COMPLYING WITH COLORADO HOUSE BILL 22-1326

A GUIDEBOOK FOR COLORADO'S RURAL COUNTY JAILS SUPPLYING MEDICATIONS FOR OPIOID USE DISORDER

New Otero County Jail under construction 2024. Photo taken by The Schreiber Research Group (Terri Schreiber and Maddie Peloff).

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EXECUTIVE SUMMARY

This guidebook is a resource developed for Colorado's rural county jails to aid in the implementation of medications for opioid use disorder (MOUD) as mandated by Colorado House Bill 22-1326.[1] This manual provides essential guidelines to effectively address the opioid use disorder (OUD) within the jail system, offering both practical strategies and regulatory compliance methods for the administration of MOUD.

This guidebook is designed to guide jail administrators in managing OUD among people who are incarcerated. By implementing the recommended practices, jails can not only improve health outcomes for individuals but also reduce the societal effects of the opioid epidemic. The executive summary highlights the guidebook's purpose to empower and guide jail administrators on integrating MOUD effectively, ensuring legislative compliance and improving the treatment infrastructure within the Colorado county jails.

This study was informed by research conducted by The Schreiber Research Group, funded by Colorado Senate Bill 21-137,[2] the Behavioral Health Recovery Act, which assessed MOUD services across seven county jails.[3] The funding was provided through a grant from the Colorado Consortium for Prescription Drug Abuse Prevention to Valley-Wide Health Systems, with TSRG serving as a subcontractor to the Rural Recovery Network. This guidebook underscores the value of MOUD in managing OUD, particularly in rural Colorado. The guidebook complements national practices with practical tools, treatment programs, workflows, and references, enabling jail administrators to implement and maintain effective MOUD programs. This collaborative approach is crucial for addressing the opioid epidemic across Colorado and the broader United States. Below is a summary of the key objectives and strategies included.

Key Objectives and Strategies Contained Within:

ADA Compliance (Page 6)	This section highlights the significance of the Americans with Disabilities Act, under which individuals with OUD are considered to have a disability. This designation mandates that state and local government facilities, including jails, must provide necessary treatments for OUD to prevent discrimination.
Financial and Logistical Challenges (Pages 7, 10)	This section discusses funding mechanisms, cost management, and solutions to common challenges such as preventing drug diversion and ensuring continuity of care post-release.
Implementation Guidelines (Page 8)	This section provides detailed protocols for the assessment, prescription, and administration of MOUD, including innovative delivery methods like telehealth and mobile services.
Legislative Compliance (Page 6, 15, 18)	This section explains the obligations under HB22-1326, emphasizing the need for jails to provide MOUD or report why they cannot.
MOUD v. MAT (Page 6)	This section clarifies the distinction between medication assisted treatment (MAT) and medications for opioid use disorder (MOUD), advocating for MOUD as a more focused term.
Operational Guidance (Page 10, 16, 30, 31, 32, 33, 34, 35)	This section outlines the infrastructure requirements, staff training protocols, and collaborative guidance necessary to facilitate MOUD programs effectively.
Regulatory Adherence (Page 16, 35)	This section highlights the importance of complying with federal and state guidelines for the safe handling and storage of medications to prevent misuse.

Disclaimer

This guidebook is based on current best available evidence regarding OUD framed within the context of legal and regulatory provisions. It is intended as a general guide to be applied in OUD care within detention programs and correctional settings. It is not intended for addressing other substance use disorders (SUDs) nor co-occurring mental health conditions. Detention and correctional settings have ultimate discretion and responsibility for their provision of clinical care as well as associated policies, procedures, and protocols. As the evidence base and direct experience are constantly evolving and specific practices vary widely, applications of this guide are expected to be continually evolving to remain relevant and effective.

CONEJOS COUNTY JAIL SOURCE: INMATE AID (2024).

Table 1. Common Terms and Acronyms

Acronym	Definition
42 CFR	Title 42 Code of Federal Regulations (Part 2, and Part 8) which includes requirements related to protecting the confidentiality of certain specific health information.
ADA	Americans with Disabilities Act is a federal law that protects the rights of individuals with disabilities. A diagnosed SUD may be considered a disability under the ADA, and denying medications for use disorders can place jails at risk for litigation.
ASAM	ASAM stands for the American Society of Addiction Medicine. It is a professional society representing over 7,500 physicians, clinicians, and associated professionals in the field of addiction medicine.
CFR	Code of Federal Regulations, which is updated annually with regulations for the operation of each federal government agency.
COWS	The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scoring system used by clinicians to rate and monitor the signs and symptoms of opiate withdrawal in patients. This tool helps to quantify the severity of opiate withdrawal and guide treatment decisions. It differs from SOWS in that it does include vital signs.
DEA	The Drug Enforcement Administration is a federal law enforcement agency within the U.S. Department of Justice. The DEA provides regulatory oversite in administration of MOUD in jail settings, ensuring controlled substances are provided in a safe, effective, and legal manner.
FDA	Food and Drug Administration, which is a federal agency within the Department of Health and Human Services. The FDA oversees approval and regulation of drugs for use to ensure safe and effective use.
HIPAA	Health Insurance Portability and Accountability Act of 1996 (HIPAA) Health Information Privacy, which includes requirements related to protecting the confidentiality of certain specific health information.
JBBS	Jail Based Behavioral Health Services is a branch of the Colorado Behavioral Health Administration (BHA). JBBS supports Colorado jails in providing behavioral health services to incarcerated populations.
MARC	The Medication Assisted Recovery Center is an Opioid Treatment Program (OTP) located in Pueblo, and Trinidad, Colorado. MARC provides various addiction treatment services, including all three FDA-approved MOUDs and other therapeutic options.
MAT	Medication Assisted Treatment (medications and behavioral health treatment for substance use disorders)
MOU	A Memorandum of Understanding is a legal contract that outlines an agreement between two or more parties.
MOUD	Medications for Opioid Use Disorder
NCCHC	National Commission on Correctional Health Care, an independent, non-profit organization whose mission is to improve the quality of health care in jails, prisons, and juvenile facilities.
NP	Nurse Practitioner (able to prescribe buprenorphine)
NTP	Narcotic Treatment Program (SAMHSA certified for methadone administration, interchangeable with OTP and a term used by the DEA)
OTP	Opioid Treatment Program (SAMHSA certified for methadone administration, interchangeable with NTP and a term used by SAMHSA)
OUD	Opioid Use Disorder
PA	Physician Assistant (able to prescribe buprenorphine with a federal waiver)[4]
PDMP	Prescription Drug Monitoring Program, which is an electronic database that tracks the prescriptions of controlled substances.
QMAP	In Colorado, a Qualified Medication Administration Personnel (QMAP) is trained to administer medications under certain conditions and in specific settings. However, the guidelines for QMAPs do not explicitly mention their authorization to administer medications in correctional facilities, such as jails.
SAMHSA	Substance Abuse and Mental Health Services Administration, which is a federal agency within the U.S. Department of Health and Human Services that leads national public health efforts to address behavioral health issues and improve behavioral healthcare service delivery.
SNAP	Supplemental Nutrition Assistance Program is a federal program that provides benefits to eligible families to support their grocery costs.
SOAP	Standard medical record notes inclusive of Subjective, Objective, Assessment, and Plan sections
SOWS	The Subjective Opiate Withdrawal Scale (SOWS) is a self-assessment tool designed to measure the intensity of opiate withdrawal symptoms from the patient's perspective. It comprises 16 items that patients rate on a scale from 0 (not at all) to 4 (extremely), reflecting the severity of each symptom they experience. It differs from COWS in that it does not include vital signs.
SUD	Substance Use Disorder
TSRG	The Schreiber Research Group is a Colorado-based non-profit that utilizes research and community engagement to improve outcomes associated with addiction-prone substances.
XR-NTX	Extended-release injectable naltrexone (Brand name: Vivitrol)

MANDATE REQUIREMENTS

What is HB22-1326?

In 2021, 921 fentanyl-related overdoses occurred in Colorado, which accounted for about 63% of overdoses in the state (about a 70.5% increase from the previous year).[5] Incarcerated populations are also disproportionately impacted by SUDs. A report from the U.S. Department of Justice estimates the prevalence of SUD* in US jails to be 63%[6] and prevalence of OUD is estimated at 15%.[7] To address the rising threat of fentanyl deaths, the Colorado legislature passed HB22-1326, or the Fentanyl Accountability and Prevention Act, in May 2022.[1] This law changes sentencing protocol for persons found with fentanyl in their possession, increases naloxone availability and fentanyl testing, and develops a Fentanyl Education Program (FEP).[8] It also required county jails facilities in the state of Colorado to provide medication-assisted treatment (MAT) to people who are incarcerated with substance use disorder by July 1, 2023. Under the legislation, jails must 1) provide medication-assisted treatment and other appropriate withdrawal management care through the duration of the person's incarceration, or 2) if a jail is not able to provide medication-assisted treatment, they shall assist the individuals with accessing a community-based medication assisted treatment provider and must submit a report to the Division of Colorado county jails explaining why the facility is unable to meet the requirements of the mandate and what resources they need to achieve these goals (see Appendix 1). Under this law, jails are encouraged to also establish behavioral health or mental health screening protocols for newly incarcerated persons as required to participate in the Jail-based Behavioral Health Service program (JBBS). Procedures are required to be developed to identify withdrawal symptoms, determine necessary medical interventions and referrals, and provide access to emergency services during the withdrawal management if necessary.

Medication-Assisted Treatment (MAT) vs. Medications for Opioid Use Disorder (MOUD)

Medication for opioid use disorders (MOUD) is the gold standard[9] for treatment for individuals with an OUD using any one of three medications approved by the Food and Drug Administration (FDA, table 2).[10] These medications relieve the symptoms and psychological cravings that occur during opioid withdrawal and recovery. This term is sometimes used interchangeably with the term MAT, which uses the same three medications in conjunction with behavioral therapies to treat various SUDs, including OUD.

Research shows that MOUD, especially when coupled with evidence-based behavioral therapy, leads to increased retention in treatment, improved social functioning, and overall improved quality of life for those struggling with opioid misuse and abuse.[10] MOUD has clearly demonstrated a significant impact in reducing opioid use post-incarceration,[14] and potentially lowering rates of recidivism among individuals with OUD.[14-16]

*Note: This 63% refers to the percentage of incarcerated populations affected by SUD in the U.S. between 2007-2009. While this data is somewhat outdated, it is the most reliable, nationally representative statistic.

