



ASAM American Society of Addiction Medicine

Public Policy Statement on Treatment of Opioid Use Disorder in Correctional Settings

Purpose

Individuals who are incarcerated are a vulnerable population and withholding evidence-based opioid use disorder (OUD) treatment increases risk for death during detainment and upon release. ASAM recognizes that correctional settings are diverse and that not all resources are universally available. This policy statement describes the standard of care that ASAM believes all detained and incarcerated individuals with OUD should receive. ASAM also advocates for systemic changes to ensure universal access to such care within correctional institutions.

Background

The United States has the highest incarceration rate in the world, as well as the greatest number of people detained in its criminal legal system.¹ Studies have found that nearly two-thirds of incarcerated persons have a history of substance use disorder (SUD), and an additional 20 percent who do not meet criteria for SUD have substance involvement at the time of their crime or were arrested for a drug-related offense.²

Detainment in correctional settings can pose treatment challenges for individuals with OUD: those who are receiving medications for the treatment of OUD prior to incarceration may be forced to discontinue such treatment, and those with untreated OUD are often not offered evidence-based and life-saving treatment upon entering jail³ or prison.⁴ Forced opioid withdrawal – from prescribed agonist medication or illicitly obtained opioids – can cause harm and suffering to the inmate during incarceration and post-release. Deaths from complicated opioid withdrawal as well as relapses and opioid overdoses in correctional settings have been reported.⁵ Upon release, individuals whose OUD treatment has been discontinued are less likely to reenter treatment.⁶ For all inmates with OUD, incarceration without agonist medication treatment increases risk of post-release overdose death through reduced opioid tolerance. Remarkably, nearly five percent of all deaths from illicit opioids occurs among people who were released from jail or prison in the past month.⁷

Providing addiction treatment in correctional settings is challenging. Medicaid is prohibited by law from paying for health care in jails and prisons (*“the inmate exclusion clause”* of the 1965 Social Security Act), and Medicare regulations generally prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered. Commercial health insurance plans also commonly exclude coverage and payment of medical care during incarceration.⁸ As a result, the correctional healthcare system is under-resourced, isolated from mainstream medicine and not subject to standardized accreditation or

quality reporting requirements.⁹ Nonetheless, given that buprenorphine and methadone have been shown to save lives, it is critical that people with OUD have access to these medications.

Jails and prisons face different challenges to providing evidence-based medical care to detainees and inmates with substance use disorder. Jails face uncertainty about the duration of a detainee's stay and whether they will be released to the community or sent to prison, both of which can complicate treatment initiation and planning. Treatment within prisons may be more predictable, but current laws governing the prescription and dispensing of buprenorphine and methadone, as well as concerns about possible diversion, create unique challenges to treating OUD in prisons. Some larger correctional institutions have become licensed opioid treatment programs (OTPs) or contract with clinicians with a waiver to prescribe buprenorphine, but others rely on transporting individuals to off-site clinics or do not provide services beyond withdrawal management with supportive medications. The latter two approaches can increase pressure on staff who must arrange transportation or otherwise deal with inmates who are physically ill due to inadequate treatment of OUD.

Despite these challenges, access to OUD treatment within the correctional system is a critical public health and ethical issue. Research found that more than half of individuals with OUD reported a history of involvement in the criminal legal system,¹⁰ demonstrating the potential impact that initiating treatment within correctional settings can have on the overall disease burden.¹¹ Moreover, federal courts have repeatedly found that inflexible policies that deny access to medically necessary treatment, including methadone and buprenorphine, to persons with OUD during incarceration violate the Americans with Disabilities Act (ADA) and the Eighth Amendment's prohibition of cruel and unusual punishment.^{12,13}

Providing evidence-based treatment for OUD, including offering all FDA-approved medications, either on-site or through transport, benefits incarcerated individuals, corrections professionals, and the community at-large. Research has shown that starting or continuing methadone or buprenorphine while incarcerated improves treatment entry and retention upon release and reduces post-release mortality.^{14,15,16} Continuation of methadone treatment during incarceration has been shown to reduce disciplinary tickets.¹⁷ For individuals who do not want to be treated with methadone or buprenorphine, extended-release injectable naltrexone is an alternative option for relapse prevention during detainment and after release. Compared to treatment as usual (i.e., no medication), treatment with extended-release injectable naltrexone is associated with a lower relapse rate among adults recently released from incarceration or under criminal legal supervision.¹⁸

Improving access to treatment for incarcerated persons who have OUD may improve the opportunity for persons with addiction that does not involve opioid use to receive evidence-based addiction treatment while incarcerated.

