MIDD Briefing Paper

BP 1 Prison Pre-Release Opiate Treatment

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept ☒ (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This new concept would provide pre-release Medication Assisted Treatment (MAT) in the form of buprenorphine or methadone prior to state prison release, with active linkage to post-release community-based treatment for incarcerated individuals with histories of opiate addiction who are returning to King County. Buprenorphine would likely be easier to implement, as it has fewer regulations than methadone, and requires only a few days of administration prior to release. Methadone is a less expensive medication, but is more administratively burdensome to manage, and would require a longer period to titrate to an appropriate dose. Community-based availability of methadone or buprenorphine may also be variable.

Collaborators:

Name	**Department**
Genevieve Rowe	DCHS/MHCADSD

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
Caleb Banta-Green	Epidemiologist/Opiate and overdose expert	University of Washington ADAI
Dawn Williams	Treatment Director	WA Department of Corrections
Devon Trumm	Director of Re-Entry	WA Department of Corrections

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This new concept would provide pre-release Medication Assisted Treatment (MAT) in the form of buprenorphine or methadone prior to state prison release, with active linkage to post-release community-based treatment for incarcerated individuals with histories of opiate addiction who are returning to King County. Buprenorphine would likely be easier to implement, as it has fewer regulations

than methadone, and requires only a few days of administration prior to release. Methadone is a less expensive medication, but is more administratively burdensome to manage, and would require a longer period to titrate to an appropriate dose. Community-based availability of methadone or buprenorphine may also be variable.

These medications are opiate agonists (medications that fill the opiate receptors in the brain, reducing craving) that would need to be continued upon release from prison. These medications allow individuals with histories of opiate[1] dependence to reduce craving, feel normal, and function in their lives. It could be started as a demonstration program in a single state facility, and grown over time if additional resources become available.

Mechanics of internal processes for identifying, screening, and enrolling inmates in this program will need to be worked out with the individual facility. Monroe might make the most sense, as a large number of prisoners are released to King County from that site and they have a history of innovative programming.[2] The program should be designed to fit within existing pre-release procedures to the extent possible. It is recommended that inmates who are 90 days from their release date be identified, screened, and offered this service, likely by someone involved in release-planning or health care provision within the facility. This time is needed to allow sufficient time to safely titrate up to a clinically effective methadone dose, as well as to allow time for referral and acceptance to the community-based treatment provider. Time is also needed for the inmates to make their decisions about whether or not to participate. This should be a voluntary program with no incentives or penalties for participating or not.

The goals of the program are to 1) reduce the rate of overdose death among individuals being released from prison to the community; 2) reduce recidivism by and reincarceration of this population; 3) reduce other health risks such as HIV, hepatitis C, endocarditis, abscesses, etc., and 4) enable people to focus on establishing a successful, recovery-oriented life upon release.

This relates to MIDD I strategy, 1a2, substance abuse treatment.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program.** (Select all that apply):

   ☐ **Crisis Diversion** ☐ **Prevention and Early Intervention**

   ☒ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

This primarily fits under Recovery and Re-entry strategy area, as it is an intervention focused exclusively on improving re-entry outcomes for individuals with histories of opiate dependency. It is also a System Improvement as it provides continuity of care between penal institutions and community-based care, and provides a safety net that currently doesn't exist for individuals at high risk of negative outcomes.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

[1] Opiates are naturally occurring narcotics, derived from opium, such as heroin and morphine. Opioids are synthetic opiate-like substances, such as codeine and hydrocodone. In this paper, opiate/opioid are being used interchangeably to refer to both types of substances.

[2] Phone communication with Devon Trumm, Re-Entry Director, November, 2015

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

As of September 30, 2015, there were 18,414 individuals held in confinement by the Washington State Department of Corrections (DOC).[3] Roughly 15 percent of US state prison inmates have histories of opiate dependency.[4] For the past five years, an average of 1,460 individuals has been released from state prison to King County annually. The majority come from Monroe. A study of released prisoners from 30 states, including Washington State, found that more than two-thirds (67.8%) were re-incarcerated within three years and three-quarters (76.6%) were re-incarcerated within five years.[5] According to the National Institute of Justice, only property offenses exceed drug offenses as the reason for re-incarceration,[6] and many property crimes may be related to drug use.