Table 2: FDA-approved Medications to Treat OUD[10-13]

Medication	Type	Mechanism of Action	Prescribing Requirements	Safety
Methadone	Long-acting full opioid agonist	Reduces withdrawal symptoms and cravings (also used for management of severe pain)	Dispensed only by specially licensed healthcare providers certified by the DEA to prescribe Schedule II medications in SAMHSA-accredited specialized clinics (Opioid Treatment Programs-OTP) or approved extensions (medication units)	Requires controlled administration.
Buprenorphine	Partial opioid agonist	Reduces withdrawal symptoms and cravings	Licensed healthcare providers certified by the DEA to prescribe Schedule III medications (e.g., physician, physician assistant, nurse practitioner). Can be dispensed in various settings including primary care offices, SUD treatment centers, qualified pharmacies, and detention or correctional settings.	Relatively safe under controlled treatment. Very uncommon risk of OUD development.
Naltrexone	Opioid antagonist	Blocks the effects of opioids, reducing cravings and relapse risk	Any licensed healthcare provider can prescribe for administration in various settings, similar to buprenorphine	Safe. No OUD risk development does not occur.
Naloxone (not MOUD)	Short-acting opioid antagonist	Reverse an opioid overdose,** restoring normal breathing within minutes if adequately dosed[13]	Free distribution from pharmacies and other multiple sources in the state of Colorado. No prescription required.	No OUD risk

Note: While not considered MOUD, Naloxone is included here as it is increasingly used for a quick reverse of an opioid overdose.
*More than one dose of naloxone may be required when stronger opioids like fentanyl or buprenorphine are involved.

Benefits of MOUD in the Jail Environment

Implementing MOUD in jails is key for treating opioid use disorders among incarcerated individuals. Providing MOUD treatment to incarcerated individuals can decrease recidivism, which could potentially decrease jail operating costs over time.[16] A study conducted in rural Massachusetts demonstrated that buprenorphine treatment alone during incarceration reduced the risk of recidivism by 32%.[15]

Compliance with administering MOUD in jail could also limit adverse legal repercussions. Per US court cases, individuals who are in active recovery or require buprenorphine or methadone to treat OUD are classified as "individuals with a disability."[17] Under Title II of the ADA, state and local governments are prohibited from discriminating against persons classified as having a disability.[18] Moreover, individuals who are denied MOUD experience forced withdrawal. Denying people who are incarcerated medication prescribed for them can place correctional facilities at risk for

lawsuits for ignoring their disability status and for cruel and unusual punishment (8th Amendment and 14th Amendment's Due Process Clause).[17,19] According to the 8th Amendment of the U.S. Constitution, if a jail or prison is proven to show "deliberate indifference" to "serious medical needs," they can be found liable under the 8th Amendment to the U.S. Constitution.[20] It is critical to develop clear policies that support the implementation of MOUD within the jail system. This includes establishing procedures and/or protocols for screening, assessment, and MOUD provision for eligible individuals. County jails must ensure that these policies are supported by jail administrators, medical staff, correctional officers, and networked community healthcare providers during incarceration. Below are recommendations for successful implementation.

Table 3. Guidelines for Administration of FDA-Approved Medications for OUD in Jails[3,10,12,21,22]

Medication	Subclass	Administration Frequency	Means of Administration	Prescriber or Dispenser Qualifications	Challenges in Rural Jails
Methadone		Daily	Orally as a liquid concentrate, tablet or oral solution of diskette or powder	SAMHSA-accredited OTP and their approved medication units can dispense methadone prescribed by a licensed medical provider certified by the DEA to prescribe Schedule II medications. Daily administration either on-site or take-home for stable patients.	· Cannot be dispensed without authorization from the DEA (including licensing) and SAMHSA and cannot be distributed without DEA 222 transfer between DEA licenses. · Per 42 CFR Part 8, Final Rule, for a jail to be designated as a "hospital" and be exempted from DEA regulation of being an OTP, and with this designation they can provide methadone to an incarcerated individuals as long as they have another medical condition that needs to be treated. · Requires secure storage and accounting as a Schedule II controlled substance, as well as processes to prevent diversion. · Consider chain of custody log or other record keeping of this medication for accounting and documentation purposes.
Buprenorphine	Buprenorphine	Daily (or alternative dosing regimen)	Oral-dissolving tablet or film dissolved under tongue	Any medical provider certified by the DEA to prescribe Schedule III medications.	· "Considerations around dispensing of this medication should involve limiting risk for diversion, maintaining counts and records of this CIII substance. Consider chain of custody log or other record keeping of this medication if dispensed to the 'patient/ incarcerated person' but kept within the jail's custody/secure storage."[3] · Sublocade needs to be refrigerated but can be unrefrigerated for 7 days. (36-46 degrees Fahrenheit).
	Buprenorphine implant (Probuphine)	Every six months	Subdermal		
	Buprenorphine injection (Sublocade)	Monthly	Injection (for moderate to severe OUD)		
	Buprenorphine injection (Brixadi)	Weekly	Injection (for moderate to severe OUD)		
	Buprenorphine and naloxone (Suboxone, Zubsolve)	Daily (or alternative dosing regimen)	Oral-dissolving tablet or film dissolved under tongue		
Naloxone	Naloxone	Reverse opioid overdose	Intranasal spray, or injectable (intramuscular, subcutaneous, or intravenous).	Any individual can receive this medication from a pharmacy in the state of Colorado or other sources upon request without a written prescription and can carry this medicine. Jails are considered a Category 2 Prioritization for acquiring free Naloxone from the Naloxone Bulk Purchase Fund. There are varying administration route and doses for overdose reversal (e.g. EMT might carry high dose injectable supplies)	· This is not an MOUD, but it blocks the effects of recently used opioids.* · It is available directly from any pharmacy to any Colorado resident upon request. It does not require specific storage but in general should not be exposed to direct sunlight and ideally kept between 59-86 degrees Fahrenheit.
Naltrexone	Naltrexone (XR-NTX) (Vivitrol)	Monthly	Injection		· Naltrexone can be treated as any non-controlled medication but should be stored to avoid diversion. · Consider secure storage and tracking due to cost of medication. · The entire dose pack should be stored in the refrigerator (36-46 degrees Fahrenheit). · Unrefrigerated, naltrexone can be stored at temperatures not exceeding 77 degrees Fahrenheit) for no more than 7 days prior to administration. · Do not expose the product to temperatures above 77 degrees Fahrenheit. · Naltrexone should not be frozen.

Note: While not considered MOUD, Naloxone is included here as it is increasingly used for a quick reverse of an opioid overdose.
*More than one dose of naloxone may be required when stronger opioids like fentanyl are involved.

OUD Assessment and MOUD Prescription and Administration in Colorado County Jails

Settings

Table 4 describes potential scenarios that jails and correctional facilities may encounter or can implement to prescribe and administer MOUD. The scenarios were identified during interviews with JBBS providers within rural county jails in Southern Colorado and OTP interviews in March and April 2024.[3,23] As indicated above, please note that only OTPs and Narcotic Treatment Programs (NTPs)* or their approved medication units (which can include detention settings) can prescribe, provide, and dispense methadone.

*Note: OTP is an acronym utilized by SAMHSA and NTP is an acronym utilized by the DEA. Both are used interchangeably, however, for the purposes of this document, the term OTP will be utilized to represent this classification of treatment program.

Table 4. Prescription and Administration Scenarios for MOUD in Jails[24-29]

Prescription and Administration Scenarios	OUD Screening, Prescription or MOUD Administration in Jail			Description
	Screening	Prescription	Administration	
Off-site administration	X	X	X	Jail transports patients to medical MOUD provider or OTP. Transportation coordination is needed for ongoing treatment or upon release
On-site administration by an external clinical provider/ prescriber[24-25]	X	X	X	External licensed clinical or OTP provider administers medication within the jail setting. It needs to be determined whether the medication will be stored at the jail (for multiple doses) or brought with the provider for a single dose.
On-site administration by jail personnel who is a non-clinical provider/ prescriber[26-28]	X	X	X	External licensed clinical or OTP provider prescribes medication and has it delivered to the jail, so that it can be administered by a non-clinical person within the jail.[26,27] A QMAP could potentially administer medication in the jail setting in the future, if properly trained and under a nurses and OTPs license.
On-site administration by a jail nurse or other clinically trained correctional staff[28]	X	X	X	External licensed clinical or OTP provider prescribes medication and has it delivered to the jail, so that it can be administered by a nurse or other clinically trained and licensed staff within the jail setting.[28]
Licensed correctional prescribers	X	X	X	Correctional physician, nurse-practitioner, or physician assistant can prescribe and/or administers MOUD within the facility – possibly including methadone which requires OTP certification excepting under emergency circumstances.[24,28]
Facility as a licensed OTP	X	X	X	Facility obtains an OTP license or an approved medication unit for an established OTP to prescribe and administer methadone, which also allows for prescribing and administering buprenorphine and naltrexone XR.[29]
Telehealth	X	X	X	Telehealth treatment rapidly emerged during social distancing imposed by COVID-19. With the SAMHSA final rule becoming effective in April 2024 and compliance being required in October 2024, medications can be prescribed in jails by an OTP physician, a primary care physician, and other authorized health care professionals under the supervision of a program physician via telehealth.[29] DEA and SAMHSA guidance permits buprenorphine initiation for new patients using telehealth, though methadone initiation still requires an in-person evaluation by a program physician.[29]

Note: This table provides guidance on potential scenarios that can be applied to the prescription and administration of all three types of FDA-approved MOUDs. For special considerations on methadone provision, please see Table 5.

Adapted on the basis of models outlined by the National Council of Behavioral Health and Vital Strategies "Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons"[25]

MOUD PROVISION IN COLORADO

Through a sub-award from the Colorado Medication-Assisted Treatment (MAT) Expansion Pilot Program, as authorized by Colorado Revised Statutes §§ 23-21-801 to 23-21-808,[30] a network of clinics offering MOUD services was established throughout various rural Colorado counties with a high risk of opioid overdose in a Hub and Spoke Treatment Model.[31-33] Under the guidance of the Colorado Consortium for Prescription Drug Abuse Prevention in partnership with the University of Colorado College of Nursing, this network of care has central "hubs" managing MOUD services, connecting with community "spokes" to provide ongoing treatment and support services. Per legislative mandate, buprenorphine was mostly offered (along with naltrexone) in most clinics, with a few sites almost exclusively offering methadone (see Appendix 2).

Methadone Service Provision within Colorado County Jails

Federal regulations only permit certified OTPs to provide methadone services, non OTP certified facilities may provide up to three days or 72 hours supply of methadone for incarcerated persons on an emergency basis. This allows for treatment of incarcerated persons as well.[29] County jails must partner with local OTPs or apply for an OTP certification through SAHMSA licensure as well as appropriate DEA certification.[11] There are 46 OTPs in Colorado with either certified or provisional status. Among these, 35 are certified OTPs, which can be found on the SAMHSA website.[34] In rural southern Colorado, several OTPs could potentially provide methadone to incarcerated persons in the jails.

Based on interviews conducted in years 2022 and 2024 with JBBS medical providers (Rio Grande, Baca, Bent, Crowley, Huerfano, Kiowa, and Otero counties), Crossroads Turning Points (Alamosa, Huerfano and Pueblo) and Elevate Healthcare personnel (Pueblo),[23] the following steps for establishing methadone service provision within jails, including referral processes and service agreements, were collectively compiled in Table 5.

