Washington State Health Care Authority

Medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD) in jails

Standard of care guidelines

Medications for opioid use disorder and medications for alcohol use disorder in jails: Standard of care guidelines

The following document outlines critical standard of care recommendations to support jails that are providing medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD). This resource is a simplified reference for jails and their clinicians to follow while treating an incarcerated individual who may present with opioid use disorder (OUD) and/or alcohol use disorder (AUD).

The Washington Association of Sheriffs and Police Chiefs (WASPC) has reviewed and approved this document. The two key resources for information in this document come from:

- 2020 ASAM National Practice Guideline for the Treatment of Opioid Use Disorder
- Guidelines for Managing Substance Withdrawal in Jails

Intake

A. Continue medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD) for individuals who are already prescribed these medications upon entering the facility. The fact that a patient missed recent doses; does not have evidence of the medication in their body; has evidence of other substances in their body; or has a recently expired prescription, should not preclude the need to continue the medication. It may, however, influence initial dosages.

B. Continue the individual on the same medication at the same dose unless ordered otherwise by the jail prescriber based on clinical need (documented in the individual's medical record) with the exceptions listed below:

    i. Injectable long-acting naltrexone may be converted to an equivalent oral dose until just prior to release at which time the injectable form should be restarted.

    ii. Injectable long-acting buprenorphine may be converted to an equivalent oral dose until just prior to release at which time the injectable form should be restarted.

    iii. Oral buprenorphine may be converted among the three formulations: film, tablet with naloxone, tablet without naloxone.

    iv. Though MOUD/MAUD may not be discontinued on a policy or administrative basis because of the presence of other illicit or controlled substances, administration of the community-based MOUD or MAUD may be adjusted if clinically necessary due to pharmacologic risks of drug-drug interaction or other new clinical risk.

C. Screen all newly admitted individuals for risk of acute withdrawal from opioids and alcohol upon intake. If, for safety or clinical reasons, it is not possible to safely conduct the screening, it may be deferred pending the immediate evaluation by a practitioner (i.e., physician, nurse practitioner, physician assistant) in the jail or in the community.

D. Offer initiation of MOUD or MAUD treatment to individuals who are physically dependent on opioids or alcohol.

E. Educate individuals on treatment choices and the process for continuation of access to MOUD or MAUD, during incarceration and upon release.

F. Make available and offer treatment for OUD using some formulation of methadone, buprenorphine, or naltrexone based on a mutually agreed-upon plan between the prescriber and the individual, with the following exceptions or caveats:

i. The jail may decline to offer methadone if there is no opioid treatment program (OTP) within reasonable distance of the individual's release residence.[1]

ii. If withdrawal is not clinically indicated and the only reason for considering discontinuation of buprenorphine is the lack of an available buprenorphine provider in the community to which the individual will release, a decision whether or not – or when – to discontinue buprenorphine prior to, or upon, release should be made based on a plan mutually agreed upon between the individual and the prescriber based on the length of time the individual is expected to remain in the jail, the risks of opioid misuse or overdose during the incarceration, and the individual's willingness to receive a dose of an extended release injectable buprenorphine just prior to release that will provide the individual a safe tapered withdrawal in the community if no provider is available.

iii. Provide naltrexone in oral formulation while the individual is incarcerated. Offer injectable long-acting naltrexone or buprenorphine as an option prior to release.

iv. Offer oral buprenorphine without naloxone while the individual is incarcerated, but must discharge the individual on a formulation of buprenorphine with naloxone unless there is a clinical reason not to do so (e.g., the individual is discharged on injectable buprenorphine, the individual is allergic to naloxone).

G. The jail should not facilitate forced opioid withdrawal (including withdrawal using a tapering dose of buprenorphine or methadone) unless the individual provides an informed refusal of treatment or the individual elects MOUD treatment with naltrexone, in which case withdrawal is clinically required.

i. In such case, the jail may use other medications (clonidine, anti-emetics, anti-diarrheal, analgesics) in place of buprenorphine or methadone if the individual so chooses or as adjuncts to these medications, but they may not be the only withdrawal treatment available.

