



# The Provision of Medications for Opioid Use Disorder in Correctional Settings in the Time of COVID-19: Opportunities and Solutions

By Lauren Brinkley-Rubinstein and Nickolas D. Zaller

## BACKGROUND

Correctional settings can be vectors of infectious disease due to overcrowding, unsanitary living conditions, and inadequate space for social distancing. COVID-19 outbreaks were first identified in the New York City and Cook County jails, with infection rates far exceeding community rates. Each day, in other parts of the country, new cases are being identified in other correctional facilities.

People who are incarcerated are at increased risk of experiencing severe COVID-19 symptoms because of the high prevalence of other underlying illnesses such as cardiovascular, respiratory and infectious disease in this population. In response, correctional systems are implementing changes to mitigate the spread of COVID-19, including reducing admissions, expediting releases, and seeking to control spread within jails and prisons. While these initiatives have engaged staff in stemming viral transmission, they may impinge on other activities, including programs that provide medications for opioid use disorder (MOUD).

## Leveraging Telemedicine

During the pandemic, telemedicine should be used to the greatest extent possible. Recent federal guidance allows for the expanded use of telemedicine for prescribing controlled substances, including buprenorphine. On January 21, 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) [lifted the requirement](#) mandating an in-person physical evaluation before initiating buprenorphine treatment. Therefore, individuals in jails or prisons may be allowed to access buprenorphine via telemedicine and/or can continue treatment via telemedicine after release. Importantly, to facilitate greater use of telemedicine, the Department of Health and Human Services has [temporarily waived sanctions](#) and HIPAA Privacy Rule penalties associated with using telemedicine platforms such as FaceTime or Skype.

## TAKEAWAYS

Correctional facilities should strive to continue MOUD programs during the pandemic, but may need to modify practices to accommodate staff shortages and reduce the risk of coronavirus transmission.

These three case examples illustrate different ways to expand access to care and reduce the risk of serious illness from COVID-19 before, during, and after incarceration.

One of the key challenges for incarcerated individuals taking MOUD is connecting to services upon release from criminal justice settings.

## Best Practices for Delivering MOUD in Correctional Settings During the COVID-19 Pandemic

Correctional facilities should strive to continue MOUD programs during the pandemic, but may need to modify practices to accommodate staff shortages and reduce the risk of coronavirus transmission.

### During Incarceration



Continue to screen for OUD at intake but consider shortening the process. Many facilities use a validated screening tool but administering those may create undue burden during this time. An alternative approach could include **asking people two questions**:

- 1) *Do you regularly take any opioids?*
- 2) *Do you currently have a prescription for any MOUD?*



Deliver medications to inmates in cells when possible and **practice social distancing** in the medication line, while ensuring medical staff dispensing MOUD have appropriate personal protective equipment (PPE).

Leverage telemedicine platforms as needed. If telemedicine equipment is not available, consider establishing relationships with **community-based treatment providers** who can provide MOUD services remotely in concert with other health care services.



Offer virtual peer **support and recovery services** for substance use disorder and OUD, as well as online educational programming.

### For Those Nearing Release



Consider providing a prescription and/or take-home doses of MOUD upon release. Also consider using **injectable formulations of MOUD to reduce the amount of medication needed upon release**. This may require initiating treatment with injectable MOUD formulations before release.



Offer referrals or warm handoffs to MOUD services in the community. **Schedule the first appointment for MOUD** as soon after the release date as possible and make sure to provide access to naloxone and other harm reduction resources.

Take note of new federal policy guidance relevant to MOUD provision in the community to inform **discharge planning** efforts.



Leverage **increased housing support** that may be available. For example, in North Carolina, some COVID-19 response funds have been used to pay for hotel rooms for people being released from correctional facilities who do not have stable housing.

While the new guidance around physical evaluations does not apply to people being treated with methadone, current methadone patients on stable doses can be maintained via telemedicine as per the new SAMHSA guidelines.