Table 5: Steps to Establish Methadone Service Provision in County Jails[23]

Establish Partnerships	Create a Memorandum of Understanding (MOU) between the OTP and the county jail.	
Assessment of Methadone Treatment Status	Verify if the incarcerated individual is currently registered at and receiving methadone from a SAMHSA-certified and DEA-certified prescriber via the central registry or via the local OTP.	

	If so:
	- Verify dosage
	- Provide methadone dosing per the 72-hour rule,[29] if necessary
	- Ensure timely methadone provision by the OTP so as to not exceed the 72-hour allowance period
		If not:
		- Register and induct the incarcerated person into an OTP.
		- Coordinate with the OTP to initiate induction, which may include:
		  - Transport the incarcerated person to the OTP.
		  - Arrange for the OTP to conduct induction at the jail, subject to OTP's discretion.
		- Arrange subsequent methadone provision

Funding and Financial Arrangements	- Collaborate with JBBS to cover methadone treatment costs. - Establish financial agreements between JBBS and OTP to ensure OTP payment. - Explore alternative financial arrangements with OTP if JBBS funding is not an option.	
Methadone Supply Management	- Plan with the OTP for the frequency and amount of methadone delivery. - Comply with SAMHSA regulations allowing up to 28 days of methadone supply for take home. If the jail is not considered an OTP, the incarcerated person will need to be guest dosed through an OTP. - Establish safe and secure storage to include rigorous record keeping involving trained, competent, reliable staff. - Manage the dispensation and destruction of excess dosing to prevent diversion or misuse.	
Counseling and Support	- Offer counseling in combination with MOUD, as needed by detainees and as required by JBBS-funded programs. - Offer counseling via in-person or telehealth services.	
Establish New Service Relationships	- If there is no existing counseling service provider on staff or contracted, make necessary arrangements for service delivery mode (in-person or telehealth). - Contract and/or network to ensure medical services other than OUD treatment are available to detainees, including other SUDs and mental health	

Note: each jail should contact the OTP independently to determine current service provision and establish agreements.

Mobile Delivery within Colorado County Jails

Mobile MOUD provision is another option for providing medications[35] to people who are incarcerated and have been assessed and determined to have an OUD. Mobile MOUD providers can deliver medications and other services directly to the jail facility. In Colorado, mobile health units (also called "MOUD vans") offer services such as counseling, drug testing, referral to wraparound services, and telehealth sessions with providers who can prescribe MOUD. Mobile units are legally able to operate at jails so long as they follow DEA guidelines outlined in the Narcotic Treatment Program Manual, Section 12.[36]

Porch Light Health[37] (formerly Front Range Clinic) has over 60 points of care in Colorado, which includes locations in rural southern Colorado. They provide MOUD (buprenorphine and naltrexone) and behavioral health services. Porch Light is actively working to become a SAMHSA registered provider.

Each county jail will need to determine if a mobile MOUD option is for its specific needs and decide whether the services will be delivered inside the jail facility or via a mobile unit. For example, if medication cannot be administered directly within the jail, some facilities may opt to partner with a mobile service provider to ensure medication delivery and treatment continuity.

Telehealth within Colorado County Jails

Telehealth can be an efficient tool for supporting an MOUD program[38-40] in rural county jails because it reduces transportation barriers and scheduling issues when medical staff are not available. However, each jail will need to define its own procedures to set

up an adequate telehealth program.[40-43] It is essential to allocate private space where telehealth sessions between the provider and incarcerated person can take place such as a small office or other infrequently used space.

Jails must also ensure that their technology is capable of supporting telehealth sessions that meet the needs of the people who are incarcerated. Specifically, each facility should ensure its telehealth infrastructure provides secure, private, and reliable internet access to maintain confidentiality and offer consistent service quality.

Telehealth requires a high internet speed and a protected, secure platform for performing telehealth appointments.[40-42] Audio-only telehealth options may be available, so it's important to verify this with your provider. Consulting with the chosen telehealth provider can help determine security measures to protect health-related information. The Rural Health Information Hub Rural Telehealth Toolkit[43] provides more resources for overcoming barriers in establishing and maintaining rural telehealth programs.

Telehealth provides a valuable option for rural county jails that require MOUD prescriptions, since both buprenorphine and naltrexone can be prescribed remotely by a provider licensed in Colorado. Several clinics offer online remote visits for prescriptions for buprenorphine and medications to assist with withdrawal. At the time of this writing, there are several known telehealth providers that can support rural county jails in MOUD provision. (See Appendix 3 for more information on these providers.)

Establishing Protocols and Relationships with a New Provider

Several key steps will need to be undertaken to successfully implement the MOUD mandate outlined in HB22-1326.[1] These include establishing new partnerships, hiring staff or contractors, signing MOUs, developing protocols, and conducting staff training. However, utilizing this guidebook, coupled with guidance from JBBS and forging connections with other county jails, should provide ample support to ensure jails are well-equipped to meet these requirements.

If a county jail does not have an in-house medical provider, MOUD prescriber, or counseling services, they have the option to secure telehealth providers to provide MOUD services. SAMHSA has a list of potential buprenorphine providers.[44] Jail personnel have the option of independently setting up relationships with a provider, identifying a telehealth provider, connecting with JBBS[45] or reaching out to other county jail personnel to learn of their MOUD service providers.

Management of Individuals with an OUD/SUD when Medical Personnel is Not on Duty

Not all county jails have medical personnel around the clock, and those with medical staff may not have coverage during off-hours. This can result in significant challenges due to the lack of continuous medical staffing, especially since individuals with SUD or OUD may be incarcerated at any hour. It is crucial for these facilities to develop robust after-hours protocols to effectively manage and address the medical needs of these individuals as soon as they enter the jail.[46] This preparation includes prompt medical screening and assessments, the provision of necessary withdrawal treatments, and the ability to respond to other urgent medical needs. Specific recommendations can be found in Appendix 4 of this guidebook.

Training non-medical staff to recognize withdrawal symptoms and understand the procedures for escalating care to medical professionals or transferring the individual to a medical facility may be necessary. Additionally, facilities should ensure that they have protocols for the safe administration and storage of medications needed for withdrawal management.[46] Effective management of these situations protects the health of the incarcerated individuals and supports the safety and operation of the facility. Proactive preparation is vital in supporting the medical and safety needs of incarcerated individuals during all hours.

Cost of MOUD

Cost of MOUD is based on the following factors:

The actual price of medications such as methadone, buprenorphine, or naltrexone can vary based on factors like brand name versus generic, dosage, and duration of treatment.

There is limited publicly available information on the pricing for MOUD. To verify information on the cost of methadone,[47] naltrexone,[47] and buprenorphine,[48] the project team contacted Walgreens and GoodRx pharmacies. Local pharmacists shared that the pricing of these medications varies considerably based on geography, insurance, and other factors. Therefore, we recommend that each jail contact a pharmacy in their jurisdiction to determine current pricing. Pricing information for MOUD can be obtained from several sources:

Pharmacies:
Retail and specialty pharmacies can provide information on the cost of MOUD medications for individual prescriptions. Some examples include CVS, Walgreens, or local independent pharmacies.

State Health Departments:
Health departments may have negotiated prices for these medications, especially if they are part of state-funded programs or initiatives like Medicaid.

Medicaid and Medicare:
Public insurance programs often have information on the reimbursement rates and costs of medications for beneficiaries. This can give a sense of the costs covered for those eligible under these programs.

In the United States, Medicaid plays a crucial role as the largest payer of SUD services, covering approximately 38% of non-elderly adults with OUD.[49] This coverage is vital in addressing the opioid epidemic and facilitating access to treatment. While specific data for rural Colorado is not detailed, nationally, the prevalence of OUD is somewhat higher among rural Medicaid enrollees (5.4%) compared to their urban counterparts (4.8%).[49] This reflects the significant impact of the opioid epidemic within rural communities. Medicaid coverage for individuals who are incarcerated is suspended. On the other hand, recent changes in federal law and actions by Centers for Medicare &

Medicaid Services (CMS) have eased the long-standing prohibition on Medicaid reimbursement for services provided to incarcerated enrollees. This means that Medicaid can reimburse hospital care provided to an incarcerated person if the in-patient hospitalization exceeds 24 hours. Upon release from incarceration, individuals can have their Medicaid benefits reinstated, ensuring continuity of care and access to necessary treatments, including for OUD, which is crucial for reducing return to use and overdose risks.

Once MOUD is indicated, the medical provider and the incarcerated person consider the medication choices. If the detainee is or has been safely and successfully taking a particular medication, continuation is generally preferred. However, cost can be an important consideration. For example, if buprenorphine is thought to be the better option, and there are no contraindications, the sublingual generic daily form might be preferred over the far more expensive Sublocade, providing there is patient consent. Note that the costs of Sublocade and Vivitrol are extremely expensive and may be cost prohibitive for some facilities, if not supported by JBBS funding or insurance.

It is also noteworthy that a Section 1115 waiver as utilized under the Medicaid Reentry Demonstration Opportunity, permits states to provide Medicaid services to incarcerated individuals up to 90 days before their release.[50] This initiative seeks to enhance healthcare access for those exiting incarceration, focusing on managing SUDs, other chronic conditions, community reintegration, and reducing health disparities, but it has not yet been approved in Colorado. California was the first state to implement such a waiver, setting a precedent for a system that facilitates smoother transitions by covering critical health services prior to release. With their Section 1115 waiver, California can now provide Medicaid reimbursed comprehensive care coordination, case management, and necessary medical treatments, which are expected to help decrease issues like recidivism, overdose, and other adverse outcomes associated with reentry. As of April 2024, Colorado has applied for the Section 1115 waiver and is awaiting decision-making.

MOUD Storage Within a Colorado County Jails Facility

In Colorado, the storage and management of MOUD in jails are defined by a combination of federal and state guidelines, along with specific jail policies.[22,25,51-52] These regulations ensure the secure and appropriate handling of these medications to prevent diversion and misuse within the facility.

Federal directions, as outlined by SAMHSA[53] and the DEA[54] provide broad guidelines as well as specific "must do" regulations on how to manage MOUD in a correctional setting and ensure that controlled medications like methadone and buprenorphine are handled and stored securely to prevent diversion for the safety and security of medications, detainees, staff, and facility. Key aspects of DEA regulations regarding the storage of controlled substances in jails include the following:

***Table 6: DEA Regulations for Managing Controlled Substances within Facilities[54]**

Security Requirements	The DEA requires that controlled substances be stored in securely locked, substantially constructed cabinets or safes. In some cases, particularly for larger quantities or more potent formulations, stricter security measures such as vaults may be necessary.
Access Control	Access to stored controlled substances must be limited to authorized personnel only. This helps minimize the risk of diversion by ensuring that only individuals with a legitimate medical or administrative reason can handle these medications.
Inventory and Record Keeping	Facilities must maintain accurate and up-to-date inventories and records of all controlled substances received, stored, administered, or otherwise disposed of. These records help track the movement of controlled substances within the facility and are critical for compliance audits by the DEA.
Disposal and Waste Management	The DEA regulates the disposal of unused or expired controlled substances. Jails must have procedures in place to dispose of these substances safely and in accordance with DEA requirements to prevent pollution and unauthorized access. A product containing activated charcoal renders the medication inert.
Inspections and Compliance	Correctional facilities and jails are subject to regular inspections by the DEA to ensure compliance with all regulations. These inspections can include audits of records, physical security checks, and assessments of compliance with handling and storage protocols.
Inspections and Compliance Training and Awareness	Personnel involved in the handling and administration of controlled substances must receive training on DEA regulations and the facility's specific procedures. This training includes understanding the legal responsibilities and security protocols necessary to prevent diversion and ensure the safety of the facility and its occupants. Competency verification is important.