A 2007 Washington State study published in New England Journal of Medicine found that during the first two weeks after release from prison, the risk of death among former inmates was 12.7 times that among other state residents, with overdose being far and away the leading cause of death. During the first week after release, the death rate was even higher, 16.4 times that of other state residents[7].

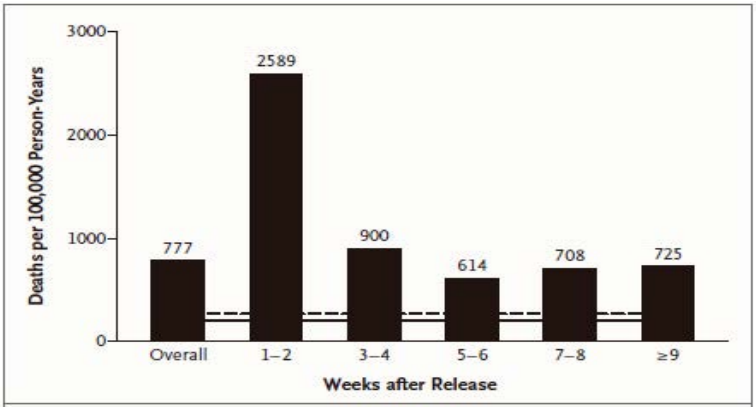

Figure 1. Mortality Rates among Former Inmates of the Washington State Department of Corrections during the Study Follow-up (Overall) and According to 2-Week Periods after Release from Prison.

The dashed line represents the adjusted mortality rate for residents of the State of Washington (223 deaths per 100,000 person-years), and the solid line represents the crude mortality rate among inmates of the state prison system during incarceration (201 deaths per 100,000 inmate person-years).

[3] http://www.doc.wa.gov/aboutdoc/docs/msFactCard.pdf. Accessed 11-3-15
[4] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3372322/
[5] http://www.bjs.gov/content/pub/pdf/rprts05p0510.pdf
[6] http://www.nij.gov/topics/corrections/recidivism/Pages/welcome.aspx#note1
[7] Ingrid A. Binswanger, M.D., Marc F. Stern, M.D., Richard A. Deyo, M.D., Patrick J. Heagerty, Ph.D., Allen Cheadle, Ph.D., Joann G. Elmore, M.D., and Thomas D. Koepsell, M.D., *Release from Prison — A High Risk of Death for Former Inmates*, NEJM, N Engl J Med 2007;356:157-65.

Opiate craving is commonly reported at release, no matter how long people may have been abstinent behind bars[8]. Without a program to protect individuals from taking their first dose upon release, individuals with opiate histories being released from prison will continue to return to drug use and prison, and to die at high rates.

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

This New Concept addresses the need outlined above by providing an evidence-based intervention prior to release that significantly reduces the likelihood that someone will engage in opiate use immediately upon release to the community. It also provides for continuity of care that will assist that individual in continuing to avoid opiate use. By preventing opiate use, the associated harms of crime, reincarceration, infectious disease transmission, and, most importantly, overdose death can also be reduced.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

The Washington State Institute for Public Policy (WSIPP) lists both buprenorphine and methadone treatment as highly cost effective, evidence-based practices[9]. There are thousands of articles documenting the effectiveness of both methadone and buprenorphine for managing opiate dependence: a recent search on Google Scholar found 19,000 citations on this topic.[10] Opioid maintenance therapies are currently recommended by the World Health Organization and the United Nations for both general and incarcerated populations.[11] [12] A Massachusetts study of 33,923 Medicaid beneficiaries receiving either buprenorphine, methadone, drug-free treatment, or no treatment during the period 2003–07 found that mortality rates were 75 percent higher among those receiving drug-free treatment, and more than twice as high among those receiving no treatment, compared to those

[8] Springer, S, Chen S., Altice, F., Improved HIV and Substance Abuse Treatment Outcomes for Released HIV-Infected Prisoners: The Impact of Buprenorphine Treatment,, July 2010, Volume 87, Issue 4, pp 592-602

[9] http://www.wsipp.wa.gov/ReportFile/1556/Wsipp_Inventory-of-Evidence-based-Research-based-and-Promising-Practices-Prevention-and-Intervention-Services-for-Adult-Behavioral-Health_Inventory.pdf Accessed 10-30-15.

