

What chaplains need to know about MAT

By Robert Sherrick, Michael White and David Young

Correctional chaplains have been working with wounded and ailing inmates in the U.S. since the Civil War. However, the wounds and brokenness that require healing today are not as much physical as they are mental, emotional and spiritual. Approximately four out of five (80 percent) of the 2.3 million individuals incarcerated in more than 5,000 U.S. jails and prisons suffer from addiction — referred to as a substance use disorder (SUD).¹ In the majority of correctional facilities, chaplains are members of a team implementing recovery programs for SUDs and assisting with successful reintegration into the community, thus reducing recidivism.² As team members, it is of the utmost importance that correctional chaplains stay informed with up-to-date information and knowledge of evidence-based best practices for SUDs. With nearly 200 overdose deaths per day (72,000 in 2017), the U.S. is experiencing the worst drug-induced death epidemic in history.^{3,4} The impact of addiction and SUDs on law enforcement, corrections, health care, families and communities is far reaching and costly to society. Abuse of alcohol, tobacco and illicit drugs costs more than \$740 billion annually due to

crime, decreased work productivity and health care expenses.⁵

With such a large population suffering from a SUD in correctional facilities, less than 15 percent receive treatment during incarceration. Unfortunately, untreated inmates with SUDs have a relapse rate of 90-95 percent upon release into the community. The World Health Organization (WHO) recommends the initiation of opioid agonists prior to release from incarceration to prevent relapse or overdose.⁶ Incarceration alone is not the answer for SUD. In fact, incarceration has been reported to be a catalyst for worsening health.⁷ Appropriate SUD treatment for the justice-involved population is a topic of concern in news releases, at conferences and in publications.^{8,9} The legality of withholding appropriate SUD treatment from individuals while incarcerated is an issue of concern for correctional facilities.^{10,11}

Key Definitions

Medicated-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, for the treatment of SUD (Substance Abuse and Mental Health Services Administration — SAMHSA).

SUDs occur when the recurrent

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use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school or home. According to the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5), a diagnosis of a SUD is based on evidence of impaired control, social impairment, risky use and pharmacological criteria.

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in

an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by the inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. According to the American Society of Addiction Medicine (ASAM) addiction, without treatment or engagement in recovery activities, is progressive and can result in disability or premature death.

Facts about SUDs:

- Justice-involved individuals have rates of SUD nearly 12 times the general population.
- 63 percent of individuals incarcerated in jails suffer from a SUD.
- 58 percent of individuals incarcerated in prisons suffer from a SUD.
- Formerly incarcerated individuals are 40 times more likely to die of an opioid overdose within two weeks of release as compared to the general population.
- Of 5,000 jails and prisons, fewer than 40 (one percent) offer MAT to inmates.
- Individuals receiving MAT are up to 75 percent less likely to die from a SUD.
- Every dollar invested in SUD treatment yields a return of \$4-\$7.
- Treatment and recovery plans for individuals with a SUD should span at least 3-5 years.

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Facts about MAT

Strong scientific evidence unequivocally shows that for opioid use disorder, medication is the essential component of treatment, not merely one component.¹² There is clear evidence that using MAT during incarceration and before release improves outcomes, with fewer behavioral issues with inmates, less recidivism and better engagement in continuation of treatment after release.¹³

In spite of this documented knowledge, correctional officials in prisons and jails have been slow to implement MAT. Some of the barriers include misunderstandings and a lack of knowledge of the science behind MAT, but significant stigma and negative bias also exists towards inmates who have an opioid addiction as well as against MAT. After

release, inmates may face resistance from parole officers, judges or family members and be urged to stop their medication, even though it is effective and essential to their recovery.

Many people think of MAT as “substituting one addiction for another,” when nothing could be further from the truth. Individuals on MAT do not get “high” from their medication doses; they feel normal with the stabilization of abnormal brain circuits that have been altered by years of exposure to illicit drug use. Many studies show better outcomes, including better treatment retention, less illicit drug use, less criminal activity, increased employment and housing and more stable family relationships when clients are on MAT compared to abstinence-only treatment that does not use medications.

