and LASD.[269] The DHS is also able to readily increase X-waiver trainings among their staff because they offer these trainings on-site and have a dedicated staff member who conducts the trainings.[270] Requiring all staff to receive education on OUD, MAT, and destigmatizing language when working with individuals with SUD, however, will likely be administratively more challenging because it will require the development of curriculum, dedicated time for training, space to conduct the trainings, and staff to lead the trainings. We recommend for DPA to call on DHS and LASD to invest resources in staff training so that the implementation of MAT within the jails will be successful. Among our long-term policy recommendations, two interviewees stated that creating and training staff on buprenorphine treatment protocols would be relatively easy.[271] One interviewee shared that there are already draft protocols available for the use of buprenorphine in withdrawal management and the protocols are similar to others that nurses are trained to use.[272] Finally, all of our educational recommendations would be more administratively feasible with additional state or federal funding. SAMHSA has previously allocated grant funding to California to increase MAT implementation in criminal justice settings, but DPA can highlight the need for additional funds to provide MAT education to staff within the jails more broadly including correctional officers and nurses.[273]

269. SafeMed LA "Drug Overdose Deaths"; Health Management Associates. (2020). "Resource Library". Addiction Free California: A MAT Expansion Website. https://addictionfreeca.org/Resource-Library; Help for Addiction Recovery & Treatment (HEART) Los Angeles County. Opioid Message Toolkit. 2018. http://publichealth.lacounty.gov/sapc/prevention/PP/OpioidMessageToolkit.pdf.
270. Interviews CPA4, CPA5.
271. Interviews CPA2, CPA6.
272. Interview CPA6.
273. California Department of Health Care Services.

STEP 3: INCREASE TARGETED FUNDING

Several interviewees shared that a significant barrier to expanding buprenorphine access in LA County jails is a lack of funding. Although the Board of Supervisors is supportive of expanding MAT for justice-involved populations and approved funding for staffing related to MAT in the jails, it is unclear among correctional health leadership and physicians if this funding will be used to purchase buprenorphine and offer it as a treatment for OUD in the jails. Therefore, we provide policy recommendations that specify how funding for MAT in LA County jails is used, increase oversight over the use of this funding, and encourage the identification of additional funding streams.

Level of Government	Funding Policy Recommendations	Short Term	Long Term
Local	3.1 Recommend for future L.A. County MAT funding allocations to be attached to specific deliverables such as the purchase of buprenorphine. <u>Advocacy Strategies</u> a. Increase BOS awareness about concerns among DHS leadership about the persistent lack of funding to purchase MAT medications b. Highlight the need for increased transparency in how MAT funding is being allocated in the jails	●	
	3.2 Encourage BOS to require progress reports when funding is allocated to the jail MAT services. <u>Advocacy Strategies</u> a. Emphasize to BOS the lack of progress made in implementing a jail MAT program b. Call for increased BOS oversight and involvement to determine the funding needs and timeline required to implement a buprenorphine pilot program in the jails	●	
	3.3 Advocate for DHS to pursue additional grant funding for the purchase of buprenorphine and launch of a buprenorphine treatment program in the jails.		●
	3.4 Recommend for L.A. County to identify a consistent funding stream for jail MAT services.		●
	3.5 Advocate for increasing state funding for educational efforts regarding OUD and MAT in criminal justice settings.		●

State & Fed	3.6 Advocate for the federal government to repeal the Medicaid Inmate Exclusion Policy.		●

Table 4. Funding Policy Recommendations

ANALYSIS OF FUNDING POLICY RECOMMENDATIONS

POLITICAL FEASIBILITY

Correctional health physicians, administrators, and researchers expressed concern about a lack of funding in the LA County jail system to purchase buprenorphine and other FDA-approved medications for OUD.[274] Although DHS received over five million in funding to staff a MAT expansion project last year, our first policy recommendation calls for future MAT funding allocations from the LA County general fund to be for purchasing medications, the next critical step to making a buprenorphine treatment program possible. We anticipate that DHS may not support this recommendation and would prefer to have flexibility in how MAT funds are used.[275] The lack of a clear timeline or plan for widely offering buprenorphine, however, raises concern among correctional physicians and highlights the need for increased transparency within DHS about the status of their MAT expansion efforts.[276] One interviewee stated that the BOS are supportive of MAT expansion efforts, but may not be aware about ongoing concerns about purchasing the medication.[277] Therefore, another short-term recommendation is for DPA to call on the BOS to make the implementation of buprenorphine in the jails a priority and to utilize their oversight power by asking DHS for progress reports and a timeline. Given the many competing funding needs of LA County, it may be challenging to get the BOS to commit to providing a more consistent and long-term funding stream for buprenorphine treatment in the jails.[278] DPA can advocate for the BOS to divert funds from the LASD to fill this need or highlight the need for the BOS to renegotiate the jail's primary medical contract to include funding for MAT medications.[279]

At the state and federal levels, we recommend for DPA to support current pending legislation that will increase funding opportunities for local jail MAT programs. One example is in California is Assembly Bill 1557, which would

274. Interviews CPA1, CPA2, CPA4, CPA5, CHR1.
275. Interview CPA4.
276. Interviews CPA1, CPA2, CPA4, CPA5, CPA6, CHR1, CHR2, CHR3.
277. Interviews CHR1.
278. Interviews CPA4, CPA5, CHR1, CHR3.
279. Interview CHR3.

establish and fund a three-year pilot MAT program in the San Francisco jail system.[280] Another example of federal legislation is the Community Re-Entry through Addiction Treatment to Enhance Opportunities Act, which was introduced in the House and would create a MAT Correction and Community Reentry Program within the Department of Justice and allocate $50 million to support the expansion of MAT in U.S. correctional facilities.[281] Our interviews suggest, however, that the most significant issue related to MAT funding in jails is the Medicaid Inmate Exclusion Policy that prevents the LA County jail system from billing to Medicaid for SUD treatment services.[282] It is this exclusionary policy that forces the LA County jail system to rely on general county funds and correctional health experts are supportive of repeal efforts, but many acknowledged that this is highly unlikely to happen under the Trump administration.[283]

ADMINISTRATIVE FEASIBILITY

Our interviews suggested that the LA County jail system does not currently have the funding available to purchase buprenorphine, although some interviewees stated that this was more an issue of funding priorities rather than a lack of available funding.[284] When implementing these policy recommendations, DPA can emphasize that the jail system already purchases buprenorphine for pregnant women, and that they can trial an expansion of buprenorphine using their existing procurement process.[285] The LA County jail system can also assess if they can offset buprenorphine costs by implementing the program in collaboration with the Correctional Health Services Division at the Los Angeles County+USC Medical Center, where some pregnant women in the jail are started on buprenorphine.[286] Other potential administrative challenges are if the BOS lack the capacity and resources necessary to increase their oversight of MAT funding and if DHS lacks staffing capacity to pursue additional MAT funding through state grants. DPA can collaborate with the Office of Inspector General and Sheriff Civilian Oversight Commission to explore MAT funding oversight possibilities and can advocate for DHS to dedicate one of the 31 new staff positions recently funded by the BOS to be dedicated to pursuing additional funding streams for buprenorphine treatment.

280. A.B. 1557.
281. U.S. Congress House. Community Re-Entry through Addiction Treatment to Enhance Opportunities Act of 2019, HR 3496, 116th Congress, 1st Sess. https://www.congress.gov/bill/116th-congress/house-bill/3496/text.
282. Interviews CPA1, CPA3, CPA4, CPA5, CPA7, CHR1, CHR2, CHR3.
283. Interviews CPA1, CPA4, CPA5, CPA7, CHR1, CHR2, CHR3.
284. Interviews CPA1, CPA4, CHR1, CHR2, CHR3.
285. Interviews CPA1, CPA2.
286. Interviews CPA1, CPA2, CPA3, CPA5.