*This table was adapted from the DEA Diversion Control Division's Practitioners Manual.[54]

Table 7 below describes specific requirements for each MOUD with respect to storage, documentation, dispensing, and distribution upon release (of the incarcerated individual) in Colorado jail facilities. These medications are usually dispensed by medical or trained custody staff with competency verification, following strict protocols and guidelines for safe and appropriate administration only after being prescribed the specific MOUD by a licensed and authorized healthcare professional employed or contracted by the jail. All medications, if stored in the detention facility, must be kept in a locked storage unit. If the medication requires refrigeration, then that refrigerator is to be locked and cannot hold anything other than medications, such as staff food and beverages. Locked cabinets and locked refrigerators should be held within a locked room.

Table 7. MOUD Storage, Documentation, Dispensing, and Distribution Upon Release in Jail Settings[54]

Medication	Storage	Documentation	Dispensing in Jails	Distributing Upon Release
Buprenorphine	- Sublingual product: locked cabinets - Injectable buprenorphine (Sublocade): locked refrigerator - Count prior to each dose - Missed/refused doses returned to locked cabinets	Tracking log detailing medication name, dose, formulation, initial count, and signatures of two authorized jail staff.	Medical or trained custody staff with competency verification	Incarcerated person receiving any unused medication upon release must sign form accepting responsibility.
Methadone	- Locked cabinets - Count prior to each dose - Missed/refused doses returned to locked cabinet and must be destroyed.	Tracking log detailing medication name, dose, formulation, initial count, and signatures of two authorized jail staff.	Medical or trained custody staff with competency verification	- Two authorized staff count remaining medication and sign off on medication tracking log. - Incarcerated person receiving medication upon release must sign form accepting responsibility.
Naltrexone	- Injectable naltrexone: refrigeration. - Refrigerator does not have to be locked and can be stored with general refrigerated medications.	No counting or locking requirements.	Medical or trained custody staff with competency verification	Incarcerated person receiving medication upon release must sign form accepting responsibility.

Facility Policies, Procedures and Protocols

Providing medical care is a complex task that demands clear, coordinated, and consistent procedures across both medically trained and non-medical personnel, each with differing levels of training, skills, and capabilities, yet while working together as a team to deliver care. This complexity is heightened in correctional environments, where medical care often differs from that provided in other settings. Additionally, the medical capabilities of detention facilities can vary significantly, further complicating the delivery of care.

To guide the complexities of delivering medical care, it is crucial that county jails or external providers offer medical expertise that adheres to both federal and state laws and regulations. It is beneficial for the jail to establish clear policies, procedures, and protocols that are consistent with the facility's mission, vision, values, and expectations. Ensuring these guidelines are effectively communicated to everyone involved is also important. In addition, all staff need to be aware of organizational structure and hierarchy of the detention center (and parent company, if that is the case) to understand and clearly apply their roles, responsibilities, and expectations within the network of the others involved. Below is a summary table to help distinguish between policy, procedure and protocol.

Appropriately constructed, procedural documents include "must do" activities and "guidance" in which judgment is to be applied in the particular circumstances and for the particular individuals involved. The procedural document must make clear which activities are "must do" and which are intended as "guidance".

- Procedural documents might indicate that a correctional officer must notify medical personnel of an individual detained in jail having withdrawal symptoms and that medical care personnel must take steps to manage withdrawal but then describe guidance as to what medications might be used.

- Much medical care essentially involves judgment applied in the context of a varying array of particular patient characteristics, medical conditions, treatments already underway, available resources and safety considerations.

- Within correctional settings, guidance should not be misconstrued as inviolable rules or medical/legal standards of care or requirements. Disclaimers consistent with this principle are appropriate and expected.

Policies, procedures and protocols must provide clarity. Responsibilities and responsible parties as well as boundaries of allowed activities by various staff are to be clearly defined. As living documents, they require periodic revision which may be identified though new regulatory requirements, newly understood deficiencies, newly available medical interventions, one-on-one problem solving with staff, or formal Continuous Quality Improvement and Quality Assurance processes.

It is neither feasible nor practical for a correctional medical system to create procedures or protocols for every possible medical condition. In fact, attempting to do so could be counterproductive and would divert scarce resources. Policies, procedures, and protocols we reference should be specifically tailored to SUDs rather than applied universally to all medical conditions.

Table 8: Policy, Procedure and Protocol Defined[55-57]

Policy	**Definition:** A policy is a high-level statement of intent for decision-making within an organization or jurisdiction.[55] Policies set the standard for various operations and define the organization's stance on specific issues. **Purpose:** The purpose of a policy is to offer a broad framework that guides the overall behavior and decision-making processes. It serves as the foundation for developing procedures and protocols. **Scope:** Policies are generally broad and cover a wide range of activities or behaviors within an organization. They do not specify how the tasks should be performed but rather establish the ground rules or expected outcomes. **Usage:** Policies are used to communicate an organization's values and expectations to its employees and stakeholders, ensuring consistency in the application of its principles and standards. Example MAT Treatment Policy:[58] (see Appendix 12) **Policy example:** individuals will be screened for SUD/OUD within 24 hours of incarceration.
Procedure	**Definition:** A procedure is a series of detailed steps that describe how specific tasks or operations should be performed to achieve a set outcome.[56] **Purpose:** The purpose of a procedure is to ensure that activities are performed consistently and correctly by all individuals involved. It provides a sequence of actions to follow. **Scope:** Procedures are more specific than policies and focus on particular operations or tasks within an organization. They provide clear instructions that must be followed to comply with established policies. **Usage:** Procedures are commonly used in daily operations across various departments of an organization to standardize practices and maintain quality and efficiency. **Procedure example:** jail staff will screen each individual using GAINS tool, this will be documented in XX, if scores >X then XX will be notified.
Protocol	**Definition:** A protocol describes how to conduct specific activities as a series of sequential steps, typically in specialized fields such as medicine, science, or technology.[57] **Purpose:** Protocols ensure that complex or critical tasks are carried out with precision and adherence to certain standards. They are often used in situations where uniformity and predictability are crucial. **Scope:** Protocols are usually very detailed and technical, providing step-by-step guidance that leaves little room for variation. They are typically more rigid than procedures and are often mandatory. **Usage:** Protocols are crucial in fields where specific methods need to be rigorously followed to ensure safety, accuracy, and legality. Examples include clinical trials, network communications, and emergency response. Example Jail Protocol Template:[59] **Protocols is a step-by-step guide:** example would be used for withdrawal medications, monitoring, and decisions on how to treat. All authorized by a medical provider/prescriber.
Key Differences	**Level of Detail:** Policies provide the least detail, focusing on what should be done and why. Procedures provide more detail, explaining how things should be done. Protocols offer the most detail, often including precise specifications that leave little to no room for interpretation. **Context of Use:** Policies are used broadly across an organization for governance. Procedures are used operationally across various departments to standardize activities. Protocols are used in specialized contexts to ensure uniformity in critical operations.

This table adapts information from the "Policy" page on WikiMili, the "Policy vs. Procedures" page on ComplianceBridge, and Merriam et al.'s "Clinical Protocols" textbook chapter.

"

SECTION 1115 WAIVER, AS UTILIZED UNDER THE MEDICAID REENTRY DEMONSTRATION OPPORTUNITY, PERMITS STATES TO PROVIDE MEDICAID SERVICES TO INCARCERATED INDIVIDUALS UP TO 90 DAYS BEFORE THEIR RELEASE.[50]

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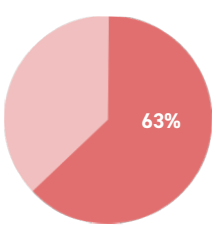
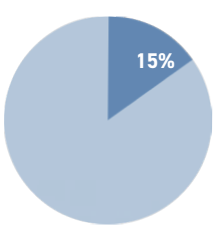
The prevalence of SUD in US jails is estimated to be 63%[6] and prevalence of OUD is estimated at 15% among incarcerated individuals.[7]



% of Incarcerated Individuals with SUD Diagnosis



% of Incarcerated Individuals with OUD Diagnosis

Both prevalence and actual/potential severity involving SUD/OUD require sufficient policies, procedures, and protocols to effectively address the needs of the population It is the ultimate responsibility of jails, prisons, or their parent organizations to have appropriate, evidence-based protocols in place. Jails, prisons, or their parent organizations are to employ or contract with medically trained personnel with knowledge of SUDs, including OUD, and the relevant federal and state legal and regulatory requirements and guidance. This cannot be overemphasized. TSRG and partners can provide technical assistance and advice in their development and on-the-ground implementation.

Withdrawal Management Protocol

Upon arrival at a facility, a timeline begins for assessing OUD which requires the initiation and ordering of specific protocols by a licensed medical provider. These protocols are typically overseen by the facility's medical personnel or responsible consulting medical provider and include several recommended practices (see Appendix 6: Resources). These practices aim to ensure the safety of the incarcerated individual while ameliorating the symptoms of substance withdrawal. First, if feasible, the individual should be separated from others and provided with a private space where staff can closely monitor their condition. Safety measures may include assigning a lower bunk or a sleeping space close to the floor to prevent injuries from falls. A person's condition should be frequently assessed and monitored using validated scales like the Clinical Opioid Withdrawal Scale (COWS)[60,61] or the Subjective Opioid Withdrawal Scale (SOWS),[60] with staff well-trained in their administration (see Appendix 4 and Appendix 12).

Physical activity should be limited, with ample space and time allowed for rest. Proper hydration must be maintained by ensuring the provision of water or electrolyte-rich fluids. Additionally, medications may be administered as necessary, depending on the symptoms' type and severity and with the detainee's consent.

Options include but are not limited to the following:

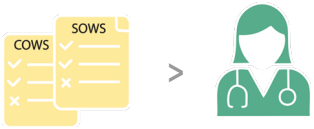
- Medication for pain (e.g., ibuprofen, naproxen, acetaminophen)
- Medication for diarrhea, (e.g., loperamide)
- Medication for shakes, sweats, anxiety (e.g., clonidine, lofexidine)
- Medication for nausea, vomiting (e.g., ondansetron, promethazine)
- Medication for abdominal cramping (e.g., hyoscyamine)
- Medication for anxiety (e.g., hydroxyzine - avoid benzodiazepines)

Each of these steps is critical to effectively managing withdrawal symptoms in a controlled and humane manner.

