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

Purpose

Individuals who are incarcerated are a vulnerable population at high risk of overdose from opioid use disorder (OUD) during detainment and upon release. Medications for OUD (MOUD), including methadone, buprenorphine, and extended release (ER) naltrexone, are the standard of care for OUD. Methadone and buprenorphine (agonist medications) decrease the risk of overdose death by approximately 50%.[1] Withholding MOUD is contrary to the standard of care in any treatment setting, including correctional settings. Moreover, courts have 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)[2] and the Eighth Amendment's prohibition of cruel and unusual punishment. Denial of MOUD may also violate state statutes or regulations that require MOUD access in correctional settings. ASAM recognizes that correctional settings are diverse and may face significant barriers to providing MOUD access. Therefore, ASAM advocates for systemic changes to ensure universal access to MOUD within correctional institutions.

Background

The United States has the highest incarceration rate in the world, as well as the greatest number of persons detained in its criminal legal system.[3] Studies have found that nearly two-thirds of incarcerated persons have a history of substance use disorder (SUD), and an additional 20% who do not meet criteria for SUD have substance involvement at the time of their crime or were arrested for a drug-related offense.[4]

Refusal to offer evidence-based, lifesaving treatment in correctional settings, or prohibitions on continued use of such treatment, violates bedrock ethical principles of beneficence and non-maleficence. Unfortunately, access to MOUD remains limited in correctional settings throughout the U.S. For example, a nationally representative survey of jails from 2022-2023 found fewer than half of jails offered MOUD to at least some incarcerated individuals (e.g., to pregnant persons), and only 13% offered MOUD to any individual with OUD.[5] Jails in counties with higher social vulnerability, as measured by factors such as unstable housing, unemployment, and poverty, were among those least likely to offer MOUD.[5] Some correctional settings offer only one or two forms of MOUD, but a person-centered approach to OUD treatment involves offering all forms of

MOUD and involving the patient in decision-making. For example, one study found many individuals with OUD did not choose to participate in ER naltrexone treatment due to preferences for agonist treatment.[6] Other research has also found that persons in correctional settings may have strong preferences regarding MOUD type.[7] Additionally, some studies have found troublingly low doses of MOUD when offered in correctional settings,[8] even though insufficient doses inadequately manage cravings and withdrawal symptoms.

Some correctional settings force persons with OUD to endure opioid withdrawal from prescribed agonist medication or illicitly obtained opioids, causing suffering to the person during incarceration and post-release. Deaths from complicated opioid withdrawal as well as return to use and opioid overdoses in correctional settings have been reported.[9] When MOUD is discontinued during incarceration, persons with OUD are less likely to engage in post-release community treatment than if MOUD is continued during incarceration.[10] Furthermore, persons with OUD who have been forced to withdraw from opioids are at high risk of post-release overdose death through reduced opioid tolerance. Remarkably, nearly ten percent of all deaths from illicit opioids occurs among persons who were released from jail or prison in the past month.[11]

In contrast, providing MOUD to persons with OUD in correctional settings results in significant benefits. Starting or continuing agonist MOUD while incarcerated decreases post-release morbidity (e.g., emergency department utilization),[12] decreases future arrests or incarceration,[13] increases treatment engagement and retention upon release[14,15], and reduces post-release mortality,[16] with one study finding agonist treatment in jail was associated with an 80% reduction in overdose death during the first month following re-entry into the community.[17] Retention on ER naltrexone initiated in correctional settings is also associated with reduced mortality and illicit opioid use after reentry into the community.[18,19] Some persons with OUD may additionally benefit from psychosocial treatment as an adjunct to MOUD. However, scholars recommend against mandating psychosocial treatment, as studies in outpatient settings suggest not all persons derive additional benefits from psychosocial treatment when undergoing MOUD treatment.[20]

