Best Practices

Care for Patients with Opioid Use Disorder Who Are in Custody

OVERVIEW

AUDIENCE: Healthcare providers in community and academic medical centers who are caring for patients in custody

BACKGROUND: Many community and academic medical centers care for patients who are in custody. In these settings, providers often use evidence-based practices to treat opioid use disorder (OUD), opioid overdose, and opioid withdrawal with medications for opioid use disorder (MOUD).

People who have been incarcerated are at risk of death from overdose 100 times greater than the general population. Providing MAT in correctional facilities decreases the overdose mortality by over 60 percent.[1] It is important to treat OUD, and other substance use disorders, as chronic medical conditions with effective treatment for all patients. Patients in custody have the same right to health care services as all other patients, and there is broad support by national criminal justice and health care organizations for making all forms of Medication for Addiction Treatment (MAT) available to persons with OUD within the justice system.

Across the country, jails vary in their readiness to implement MAT. In California, more than 30 jails representing over 80 percent of the state population have committed to improvements to the accessibility of MAT. Still, transitions of care between confinement and community settings are critical to ensure rapid identification and treatment of OUD for all patients.

Because most jails do not have methadone licenses or contracts, this document highlights the use of buprenorphine (Bup) treatment of OUD. Additionally, some patients, upon release from structured care settings like jail, do not want to connect to daily observed dosing that is required by methadone centers. Bup provides safe, effective, and flexible outpatient care for patients experiencing OUD.

KEY MESSAGES

- While it is preferable to continue Bup without interruption, it is always better to start or provide Bup even when you can't ensure it will be continued. Exposure to treatment with Bup provides a period of symptom relief, immediate overdose protection, and familiarization with the positive effects of the medication. These benefits occur even when patients are unable to continue treatment while incarcerated.
- Any positive treatment experience, even for just one dose, supports a patient's understanding that OUD is a treatable medical condition and that the healthcare system can provide a positive healing experience.
- Providers should treat patients in custody the same as all other patients: do not share protected health information without your patient's consent or a court order. Sheriffs and police officers are not medical providers: do not share medical information with non-medical personnel of a jail unless given permission or court ordered.
- Just like hospital to nursing home transfers, it is appropriate and expected to share transition of care information to a medical care team in a custody setting.
- Many patients in jail custody have not been convicted of a crime and are released within a few days or weeks. Therefore, encourage all patients to return to their outpatient medical care teams upon release.
- Remind patients that on release from jails, community EDs and urgent cares in the CA Bridge program serve as 24/7 safety nets allowing them access to Bup to start or restart treatment at any time.

GUIDING PRINCIPLES

Across the medical care continuum, provide evidence-based treatment for opioid withdrawal and OUD.

Just like any patient population, patients in custody are excellent candidates for treatment of withdrawal and opioid use disorder. Patients in custody may be cared for in any care setting. At some point, nearly all hospitals and emergency departments (EDs) care for patients in custody – often in the usual care areas of the emergency room (ER), hospital, specialty clinic, intensive care unit (ICU), or surgical centers. There also may be a special jail ward in your hospital or ER. It is important to recognize and treat patients for OUD and opioid withdrawal in any and all care settings.

Across the legal continuum, provide treatment for opioid withdrawal and OUD.

Your patients may be evaluated for medical care in any stage of legal process: prior to booking, while awaiting trial, during trial, pre or post conviction. If a patient is in your care, you can treat OUD and opioid withdrawal across the legal process. Buprenorphine is the first line treatment for OUD and opioid withdrawal for all patients, regardless of their legal status.

Even one dose of buprenorphine supports a patient's recovery.

One dose of Bup for a patient in active withdrawal will lessen a patient's withdrawal symptoms. While we strongly recommend continuation of Bup in jail, the decision to treat opioid withdrawal or OUD in other institutions will vary.

STEPS TO ENSURE HIGH QUALITY, CONTINUOUS CARE FOR PEOPLE WITH OPIOID USE DISORDER IN CUSTODY

1. Make a clear diagnosis.

Clearly diagnose "OUD, moderate or severe" (ICD-10-CM code F11.21) or "Opioid Overdose" (T40.2X1A) or "Opioid withdrawal" (F11.23) in your EMR to ensure transition of care information is clearly recorded.