STEP 4: PILOT A BUPRENORPHINE TREATMENT PROGRAM

The majority of individuals within the LA County jail system with OUD do not have access to buprenorphine for maintenance therapy. Our interviews with correctional health leadership suggested a lack of urgency within correctional settings because opioid withdrawal is rarely fatal and some staff perceive access to MAT as rewarding bad behavior.[287] Unfortunately, these perceptions contribute to needless suffering in an already vulnerable population and ignore increased post-release overdose mortality rates. Based on information gathered from our interviews, we recommend for LA County Correctional Health to increase access to buprenorphine by first piloting a buprenorphine treatment program among the highest risk populations with OUD in the jails.

287. Interviews CPA1, CPA2, CPA3, CPA4, CPA5, CPA6, CHR2, CHR3

Level of Government	Treatment Access Policy Recommendations	Short Term	Long Term
Local	4.1 Push for the DHS to finalize a buprenorphine implementation plan with a timeline for the launch of a buprenorphine pilot program in the jails. <u>Advocacy Strategies</u> a. Express concern over the lack of a clear timeline and plan for expanding access to buprenorphine within the jails b. Encourage use of resources available for jails to develop a MAT implementation plan	●	
	4.2 Call for the DHS to approve staff protocols for the administration of buprenorphine for maintenance therapy based on existing protocols for pregnant women. <u>Advocacy Strategies</u> a. Highlight the lack of progress DHS leadership has made to approve a protocol for the administration of buprenorphine in the jails a. Urge DHS to prioritize an expedited approval of a buprenorphine maintenance treatment protocol with staff training	●	
	4.3 Recommend launching a small buprenorphine pilot program within one of the jails targeted to high risk populations (e.g., prior overdose, HIV, and other chronic conditions).	●	
	4.4 Offer all FDA-approved MAT medications for the treatment of OUD in all LA County jails.		●
	4.5 Advocate for integration of substance use and mental health treatment within the jails given the high rates of co-occurring disorders.		●
State & Fed	4.6 Advocate for California legislation requiring all county jails to offer all FDA-approved medications for the treatment of OUD.		●
	4.7 Appeal to the Americans with Disabilities Act (ADA) and the Eighth Amendment of the U.S. Constitution to advocate for access to buprenorphine in jails throughout the country.		●

Table 5. Treatment Access Policy Recommendations

ANALYSIS OF TREATMENT POLICY RECOMMENDATIONS

POLITICAL FEASIBILITY

Our first short-term policy recommendation calls for DHS to create and finalize a buprenorphine treatment implementation plan with a clear timeline for when a pilot program could launch in the jails.[288] Correctional health administrators stated that they already have a plan to implement buprenorphine and methadone in the jail, phase one of which will involve the jail partnering with an outside OTP site to provide the medications.[289] Other interviewees, in contrast, stated that the jail system has been talking about offering MAT for over ten years and that they are unlikely to implement the medications any time soon.[290] Finalizing a buprenorphine implementation plan will require the support and collaboration of DHS and LASD leadership. One interviewee stated that efforts to increase MAT in the jails was previously making great progress, but was significantly set back when leadership under the new Sheriff changed and replaced individuals who were supportive of MAT expansion.[291]

Within DHS, correctional physicians expressed concern about the lack of transparency over why buprenorphine treatment protocols, which have already been drafted several times and are currently utilized for pregnant women, are not being implemented throughout the jail system.[292] We recommend for DPA to urge DHS to finalize buprenorphine treatment protocols and include correctional physicians in the implementation process. The final short-term recommendation is for DHS to launch a pilot buprenorphine program for high risk populations in the jail. One correctional health expert stated that buprenorphine treatment programs have been more successful in jail settings when they are first implemented on a small scale so that any problems can be identified and quickly address before scaling up.[293] Likewise, this interviewee stated that LA correctional health leadership is more likely to be supportive of small scale launch rather than a statewide mandate.[294]

In the long-term, we recommend for DPA to advocate for the integration of health, mental health, and SUD treatment services within the jail to decrease the number of departmental divisions that are negatively affecting collaboration efforts and treatment administration. Given that the various departments within the jail are often siloed, the political feasibility of this recommendation is low, but it is essential given that the majority of individuals with SUDs in the jail also have

288. National Council for Behavioral Health, MAT in Jails and Prison Toolkit, 20.
289. Interviews CPA2, CPA5.
290. Interviews CPA4, CHR2, CHR3.
291. Interviews CPA4, CPA5, CHR2, CHR3.
292. Interviews CPA1, CPA4, CPA6.
293. Interview CHR2.
294. Interview CHR2.

cooccurring chronic medical and mental health conditions.[295] One interviewee stated that administering MAT in the jails would not be as challenging if the correctional health leadership integrated SUD treatment into existing medical services.[296] This interviewee shared that there is nothing unique about OUD treatment and that all existing physicians, both general medicine and psychiatrists, should be able to provide buprenorphine treatment.[297] On the state and federal levels, advocating for state or federally mandated OUD treatment in jails will likely be met with political pushback from the jail systems, but these efforts may be needed if buprenorphine implementation continues to be delayed at the local level.[298] The Legal Action Center argues that denying access to MAT in correctional facilities violates the Americans with Disabilities Act (ADA) and potentially violates the Eighth Amendment of the U.S. Constitution that prohibits "cruel and unusual punishment."[299] DHS and LASD will likely want to avoid appeals to ADA and the U.S. Constitution, but DPA can utilize these legal arguments, which have already been shown to be effective in court, to further their advocacy at the state and federal levels.[300]

ADMINISTRATIVE FEASIBILITY

One administrative challenge that has delayed the implementation of buprenorphine in the LA County jail system has been the lack of space and addiction medicine treatment infrastructure within the jails.[301] Others, however, felt that space and infrastructure would not be a problem if correctional health leadership utilized existing infrastructure for other medical and SUD treatment services.[302] While staffing should not be an issue on the correctional health side given the recent increase in MAT staff positions, interviewees stated that a buprenorphine treatment program will likely need a dedicated sheriff deputy to bring individuals to the treatment location and monitor as they take the medication.[303] Some interviewees expressed concerns about the LASD's willingness to dedicate staffing to a buprenorphine treatment program.[304] Likewise, because sheriff and nurse working hours are negotiated through their respective unions, correctional health leadership should include union representatives in buprenorphine treatment program planning.[305] If DPA pursues state or federal mandates for MAT in jails, county jails should receive funding to secure the resources needed to provide high quality OUD treatment.[306]

295. Interview CPA4, CPA5, CPA7, CHR3.
296. Interview CPA4.
297. Interview CPA4.
298. Interviews CHR1, CHR2, CHR3.
299. Friedman Sally and Kate Wagner-Goldstein. 2016. Medication-Assisted Treatment in Drug Courts; Recommended Strategies. Legal Action Center. https://www.lac.org/resource/medication-assisted-treatment-in-drug-courts-recommended-strategies, 16-17.
300. Smith v. Aroostook County, 922 F.3d 41 (1st Cir. 2019).
301. Interviews CPA2, CPA5.
302. Interviews CPA1, CPA2, CPA4, CPA6.
303. Interviews CPA1, CPA2, CPA5.
304. Interviews CPA1, CPA4, CHR2, CHR3.
305. Interview CPA3.
306. Interview CHR2.

Implementing a pilot program will also require an evaluation of the program's effectiveness. An effective pilot program will reduce patient suffering, provide consistent access to buprenorphine treatment in the jails, connect patients to buprenorphine treatment upon release, reduce recidivism rates among individuals with OUD, and reduce post-release overdose rates. We recommend for DHS to contract with an outside organization to evaluate the buprenorphine pilot program and to use the findings to make informed decisions about how to expand the program to all who would benefit from buprenorphine treatment while in the jail system.

