

Opioid Use Disorder Treatment in Correctional Settings

Introduction

Deaths from opioid overdose reached an all-time high, estimated at more than 83,000 in 2020 (Centers for Disease Control and Prevention, 2020). These deaths are largely preventable. Opioid use disorder (OUD) is a chronic treatable illness and disability that is best treated in the community. Drug courts and attorneys should be educated about alternatives to incarceration that can better promote recovery and be more appropriate than incarceration for certain individuals (Cruzado-Quinones et al., 2016).

Nevertheless, there is a high prevalence of OUD among people in prisons, jails, and detention centers, and thus correctional facilities have important roles to play in ensuring appropriate treatment for people with this chronic illness (Bronson et al., 2017). Scientific evidence has firmly established that medications to treat opioid use disorder (MOUD) save lives (National Academies of Sciences, Engineering, and Medicine [National Academies], 2019). By providing access to MOUD and behavioral treatment based on national standards, prisons, jails, and detention facilities can reduce deaths, improve long-term health outcomes, interrupt the cycle of recidivism (National Academies, 2019), and minimize litigation.

MOUD treatment (also referred to as “MAT,” medications for addiction treatment) improves medical and mental health outcomes and reduces relapses and recidivism (Amato et al., 2005; Bird et al., 2015; Egli et al., 2009). The FDA-approved treatments are methadone (for patients ≥ 18 years), buprenorphine (for patients ≥ 16 years), and extended-release naltrexone (for patients ≥ 18 years). The American Society of Addiction Medicine (ASAM, 2020a, 2020b), National Academies (2019), and National Governors Association (2021) recommend that all three FDA-approved MOUD be available within corrections.

While medication treatment alone is effective for the treatment of OUD, its efficacy is enhanced when used in combination with appropriate behavioral interventions that address underlying psychological contributors to OUD, as well as co-occurring mental health conditions. Assessment and treatment of people’s mental health and social resource needs are a critical part of comprehensive treatment plans for people with OUD. Basic support groups such as Narcotics Anonymous can also provide benefit for people’s recovery. Such counseling and support are important parts of treatment, but if counseling is not available, provision of medication alone is still recommended (see ASAM national practice guideline, 2020, and National Academies, 2019). Appropriate screening for opioid use and OUD, along with thorough counseling on treatment options by appropriately trained health care professionals, can help identify those who would benefit most from engaging in medication and behavioral treatment.

A robust body of evidence has demonstrated the feasibility and benefits of providing MOUD in correctional settings. There is a striking mortality benefit of providing MOUD in corrections. People leaving prison without MOUD have up to 40 times higher risk of dying from overdose in the first 2 weeks following their discharge than the general population (Merrall et al., 2010; Ranapurwala et al., 2018). MOUD significantly reduces postdischarge overdose deaths (Bird et al., 2015; Gisev et al., 2015); one state showed a two-thirds reduction in statewide opioid overdose deaths when its correctional system made MOUD available in custody (Green et al., 2018). A modeling study showed that 1,840 lives could be saved annually if all people with OUD received appropriate MOUD in jails and prisons (Macmadu et al., 2020). While the prevalence of OUD is similar by race and ethnicity

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(Shearer et al., 2020), Black and Brown people are more often incarcerated and more often have their treatment interrupted by incarceration (Pro et al., 2020), thus exposing people of color to higher death rates.

Providing treatment in custody also promotes engagement in and continuity of treatment in the community after incarceration, especially when linkages to community treatment and services are facilitated (Brinkley-Rubinstein et al., 2018; Krawczyk et al., 2020; Moore et al., 2018; Rich et al., 2015). It also provides an opportunity to assess for untreated mental health conditions that may be contributing to OUD. While both methadone and buprenorphine treatment pose some risk for diversion in prisons and jails, evidence suggests that overall rates of illicit drug use decline following introduction of MOUD and reduce disciplinary problems (Larney et al., 2014).

Incarcerated people with OUD should not be forced to undergo withdrawal, nor should they be forced to be on MOUD if they decline or otherwise do not meet criteria. Forced withdrawal discourages engagement in community treatment, increases the risk for substance use during incarceration, and increases the risk death for after discharge (Brinkley-Rubinstein et al., 2018; Moore et al., 2018; Rich et al., 2015). If, after education about the benefits of treatment, patients decline MOUD and choose withdrawal, then withdrawal (if moderate or greater) should be accomplished using buprenorphine in tapering doses using an opioid withdrawal scale (World Health Organization, 2009). Pregnant people in particular should have timely access to MOUD and avoid withdrawal due to maternal and fetal risks of opioid withdrawal for this population.

Correctional facilities should also consider provision of intranasal naloxone (IN)² at discharge (in the person's property or via e-prescribing) to prevent overdose death, accompanied by training in its use to patients and their family/friends. Partnering with local public health agencies may offset costs of IN and offer opportunities to provide IN training and medication to visitors. Discharge planning should begin at admission to facilitate linkages to MOUD treatment in the community. Correctional health advocates/liaisons can facilitate access to MOUD in community settings through direct referral or by setting up a contact person in correctional health. Evidence-based models for coordinating care have demonstrated workflows and offer job descriptions and approaches.

Adolescents with OUD are a special population in juvenile corrections. While the use of MOUD remains off-label for youth (methadone and extended-release naltrexone are approved for patients \geq age 18 and buprenorphine for those \geq 16) and has limited evidence compared to the extensive research conducted with adults, it still represents an effective and accepted treatment option. Considerations for the treatment of adolescents include the importance of including family in treatment as much as possible, incorporating psychosocial interventions alongside any pharmacological interventions, understanding and addressing complex issues of confidentiality and consent especially in the juvenile justice system, recognizing and treating the likely co-occurring psychiatric conditions, and accessing developmentally appropriate interdisciplinary treatment programs whenever possible. ASAM's National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use includes treatment in correctional facilities and options for using MOUD with adolescents (2020a).