2. Provide treatment.

Provide Bup dosing while the patient is in your care, for patients with withdrawal, even when you cannot confirm that the patient will be continued on Bup later. If you anticipate a one-time only dose to treat withdrawal because your local jail will be unlikely to continue treatment, dose at 24mg or 32mg total daily dose for increased duration of effect. This higher dose may suppress cravings and protect against overdose for 2 days or more.

- If a patient is outside of withdrawal window and with clear opioid use diagnosis, starting treatment at 8mg Bup daily to prevent relapse is reasonable.
- If your patient is on MAT previously started in the community, reconcile this treatment as a "home medication." While a patient is in your care, generally continue MAT. On transfer, encourage MAT continuation upon transition to jail.

3. Advocate for the continuation of MAT.

As a healthcare provider, you should strongly advocate for the continuation of MAT for all patients. Hospitals and EDs may be an immediate source of MAT for patients in custody. Reach out to the jail to recommend continuation of Bup and discuss how this could occur. Many jails are building the capacity to continue Bup started in the community. You may discover that the hospital can send a prescription or several days of medication to cover the jails' need to access continuation medication since many jails are not able to stock this controlled substance.

- If your patient is pregnant, it is extremely important that the patient is treated for OUD, with Bup as the first line medication to support maternal and fetal health. Most facilities will provide Bup for pregnant patients.
- Other special populations that may be supported by jail health services may include pediatrics, patients who are co-infected with HIV or Hep C, or high risk of recurrent overdose while in custody.

4. Provide clear instructions to the patient.

Provide clear verbal and written patient instructions that include diagnosis, treatment plan, and follow-up available in the community. Provide written transition of care information to the accepting medical team in jail. Consider warm hand-off to the jail's medical team if this will increase your patient's chances of continuing MAT in jail.

5. Get medication to patients along with options to access care for mixed stages of institutional readiness.

When your jail system does not provide treatment for patients with OUD to support post-release care upon re-entry to the community:

- Send a prescription for naloxone and buprenorphine-naloxone (8-2mg 2 tab SL daily dispense 14) to the outpatient pharmacy.
- Select a pharmacy in your care system at a location near to a patient's anticipated discharge home or near the jail. Prescriptions for controlled substances like Bup are active for up to six months. Other medications can be active for up to a year after prescribing. Naloxone rescue is active for a year.
- Inform your patient that these prescriptions will be available upon release from jail for pick up in the community. Alternatively, provide a printed Bup prescription and dispense naloxone from the ED or urgent care during medical clearance to be secured along with patient's possessions while in custody, then returned to the patient upon release.

6. Advocate within the jail health team for evidence-based treatment for your patients.

Make clear your individualized medical recommendation to jail providers. The general recommendation is to continue treatment of at least 8-16mg SL Bup (1-2 tab/film buprenorphine-naloxone 8mg-2mg) daily while your patient is in jail. Clearly state your medical opinion that your patient receives appropriate treatment while in jail. Reinforce that using Bup for withdrawal only is not an evidence-based practice, and does nothing to reduce cravings or the risk of relapse. It is ethical and legal to document you made appropriate medical decision and attempted to ensure care continuity for all your patients, even when presented with external institutional barriers.

7. Identify and support modifiable care gaps across institutions.

- ***Example:*** *"We don't do buprenorphine"*

  If your jail is currently resistant to providing medical standard of care for treatment of OUD, continue to advocate treatment of each individualized case. You are not alone! Reach out for support on how to build relationships to transform the culture of health on this issue.

- ***Example:*** *Your jail supports treatment but does not have an X-waivered prescriber, or lacks buprenorphine on formulary for dispensing in jail.*

  Consider offering operational support. Some jails will accept outside supply of Bup and will provide patient's dispensing of Bup with medications filled from community pharmacies from outside prescribers. Discuss this with your jail. It is useful to understand if Bup is on-formulary in jail. You can prescribe Bup to a non-jail pharmacy to fill "discharge" or "outpatient" medications. Your local custody team, or patient advocate, transports these medications back to the jail pharmacy or nurse team. Some jails can dispense outside supplied medications in jail as they would any controlled substance medication.

8. Exiting jail, hospital, and ED and returning back to the community is a high risk time for overdose deaths.

You should encourage patients to be started, continued, or restarted on MAT and provide them with naloxone before release into the community. While the medical standard is to continue the stable dose of Bup throughout custody without interruption, operational or political barriers often make this impossible. Alternatively, start or restart patients on Bup before release into the community. There is no strong evidence for significant central sedation caused by treatment doses of Bup; even when restarting, central sedation is far less common than any other opioid such as methadone.