CONCLUSION

Access to medication-assisted treatment for opioid use disorder in criminal justice settings is associated with a number of individual and societal benefits including lower rates of overdose mortality, recidivism, hospital admissions, and crime.[307] Despite the abundance of research supporting MAT in criminal justice settings, only a handful of jails and prisons throughout the United States offer buprenorphine treatment to individuals with opioid use disorder. Drug Policy Alliance asked us to evaluate the barriers to buprenorphine treatment in LA County jails and to provide policy strategies to address these barriers. In doing so, we identified five main barriers to buprenorphine treatment in LA, which included a lack of data, misinformation about buprenorphine treatment, stigmatizing attitudes amongst staff, lack of funding, and deficient systems to link individuals to buprenorphine treatment upon release.

Using the information gained from our extensive review of the literature, evidence synthesis, and 20 semi-structured interviews, we developed a stepwise framework to address the significant barriers to buprenorphine treatment in the jails. We identified that Drug Policy Alliance should first prioritize policy recommendations that will increase data collection efforts, followed by education, funding, and program implementation recommendations. We then created a comprehensive list of local, state, and federal policy recommendations to inform Drug Policy Alliance's advocacy within each step. To not overwhelm Drug Policy Alliance's advocacy capacity, the policy recommendations are intended to be followed in a stepwise fashion and implemented as advocacy opportunities arise. Although we believe that these policy recommendations are an important first step in increasing access to buprenorphine in jail settings, we know that there is still a significant amount of work left to be done on this issue. We support Drug Policy Alliance's mission to create a world where individuals can receive treatment instead of punishment and incarceration to address substance use.

307. SAMHSA. Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings, 18-37.

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APPENDIX A-G

APPENDIX A: DE-IDENTIFIED INTERVIEW LIST

Stakeholder Category	Interview Code	Date
Substance Use Treatment Providers & Administrators	SUD 1	1/9/2020
Substance Use Treatment Providers & Administrators	SUD 2	1/11/2020
Substance Use Treatment Providers & Administrators	SUD 3	1/16/2020
Substance Use Treatment Providers & Administrators	SUD 4	1/20/2020
Substance Use Treatment Providers & Administrators	SUD 5	1/30/2020
Correctional Physicians and Administrators	CPA 1	1/16/2020
Correctional Physicians and Administrators	CPA 2	1/17/2020
Correctional Physicians and Administrators	CPA 3	1/20/2020
Correctional Physicians and Administrators	CPA 4	1/20/2020
Correctional Physicians and Administrators	CPA 5	1/23/2020
Correctional Physicians and Administrators	CPA 6	1/27/2020
Correctional Physicians and Administrators	CPA 7	1/31/2020
Correctional Health Policy Makers & Researchers	CHR 1	1/27/2020
Correctional Health Policy Makers & Researchers	CHR 2	2/3/2020
Correctional Health Policy Makers & Researchers	CHR 3	2/11/2020
Correctional Officers	CO 1	1/30/2020
Drug Court Judges	DCJ 1	1/30/2020
Drug Court Judges	DCJ 2	2/5/2020
Drug Court Judges	DCJ 3	2/6/2020
Drug Court Judges	DCJ 4	2/11/2020

APPENDIX B: INTERVIEW GUIDES

INTERVIEW PROTOCOL A – CORRECTIONAL STAFF (JAIL, PROBATION, PAROLE)

Title: Access to Buprenorphine in LA County: Perceptions of Professionals Working with Justice-Involved Individuals
Project Overview: Our study seeks to identify and evaluate access to buprenorphine medication-assisted treatment for justice-involved individuals with opioid use disorder in Los Angeles County. Justice-involved populations include individuals in jail, drug court programs, probation, and parole. We will apply the information learned to create policy recommendations based on a harm reduction framework to address access to buprenorphine and quality of life for justice- involved individuals with opioid use disorder.

Note to the Interviewer: Greet the interviewee, obtain consent to audio record, set up audio recorder, review consent form, and provide the interviewee with an overview of interview question themes.

I. JOB DETAILS	
1. What type of criminal justice setting do you work in?	
2. What is your job within the institution and how long have you been in this role?	
3. What are some of your responsibilities within this role?	
4. Do you see yourself playing a role in the rehabilitation of justice-involved individuals?	*If yes, how so?* *If not, why not?*

<table>
<tr><th colspan="3">III. ACCESS TO BURPRENORPHINE</th></tr>
<tr><td>1. What do you know about the medications used for medication-assisted treatment of OUD?</td><td colspan="2">How did you learn this information?
Do you and your colleagues receive training on this information?</td></tr>
<tr><td colspan="3">If needed, review MAT information sheet with interviewee and answer any questions.</td></tr>
<tr><td>2. Do you think buprenorphine works?</td><td colspan="2">If yes, why?
If no, why not?
If not already discussed, how do you think buprenorphine compares with the other medication options?</td></tr>
<tr><td colspan="3">3. Does your organization offer buprenorphine to clients?</td></tr>
<tr><td colspan="2">IF YES:
Is buprenorphine offered for withdrawal management, maintenance therapy, induction prior to release, or some combination?

<u>If buprenorphine use is limited</u>:
Why is it only used for that purpose/those purposes? (for example, only used for withdrawal management and not for maintenance therapy)</td><td>IF NO:
Why is the medication not currently offered or approved for use?

Do you think this is an issue within your organization? Why or why not?
Do you think the medication should be offered? Why or why not?</td></tr>
</table>

*If offered for **withdrawal support**:* *Which version of the medication is used for justice-involved populations?* *What are the demographics of the people who receive it? (e.g., age, race/ethnicity, gender, insurance, and pregnancy status)* *What is the process of getting the medication?* *What do you think this process is like for clients?* *Who are the physicians who prescribe it?* *Do you communicate with their treatment team?* *How long can they receive the medication for?* *What happens when the client is no longer at risk for withdrawal?*	**NO BURPRENORPHINE AT ORGANIZATION – SKIP TO QUESTION 3**
*If offered for **maintenance therapy**:* *Which version of the medication is used for justice-involved populations?* *What are the demographics of the people who receive it? (e.g., age, race/ethnicity, gender, insurance, and pregnancy status)* *What is the process of getting the medication?* *What do you think this process is like for clients?* *Who are the physicians who prescribe it?* *Do you communicate with their treatment team?* *How long can they receive the medication for?* *What happens when the client completes the program and transitions to the community?*	**NO BURPRENORPHINE AT ORGANIZATION – SKIP TO QUESTION 3**

*<u>If offered for **induction prior to release**:</u>* *Which version of the medication is used?* *What are the demographics of the people who receive it? (e.g., age, race/ethnicity, gender, insurance, and pregnancy status)* *What is the process of getting the medication?* *What do you think this process is like for clients?* *When is the process initiated?* *Who are the physicians who prescribe it?* *Do you communicate with their treatment team?* *Is there follow-up to ensure that they are connected to an opioid treatment program in the community upon release?*	**NO BURPRENORPHINE AT ORGANIZATION – SKIP TO QUESTION 3**
3. Is there a policy at your organization related to buprenorphine?	*If so, what is the policy? What are your thoughts on the policy?* *If not, why do you think no policy exists?* *Do you think additional buprenorphine policies are needed at your drug court/agency, locally, or on the state/federal levels?*
4. To what extent do you believe buprenorphine should be available and used within the criminal justice system?	*Why?* *Should use of buprenorphine be expanded in these settings? Why or why not?* *If so, what do you think it would take to make this happen?* *Why do you think buprenorphine has not been more widely used in these settings?*

IV. CLOSING	
1. Is there something that I have not asked you about that you think is important, or that you think I might want to know?	
2. Do you have any colleagues that you would recommend for us to speak with	

Bring up any individuals mentioned throughout the interview. Ask interviewee for their contact information.