Recommendations:

The American Society of Addiction Medicine recommends:

1. Access to evidence-based OUD treatment including all FDA-approved medications, either on site or through transport, is the standard of care for all detained or incarcerated persons. In many areas of the country, this treatment remains inaccessible, so expansion in jails and prisons should happen in concert with other expansion efforts at the community level.

Achieving this vision will require a major cultural and practical shift for correctional systems, and should include the establishment of:

- a. New/expanded partnerships with community treatment providers to continue medication treatment for pre-trial detainees and sentenced persons, confirm prescribing and dosing on prison entry, and initiate treatment through community providers when treatment is not directly available within the facility.
 - b. New policies and procedures for connecting detained and incarcerated persons to treatment services either through provision within the facility, mobile treatment units, transition clinics,¹⁹ telehealth or community transport,
 - c. Suitable space for medication storage, administration and monitoring,
 - d. Extensive training of health care and corrections staff, and
 - e. Education of patients with OUD who are incarcerated regarding OUD, medications for OUD treatment, and recovery.
2. All detainees at jails and prisons should be screened for OUD and other substance use disorders upon entry using a validated assessment tool.¹ Those who were being treated with medication for OUD prior to incarceration should be allowed to continue on their same medication at a generally equivalent dose. When that is not feasible, then the patient should be able to continue a medication in the same class. Incoming detainees with previously untreated OUD and/or who experience opioid withdrawal upon incarceration should be assessed and offered medication and psychosocial treatment as clinically indicated.
 3. All correctional facilities should have naloxone readily available throughout the facility to reverse opioid overdoses. Correctional and healthcare staff should be trained to recognize the signs and symptoms of an opioid overdose and to use naloxone to reverse an overdose. Correctional facilities should provide overdose recognition and response training to all interested detainees and distribute naloxone at time of release.
 4. Counseling services, case management and peer support services should be offered to detained and incarcerated persons with OUD as part of a comprehensive treatment plan. Medications should be offered even if the full complement of services cannot be or the incarcerated person chooses not to engage in other services.
 5. Telemedicine/telehealth should be expanded as a means of increasing access to medication management and non-pharmacological, behavioral health services in correctional facilities that cannot offer such treatments on-site.
 6. The “inmate exclusion” that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons should be repealed and the inmate limitation on benefits under Medicare should be removed. Continuation of healthcare coverage during detention and incarceration will facilitate treatment continuity and retention.
 7. The federal government should make legislative or regulatory changes to create a special registration exemption for jails, prisons, and their authorized personnel to prescribe and otherwise dispense controlled medications for initiation, maintenance or withdrawal

¹ Toxicology alone is not a validated assessment tool.

management of OUD that is significantly less burdensome than the applicable registration requirements in the Controlled Substances Act and related regulations. The special registration should not limit the number of detained or incarcerated persons who can be treated with such medications by a qualified practitioner.

8. Community-correctional partnerships, including low-threshold transitional clinics that emphasize engagement and harm reduction to bridge the gap between incarceration and community treatment, should be supported and financed to coordinate care upon entry and release to avoid dangerous interruptions in treatment.
9. Correctional settings should collect data on numbers of people screened for OUD and SUD, numbers formally assessed and treated, including types of medications for opioid use disorder, and use these data for continuous quality improvement of services. Aggregated, de-identified data should be shared with public health officials to monitor trends in prevalence and treatment of substance use disorders among incarcerated individuals to inform policy changes that can improve individual and public health.
10. Correctional facilities should be viewed as part of the community treatment continuum and included in partnerships and coalitions that are addressing OUD. Public funding, training and technical assistance supporting medication treatment access should be inclusive of jails and prisons.

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¹ World Prison Brief. <https://www.prisonstudies.org/highest-to-lowest/prison-population-total>

² CASAColumbia. Behind Bars II: Substance Abuse and America's Prison Population. February 2010. Available at: <https://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america%E2%80%99s-prison-population>

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