[10] http://scholar.google.com/scholar?hl=en&q=methadone+buprenorphine+effectiveness&btnG=&as_sdt=1%2C48 Accessed 10-30-15.

[11] WHO Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. Geneva: WHO; 1999. http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf [PubMed]

[12] UNODC/WHO/UNAIDS HIV/AIDS prevention, care, treatment, and support in prison settings. Vienna: UN Office on Drugs and Crime; 2006. http://data.unaids.org/pub/Report/2006/20060701_hiv-aids_prisons_en.pdf

receiving buprenorphine.[13] Data for agonist treatment is significantly more robust than data for antagonist treatment.[14]

A 2010 Baltimore study found that inmates who received counseling plus methadone prior to prison release were significantly more likely than both counseling only and counseling + transfer participants to be retained in drug abuse treatment ($P = 0.0001$) and significantly less likely to have an opioid-positive urine specimen compared to counseling only ($P = 0.002$). Furthermore, counseling + methadone participants reported significantly fewer days of involvement in self-reported heroin use and criminal activity than counseling only participants[i15]. A review article of 21 studies found that pre-release medication assisted opioid treatment was associated significantly with increased treatment entry and retention after release if arrangements existed to continue treatment. Four of five studies found post-release reductions in heroin use. There was limited evidence of reduced post-release mortality[16]. Prison pre-lease medication assisted opioid treatment with linkage to community care has been successfully implemented in multiple states and countries, including Rhode Island, Maryland, Puerto Rico, Malaysia and Australia.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection.**

   Please see response to question 3 for more detail. The updated 2014 WSIPP inventory of best practices, http://www.wsipp.wa.gov/ReportFile/1556/Wsipp_Inventory-of-Evidence-based-Research-based-and-Promising-Practices-Prevention-and-Intervention-Services-for-Adult-Behavioral-Health_Inventory.pdf, identifies Medication Assisted Treatment as an evidenced based practice for opiate dependence. There is an increasing body of evidence on the effectiveness of the use of pre-release MAT with linkage to care.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Reduced overdose death of released inmates
Improved linkage to treatment
Engagement and retention in treatment
Reduced reincarceration

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[13] Clark, R., Samnaliev, M., Baxter, J., Leung, G., The Evidence Doesn't Justify Steps By State Medicaid Programs To Restrict Opioid Addiction Treatment With Buprenorphine, doi: 10.1377/hlthaff.2010.0532 Health Aff August 2011 vol. 30 no. 8 1425-1433

[14] Medication-assisted treatment of opioid use disorder: review of the evidence and future directions. Conner HS. *Harvard Review of Psychiatry* 2015;23(2):63-75.

[15] Gordon, M. S., Kinlock, T. W., Schwartz, R. P. and O'Grady, K. E. (2008), A randomized clinical trial of methadone maintenance for prisoners: findings at 6 months post-release. Addiction, 103: 1333–1342. doi: 10.1111/j.1360-0443.2008.002238.x

[16] Hedrich, D., Alves, P., Farrell, M., Stöver, H., Møller, L. and Mayet, S. (2012), The effectiveness of opioid maintenance treatment in prison settings: a systematic review. Addiction, 107: 501–517. doi: 10.1111/j.1360-0443.2011.03676.x

Reduced opiate use
Reduced emergency department visits

Outcomes for those receiving this intervention could potentially be compared to a similar group being released without this intervention. Data sources include death data from the Medical Examiners' office that MHCADSD already pays to access; internal data that MHCADSD already collects on treatment admission and retention, and use; booking and length of stay data already available to MHCADSD from municipal jails, county jails, and state prisons; and data available through negotiated agreement with the state Emergency Department Information Exchange (EDIE).

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☐ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☒ **Adults**	☐ **Immigrant/Refugee**
☐ **Older Adults**	☐ **Veteran/US Military**
☐ **Families**	☐ **Homeless**
☐ **Anyone**	☐ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☐ **Women**

☒ **Other – Please Specify:** Adults with histories of opiate dependence transitioning from prison to King County community settings.