Prisons and jails can use several different approaches to administering MOUD. They can hire or contract with practitioners who offer buprenorphine and XR naltrexone, including through telehealth.[21,22] Some research recommends that correctional settings explicitly describe provision of MOUD in practitioners' contracts.[23] Correctional institutions can also be licensed as opioid treatment programs (OTPs) to offer methadone. Alternatively, correctional settings can develop a relationship with a community-based OTP and do one of the following to ensure methadone access: pick up methadone from the OTP and dispense it to incarcerated persons at the correctional facility; transport incarcerated individuals to the OTP for medication; or have a mobile medication unit (MMU) from the OTP visit the correctional facility. Furthermore, recent revisions to federal regulations for OTPs allow correctional facilities to adopt the hospital/clinic designation, thereby allowing correctional facilities to stock and dispense methadone without becoming an OTP, so long as patients have an additional diagnosis besides opioid withdrawal syndrome and/or OUD.[24]

Providing MOUD in correctional settings can be challenging for several reasons. The correctional healthcare system is under-resourced, isolated from mainstream medicine and not subject to standardized accreditation or quality reporting requirements. Furthermore, 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 beneficiary who is incarcerated or in custody at the time services are delivered.[25,26]

States can seek 1115 waivers from the Centers for Medicare and Medicaid Services (CMS) to avoid the inmate exclusion clause and to provide insurance coverage 90 days before release.[27] MOUD in correctional settings saves future healthcare costs.[28] Additionally, under the Consolidated Appropriations Act of 2024, states may no longer terminate Medicaid enrollment based on incarceration, beginning January 1, 2026.

Continuity of MOUD treatment begun in prisons or jails can also be challenging.[14] For example, jail staff may face uncertainty about the duration of a detainee's stay and whether the detainee will be released to the community or sent to prison, complicating treatment planning. Transfer of incarcerated persons between jails or prisons can lead to abrupt termination of MOUD, with one study from 2020 finding 80% of detainees had their MOUD discontinued upon transfer from jail to a different correctional facility.[29] Correctional staff could plan for transfers by communicating with receiving facilities to ensure continuous MOUD access.

Reentry into the community may also cause unintended gaps in MOUD treatment. Correctional staff could help arrange appointments with MOUD practitioners in the community for the day after persons reenter the community,[30] or correctional staff could provide a take-home supply of MOUD for persons reentering the community who cannot obtain an immediate appointment in the community with an MODU practitioner.[31] Correctional staff could also help persons secure housing prior to release, thereby helping persons re-entering the community avoid returning to environments that trigger drug use or that prevent treatment engagement.[30] Unfortunately, punitive social policies that limit access to housing and employment for persons with a history of criminal justice involvement serve as strong barriers to sustained treatment and recovery.[30,32] Peer support specialists or community navigators could help assist persons reentering the community in navigating social determinants of health and policy barriers to continued treatment.[33,34] Incarcerated individuals may also benefit from education about OUD and continued MOUD utilization, prior to reentry into the community.[35] Finally, enrollment in insurance prior to reentry, as opposed to after reentry, predicts greater engagement in SUD treatment in the community.[36,37]

Despite these challenges, access to MOUD in correctional settings and upon release is a public health priority. As many as half of persons with OUD have a history of criminal justice system involvement,[38] demonstrating the potential impact that initiating MOUD within correctional settings could have on overall public health. Furthermore, when jails and prisons improve access to MOUD, they may also improve access to SUD treatment more generally through infrastructure, policy, or staffing changes, thereby benefiting the health of incarcerated persons with other SUD diagnoses as well.

Recommendations

The American Society of Addiction Medicine recommends the following:

1. Correctional facilities should be viewed as part of the community treatment continuum and included in partnerships and coalitions that are addressing OUD. Public funding, including the use of opioid settlement funds, for training and technical assistance supporting MOUD access should be inclusive of jails and prisons.
2. All correctional settings should provide access to evidence-based OUD treatment, including all FDA-approved medications for OUD, either on site or through transport. 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 between correctional systems and community treatment practitioners to continue medication treatment for pre-trial detainees and sentenced persons, confirm prescribing and dosing on jail or prison entry, and initiate treatment through community practitioners 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, telehealth or community transport;

c. Suitable space for medication storage, administration and monitoring;

d. Extensive training of health care and corrections staff about SUD and stigma reduction;

e. Hiring or training of correctional staff, peer support specialists, and/or community navigators to connect persons leaving correctional facilities with community MOUD providers and to help navigate other barriers to sustained MOUD treatment in the community (e.g., housing instability); and

f. Education of incarcerated persons with OUD about the nature of OUD, MOUD and other treatments, and recovery.

