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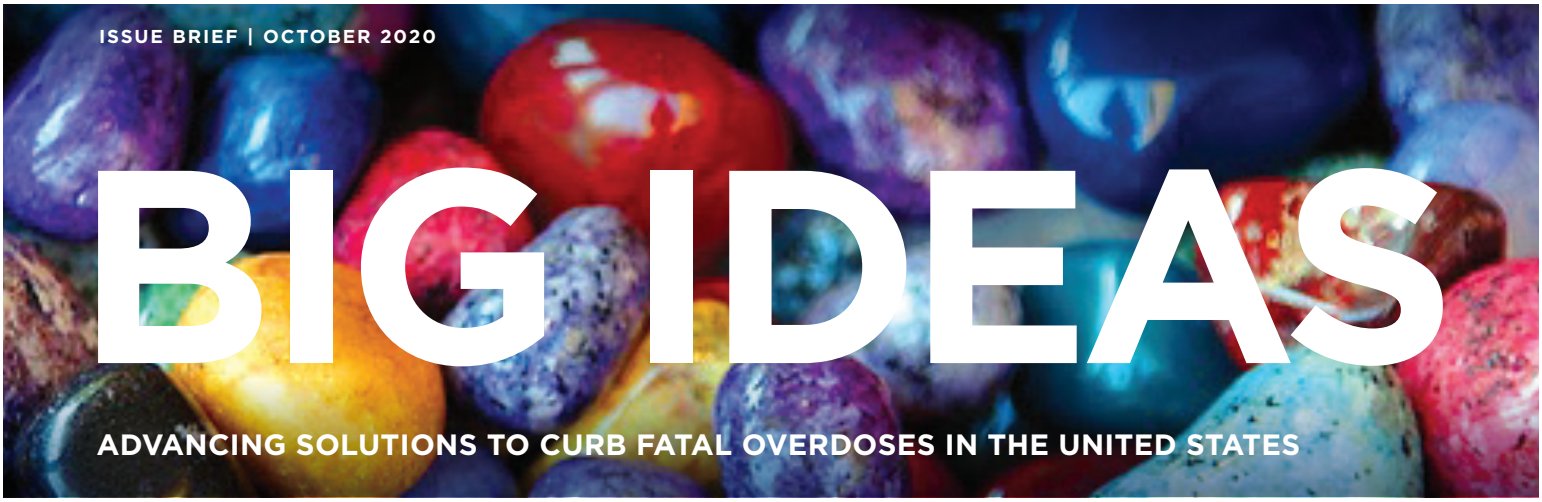

BIG IDEAS

ADVANCING SOLUTIONS TO CURB FATAL OVERDOSES IN THE UNITED STATES

CORRECTIONAL INSTITUTIONS AS AN INTERVENTION POINT FOR OPIOID USE DISORDER TREATMENT

THE ADDICTION AND PUBLIC POLICY INITIATIVE at Georgetown University Law Center's O'Neill Institute hosted a four-part **Applying the Evidence Summer Series in Summer 2020**. The events brought together criminal justice professionals, health care providers, scientists, researchers, and advocates to discuss medication based treatment for opioid use disorder in correctional facilities.

DURING THE FIRST TWO WEEKS AFTER RELEASE from a correctional institution, individuals have a risk of death almost 13 times greater than that of the general public.[1] During this vulnerable period, overdose is the leading cause of death.[2] Ensuring access to evidence-based treatment for opioid use disorder during incarceration and connecting to care immediately upon reentry are critical to stem the tide of overdose death in the United States.

The consensus among the medical profession is that the standard of care for opioid use disorder is treatment with FDA-approved medications (methadone, buprenorphine, and naltrexone).[3] However, in 2018, less than 1% of jails and prisons in the U.S. offered **medication for opioid use disorder** (MOUD).[4] Failing to provide MOUD in correctional facilities has fatal consequences.

Providing MOUD in corrections has been empirically shown to:

- Reduce the risk of fatal overdose upon release[5]
- Reduce the risk of suicide in correctional facilities[6]
- Reduce behaviors that increase the risk of HIV/HCV transmission (i.e. injection drug use) upon release[7]
- Increase treatment retention and reduce illicit opioid use upon release[8]
- Reduce criminal activity upon release[9]

PROVIDING MOUD IS MORE COST EFFECTIVE THAN INCARCERATING PEOPLE WITH OPIOID USE DISORDER[10]

$4,700 PER PATIENT

The average cost for 1 full year of methadone treatment in an opioid treatment program is approximately $4,700 per patient.

$24,000 PER PRISONER

The average cost for 1 full year of imprisonment costs approximately $24,000 per person.

"AND FOR THOSE OF YOU WHO THINK THAT YOUR REGION SOMEHOW WON'T BE FORCED TO DO THIS BY THE COURTS, I DON'T KNOW HOW ANYBODY IS GETTING AWAY WITH NOT DOING IT. BECAUSE EVERY SINGLE COURT CASE THAT HAS BEEN BROUGHT AT THE DISTRICT LEVEL, STATE LEVEL, FEDERAL LEVEL HAS BEEN DECIDED, AGAIN, IN FAVOR OF THE PLAINTIFF OR THE PATIENT WHO'S SAYING, 'I AM SICK, I AM SUFFERING.'"

