



Medications for Opioid Use Disorder in Jails and Prisons: Moving Toward Universal Access



JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Bloomberg American
Health Initiative

Medications for Opioid Use Disorder in Jails and Prisons: Moving Toward Universal Access

Updated July 2021

Authors:

Johns Hopkins Bloomberg School of Public Health

Sachini Bandara, *PhD, Assistant Professor of Mental Health*

Alene Kennedy Hendricks, *PhD, Assistant Professor of Health Policy and Management*

Sydney Merritt, *MSPH, Project Coordinator, Department of Health Policy and Management*

Brendan Saloner, *PhD, Associate Professor of Health Policy and Management*

NYU Grossman School of Medicine

Noa Krawczyk, *PhD, Assistant Professor of Population Health*

NaphCare

Jeffrey Alvarez, *MD, Chief Medical Officer*

Yale University and National Harm Reduction Coalition

Kimberly Sue, *MD, PhD,*

Instructor; Medical Director, National Harm Reduction Coalition

Rhode Island Department of Corrections

Justin Berk, *MD, MPH, MBA, Director, Medical Services*

Viaduct Consulting, LLC

Vikki Wachino MPP, *Principal*

Camden County Department of Corrections

Karen Taylor, *Administrator and Warden*

Endorsing Attendees (listed alphabetically)

This page provides a list of attendees to the “Moving the Field Forward Event” who endorse the principles of this document. Organizational affiliations are provided for attribution purposes.

Deborah Agus, JD

Johns Hopkins Bloomberg School of Public Health/Baltimore Health Leadership Institute

G. Caleb Alexander, MD, MS

Johns Hopkins Bloomberg School of Public Health

Alejandro Alves, MPP

Vital Strategies

Barbara Andraka-Christou, JD, PhD

University of Central Florida

Michael L. Barnett, MD, MS

Harvard T.H. Chan School of Public Health

Atharva Bhagwat

Johns Hopkins University

Alexandra Duncan, DrPH, MPH

The Pew Charitable Trusts

Michael Fingerhood, MD

Johns Hopkins School of Medicine

Peter Friedmann, MD, MPH

University of Massachusetts Medical School-Baystate

Brandon George, BS

Indiana Addiction Issues Coalition

Marianne Gibson, MSc

State of Maryland

Jonathan Giftos, MD

Albert Einstein College of Medicine

Daliah Heller, PhD

Vital Strategies

Benjamin A. Howell, MD, MPH, MHS

Yale School of Medicine, SEICHE Center for Health and Justice

Eric G Hulsey, DrPH

Vital Strategies

Ali Jalali, PhD

Weill Cornell Medical College

Jacqueline Jetter, MSc
Hudson County Department of Housing and Community Reintegration

Rebekah Joab
JD Legal Action Center

Herbert Kaldany, DO
New Jersey Department of Corrections

Utsha G. Khatri, MD, MSHP
National Clinician Scholars Program, University of Pennsylvania

Kathryn McCollister, PhD
University of Miami Miller School of Medicine

Beth McGinty, PhD
Johns Hopkins Bloomberg School of Public Health

Jake Morgan, PhD
Boston University School of Public Health

Sean M. Murphy, PhD
Weill Cornell Medical College

Josiah D. Rich, MD
Brown University

Saba Rouhani, PhD
Johns Hopkins Bloomberg School of Public Health

Julie Rwan, MPH
Vital Strategies

Hridika Shah
Johns Hopkins University

Elizabeth Stone, MS
Johns Hopkins Bloomberg School of Public Health

Carolyn Sufirin, MD, PhD
Johns Hopkins School of Medicine/ Johns Hopkins Bloomberg School of Public Health

Ashish P Thakrar, MD
Johns Hopkins School of Medicine

Noel Vest
PhD Stanford University

Shelly Weizman, JD
O'Neill Institute for National and Global Health Law, Georgetown Law

Michael White, MCJ
Community Medical Services

Sarah White, MSPH
Johns Hopkins Bloomberg School of Public Health

Motivation for the Project

Against the backdrop of an unprecedented drug overdose crisis, the number of jails and prisons offering medications for opioid use disorder (MOUD) have grown substantially in recent years. However, MOUD is still not available in most facilities and, even where available, it may be difficult for many individuals to promptly access treatment. Although jails and prisons are not an ideally therapeutic setting for treatment, they can serve as an important access point to MOUD. Several national authorities have released consensus statements, model legislation, and toolkits to support MOUD in jails and prisons (Box).

