Spectrum Health Systems, Inc.

& New England Addiction Technology Transfer Center Network

Advancing Medications for Addiction Treatment in Correctional Settings ECHO Program

Participant Welcome Guide

Regarding the general format and partial content of this guide, we wish to acknowledge and credit the Arizona Telemedicine Program Rheumatology TeleECHO™ Clinic and its Participant Welcome Guide (2017).

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Overview

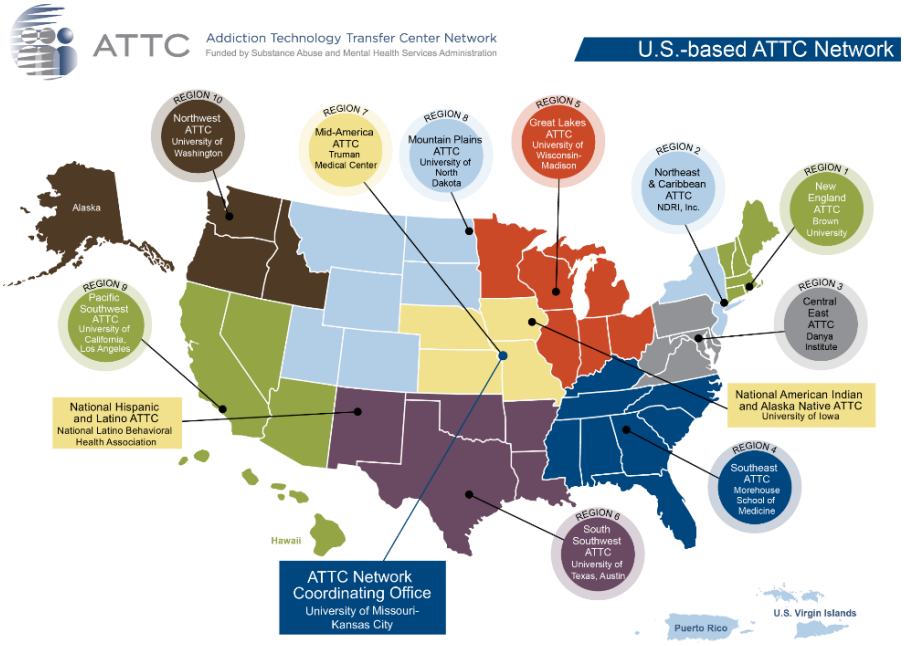
About Spectrum Health Systems, Inc.

Founded in 1969, Spectrum Health Systems, Inc. is a private, nonprofit organization dedicated to improving the lives of individuals impacted by addiction and/or mental health disorders. For more than 50 years, Spectrum has become known as an industry leader, helping thousands of individuals overcome addiction.

Spectrum's continuum of services includes inpatient detoxification, clinical stabilization, residential treatment, outpatient counseling, medication for substance use disorders, mobile opioid use disorder treatment, and peer recovery support. In addition, we operate residential programs for adolescents and young adults committed to the Massachusetts Department of Youth Services. We also contract with state and county correctional authorities to provide specialized programming for justice-involved individuals.

For more information, please visit: https://www.spectrumhealthsystems.org/

About the New England Addiction Technology Transfer Center



The New England Addiction Technology Transfer Center (ATTC) is an organization federally funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) that provides training, technical assistance, and resources to support the workforce in the field of substance use treatment and recovery across the six New England states. Its mission is to accelerate the adoption and implementation of evidence-based practices and improve the quality of addiction services. For more information, see the ATTC's explainer video.

What is Project ECHO?

Project ECHO (Extension for Community Healthcare Outcomes) is a guided-practice model that aims to increase workforce capacity by sharing knowledge. Specialists at the "hub" site meet regularly with providers in local communities via videoconferencing to train primary care providers in the delivery of specialty care services.

The ECHO model™, developed at the University of New Mexico Health Sciences Center, does not actually provide care directly to patients. Instead, it provides front-line workers with the knowledge and support they need to manage patients with complex conditions in the patients' own communities. This dramatically increases access to specialty treatment, particularly in rural and underserved areas.

Since the start of Project ECHO in 2003, the model has greatly expanded and has been implemented in over 1,400 hubs – both in the U.S. and internationally – covering dozens of complex conditions and problems.