While there is variability based on local constraints, you should provide a pre-release on-ramp to community treatment. This includes at least 3-5 days of 16mg daily sublingual Bup immediately before release. In a community setting, there is strong evidence for 16mg Bup as a dose that reasonably allows our patients to reach a steady-state therapeutic level before release. Since many people in custody have short stays and unexpected release, focus should be on brisk titration to therapeutic levels.

Many people with OUD leaving custody settings are opioid non-dependent patients i.e. they are not currently taking Bup or other opioids, typically due to facility restrictions on access to MAT.

- **A reasonable rapid Bup start or restart prior to release for these patients is:**
    - Day 1: 8mg SL Bup daily
    - Day 2 until release: 16mg SL Bup daily
    - We recommend implementing a protocol that maximizes the number of days patients receive treatment, within local constraints.
- **When able to predict release date, a slower titration on Bup is also reasonable, such as starting at:**
    - 2mg SL Bup daily and by 2mg Bup daily until at 16mg SL Bup daily over 1-2 weeks
- **Other important details to consider upon exiting jail:**
    - Give the patient Bup on the day of release or transfer to a new facility, even when that means providing Bup earlier than usually scheduled.
    - For patients that are released unexpectedly without prior starts of Bup, even one dose of 8mg SL buprenorphine-naloxone on release day will confer some protective effect against opioid overdose death.
- **On release:**
    - Prescribe a bridging supply of Bup, at least 16mg SL Bup daily (2 tab buprenorphine-naloxone 8mg-2mg) as discharge medication – ideally in hand – for all patients with OUD.
    - If the patient is not on treatment while in jail or has not been given Bup before release, it is appropriate to have the patient start a rapid titration schedule, such as using 8-2mg buprenorphine-naloxone tabs/films:
        - Day 1: 0.5 tab/film (4mg-1mg) SL daily;
        - Day 2: 1 tab/film SL, then 2 tab/film SL daily

9. Encourage and support the jail team to provide at least a one-month supply of medication for outpatient transition.

Immediate access to treatment with medications in hand is nearly always beneficial regardless of a patient's stated readiness to engage with any other service planning like housing, employment, counseling, or other support programs. Even when a patient states they intend to return to their prior patterns of illicit drug use, it is beneficial to provide MAT in hand. If there is concern for medication diversion or theft, prescribe a one week supply with four refills. If jail facilities are unable to provide treatment in hand upon discharge, we suggest one of the aforementioned strategies above – Bup in community pharmacy available upon release, written as a discharge medication from community providers.

10. Returning to the community upon release from jail is a moment of high risk for opioid overdose deaths.

In addition to encouraging the start and continuation of treatment, always provide patients with naloxone in hand when leaving jail.

11. Encourage all patients to return to your follow-up care resource upon release from jail.

Encourage patients to return to their community providers to obtain MAT upon release alongside assistance in navigating barriers such as lack of transportation, lack of insurance, stigma and cultural barriers.

Even when a care transition to an outpatient clinic is arranged, all patients should be informed that their local ED or urgent care centers within the CA Bridge program are a safety net to access Bup and other care at anytime. These sites welcome everyone, even after a period of return to substance use. During medical clearance for incarceration and at time of release from incarceration, patients should be clearly and explicitly made aware that CA Bridge sites have the capacity to administer Bup on-demand 24 hours a day, 7 days a week, and link to ongoing MAT.

12. Build care connections across the jail experience.

Consider developing a list of patients as a population health management strategy, with the permission of your patients. A care manager, social worker, community health worker, can support the coordination of care for patients upon release from jail or upon transition back to jail. Most patients benefit from support with their applications for Medi-Cal and engagement to Bup capable primary care services. Transitions Clinic Network (TCN) can be a resource to support building care connections across the jail experience.

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RESOURCES

California Bridge Program www.bridgetotreatment.org

Transitions Clinic Network (TCN) transitionsclinic.org/transitions-clinic-network

REFERENCES

1. Green, T. C., Clarke, J., Brinkley-Rubinstein, L., Marshall, B. D., Alexander-Scott, N., Boss, R., & Rich, J. D. (2018). Postincarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system. *JAMA Psychiatry*, *75*(4), 405-407. https://dx.doi.org/10.1001%2Fjamapsychiatry.2017.4614