Thank interviewee for participating in the interview. Turn off audio recording. Inform them again that all responses are confidential. If quotes are used, they will be anonymous, and we will reach out with the opportunity to review and edit. Ask interviewee if they would like a copy of the report when complete.

INTERVIEW PROTOCOL B – DRUG COURT SYSTEM

Title: Access to Buprenorphine in LA County: Perceptions of Professionals Working with Justice-Involved Individuals
Project Overview: Our study seeks to identify and evaluate access to buprenorphine medication-assisted treatment for justice-involved individuals with opioid use disorder in Los Angeles County. Justice-involved populations include individuals in jail, drug court programs, probation, and parole. We will apply the information learned to create policy recommendations based on a harm reduction framework to address access to buprenorphine and quality of life for justice- involved individuals with opioid use disorder.

Note to the Interviewer: Greet the interviewee, obtain consent to audio record, set up audio recorder, review consent form, and provide the interviewee with an overview of interview question themes.

I. JOB DETAILS	
1. What type of criminal justice setting do you work in?	
2. What is your job within the institution and how long have you been in this role?	
3. What are some of your responsibilities within this role?	
4. Do you see yourself playing a role in the rehabilitation of justice-involved individuals?	*If yes, how so?* *If not, why not?*

II. OPIOID USE DISORDERS	
1. Approximately what percentage of clients in your program have an OUD?	*If unsure of percentage, are there any patterns that you have noticed?* *Has the percentage changed in recent years? Please explain*
2. How do you know if someone has an OUD?	
3. What steps are taken at your institution once it is known that someone has an OUD?	
As you know, there are various treatment options for OUD. These include: counseling, 12-step groups, residential treatment, and medications including methadone, buprenorphine, and naltrexone. ***Provide interviewee with treatment options information sheet.***	
3. Which treatment options are typically encouraged for individuals with OUD within your organization?	*Are any of these treatments required? If so, which?* *Are any of these treatments restricted or not allowed? If so, which?* *How long can someone receive these treatments?*
4. Which type of treatment for OUD do you think works best for justice-involved populations? Please explain.	*Which do you think is the worst? Please explain.* *How do you think medications compare with counseling and 12-step groups?* *If medications are offered, which medication do you think works best for this population and why?* *How does it compare with the other medication options?*
5. What health services do you think should be offered to this population that is not currently available within your organization?	

<table>
<tr><th colspan="3">III. ACCESS TO BURPRENORPHINE</th></tr>
<tr><td>1. What do you know about the medications used for medication-assisted treatment of OUD?</td><td colspan="2">How did you learn this information?
Do you and your colleagues receive training on this information?</td></tr>
<tr><td colspan="3">If needed, review MAT information sheet with interviewee and answer any questions.</td></tr>
<tr><td>2. Do you think buprenorphine works?</td><td colspan="2">If yes, why?
If no, why not?
If not already discussed, how do you think buprenorphine compares with the other medication options?</td></tr>
<tr><td colspan="3">3. Does your organization offer buprenorphine to clients?</td></tr>
<tr><td colspan="2">IF YES:
Is buprenorphine offered for withdrawal management, maintenance therapy, induction prior to release, or some combination?

<u>If buprenorphine use is limited:</u>
Why is it only used for that purpose/those purposes? (for example, only used for withdrawal management and not for maintenance therapy)</td><td>IF NO:
Why is the medication not currently offered or approved for use?
Do you think this is an issue within your organization? Why or why not?
Do you think the medication should be offered? Why or why not?</td></tr>
</table>

*<u>If offered for **withdrawal support**:</u>* *Which version of the medication is used for justice-involved populations?* *What are the demographics of the people who receive it? (e.g., age, race/ethnicity, gender, insurance, and pregnancy status)* *What is the process of getting the medication?* *What do you think this process is like for clients?* *Who are the physicians who prescribe it?* *Do you communicate with their treatment team?* *How long can they receive the medication for?* *What happens when the client is no longer at risk for withdrawal?*	**NO BURPRENORPHINE AT ORGANIZATION – SKIP TO QUESTION 3**
*<u>If offered for **maintenance therapy**:</u>* *Which version of the medication is used for justice-involved populations?* *What are the demographics of the people who receive it? (e.g., age, race/ethnicity, gender, insurance, and pregnancy status)* *What is the process of getting the medication?* *What do you think this process is like for clients?* *Who are the physicians who prescribe it?* *Do you communicate with their treatment team?* *How long can they receive the medication for?* *What happens when the client completes the program and transitions to the community?*	**NO BURPRENORPHINE AT ORGANIZATION – SKIP TO QUESTION 3**

*<u>If offered for **induction prior to release**:</u>* *Which version of the medication is used?* *What are the demographics of the people who receive it? (e.g., age, race/ethnicity, gender, insurance, and pregnancy status)* *What is the process of getting the medication?* *What do you think this process is like for clients?* *When is the process initiated?* *Who are the physicians who prescribe it?* *Do you communicate with their treatment team?* *Is there follow-up to ensure that they are connected to an opioid treatment program in the community upon release?*	**NO BURPRENORPHINE AT ORGANIZATION – SKIP TO QUESTION 3**
3. Is there a policy at your organization related to buprenorphine?	*If so, what is the policy? What are your thoughts on the policy?* *If not, why do you think no policy exists?* *Do you think additional buprenorphine policies are needed at your drug court/agency, locally, or on the state/federal levels?*
4. To what extent do you believe buprenorphine should be available and used within the criminal justice system?	*Why?* *Should use of buprenorphine be expanded in these settings? Why or why not?* *If so, what do you think it would take to make this happen?* *Why do you think buprenorphine has not been more widely used in these settings?*

IV. CLOSING	
1. Is there something that I have not asked you about that you think is important, or that you think I might want to know?	
2. Do you have any colleagues that you would recommend for us to speak with	

Bring up any individuals mentioned throughout the interview. Ask interviewee for their contact information.

Thank interviewee for participating in the interview. Turn off audio recording. Inform them again that all responses are confidential. If quotes are used, they will be anonymous, and we will reach out with the opportunity to review and edit. Ask interviewee if they would like a copy of the report when complete.

INTERVIEW PROTOCOL C – CORRECTIONAL HEALTHCARE PROVIDERS

Title: Access to Buprenorphine in LA County: Perceptions of Professionals Working with Justice-Involved Individuals
Project Overview: Our study seeks to identify and evaluate the accessibility of buprenorphine medication-assisted treatment for justice-involved individuals with opioid use disorder. We will apply the information learned to create policy recommendations based on a harm reduction framework to address access to buprenorphine and quality of life for justice- involved individuals with opioid use disorder.

Note to the Interviewer: Greet the interviewee, obtain consent to audio record, set up audio recorder, review consent form, and provide the interviewee with an overview of interview question themes.

I. JOB DETAILS	
1. In what agency or criminal justice settings do you practice?	
2. What is your job within this setting and how long have you been in this role	
3. What are some of your responsibilities within this role?	-
4. Do you see yourself playing a role in the rehabilitation of justice-involved individuals?	*If yes, how so?* *If not, why not?*

II. OPIOID USE DISORDERS	
1. Approximately what percentage of your clients have an OUD?	*If unsure of percentage, is there a pattern that you have noticed?* *Has the percentage changed in recent years?*
2. What steps are taken within your organization once it is known that someone has an OUD?	
3. How do justice-involved individuals with OUD get referred to you?	
As you know, there are various treatment options for OUD. These include: counseling, 12-step groups, residential treatment, and medications including methadone, buprenorphine, and naltrexone.	
4. Which treatment options are typically encouraged for individuals with OUD within the agency/criminal justice settings where you practice?	*Are any of these treatments required?* *Are any of these treatments restricted or not allowed?* *How long can someone receive these treatments?*
5. Which type of treatment for OUD do you think works best for justice-involved populations? Please explain.	*Which do you think is the worst? Please explain.* *How do you think medications compare with counseling and 12-step groups?* *If medications are offered, which medication do you think is best for this population and why? How does it compare with the other medication options?* *If buprenorphine is mentioned, which route of administration do you think is best in criminal justice settings?*
6. What health services do you think should be offered to this population that is not currently available within your organization?	

