All-Team Quarterly Learning Collaborative:

Jail MAT and Drug Court Teams

September 21, 2023

12:00 – 2:00 pm PDT

DISCLAIMER

- Please note this content has not been professionally edited and the session was conducted using Zoom.
- In the case of any security issues that may occur, this session will immediately end. A separate email will be sent to all participants with further instruction.
- Any data and information collected through polls and chats will only be used to inform future webinar/ learning collaborative topics and to provide DHCS with evaluation results.

AGENDA

- Welcome & Updates
- Understanding Best Practices in Toxicology to Support an Integrated Team Approach to MAT
- The “T” in MAT: Enhancing Treatment Through Culture and Interventions to Support Recovery in Your Jail and Justice System
- CalAIM Update
- Wrap Up and Next Steps

WELCOME & UPDATES

12:00 – 12:10 PDT

Presenter: Bren Manaugh

INTRODUCTION – HMA CORE TEAM

Project Leadership

Bren Manaugh, LCSW-S
Project Director

Amanda Ternan, PMP
Project Manager

Kelly Wright, MA
Project Manager

HMA Coaches and Subject Matter Experts (SME)

Carol Clancy, PsyD
Jail MAT & Juvenile Justice Coach

Akiba Daniels, MPH
Health Equity SME, PM Support

Brittany Doughty, MPH
PM Support

Margaret Kirkegaard, MD, MPH
Jail MAT Coach

Marc Richman, PhD
Jail MAT Coach

Charles Robbins, MBA
Child Welfare Coach

Shannon Robinson, MD
Addiction and Prescriber SME

Margot Swift, MPH
Jail MAT Coach

Rich VandenHeuvel, MSW
Jail MAT Coach

Julie White, MSW
Jail MAT Coach

Judge Leonard Edwards (Ret.)
Judicial and Child Welfare SME

Howard Himes, MSW
Child Welfare Coach

Paul Kunkel
Custody SME

Liz Stanley-Salazar, RN, MPH
Child Welfare & Juvenile Justice Coach

Mark Varela
Juvenile Justice SME

Keegan Warren, JD, LLM
Legal SME

Welcome to our newest team member!

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STATUS OF GRANTS AND MOUs

MOU executed; 1st half of grant funds sent

- Fresno County
- Inyo County
- Mariposa County (being sent next week)
- Mendocino County
- San Joaquin County
- San Mateo County
- Santa Clara County
- Santa Cruz County
- Shasta County
- Siskiyou County
- Solano County (Drug Court)
- Ventura County

MOU generated; awaiting county signature

- Alameda County (missing W-9)
- Calaveras County
- Imperial County
- Sacramento County
- Solano (Jail MAT Mentor Stipend)

Budget not submitted

- Monterey County
- Plumas County
- Riverside County
- Santa Barbara County
- Sutter County
- Yolo County

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MEDICATIONS FOR OPIOID USE DISORDER (MOUD): NALMEFENE

- New overdose reversal agent released
- Nalmefene + dodecyl maltoside (Opvee®)

	Nalmefene (Opvee®)	Naloxone (Evzio®, Narcan®, Kloxxado®)
Half life	Longer	Shorter
Recurrent overdose	No	Yes
Potency	Higher	Lower
Available over the counter	No	Yes

UPCOMING EVENT: BJA WITHDRAWAL MANAGEMENT GUIDELINES WEBINAR SERIES

- Upcoming sessions:
  - October 17, October 31, and November 14
  - 1:00 pm to 2:00 pm PDT
- All sessions will be recorded
- Series will be repeated starting January 2024

"Buprenorphine and methadone are first line treatments for opioid withdrawal and OUD."
- BJA Withdrawal Management Guidelines

Register Here

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UPCOMING EVENT: SCREENING AND ASSESSMENT WEBINAR

- Thursday, October 26th
  - 1:00 pm to 2:00 pm PDT
- Applicable to Jail MAT and Drug Court teams
- Flyer will be sent with recordings/materials from today's event

Register Here

DATA

- Links for new data collection process will be sent tomorrow and Monday, September 25th (individual emails to counties).

9/13 Data Training Recording

UNDERSTANDING BEST PRACTICES IN TOXICOLOGY TO SUPPORT AN INTEGRATED TEAM APPROACH TO MAT

12:10 – 1:10 pm PDT

Presenter: Shannon Robinson, MD

WHY DO WE DO TOXICOLOGY TESTING?

Toxicology is conducted to:

- monitor chronic disease
- identify drug use
  - Expected substances (prescribed and/ or reported by patient)
  - Unexpected substances (not prescribed or reported by patient)

- This is not a “gotcha”; we do this to:
  - Identify the level of stability
  - Guide patient care
  - Improve treatment planning

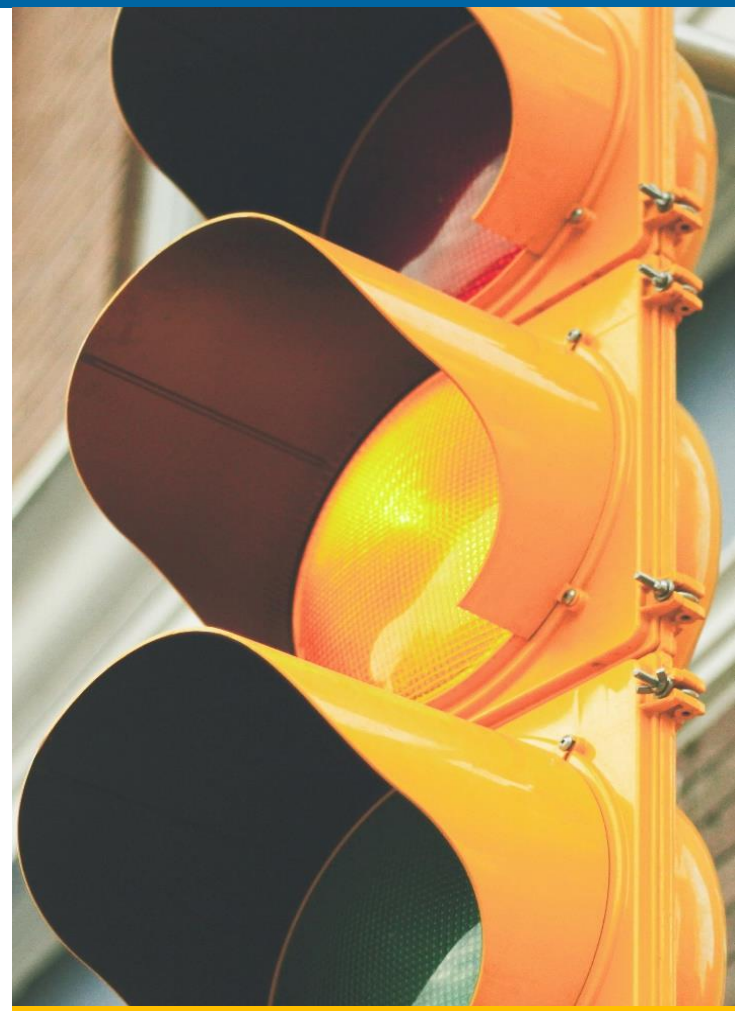

Image provided by Unsplash Photos: David Geunther

A DRUG TEST…

- Does NOT make a diagnosis of SUD, only of use of a substance
- Drug tests have consequences
  - Level of treatment
  - Freedom
  - Work
  - Keeping children in home or getting children returned

Photo by Matthew Ansley on Unsplash

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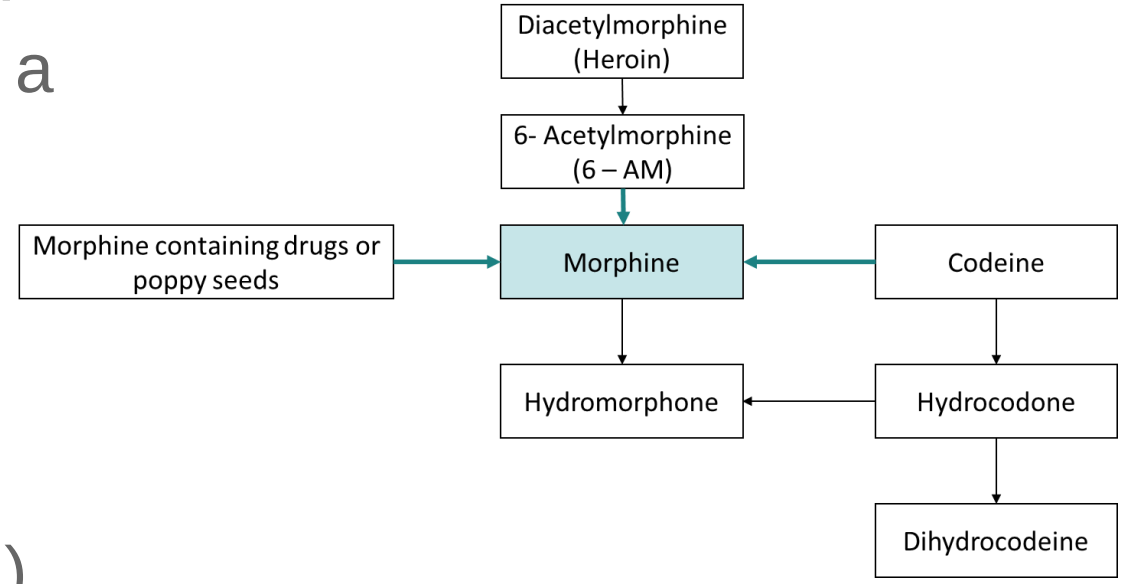
DEFINITIONS

- **Screen:** a qualitative test indicating if a substance is or is not detected
  - Designed to detect a class of drug, not a specific drug
  - Confidence in results may be poor as sensitivity and specificity vary
  - Easy to perform
  - Cost effective
  - Also called preliminary, (enzyme linked) immunoassay, or point of care
  - Susceptible to cross-reactivity