DR. RUTH POTEE

MD, MEDICAL DIRECTOR, FRANKLIN COUNTY HOUSE OF CORRECTIONS

BEYOND INCARCERATION

This resource is intended to provide policy-makers and criminal justice stakeholders with the information they need to address the immediate healthcare needs of incarcerated individuals with opioid use disorder. However, criminal justice stakeholders and policymakers should concurrently establish pre-arrest diversion programs to shift reliance away from corrections and onto community-based programs. To accomplish this, communities must expand local treatment programs to accommodate participants that would otherwise be treated in corrections. Further, policymakers should implement laws and programs to address the upstream social determinants of opioid use disorder by expanding affordable housing, supporting family centered treatment, establishing equitable education and vocational opportunities, and re-imagining healthcare systems that are centered on patients, their families, and their communities.

STRATEGIES TO ENSURE THE SUCCESS OF MOUD IN CORRECTIONS

- Provide peer support to improve outcomes, trust, and medication adherence.
- Partner with judges, prosecutors, court appointed attorneys, probation officers, and community corrections to support participants receiving MOUD.
- Encourage staff buy-in and listen to their concerns, seek input, share overdose and mortality data, and educate them about the neurobiology of addiction. (Resources: Dr. Corey Waller's **Addiction Neuroscience 101** and Dr. Ruth Potee's **The Physiology of Addiction**).
- Attach data collection requirements to the funding contract with third-party healthcare providers.
- Begin with a pilot program. This reduces the need to transfer participants to different facilities, posing a challenge for data collection.
- Establish dedicated housing units for participants to maximize staffing, decrease diversion, and support a therapeutic environment.
- Partner with community-based organizations to facilitate continuation of treatment upon release.

"WHAT IS THE BEST MEDICATION TO USE? ACTUALLY, IT IS THE ONE THE PATIENT IS WILLING TO TAKE. PROGRAMS SHOULD HAVE AVAILABILITY OF ALL THREE."

DR. MARC F. STERN
MD, MPH, UNIVERSITY OF WASHINGTON SCHOOL OF PUBLIC HEALTH

BUILDING SUPPORT FOR MOUD

COLLECT OUTCOME DATA:

"Folks who are making decisions about budget and policies, they've got stories, but if you combine that with data, then that's effective in advocating for resources, particularly for populations that are highly stigmatized, like those who are incarcerated and those who have been diagnosed with opioid use disorder." — **Dr. Amanda Latimore**, *Adjunct Assistant Professor*, Johns Hopkins University AIR, *Director*, Center for Addiction Research and Effective Solutions

BUILD RELATIONSHIPS WITH JUDGES, SHERIFFS, AND OTHER COMMUNITY STAKEHOLDERS:

Brandon George, an advocate with lived experience in Indiana, emphasized the personal connection and trust he had built with a local sheriff. This relationship helped change the sheriff's mind about MOUD. Brandon said it marked, "the turning point specifically for [that county]." **— Brandon George**, *Director*, Indiana Addiction Issues Coalition

USE PERSONAL NARRATIVES:

"When you have one person who's, let's say, been in and out of this revolving door of the jail for the last two, three, four years, you implement your program and you don't see them again for a year and they have a job and they haven't come back, if they're willing, bring them to the County Commissioner Meeting and have them tell their story. It can be a really powerful way of getting additional funding and showing how the work that you've been doing does pay back not only to the jail, but to the community." **— Dr. Marc F. Stern**, MD, MPH, University of Washington School of Public Health