III. ACCESS TO BURPRENORPHINE	
1. Do you have an X-waiver to prescribe buprenorphine?	
IF YES: *Why did you apply for the waiver?* *What was the process like to obtain the waiver?* *How many patients can you treat?* *How do you think the waiver impacts access to buprenorphine?* *Which route of administration do you usually prescribe?* *What is your experience like prescribing the medication in criminal justice settings?*	**IF NOT:** *Why have you not applied for the waiver?* *Do you want to apply for the waiver in the future?* *Do any providers within your organization have the waiver?* *Do you know which route of administration waivered prescribers usually prescribe?* *If known, what experiences do you colleagues have when prescribing the medication in criminal justice settings?* *How do you think the waiver impacts access to buprenorphine?*
2. Does your organization offer buprenorphine to clients?	
IF YES: Is buprenorphine offered for withdrawal management, maintenance therapy, induction prior to release, or some combination?	**IF NO:** *Why is the medication not currently offered or approved for use?* *Do you think this is an issue within your organization? Why or why not?* *Do you think the medication should be offered? Why or why not?*

*<u>If offered for **withdrawal support**:</u>* *Which version of the medication is used for justice-involved populations?* *What are the demographics of the people who receive it? (e.g., age, race/ethnicity, gender, insurance, and pregnancy status)* *What is the process of getting the medication?* *What do you think this process is like for clients?* *How long can they receive the medication for?* *What happens when the client is no longer at risk for withdrawal?*	**NO BURPRENORPHINE AT ORGANIZATION – SKIP TO QUESTION 3**
*<u>If offered for **maintenance therapy**:</u>* *Which version of the medication is used?* *What are the demographics of the people who receive it? (e.g., age, race/ethnicity, gender, insurance, and pregnancy status)* *What is the process of getting the medication?* *What do you think this process is like for clients?* *When is the process initiated?* *How long can they receive the medication for?* *Is there follow-up to ensure that they are connected to an opioid treatment program in the community upon release?*	

*<u>If offered for **induction prior to release**:</u>* *Which version of the medication is used?* *What are the demographics of the people who receive it? (e.g., age, race/ethnicity, gender, insurance, and pregnancy status)* *What is the process of getting the medication?* *What do you think this process is like for clients?* *When is the process initiated?* *Is there follow-up to ensure that they are connected to an opioid treatment program in the community upon release?*	**NO BURPRENORPHINE AT ORGANIZATION – SKIP TO QUESTION 3**
3. Is there a policy at your organization related to buprenorphine?	*If so, what is the policy?* *What are your thoughts on the policy?* *If not, why do you think no policy exists?* *Do you think additional buprenorphine policies are needed at your organization, locally, or on the state/federal levels?*
4. What are your thoughts on the education and training available regarding buprenorphine in your profession and within the criminal justice system?	
5. What are your thoughts on the supply of buprenorphine prescribers in criminal justice settings in LA County?	

IV. CLOSING	
1. Is there something that I have not asked you about that you think is important, or that you think I might want to know?	
2. Do you have any colleagues that you would recommend for us to speak with	

Bring up any individuals mentioned throughout the interview. Ask interviewee for their contact information.

Thank interviewee for participating in the interview. Turn off audio recording. Inform them again that all responses are confidential. If quotes are used, they will be anonymous, and we will reach out with the opportunity to review and edit. Ask interviewee if they would like a copy of the report when complete.

INTERVIEW PROTOCOL D – RESEARCHERS & POLICY MAKERS

Title: Access to Buprenorphine in LA County: Perceptions of Professionals Working with Justice-Involved Individuals
Project Overview: Our study seeks to identify and evaluate the accessibility of buprenorphine medication-assisted treatment for justice-involved individuals with opioid use disorder. We will apply the information learned to create policy recommendations based on a harm reduction framework to address access to buprenorphine and quality of life for justice- involved individuals with opioid use disorder.

Note to the Interviewer: Greet the interviewee, obtain consent to audio record, set up audio recorder, review consent form, and provide the interviewee with an overview of interview question themes.

I. JOB DETAILS	
1. Can you tell me about the organization that you work for and your role in this setting?	
2. Can you talk more about your experience working in correctional health care and with justice-involved individuals with opioid use disorder?	

II. OPIOID USE DISORDERS	
1. Have you noticed a change in the prevalence of opioid use disorder among individuals in correctional settings in the US?	*In California?* *In Los Angeles?*
2. How are individuals with opioid use disorder typically identified within LA County jails and prisons?	

3. Which treatment options are typically encouraged for justice-involved individuals with opioid use disorder in LA?	*How long can someone receive these treatments?*
4. Which type of treatment for OUD do you think works best for justice-involved populations? Please explain.	*Which do you think is the worst? Please explain.* *How do you think medications compare with counseling and 12-step groups?* *If medications are offered, which medication do you think works best for this population and why?* *How does it compare with other medication options?* *If buprenorphine is mentioned, which formulation and route of administration do you think is best in criminal justice settings?* *Are the treatments identified as best currently available in LA County correctional settings?*
6. What health services do you think should be offered to this population that is not currently available within LA County correctional settings?	

III. MEDICATION-ASSISTED TREATMENT (MAT)	
1. What do you think are the main barriers and facilitators to integrating MAT into prison and jail health systems?	*How can these barriers be overcome?* *Do the barriers and facilitators differ based on the medication?* *If yes, how so?* *Which medication is the most challenging to integrate into correctional health systems and why?*

IV. ACCESS TO BURPRENORPHINE

Within LA County jails, buprenorphine is currently only used for withdrawal management for pregnant women.	
1. Why is buprenorphine currently only available to pregnant women?	*Who prescribes the medication?* *Correctional health providers or contracted agencies?*
2. Is methadone maintenance therapy currently offered within LA County jails?	*If so, why methadone maintenance instead of buprenorphine maintenance?* *If not, what are some of the challenges in implementing maintenance therapy in these settings?*
3. What are some of the key issues for correctional health systems when exploring offering buprenorphine for all inmates for withdrawal management, maintenance therapy, and/or induction prior to release?	*Where is LA County in this process?* *What are the main challenges?* *How long before these programs get implemented?*
4. Do you think additional policies related to buprenorphine in correctional settings are needed at the organizational, local, and/or state/federal levels?	*If so, what types of policies are needed?* *If not, why not?*
5. To what extent do you believe buprenorphine should be available and used within the criminal justice system?	*Why?* *Should use of buprenorphine be expanded in these settings? Why or why not?* *If so, what do you think it would take to make this happen?* *Why do you think buprenorphine has not been more widely used in these settings?*

IV. CLOSING	
1. Is there something that I have not asked you about that you think is important, or that you think I might want to know?	
2. Do you have any colleagues that you would recommend for us to speak with	

Bring up any individuals mentioned throughout the interview. Ask interviewee for their contact information.

Thank interviewee for participating in the interview. Turn off audio recording. Inform them again that all responses are confidential. If quotes are used, they will be anonymous, and we will reach out with the opportunity to review and edit. Ask interviewee if they would like a copy of the report when complete.