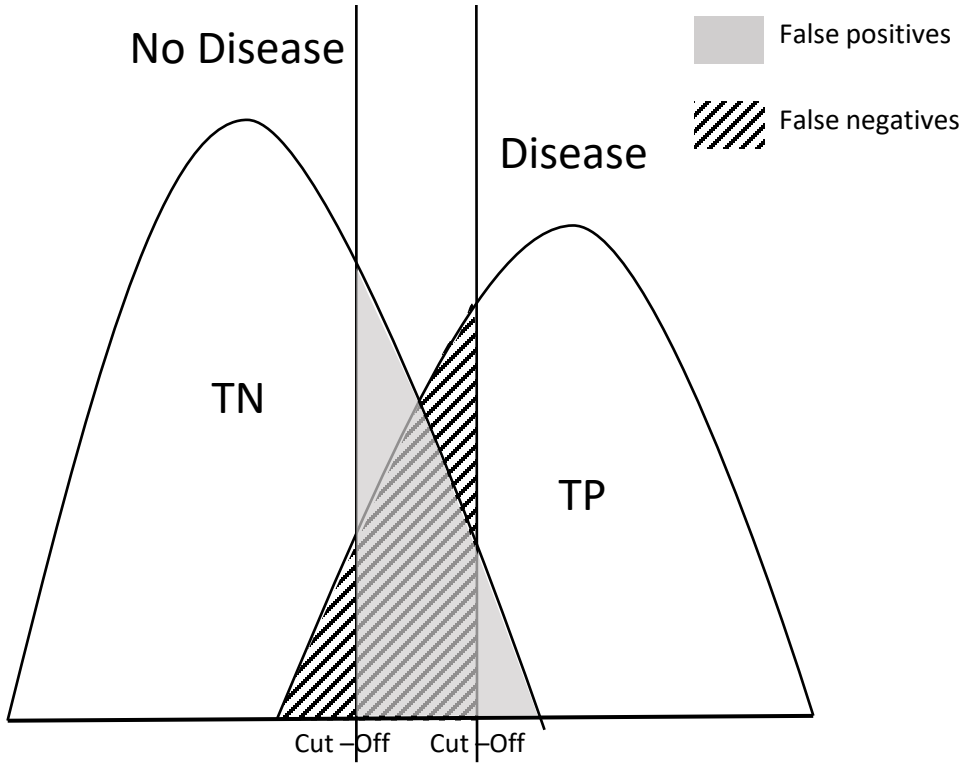


DEFINITIONS

- **Confirmation:** a test designed for very high confidence in identification of specific drugs
  - Qualitative or quantitative (reports the amount of drug present)
  - Confidence in results is high as sensitivity & specificity are higher & cut offs generally lower
  - Technically more complex to perform and require equipment not available at most offices
  - Cost more
  - Also called chromatography, spectrometry

DEFINITIONS – CONTINUED

- **Cutoff:** concentration above which a substance is indicated as detected & below which is indicated as not detected
  - Defined by manufacturer
  - Also called limit of detection

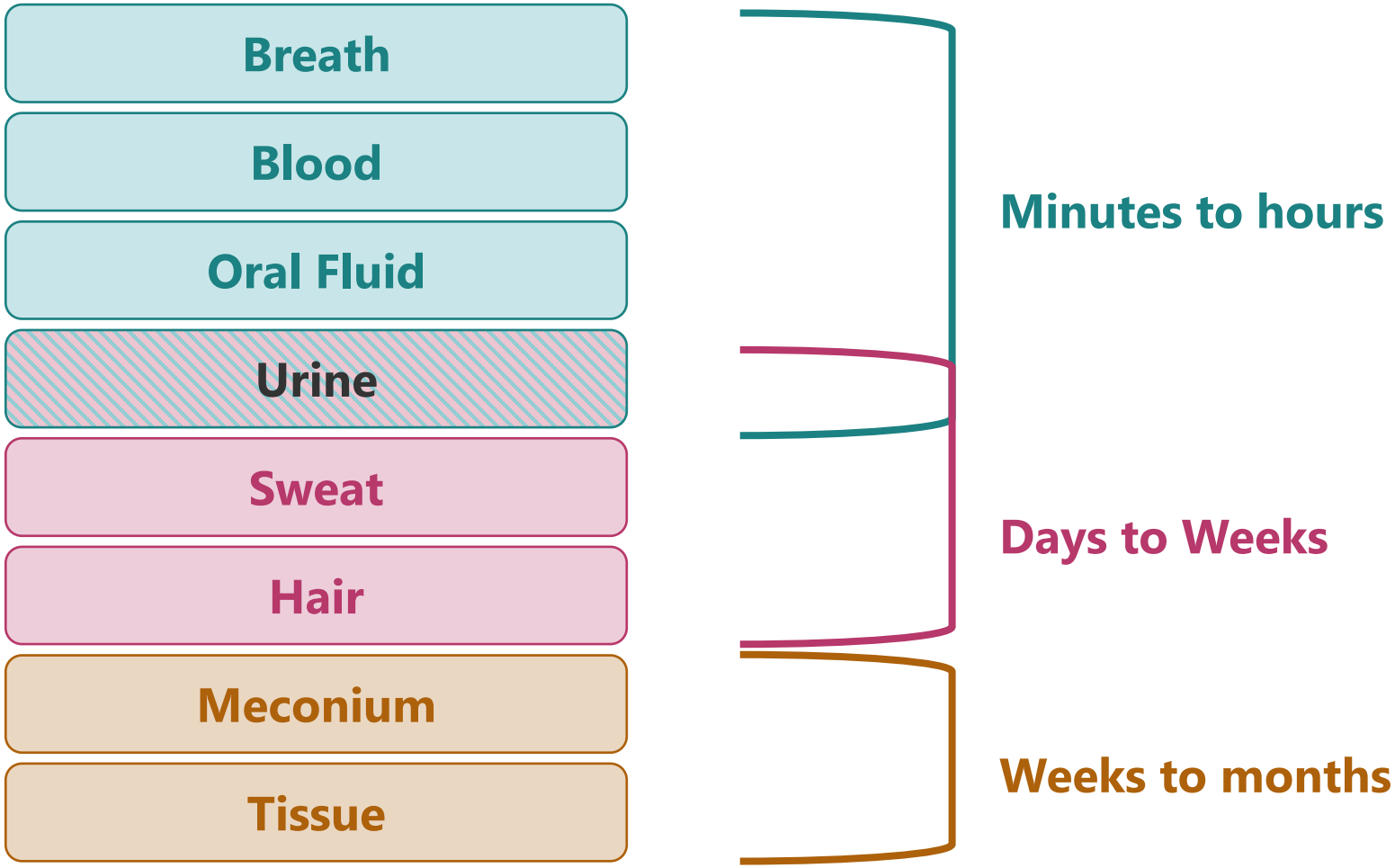


Low cut off scores generate more false positive test results, have higher sensitivity and lower specificity than a higher cuff off value

High cut off scores generate more false negative test results, have lower sensitivity and higher specificity than a lower cuff off value

HMA generated image

WHAT SPECIMENS TO MEASURE?



HOW DO YOU KNOW IT IS URINE?

- Over-hydration
- Substitution
  - Synthetic urine
  - Someone else's urine
- Additives
  - Sodium chloride, Bleach, Soap, Drano, Lemon juice, Nitrites (Urine Luck), Vitamin C, Visine eye drops, Glutaraldehyde, Peroxidase (Stealth)

Validity Testing

- ✓ Check color, creatinine, specific gravity
- ✓ Check urine temperature
- ✓ Check urine pH

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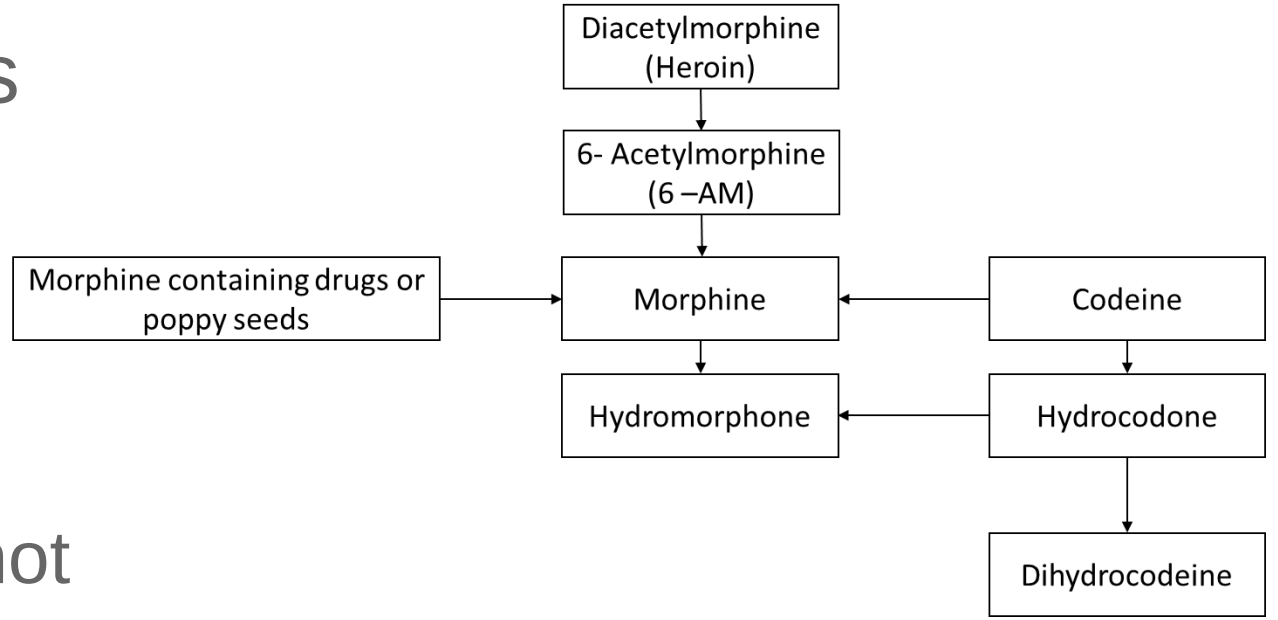
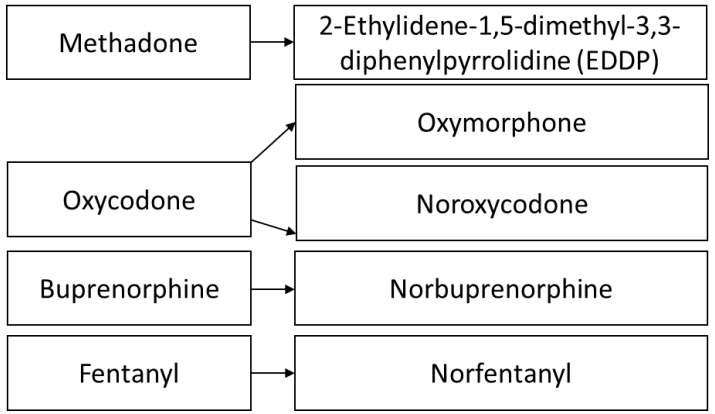
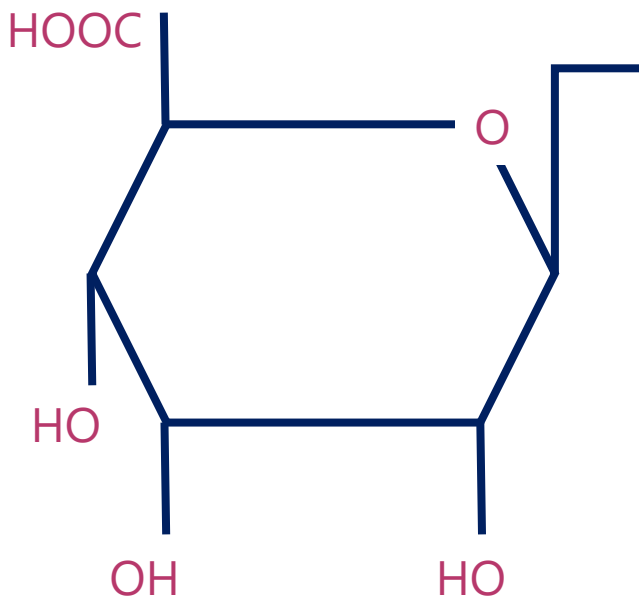
WHY MEASURE DRUG METABOLITES?