Additionally, in March 2020, SAMHSA issued [updated recommendations](#) around take-home medications stipulating that all stable patients can receive 28 days of take-home medications for OUD. And while the recommendations are intended for opioid treatment programs, many correctional facilities providing MOUD have become certified as opioid treatment programs. Furthermore, even if correctional facilities are not certified as such programs but are providing buprenorphine to treat OUD, they should provide adequate medication (at least a 14-day supply) to individuals upon release. This is especially important given the high risk for overdose during the first few weeks after release.

In addition to provision of medication management via telemedicine, psychosocial counseling and peer support can be delivered remotely. While American Society of Addiction Medicine [guidance](#) recommends waiving requirements for counseling associated with MOUD, many patients receive significant benefit from ongoing counseling support. As such, online support groups are being encouraged to allow for social distancing. Virtual support groups may be appropriate in some correctional settings in lieu of traditional substance use disorder (SUD) treatment groups provided sufficient space is available for social distancing. This may mean restricting group sizes. Virtual peer support can also be an important component of re-entry, providing individuals a means of connecting or reconnecting to treatment and recovery support services after release.

### **RHODE ISLAND DEPARTMENT OF CORRECTIONS: ENSURING CONTINUATION OF MOUD DURING INCARCERATION**

The Rhode Island Department of Corrections has modified policies to prevent COVID-19 transmission in its facilities while still ensuring the continuation of MOUD.

MOUD providers are still allowed to enter the facilities. However, when facilities are in lockdown, medications are administered cell-side, rather than in the medical units. When facilities are not on lockdown, people come to the medical units to receive MOUD but only from four cells at a time. People from each cohort always travel to the medical unit together, making it easier to do contact tracing if the facility has a COVID-19 case. In addition, people stand at least six feet apart while waiting to receive medication. Nursing staff wear full PPE when distributing MOUD. Mouth checks during MOUD provision are still completed, but the procedure has been modified: the officers stand behind a plexiglass shield and wear masks at all times. Random urine testing is on hold indefinitely.

The Department of Corrections has created and distributed educational packets to cover material that would otherwise be covered during in-person, group MOUD sessions.

There is an effort to transition more people from Suboxone film to extended-release injections to reduce the risk of viral exposure. This requires gauging people's interest in switching and assigning nursing staff to follow up. A discharge planning questionnaire has been developed to help identify needs related to MOUD in the community.

## KENTUCKY: ENSURING ACCESS TO MOUD UPON RE-ENTRY

Collaborative efforts between Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities, its Department of Corrections (DOC), and its Office of Drug Control Policy have grown significantly in part through funding from the federal government's State Targeted Response to the Opioid Crisis and State Opioid Response grants. These grants, awarded by SAMHSA, offer funding for states to expand MOUD in state prisons and to coordinate their efforts with re-entry service providers.

During the COVID-19 pandemic, Kentucky has rapidly expanded its efforts to release people with naloxone; the protocol is now in place in 72 jails and 13 prisons across the state. In addition to the partner organizations referenced above, this work has involved the state and local public health departments, the Kentucky Pharmacists Association, the Kentucky Income Reinvestment Program, and community mental health centers.

During the pandemic, the DOC has also been sharing pending release orders with the Department for Behavioral Health, Developmental and Intellectual Disabilities and the Department of Medicaid Services. The Kentucky Department of Medicaid Services has also expanded its Presumptive Eligibility program to ensure individuals leaving correctional facilities have access to Medicaid services through June 30, 2020, while their longer-term eligibility for the program is determined.

Kentucky is still working through challenges, including delays in activating health care and social service benefits after release, limited capacity for community supervision for people who have their sentences commuted, and inadequate staffing to support broader implementation. Despite these challenges, Kentucky provides an example of how state agencies can quickly come together to protect public health and save the lives of criminal justice-involved people with OUD.

## Ensuring Access to Re-Entry Services

One of the key challenges for incarcerated individuals taking MOUD is connecting to services upon release from criminal justice settings. As noted by the current director of the National Institute on Drug Abuse, Nora Volkow, M.D., people with SUD may be at **risk** of becoming seriously ill from COVID-19 because of factors beyond their substance use such as housing instability, lack of social support, and reduced access to health care (e.g., substance use disorder treatment, recovery support, psychiatric care, and other medical care to treat chronic health conditions).