APPENDIX C: JOHNS HOPKINS EBP METHODS

We sought journal articles, professional publications, conference abstracts, and opinion pieces in multidisciplinary databases. On September 19, 2019 we searched the following databases: PubMed, Embase, Cochrane Library, CINAHL, PsycINFO, SocINDEX, Web of Science, and Google Scholar. We built sensitive search strategies including keywords and controlled vocabularies (when available) for the concepts of buprenorphine, opioid use disorder, and incarceration.

PubMed (National Library of Medicine)
("Opioid-Related Disorders"[Mesh] OR ((opioid OR opioids OR heroin OR morphine OR opium OR opiate OR narcotic OR narcotics) AND (dependen* OR disorder OR disorders OR use OR misuse OR abuse OR addict*))) AND ("Buprenorphine"[Mesh] OR buprenorphine OR buprenex OR prefin OR subutex OR buprex OR temgesic) AND ("Prisons"[Mesh] OR "Prisoners"[Mesh] OR prison* OR jail OR jails OR inmate OR inmates OR incarcerat* OR imprison* OR penitentiary OR penitentiaries OR correctional OR probation* OR parole OR parolee OR parolees OR drug court OR drug courts OR "juvenile hall" OR justice OR criminal)

Embase (Elsevier)
'opiate addiction'/exp OR ((opioid OR opioids OR heroin OR morphine OR opium OR opiate OR narcotic OR narcotics) AND (dependen* OR disorder OR disorders OR use OR misuse OR abuse OR addict*)) AND ('buprenorphine'/exp OR buprenorphine OR buprenex OR prefin OR subutex OR buprex OR temgesic) AND ('prison'/exp OR 'prisoner'/exp OR prison* OR jail OR jails OR inmate OR inmates OR incarcerat* OR imprison* OR penitentiary OR penitentiaries OR penal OR correctional OR probation* OR parole OR parolee OR parolees OR drug court OR drug courts OR "juvenile hall" OR justice OR criminal)

CINAHL (EBSCO)
((opioid OR opioids OR heroin OR morphine OR opium OR opiate OR narcotic OR narcotics) AND (dependen* OR disorder OR disorders OR use OR misuse OR abuse OR addict*)) AND (MH "Buprenorphine" OR buprenorphine OR buprenex OR prefin OR subutex OR buprex OR temgesic) AND (MH "Correctional Facilities" OR MH "Correctional Health Services" OR MH "Correctional Facilities Personnel" OR MH "Prisoners" OR prison* OR jail OR jails OR inmate OR inmates OR incarcerat* OR imprison* OR penitentiary OR penitentiaries OR penal OR correctional OR probation* OR parole OR parolee OR parolees OR drug court OR drug courts OR "juvenile hall" OR justice OR criminal)

PsycINFO (ProQuest)
(DE "Opioid Use Disorder" OR DE "Heroin Addiction" OR DE "Morphine Dependence" OR ((opioid OR opioids OR heroin OR morphine OR opium OR opiate OR narcotic OR narcotics) AND (dependen* OR disorder OR disorders OR use OR misuse OR abuse OR addict*))) AND (DE "Buprenorphine" OR buprenorphine OR buprenex OR prefin OR subutex OR buprex OR temgesic) AND (DE "Prisoners" OR DE "Probation" OR DE "Correctional Institutions" OR DE "Prisons" OR DE "Reformatories" OR DE "Correctional Psychology" OR DE "Corrections Officers" OR prison* OR jail OR jails OR inmate OR inmates OR incarcerat* OR imprison* OR penitentiary OR penitentiaries

OR penal OR correctional OR probation* OR parole OR parolee OR parolees OR drug court OR drug courts OR "juvenile hall" OR justice OR criminal)

SocIndex (EBSCO)
(((opioid OR opioids OR heroin OR morphine OR opium OR opiate OR narcotic OR narcotics) AND (dependen* OR disorder OR disorders OR use OR misuse OR abuse OR addict*))) AND (buprenorphine OR buprenex OR prefin OR subutex OR buprex OR temgesic) AND (prison* OR jail OR jails OR inmate OR inmates OR incarcerat* OR imprison* OR penitentiary OR penitentiaries OR penal OR correctional OR probation* OR parole OR parolee OR parolees OR drug court OR drug courts OR "juvenile hall" OR justice OR criminal)

Web of Science (Clarivate Analytics)
(((opioid OR opioids OR heroin OR morphine OR opium OR opiate OR narcotic OR narcotics) AND (dependen* OR disorder OR disorders OR use OR misuse OR abuse OR addict*))) AND (buprenorphine OR buprenex OR prefin OR subutex OR buprex OR temgesic) AND (prison* OR jail OR jails OR inmate OR inmates OR incarcerat* OR imprison* OR penitentiary OR penitentiaries OR penal OR correctional OR probation* OR parole OR parolee OR parolees OR drug court OR drug courts OR "juvenile hall" OR justice OR criminal)

We exported the resulting citations from each database into EndNote Online. Research team members sorted through the title and abstracts for relevance and included publications from the last 10 years that were relevant to the questions regarding effectiveness and barriers to access among incarcerated populations. We used the JHEBP critical appraisal tools for research and non-research evidence to determine the level of evidence and its quality. A summary of this process can be found in Appendix D.

APPENDIX D: JOHNS HOPKINS EBP FINDINGS

INDIVIDUAL EVIDENCE SUMMARY TOOL

EBP Question: Does buprenorphine safely and effective treat opioid use disorders (OUDs) among justice involved individuals?

Date: 2020-02-02

Article Number	Author and Date	Evidence Type	Sample, Sample Size, Setting	Findings That Help Answer the EBP Question	Observable Measures	Limitations	Evidence Level, Quality
1	Gordon et al 2014	Randomized Controlled Trial	**Male & Female Pre-Release Prisoners in Baltimore N = 211** ❑ N/A	Buprenorphine is a feasible treatment for OUDs in the prison setting with a low rejection rate by inmates Buprenorphine for treat OUDs facilitates community re-entry Diversion is a valid concern for buprenorphine use in prisons	Entered Prison Treatment Completed prison treatment Entered community treatment	Baltimore only Excluded psychosis and suicidality Mostly male	Level I Quality B
2	Gordon et al 2017	Randomized Controlled Trial	**Male & Female Pre-Release Prisoners in Baltimore N = 211** ❑ N/A	In-prison treatment condition effect had a higher mean number of days of community buprenorphine treatment compared to the condition in which participants initiated medication after release	Self-reported drug use	Urine testing loss due to follow up Mostly male	Level I Quality B
3	Bi-Mohammed et al 2017	Systematic Review	**10 qualitative and observational studies** ❑ N/A	Prisons are susceptible environments for diversion – age and comorbidities increase odds of victimization Mono-buprenorphine more likely to be abused/diverted than buprenorphine-naxolone combo Opioid drugs should be prescribed in least abuseable forms Balance between not under-dosing (prisoners	Illicit drug use Treatment characteristics	Lack of high-quality empirical studies	Level III Quality B

				resorting to illicit opioids) and avoiding excessive prescriptions (prisoners relying on diversion)			
4	Banta-Green et al 2017	Randomized Controlled Trial	**15 males entering probation** ❑ N/A	Treatment decision making and care navigation were well received by participants (value in education in providing EBP) Infeasible given logistical issues with corrections systems and competing demands on people being released from prison.	Demographics Treatment navigation	Misclassification of participants Unable to compensate participants Changes in release schedules	Level I Quality B
6	Bahji et al 2019	Systematic Review with Meta-Analysis	**11 studies involving 1,045 justice-involved patients** ❑ N/A	Naltrexone efficacious and acceptable for treating OUDs among justice-involved individuals More adverse events compared to treatment as usual and not associated with reduced use in cannabis, alcohol, benzodiazepines, or stimulants	Re-incarceration Retention in treatment Opioid abstinence Other substance use OUD symptoms Adverse events	Most studies small, unblinded, and short Over-representation of young white males without comorbidities	Level II Quality A
7	Cropsey et al 2011	Randomized Controlled Trial	**39 justice involved women** ❑ N/A	Buprenorphine initiated in a controlled environment and continued in community prevents/delays relapse to opioid use. Efficacy only during time of medication administration (most relapsed 3 months following). Acceptable and feasible in community-based setting Illicit use of buprenorphine not in treatment group attempt to avoid withdrawal while waiting for treatment	Addiction Severity Index Vital Signs Urine drug screening	Pilot study – small number of participants Only adult women Buprenorphine causes positive urinary analysis	Level I Quality B
8	Crowley et al 2017	Systematic Review	**14 studies 18,294 participants**	Prisoners on buprenorphine or methadone on discharge had reduced mortality risks in the immediate 4 weeks post-release Insufficient evidence demonstrating reduction in non-fatal overdoses or continuing other illicit drug use	Treatment retention Non-fatal overdose Overdose mortality Continued drug use Quality study appraisal	Most studies small, male only, without mental illness Limited synthesis due to study design Lack of geographical diveristy	Level III Quality B