For more information, please visit: https://echo.unm.edu.

Core Principles of Project ECHO

The ECHO model develops knowledge and capacity among community providers through ongoing tele-mentoring and education. Its core principles are:

- Use technology to leverage scarce resources
- Share "best practices" to reduce disparities
- Use case-based learning to master complexity
- Evaluate and monitor outcomes

How Does It Work?

Inspired by the way clinicians learn from medical rounds during residencies, the ECHO Model® has evolved into a learning framework that applies across disciplines for sustainable and profound change.

During an ECHO session, participants present real (anonymized) cases to the specialists—and each other—for discussion and recommendations. Participants learn from one another, as knowledge is tested and refined through a local lens.

This continuous loop of learning, mentoring and peer support is what makes ECHO unique, with a long-lasting impact far beyond that of an in-person training, webinar or e-learning course. Our knowledge-sharing model brings together specialists from multiple focus areas for a robust, holistic approach.

Image Credit: Project ECHO

How a Typical ECHO Session is Structured

- Sessions are held on the third Thursday of the month from 11:30 AM – 1:00 PM (Eastern time). This program will begin on March 27, 2025, and continue through February 2026.
- ECHO sessions take place via real-time, interactive videoconferencing, using a PC/Mac, laptop, tablet, or smart phone equipped with a webcam, and Zoom.
- The first half of the session is dedicated to a 30-minute didactic presentation given by a subject matter expert on a scheduled topic. After the presentation, there will be 10 minutes allotted for a Q&A with the subject matter expert.
- The second half of the session is dedicated to a case presentation and peer learning. A participant who has submitted a case in advance (see *Case Presentations)* will have 20

minutes to present their case and its challenges, and the group will then have 15 minutes to ask questions, provide feedback, and collaborate on solutions. All participants are encouraged to contribute actively to the case discussion.

- Recommendations are summarized verbally at the conclusion of a case presentation, transcribed, and forwarded in writing to the participant whose case was discussed.

Evaluations

It is important for us to evaluate the effectiveness of our curriculum and program; thus, we ask ECHO participants to complete a survey after each session. *Completing the post-session evaluation is required if you wish to qualify for Continuing Education credits.*

History and Context

MAT in Correctional Settings[1]

Medications for addiction treatment (MAT) have been carefully studied and shown to be effective in treating OUDs. Yet, despite the overwhelming evidence of effectiveness, it is estimated that fewer than 1 percent of jails and prisons in the U.S. provide access to medications. OUD is highly prevalent among justice-involved individuals; yet, more than 80 percent of individuals who are incarcerated and have a history of opioid use do not receive treatment. Studies have similarly reported gross underutilization of MAT in community corrections programs, such as probation, parole, and treatment courts, as well as non-criminal justice treatment programs. Several studies found that only about 2 to 10 percent of persons with OUDs on probation or parole received MAT.

Efforts are rarely made to ensure that returning jail or prison inmates have access to this evidence-based treatment when they transition back into the community. Less than half of state and federal prisons in 2009 referred inmates for methadone maintenance after release, and less than one-third provided referrals for buprenorphine.

For persons using opioids, the odds of being arrested and becoming involved in the criminal justice system are greatly increased. 24 to 36 percent of individuals with a heroin use disorder

[1] Material in this section was adapted from (1) “Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings” (2019) by the Substance Abuse and Mental Health Services Administration (SAMHSA); and (2) “Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit” (2020) by The National Council for Behavioral Health and Vital Strategies.

pass through American correctional facilities annually, and an estimated 17 percent of state prison inmates and 19 percent of jail inmates report regularly using opioids. Roughly 30 to 45 percent of inmates report suffering from serious withdrawal symptoms or an inability to control their use, indicative of severe symptoms of drug dependence.

The impact of opioid use on individuals transitioning from jail or prison back to the community is overwhelmingly negative. Outcomes include higher rates of returning to the criminal justice system, harm to families, negative public health effects such as the transmission of infectious diseases, and death. Within 3 months of release from custody, 75 percent of formerly incarcerated individuals with an OUD relapse to opioid use, and approximately 40 to 50 percent are arrested for a new crime within the first year.