H. Initiation of buprenorphine or methadone, whether for induction of treatment or for withdrawal, may not be delayed for administrative reasons (e.g., unavailability of a jail prescriber) beyond when they are clinically indicated to be started.

I. Offer treatment for alcohol withdrawal with benzodiazepines to individuals entering the facility who are physically dependent on alcohol, if clinically appropriate.

J. Provide immediate evaluation of individuals at risk for, or in, opioid or alcohol withdrawal who refuse treatment, by a medical or mental health prescriber or a licensed mental health professional at the masters' level or higher, to determine if they have decision-making capacity. If they do not, they must be transported to a community hospital and may not return to the jail until:

i. It is clinically safe to do so AND have regained decision-making capacity, or

ii. Return with a court order or results of a Harper process allowing involuntary administration of medication.

During incarceration

A. Screen for OUD and AUD without physical dependence (i.e., without a risk of acute withdrawal) after intake, as long as the delay does not impair the ability to begin treatment prior to release.

[1] Update to providing methadone coming soon. Jails now have the ability to apply to the DEA for a hospital/clinic license and this allows for jails to prescribe and administer methadone. Jails should be moving towards this licensure.

B. Offer initiation of MOUD/MAUD to individuals with OUD/AUD not already identified and/or offered treatment at intake (e.g., individuals with OUD but without physical dependence; individuals with AUD who underwent withdrawal).

C. Educate individuals on treatment choices and the process for continuation of access to MOUD/MAUD, during incarceration and upon release.

D. Administer methadone and buprenorphine daily or more frequently. The jail will not use alternate-day ("balloon") dosing of buprenorphine.

E. Offer counseling or continued support to individuals for their OUD and/or AUD who are expected to remain in jail for longer than one month. However, a patient's refusal to participate in counseling is not grounds for denying medication treatment.

Release

The jail must accomplish the following prior to release:

A. Complete release planning and reentry coordination as soon as possible after intake to ensure an effective plan is in place prior to release or in the event of an unexpected release of an individual who needs continued treatment and services.

B. Provide at least two (2) doses of standard-dose naloxone (e.g., Narcan® Intranasal 4 mg.) and training on how to administer the medications to all individuals with OUD.

C. Schedule the first community appointment with a treatment facility for continuation of MOUD or MAUD.

D. Provide-in hand, upon release, and at no cost to the individual-sufficient doses of MOUD and/or MAUD to bridge individual until scheduled MOUD/MAUD follow-up appointment at community treatment facility (does not apply to individuals treated with injectable MOUD/MAUD) or a minimum of a 30-day supply, whichever is shorter.

E. Inform individuals who are released directly from court, that they may request to be transported back to the jail by staff to receive these medications prior to going home.

F. In situations where a follow-up appointment in the community cannot be made (e.g., after-hours bail-out), give the individual enough medication to last until the next available appointment at the community treatment facility. If the appointment date is unknown, give the individual a minimum of a 30-day supply.

G. In situations where medications cannot be provided upon release (e.g., unscheduled release at a time when medical staff are not present in the jail):

    i. Inform the individual they may either return to the jail in the morning to receive bridge medications; or

    ii. If no medical staff are present the following day, call in a prescription for the same bridging medication to a local pharmacy, at no cost to the individual.

H. Assist Medicaid-eligible individuals to sign-up with Medicaid or assist individuals whose Medicaid coverage has been terminated to reestablish coverage.

I. For any individual with Medicaid coverage, work cooperatively with the individual's managed care organizations (MCO) to facilitate reentry, including but not limited to allowing the MCO's agent timely access to the facility and the individual.

Authors

Marc F. Stern, MD, MPH, Affiliate Assistant Professor, School of Public Health, University of Washington

Clinical Associate Professor, School of Public Health, University at Albany

Consultant in Correctional Health Care

Mandy D. Owens, PhD, Assistant Professor, Addictions, Drug & Alcohol Institute (ADAI)

Dept. of Psychiatry & Behavioral Sciences, University of Washington School of Medicine

Rachel Meade, BA, Washington State Health Care Authority (HCA), MOUD/MAUD in Jails Program Administrator