Managing Opioid Withdrawal

Opioid withdrawal is common in jail settings and can be very uncomfortable for a person experiencing it. Jail personnel should screen for current or potential opioid withdrawal, and having identified such, relay detailed medical information (including current withdrawal severity using COWS or SOWS) to the on-site or on-call medical staff, including history of withdrawal severity and its current status (e.g., using COWS or SOWS). An individual withdrawing from opioids can experience a variety of symptoms.

Jail personnel should screen current or potential opioid withdrawal



Jail personnel should relay detailed medical information using COWS or SOWS

Jail personnel should refer incarcerated persons who experience symptoms of withdrawal for clinical assessment.[62,63] Withdrawal symptoms can include muscle aches and pains, hyperalgesia, diarrhea, vomiting, insomnia, chills and goosebumps, anxiety, depression, and weakness.[63] However, it is usually not life threatening.[62,63] The onset of withdrawal varies based on the drugs used and the time of last use, as well as the frequency and amount of typical use. For short-acting opioids like heroin, withdrawal symptoms can appear in as little as 12 hours after use and peak within 36 – 72 hours and can last up to 7-10 days.[63] For long-acting opioids like methadone, withdrawal symptoms can begin within 30 hours after last use and peak within 72 – 96 hours and last up to 14 days.[63]

Withdrawal Symptoms of Short-acting Opioids (e.g., Heroin)			Withdrawal Symptoms of Long-acting Opioids (e.g., Methadone)		
Appear within	Peak within*	Duration	Appear within	Peak within	Duration
6-12 Hours after use	1-3 Days	5-7 Days	30± Hours after use	5-7 Days	8-10 Days

* These are generalizations and are dependent on extent of tolerance / duration of use, amount used, co-occurring mental health issues.

Monitoring

Individuals experiencing withdrawal symptoms should be monitored closely. Jail personnel should monitor vital signs and use validated severity scales, such as COWS[61] or SOWS[60], at least every 2-4 hours. Incarcerated persons in withdrawal should be located somewhere where staff can monitor via camera or see the individual every 2 hours at a minimum. The facility should have 24/7 access to a licensed healthcare professional if additional support or assessment is needed, either in person, via telehealth or through phone call. Healthcare personnel should determine if the incarcerated person needs a higher level of care based on

the capacity of the jail's team to treat and monitor the individual's symptoms. If necessary, the healthcare professional and jail personnel should coordinate the incarcerated person's transfer to a facility that can provide adequate mental health care and consistent withdrawal monitoring. Please see examples of withdrawal protocols from opioids used by county jails in Appendix 12.

It is also important to note that agonist medications can be used to help withdrawal and transition to MOUD. Buprenorphine and methadone can reduce withdrawal symptoms, and methadone can be used to manage severe pain.[10] Naltrexone can unblock the effects of opioids and reduces the risk of return to use. However patients must completely detox from opioids before starting on naltrexone[10] before starting on naltrexone, which can be anywhere from 7 to 14 days since they last used opioids.

Jail personnel should closely monitor withdrawal symptoms, ideally every **2 to 4 hours**

Check vital signs

Use of COWS[61] or SOWS[60]

Developing Transition Plans Post-release

In addition to supplying MOUD, the Colorado HB22-1326 mandate[1] requires that when incarcerated persons receive MOUD, a transition plan is developed so they can connect with resources post-release. There are four main components to a transition plan post-release:

Connection to a community provider

Connecting individuals to a provider post-release may be as simple as connecting them with the provider whom they met with during their incarceration or to reconnect with a provider the individual had been seeing prior to incarceration. Please follow the link to the directory of community MOUD or behavioral health providers[64] Setting up an initial appointment to help connect individuals with care post-release might be key for success. Some treatment centers may offer transportation services.

Connection to health insurance

Connecting incarcerated individuals to health insurance post-release is an essential part of a transition plan to continue treatment, which prevents overdose and recidivism. Each facility should develop a Medicaid enrollment protocol for connecting incarcerated individuals to care once they are released, which should be developed for each facility in partnership with the county Department of Human Services and Department of Public Health. The Colorado Department of Health Care Policy and Financing (HCPF) provides example workflows* for local jails in Colorado when setting up a Medicaid connection program.

*Please note, HCPF is updating these workflows at the publication date of this guidebook. We anticipate information will be provided at a future date on how to share these resources. In the meantime, you can direct questions on Medicaid enrollment towards the contacts listed on this website.

Linkage to social and wrap-around services.

Linking individuals to vital social services can also prevent recidivism post-release, enhance overall quality of life. Some examples of services include assisting individuals in determining SNAP eligibility and applications,[66] applying to affordable housing (e.g. see examples in Costilla[67] or Conejos Counties)[68] or accessing child care or transportation.

Overdose prevention

Overdose is the leading cause of death among recently incarcerated people who experience a 12.7 times higher risk within the first two weeks after release from jail due to all causes compared to the average state resident.[69] To prevent overdose post-release, in addition to connecting to an appropriate medical provider as well as sufficient prescription dosing to cover the interval to the appointment, a local jail should supply an individual with naloxone. The Colorado mandate[1] requires that if a person receives MOUD, or upon request, the facility should provide at least 8mg of naloxone (two doses of Narcan or one dose of Kloxxado). This, along with educating the incarcerated population and their significant others prior to release on the changes in tolerance level, some commonsense approaches to harm reduction, and general safety related to drug use,[70] and use of naloxone (including 911 - call and rescue breathing), can prevent fatal overdoses post-release and allow for more time to coordinate care with an outside provider. There are also several local and public health entities that provide education and distribution of naloxone kits in the community.

Provision of Bridging MOUD

A bridging strategy for individuals taking MOUD when they leave jail is crucial for ensuring continuity of care and preventing relapse. Upon release, individuals are at heightened risk of overdose and relapse due to the sudden lack of structure and access to medical care they experienced while incarcerated.[69] A comprehensive bridging plan helps connect them with community-based treatment providers, offers support in managing their medication, and facilitates access to other vital services such as housing, mental health support, and employment assistance.

CHALLENGES AND SOLUTIONS

Preventing Diversion In and Out of the Colorado County Jails Facilities

A common concern among jail administrators when implementing MOUD programs in their facilities is the possibility of medication diversion.[54] While considered uncommon,[71] diversion could occur inside of chain of custody or when individuals get access to medication in ways other than indicated, potentially leading to redistributing to other persons or overdose.

To prevent diversion, it is essential that prior to implementing MOUD programs, jails develop diversion protocol. This Diversion Control Plan,[52] is an example of protocol from an SUD treatment facility that can be adapted to fit the needs of a correctional facility. Clearly outlining the roles and responsibilities of the jail administration staff, medical staff, and incarcerated individuals as well as instituting the guardrails indicated in the plan can help prevent diversion from occurring. Diversion control protocols may also provide guidance for staff on how to counsel patients when diversion occurs, rather than enforcing immediate removal from the MOUD program.

Various strategies to implement diversion control are provided in the National Council for Behavioral Health's Medication Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit[25] and SAMHSA's Medication Assisted Treatment Inside Correctional Facilities.[72] Strategies include the following:

Diversion Control Strategies

1. Counseling patients on medication diversion
2. Patient agreements that individuals receiving MOUD sign
3. Separating MOUD dispensing from other medications
4. Locked controlled medication storage
5. Staff training about security protocols and safe medication handling and accounting
6. Controlled medication counts by two staff
7. Periodic review of controlled medication procedures
8. Holding patients in a waiting area after taking medication and performing mouth checks before allowing them to return to general population
9. Video monitoring rooms where medications are dispensed Random urine drug tests to ensure only patients prescribed MOUD are testing positive for those medications

Training of Colorado County Jails Personnel

Knowledge, attitudes, and practices of custody and clinical care staff in detention and incarceration settings can be widely variable. Further, there is not a single, unified national standard in the United States for training medical and non-medical personnel to provide care to people in jails with OUD or within Colorado. However, there are guidelines, best practice frameworks, and accreditation standards that serve to guide the management and treatment of individuals with OUD in correctional settings. A list of recommended training resources is included in Appendix 6.

No unified national standard for training medical and non-medical personnel exists in the U.S. or Colorado

Guidelines, best practice frameworks, and accreditation standards guide the management and treatment of individuals with OUD.

While these resources provide a framework for the treatment of OUD in carceral settings, the implementation of these practices can vary widely. It highlights the need for standardized training and procedures for staff and contracted personnel to ensure that individuals with OUD receive consistent and evidence-based care regardless of where they are incarcerated. This is not to end with training and updated training but jails and/or their parent organization(s) are to have a mechanism to assess and ensure the competence of trained staff, both custody and medical. Collaboration between jails, healthcare providers, and regulatory bodies is essential to develop and maintain standards that improve outcomes for individuals with OUD in the justice system.

Final Thoughts

The health, safety, and wellbeing of incarcerated individuals with opioid use problems such as OUD requires significant care, attention to details, forethought, planning, and execution. This guide can serve as a framework to develop the essential elements of a successful program that can safely assist those who are affected and detained as well as possibly reduce recidivism. The text here and the appendices can be helpful in building and maintaining an effective and compliant program with policies, procedures, protocols, workflows, diagnostic criteria, screening and monitoring tools, directories, references, and resources. Indeed, your efforts are important not only to these individuals but also to our community as a whole. TSRG and others remain available to collaborate with you.