Drug overdose is a leading cause of death among formerly incarcerated individuals. Prisoners and jail inmates released to the community are between 10 and 40 times more likely to die of an opioid overdose than the general population, especially within the first few weeks after reentering society.

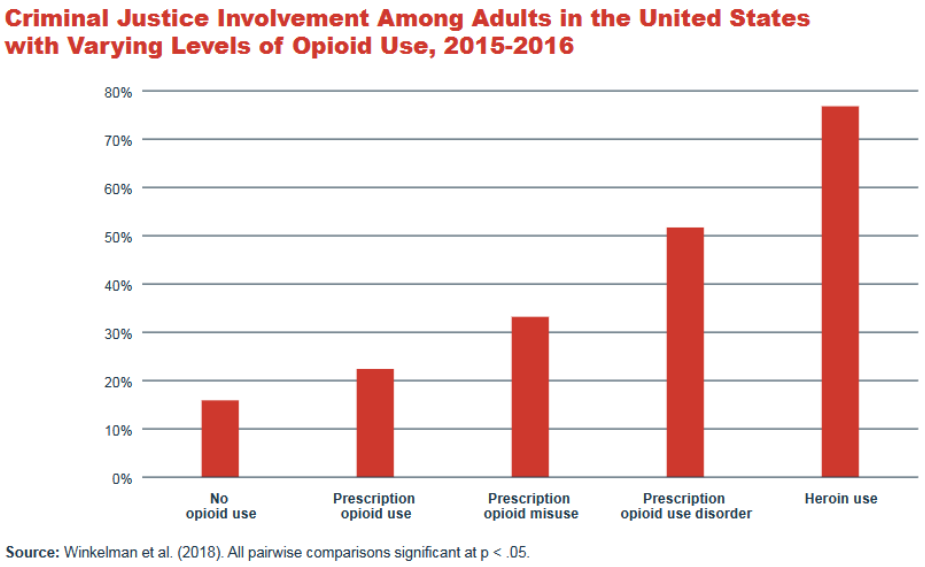


Image Credit: SAMHSA

Correctional administrators and healthcare providers are on the front lines of the opioid epidemic. Supporting the adoption of MAT in correctional settings, the National Sheriffs' Association (NSA) and the National Commission on Correctional Heath Care (NCCHC) cite a range of potential benefits, including:

- Stemming the cycle of arrest, incarceration, and release associated with substance use disorders.
- Contributing to the maintenance of a safe and secure facility for inmates and staff.

- Reducing costs.
- Minimizing the risk of post-release overdose and death.
- Facilitating a path to recovery for individuals with SUD.

A growing number of national organizations are calling for the adoption of MAT within correctional settings. Additionally, jurisdictions across the nation are increasingly establishing the provision of evidence-based treatment for SUD within correctional facilities as a legal requirement. The legality of denying access to medications for OUD in correctional facilities has been challenged in courts as unconstitutional. As research on the science of addiction becomes more advanced, courts have acknowledged that MAT is not only the most effective treatment for OUD, but that denying access to MAT presents a serious risk of harm, including death, to the individual.

Our Program & Curriculum

There has been a demonstrated gap in knowledge and skill—consistent data shows that there is limited understanding of the clinical evidence supporting medications for addiction treatment as a standard of care within carceral settings, and a lack of skills and strategies to implement this treatment in jails and prisons. Healthcare teams require a deeper understanding of the clinical evidence supporting MOUD, the specific benefits of medications for addiction treatment, and frameworks for providing addiction treatment in correctional settings. Teams also need training in practical skills such as administering MOUD safely, managing logistical challenges, engaging patients, and developing continuity-of-care plans for individuals transitioning out of incarceration.

As such, this educational ECHO series is designed to address the growing need for medications for substance use disorders (MOUD) in correctional facilities across the United States. With only a limited number of states offering these life-saving interventions, this series aims to empower correctional systems to adopt and implement MOUD programs effectively.

When planning our program, we began by conducting a comprehensive needs assessment to identify gaps in knowledge, skills, and resources related to the adoption of MOUD programs in jails and prisons. This included reviewing data on current MOUD access in correctional facilities and gathering feedback from correctional administrators, healthcare providers, and stakeholders throughout the USA. A curriculum was developed based on needs and input from our planning committee (see *About Our Team)* and includes key topics such as efficacy of MOUD, logistical considerations, importance of staff training, and strategies for program sustainability.