9	Green et al 2018	Retrospective Cohort Study	**4,000+ inmates**	The launch of a standard screening and MAT protocol in Rhode Island prisons 12.3% reduction in overdose deaths Increase in prescription of MAT following release with a decrease in naloxone	Overdose deaths	Small sample Lack of data post-release Misclassification program exposure	Level III Quality A
10	Banta-Green et al 2020	Retrospective Cohort Study	**3,742 inmates**	Implementation of a one-time treatment decision making model associated (MOUD education, history of use, motivational interviewing) with increase in MOUD update during first month after release with no significant difference after the first month White women most likely to initiate MOUD	Criminal history MAT received	Misclassification of OUD status Unintentional cross over Loss to follow up	Level III Quality B
11	Brezel et al 2019	Ethical Analysis	**N/A**	Persons who are incarcerated have the right to evidence-based healthcare Prisons are government institutions and have an obligation to provide that evidence-based treatment	Stigma Security Safety Lack of Resources	Non-research	Level V Quality B
12	Fox et al 2014	Retrospective Cohort Study	**27 released inmates**	6 month retention low for opioid dependence (33%) 19% of buprenorphine recipients reduced opioid use Poor results led to initiative of peer-mentorship program	Time between release and treatment entry Treatment retention	Small sample size Retrospective Lack of control group Patient transfers Community health workers not always available	Level III Quality C
13	Gisev et al 2015	Population-based Retrospective Data Linkage	**13,468 released inmates**	Methadone and buprenorphine given on release from prison is cost-effective in reducing mortality in the first 6 months of release	Mortality Costs of treatment, incarceration, crime	Conservative cost analysis Observational data Population level Underestimate of criminal activity	Level III Quality A
14	Malta et al 2019	Systematic Review	**46 studies**	Participants treated at correctional institutions with medication assisted therapy had higher adherence to addiction treatment, lower rates of relapse, less likely to be re-incarcerated and more likely to be working 1 year later Participants who received opioid agonist treatment	Population Study Design Intervention Outcomes	Heterogeneity of studies Insufficient data about incarcerated women Missing data from un-	Level III Quality B

				while incarcerated and were adequately linked into post-release care were less likely to experience nonfatal overdoses and reduced mortality		published studies	
15	Velasquez et al 2019	Qualitative	**33 released inmates**	Participants receiving buprenorphine-naloxone for maintenance reported satisfaction and intention to continue treatment. Participants also reported office-visits as a barrier and waitlists to receive care.	Demographics Barriers Facilitators	Convenience sampling Small number of participants No buprenorphine dropouts	Level III Quality B
17	Pierce et al 2016	National Cohort Study	**151,983 participants**	Patients who received only psychological support for opioid dependence in England appear to be at greater risk of fatal opioid poisoning than those who received opioid agonist pharmacotherapy.	Fatal overdoses Time in treatment Demographics	Inaccurate treatment end date Observational study Lack of psychotherapy type data	Level III Quality A
18	Kampman & Jarvis 2015	Guidelines	**N/A**	Pharmacotherapy for the continued treatment of opioid use disorders, or the initiation of pharmacotherapy, has been shown to be effective and is recommended for prisoners and parolees regardless of the length of their sentenced term. Individuals with opioid use disorder who are within the criminal justice system should be treated with some type of pharmacotherapy in addition to psychosocial treatment. Opioid agonists (methadone and buprenorphine) and antagonists (naltrexone) may be considered for treatment. There is insufficient evidence to recommend any one treatment as superior to another for prisoners or parolees. Pharmacotherapy should be initiated a minimum of 30 days before release from prison.	N/A	Non-research	Level IV Quality A
19	Blue et al 2019	Randomized Controlled Trial	**211 inmates**	Participants assigned to begin buprenorphine in the community experienced a greater decrease in injection drug use over time compared to participants assigned to begin buprenorphine in prison.	HIV risk behaviors	Low response rate (54%) Assumptions of hierarchal linear models Self-reported data	Level I Quality A

21	Krawczyk et al 2017	Case Control Study	**72,084 treatment episodes**	Only 4.6 percent of justice-referred clients received agonist treatment, compared to 40.9 percent of those referred by other sources. Of all criminal justice sources, courts and diversionary programs were least likely to refer people to agonist treatment.	MAT use in treatment Referral source	Limited to first time treatment Missing data for some states Variation in referral reporting Missing office-based prescription from primary care Dose and length of treatment missing	Level III Quality A

Attach a reference list with full citations of articles reviewed for this EBP question.

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APPENDIX E: COST CALCULATOR

The Franklin County Sheriff's Office in Massachusetts made a detailed calculator for the costs of providing buprenorphine/naloxone (brand name Suboxone®) treatment in their jails to 30 individuals. Although the costs may vary between states and counties, it can be a useful estimator for jails planning to implement buprenorphine. The calculator is divided into three parts: medication costs, drug screening costs, and staffing costs. Because this calculator was designed for buprenorphine treatment, they calculated the medication cost based on an 8mg daily dose of Suboxone® per patient, per year. For drug screening, the jail used a 11-panel test ($10) and a quick cups test ($1.46), specifically, for fentanyl. The 11 panels tests for amphetamine, cocaine, opiates, benzodiazepine, THC, oxycodone, heroin, buprenorphine, alcohol, creatine, and K2. Throughout the week, jail staff administer various random and scheduled screening which amounts to 63 screens per week. Lastly, staffing costs are split into two group: dispensing/prescribing and psychosocial therapy. For dispensing and prescribing purposes, the jail requires a total of three security staff, one registered nurse, and one prescriber. For psychosocial therapy, the jail implemented cognitive behavioral therapy (CBT) which requires additional staffing hours for therapy, case management, and administration. The total cost of their Suboxone® treatment program came out to be $376,688.71 per year, which translates to $12,556.29 per patient.