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

This program is proposed for incarcerated individuals with histories of opiate dependence who are exiting state prison facilities to King County.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

This program is proposed for individuals returning anywhere within King County. Depending on the feasibility of developing treatment transfer agreements with opiate treatment programs or with buprenorphine prescribers throughout the county, it could be done in more geographically limited way.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Collaborations would be necessary. Agreement from the Department of Corrections (DOC) would need to be obtained. Preliminary conversations with DOC found interest in this idea from release planning, but not from the treatment division. Cross-sector buy-in within DOC would need to be championed in order for this program to be successful. As the DOC is a hierarchical organization in transition and awaiting new leadership, the acceptance of this concept would likely depend heavily on the philosophy and priorities of the new DOC Secretary. A prison facility with a supportive warden, and, preferably a supportive health care team, would need to be engaged. County, facility, and provider agreements would need to be developed. These would include data sharing agreements, scope of work development for contracts, clarification of responsibilities between entities, and budgets. Linkage would need to be made with community based opiate treatment programs (Evergreen, THS, possibly others) and/or with buprenorphine prescribers who might be in clinics or in private practice.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?

Community based availability of methadone or buprenorphine treatment would impact feasibility. Ability to design and execute agreement with State DOC is a key driver.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

There are multiple potential barriers. County leadership may be more interested in prioritizing programs and interventions that focus on County and municipal jails that could potentially save the County and towns money, rather than creating programs within the state system. Identifying champions inside of the DOC and particular facilities could be a barrier. There could be resistance from in-facility drug treatment counselors and administrators if they ascribe to abstinence only philosophy. Prison health, drug treatment, and release-planning staff may feel they are already overworked and be less than enthusiastic about the additional work that would be created by this program. Champions within DOC administration and within the facility(ies) would need to be identified. Champions could come from health services administration, social work, drug treatment, or from administration. Buy-in from higher level officials and administrators will be essential for buy-in at the operations level, given the hierarchical structure within DOC. If a DOC facility chooses to implement on-site methadone, Drug Enforcement Agency (DEA) and state licensing involvement will be necessary. Community based treatment programs might need to guarantee a certain amount of capacity to assure continued access on release. This could be challenging for them to provide, as current opiate treatment programs are often at capacity. Coordinating linkage to programs at the time of release, including transportation, to assure dosing continuity could be a barrier. Individuals involved in DOC release planning would need to be involved in the process, along with intake coordinators or identified liaisons at the opiate treatment programs. MHCADSD management would likely need to be involved in working out capacity issues. MHCADSD would also need to likely allocate a substantial amount of at least one manager's time to coordinate planning. Budget issues could also be a barrier- determining what would need to come from the DOC budget vs. MIDD dollars regarding paying for staffing, training, medication, medication security, and counseling costs, along with identifying the amount of the costs. Medicaid will be able to cover community-based treatment costs for a good number, but not all, of the individuals who would be served by this program. It does not cover any in-prison care.

Education of all parties involved on the costs of non-action could be helpful, including finding ways to frame the benefits around issues each party is interested in. Potential benefits for DOC staff include: 1) knowing there will be continuity of care after release and that any recovery related gains achieved in prison have an increased chance of being maintained post-release; 2) reduced recidivism rates; 3) potential good PR about DOC investing in the lives and health of released inmates and the safety of the communities they are being released to; 4) improved relationships with community providers, leading to easier/more effective release planning overall. Getting buy-in from high level officials, and having a multi-entity planning group that includes people who would make the project work at the operational level would also be helpful.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

There could be the unintended consequences for individuals in the community attempting to access opiate treatment if this program has a significant impact on capacity. Individuals might have to wait longer for treatment if individuals being released from prison are prioritized. There could be consequences for agencies as they attempt to manage their caseload size and mix. There could also be disruptions to their routine intake procedures if they are coordinating seamless care upon release. Staff could potentially need to obtain clearance to make pre-release visits. Unintended consequences for DOC include might include disruptions to workspace and work flow, challenges managing increased workload created by this program, and the need to manage employee resistance to change. The facility may have increased risk with the DEA related to managing controlled substances.