This report summarizes a convening led by the Johns Hopkins Bloomberg School of Public Health on April 20th, 2021. The report authors led break-out groups related to each topic. Additional attendees who endorse the document principles are listed on page 2. The current document builds upon these efforts by highlighting five key areas where there are currently significant barriers, but also opportunities for change:

- Methadone and buprenorphine regulation
- Low-threshold treatment
- Collaboration between security and medical staff
- Harm reduction
- Reentry services and Medicaid enrollment

We outline a vision in each area, identify current challenges, and propose potential solutions. In some cases, these solutions can be advanced at the level of individual programs, while other changes will require legislative or regulatory change (e.g., changes to controlled substances regulations).

Select Policy Resources on MOUD in jails and prisons

[Substance Abuse and Mental Health Services Administration. 2019. Use of medication-assisted treatment for opioid use disorder in criminal justice settings.](#)

[Georgetown University Law Center, O'Neill Institute for National and Global Health Law and Legislative Analysis and Public Policy Association \(LAPPA\)2020. Medication-Based Treatment for OUD in Corrections: Model State Legislation.](#)

[National Governors Association and American Correctional Association. 2021. Expanding Access To Medications For Opioid Use Disorder In Corrections And Community Settings.](#)

[Vital Strategies and the National Council's Medication Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit](#)

Cross-Cutting Values

All residents within jails and prisons should have access to all FDA-approved forms of pharmacotherapy for opioid use disorder. The recommendations provided here are informed by consensus of the authors about how to get to this goal and are grounded in several cross-cutting values:

- **Patient-centered care:** The cornerstone of any substance use treatment program – including those in jails and prisons – must be individual patient choice. Individuals should have rights to choose whether to receive treatment, and should be able to engage in shared decision-making with their clinician about how best to realize their goals.
- **Racial equity:** Black, Latinx, and American Indian/Alaska Native/Native Hawaiian people are disproportionately incarcerated, which shapes their access to evidence-based treatment services. In this report, we refer to the combination of discriminatory policies and institutional practices that have led to unfair treatment of minority populations as structural racism. Programs treating opioid use disorder in jails and prisons must develop specific plans to address discrimination and bias that could lead to unequal treatment in carceral settings.
- **Commitment to evidence:** Treating opioid use disorder with MOUD is an evidence-based practice. The evidence about how to scale-up programs and optimally help patients under real world conditions is evolving. The practices described here are informed by existing evidence about what works for opioid use disorder, and further research should guide the implementation of programs in real world settings.
- **Holistic attention to health:** People with opioid use disorder often have health needs other than substance use. Substance use services in correctional settings should holistically address patient health through offering other services, including harm reduction and mental health services, and these services should also be based on the principles of individual choice. Holistic attention to health also recognizes the importance of integrated and continuous care with community providers after release from incarceration.

Disclaimer and Acknowledgement

The authors acknowledge generous funding support for research and activities related to the report from Arnold Ventures and Bloomberg Philanthropies. The views expressed in this document are solely those of the authors, and do not necessarily represent the positions of the funders, or the organizations of the authors. Event attendees have provided their own personal endorsement, and likewise do not necessarily represent the positions of their organizations.

Methadone and Buprenorphine Regulation

The Vision:

Revise existing regulations or clarify regulatory language for jail and prisons to reduce barriers to dispensing methadone and prescribing buprenorphine that are impeding carceral settings' ability to provide these medications. All jails and prisons should be able to offer these medications to people with opioid use disorder (OUD) in their facilities and existing regulations or regulatory interpretation that constrain jail and prison provision of opioid agonists should be amended to make this process easier.

The Problem:

Methadone and buprenorphine are subject to Drug Enforcement Administration (DEA) controlled substances regulations. Methadone for OUD treatment is only accessible through licensed opioid treatment programs (OTP) that federal and state agencies strictly regulate. Patients in methadone programs typically must visit OTPs daily to receive their dose of medication, though the DEA released regulations in June 2021 to permit OTPs to operate mobile methadone programs which could serve jails and prisons. Traditionally, buprenorphine could only be prescribed by clinicians that have participated in additional training and apply to the DEA for a special type of prescriber identification number, referred to as the X-waiver. On April 27th, 2021, the U.S. Department of Health and Human Services announced policy changes that will allow physicians, nurse practitioners, and physician assistants to prescribe buprenorphine up to 30 patients with OUD without additional training requirements, but this still sets limits on how many patients can be prescribed buprenorphine for most clinicians.