3. 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 a MOUD prior to incarceration should be allowed to continue 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 or who exhibit symptoms of opioid withdrawal upon incarceration should be assessed and offered MOUD, as clinically indicated, with consideration of the treatment preferences of the patient using a shared decision-making process.

4. All correctional facilities should have overdose reversal medication readily available throughout the facility, including where persons sleep. Correctional and healthcare staff should be trained to recognize the signs and symptoms of an opioid overdose and to use overdose reversal medication appropriately to reverse an overdose. Correctional facilities should provide overdose recognition and response training to all interested detainees and distribute overdose reversal medication at the time of release.

5. 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. However, MOUD utilization should not be contingent on participation in counseling, case management, or peer support services.

6. 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.

7. 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

[1] Toxicology alone is not a validated assessment tool.

limitation on benefits under Medicare should be removed. Until the inmate exclusion is repealed, states should seek waivers from the Centers for Medicare and Medicaid services to pay for treatment in correctional settings with federal Medicaid matching funds. Continuation of healthcare coverage during detention and incarceration will facilitate treatment continuity and retention. States should consider mandating private insurers to cover healthcare in correctional settings to the extent allowable under federal law.

8. Jails and prisons that do not currently offer methadone should use one of the following paths to begin offering methadone: using the hospital/clinic designation to stock and dispense methadone to treat acute opioid withdrawal syndrome and initiate or continue methadone in someone with OUD, so long as that individual has another health condition necessitating treatment; pursue the process of becoming an OTP; or establish a relationship with a community-based OTP for guest dosing or through mobile units.
9. 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.
10. Correctional settings should collect data on numbers of persons screened for OUD and SUD, numbers formally assessed and treated, including types of MOUD, 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 SUD among incarcerated persons, to inform policy changes that can improve individual and public health.
11. Policymakers should remove unnecessary policy barriers to employment, housing, and education for persons with drug-involved criminal justice histories, thereby helping to facilitate sustained treatment engagement and recovery for persons leaving correctional settings. Persons leaving correctional settings without stable housing or employment opportunities may have no feasible options other than to live on the street or return to environments that are not conducive to sustained recovery.

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References

1. Santo T, Jr., Clark B, Hickman M, et al. Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People With Opioid Dependence: A Systematic Review and Meta-analysis. *JAMA Psychiatry*. 2021;78(9):979-993. doi:10.1001/jamapsychiatry.2021.0976
2. Legal Action Center. *Cases Involving Discrimination Based on Treatment with Medication for Opioid Use Disorder (MOUD)*. 2022.
3. World Prison Brief. Highest to Lowest - Prison Population Total. https://www.prisonstudies.org/highest-to-lowest/prison-population-total?field_region_taxonomy_tid=All
4. Center on Addiction. Behind Bars II: Substance Abuse and America's Prison Population. https://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america's-prison-population
5. Flanagan Balawajder E, Ducharme L, Taylor BG, et al. Factors Associated With the Availability of Medications for Opioid Use Disorder in US Jails. *JAMA Netw Open*. Sep 3 2024;7(9):e2434704. doi:10.1001/jamanetworkopen.2024.34704
6. Di Paola A, Lincoln T, Skiest DJ, Desabrais M, Altice FL, Springer SA. Design and methods of a double blind randomized placebo-controlled trial of extended-release naltrexone for HIV-infected, opioid dependent prisoners and jail detainees who are transitioning to the community. *Contemporary Clinical Trials*. 2014;39:256-268. doi:10.1016/j.cct.2014.09.002
7. Kaplowitz E, Truong AQ, Berk J, et al. Treatment preference for opioid use disorder among people who are incarcerated. *J Subst Abuse Treat*. Jun 2022;137:108690. doi:10.1016/j.jsat.2021.108690
8. Tamburello A, Masumova F, Edelman K. Practice Patterns in Prescribing Buprenorphine in the New Jersey Department of Corrections. *J Am Acad Psychiatry Law*. Mar 15 2022;doi:10.29158/jaapl.210087-21
9. Fiscella K, Noonan M, Leonard SH, et al. Drug- and Alcohol-Associated Deaths in U.S. Jails. *J Correct Health Care*. Apr 2020;26(2):183-193. doi:10.1177/1078345820917356
10. Maradiaga JA, Nahvi S, Cunningham CO, Sanchez J, Fox AD. "I Kicked the Hard Way. I Got Incarcerated." Withdrawal from Methadone During Incarceration and Subsequent Aversion to Medication Assisted Treatments. *J Subst Abuse Treat*. Mar 2016;62:49-54. doi:10.1016/j.jsat.2015.11.004
11. Mattson CL, O'Donnell J, Kariisa M, Seth P, Scholl L, Gladden RM. Opportunities to Prevent Overdose Deaths Involving Prescription and Illicit Opioids, 11 States, July 2016-June 2017. *MMWR Morb Mortal Wkly Rep*. Aug 31 2018;67(34):945-951. doi:10.15585/mmwr.mm6734a2
12. Will J, Abare M, Olson M, Chyorny A, Wilhelm-Leen E. Emergency department utilization by individuals with opioid use disorder who were recently incarcerated. *J Subst Abuse Treat*. Jul 12 2022;141:108838. doi:10.1016/j.jsat.2022.108838
13. Evans EA, Wilson D, Friedmann PD. Recidivism and mortality after in-jail buprenorphine treatment for opioid use disorder. *Drug and Alcohol Dependence*. 2022;doi:10.1016/j.drugalcdep.2021.109254
14. Krawczyk N, Lim S, Cherian T, et al. Transitions of care between jail-based medications for opioid use disorder and ongoing treatment in the community: A retrospective cohort study. *Drug Alcohol Depend*. Aug 1 2024;261:111377. doi:10.1016/j.drugalcdep.2024.111377
15. Hedrich D, Alves P, Farrell M, Stöver H, Møller L, Mayet S. The effectiveness of opioid maintenance treatment in prison settings: A systematic review. *Addiction*. 2012;107:501-517. doi:10.1111/j.1360-0443.2011.03676.x

