

MEDICATION FOR OPIOID USE DISORDER IN PENNSYLVANIA JAILS AND PRISONS

A Report by the Pennsylvania Institutional Law Project

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CONTENTS

Executive Summary	3
Introduction	4
Background	5
Opioid Use Disorder.....	5
The Overdose Epidemic.....	5
Medication for Opioid Use Disorder.....	6
The Importance of MOUD in Jails and Prisons.....	9
The Disparate Impact on People of Color.....	10
MOUD in Pennsylvania Jails	11
Methodology.....	11
Summary of Findings.....	12
Categories of MOUD Offered.....	13
Pennsylvania Department of Corrections	25
Legal Landscape	27
Recommendations	29
Resources	31
Conclusion	31
References	32
Appendix A	36
Appendix B	37

SUMMARY

The standard of care for treating Opioid Use Disorder (“OUD”) in the medical community is treatment with Medication for Opioid Use Disorder (“MOUD”), specifically agonist medications, such as methadone or buprenorphine (often in the form of Suboxone), as compared to antagonist medications, such as naltrexone. The consensus around the importance of agonist MOUD stems from data showing that it is the most effective treatment at reducing overdoses, relapse, and recidivism, and increasing the ability of people with OUD to enter recovery. However, the stigma associated with drug use—and the mistaken belief that agonist MOUD is just replacing one drug with another—poses a serious barrier to access to MOUD, especially in jails and prisons.

OUD is very common among incarcerated people, but despite the effectiveness of MOUD, access is frequently limited or completely nonexistent in jails and prisons. As a result, individuals with OUD entering jail or prison must endure withdrawal, a painful and medically dangerous experience, for which they receive little or no care. When individuals are forced to withdraw and not provided MOUD, they also face a significantly increased risk of death upon release.

This report examines the availability and accessibility of MOUD for incarcerated people in county jails across the state of Pennsylvania. The policies and practices of each of the 62 county jails in Pennsylvania were categorized into six groups:

- **No MOUD**
- **Pregnant People Only**
- **Naltrexone Only**
- **Likely No Continuation:** Jails in this category likely do not provide continuation to most people.
- **Continuation:** Jails in this category provide agonist MOUD to people who enter the jail with an active prescription.
- **Induction:** Jails in this category will start people with OUD on agonist MOUD.

In summary, jails in the *No MOUD*, *Pregnant People Only*, *Naltrexone Only*, and *Likely No Continuation* categories provided no MOUD, only provided MOUD on a very limited basis, or only provided ineffective medication. 68% (42 of 62) of the jails in Pennsylvania fall into these categories.

Jails in the *Continuation* or *Induction* categories constitute 32% (20 of 62) of Pennsylvania jails. These jails have made more progress towards providing MOUD to those who need it, although barriers to treatment may still exist for incarcerated people. Some barriers include arbitrary or burdensome criteria for participation in their programs, complicated rules which allow individuals to be removed from their medication with no recourse, or non-medical personnel making medical decisions.

After reviewing the availability and issues related to provision of MOUD in Pennsylvania’s jails, this report makes recommendations as to how jails and prisons can improve access to this necessary medical treatment.

INTRODUCTION

The goal of this study was to understand the availability of Medication for Opioid Use Disorder (“MOUD”)* in the 62 county jails across Pennsylvania. MOUD refers to three FDA-approved medications: methadone, buprenorphine (frequently referred to as Suboxone), and naltrexone (frequently referred to as Vivitrol).

The overdose epidemic has affected countless communities, and unfortunately individuals with Opioid Use Disorder (“OUD”) frequently cycle in and out of the criminal legal system. The standard of care across the medical community, including national organizations such as the Substance Abuse and Mental Health Services Administration (“SAMSHA”), provides that people with OUD be treated with agonist MOUD. National criminal legal organizations such as the National Sheriff’s Association and the National Commission on Correctional Health Care have also recognized agonist MOUD as necessary medical care. However, many jails in Pennsylvania have not caught up with the latest guidance.