Challenges to Overcome:

- Few carceral facilities have successfully obtained licensure to operate as OTPs so that they can dispense methadone for OUD treatment on-site. The few licensed OTPs operating out of jail or prison settings report the process took years, which is too long given the urgency of the overdose crisis. OTPs also impose substantial requirements around providing counseling that may interfere with a “medication-first approach” (i.e., an approach to providing MOUD without pre-conditions). Also, many of the security requirements around medication storage (i.e. alarmed storage with direct notification of local police) do not account for the existing security regime within these facilities.
- For the vast majority of jails and prisons that are not licensed OTPs, partnering with a community OTP to ensure incarcerated individuals receive daily methadone doses may be logistically challenging or financially infeasible depending on whether there is a nearby OTP that is able to provide affordable, onsite methadone dispensing. The new mobile methadone regulations, however, create the potential to expand OTP reach to jails and prisons.
- Jails with high volumes of people cycling through for short, multi-day periods of incarceration may be able to leverage the 72-hour rule (under §1306.07) to prescribe methadone or buprenorphine without an OTP license or X-waiver; however, guidance from the DEA is unclear. Similarly, coordinating take home doses for patients during reentry is a major challenge and requires strong coordination with community providers.
- Caps on the number of patients to which a single clinician can prescribe buprenorphine constrains the number of incarcerated people with OUD that carceral medical staff can treat.

Model Policies and Practices:

- Reduce the logistical barrier of partnering with community OTPs to provide methadone by: changing regulations through the US Substance Abuse and Mental Health Services Administration (SAMHSA) to allow more flexible take home (or more accurately, “take to jail/prison” doses) medication rules for people in carceral facilities and/or leveraging existing pandemic emergency regulations to make the currently more flexible take home arrangements and telehealth regulations permanent and clarifying that these extend to carceral settings. Further, federal agencies should release guidance around acceptable practices around transportation and storage of medications, and the legal responsibilities of the OTP and the carceral facility.
- To augment recent mobile methadone regulations, DEA and SAMHSA should release best practice guidelines on how mobile units can operate in coordination with jails and prisons.
- Allow physicians, nurse practitioners, and physician assistants working in carceral settings to prescribe buprenorphine for OUD to >30 patients without additional training requirements.
- Clarify the 72-hour rule under §1306.07 and whether it extends to carceral facilities (not constrained to hospitals).
- Extend the 72-hour rule to a longer time period for carceral settings (e.g., the length of a weekly stay in jail).
- Have the federal regulatory agencies (SAMHSA and DEA) work with the National Commission on Correctional Health Care to create more flexible requirements for OTPs located in carceral institutions.

Low Threshold Treatment

The Vision:

Low-threshold treatment emphasizes providing medications for opioid use disorder (MOUD) as quickly as possible and without requiring counseling or immediate abstinence to be eligible to receive this treatment. Low threshold programs expand access to more vulnerable individuals and reduce overdose risk by removing barriers to entry and retention in treatment and avoiding punitive practices. Additionally, the low threshold paradigm supports keeping patients in treatment for as long as adequate at a dose that is individualized to the patient's needs. All incarcerated individuals with opioid use disorder (OUD) should be able to start an MOUD of their choice during their confinement as soon as possible and remain on medication for as long as is clinically indicated.

The Problem:

Many carceral programs limit the eligibility for MOUD programs to people who meet stringent criteria, arbitrarily limit the dosage or duration of treatment, impose additional requirements on participants in a medication program such as counseling or mutual aid groups, and terminate treatment for people who engage in ongoing substance use or diversion rather than allowing for some other form of non-punitive remediation. These practices are not in line with evidence-based guidelines.

Challenges to Overcome:

- Carceral facilities have a legitimate interest in restricting participation to individuals who meet screening criteria for OUD, but complex medical assessment may interfere with rapid initiation of treatment.
- Non-medication treatment, including counseling and mutual aid groups, are a deeply ingrained element of addiction treatment in carceral facilities. Allowing people to take medication without counseling participation is sometimes perceived as too “loose” or, wrongly, considered ineffective.
- Buprenorphine is a commonly reported form of smuggled contraband. Although a medication program is likely to reduce demand for illicit buprenorphine, custodial staff are frequently concerned about medication dispensed in the facility getting diverted.
- Uncertainty about when patients are going to be released or transferred to other facilities often delays on demand medication in jails, as medical staff are reluctant to start patients who may need to be subsequently tapered.

Model Policies and Practices:

- Starting patients immediately on bridge medications on their way into the facility, while the staff further assesses the patient's need and likely length of stay. Offering bridge programs as patients leave, including providing them with several days of medication on their way out, and a “warm handoff” to a community provider.
- Educating carceral medical providers about best practices around MOUD provision. Consensus recommendations hold that counseling should not be a requirement of MOUD programs. Despite this, we recognize that there are currently requirements for methadone patients to receive counseling (though some patients may opt for a more minimum counseling program).
- Using non-punitive approaches to address diversion of medication and providing counseling and opportunities for remediation instead of immediately terminating program participation.
- Customizing dosage and duration to patient needs, and allowing patients to receive dosage on par with community programs (e.g., above 16 milligrams/day of buprenorphine where

clinically indicated).