Some individuals may choose to be released into King County to be able to utilize the program.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

Individuals with opiate histories being released from prison will continue to return to opiate use at high rates, engage in drug-related crime, contract and spread infectious diseases such as HIV and Hepatitis C, and die from high rates of overdose. In 2012, it cost $24,663 to $34,124 per year (minimum vs maximum security) to incarcerate someone within a state facility.[17] Medication alone to cure one case of Hepatitis C is $84,000 ($1000 per pill)[18], and the average lifetime costs of treating one case of HIV is estimated to be $250,000 to $600,000, depending on when treatment is initiated.[19] Overdoses often require use of ambulance and emergency department resources. When the overdose results in death, additional resources, such as the morgue and the coroner's office come into play. All of these health costs are often financed by public dollars through programs such as Medicaid, Medicare, and the AIDS Drug Assistance Program (ADAP). These public dollars will continue to pay for high cost disease and crisis care if no systemic changes are made.

[17] http://www.doc.wa.gov/aboutdoc/docs/CostperOffenderFY2010-FY2012.pdf Accessed 11-4-15.
[18] http://www.sfgate.com/health/article/Cost-of-Gilead-s-hepatitis-C-pill-Sovaldi-spurs-5398315.php Accessed 11-4-15.
[19] http://aids.about.com/od/treatmentquestions/fl/What-Is-the-Lifetime-Cost-of-HIV.htm Accessed 11-4-15.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

Alternative approaches currently available are traditional referral to treatment and negotiating access post release. The problem with this approach is that many people don't make it to treatment and die of overdose in the interim, as indicated in the New England Journal of Medicine article previously cited. Those who don't die and continue to use are at much greater risk of recidivating, recycling through jails and prison. There would be additional costs to the system to initiate the pre-release treatment proposed in this new concept; however, there could be cost offsets to society as a whole from reduced crime, reincarceration, and first responder/emergency department use delineated in question 4. Depending on Medicaid eligibility status of individuals being released, some individuals being served by this strategy would likely also need to be served by MIDD I strategy of 1a2, drug treatment. This is a unique strategy serving a specialty population that it would not be feasible to merge with another strategy.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

This fits within the County's strategic plan goals related to health and human potential. This concept increases the possibility of at-risk residents living healthier, longer lives. It also fits within criminal justice initiatives to keep individuals out of costly correctional institutions, and to provide treatment rather than sanctions for substance use disorders.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

Opiate use creates structural changes in the brain, including changes in gray matter density[20], neuronal structure[21], neurotransmitter levels and brain signaling[22], among others. This concept is rooted in science that has demonstrated that if the biochemical aspects of substance use disorder, including brain changes and drug craving, are effectively addressed via medication that allows individuals to function normally without craving or illness, they can and often will engage in treatment and in activities that lead to recovery and healthier, more meaningful and productive lives. This concept reflects the principle

[20] Yi Yuan, Zude Zhu, Jinfu Shi, Zhiling Zou, Fei Yuan, Yijun Liu, Tatia M.C. Lee, Xuchu Weng, *Gray matter density negatively correlates with duration of heroin use in young lifetime heroin-dependent individuals*, Brain and Cognition, Volume 71, Issue 3, December 2009, Pages 223–228

[21] Robinson, Terry E.; Kolb, Bryan (1999)."Morphine alters the structure of neurons in the nucleus accumbens and neocortex of rats." Synapse 33(2): 160-162.

[22] Iversen, Leslie, and Solomon Snyder, eds. *Handbook of Psychopharmacology: Volume 19 New Directions in Behavioral Pharmacology*. Vol. 19. Springer Science & Business Media, 2013.

that individuals have the right to be treated with dignity and to be able to put their lives back together, even after drug use and incarceration.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

This concept seeks to directly reduce the disparity where some individuals die a rate more than 16 times greater than that of other county residents..