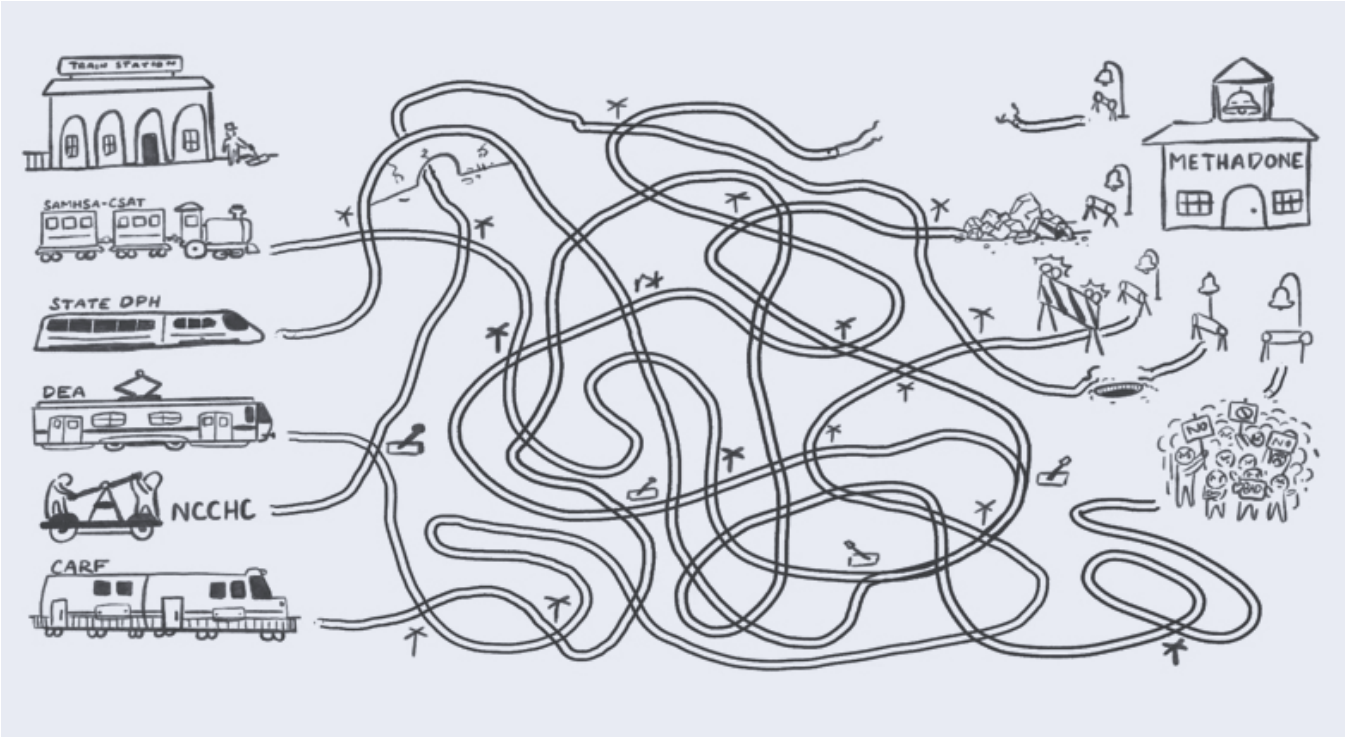

FIGURE 1. An illustration from Dr. Ruth Potee depicting the difficulty of obtaining a methadone license in a correctional facility.

FEDERAL LEGISLATIVE/ REGULATORY PROPOSALS

- The Medicaid Reentry **Act, H.R. 4005**, would allow Medicaid payments for incarcerated individuals 30 days prior to release.
- The Humane Correctional Healthcare **Act, H.R. 4141**, would remove the Medicaid Inmate Exclusion and allow for Medicaid reimbursement during incarceration.
- The Mainstreaming Addiction Treatment **Act, H.R. 2482**, would eliminate the waiver requirement for prescribing buprenorphine.
- Federal regulations on methadone and buprenorphine prescribing and telemedicine have been temporarily revised to facilitate treatment during the COVID-19 pandemic. Stakeholders have called for making several of these revisions permanent, including easing restrictions on "take home" methadone and telehealth provisions to expand access.
- Revisions to the mobile methadone van regulation are **currently pending**. Pending revisions to mobile methadone van regulations would potentially expand methadone availability in underserved rural areas and ease access to methadone treatment for correctional facilities.

"I'VE HAD THREE KIDS, I RAN MARATHONS, I WENT TO MEDICAL SCHOOL. ONE OF THE HARDEST THINGS I'VE EVER DONE IN MY LIFE IS TO GET A METHADONE LICENSE [FOR THE JAIL]."

DR. RUTH POTEE

MD, MEDICAL DIRECTOR, FRANKLIN COUNTY HOUSE OF CORRECTIONS

ADDITIONAL RESOURCES

- The National Council and Vital Strategies toolkit: **Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit**
- The Rhode Island Department of Correction: **Video series on Medication for Opioid Use Disorder**
- The Opioid Resource Network conference: **Medication for Opioid Use Disorder in Correctional Settings (January 2020)**
- SAMHSA resource: **Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings**

SPOTLIGHT ON EATON COUNTY, MICHIGAN: THE WARM HAND OFF

- Staff set up an OUD counseling appointment within 7-10 days of an individual's release, and supply enough medication to the participant for that time period.
- Michigan Works! guarantees employment to anyone who is unemployed and wants a job.
- Staff provide up to 90 days of free transportation vouchers.
- The county has an agreement to provide unhoused individuals with housing for at least 90 days, and up to 9 months.
- Each participant leaves with active health insurance.
- Staff provide a "release backpack" that includes two weeks of hygiene supplies and two doses of naloxone. In the winter, the backpack also contains warm socks, hats, mittens, and gloves.
- 50% of the budget comes in the form of cost savings to the county as a result of early release due to successful engagement in the program.

- The American Correctional Association and American Society of Addiction Medicine: **Joint Policy Statement on Opioid Use Disorder Treatment in Justice System**
- The National Sheriffs' Association, National Commission on Correctional Health Care and National Institute of Corrections: **Jail-Based Medication Assisted Treatment**

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ENDNOTES

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