This is a descriptive report that reflects data collected on the availability and accessibility of MOUD in all 62 county jails in Pennsylvania during a snapshot in time (2021-2022). This study focused on jails because they are the entry point for people involved in the criminal legal system.

Data was collected through Right-to-Know Law requests, interviews or communications with incarcerated people, and other publicly available information, and each jail was placed into one of six categories. Even among those facilities where MOUD is more available, many challenges to access remain. This report examines those policies and challenges and makes recommendations on where jails should go from here.

This report is the result of a study undertaken by the Pennsylvania Institutional Law Project (“PILP”), with significant support from Vital Strategies, Inc., and additional support from the Independence Foundation.

* MOUD is also sometimes referred to as Medication-Assisted Treatment (“MAT”). MAT is no longer preferred terminology as it implies medication takes a secondary role to other forms of treatment.

BACKGROUND

Opioid Use Disorder

Opioid Use Disorder (“OUD”) is a chronic disease that can have significant economic, personal, and public health consequences.¹ In the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (“DSM-5”),² OUD is defined as “a problematic pattern of opioid use leading to clinically significant impairment or distress.”³ The DSM-5 lists multiple criteria to diagnose OUD, and the severity of the diagnosis increases with the number of criteria met.⁴

OUD results from chronic opioid abuse which causes changes in the brain, altering the brain’s signaling pathways.^{5,6} Understanding the neuroscience behind OUD can help individuals with OUD and others understand that “their illness has a biological basis and does not mean they are ‘bad’ people.”⁷ OUD can be progressive, meaning it often becomes more severe over time,⁸ and may be unresponsive to non-medication-based, abstinence-only treatment, which is popular in treating alcohol use disorder. Just like other chronic diseases, OUD requires long-term management.⁹

When an individual with opioid dependence is deprived of opioids, the lack of opioids causes profound mental and physical pain (including severe abdominal cramping, nausea, diarrhea, anxiety, and convulsions), and can have serious medical consequences for pregnant people and their fetuses, immunocompromised people, and people suffering from co-morbid medical disorders.¹⁰ These are the symptoms of what is commonly known as withdrawal.

The Overdose Epidemic

According to the Centers for Disease Control, the United States reached the grim milestone of 100,000 overdose deaths in 2021.¹¹ The overdose epidemic has devastated Pennsylvania for years—and has been exacerbated by the coronavirus pandemic—despite the availability of effective medical treatment. Pennsylvania has one of the highest rates of death due to drug overdose. In the most recent data from 2018, 65% of drug overdose deaths involved opioids.¹² Pennsylvania has a combination of urban and rural areas, and 78% of Pennsylvania counties had overdose death rates higher than the national average.¹³

Unfortunately, the overdose epidemic has been exacerbated during the COVID-19 pandemic. A recent study of opioid-related overdoses in Pennsylvania showed that the average number of overdoses increased from 374 during the 4 months prior to Pennsylvania's stay-at-home order (December 1, 2019, through March 31, 2020), to 437 in the 4 months following April 1 (April 1, 2020, through July 31, 2020).¹⁴

Medication for Opioid Use Disorder

MOUD refers to three FDA-approved medications: methadone, buprenorphine (e.g., Suboxone or Sublocade), and naltrexone (e.g. Vivitrol). There are two types of MOUD: agonists and antagonists. Agonist medications attach to and activate the same receptors in the brain as other opioids, therefore relieving cravings and eliminating withdrawal symptoms without producing the euphoria associated with illicit drug use.¹⁵ Antagonist medications block those same receptors, preventing them from becoming activated. Antagonist medications do not control withdrawal symptoms or cravings, and only prevent opioids from producing euphoria.¹⁶ A "wealth of evidence" including clinical studies, randomized controlled trials, and systematic reviews have demonstrated clearly that agonist MOUD is the most effective treatment for preventing withdrawal, decreasing relapse, and reducing overdoses, and is the standard of care for treating OUD.¹⁷

The American Medical Association, the American Society of Addiction Medicine ("ASAM"),¹⁸ the U.S. Department of Health and Human Services,¹⁹ the U.S. Food and Drug Administration ("FDA"),²⁰ the National Institute on Drug Abuse,²¹ and the Substance Abuse and Mental Health Services Administration ("SAMHSA") have all endorsed the necessity of MOUD.

