**Name**

**Jail Health Policy**

**MAT (Medication Assisted Treatment)/MOUD (Medication for Opioid Use Disorder)**

**Policy:**

It is the policy of the Name Jail that all jail and medical staff will be trained in the use, storage, and compliance with Medication Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD).

**Purpose:**

To establish a MAT/MOUD program for the Name Jail to continue and start treatment for opioid use disorder as well as to prevent fatalities from opioid overdoses as incarcerated individuals are released from the jail setting.

**Responsible Parties:**

Jail Staff, Public Health Nurse, RN, Jail physician

**Equipment:**

Methadone(liquid), Subutex®(sublingual tablet/subcutaneous injectable), Suboxone® (sublingual tabs/strips), Naltrexone(tablet/IM as Vivitrol®), gloves, water, crackers.

**Warning:**

--Suboxone® contains both buprenorphine and naloxone, whereas Subutex® contains only

buprenorphine.

--Methadone is a Schedule II substance; buprenorphine is a Schedule III substance (lower

potential for abuse)

--Buprenorphine is an opioid medication used to treat OUD as well as pain. Subutex ® and Suboxone ® are only FDA approved for OUD.

--Dosage changes are rarely warranted in some hepatic and renal impairment cases

\*Do not give MOUD if there is a known allergy to approved MAT/MOUD program medications (as listed above). MOUD medications may have side effects. Common side effects include headaches, nausea, fatigue, and sweating. Other side effects (including dizziness, low blood pressure (hypotension), slowed breathing, constricted pupils, spinning (vertigo), vomiting) are rare.

**Procedure:**

-Inmate arrested, and booked into the CCJ

-Staff assists to complete Medical Questionnaire and forward to nursing staff

\*Nursing staff will assess the need for treatment with the MAT/MOUD program and refer to the next available doctor appointment if inmate is interested in starting Buprenorphine\*

**The nursing staff to complete the following:**

1) Buprenorphine induction tool

2) Current medication list

3) DSMV SUD diagnostic tool

4) Urine drug screen, if indicated

**Medications**

If an inmate is currently prescribed buprenorphine:

* Verify current Rx, verify refills and order for inpatient stay, if indicated
* If current prescription is found and can be ordered, or dropped off for inmate, nursing will be sure that inmate understands the precipitated withdrawal that can occur if there is also an opioid in their system. This will be reflected in the MAT Contract that the inmate will sign.

If an inmate is not currently prescribed MOUD and is interested: Reach out to the jail physician for the ok to order and set up to be seen for the next doctor call

If an inmate is currently receiving **Methadone**:

-Nursing works with Clearpath to obtain doses. Chain of custody paperwork should be sent back to Clearpath. Guest dosing from other OTPs (Opioid Treatment Programs) may be set up through Clearpath, but the inmate patient will be responsible for finding a pay source for $20 daily.

Educate the patient (Obtain informed consent if needed): How the medication works

-Associated risks and benefits and educate on overdose prevention.

\*There is potential for withdrawal, relapse & overdose if the medication is discontinued. Patients should be educated about the significant chance of overdose and death if MOUD is declined or if patient started on naltrexone (Vivitrol) is initiated as opioid tolerance is lost.\*

Patients should be medically evaluated and monitored throughout treatment with additional appointments with the Jail physician, if needed.

**Address co-occurring disorders**

Staff to continue to manage/treat substance use disorder, medical/mental health, and social needs of a patient. \*Referrals for outside sources if needed if treatment is to continue after release\*

**Administration of Medication:** All medications are to be administered in the presence of staff.

* After medication administered, observe patient for ~5 minutes to ensure fully dissolved, then give water and crackers to assure medication was ingested completely.
* Check mouth for any remaining or deferred medication.
* Double signing done by staff when controlled substance is dispensed.
* Controlled substances should always be maintained behind a double lock

**Release**

-All inmates released on MAT/MOUD are provided with a provider list of options. -For inducted inmates, nursing staff will set up and provide information for an initial, and timely (ideally same day or withing 1-2 days), appointment with a community provider.

-Those working with ClearPath for Methadone maintenance will be encouraged to reinstate care with them. Staff will notify ClearPath upon release of inmate.

-Inmates should be released with all remaining doses of buprenorphine

-If transferred to another facility that allows Methadone maintenance-doses may be handed off to that facility with proper chain of custody.

-If transferred to another facility that does NOT allow Methadone maintenance- doses should be destroyed.

**Buprenorphine/Buprenorphine-Naloxone (Subutex®/Suboxone®)/Methadone Care Plan**

I understand my provider at the Name Jail is prescribing a Medication for Opiate Use Disorder (MOUD) to assist me in managing my opioid dependence. This agreement will assist members of my care team and I to comply with the law and best practice guidelines regarding controlled medicines.

I, (print name), (DOB), have agreed to use the following medications as a part of a care plan for my condition. I understand that these medications may not eliminate my condition but may improve my condition and my activities of daily living.

Diagnosis(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication to be used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Terms of Agreement:**

* I have been made aware of the risks associated with using MOUD to treat my condition.
* I will not use illegal substances, street drugs or abuse alcohol while taking controlled medications. I will not take controlled medications prescribed for others nor will I share controlled medications that are prescribed to me with others. I will keep all controlled medications away from children.
* I will not be involved in the sale, illegal possession or diversion of controlled medicines.
* Additional programs (inpatient treatment, outpatient treatment, mental health etc.) may be recommended by my care team.
* I will actively participate in any program(s) designed to improve function including social, physical, psychological, and daily/work activities.
* I agree to allow my care team to communicate with other health care professionals regarding my controlled medications use as deemed necessary.
* I understand this mode of treatment will be stopped if any of the following occur:
  + I give away, sell, or misuse my prescribed medications or use controlled medicines prescribed for others
  + I am non-adherent with any of the terms of this agreement
  + I develop significant side effects, rapid tolerance or loss of function as a result of my treatment
* ***I understand that if I take this medication with any opioids already in my system that I could experience life threatening withdrawal and the nurse has shared this information with me.***

I have read and understand these terms and have asked all relevant questions. I consent to the agreed upon treatment in my care plan under the terms of this agreement. This agreement will remain in effect for the duration of my medication assisted treatment and updated as appropriated and/or annually, whichever occurs first.

**Patient’s signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**