This program is designed to enhance learners' skills in implementing evidence-based MOUD programs within correctional facilities, improve strategies for addressing logistical and systemic barriers, and foster collaboration among healthcare teams. These changes aim to increase MOUD access, improve patient outcomes, and reduce opioid-related morbidity and mortality in

incarcerated populations. It promotes active learning through case-based discussions, interactive Q&A sessions, and peer-to-peer knowledge sharing. The ECHO model engages participants in real-world problem-solving, fosters collaboration, and encourages applying evidence-based practices to address challenges in implementing and sustaining MOUD programs in correctional settings.

We will ensure valid content by incorporating current clinical guidelines, peer-reviewed research, and evidence-based practices. Regular planning committee review, participant feedback, and alignment with SAMHSA and other authoritative standards will ensure accuracy, relevance, and applicability to correctional healthcare settings.

Case Presentations

What Cases Should I Present?

You do not need to present a case to participate in an ECHO session. However, the submission of cases for presentation and discussion is a vital component of the ECHO model, fostering collaborative learning through real-world scenarios. Therefore, it is strongly encouraged. By sharing cases, participants can gain insights into implementing MOUD programs, addressing systemic and logistical barriers, and improving patient care within correctional settings. Case presentations need not be only about specific patients, but also about systemic challenges with implementation.

What Information Should Be Included in a Case Presentation?

We will provide you with a Case Presentation Form that asks specific questions about your case. Complete it with as much information as you can to help the group address your questions and concerns.

It is absolutely critical to preserve patient confidentiality at all times during case presentations. *No HIPAA identifiers may be mentioned or shown during case presentations.* In addition, no other information that might identify the patient – such as social history details that may identify a patient residing in a small community – may be mentioned.

A case presentation should include the following information:

- Patient profile (if applicable)
  - Age, gender, and basic demographics (while maintaining confidentiality).
  - History of substance use and involvement with corrections.

- Clinical and treatment history (if applicable)
  - Substance use disorder diagnosis and other relevant mental health conditions.
  - Details of the MOUD provided (e.g., medication type, initiation date, dosage).
- Current challenges
  - Barriers, issues, or concerns related to MOUD implementation or adherence.
  - Examples include diversion, refusal of medication, interactions with other inmates, or systemic barriers.
- Systems and logistical context
  - Facility-specific factors affecting care delivery (e.g., policies, staffing, or resource constraints).
  - Efforts made to address challenges (e.g., team interventions, policy adjustments).
- Outcomes and questions
  - Outcomes or progress to date.
  - Specific questions for the ECHO group, focusing on areas where mentorship or peer input is needed.

Case presentation ideas include, but are not limited to:

- Medication diversion
- Patient refusal to continue MOUD
- Complex co-morbidities
- Transition to community care
- Challenges in staffing and training for MOUD implementation
- Red tape hindering MOUD implementation

Here is an example of a case presentation on the topic of medication diversion:

- Patient profile: "Juan," a 35-year-old Hispanic male with opioid use disorder (OUD) who has been incarcerated for two years.
- Clinical history: Initiated buprenorphine six months ago with positive initial adherence. Reports a previous diagnosis of bipolar disorder but has not had relevant symptoms since incarceration.
- Current challenge: Recently caught diverting medication to other inmates, raising concerns about safety and program integrity.
- Systemic context: Limited staff available for directly observed therapy and no access to medication tamper-evident packaging.
- Key questions: What strategies can the team implement to prevent diversion while maintaining the integrity of the MOUD program?

How to Present a Case

- Submit a Case Presentation Form, in which you will complete a summary following the outline above, as well as your primary questions for the ECHO group. Remember, all patients should be anonymized.
- Case presentations will be selected based on their potential to address key learning objectives and foster robust discussion. If your case is selected, you will be contacted via email with the date of your scheduled presentation.
- During the ECHO session, the session Facilitator will call on you to present your case. The Coordinator will display your case information on the screen. Please verbally summarize your case in five minutes or less.
- The Facilitator will then promote discussion among all participants, starting with clarifying questions for the case presenter. At the conclusion of the discussion, the Facilitator will summarize recommendations from all participants.