16. Klemperer EM, Wreschnig L, Crocker A, et al. The impact of the implementation of medication for opioid use disorder and COVID-19 in a statewide correctional system on treatment engagement, postrelease continuation of care, and overdose. *J Subst Use Addict Treat*. Sep 2023;152:209103. doi:10.1016/j.josat.2023.209103
17. Lim S, Cherian T, Katyal M, et al. Association between jail-based methadone or buprenorphine treatment for opioid use disorder and overdose mortality after release from New York City jails 2011-2017. *Addiction*. Oct 28 2022;doi:10.1111/add.16071
18. Lier AJ, Seval N, Vander Wyk B, Di Paola A, Springer SA. Maintenance on extended-release naltrexone is associated with reduced injection opioid use among justice-involved persons with opioid use disorder. *J Subst Abuse Treat*. Jul 30 2022;142:108852. doi:10.1016/j.jsat.2022.108852
19. Lee JD, Friedmann PD, Kinlock TW, et al. Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders. *New England Journal of Medicine*. 2016;374:1232-1242. doi:10.1056/NEJMoa1505409
20. Wyse JJ, Morasco BJ, Dougherty J, et al. Adjunct interventions to standard medical management of buprenorphine in outpatient settings: A systematic review of the evidence. *Drug Alcohol Depend*. Jul 29 2021;228:108923. doi:10.1016/j.drugalcdep.2021.108923
21. Belcher AM, Kearley B, Kruis N, et al. Correlates of Staff Acceptability of a Novel Telemedicine-Delivered Medications for Opioid Use Disorder Program in a Rural Detention Center. *J Correct Health Care*. Jun 26 2024;doi:10.1089/jchc.23.11.0097
22. Belcher AM, Coble K, Cole TO, Welsh CJ, Whitney A, Weintraub E. Buprenorphine Induction in a Rural Maryland Detention Center During COVID-19: Implementation and Preliminary Outcomes of a Novel Telemedicine Treatment Program for Incarcerated Individuals With Opioid Use Disorder. *Front Psychiatry*. 2021;12:703685. doi:10.3389/fpsyt.2021.703685
23. McGladrey M, Kelsch J, Lofwall MR, Fanucchi LC, Walsh SL, Oser CB. Get It in Writing: How to Make Medications for Opioid Use Disorder Available During Incarceration. *J Correct Health Care*. Dec 26 2023;doi:10.1089/jchc.23.08.0065
24. Johns Hopkins University. Brief FAQ on Methadone Use to Treat Opioid Use Disorder (OUD) in Carceral Settings Using the Hospital/Clinic Designation. 2024;
25. Regenstein M, Rosenbaum S. What the Affordable Care Act means for people with jail stays. *Health Aff (Millwood)*. Mar 2014;33(3):448-54. doi:10.1377/hlthaff.2013.1119
26. Centers for Medicare and Medicaid Services. Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1809-FC). 2025;
27. Hinton E, Pillai A, Diana A. Section 1115 Waiver Watch: Medicaid Pre-Release Services for People Who Are Incarcerated. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/section-1115-waiver-watch-medicaid-pre-release-services-for-people-who-are-incarcerated/
28. Chatterjee A, Weitz M, Savinkina A, et al. Estimated Costs and Outcomes Associated With Use and Nonuse of Medications for Opioid Use Disorder During Incarceration and at Release in Massachusetts. *JAMA Netw Open*. Apr 3 2023;6(4):e237036. doi:10.1001/jamanetworkopen.2023.7036
29. Pourtaher E, Gelberg KH, Fallico M, Ellendon N, Li S. Expanding access to Medication for Opioid Use Disorder (MOUD) in jails: A comprehensive program evaluation. *J Subst Use Addict Treat*. Dec 9 2023:209248. doi:10.1016/j.josat.2023.209248
30. Hoffman KA, Thompson E, Gaeta Gazzola M, et al. "Just fighting for my life to stay alive": a qualitative investigation of barriers and facilitators to community re-entry among people with opioid use disorder and incarceration histories. *Addict Sci Clin Pract*. Mar 21 2023;18(1):16. doi:10.1186/s13722-023-00377-y