These risks are compounded by the stigma associated both with SUD and criminal justice involvement. As health care providers in some regions have struggled to provide care to the waves of COVID-19 patients, the potential necessity of rationing care has been debated. It is imperative that decisions regarding care not be influenced by explicit or implicit biases against individuals who have a history of SUD and/or criminal justice involvement.

## Ensuring Readiness for the Next Pandemic

Correctional agencies and community-based organizations must work together to ensure that best practices for MOUD are followed, to the extent possible, even in times of crisis. Many of the practices described here can be implemented as part of routine treatment in criminal justice settings. At a minimum, this should include:

- Expanded use of telemedicine for health care services, especially behavioral health, to minimize disruptions to treatment for individuals receiving MOUD;
- Protocols for alternative forms of administration of MOUD if populations need to be cohorted and/or quarantined; and
- Specific protocols to facilitate linkages to MOUD upon re-entry that can be rapidly implemented during times of crisis. These protocols also need to consider social support services, especially housing, for those being released.

In addition, correctional administrators must partner with public health practitioners to educate policymakers and the general public about the impacts of overcrowding in prisons and jails, especially during a pandemic. More broadly implementing diversion programs for individuals with OUD would reduce the number of incarcerated individuals and could avert the alarming coronavirus outbreaks we have seen in correctional facilities during the pandemic. People with SUD, including OUD, are disproportionately represented in correctional facilities and will benefit the most from such policies.

### **REDUCING DRUG-RELATED ARRESTS IN CHICAGO**

Chicago's Cook County Jail is one of the largest in the nation, with a daily census between 5,500 and 6,200 individuals over the past few years. During the pandemic, the jail has reduced its population by 25 percent and now has the fewest number of individuals detained since the early 1980s.

Two factors have enabled this reduction. The first is collaboration across the offices of the Cook County Sheriff, the Chief Judge of the Circuit Court, the State's Attorney, and the Public Defender to reconsider the bond originally set for pre-trial detainees. As a result, hundreds of detainees at high risk of complications from COVID-19 or low risk for recidivism have been released on their own recognizance or onto electronic monitoring.

The second factor is the reduced flow of pre-trial detainees entering the jail. Less crime is being reported and fewer arrests are being made. In addition, Cook County State's Attorney Kim Foxx announced that her office will not prosecute low-level, non-violent drug offenses during the pandemic. According to data compiled by the Loyola University Center for Criminal Justice Research Policy and Practice, arrests for non-marijuana drug law violations in Chicago have declined nearly 75 percent during Illinois' stay-at-home order, compared to the average during the same period over the past three years.

While the number of individuals incarcerated in the Cook County jail with an SUD is certainly much lower now than in recent history, it may mean some people are not finding their way to treatment because arrests for drug offenses are often entries into treatment. Therefore, efforts to reduce jail populations and prevent widespread outbreaks must be complemented by efforts to provide linkages to community-based treatment services.

Law enforcement personnel can facilitate access to community-based addiction treatment. A recent [report](#) by the group Law Enforcement Leaders to Reduce Crime and Incarceration advocates for expanded resources to fund behavioral health diversion programs for individuals with SUD. Such diversion programs include the Law Enforcement Assisted Diversion program, which began in Seattle and has since expanded to sites across the country, and Philadelphia's Police Assisted Diversion program. Such programs are even more essential during the current crisis to ensure individuals with SUD who are vulnerable to severe complications from COVID-19 are linked to community-based treatment and health care services.

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Zaller has more than a decade of experience working with substance-using and criminal justice-involved populations in both domestic and international settings. He has focused his research on understanding risk for HIV acquisition and transmission among substance-using and criminal justice-involved populations, as well as access to HIV and substance use treatment after release from incarceration. His research seeks to inform evidence-based policy with respect to ameliorating the adverse consequences associated with substance use, which include incarceration and excess morbidity and mortality.



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