- Most drugs are eliminated as metabolites
- Widens opportunity for drug detection
  - For example: if only buprenorphine is detected & not norbuprenorphine this represents very recent use or putting some buprenorphine into the urine





ALCOHOL METABOLISM



Ethyl glucuronide (EtG)

UDP-glucuronosyl transferase

CH_3CH_2OH
Ethanol

Sulfotransferase

$C_2H_5O\text{-}SO_3H$
Ethyl sulphate (EtS)

Alcohol dehydrogenase

CH_3CHO
Acetaldehyde

Aldehyde dehydrogenase

CH_3COOH
Acetic acid

AMPHETAMINE METABOLISM & CROSS REACTIVITY

- Selegiline ----> methamphetamine (Vick's inhaler) ----> amphetamine ----> norephedrine…
- Cathinone ----> norephedrine
- MDMA ----> MDA
- Captogen ----> amphetamine and theophylline
- Pseudoephedrine ----> norpseudoephedrine*
- Ephedrine ----> phenylpropane*
- Phentermine ----> hydroxyphentermine
- ----> nitrophentermine
- Bupropion ----> hydroxybupropion

Cross Reactivity with

Amino acids
Antacids
Antiarrhythmics
Antiemetics
Antihypertensives
Antimalarials
Antipsychotics

Adapted from: Broussard L, Handbook of Drug Monitoring Methods, Humana Press, 2007

** pseudoephedrine & ephedrine can be made into methamphetamine in a lab, but this doesn't occur naturally*

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Window of Detection

Drug	Urine (days)
Amphetamines	2-3
Barbiturates	3-15
Benzodiazepines	2-10
Buprenorphine	1-14
Cannabinoids	3-30
Cocaine	4
Ethanol	1-4
Fentanyl	7-13 days
Heroin	4
Methamphetamine	6
Methadone	1-14
Morphine	6

Window of detection varies with

- Formulation (short acting vs long acting)
- Route of administration
- Dose
- Chronicity of use
- Fat solubility of drug
- Co administration with metabolic inhibitors/ inducers
- Kidney/ liver function
- Protein binding
- Body size
- Pregnancy status
- Hydration status
- Genetics
- Limit of detection of test…

DETECTION IS AFFECTED BY HYDRATION STATUS

Sample 1:

- THC: 728 ng/mL
- creatinine: 200 mg/dL

$$\frac{\text{THC x 100}}{\text{creatinine}}$$

= 364 ng THC per gram of creatinine

Sample 2:

- THC: 374 ng/mL
- creatinine: 50 mg/dL

$$\frac{\text{THC x 100}}{\text{creatinine}}$$

= 748 ng THC per gram of creatinine

DON'T LOOK AT THE NUMBERS AND JUMP TO CONCLUSIONS

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WHAT CAUSES UNEXPECTED POSITIVE DRUG TEST?

Don't be too quick to assume your patient is using…

Drug detected is part of something over the counter

Drug detected has cross reactivity with an over the counter or prescribed drug

Drug detected is a metabolite of a prescribed drug

Pt stopped drug, but the drug is still in the system

- long half life of fat-soluble drugs
- poor kidney dysfunction
- metabolism inhibited

Clinic or lab mix up

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WHAT CAUSES UNEXPECTED POSITIVE DRUG TEST

However sometimes your assumptions are correct…

- Patient obtained and used substance illicitly
- Patient obtained prescription from another provider
- Not your patient's urine

WHAT CAUSES UNEXPECTED NEGATIVE DRUG TEST?

- Drug was not absorbed
  - naloxone when buprenorphine/naloxone taken sublingually
- Drug was taken incorrectly
  - swallowed buprenorphine tab rather than sublingually absorption
- Accelerated metabolism/elimination
  - Drug A taken with drug B that speeds up the metabolism of drug A
- Urine was dilute and concentrations fell below detection limits
- Urine was adulterated
- Specimen was not handled appropriately
- Not your patient's urine

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MONITORING

Image source: https://www.viviendobien.net/category/enfermedades/analisis-medico/

HOW IS THE PERSON DOING, SUBJECTIVELY?

- Side effects
- Drug or alcohol use
  - Drug of choice
  - Other illicit substances
  - Cannabis or alcohol
- Cravings
- Attendance at SUD treatment or mutual support
- High risk behaviors

Image provided by Unsplash Photos: adam jaime

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HOW IS THE PERSON DOING, OBJECTIVELY?

- Appearance
- Progress toward treatment goals
- Collateral reports from family, friends, group members
- Observations of behavior pre/ post and during appointments
- Toxicology
- Other labs

IF THE PERSON IS DOING WELL

- Continue current treatment plan
- Gradually decrease frequency of contact with patient
  - Don’t decrease frequency of individual & group at the same time
  - Don’t decrease frequency of professional & mutual support at the same time
  - Don’t decrease medication and individual or group contact at the same time

Stock photo. Posed by model.

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IF THE PERSON IS NOT DOING WELL

- Is the dose of buprenorphine therapeutic?
- Does the patient have a co-occurring disorder that needs addressed?
- Is the living situation conducive to the patient's goals?
- Is the patient better served by a higher level of care for SUD?
  - Higher level of psychosocial treatment or peer/ mutual support
  - Higher level of medication treatment
    - Opioid Treatment Program with daily observed dosing for either buprenorphine or methadone
    - Methadone doesn't have a ceiling effect, but buprenorphine does

CO-OCCURRING CONDITIONS

- Co-occurring SUD
  - Medication is being used for OUD, not other substance use
    - Patients frequently use multiple substances
    - Multiple studies show treatment of OUD with MOUD reduces or eliminates other substance use over time
- Co-occurring mental health issue
- Co-occurring physical health issue

https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications#:~:text=Safety%20Announcement,central%20nervous%20system%20(CNS).; BJA Withdrawal Management Guidelines

Photo: used with permission from Shannon Robinson

FOOD FOR THOUGHT

- Does your primary care doctor stop your diabetes medication (insert whatever chronic disease you like) if your diabetes is getting worse?
- Does your primary care doctor stop your diabetes medication, if you also have hypertension?
- Does your primary care doctor stop your diabetes medication if your diabetes was stable but is not stable now?
  - Relapse is expected in chronic diseases

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SUMMARY

Use toxicology in combination with person's self reporting, collateral information and observation to monitor substance use disorders

Don't jump to conclusion that the person is using

- There are many explanations for false positive and false negative tests

Discrepancy between what person says and what the test shows is a great place for a therapeutic discussion

- Use motivational interviewing skills to find out what are the person's goals
- Probation is part of the therapy team in this way

When patient is not stable, then we adjust the treatment plan

THE “T” IN MAT:
ENHANCING TREATMENT THROUGH CULTURE & INTERVENTIONS TO SUPPORT RECOVERY IN YOUR JAIL AND JUSTICE SYSTEM

1:10 – 1:40 pm PDT

Presenters:
Bren Manaugh, HMA
Paul Kunkel, Interim Assistant Sheriff, San Mateo County Sheriff’s Office

Our North Star

Access to MAT for Californians with Justice Involvement

which is ultimately about…

Supporting RECOVERY for Californians with OUD

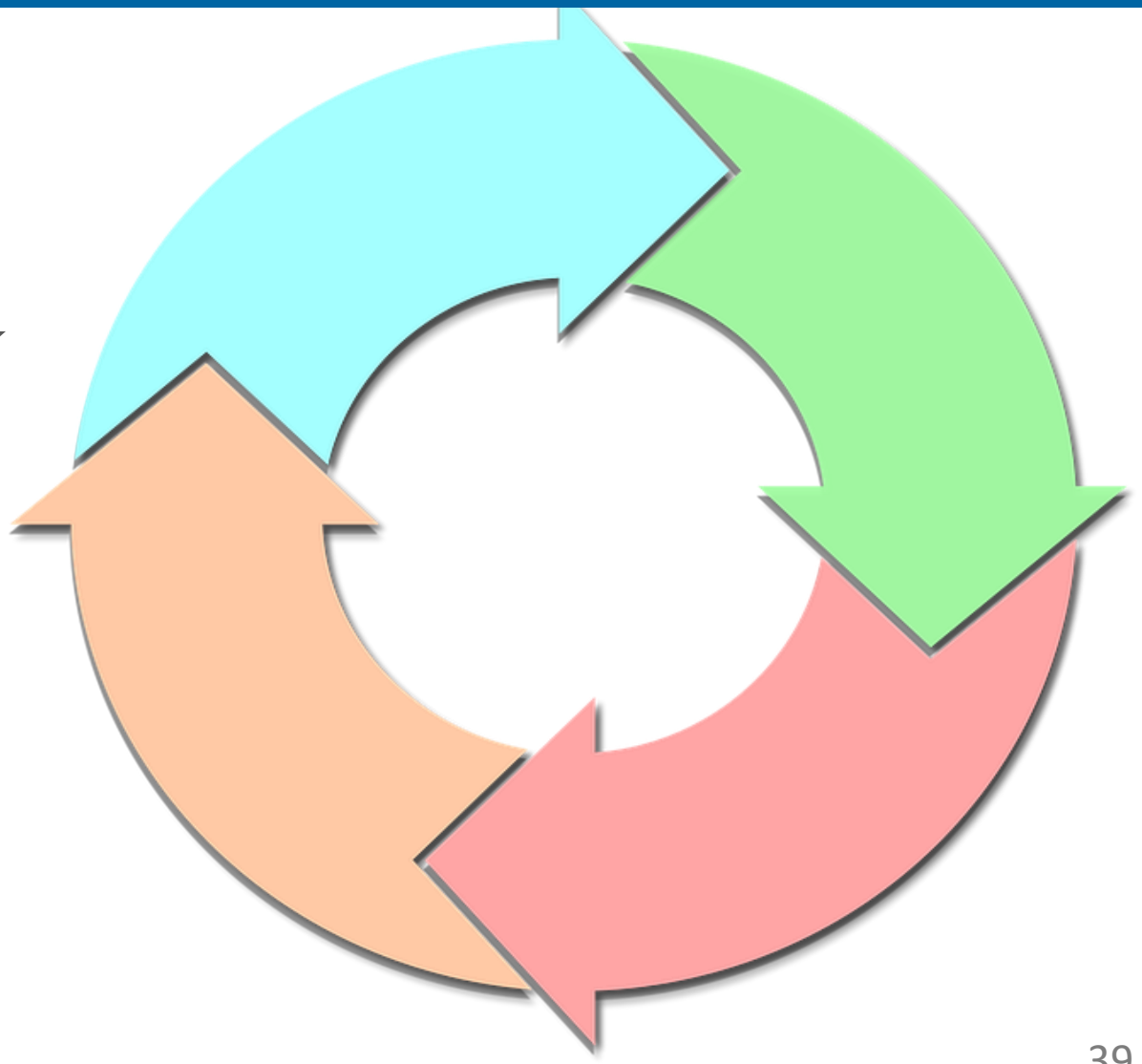
Stock photo. Posed by model.