> THIS GUIDE CAN SERVE AS A FRAMEWORK TO DEVELOP THE ESSENTIAL ELEMENTS OF A SUCCESSFUL PROGRAM THAT CAN SAFELY ASSIST THOSE WHO ARE AFFECTED AND DETAINED AS WELL AS POSSIBLY REDUCE RECIDIVISM

APPENDICES/TABLES

ID	Name	Description
Table 1	Common Acronyms for MOUD	List of common acronyms related to MOUD found in this guidebook
Table 2	FDA-Approved Medications for OUD (List)	Outlines the three (3) FDA-approved medications for MOUD
Table 3	FDA-Approved Medications for OUD (Full Table)	Highlights certain important elements involved in providing the three (3) FDA-approved MOUD medications as well as the overdose rescue medication naloxone
Table 4	Prescription and Administration Scenarios for MOUD in Jails	Describes options detention centers need to consider in establishing how to prescribe or administer MOUD in jails
Table 5	Steps to Establish Methadone Service Provision in County Jails	Highlights different scenarios for establishing methadone service provision.
Table 6	DEA Regulations for Managing Controlled Substances within Facilities	Outlines DEA regulations required for handling controlled substances provided in facilities such as jails
Table 7	Medication, Storage, Documentation, Dispensing and Distribution Upon Release of MOUD in Jails	Further details how the three (3) FDA-approved MOUD medications should be stored, tracked, dispensed, and distributed upon release of individuals from jails
Table 8	Policy, Procedure, and Protocol	Provides definitions of policies, procedures, and protocols to guide jails developing these documents
Appendix 1	Legislative mandate	Legislative mandate for provision of MOUD in county jails facilities in Colorado
Appendix 2	Colorado MAT Expansion Program Grantee Hub and Spoke Clinic Distribution	SB 21-137 Colorado MAT Expansion Clinics for the Rural Recovery Network
Appendix 3	Telehealth & Mobile Providers Available in the Region	Partial list of available telehealth and mobile providers. Additional providers can be included once they are identified.
Appendix 4	Workflows in Managing Opioid Withdrawal in Jails	Examples of workflows by the Bureau of Justice Assistance addressing 1) General SUD withdrawal management and 2) Opioid withdrawal management using buprenorphine or methadone (does not include naltrexone (Vivitrol))
Appendix 5	Behavioral Health Screening Tool	The Global Appraisal of Individual Needs – Initial (GAIN – I) assessment tool
Appendix 6	Resources	Names and hyperlinks of literature sources and resource information
Appendix 7	OTP Directory	SAMHSA's Opioid Treatment Program Directory for Colorado
Appendix 8	OUD Diagnosis Criteria	Diagnostic Criteria from the DSM V
Appendix 9	Communication	Guidance on communication regarding medical records is included for reference.
Appendix 10	Withdrawal Protocols	Samples of withdrawal protocols are provided for downloading and reference.
Appendix 11	COWS and SOWS	Clinical Opiate Withdrawal Scale and the Scale for Opioid Withdrawal Symptoms forms are included for downloading and reference.
Appendix 12	Jail-Based Medication-Assisted Treatment Policy and Protocols	The Steadman Group worked with the Jail-Based Behavioral Health Services in 2019 to develop Medication-Assisted Treatment Policy and Protocols. The original documents are included for reference.

Appendix 1: Legislative Mandate (HB22-1326) for Provision of MOUD in County Jails Facilities in Colorado[1]

Requirement	Legislation
For individuals within the county jail system receiving MAT during their stay, upon release the jail must: 1. provide post-release resources, 2. provide a list of available substance use providers, 3. provide ≥ 8mg of opioid antagonist (e.g. Narcan), 4. prescribe MOUD and educate person on how to take medications, 5. coordinate care post-release (schedule appointment, provide prescription, etc).	"C.R.S. 17-26-140: If a person is treated for a substance use disorder at any time the person's incarceration, the county jail shall, at a minimum, conduct the following before releasing the person from the county jail's custody: (a) Provide post-release resources developed pursuant to section 17-1-103 (1)(r) to the person; (b) Provide a list of available substance use providers, to the extent the administration in the department of human services has such a list available; (c) If the person received or has been assessed to receive medication-assisted treatment while in jail, has a history of substance use in the community or while in jail, or requests opiate antagonists upon release, provide the person, upon release from the jail, at least eight milligrams of an opiate antagonist via inhalation or its equivalent and provide education to the person about the appropriate use of the medication; (d) If the person received medication-assisted treatment while in jail, has a history of substance use, or requests opiate use-disorder medication, prescribe to the person, upon release from the jail, medication for an opiate use disorder and provide education to the person about the appropriate use of the medication; and (e) Coordinate continued care for the person, including scheduling an appointment for the person with a substance use provider with the ability to continue the person's treatment, provide the person with detailed information about the scheduled appointment, provide the person with a prescription for the medication that the person was taking while in custody at the facility in an amount that is at least sufficient to sustain the person until the scheduled appointment, and provide the person with a referral to the care coordination infrastructure described in section 27-60-204"

Please see naming convention: MOUD will be used in this document instead of MAT.

Appendix 2: Colorado MAT Expansion Program Grantee Hub and Spoke Clinic Distribution[33]

The Colorado MAT Expansion Leadership Team is finalizing its Final Legislative Report for SB21-137. Appendix III of this report provides a list of MAT clinics throughout Colorado. At the date of this guidebook's publication, the report has not yet been publicized, but we expect the report to be posted shortly on the websites for the University of Colorado College of Nursing and the Colorado Consortium for Prescription Drug Abuse Prevention. We will update this Appendix with the link to this resource when it is available. In the meantime, the MAT Expansion Leadership team can be reached at this address: MATExpansion@ucdenver.edu.

Appendix 3: Telehealth and Mobile Service Providers Available in the Region

1. Bicycle Health[73] provides telehealth treatment of opioid use disorders. "Through a single app, Bicycle Health combines MOUD with behavioral healthcare, drug screening, therapy, and peer support. Bicycle Health is the largest medical group in the U.S. providing MOUD treatment via telemedicine. They have a full-time medical team of physicians, PAs, and nurses licensed across 32 states and have insurance contracts that cover nearly 120 million lives."

2. Porch Light Health (previously Front Range Clinics)[37] provides mobile services to multiple regions in Colorado for individuals seeking recovery from SUD and OUD. A mobile addiction clinic does serve rural Southeast Colorado through community partnerships and pop-up partnership locations providing MOUD (buprenorphine and naltrexone), counseling, and supportive services (through clinical case managers). The mobile sites will have assigned locations that are visited weekly to provide MOUD services. Porch Light can provide phone and virtual visits.

Appendix 4: Workflows in Managing Opioid Withdrawal in Jails[74,75]

- The Bureau of Justice Assistance created Guidelines for Managing Substance Withdrawal in Jails: https://bja.ojp.gov/doc/guidelines-managing-substance-withdrawal-jails.pdf
- The Colorado Consortium for Prescription Drug Abuse Prevention Treatment Workgroup has created workflows that summarize opioid withdrawal management: https://drive.google.com/drive/folders/1xcTWZ9TwKMjgyxpSXda3PxKlt3qBYUxX

Appendix 5: Behavioral Health Screening Tool

The Global Appraisal of Individual Needs - Initial (GAIN-I) Screening Tool[76] is a bio-psycho-social assessment tool used by clinicians to diagnose and develop treatment plans for various mental health disorders, including SUDs. The table below summarizes the GAINS-I sections that relate to substance use. The next questions are about treatment for mental, emotional, behavioral or psychological problems. This includes taking medication like Ritalin that a regular doctor may have given you to help you focus or calm down. Do not count treatment that was only for substance use or health problems.

Page #	Section Title	Question(s)	Description
7	A4. Presenting Concerns	A4a	Primary reason for seeking treatment
13-24	S. Substance Use (Alcohol, Marijuana, and Other Drugs)	S1, S2, S3, S3, S5, S6	Substance use behaviors, frequency of substance use
26-36	S. Substance Use (Alcohol, Marijuana, and Other Drugs)	S7, S8, S9	Substance use behaviors, frequency of substance use
38-40	S. Substance Use (Alcohol, Marijuana, and Other Drugs)	S9c, S10	Presence of substance dependence and withdrawal, desire to seek help
49	P. Physical Health	P12	Family history of SUDs
51-52	R. Risk Behaviors and Disease Prevention	R1	Risk behavior related to substance use
59	R. Risk Behaviors and Disease Prevention	R7	Desire to change risk behaviors (including injection drug use)
62	M. Mental and Emotional Health	M1j, M1k	Interaction between psychological problems and drug use
68	M. Mental and Emotional Health	M5a	Previous behavioral health diagnoses, including alcohol or other substance use disorders
88	L. Legal and Criminal	L3	Illegal activity while using substances or to obtains substances
111-112	Z. End	CS9c.	Quetstions for staff about participant substance use

Appendix 6: Resources

American College of Obstetricians and Gynecologists (ACOG)	Committee on Obstetric Practice. Opioid Use and Opioid Use Disorder in Pregnancy. 2021.[77] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy
American Society of Addiction Medicine (ASAM)	- Public Policy Statement of Treatment of Opioid Use Disorders in Correctional Settings. 2020.[78] https://www.asam.org/docs/default-source/public-policy-statements/2020-statement-on-treatment-of-oud-in-correctional-settings.pdf - DSM-5 Diagnostic Criteria for Opioid Use Disorder[79] [checklist provided by CDC] https://www.cdc.gov/overdose-prevention/hcp/clinical-care/opioid-use-disorder-diagnosis.html - Subjective Opiate Withdrawal Scale. 1987.[60] https://www.asam.org/docs/default-source/education-docs/sows_8-28-2017.pdf
Bureau of Justice Assistance [US government]	- Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals. 2023.[74] https://bja.ojp.gov/doc/guidelines-managing-substance-withdrawal-jails.pdf - Medication Assisted Treatment Inside Correctional Facilities.[72] https://store.samhsa.gov/sites/default/files/pep19-mat-corrections.pdf - Managing Substance Withdrawal in Jails: A Legal Brief. 2022.[80] https://bja.ojp.gov/doc/managing-substance-withdrawal-in-jails.pdf - Using Telehealth for Behavioral Health in the Colorado County Jails System.[81] https://www.cossup.org/Content/Documents/BriefingSheets/Using_Telehealth_for_Behaviorial_Health.pdf
Center for Health and Justice	Safe Withdrawal in Jail Settings. 2018.[46] https://www.centerforhealthandjustice.org/tascblog/Images/documents/Publications/Safe%20Withdrawal%20in%20Jail_010918.pdf
Centers for Medicare & Medicaid Services [US government]	Reentry Section 1115 Demonstration Opportunity.[50] https://www.medicaid.gov/medicaid/section-1115-demonstrations/reentry-section-1115-demonstration-opportunity/index.html
Colorado Behavioral Health Administration	- Opioid Treatment Programs: Directory of OTPs. 2023.[82] https://drive.google.com/file/d/1naco-pLi0honGtdSd62m3XuQuGkdwKDF/view - Jail Based Behavioral Health Services.[45] https://bha.colorado.gov/behavioral-health/jbbs - Jail Based Behavioral Services Discharge Planning Sheet.[83] https://drive.google.com/file/d/1TpdAG1uQ3QxhbcOZmxyobNNBTblYjEvn/view
Colorado Department of Health Care Policy and Financing	Intersection of Medicaid and Jails Toolkit for Counties. 2016.[65] Note: This document is currently being updated by HCPF. We are anticipating information from the organization on how to share the most updated version, and we will update the resource and link shortly.
Conejos County [affordable housing applications]	Conejos County Housing Authority. 2024.[68] http://www.conejoshousing.org/forms-policies
Costilla County [affordable housing applications]	Costilla County Housing Authority. 2024.[67] https://www.costillacountyhousingauthority.com/apply/index.php
Council of State Governments Justice Center	Three Things to Know About Implementing Telehealth in Correctional Facilities. 2021.[41] https://csgjusticecenter.org/2021/04/12/three-things-to-know-about-implementing-telehealth-in-correctional-facilities/
Department of Health and Human Services [US government]	HIPPA and [42 CFR] Part 2 [81]. [protection of medical records of those with SUD(s)][84] https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-part-2/index.html
Drug Enforcement Administration [US government]	- Narcotic Treatment Program Manual: A Guide to DEA Narcotic Treatment Program Regulations. 2022.[36] https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-056)(EO-DEA169)_NTP_manual_Final.pdf - Practitioner's Manual: An Informational Outline of the Controlled Substances Act. 2023.[54] https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-071)(EO-DEA226)_Practitioner's_Manual_(final).pdf - Quick Tips: DEA Requirements for MAT Storage. 2020.[85] https://sites.rutgers.edu/mat-coe/wp-content/uploads/sites/473/2020/09/DEA-Requirements-for-Medication-Storage-Module-for-use.pdf
Federal Bureau of Prisons	Medically Supervised Withdrawal for Inmates with Substance Use Withdrawal. 2020.[86] https://www.bop.gov/resources/pdfs/medically_supervised_withdrawal_cg.pdf
Food and Drug Administration	Information about Medication Assisted Treatment. 2024.[87] https://www.fda.gov/drugs/information-drug-class/information-about-medications-opioid-use-disorder-moud