31. Stopka TJ, Rottapel RE, Ferguson WJ, et al. Medication for opioid use disorder treatment continuity post-release from jail: A qualitative study with community-based treatment providers. *Int J Drug Policy*. Jul 27 2022:103803. doi:10.1016/j.drugpo.2022.103803
32. van Olphen J, Eliason MJ, Freudenberg N, Barnes M. Nowhere to go: how stigma limits the options of female drug users after release from jail. *Subst Abuse Treat Prev Policy*. May 8 2009;4:10. doi:10.1186/1747-597X-4-10
33. Tillson M, Fallin-Bennett A, Staton M. Providing peer navigation services to women with a history of opioid misuse pre- and post-release from jail: A program description. *J Clin Transl Sci*. 2022;6(1):e106. doi:10.1017/cts.2022.441
34. Matsumoto A, Santelices C, Evans EA, et al. Jail-based reentry programming to support continued treatment with medications for opioid use disorder: Qualitative perspectives and experiences among jail staff in Massachusetts. *Int J Drug Policy*. Aug 19 2022;109:103823. doi:10.1016/j.drugpo.2022.103823
35. Treitler PC, Enich M, Reeves D, Crystal S. Medications for opioid use disorder in state prisons: Perspectives of formerly incarcerated persons. *Subst Abus*. 2022;43(1):964-971. doi:10.1080/08897077.2022.2060448
36. Wennerstrom A, Sugarman OK, Reilly B, Armstrong A, Whittington A, Bachhuber MA. Health services use among formerly incarcerated Louisiana Medicaid members within one year of release. *PLoS One*. 2023;18(5):e0285582. doi:10.1371/journal.pone.0285582
37. Burns ME, Cook S, Brown LM, et al. Association Between Assistance With Medicaid Enrollment and Use of Health Care After Incarceration Among Adults With a History of Substance Use. *JAMA Netw Open*. Jan 4 2022;5(1):e2142688. doi:10.1001/jamanetworkopen.2021.42688
38. Winkelman TNA, Chang VW, Binswanger IA. Health, Polysubstance Use, and Criminal Justice Involvement Among Adults With Varying Levels of Opioid Use. *JAMA Netw Open*. Jul 6 2018;1(3):e180558. doi:10.1001/jamanetworkopen.2018.0558