

ACCP Position Paper on Treating People with Opioid Use Disorder in Correctional Facilities

Introduction.

The opioid epidemic has had a devastating effect on all aspects of our society. This has been especially true in jails and prisons. People incarcerated in jails and prisons have an incidence of Opioid Use Disorder (OUD) much higher than the general population. The vast majority of incarcerated patients with OUD experience a relapse after release. Incarcerated patients with OUD who are newly released to the community have a devastatingly high incidence of death due to overdose. It is well established that treatment with medications for Opioid Use Disorder (MOUD) is highly effective at lowering the incidence of opioid abuse and decreasing overdose deaths. Despite this knowledge, MOUD is not available at many jails and prisons, and even when MOUD is available, it often is not coordinated with outside agencies. Some correctional facilities do not even offer effective treatment for opioid withdrawal. This is regrettable because jails and prisons are a logical place for society to diagnose OUD disorder and offer effective intervention in the form of MOUD.

In April of 2022, The US Department of Justice (DOJ) published guidelines stating that incarcerated patients with OUD are protected under the Americans with Disabilities Act (ADA). Individuals being treated with MOUD have the right to continue MOUD treatment while incarcerated. Treating incarcerated patients appropriately for OUD is therefore not just good medicine but also mandated by the ADA.

Definitions of terms.

Opioid Withdrawal (OW): The medical syndrome that results when a patient habituated or addicted to opioids suddenly stops taking them. Opioid withdrawal typically causes agitation, rhinorrhea, “goose-flesh,” insomnia, sweating, diarrhea, vomiting, and abdominal cramping. These symptoms can be severe and can result in death.

Opioid Use Disorder (OUD): Any use of opioids that causes significant impairment or distress. Patients with OUD typically experience withdrawal symptoms when opioid use is disrupted. The precise diagnostic criteria for OUD are found in The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

Medication for Opioid Use Disorder (MOUD): Using methadone, buprenorphine or naltrexone to treat Opioid Use Disorder, also referred to in the past as “Medication Assisted Treatment” (MAT).

Although alpha 2-noradrenergic agonists (alpha agonists) such as clonidine and lofexidine are effective at reducing signs and symptoms of opioid withdrawal, they do not directly treat OW and do not substitute for MOUD in pregnancy.

It is the position of The American College of Correctional Physicians (ACCP) that:

Opioid Screening.

1. All newly incarcerated people should be screened at booking for
 - a. Current use of opioids prescribed for pain.
 - b. Illicit use of opioids
 - c. Potential opioid withdrawal
 - d. Current use of MOUD
2. Patients identified at screening as positive for any of these four items should be seen by medical staff within 24 hours and by a practitioner within seven days.
3. Patients taking prescribed opioids for pain should have these prescriptions continued until they are seen by a medical practitioner.
4. Patients taking MOUD should have this therapy continued until they are seen by a medical practitioner.
5. Patients identified as being at risk for opioid withdrawal should be monitored daily using a standardized opioid withdrawal assessment tool, such as the Clinical Opioid Withdrawal Score (COWS).

Opioid Withdrawal

1. All patients with signs and symptoms of OW should be treated; no patient should ever be forced to suffer through OW "cold turkey."
2. All patients with OW should be seen by a medical practitioner.
3. MOUD and alpha-agonists are highly effective treatments for opioid withdrawal.
4. MOUD is preferable to alpha-agonists for treating opioid withdrawal. However, if MOUD cannot be used, alpha-agonists are very effective and should be employed to reduce symptoms.
5. MOUD should be used for all pregnant patients in OW. Alpha-agonist therapy is not appropriate for pregnant patients experiencing OW.
6. Other medications may be prescribed for symptomatic relief in OW patients (for example, anti-nausea medications, anti-diarrheal medications) but these medications should always be prescribed in conjunction with MOUD and/or alpha-agonists, not as a stand-alone substitute for MOUD/alpha agonists.
7. All patients being treated for OW should be monitored using a standardized OW assessment tool, such as COWS.

Opioid Use Disorder

1. Correctional facilities should have a close and active partnership with all OUD Treatment programs in their vicinity.
2. Patients who were taking MOUD prior to jail incarceration should have that therapy continued during their incarceration unless there is a well-defined and documented reason for the interruption.
3. All patients being treated for OW or who have a history of illicit opioid use should be offered enrollment into an OUD Treatment Program.

4. Patients being treated with MOUD while incarcerated should transition into community-based MOUD programs at release. This should be arranged in advance as part of their overall treatment plans.
5. Naloxone should be considered for OUD patients being released from custody.
6. All long-term detention facilities (prisons) should offer MOUD for opioid use disorder.
7. Correctional facilities should have active diversion programs for motivated OUD patients to allow them supervised return to the community in order to receive OUD treatment.

Opioid Use for Chronic Pain

1. Patients taking prescribed opioids for chronic pain should be allowed to continue their prescribed opioids until they are seen by a medical practitioner.
2. Correctional practitioners should coordinate treatment for chronic pain during incarceration with the patient's outside pain specialist.

Conclusion

All jails and prisons should have policies and procedures in place for the identification of OUD patients, for the treatment of OW, and for the use of MOUD.