Continued **Appendix 6: Resources**

Legislative Analysis and Public Policy Association (LAPPA)	- Performance Measures for Medication-assisted Treatment in Correctional Settings. 2022.[88] https://legislativeanalysis.org/wp-content/uploads/2022/12/Performance-Measures-for-Medication-assisted-Treatment-in-Correctional-Settings.pdf
National Commission on Correctional Health Care (NCCHC)	- Opioid Use Disorder Treatment in Correctional Settings. 2021.[89] https://www.ncchc.org/wp-content/uploads/Opioid-Use-Disorder-Treatment-in-Correctional-Settings-2021-1.pdf - Standards for Opioid Treatment Programs [in correctional facilities]. 2016.[90] https://www.ncchc.org/opioid-treatment-programs-standards/
National Council for Behavioral Health/National Council for Mental Wellbeing	- Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons. 2020.[25] https://www.thenationalcouncil.org/wp-content/uploads/2022/08/23.03.03_MAT_in_Jails_Prisons_Toolkit_Updated.pdf
See Appendix G: Sample Policies and Forms	- HEALTH AND SAFETY Diversion Control Plan: Prevention of Opioid Diversion. 2016.[52] https://www.thenationalcouncil.org/wp-content/uploads/2023/01/Community-Medical-Services-Diversion-Policy.pdf
National Institute on Drug Abuse	- Clinical Opioid Withdrawal Scale. 2003.[61,91] https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf
Office of Justice Programs [US government]	- Guidelines for Managing Substance Withdrawal in Jails. 2023.[74] https://www.cossup.org/Content/Documents/JailResources/Guidelines_for_Managing_Substance_Withdrawal_in__Jails_6-6-23_508.pdf
Pew Charitable Trusts	- Opioid Use Disorder Treatment in Jails and Prisons. 2020.[92] https://www.pewtrusts.org/-/media/assets/2020/04/caseformedicationassistedtreatmentjailsprisons.pdf
Research Triangle Institute International	- A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons. 2019.[93] https://harmreduction.org/wp-content/uploads/2020/09/A-primer-for-implementation-of-OEND-in-jails-and-prisons-Wenger-2019-RTI.pdf
Rural Health Information Hub	- Rural Medication for Opioid Use Disorder (MOUD) Toolkit. 2021.[94] https://www.ruralhealthinfo.org/toolkits/moud
Substance Abuse and Mental Health Services Administration (SAMHSA) [US government]	- National Hotline for Patients and Families (800) 662-HELP (4357) - Principles of Community-based Behavioral Health Services for Justice-Involved Individuals. 2019.[95] https://store.samhsa.gov/sites/default/files/sma19-5097.pdf - Buprenorphine Quick Start Guide.[96] https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf - Tip 63: Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families Published 2021.[97] https://store.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002 - Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings. 2019.[53] https://store.samhsa.gov/sites/default/files/treatment-criminal-justice-pep19-matusecjs.pdf - How to Become Certified? Opioid Treatment Program (OTP). 2024.[11] [methadone certification] https://www.samhsa.gov/medications-substance-use-disorders/become-accredited-opioid-treatment-program - Disclosure of Substance Use Disorder Patient Records: How do I Exchange Part 2 Data?[98] https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf - Treatment Locator for Mental and Substance Use Disorders.[64] https://findtreatment.gov/ - Buprenorphine Practitioner Locator. 2024.[44] https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator - Tip 51: Substance Abuse Treatment: Addressing the specific Needs of Women. 2015.[99] https://store.samhsa.gov/product/tip-51-substance-abuse-treatment-addressing-specific-needs-women/sma15-4426
World Health Organization	- Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings. 2009.[100] https://iris.who.int/handle/10665/207032

Appendix 7: OTP Directory

Colorado OTP's in SAMHSA's Opioid Treatment Program Directory[34]

Program Name	DBA*	Street	City	State	Zip Code	Phone	Certification	Full Certification
A.R.T.S. Parkside Clinic		1620 Gaylord St.	Denver	CO	80206	(303) 388-5894	Certified	1/1/04
ARTS Westside Center for Change		6303 Wadsworth Bypass	Arvada	CO	80003	(303) 935-7004	Certified	7/9/08
AURORA THERAPY CENTER LLC		15501 E 13th Avenue	Aurora	CO	80011	(303) 942-0740	Certified	9/2/22
BayMark Health Services of Colorado, Inc.	BAART Programs Brighton	5 S 1st Avenue	Brighton	CO	80601	(720) 909-6008	Certified	9/25/19
Behavioral Health Services		667 Bannock St., Unit 9	Denver	CO	80204	(303) 602-7064	Certified	5/16/03
Colorado Community Care		5701 E Evans Ave	Denver	CO	80222	(720) 504-3033	Provisional	
Colorado Treatment Services LLC		5360 N Academy Blvd, Suite 290	Colorado Springs	CO	80918	(719) 434-2061	Certified	1/18/06
		3400 W 16TH ST STE P	Greeley	CO	80634	(970) 978-4386	Certified	4/25/18
		275 W. ABRIENDO AVENUE	Pueblo	CO	81008	(719) 621-1929	Certified	4/25/18
Community Medical Services - Aurora on Exposition		14300 East Exposition Avenue	Aurora	CO	80012	(720) 853-4230	Certified	9/26/23
Community Medical Services - Englewood		4348 South Federal Boulevard	Englewood	CO	80110	(720) 699-1050	Provisional	
Community Medical Services - Greenwood Village		6801 S Dayton St Suite 312	Greenwood Village	CO	80112-3624	(480) 228-8823	Provisional	
Community Medical Services - Lakewood		7205 West Colfax Ave Suite 101D	Lakewood	CO	80214	(720) 685-6250	Provisional	
Community Medical Services - Northglenn		11880 N Washington St	Northglenn	CO	80233		Provisional	
Community Medical Services - Westminster		7500 W Sheridan Blvd	Westminster	CO	80003	(720) 853-4230	Provisional	
Community Medical Services – Aurora on Del Mar		10690 Del Mar Pkwy	Aurora	CO	80010	(480) 228-8823	Provisional	
Comprehensive Behavioral Health Center		2217 Champa St.	Denver	CO	80205	(720) 398-9666	Certified	2/21/17
		5300 West Alameda Ave.	Lakewood	CO	80226	(720) 762-5284	Certified	9/2/22
Crossroads' Turning Points		509 East 13th St.	Pueblo	CO	81001	(719) 546-6666	Certified	7/1/04
		2265 Lava Lane	Alamosa	CO	81101	(719) 589-5176	Certified	12/6/16
		3501 South Main Street	Lamar	CO	81052	(719) 336-2600	Certified	11/5/19
Denver Reception and Diagnostics Center		10900 Smith Rd	Denver	CO	80239	(303) 307-2332	Provisional	

* Doing Business As (DBA) is the working name of the organization
Note: The directory of OTP's in this document was created May 2024 and updated October 2024.

Continued **Appendix 7: OTP Directory**

Program Name	DBA*	Street	City	State	Zip Code	Phone	Certification	Full Certification
Denver Recovery Group	ALT Recovery Group	2822 E. Colfax	Denver	CO	80206	(303) 953-2299	Certified	6/21/16
Denver Recovery Group - Central		1801 West 13th Avenue	Denver	CO	80204	720-616-0049	Certified	12/13/17
Denver Recovery Group - Colorado Springs		2531 Airport Road	Colorado Springs	CO	80910	(719) 300-7021	Certified	4/21/21
Denver Recovery Group - Glenwood Springs		1429 Grand Avenue	Glenwood Springs	CO	81401	(720) 940-3813	Certified	8/22/23
Denver Recovery Group - Lakewood		8790 West Colfax	Lakewood	CO	80205	(720) 940-3813	Certified	8/19/20
Denver Recovery Group - Montrose		130 North Park	Montrose	CO	81401	(720) 940-3813	Certified	8/22/23
Denver Recovery Group - Thornton		11658 Huron Street	Northglenn	CO	80236	(720) 940-3813	Certified	10/11/22
Denver Recovery Group/ South		72 East Arapahoe Road	Littleton	CO	80122	(720) 283-3055	Certified	5/9/17
Denver Recovery Group/ West		5330 Manhattan Circle Unit H	Boulder	CO	80301	(720) 536-5571	Certified	4/5/18
ELEVATE HEALTHCARE LLC		212 W 13TH ST	PUEBLO	CO	81003	(719) 696-9027	Certified	1/12/24
FCC Florence		5880 State Hwy 67 S	Florence	CO	81226		Provisional	
FCI Englewood		9595 W. Quincy Ave	Littleton	CO	80123		Provisional	
Health Solutions Medication Assisted Recovery Center		41 Montebello Road, Suite 120	Pueblo	CO	81001-1366	(719) 423-1500	Certified	11/19/20
Mesa County Detention Facility		215 Rice Street	Grand Junction	CO	81501	(970) 244-3382	Provisional	
Metro Treatment of Colorado, L.P.	New Season 460-461 Treatment Center	2956 North Avenue	Grand Junction	CO	81504	(970) 208-1130	Certified	2/2/16
Mile High Treatment and Recovery INC		6310 E Exposition Avenue	Denver	CO	80224		Certified	2/14/24
The ARTS Potomac Street Center		750 Potomac Street Suite L11	Aurora	CO	80011	(303) 283-5991	Certified	1/1/04
THRIVE MEDICAL GROUP INC	THRIVE BEHAVIORAL HEALTH AND RECOVERY	3601 S BROADWAY	ENGLEWOOD	CO	80113	(303) 658-0059	Certified	
VCPHCS X, LLC	BHG Fort Collins Treatment Center	2114 MidPoint Drive Suite 4	Fort Collins	CO	80525	(970) 372-3144	Certified	10/26/17
	BHG Longmont Treatment Center	850 23rd Avenue	Longmont	CO	80501	(303) 245-0123	Certified	11/1/04

* Doing Business As (DBA) is the working name of the organization
Note: The directory of OTP's in this document was created May 2024 and updated October 2024.