WHAT IS RECOVERY?

WHAT IS RECOVERY?

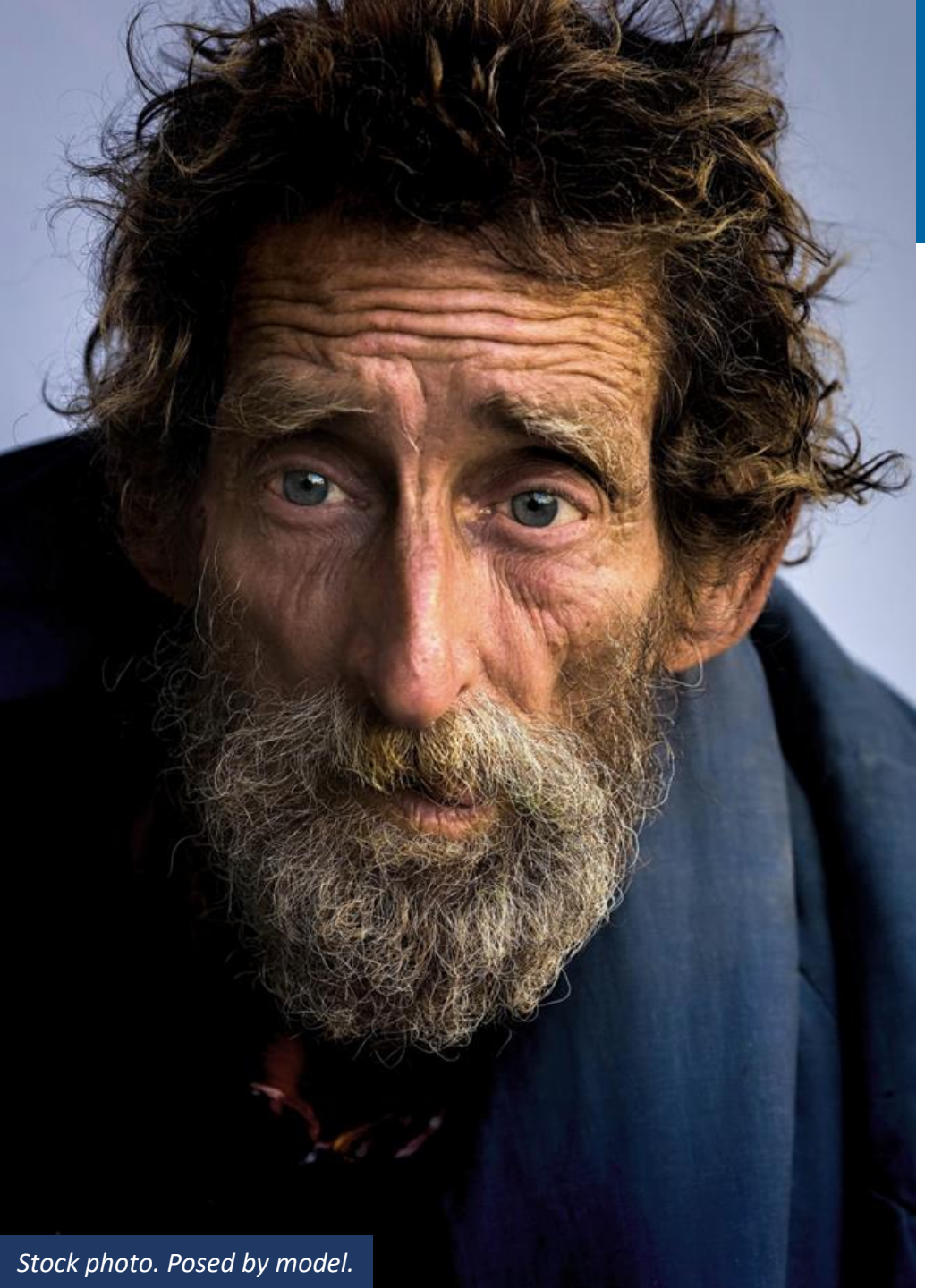
Recovery from substance use disorders (SUD) is

- *A **process of change** whereby individuals achieve SUD remission, work to improve their own health and wellness, and live a meaningful life in a community of their choice while striving to achieve their full potential.* SAMHSA, 2009
- **not linear**; people progress and regress
- defined by each person for him/her/themselves



TO SUPPORT POSITIVE CHANGE, START WITH ENGAGEMENT

- Seeing and relating to someone as a human and not as a “job” or problem
- Challenging in the jail!



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ENGAGEMENT THROUGH PERSON-CENTEREDNESS

- Be mindful of that person's individual life experience, culture, strengths, and goals.
- "The Golden Rule" as guidance in engagement –

  How would we want our loved one to be treated?

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PERSON-CENTERED?

- Treatment and planning for treatment
  - Incorporate recovery, reoccurrence and remission – remember recovery is not linear
  - Treatment and services that best meet the person's needs and goals
- Make the system work for the person instead of making the person work to try to get help from the system - "low barrier access"
- Again – challenging in the jail! ("churn" - timing of detention, release, etc.; security and space/staffing and other infrastructure issues.)

Stock photo. Posed by model.

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CONSIDERATIONS FOR TREATMENT IN A JAIL

- There are infrastructure and operational challenges to effective psychosocial treatment in jails
  - Lack of space
  - Lack of treatment staff
  - Challenges with in-reach
  - Siloed teams
  - Fitting treatment groups into pod schedule
  - Classification issues
    - May have to repeat the same group on different pods or different times to keep classifications separate

BEING TRAUMA-INFORMED FOR EFFECTIVE ENGAGEMENT AND INTERVENTIONS

- *What happened to you*?
  Instead of *What's wrong with you?*
- We tend to think: *Why do you keep making bad decisions???*
- Often, what people "should do" is obvious to those trying to help.
- What is not so obvious is where they are on their journey toward change, and why they are not taking the next step; or why they keep "mis-stepping."
- Getting at "The Why" to Support Change (thoughts and feelings)

Stock photo. Posed by model.

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WHO'S UP FOR CHANGE?

- No one looks forward to change except a baby with a wet diaper…

Stock photo. Posed by model.

CHANGE IS HARD FOR EVERYONE

Factors enhance people's motivation to change

- Distress levels
- Critical life events
- Re-evaluation or appraisal
- Recognizing negative consequences
- Positive and negative external incentives
- Our role is to elicit and enhance motivation
- All members of the "treatment team" - including custody - can do this!
- Use MI
- Consider how the current circumstance of being incarcerated can be used to enhance motivation to address SUD

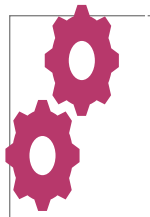
POLL

- Have you been trained in Motivational Interviewing (MI)?
  - Yes
  - No
- If yes, do you use MI regularly in your work at the jail or in the drug court?
  - Yes
  - No

EFFECTIVE TREATMENTS FOR SUBSTANCE USE DISORDERS INCORPORATE :

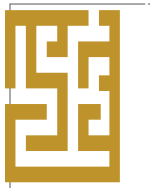
- Location and Level of Care of Treatment
- Medication Assisted Treatment (MAT)
- Behavioral Therapies and Recovery Supports

STAGES OF CHANGE



Pre-Contemplation

"No problem here"



Contemplation

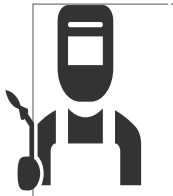
"Could this be a problem?"

Preparation

"What do I do about this?"

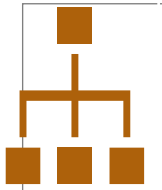
Action

"Let's see if this works"



Maintenance

"Keeping up what works"

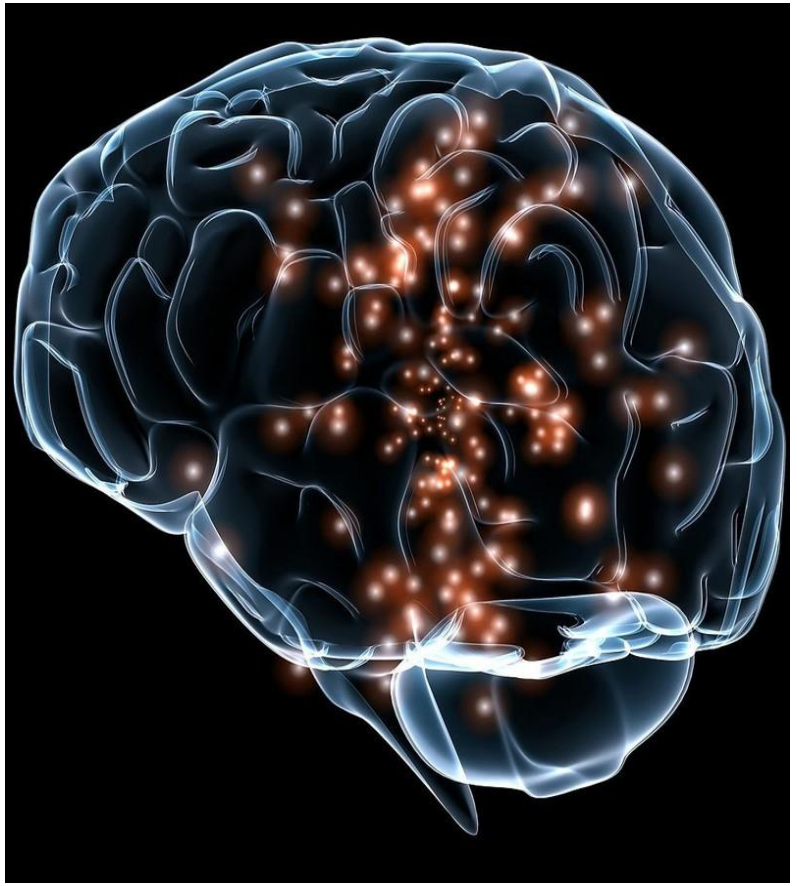


Lapses

"Setbacks are normal, but don't have to be long"

EVIDENCE-BASED PSYCHOSOCIAL THERAPIES

- Shown to be effective in treating substance use disorders.
- Studied extensively; have a well-supported evidence base – effective across many types of substance use disorders and across ages, sexes, and racial and ethnic groups.