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

Resources would be slightly different, depending on whether the penal institution would prefer to implement buprenorphine or methadone, depending on which is more feasible and acceptable to them and to the County. A medical prescriber and someone to dispense medication would be needed for either medication. Methadone would also require a safe, and possibly a dispensing machine, depending on whether the institution selects a liquid or tablet formulation. Training of both DOC facility and community-based treatment staff would be needed on program rationale and procedures. DOC health staff will need additional training on methadone titration and/or buprenorphine induction. Prison release planner and agency intake staff time would be needed. Administrator time for planning would be needed. If UAs over and above those normally administered during treatment are needed for evaluation, those could be an additional minor cost.

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

Portions of salaries, training, possibly medication, safe/dispensing technology, increased number of treatment slots.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

It's possible some of the costs involved could be covered by the DOC health care budget. For Medicaid eligible individuals, costs of the community-based treatment could be covered by Medicaid.

4. **TIME to implementation: 6 months to a year from award**
    a. **What are the factors in the time to implementation?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

4a. Factors include openness of high level DOC administrators and facility administrators to implement; how much facility modification would be necessary to meet DEA requirements; obtaining DEA approval if methadone used; working out processes for assuring linkage to community based opiate agonist treatment; identifying participants and procedures to opt in; and coming to agreement on costs.

4b. The first step is outreach to DOC – determining if there is interest on the part of the State in collaborating with King County on this project and identifying which facility might participate. The

second step would require creating an interagency planning group. Other steps include exploring feasibility of different options within the facility, identifying regulatory and institutional policies that need to be met or developed, along with creating policies and procedures, and training staff. The data collection and evaluation of the program's impact would also be necessary.

4c. No.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

Suggest looking at DOC data that identifies what DOC facility appears to be releasing the largest numbers of individuals to King County or the facility. The County may also wish to consider working with DOC to determine what facility would be open to participating in this project.

#1

Working Title of Concept: Prison Pre-Release Medication Assisted Treatment with Linkage to Community Based Care

Name of Person Submitting Concept: Laurie Sylla
Organization(s), if any: DCHS/MHCADSD
Phone: 263-9108
Email: laurie.sylla@kingcounty.gov
Mailing Address: Mailing Address Here

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Conduct a demonstration program to provide pre-release Medication Assisted Treatment (MAT) in the form of buprenorphine or methadone prior to PRISON release with active linkage to post-release community based treatment for incarcerated individuals with histories of opiate addiction who are returning to King County post release. These are opiate agonists that need to be continued upon release. An additional treatment could also include pre-release antagonist treatment with oral, then depo-naltrexone prior to release with linkage to treatment. Naltrexone makes individuals sick when they use opiates/alcohol and there is some data to support its effectiveness. Depo-naltrexone is a shot that lasts 30 days.

2. What community need, problem, or opportunity does your concept address?

Please be specific, and describe how the need relates to mental health or substance abuse.

Individuals leaving prison are at high risk of death. They are nearly 13 times as likely as other state residents to die during the first 2 weeks post release(NEJM, 2007). Opiate overdose is the number one cause of death for these individuals. These are preventable deaths.

3. How would your concept address the need?
Please be specific.

By initiating MAT prior to release, you eliminate drug craving upon release, and therefore you help the individual avoid taking their first fatal dose of drug.. Individuals who are on buprenorphine would not even feel the effects of another opiate if taken (it binds more tightly to the body's opiate receptors than other opiates, thereby blocking the other opiate from causing a high or an overdose). A number of studies have shown that providing pre-release OAT with post-release treatment linkage reduces overdose death, increases treatment retention, reduces drug use, and reduces reincarceration.

4. Who would benefit? Please describe potential program participants.

Individuals with histories of opiate use who have been incarcerated. Majority would be adult males.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Linkage to community based care (we could match to treatment admission data)
Retention rate in community based care (currently collect)
Reduced opiate use (measured by urine toxicology (could get from treatment programs)
Recidivism rate (jail/prison bookings and days). We currently have jail data and now have a data sharing agreement with DOC for prison data
Reduced overdose (compared to those not in program)
Reduced death (compared to those not in program)

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Improving timely access to treatment, reducing overdose, reducing death, and reducing reincarceration are all outcomes consistent with the MIDD II objective.

8. What types of organizations and/or partnerships are necessary for this concept to be successful?
Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

DOC officials, prison wardens, DOC health providers, opiate treatment programs, office-based buprenorphine providers

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.