Breakdown of Costs

Medication Cost

Suboxone 8mg - $2.70

Patients	**Cost/dose**	**Days/year**	**Total**
30	$2.70	365	$29,565.00

Drug Screening

Screens/week	Cost	Weeks/year	Total Cost
63	$11.46	52	$37,542.96

Staffing Costs

Security
For Dispensing Process

Staff	Hrs/day	Days/Year	Wage/hour	Total
3	2.5	365	$26.70	$73,091.25

Registered Nursing
For Dispensing & Intake

Staff	Hrs/day	Days/Year	Wage/hour	Total
1	5	365	$35	$63,875

Prescribing Staff (nurse practitioner)

Staff	Hrs/day	Days/Year	Wage/hour	Total
1	2	365	$56.25	$41,062.50

Cognitive Behavioral Treatment
3 Groups of 10 people/Group
Psychoeducation and Recovery Planning

Staffing Hours
includes prep, casenotes, group delivery

Hours/week	Wage/Hour	Weeks/Year	Total
9	$32	52	$14,976

Case Management
Specific to MAT (not general reentry case management)

Hours/week	Wage/Hour	Weeks/Year	Total
20	$32	52	$33,280

Post Release Case management

Annual Cost
$60,000

Administration

Medical, Security, Treatment

Hours/week	Wage/Hour	Weeks/Year	Total
8	$56	52	$23,296

Buprenorphine/Naloxone Program Cost

Medication	$29,565.00
Drug Screening	$37,542.96
Security Staff	$73,091.25
Nursing Staff	$63,875
Prescribing Staff	$41,062.50
CBT	$14,976
Case Management	$33,280
Post-Release Case Management	$60,000
Administration	$23,296
Total	$376,688.71

Cost per person per year	**$12,556.29**

APPENDIX F: COMMUNITY ACCESS POLICY RECOMMENDATIONS

Another significant barrier not discussed in the report is ensuring that there is sufficient access to buprenorphine in community treatment settings to provide continuity of care upon release from LA County jails. If the LA County jail system offers buprenorphine to individuals with OUD, they will become the largest buprenorphine provider in LA County and possibly in the nation.[308] The scale of the county jail system has contributed to concerns among correctional health leadership, physicians, and researchers about the availability of buprenorphine providers in the community to continue maintenance therapy upon release.[309] One interviewee shared the example of the Rhode Island DOC who started offering buprenorphine in the jails, but then realized that there were not a sufficient number of buprenorphine providers in the community to meet the demand upon release.[310] Others, in contrast, believed that this deficiency would not be replicated in LA County, and felt that these concerns should not delay providing MAT access in the jail.[311] One correctional physician stated that the issue is not the availability of buprenorphine providers in the community, but rather the lack of pipelines available to connect individuals with OUD to existing LA County MAT providers upon release.[312] This interviewee stated that current county MAT services are underutilized, possibly because of a lack of awareness of these services and a need to support justice-involved populations in accessing these treatment centers.[313] While LA County pharmacies will provide access to buprenorphine, other local pharmacies may be apprehensive to provide buprenorphine in the community due to increased DEA oversight, additional security requirements for storing buprenorphine, and perceived stigma associated with serving MAT clients.[314]

Our interviews and evidence synthesis illustrated the importance of developing a coordinated jail-to-community referral system and a comprehensive network of buprenorphine treatment providers who will serve justice-involved populations in the community.[315] In 2014, only 4.6% of justice-involved individuals in the U.S. received referrals for methadone or buprenorphine treatment compared to 40.6% of their general population counterparts.[316] Incarceration interrupts an individual's insurance coverage and post-release many individuals face compounding stressors such as poverty, mental health conditions, and disrupted social supports that make it difficult to access buprenorphine treatment and

308 Interview CPA5
309 Interview CPA2, CPA4, CPA5, CPA7
310 Interview CPA5
311 Interviews CPA2, CPA3, CPA4, CPA7
312 Interview CPA4
313 Interview CPA4
314 Interviews CPA5, CHR3
315 Interviews CPA4, CPA5, CPA7, CHR3
316 Krawczyk, 2050.

increases the risk of post-release opioid overdose.[317] California has already been working to address this issue through the California Hub and Spoke MAT Expansion Program.[318] The California Department of Health Care Services (DHCS) received funding from SAMHSA to develop a Hub and Spoke system, modeled by Vermont, to identify SUD treatment agencies (Hubs) that can partner with community health clinics (Spokes) to develop a MAT treatment network that will reach individuals who otherwise may not engage with or be able to access specialty SUD treatment services.[319] In LA County there are two Hub sites (Clare I Matrix and Tarzana Treatment Centers) that are partnered with 38 clinic sites.[320] The Substance Abuse Prevention and Control (SAPC) Division of DPH has also been working in LA County to increase the number of X-waivered providers and move community clinics from the contemplative phase into implementing MAT services.[321]

Below are the short and long-term policy recommendations to address community access to buprenorphine for newly released individuals on the local, state, and federal levels:

Level of Government	Community Access Policy Recommendations	Short Term	Long Term
Local	A.1 Encourage SAPC and Correctional Health to connect individuals released from the jail to community treatment providers who offer MAT services.	●	
	A.2 Advocate for LA County to target MAT expansion efforts among substance use treatment providers contracted to work within the criminal justice system including the jails and drug courts.	●	
	A.3 Call for the LA Sheriff's Department to increase collaboration and transparency of release dates and times so that connections to community substance use treatment agencies can be established prior to release.	●	
	A.4 Recommend for LA County to create MAT bridge clinics for individuals newly released from the jail system.		●

317 Joudrey, 2-8.
318 Darfler, K., Urada, D., Antonini, V., Padwa, H., Joshi, V., & Sandoval, J. (2018). California State Targeted Response to the Opioid Crisis: Year 1 Evaluation Report. Los Angeles, CA: UCLA Integrated Substance Abuse Programs,13.
319 Darfler, 12-14.
320 Darfler, 14-15; California Hub and Spoke System: MAT Expansion Project. 2020. Find a Treatment Center
321 Interview CPA7

	A.5 Advocate for the LA Sheriff's Department to work with DHS to create a standardized system for connecting individuals in the jail with resources and referrals to treatment services prior to release.		●
State & Fed	A.6 Advocate for California Hub and Spoke funding to be granted to LA County for the expansion of jail MAT services.		●
	A.7 Support legislative efforts that increase funding to the expansion of MAT among community substance use treatment agencies.		●
	A.8 Advocate for the removal of the federal X-waiver requirement in order to prescribe buprenorphine in community and jail treatment settings.		●

APPENDIX G: IMPLICATIONS OF COVID-19 PANDEMIC

In light of the COVID-19 pandemic individuals with opioid-use disorders are at an increased risk of relapse and overdose and stay at home orders have been documented as a triggering phenomenon.[322] Under social distancing practices, clinicians have been shifting towards telemedicine for prescribing and managing medication-assisted treatment for opioid use disorder. Telemedicine typically refers to the use of videoconferencing software to connect providers and patients in real time for direct care delivery but can also include the asynchronous transmissions of medical information or the use of telephones or text-messaging.

During public health emergencies, the Drug Enforcement Agent of the United States (DEA) allows for registered practitioners to issue prescriptions for controlled substances without an in-person evaluation under the following three conditions[323]:

1. Practitioner is acting in the usual course of their professional practice
2. Practitioner delivers treatment via telemedicine
3. Practitioner acts in accordance with Federal and State law

Following these guidelines additional accommodations for telemedicine were endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) allowing for the initiation of buprenorphine without an in-person visit using videoconferencing or over the telephone.[324]

In addition to a systematic review documenting the safety and effectiveness of prescribing buprenorphine in the telemedicine setting[325], we see the opportunity in crisis for further investigation of using telemedicine in expanding access to buprenorphine, particularly among justice-involved individuals. Of particular interest will be barriers practitioners are currently experiencing including how to conduct urinalysis among their patients, how to keep up with constantly changing regulations, as well as patient and clinician comfort with technology.

322. Providers Clinical Support System. Telemedicine-Delivered Buprenorphine Treatment in the Age of COVID-19. April 2, 2020.
323. U.S. Department of Justice Drug Enforcement Administration. Letter to DEA Qualifying Practitioners, DEA068. March 31, 2020.
324. Substance Abuse and Mental Health Administration. COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance. March 31, 2020.
325. Lin, L. A., Casteel, D., Shigekawa, E., Weyrich, M. S., Roby, D. H., & McMenamin, S. B. (2019). Telemedicine-delivered treatment interventions for substance use disorders: A systematic review. Journal of substance abuse treatment, 101, 38-49.