Continued **Appendix 7: OTP Directory**

Program Name	DBA*	Street	City	State	Zip Code	Phone	Certification	Full Certification
VCPHCS XII, LLC	BHG Westminster Treatment Center	8402 Clay Street	Westminster	CO	80031	(303) 487-7776	Certified	11/1/04
	BHG Centennial Treatment Center	7286 S.Yosemite Street Suite 125	Centennial	CO	80112	(303) 824-5866	Certified	2/20/18
	BHG Colorado Springs Treatment Center	4157 Centenniel Blvd	Colorado Springs	CO	80907	(719) 598-9750	Certified	2/17/21
	BHG Denver Treatment Center	5250 Leetsdale Drive, Ste. 220	Denver	CO	80204	(303) 629-5293	Certified	4/1/04

* Doing Business As (DBA) is the working name of the organization
Note: The directory of OTP's in this document was created May 2024 and updated October 2024.

Appendix 8: Diagnostic Criteria for Opioid Use Disorder[79]

The following language is pulled directly from the CDC resource Opioid Use Disorder: Diagnosis, which is based on DSM-5 diagnostic criteria.[76]

OUD is demonstrated by at least 2 out of the 11 criteria below occurring within a year. Severity of OUD is determined based on the number of criteria met (mild: 2-3 criteria, moderate: 4-5 criteria, severe: greater than or equal to 6 criteria).

1. Taking opioids in larger amounts or over a longer period of time than intended
2. Having a persistent desire or unsuccessful attempts to reduce or control opioid use
3. Spending excess time obtaining, using, or recovering from opioids
4. Craving opioids
5. Continued opioid use causing inability to fulfill work, home, or school responsibilities
6. Continuing opioid use despite having persistent social or interpersonal problems
7. Lack of involvement in social, occupational, or recreational activities
8. Using opioids in physically hazardous situations
9. Continuing opioid use in spite of awareness of persistent physical or psychological problems
   - A need for markedly increased amounts of opioids to achieve intoxication or desired effect, or
   - Markedly diminished effect with continued use of the same amount of an opioid.
10. Exhibiting withdrawal symptoms, as manifested by either of the following:*
    - The characteristic opioid withdrawal syndrome, or
    - Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Appendix 9: Communication Including Medical Records

In detention centers, the roles of custody and medical care staff vary due to shifts and on-call changes, which are vital for responding emergency personnel and external medical providers. Furthermore, to meet the basic standards of medical practice, maintaining secure yet accessible communication about the changing medical conditions of detainees is crucial. This includes documenting their medical status and treatment in a medical record that is protected as per HIPAA and 42 CFR part 2[84] laws and their associated regulations.

Appendix 10: Sample Withdrawal Protocols

Inmate Medication, Controlled Substance Tracking Form

Inmate Name: ______________________________ ID: __________________________

Medication Receiving						
Medication Name	Strength (mgs)	Dosage Form (pill, liquid, patch etc.)	Date Received	Volume/Quantity Received	Staff #1 Verification	Staff #2 Verification

Daily Count						
Date	Time	Action (Admin, Waste, Inventory Count	Dosage (mgs) Administered/Wasted	Count Remaining	Count Verifier #1	Count Verifier #2
		Beginning Inventory=	--------			

Medication Returned to Inmate/Representative					
Day	Count	Staff Witness #1	Staff Witness #2	Person Receiving Signature	
End of Month- Manager Review & Sign off Date & Time		Date & Time	Signature	Discrepancies & Follow Up:	

(INSERT JAIL LOGO AND INFO HERE)	Inmate Name / ID:

Source: Rio Grande County Jail (2024).

Continued **Appendix 10: Sample Withdrawal Protocols**

INTAKE PAPERWORK

Patient Name	DOB	Gender (circle one): Male Female Other Transgender Non-binary
Chief Compliant:		
Current Medication(s)		

_____ will be providing telehealth sessions (video) using doxy.me. Laws governing confidentiality to health information, including, but not limited to the Health Insurance Portability and Accountability Act (HIPPA) apply in telehealth. Access to the transmission of data will be limited to the necessary people, organization and staff of the provider and shall not be transmitted to anyone outside unless otherwise with your prior written consent. In general, the law protects the privacy of all communications between patient and psychiatric nurse practitioner. However, certain situations may require the disclosure of a patient's treatment to prevent harm. Some examples include threats of self-harm and/or threats of serious harm to others.

I consent to participate in evaluation and treatment offered by _____ via telehealth. Furthermore, I understand that I may stop this treatment at any time but will discuss this with my provider first to avoid any risks associated with the discontinuation of medications.

I have read and understand the above information.

_____ _____ _____

Patient Name **Patient Signature** **Date**

I authorize _____ to share information regarding my mental health treatment with (name/location) _____

_____ _____ _____

Source: Rio Grande County Jail (2024).

Appendix 11: COWS and SOWS[60,61]

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ **Date & Time:** _____

Reason for this assessment: _____

Resting Pulse Rate: beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** over last 1/2 hour 0 no GI symptoms 1 stomach cramps 2 nausea 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score The total score is the sum of all 11 items Initials of person completing assessment:

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
This version may be copied and used clinically.

Volume 35 (2), April - June 2003

Journal of Psychoactive Drugs

Source: Wesson, D.R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253-9.
https://www.montgomerycollege.edu/_documents/academics/departments/nursing-tpss/nursing-simulation-scenario-library/clinical-opiate-withdrawal-scale.pdf

Continued **Appendix 11: COWS and SOWS**[60,61]

Name: _____

Date: _____

Subjective Opiate Withdrawal Scale (SOWS)

Instructions: We want to know how you're feeling. In the column below today's date and time, use the scale to write in a number from 0-4 about how you feel about each symptom right now.

Scale: 0 = not at all 1 = a little 2 = moderately 3 = quite a bit 4 = extremely

Date					
Time					
SYMPTOM	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCROE**
1. I feel anxious					
2. I feel like yawning					
3. I am perspiring					
4. My eyes are tearing					
5. My nose is running					
6. I have goosebumps					
7. I am shaking					
8. I have hot flushes					
9. I have cold flushes					
10. My bones & muscles ache					
11. I feel restless					
12. I feel nauseous					
13. I feel like vomiting					
14. My muscles twitch					
15. I have stomach cramps					
16. I feel like using now					
TOTAL					

Mild withdrawal = score of 1 -10
Moderate withdrawal = 11 -20
Severe withdrawal = 21 -30

Source: Reprinted from Handelsman et al. 1987, p. 296, by courtesy of Marcel Dekker, Inc. .

For use outside of IT MATTTRs Colorado, please contact ITMATTTRsColorado@ucdenver.edu
https://www.asam.org/docs/default-source/education-docs/sows_8-28-2017.pdf?sfvrsn=f30540c2_2%22

Appendix 12: Jail-Based Medication-Assisted Treatment Policy[58]

The language for this policy example is pulled directly from the Example MAT Treatment Policy[58] developed by the Opioid Response Network, the Colorado Office of Behavioral Health, the Northern Colorado Health Alliance, and the Steadman Group, LLC.

I. Regulatory

A. If methadone is administered at the facility, correctional healthcare staff will work with the opioid treatment program (OTP) that provides the medication to ensure that all federal and state regulations are met.
B. The facility will otherwise ensure that normal controlled substance policy is followed when storing and distributing MAT medications that are controlled substances.

II. Screening and Diagnosis

A. A comprehensive substance use screening, with specific questions about opioids and MOUD medications, should be administered as soon as feasible or urgently if withdrawal is suspected.
B. Correctional healthcare staff should use self-report, objective medication reconciliation, urine drug screen (if applicable), and physical exam to diagnose substance use disorder using DSM-V criteria.
C. Validated withdrawal scales, such as COWS and CIWA, will be used to assess initial withdrawal and monitor progress.
D. Healthcare staff recognize that initial screening may miss some patients who can benefit from MOUD and consider treatment for these individuals who are identified by custodial staff or self-report during incarceration.

III. Treatment

A. Patients will receive education on the risks and benefits of treatment of withdrawal and substance use disorder, including information on alternative treatments and the risk of no treatment at all.
B. Treatment should involve judicious consideration of all available medications for SUD, recognizing that the most convenient may not be the most effective.
C. Treatment decisions should be made between the healthcare provider and patient. They should not involve any loss or gain of privileges depending on choices. Likewise, treatment decisions should not be influenced by disciplinary actions unless those involve medication diversion.
D. Treatment should weigh the potential medical benefit against drawbacks and consider the patient's well-being upon release.
E. Treatment decisions should consider the patient's likely disposition and the availability of MOUD in that setting.
F. Patients who enter incarceration taking a MOUD medication should be maintained on the same medication and dose whenever feasible.
G. Correctional healthcare staff may consider initiating MOUD for patients who are not currently taking MOUD but could benefit from it either for withdrawal management or because they are at high risk of relapse upon release.
H. Correctional healthcare staff should use a validated withdrawal scale and evidence-based guidelines prior to the first dose of MOUD in order to minimize the chance of precipitated withdrawal.
I. MOUD dosing should be titrated to achieve an effective dose as rapidly as possible.
J. The administration of MOUD medications should balance the health benefits of MOUD to the patient with the security requirements and availability of custodial staff.
K. MOUD medication should not be immediately withdrawn except in outstanding circumstances, because cessation of MOUD medications can cause severe withdrawal.

IV. Safety

A. Custodial and healthcare staff should collaborate to minimize diversion of MOUD medications. Normally, this consists of healthcare staff administering the medication and custodial staff monitoring patients for diversion.
B. Storage and administration of MOUD medications should follow all federal, state, and facility guidelines for controlled substances.
C. Healthcare staff should be familiar with the common contraindications and adverse reactions to MOUD medications as well as the signs and symptoms of withdrawal, and common treatments for all the preceding issues.

V. Counseling

A. The facility should make SUD counseling available to all patients on MOUD who desire it.
B. Healthcare staff may take counseling attendance into account when determining whether ongoing MOUD therapy is appropriate for a patient.
C. The lack of counseling capacity should not preclude a patient from receiving MOUD; counseling and medication work independently but synergistically.
D. Ideally, counseling should consist of an evidence-based intake, individual or group counseling, and linkage to counseling upon release.
E. Individuals diagnosed with behavioral conditions other than SUD should be linked to psychiatric care and treatment.

VI. Linkage to Care

A. Connection to outpatient MOUD treatment is a crucial aspect of a correctional MOUD program. Every effort will be made to identify high-quality outpatient treatment providers, link patients with treatment immediately upon release, and improve the quality and duration of follow-up care.
B. Discharge planning should consider psychosocial barriers to treatment follow-up, including transportation and insurance. When possible, discharge planning should attempt to provide medical records to outpatient healthcare providers given the proper release of information.
C. Healthcare and counseling staff in the facility will provide naloxone to patients at risk of overdose, either directly or through community providers, prior to release.

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