Words Matter: Recovery-Oriented and Non-Stigmatizing Language

Language shapes perceptions, influences attitudes, and affects outcomes in substance use and mental health care. Recovery-oriented and non-stigmatizing language fosters a supportive environment that empowers individuals and reduces barriers to treatment and recovery. The below section outlines the importance of using recovery-oriented language, provides evidence supporting its impact, and offers practical guidance on replacing stigmatizing terms with respectful, person-first alternatives.

Evidence Base for Recovery-Oriented Language[2]

1. **Impact on Treatment Outcomes:** Research shows that stigmatizing language can perpetuate negative stereotypes, discourage help-seeking behavior, and adversely affect treatment outcomes. For example, a study by Kelly et al. (2010) demonstrated that terms

[2] References for this section include: (1) Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. International Journal of Drug Policy; (2) SAMHSA's "Words Matter" Guide; and (3) National Institute on Drug Abuse (NIDA): Principles of Addiction Treatment.

like “substance abuser” are associated with increased perceptions of personal culpability and decreased empathy from healthcare providers.

2. **Encourages Dignity and Respect:** Person-first language, which emphasizes the individual rather than the condition, has been shown to promote dignity, reduce stigma, and support recovery. It aligns with the principles of trauma-informed care and fosters trust and engagement.

3. **Policy and Best Practices:** Leading organizations such as SAMHSA, the American Medical Association, and the National Institute on Drug Abuse advocate for recovery-oriented language as a standard in clinical and correctional settings.

Guidelines for Recovery-Oriented Language & Terminology Table

- Use **person-first language** to prioritize the individual over their diagnosis or circumstances.
- Avoid terms that imply judgment, moral failure, or criminality.
- Recognize that addiction is a chronic medical condition, not a character flaw.
- Frame discussions around recovery, hope, and empowerment.

Use This	Not This	Why It Matters
Person with a substance use disorder	Addict, junkie, drug user	Reduces stigma and emphasizes the person rather than the condition
Incarcerated individual	Inmate, prisoner, offender	Promotes dignity and reflects humanity
Recovery journey	Clean, sober (implies moral superiority)	Focuses on recovery as a process rather than a binary state
Medication for addiction treatment	Medication-assisted treatment (MAT)	Reduces misunderstanding; emphasizes medication as primary treatment
Tested positive for substance use	Dirty drug test	Avoids moral judgment and maintains neutrality
Person experiencing homelessness	Homeless person	Centers on the individual rather than their circumstance
Person with co-occurring disorders	Dual diagnosis, mentally ill addict	Highlights the complexity of conditions without reducing individuals to labels

By ensuring recovery-oriented and non-stigmatizing language in this ECHO series and beyond, we can create a more compassionate and effective framework for advancing medications for addiction treatment in correctional settings.

Logistics

How Do I Sign Up?

Visit our iECHO page to register online. Each participant will need to sign up individually, even if there are several people participating from your site location. You will also be added to the email notification list and will receive regular updates about upcoming sessions and other announcements.

Connecting to an ECHO Session: Using iECHO

- iECHO is an online platform that supports participants in Project ECHO. iECHO will send you automated email reminders prior to the session start times with access to all your links.
    - For further guidance, a video explaining iECHO for participants can be found here.
- **iECHO will send a session reminder via email 30 minutes prior to the session's start time. Please note that administrators of the training do not have access to the Zoom link until this time.**
    - **This email includes the link to join the session. You can also join from the program's iECHO page under the "Schedule" tab.**
    - *If you are not receiving emails from iECHO, be sure to check junk or spam folders and consider adding the email to your approved senders list.*
- On the day of the session, please join a few minutes prior to the scheduled start time (11:30 AM Eastern time). This will give you sufficient time to confirm you have a stable Internet connection, test your audio and video, get comfortably situated, and ensure that the session can begin on time.
- ECHO sessions are interactive, and we ask that you participate to the best of your ability. That means keeping your camera on during sessions, if possible.
- If you have questions about Zoom or require technical support, please contact Avery Kasten (avery.kasten@spectrumhealthsystems.org).