HMA POSITION STATEMENT ON MEDICATIONS FOR ADDICTION TREATMENT (MAT) AND BEHAVIORAL HEALTH INTERVENTIONS

- Medications for Addiction Treatment (MAT), using the 3 FDA-approved MAT medications, is an evidence-based practice proven effective for helping people stabilize and recover from opioid use disorder and for preventing death from opioid overdose.[1] These medications act to restore dopamine depleted in the brain from opioid misuse. Therapy, counseling, and support interventions are advisable in conjunction with MAT to support stability and recovery as well, **though the lack of access to these interventions should not lead to delay or discontinuation of access to the MAT medications**.[2]
- For those with moderate to severe opioid use disorder in the early stages of MAT, low levels of dopamine in the brain mean that they may have difficulty attending to, and thus may not benefit from, cognitive-based interventions. Other evidence-based interventions such as Motivational Interviewing/Engagement or Seeking Safety may be most useful in engaging and responding to people in the early stages of treatment and recovery. A person-centered treatment planning approach that considers the timing – and type – of behavioral intervention(s) that meets the person where they are in terms of their ability to benefit from the treatment is key.

FDA & SAMHSA Dear Colleague Letter – Counseling/Behavioral Interventions 5/9/2023

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OPTIONS FOR PSYCHOSOCIAL INTERVENTIONS

- Screening, Assessment and Treatment Planning
- Psycho-Social and Medication Education
- Peer and Recovery Supports
- Case Management/Navigation
- MAT, Integrated Mental Health and Health Care

EVIDENCE-BASED MODALITIES

- Cognitive Behavioral Therapy
- Motivational Interviewing and Motivational Enhancement Therapy
- Contingency Management
- Dialectic Behavioral Therapy
- Community Re-enforcement Approach

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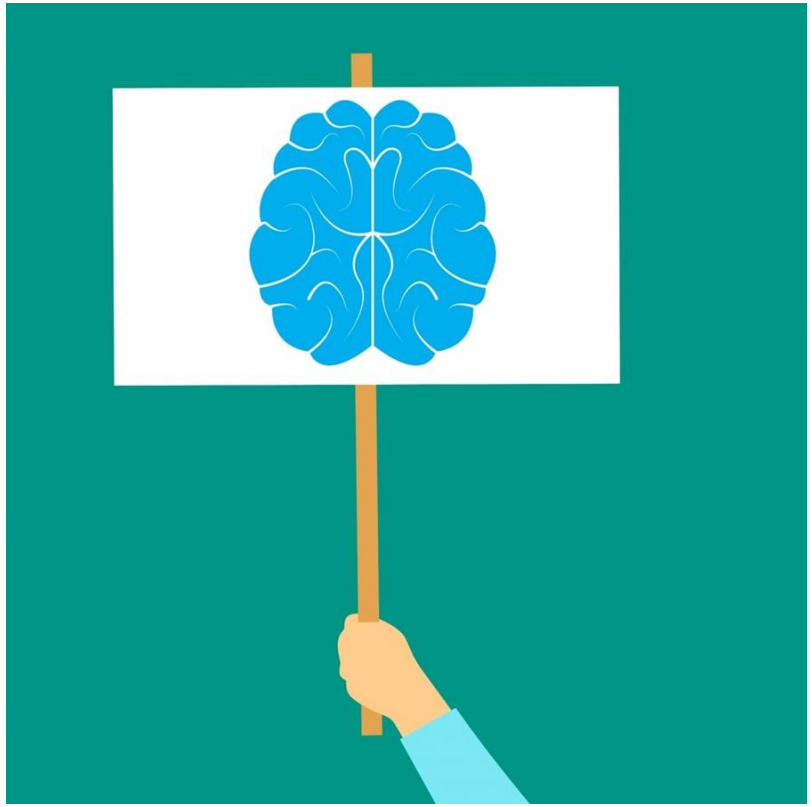
EVIDENCE-BASED PSYCHOSCIAL THERAPIES: **COGNITIVE BEHAVIORAL THERAPY (CBT)**



- Modify behaviors and improve coping skills by identifying and modifying dysfunctional thinking.
- CBT is structured and usually involves 12 to 24 weekly individual sessions.
- CBT may be the most researched and evaluated of all the therapies for substance use disorders.
- CBT can help people develop skills to recognize and manage cravings which can continue to be used and helpful after the CBT sessions are done
- Many curricula are CBT-based

PERSON-CENTERED CARE: TWO DETAINEES AT INTAKE

Stacy

- Early life trauma
  - Neglect
  - Sexual assault
- Early use of marijuana
- Heavy episodic drinking and polysubstance use in high school; dropped out of HS
- Illicit opioid RXs and heroin starting at 19 y/o
- Episodic homelessness – interpersonal violence/assaults
- At point of incarceration has 10+ year history of severe SUD/OUD and is experiencing significant opioid withdrawal

Ryan

- Parents divorced and had shared custody
  - No neglect or assault but alcoholic father
- Used cannabis in HS; continued occasional use in college along with episodic binge drinking in college
- Finished college and started graduate school; started using illicit Adderall and other substances, including opioids
- At point of incarceration has 2-year history of occasional use of opioids and other substances ; no recent use/no opioid withdrawal symptoms

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PERSON-CENTERED CARE: TWO DETAINEES AT INTAKE

Stacy

Ryan

Options for Evidence-Based Interventions considered with:

- Severity of SUD
- Stability
- Functioning
- Readiness for Change
- Supports and Coping Skills

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POLL

- Given what we know about Stacy and Ryan at intake, who would benefit more from CBT-based counseling at this point?
  - Stacy
  - Ryan

CONSIDERATIONS FOR THE "RIGHT" INTERVENTION

- CBT and other cognitive-based modalities are evidence-based and effective but *require the ability to use the higher functioning part of the brain*
- People who have severe opioid use disorders have brains that are depleted in dopamine and so struggle to think and process; they tend to be in low-functioning and "survival" mode
- This is compounded by trauma

Addiction Overview Video

EVIDENCE-BASED BEHAVIORAL THERAPIES: **SEEKING SAFETY***

- Helps people feel safe/stabilize from trauma/PTSD and SUD with present-focused coping skills. Real-time, practical application.
- Compassionate; honors what people have survived and respects their strengths.
- Doesn't require clinical license - can be conducted by all clinicians, paraprofessionals, and peers.

**This and MI on next slide are examples – HMA does not endorse any specific branded modalities or curricula*

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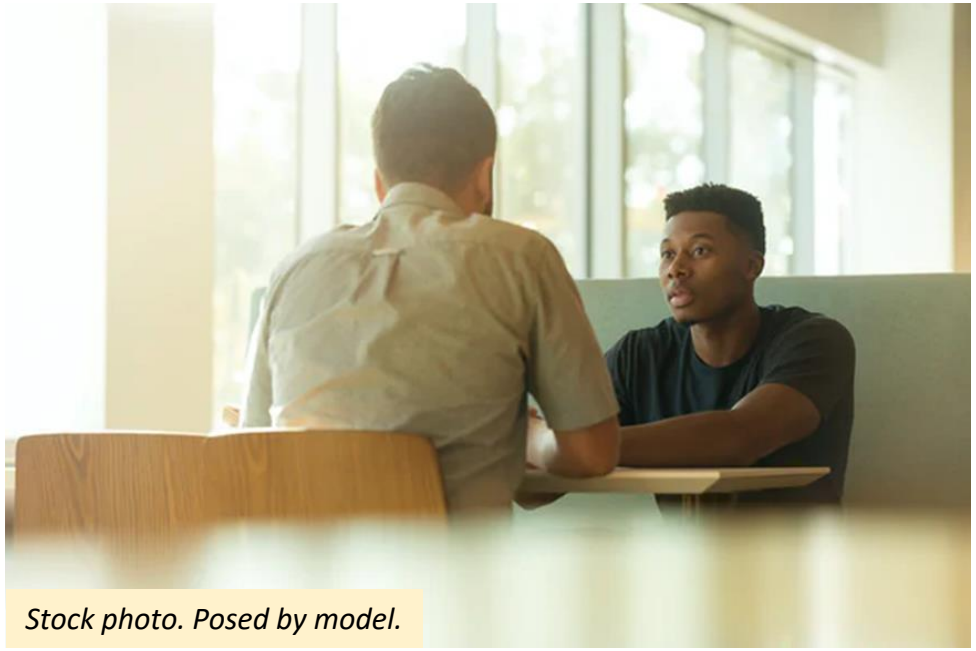
EVIDENCE-BASED BEHAVIORAL THERAPIES: **MOTIVATIONAL INTERVIEWING**

- EVERYONE can use it!
- Brief person-centered method for strengthening motivation for and commitment to change
- Goal-directed to support change
- Collaborative and empathic
- Draws on the person's own motivations, strengths and resources



Stock photo. Posed by model.

THE SPIRIT OF MOTIVATIONAL INTERVIEWING

Be Patient,
Stay Present
And Practice
Engaged
Listening

DO (ACE)

Honor: Allow the freedom not to change right now

"How ready are you to change?

Collaborate

"What do you think you'll do?"

Elicit Motivation

"What would you like to change about

AVOID

Making judgmental statements

"You really need to stop using."

Pushing for commitment

"If you delay getting sober, you could die."

Dictate

"I would urge you to quit using."

CONSIDERATIONS FOR TREATMENT IN A JAIL

- There are infrastructure and operational challenges to effective psychosocial treatment in jails
  - Lack of space
  - Lack of treatment staff
  - Challenges with in-reach
  - Siloed teams
  - Fitting treatment groups into pod schedule
  - Classification issues
    - May have to repeat the same group on different pods or different times to keep classifications separate

CUSTODY AND CLINICAL AS A TEAM

- **Address siloes among treatment teams and with custody/security.**
  - Substance use disorder assessment, treatment and patient records
    - How is this information shared – between MH, SUD and healthcare staff?
    - How is custody incorporated into cases where behavior issues and other custody concerns may be related to stimulant use (aggression, delusion/psychosis, etc.)
  - Strategies:
    - Integrated treatment planning
    - Case staffings inclusive of MH, SUD, healthcare and custody where indicated
      - Develop a protocol to determine which should be staffed

HMA DHCS

TIPS AND TRICKS

- Take stock of what you are doing now. How does it support recovery?
- Support building self-efficacy, using strengths and hope.
- Be patient. Cognitive and other impairments are real.
- Be trauma informed. Remember the person is not their crime. Most are also survivors of trauma.
- Percolate ideas and possibilities.
- Consider new partners.