Providers in correctional settings should follow ASAM guidelines when treating people with OUD. From a legal perspective, OUD is a protected disability under federal law. Recent court rulings have affirmed the right of people with OUD in jails and prisons to receive MOUD. A useful guide for implementation is Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit (Mace et al., 2020). Despite the established benefits and feasibility of providing MOUD in custody, available evidence shows that many correctional facilities do not provide access to MOUD, in some cases do not even continue

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community-initiated MOUD, or provide MOUD only in limited circumstances (Vestal, 2018). To facilitate community return, the Assess, Plan, Identify, and Coordinate (APIC) model offers a model for transitional care and care coordination (Osher, 2007).

Position Statement

NCCHC recommends that jails and prisons enact the following steps to provide access to and continuity of MOUD in order to save lives and fight the opioid epidemic.

1. Establish MOUD programs that involve universal OUD screening of people entering, offering treatment with MOUD, and ensuring MOUD treatment continuity upon entry and on discharge in coordination with community MOUD treatment providers.
2. Provide adults and adolescents with OUD with psychosocial assessments, including evaluation for mental health conditions and social needs, as well as appropriate mental health treatment, psychosocial counseling, and referral.
3. Establish partnerships and memorandums of understanding with community opioid treatment programs and buprenorphine providers so that (a) people receiving treatment continue to receive it while in custody, (b) people not engaged in treatment have MOUD initiated during their incarceration when possible, and (c) people being discharged receive appointments with community treatment providers along with adequate supplies of MOUD with back-up plans if appointments are cancelled or delayed.
4. Train correctional health care and custody staff in the science and treatment of OUD. This includes education regarding OUD as a chronic illness that requires both patient education and appropriate counseling in addition to MOUD, appropriate monitoring during MOUD administration. Training should also include provision of intranasal naloxone.
5. Establish appropriate policies and procedures that ensure that all people with OUD are offered choices regarding FDA-approved MOUD that are available in the community. This can mean ensuring that people who are currently receiving MOUD continue to receive it and those not engaged in treatment are offered treatment. This process should include appropriate counseling about OUD, patient management and recovery groups, risks associated with stopping medications and how continued treatment with buprenorphine and methadone can save lives, continuation of treatment in the community, discharge planning and care coordination, and use of naloxone.
6. Ensure that women with OUD are tested for pregnancy. Pregnant women with OUD should not go through withdrawal and should be offered pregnancy-appropriate MOUD (methadone or buprenorphine). Treatment should be provided by clinicians with expertise in MOUD during pregnancy⁴. Initiation of MOUD may require inpatient hospitalization. Other opioid medications, such as acetaminophen with codeine, hydrocodone, or oxycodone, should not be substituted for appropriate medication treatments because of risk to the pregnant woman and fetus.
7. Ensure that adolescents with OUD have access to providers with experience in MOUD as well as psychosocial interventions that are developmentally appropriate, take into consideration relevant concerns about confidentiality and consent, and include family whenever possible.
8. Seek out resources including technical assistance to help facilities establish effective programs, whether this involves partnerships with community MOUD treatment providers, certifying on-site staff to become buprenorphine providers, or obtaining a license to become an opioid treatment provider (see table).

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Table. Options for Providing MOUD in Correctional Facilities

- Transport incarcerated individuals to community opioid treatment programs (OTPs) or a hospital (this is sometimes used during pregnancy) for medication dosing. OTPs may have the option of requesting waivers for use of takeout doses in order to minimize the number of transports.
- Partner with community OTPs for dosing of incarcerated individuals within the facility. In this case, the dosing is done under the license of the community OTP.
- Have correctional providers obtain buprenorphine X-waivers. A waiver permits use of buprenorphine for treatment of OUD as well as for medication-assisted withdrawal.
- Obtain an OTP license for the facility. This permits use of methadone and buprenorphine for both treatment and withdrawal. (Note: NCCHC accredits facilities for OTP⁵.)
- Obtain state and DEA licensing as a health care facility. This entitles the facility to the same exemptions as hospitals for adjunctive use of methadone or buprenorphine in management of pregnancy or other conditions, e.g., HIV, mental illness.

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Note: This statement replaces Substance Use Disorder Treatment for Adults and Adolescents, adopted in 2016 and expired in 2021.

Notes

1. For more information on MOUD, visit the Substance Abuse and Mental Health Services Administration at <http://www.samhsa.gov/medication-assisted-treatment>.
2. See NCCHC's position statement on Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths. <https://www.ncchc.org/naloxone-for-the-prevention-of-opioid-overdose-deaths>
3. By law, buprenorphine is the only opioid agonist-type drug that physicians can prescribe (outside of an OTP) to treat opioid dependence in any patient, regardless of pregnancy. The law allows for prescribers to write for up to three days as a bridge to MOUD.
4. Current clinical guidelines are available from the following sources:
 - a. National Center on Substance Abuse and Child Welfare. Treatment for Opioid Dependence During Pregnancy. <https://www.ncsacw.samhsa.gov/resources/resources-mat.aspx>
 - b. American College of Obstetricians and Gynecologists. Committee on Obstetric Practice. Opioid Use and Opioid Use Disorder in Pregnancy. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy>
5. <https://www.ncchc.org/opioid-treatment-programs-accreditation>

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