There are three medications currently FDA-approved for the treatment of opioid use disorders — methadone, buprenorphine and extended-release (ER) naltrexone. Unfortunately, less than one percent of the prisons and jails allow access to FDA-approved medication as advised by addiction specialists.¹⁴ Some judges and prison officials have favored one drug over another, sometimes at the urging of the drug manufacturer's representatives. All of these medications should be made available for appropriate inmates, and the choice of medication should be made in consultation with the medical provider and the inmate, not by non-medical personnel.

Use of MAT in jails and prisons

While most jails and prisons do not allow MAT, several state departments of corrections (DOC)



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have successfully implemented the practice of supporting inmates with MAT.¹⁵ In 2016, Rhode Island DOC, with its unified prison/jail system, launched a new model of screening and protocolized treatment with MAT. Individuals on MAT arriving at the Rhode Island DOC were maintained on their respective medication regimens without tapering or discontinuing their medications. Inmates who were provided methadone treatment were less likely to be disciplined for bad behavior, were five times less likely to be re-arrested for a felony offense, 10 times less likely to be charged with a drug offense after release, and 41 percent more likely to continue with their treatment 30 days after release compared to 10 percent who did not participate in treatment. Other examples of successfully implementing MAT into their DOC programs include Arizona, Alaska, Connecticut, New Jersey and North Dakota. Arizona has two years of data from the SAMHSA Medication Assisted Treatment — Prescription Drug and Opioid Addiction (MAT-PDOA) grant that demonstrates MAT for opioid dependence and criminal justice-involved individuals can improve employment, permanent housing, recidivism and relapse. In 2017, the Pennsylvania DOC provided

ER naltrexone injections to a sample of inmates who were re-entering communities following up with a monthly shot and cognitive behavioral therapy post-release. In Massachusetts, the legislature has mandated MAT for inmates, including buprenorphine and methadone, in addition to ER naltrexone.¹⁶ Five Massachusetts counties

have agreed to start a pilot program offering buprenorphine to inmates with SUDs starting in September 2019.

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Endorsements of MAT for incarcerated populations

Numerous nonprofit associations, federal agencies and patient groups support MAT for patients and family members. A sampling is as follows:

- Addiction Policy Forum
- American Academy of Addiction Psychiatry
- American Correctional Association¹⁷

- American Society of Addiction Medicine (ASAM)¹⁸
- National Institute on Alcohol Abuse and Alcoholism
- Office of the Surgeon General of the United States
- Partnership for Drug-Free Kids
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- World Health Organization (WHO)

Role of correctional chaplains

Correctional chaplains are strategically placed to help facilitate continuum of care into the community for those with SUDs. Working with other prison officials, chaplains can be instrumental in a “warm handoff” into the community with peer support/mentoring and other available wrap around services. For example, more than 600 jails and prisons and over 20,000 local churches offer Celebrate Recovery, a Christ-centered 12-step recovery program where individuals and families can find healing and restoration.¹⁹ Chaplains can help families and friends understand the cycle of opioid addiction and the need for medication as well as self-help groups and spiritual support. A chaplain is an essential member of a team of professionals working with an inmate, along with their MAT, to rebuild their lives that have been ravaged by opioid addiction and to achieve and sustain recovery. In summary, what chaplains need to know about MAT is that it saves lives, saves public funds, results in healthier, productive relationships and is increasingly used in correctional facilities.

ADDENDUM

After the authors submitted this article, two publications were released that are pertinent to the central theme of this article. The authors requested that they be added as an addendum for follow-up by interested readers:

- National Sheriffs’ Association & National Commission on Correctional Health Care (2018). “Jail-Based Medication-Assisted Treatment — Promising Practices, Guidelines, and Resources for the Field.” Alexandria, VA & Chicago, IL: Author. Retrieved from <https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf>
- Justice Clearinghouse (2018). “Planning and Implementing Medication Assisted Treatment in Jails — What Justice Professionals Need to Know” — Workbook. Colorado Springs, CO: Author. Retrieved from <https://justiceclearinghouse.com/wp-content/uploads/2018/11/Workbook-Planning-and-Implementing-Medication-Assisted-Treatment-in-Jails.pdf>

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ENDNOTES

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