POLL

- I would be interested in a scheduled discussion group (2 sessions; 1 hour each) to discuss psychosocial interventions in the jail.
  - Yes
  - No

Example Discussions: What are others using? What are successes and challenges to implementing?

SOME CBT-BASED CURRICULA FOR DETAINEES WITH SUD*

Thinking for Change (T4C)	A New Direction: A Cognitive-Behavioral Therapy Program, or A New Direction: Treatment for Criminal and Addictive Behavior	The TCU Treatment System	SMART (Self-Management and Recovery Training) Recovery®	START NOW
National Institute of Corrections (NIC)	Hazelden Publishing	Texas Christian University Institute of Behavioral Research	SMART Recovery®	Carilion Clinic
Integrated evidence-based cognitive behavioral change program / curriculum	A flexible, evidence-based, cognitive-behavioral therapy curriculum that treats alcohol and substance use disorder in justice-involved clients.	A collection of free evidence-based assessments and manual-guided interventions that target specific needs and status of clients in different stages of change during treatment	A community of mutual support groups with resources including the check-up and choices app, the InsideOut program and manualized books and resources	CBT-based and incorporates MI, and trauma-and gender-sensitive care to build skills

HMA DHCS

** These are some of the curricula being used in jails and departments of correction HMA is supporting with MAT implementation. HMA does not endorse any specific curricula.*

INTERVENTIONS NOT REQUIRING CLINICAL FACILITATOR/THERAPIST

Motivational Interviewing

- https://store.samhsa.gov/product/advisory-using-motivational-interviewing-substance-use-disorder-treatment/pep20-02-02-014
- TIP 35, Enhancing Motivation for Change in Substance Use Disorder Treatment addresses the spirit, application, and fundamentals of motivational interviewing (MI), and discusses how practitioners can effectively employ MI in SUD treatment, and provides tools that practitioners can use to encourage and promote lasting positive outcomes for their clients.

Seeking Safety (Treatment Innovations)

- https://www.treatment-innovations.org/seeking-safety.html
- Fully manualized with handouts and strong research base. Most staff can deliver it with minimal training. There is also an option to train staff and follow-up with a series of coaching calls to ensure fidelity and training videos are available.

**This list is not intended to be exhaustive nor is appearance here an endorsement or recommendation.*

ADDITIONAL CURRICULA AND RESOURCES

- **Helping Women Recover: A Program for Treating Addiction** and **Helping Men Recover: A Program for Treating Addiction.** Stephanie Covington, Ph.D.]. Two separate curricula that address the concerns and issues of women/men with substance use disorders who are in correctional settings. https://www.stephaniecovington.com/
- **Trauma Recovery and Empowerment Model (TREM)**: [Community Connections]. A manualized 24- to 29-session group intervention for women (separate curricula for men) who survived trauma and have substance use and/or mental health issues. http://www.communityconnectionsdc.org/training-and-store/store
- **A New Freedom**: [A.R. Phoenix Resources, Inc.]. Offers comprehensive, flexible, and cost-effective substance abuse curriculums, behavioral health treatment resources, conflict reduction programs, and risk reduction services for both adult and juvenile correctional and community programs. http://www.newfreedomprograms.com/
- **Living in Balance**: [Hazelden Publishing]. A flexible program that draws from cognitive-behavioral, experiential and 12-Step approaches to help individuals achieve recovery includes sessions on co-occurring disorders. https://www.hazelden.org/web/public/livinginbalance.page

**This list is not intended to be exhaustive nor is appearance here an endorsement or recommendation.*

ADDITIONAL CURRICULA AND RESOURCES

- **Cognitive Behavioral Interventions for Substance Use (CBI-SU)** – formerly and still known as Cognitive Behavioral Interventions for Substance Abuse (CBI:SA): [University of Cincinnati Corrections Institute]. Structured curriculum designed for individuals who are moderate to high need in the area of substance use within the criminal justice system. https://cech.uc.edu/content/dam/refresh/cech-62/ucci/overviews/cbi-su-overview.pdf
- **The Matrix Intensive Outpatient Treatment For People with Stimulant Use Disorders**. SAMHSA supported development of a series of counselor and client materials for implementing the Matrix Model. https://store.samhsa.gov/?f%5B0%5D=series%3A5556
- **The Matrix Model for Criminal Justice Settings**: [Hazelden Publishing]. A flexible and comprehensive program the combines education and therapy on both substance use and criminal thinking and behaviors. https://www.hazelden.org/store/item/338136

This list is not intended to be exhaustive nor is appearance here an endorsement or recommendation.

SAMPLING OF OTHER RESOURCES

- **Change Companies interactive journals**. Residential Drug Abuse Program Series, used by Federal Bureau of Prisons. Can be facilitated by non-clinical staff who receive free training. https://www.changecompanies.net/interactivejournaling/
- **Crossroads (NCTI)** https://www.ncti.org/product-category/crossroads/adult-criminal-justice/ A series of workbooks and resources to address life-skills, anger management, substance use and other topics. Some available for specific populations. https://www.ncti.org/product-category/crossroads/adult-criminal-justice/
- **Dialectic Behavioral Therapy** (Marsha Linehan and Behavioral Tech) combines cognitive behavioral therapy and mindfulness practices. Research supports effectiveness with substance use and mental health conditions, including borderline personality disorder. https://behavioraltech.org/resources/
- **Moral Reconation Therapy (MRT)**: [Correctional Counseling, Inc.]. MRT workbooks must be facilitated by trained MRT-Certified facilitators. Include resources specifically on substance use, relapse prevention and other relevant topics. http://www.moral-reconation-therapy.com/criminal-justice.html
- **Path to Freedom** [Prison Mindfulness Institute, Fleet Maull, Kate Crisp]: A mindfulness-based emotional intelligence (MBEI) model for at-risk and incarcerated youth and adult prisoners. https://www.prisonmindfulness.org/path-of-freedom
- **Parenting Inside Out** [Parenting Inside Out]: An evidence-based parenting skills training program developed for criminal justice involved parents. http://www.parentinginsideout.org/welcome-to-parenting-inside-out/

**This list is not intended to be exhaustive nor is appearance here an endorsement or recommendation.*

CALAIM JUSTICE- INVOLVED DEMONSTRATION

1:40 – 1:55 pm PDT

Presenter: Julie White

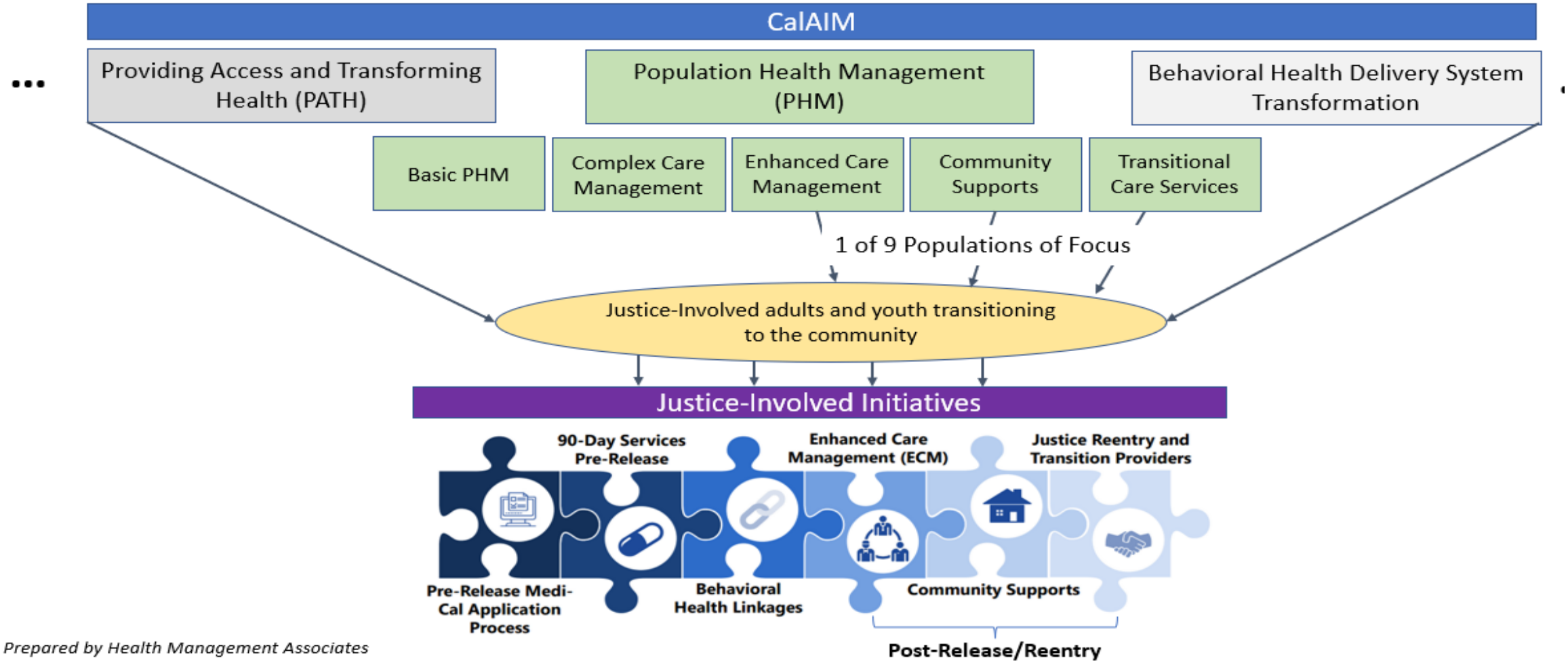
AGENDA

- Overview
- PATH 2 Updates
- PATH 3 Updates
  - Draft Guidance
  - Implementation Plan Updates
  - Readiness Assessment

SECTION 1115 REENTRY DEMONSTRATION

California is **first in the nation** to receive approval from the Federal government to offer **a targeted set of services** to incarcerated and detained individuals on Medicaid (Medi-Cal) **90 days prior to release**

CalAIM Justice-Involved Initiatives Overview



Prepared by Health Management Associates

CALAIM JUSTICE-INVOLVED INITIATIVE GOALS

Advance health equity: The issue of poor health, health outcomes, and death for incarcerated people is a health equity issue because Californians of color are disproportionately incarcerated—including for mental health and SUD-related offenses. These individuals have considerable health care needs but are often without care and medications upon release.

