PUBLIC CORRECTIONAL POLICY ON THE TREATMENT OF OPIOID USE DISORDERS FOR JUSTICE INVOLVED INDIVIDUALS

2018-2

Introduction:

Seventeen to nineteen percent of individuals in America’s jail and state prison systems have regularly used heroin or opioids prior to incarceration.¹ While release from jail and prison is associated with a dramatic increase in death from opioid overdose among those with untreated Opioid Use Disorder (OUD), there are considerable data to show that treatment with opioid agonists and partial agonists reduces deaths and improves outcomes for those with opioid use disorders.ⅱ,ⅲ Preliminary data suggest that treatment with an opioid antagonist also reduces overdose.ⅳ As a result, the 2017 bipartisan Presidential Commission on “Combating Drug Addiction and the Opioid Crisis” has recommended increased usage of medications for addiction treatment (MAT) in correctional settings.ⅴ

Policy Statement:

The American Correctional Association (ACA) supports the use of evidence-based practices for the treatment of opioid use disorders, reference as Medication for Opioid Use Disorder (MOUD). ACA has developed recommendations specific to the needs of correctional policy makers and healthcare professionals. These recommendations will enable correctional administrators and others, such as community corrections, to provide evidence-based care to those in their custody or under their supervision that have opioid use disorders.

ASAM recently published a document entitled The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Useⅵ that includes treatment recommendations specifically for individuals in the justice system. Pharmacotherapy,
behavioral health treatment, and support services should be considered for all individuals with OUD that are involved in the justice system.

ACA recommends the following for correctional systems and programs:

A. Screening/Prevention

1. Most deaths from overdose occur during the first few days following intake to the correctional facility. Screen all incoming detainees at jails and prisons using screening tools with psychometric reliability and validity that provide useful clinical data to guide the long-term treatment of those with OUD and with co-occurring OUD and mental disorders. The opioid antagonist (naloxone) should be available within the facility and personnel should be trained on its use to reverse overdose.

2. Pre-trial detainees screened upon entry that are found to be participating in an MOUD program to treat OUD and who are taking an opioid agonist, partial agonist, or antagonist should be continued on that medication, or a medication with similar properties. There are effective models for continuing treatment with each of these medications in the justice system.

3. Pre-trial detainees and newly admitted individuals with active substance use disorders who enter with or develop signs and symptoms of withdrawal should be monitored appropriately and should be provided evidence-based medically managed withdrawal (“detox”) during the period of withdrawal. Validated withdrawal scales help gauge treatment. Several medications have been shown to improve withdrawal symptoms. Withdrawal management in this setting may be utilized as a pathway to initiate MOUD treatment.

B. Treatment

1. All individuals who arrive into the correctional system who are undergoing opioid use disorder treatment should be evaluated for consideration to continue treatment within the jail or prison system. Individuals who enter the system and are currently on medication for opioid use disorder (MOUD) and/or psychosocial treatment should be maintained on that, or a similar treatment protocol.

2. Treatment refers to a broad range of primary and supportive services including medications and psychosocial and behavioral therapy. The standard of care for opioid use disorder includes both pharmacotherapy and psychosocial and behavioral treatment.

3. The standard of care for pregnant women with OUD is MOUD and psychosocial treatment and should therefore be offered/continued for all pregnant detainees and incarcerated individuals.
4. All individuals with suspected OUD should be screened for mental health disorders, especially trauma-related disorders, and offered evidence-based treatment for both disorders.

5. Ideally, three to six months prior to reentry or release, all individuals with a history of OUD should be re-assessed by a trained and licensed clinician to determine whether MOUD is medically appropriate for that individual. If clinically appropriate and the individual chooses to receive opioid use disorder treatment, evidence-based options should be offered to the individual.

6. The decisions to initiate MOUD and the type of MOUD treatment should be made jointly between the provider and individual patient who has been well informed by the trained and licensed clinician as to appropriateness of the therapy, as well as risks, benefits, and alternatives to this medical therapy. MOUD should not be mandated as a condition of release. In choosing among treatment options, the individual patient and provider should consider issues such as community clinic or provider location/accessibility to the individual, insurance access or type and medical/clinical status of the individual. Shared decision-making tools may be utilized to facilitate this communication and decision-making.

7. Treatment initiation for those individuals who choose treatment for opioid use disorder (MOUD) should begin at least 30-90 days or more prior to release, when possible.

C. Reentry and Community Supervision Considerations

1. All individuals returning to the community who have an OUD should receive education and training regarding unintentional overdose and death. An opioid antagonist (naloxone) overdose kit or prescription and financial means (such as insurance/Medicaid) for obtaining the kit should be given to the individual, along with education regarding its use.

2. When possible, an opioid antagonist (naloxone) and overdose training should include the individual’s support system in order to provide knowledge about how to respond to an overdose to those who may be in the individual’s presence if an overdose does occur.

3. Immediate appointment to an appropriate clinic or other facility for ongoing treatment for individuals returning to the community with substance use is critical in the treatment of opioid use disorder. As such, ideally the justice involved population’s reentry needs should be addressed at least 1 to 2 months prior to release in order to avoid interruption of treatment.
4. Reentry planning and community supervision should include a collaborative relationship between clinical and parole and/or probation staff including sharing of accurate information regarding MOUD.

5. Parole and probation staff should ensure that residence in a community-based halfway house or similar residential facility does not interfere with an individual’s treatment of OUD with MOUD.

D. Education

1. Scientifically accurate, culturally competent, and non-judgmental training and education regarding the nature of OUD and its treatment should be provided to all justice system personnel including custody officers, counselors, medical personnel, psychologists, community supervision personnel, community residential staff, agency heads and leadership teams.

2. This training should include education about the role of stigma involving substance use disorders and the subtle but very real impact that stigma has on those suffering from substance use disorders and those treating them.

This Joint Public Correctional Policy was unanimously ratified by the American Correctional Association Delegate Assembly at the 2018 Winter Conference in Orlando, FL, on January 9, 2018. It was last reviewed and reaffirmed at the 2020 Winter Conference in San Diego, CA on January 11, 2020.

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vi ASAM. National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (ASAM, 2015).