Collaboration Between Security and Medical Staff

The Vision:

Collaboration between security and medical staff who work with medications for opioid use disorder (MOUD) program participants is essential to adhere to safety protocols and support recovery. All staff should receive education and training on the topic of opioid use disorder (OUD) and MOUD with the goal of minimizing the impact of stigma, dispelling tensions between security and medical staff, and improving patient care.

The Problem:

Stigma towards individuals with OUD is one of the key barriers to collaboration and successful implementation of MOUD in the carceral system. Additionally, tensions may exist between security and medical staff due to disparate goals – correctional staff, in part, view their role as ensuring security and safety, including preventing contraband and diversion in the facility, while medical staff dispense MOUD (which has historically been smuggled into facilities) to relieve withdrawal symptoms and facilitate OUD remission.

Challenges to Overcome:

- Staff may not understand OUD and MOUD due to lack of education and misperceptions. For example, security staff are familiar with buprenorphine as commonly smuggled contraband and are concerned that it will be diverted if dispensed in the facility. This view of MOUD may lead to tensions between the security and medical staff.
- Changing the culture of the carceral system is difficult. Non-medication treatment is the norm in most facilities, and security staff is more familiar with keeping buprenorphine out of a facility than with the process of dispensing it.
- Individuals with OUD in the carceral system often encounter stigma due to factors that may include incarceration, substance use, and structural racism.
- The use of medication itself can be stigmatized by staff and residents as not producing “true recovery.”

Model Policies and Practice:

- Educating and training existing staff on the topics of addiction, OUD, and MOUD and ensuring that new staff are educated on these topics from the beginning of their career. Education and training should work to combat stigma associated with these topics and emphasize medication treatment as the standard of care for OUD.
- Peer education from correctional staff at other facilities that have implemented MOUD can help make the case that programs reduce diversion, illicit substance use and behavioral disruptions, improving the safety environment of facilities.
- Finding a champion in leadership who understands OUD and advocates for MOUD and is willing to be persistent in changing the culture of the facility.
- Changing language and vocabulary throughout the facility when discussing substance use, such as using non-stigmatizing, science-based, and person-first terms.
- Reviewing policies that impact individuals with OUD, along with education and training, will work

to reduce stigma and discrimination toward individuals with OUD.

Harm Reduction

The Vision:

Harm reduction is a holistic and humane approach to addressing the health needs of people who use drugs, and includes creating safer conditions for drug use. Harm reduction uses evidence-based strategies to reduce risk of overdose or infection, including access to naloxone and sterile syringes. Harm reduction is important because many people who are incarcerated may not be ready to stop using drugs, but may be open to education and access to supplies to increase their safety. Criminal legal agencies could greatly improve the health of individuals who use drugs by adopting harm reduction principles and practices.

The Problem:

Despite decades of evidence around harm reduction strategies in reducing death and other negative health outcomes, the criminal legal system (CLS) has historically resisted integration of such practices within correctional and community supervision settings. This resistance largely relates to an approach that surveils and punishes substance use, and does not align with an approach that tolerates continued use of drugs and promotes positive engagement around safer drug use. Additionally, individuals who work for the criminal legal system, from law enforcement officers to correctional officers and judges, have little training on evidence-based harm reduction principles or practices.

Challenges to Overcome:

- Stigma against drug use in the CLS has deep roots. This stigma reflects structural racism and social biases that equate drug use with individual moral failings.
- Attitudes around drug use in the CLS have historically centered on abstinence as a primary goal: even existing substance use treatment services in the CLS rarely allow for continued drug use, despite other health benefits of engaging non-abstinent patients in treatment and other health services.
- Many jurisdictions continue to outlaw certain harm reduction strategies such as sterile syringe possession that further criminalize harm reduction efforts. Thus, efforts to integrate harm reduction in the CLS would have to address the entire spectrum of law enforcement, including laws related to drug paraphernalia and the policies and practices of community supervision agencies.

Model Policies and Practices:

- There are few good examples of CLS-harm reduction alliances, so guidelines and pioneering examples are still needed to help move CLS settings to adopt such practices.
- Expand efforts to offer naloxone prior to release from incarceration. Existing programs are often limited in scope and could be expanded to include more training on overdose prevention for individuals incarcerated/on supervision as well as corrections staff.
- Create partnerships between CLS entities and community-based programs and providers that deliver harm reduction services (e.g., naloxone, syringe services programs, fentanyl testing). Individuals entering the community from incarceration or on community supervision could be

referred to these services by CLS staff.