Improve health outcomes: By implementing this initiative, California aims to provide a targeted set of services in the pre-release period to establish a supportive community reentry process, help individuals connect to physical and behavioral health services upon release, and ultimately improve physical and behavioral health outcomes.

Serve as a model for the rest of the nation: California is the first state to receive approval for this initiative. We hope our model will serve as a blueprint for the dozen additional states with pending justice-involved 1115 waivers.

HMA DHCS

CALIFORNIA: IMPACTED POPULATIONS

Medicaid-eligible youth and adults in state prisons, county jails, or youth correctional facilities are potentially eligible for the targeted re-entry services.

Enrollees in state prisons and county jails will be required to meet health need criteria to be eligible for these services

All youth in youth correctional facilities will be considered eligible without needing to meet the health criteria need.

Eligible enrollees can be either pre- or post-adjudication.

According to California's Department of Health Care Services (Medicaid agency), more than one million adults and youth enter or are released from California prisons and jails annually, and at least 80% of these justice-involved individuals are eligible for Medi-Cal.

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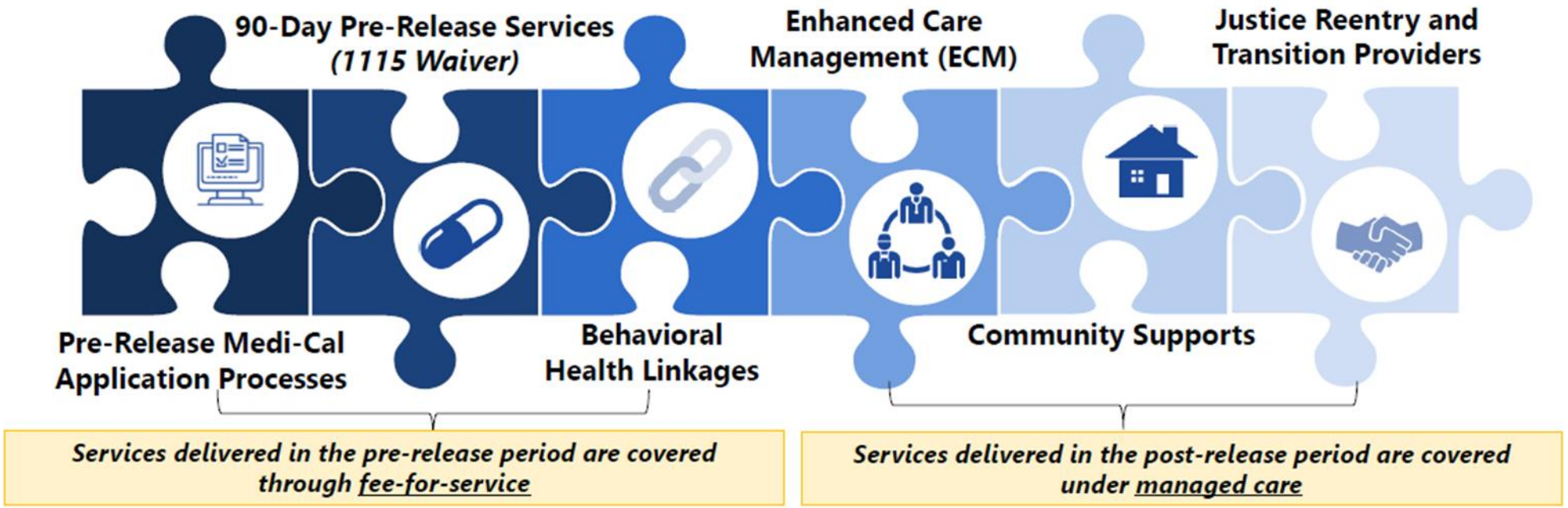
CALAIM JUSTICE-INVOLVED INITIATIVES COMPONENTS



CAL AIM JUSTICE – INVOLVED DEMONSTRATION

The intent of the demonstration is to **build a bridge to community-based care for justice-involved Medi-Cal members**, offering them services to stabilize their condition(s) and establishing a re-entry plan for their community-based care prior to release.

This demonstration is **part of California's comprehensive initiative to improve physical and behavioral health care for the justice-involved population** and builds on the State's substantial experience and investments on ensuring continuity of Medi-Cal coverage and access to care for JI populations.

With its 1115 demonstration, California will directly test and evaluate its expectation that **providing targeted pre-release services to Medi-Cal-eligible individuals will avert the unnecessary use** of inpatient hospitals, psychiatric hospitals, nursing homes, emergency departments and other forms of costly and inefficient care that otherwise would be paid for by Medi-Cal.

HMA DHCS

CAL AIM JUSTICE –INVOLVED ELIGIBILITY

Medi-Cal Eligible:

- Adults
- Parents
- Youth under 19
- Pregnant or postpartum
- Aged
- Blind
- Disabled
- Current children and youth in foster care
- Former foster care youth up to age 26

CHIP Eligible:

- Youth under 19
- Pregnant or postpartum

Criteria for Pre-Release Medi-Cal Services

Incarcerated individuals must meet the following criteria to receive in-reach services:

- ✓ Be part of a **Medicaid or CHIP Eligibility Group** and
- ✓ Meet **one** of the following health care need criteria (for adults):
  - Mental illness
  - Substance use disorder (SUD)
  - Chronic condition/significant clinical condition
  - Intellectual or developmental disability (I/DD)
  - Traumatic brain injury
  - HIV/AIDS
  - Pregnant or postpartum

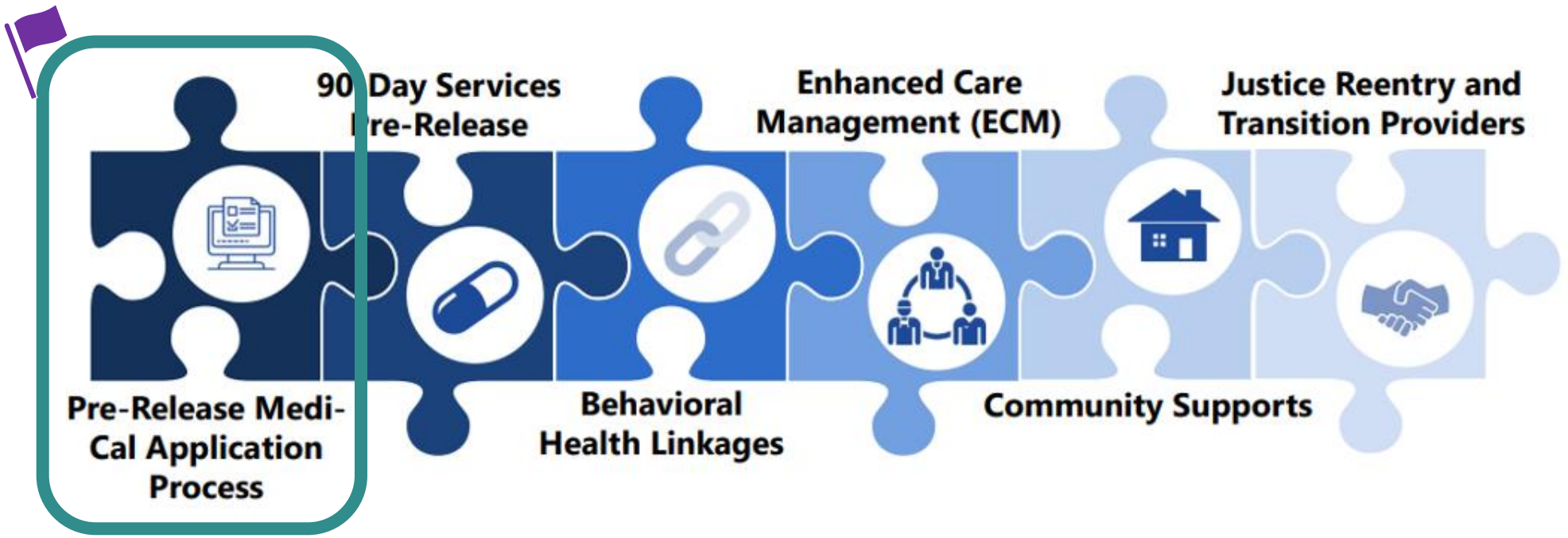
Note: All incarcerated youth are able to receive pre-release services and do not need to demonstrate a health care need.

COVERED SERVICES

- Reentry case management services;
- Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- Laboratory and radiology services;
- Medications and medication administration;
- Medications for addiction treatment (MAT), for all Food and Drug Administration-approved medications, including coverage for counseling; and
- Services provided by community health workers with lived experience.

In addition to the pre-release services specified above, qualifying members will also receive **covered outpatient prescribed medications and over-the-counter drugs** (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) and **durable medical equipment (DME)** upon release, consistent with approved state plan coverage authority and policy.

PATH 2



Medi-Cal enrollment for eligible individuals prior to release

PRE-RELEASE MEDI-CAL APPLICATION PROCESSES

California statute mandates all counties implement pre-release application processes in county jails and youth correctional facilities by January 1, 2023. Establishing pre-release Medi-Cal application processes is part of the State's vision to enhance the Medi-Cal health care delivery system for justice-involved populations.