About the Planning Committee

Sharif Nankoe, MD (he/him) is Spectrum Health Systems' Medical Director for the statewide program serving offenders with opioid use disorders in partnership with the Massachusetts Department of Correction (MADOC). Dr. Nankoe is responsible for directing a comprehensive continuum of care for offenders, and overseeing the medical team. He lends his expertise to training staff about substance use disorders and the unique challenges faced by offenders in obtaining treatment while incarcerated and remaining in recovery following release. Dr. Nankoe has extensive experience with evidence-based addiction treatment in corrections, having previously served as Medical Director for opioid use disorder treatment programs for the Vermont Department of Corrections, as well as for BAART programs in St. Johnsbury and Newport, Vermont. He also brings his skills as a consultant and educator from his time as an Assistant Professor at the University of Vermont College of Medicine.

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Lisa Dagnello, LMHC, LADC-I (she/her) has been the Clinical Director of MA Department of Corrections MOUD Programming for Spectrum Health Systems since May 2021. She has extensive experience treating patients with substance use and co-occurring disorders within outpatient and correctional settings as well as program management, development and training.

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Rachel Sasseville, LICSW, LADC-I (she/her) is the Director of Corporate Training at Spectrum Health Systems. She has worked in the field of addiction treatment for 12 years. She has held roles with Spectrum since 2016, previously as Senior Clinician at Lincoln Street Worcester OTP, and later as Clinical Program Director in Spectrum's OTP in Millbury, MA. In her role as Director of Corporate Training, she works with program leadership to develop comprehensive staff training plans, ensuring that all staff are competent in program delivery, medications for addiction treatment and substance use disorders. Ms. Sasseville also coordinates and oversees trainings provided by the Spectrum Educational Institute.

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Tonya McCallum (Tavares) has 15+ years of experience in addiction science research. She holds a BA (Psychology) from the University of RI and an MS (Behavioral and Social Sciences) from Brown University. Since 2018, she has worked to address the opioid and stimulant crises with the New England Addiction Technology Transfer Center and Opioid Response Network. Her work spans pharmacotherapy treatments for alcohol use and smoking cessation, genetic factors in addiction, and culturally adapted treatments. Her research also focuses on evidence-based practices, reducing the research-to-practice gap, coping and resilience, acculturative stress, and addressing disparities, especially those with criminal legal involvement. She enjoys making memories, big and small, with her husband and their two daughters.

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Jeffrey Baxter, MD (he/him) serves as the Chief Medical Officer at Spectrum Health Systems. He is an expert in the treatment of opioid use disorders and has extensive experience in designing, implementing, and administering medication for substance use disorders in both community-based and institutional settings. Dr. Baxter is an Associate Professor in the Department of Family Medicine at the University of Massachusetts Medical School and is board certified in Family Medicine and Addiction Medicine. He also leads buprenorphine prescriber certification courses and has served as a mentor with the SAMHSA-funded Physician Clinical Support Service (PCSS), a nationwide network which provides clinical support to clinicians offering buprenorphine treatment and pain management with opioid medications. Recently, Dr. Baxter was awarded the Nyswander / Dole Marie Award by the American Association for the Treatment of Opioid Dependence at AATOD's annual conference. This prestigious award recognizes individuals who have made outstanding contributions to opioid treatment.

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Lisa Blanchard, MA, LMHC (she/her) serves as Spectrum Health Systems' Chief Clinical Officer. Lisa is a skilled clinician with years of experience in behavioral health administration, including medication for substance use disorders, new program development, and electronic health records implementation. Ms. Blanchard also oversees training for the organization and provides training, education, and technical assistance services to other agencies, providers, and local communities. Ms. Blanchard was trained as a NIATx process improvement coach and has served as a NIATx coach and national presenter. She has worked as a consultant, presented at the national level on a variety of topics, and currently co-hosts

Spectrum's popular Airing Addiction podcast. Ms. Blanchard holds a master's degree in counseling psychology with a concentration in cognitive behavioral therapy.

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Avery Kasten (they/them) is the Training Coordinator at Spectrum Health Systems. They graduated from Smith College with a BA in English Language & Literature in 2023. They have been at Spectrum since October 2024 and provide administrative, clerical, promotional, design, and technical support to many of the organization's training initiatives. You may use Avery as your point of contact for questions, comments, and concerns regarding this ECHO program – if they cannot help you directly, they will be happy to connect you to a team member who can.

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