- Increase awareness and stigma reduction around harm reduction approaches and the evidence to support them. This initiative can include expanding training for CLS staff and law enforcement overall.
- Involve peers or other people with lived experience in the process of expanding harm reduction services or linkage to services for individuals in the CLS.
- Learn from successful efforts to expand medications for opioid use disorder in CLS settings, including successfully combating decades-long stigma and resistance to evidence-based treatment and apply these lessons to expansion of harm reduction practices and principles in these settings. Wherever possible, it is important to eliminate abstinence as a requirement of supervision (since drug use can cause individuals to violate the terms of parole and subsequently become re-incarcerated).

Reentry Services and Medicaid Enrollment

The Vision:

At the time of release, incarcerated individuals should already have been screened and enrolled in Medicaid, linked to a managed care organization (when applicable), with a Medicaid card in hand. Individuals receiving medications for opioid use disorder (MOUD) should be released with bridge medication (when applicable) and an appointment with a community-based treatment provider. These providers should be able to engage with patients prior to release and have access to carceral medical records to facilitate continuity of care. Other key reentry services include housing, medical and mental health referrals, enrollment in public benefits, employment assistance, and cell phone and identification card access.

The Problem:

Reentry is a pivotal period for reducing overdose risk, and requires coordination of services between carceral settings, social services, and community health service providers. Prompt Medicaid enrollment is key to facilitating community based MOUD treatment.

Challenges to Overcome:

- The federal “inmate exclusion” policy results in the suspension and termination of Medicaid during incarceration. Implementation of these policies and pre-release enrollment varies widely by state and county.
- Existing technological infrastructure, resources, and staffing often determine jails and prisons’ ability to suspend and enroll individuals into Medicaid at release.
- Challenges differ for jails and prisons. Jails manage unanticipated releases, and limited reentry and medical staff and weak connections to Medicaid offices. Prisons must provide reentry services for individuals released to many different communities.
- Availability of community based MOUD treatment, particularly providers that accept Medicaid or sliding-scale payments, is needed to provide effective reentry services.
- Access to housing, employment, and other essential needs for formerly incarcerated individuals are highly limited.

Model Policies and Practices:

- Medicaid expansion under the provisions of the Affordable Care Act is critically important to expanding access to Medicaid coverage for low-income adults leaving jails and prisons. As of June 2021, 38 states and the District of Columbia have a Medicaid expansion, but 12 states have not yet adopted the expansion. In non-expansion states, only people who meet other narrower eligibility categories (e.g., low-income parents, people with qualifying disabilities) are able to enroll in Medicaid.
- Investments in technology that allows for a two-way data exchange between carceral facilities and Medicaid offices can facilitate prompt Medicaid enrollment. Several states have successful data exchanges between prisons and Medicaid offices. Arizona has a well-functioning statewide initiative to connect county jails to Medicaid offices.
- States should implement streamlined Medicaid documentation requirements and automated data sharing processes to make it easier to complete applications. They should also implement specific outreach and enrollment efforts and resources dedicated to people who are

incarcerated, including using carceral staff to help process applications and peers to help educate people on health coverage and, where applicable, MCO selection.

- State policies, such as those in Ohio, New Mexico, Louisiana, and Arizona, that require MCOs to provide in-reach services prior to release can also facilitate continuity of care.
- Additional investments should be made in specialized reentry providers, such as the Transitions Clinics Network. The use of telemedicine and peer navigators and access to carceral medical records can facilitate continuity of care for people who are reentering.
- Facilities with effective Medicaid enrollment programs should also distribute naloxone immediately after release and can bill Medicaid for these services.
- Anticipated SUPPORT Act guidance offers an opportunity for Medicaid-funded services to be provided 30 days prior to release. However, implementation of this guidance, particularly for jails where release date is often unknown, may be challenging.
- Legislation to eliminate the “inmate exclusion” from Medicaid would remove the need for suspension and termination, and the gaps in coverage that it causes. An important first step in easing the inmate exclusion would be the passage of the Medicaid Reentry Act, which would allow for Medicaid coverage in the 30 days prior to release.
- States should assess whether there is an adequate network of providers to accept people undergoing reentry. For example, programs that are required to report “infractions” to parole/probation do not fit a low threshold paradigm, and may interfere with adequate access to treatment post-release.



JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Bloomberg American
Health Initiative