Rationale

- Pre-release application process will help to ensure Medi-Cal coverage upon re-entry into the community in order to facilitate access to needed Medi-Cal covered services and care

HMA DHCS

Sources: AB-133 Health; Chapter 143; AB-720 Inmates: Health Care Enrollment; ACWDLS 14-26; ACWDLS 14-26E; CalAIM Proposal

CALAIM PRE-RELEASE MEDI-CAL APPLICATION PROCESS MANDATE

» Effective January 1, 2023, for all persons who are incarcerated/detained:

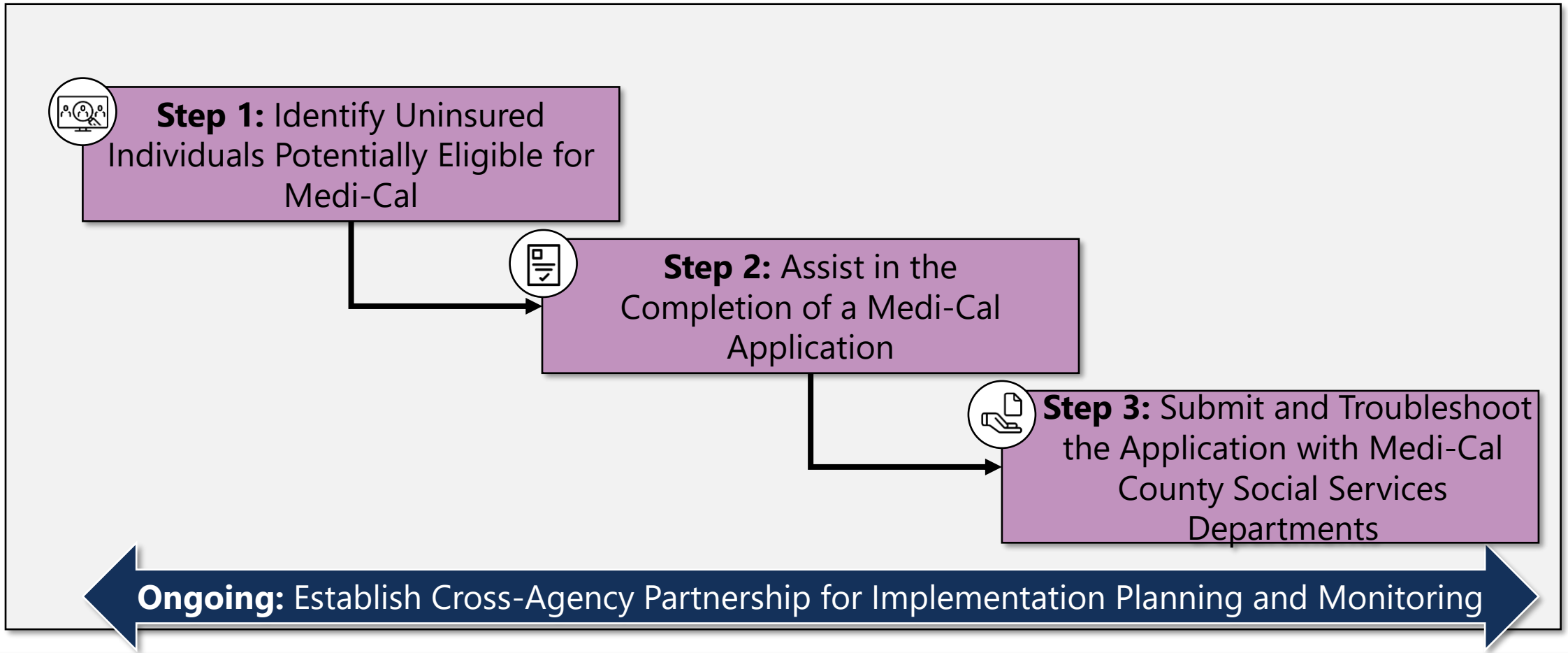
Medi-Cal Suspensions	Medi-Cal Unsuspensions	Medi-Cal Application Assistance/Processing
Suspension of Medi-Cal will not take effect before 28 days of incarceration/detention and will remain in effect during incarceration/detention	Unsuspension (re-activation) of Medi-Cal will occur within one business day of release	Counties must have policies and procedures in place to ensure eligible persons who are incarcerated/detained have Medi-Cal upon release

County correctional facilities have been focused on enrolling incarcerated/detained individuals in Medi-Cal – a critical first step to ensure eligibility for 90-day pre-release services.

HMA DHCS

DHCS All County Welfare Directors Letter 22-27, November 10, 2022

PRE-RELEASE MEDI-CAL ENROLLMENT PROCESS



There is no "one-size-fits-all" approach for pre-release Medi-Cal enrollment. DHCS shared best practices on implementing pre-release Medi-Cal applications through an issue brief and continues to meet with a pre-release application sub workgroup to foster peer-to-peer learning and support implementation.

ENROLL IN OR SUSPEND MEDI-CAL COVERAGE

At intake, or within 1 week of intake, individuals will need to be screened for and enrolled in Medi-Cal.

Roles and Responsibilities for Correctional Facilities

- Assist with Medi-Cal application process including:
  - Transferring information to county social services departments to suspend coverage for individuals upon entry into the correctional facility and unsuspend coverage upon the release date.*
  - For individuals who appear to be uninsured:
    - Facilitating the completion of Medi-Cal applications on behalf of identified individuals (or coordinating with a 3rd party contractor to complete applications);
    - Ensuring the transmission of the application and cover letter to the county social services departments; and
    - Troubleshooting with the county social services departments to ensure successful enrollment.

*Per the SUPPORT Act, states shall not terminate Medicaid eligibility when individuals under age 21 become inmates of a public institution. States may instead suspend Medicaid eligibility for the duration of incarceration.

Source: Pub. L. 115-271, https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf

JI PATH 2 CONSIDERATIONS

- Current State vs Future State
- Data Collection
- Data sharing MOUs
- Importance of these building blocks

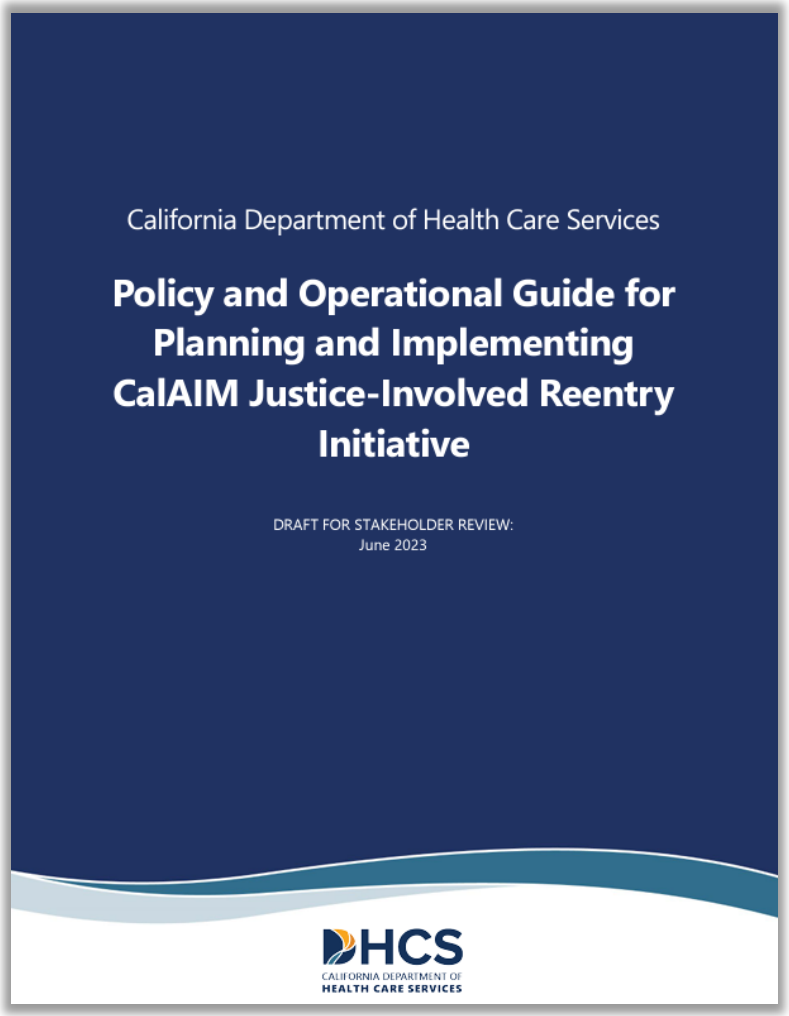
PATH JI ROUND 2 QUARTERLY DATA REPORTING

- Correctional Facilities:
  - Average number of individuals incarcerated within the facility/facilities per month
  - Total number of individuals screened for Medi-Cal within the facility/facilities per month
  - Total number of individuals who declined to apply for Medi-Cal per month
  - Total number of Pre-Release Medi-Cal applications submitted

PATH 3

- Funding
- Draft Guidance
- Implementation Plan/Budget
- Readiness Assessment

STATE POLICY AND OPERATIONS GUIDE



- "How to" guide for implementing 90-day pre-release services
- Remains in draft form
- Final version expected late September 2023

https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-Stakeholder-Comment-June-2023.pdf

IMPLEMENTATION PLAN

- Correctional facilities seeking PATH Justice-Involved Round 3 funds must demonstrate in their Implementation Plan how they plan to use funds to support the planning for and implementation of the operational processes that must be met in order to be deemed ready to go-live for pre-release services.
- The implementation plan is designed to evaluate your use of JI Round 3 funds and how they relate to your operational readiness. As required in the initial Round 3 application, your correctional facility attested to completing this implementation plan within 180 days of receiving Round 3 funding. Please complete the implementation plan by utilizing the JI Round 3 Guidance Document and the Policy and Operations Guide.

READINESS ASSESSMENT

Focus Areas	Readiness Element
1: Medi-Cal Application Processes	1a: Screening
	1b: Application Support
	1c: Unsuspension
2: 90 Day Pre-Release Eligibility Screening	2a: Screening
	2b: Eligibility Notification to State Eligibility System
	2c: Release Notification to State Eligibility System
3: 90 Day Pre-Release Service Delivery	3a: Pre-release Care Manager Assignment
	3b: Consultation Scheduling
	3c: Virtual/In-Person Consultation Support
	3d: Support for Medications
	3e: Support for Medication Assisted Treatment
	3f: Support for Prescriptions Upon Release
	3g: Support for Durable Medical Equipment Upon Release
	3h: Medi-Cal Billing and Provider/Pharmacy Enrollment
4: Re-Entry Planning and Coordination	4a: Release Date Notification
	4b: Re-Entry Care Management Warm Handoff
	4c: Re-Entry Behavioral Health Warm Handoff
5: Oversight and Project Management	5a: Staffing Structure and Plan
	5b: Governance Structure for Partnerships
	5c: Reporting and Oversight Processes

HMA DHCS

QUESTIONS?

WRAP UP & NEXT STEPS

1:55 – 2:00 pm PDT

Presenter: Bren Manaugh

SAVE THE DATE:
SEPTEMBER LEARNING COLLABORATIVE

THURSDAY, DECEMBER 13TH
12:00 – 2:00 PM PDT

If you are not currently on our listserv, please email MATinCountyCJ@healthmanagment.com to be added.

HMA DHCS

REMINDER – OFFICE HOURS

- Office Hours are offered on the 1st and 2nd Thursday of the month at noon PDT to all Jail MAT team members
  - 1st Thursday: All Team Members
  - 2nd Thursday: Prescriber
  - All team members welcome at both sessions!
- Drug Court team members are welcome to join too – please email MATinCountyCJ@healthmanagement.com to be added to the invites

POLLING QUESTIONS

1. Overall, today's session was:
   A. Very useful
   B. Somewhat useful
   C. Not very useful
   D. Not useful at all

2. The material presented today was:
   A. At the right level
   B. Too basic
   C. Too detailed

CONTACT US

FOR ANY QUESTIONS OR COMMENTS

MATinCountyCJ@healthmanagement.com