SAMHSA has explained that, "just as it is inadvisable to deny people with diabetes the medication they need to help manage their illness, it is also not sound medical practice to deny people with OUD access to FDA-approved medications for their illness."²² Further, according to ASAM's guidelines, "[o]pioid withdrawal (i.e. detoxification) on its own without ongoing treatment for opioid use disorder is not a treatment for opioid use disorder."²³ Although treatment with MOUD may consist of medication combined with counseling and other behavioral therapies, agonist medication is the primary driver of efficacy.²⁴

There is no recommended duration for treatment of opioid use disorder with medication. An individualized assessment is required to determine the best treatment for each person.

Methadone

Methadone is an agonist medication, meaning it attaches to and activates the same receptors in the brain as other opioids, and therefore relieves cravings and eliminates withdrawal symptoms without producing the euphoria associated with illicit drug use.²⁵ Methadone is taken daily and comes in several forms, including pill and liquid forms.²⁶ Methadone has been used successfully for more than 40 years to treat opioid use disorder.²⁷

One challenge with prescribing methadone is that it is highly regulated at both the state and federal levels. Methadone can only be dispensed at SAMHSA-certified Opioid Treatment Programs (“OTP”). After patients spend a certain amount of time in

treatment, they may be allowed to bring a limited amount of their medication home between visits to their Opioid Treatment Program.

In the jail and prison context in Pennsylvania, state law provides that Opioid Treatment Programs can apply for an exception for off-site dosing,²⁸ allowing for a lockbox dispensing protocol under certain circumstances, where methadone doses are locked in a travel box and taken to the jail or prison for the health provider at the jail to administer.²⁹ This method allows the jail to securely administer methadone, and reduces the number of times a person has to be transported from the jail to an Opioid Treatment Program in the community.

Buprenorphine

Buprenorphine is a partial agonist, meaning that it also attaches to the same opioid receptors in the brain as other opioids, like methadone, but activates them less strongly than a full agonist.³⁰ Buprenorphine comes in many forms under various brand names, including Suboxone and Sublocade. Suboxone is a combination of buprenorphine and naloxone (brand name Narcan) and is in the form of a film which dissolves when placed under the tongue or on the inside of the cheek. Suboxone is taken daily.³¹ Sublocade is an extended-release form of buprenorphine that is administered in a once-per-month injection.

One advantage to buprenorphine is that the regulations controlling who can prescribe it are not as strict as for methadone.

Previously, only medical providers who received training and met certain other requirements could receive a waiver from the DEA to prescribe buprenorphine for OUD. However, under new guidelines intended to expand access to treatment, medical providers can apply for a waiver without completing the training if they provide treatment to 30 or fewer patients.³²

Buprenorphine is similarly effective as methadone for treating OUD. There is no recommended duration for treatment with buprenorphine.³³

Naltrexone

Naltrexone is an antagonist, and therefore does not control withdrawal symptoms and cravings but prevents opioids from producing rewarding effects such as euphoria.³⁴

Common formulations of naltrexone are an extended-release injection (brand name Vivitrol) and an oral medication (brand name ReVia).

Before starting naltrexone, an individual must completely withdraw from opioids. Typically, 7 to 14 days must elapse from the last time the individual ingested opioids to starting naltrexone.³⁵

Naltrexone is often favored by jails and prisons because of its injectable form, and because it is not an opioid. Jails typically do not provide naltrexone as a maintenance medication, but only shortly before the individual's release, in order to avoid the risk of overdose immediately upon release. However, this approach is often not effective.³⁶ Treatment with naltrexone is not recommended by medical standards because of poor adherence and tolerability by patients, as well as higher rates of mortality after treatment discontinuation.³⁷

The Importance of MOUD in Jails and Prisons

It is estimated that 65% percent of the United States prison population has an active substance use disorder.³⁸ Based on data from 2016, 1 in 4 people with OUD had contact with some part of the criminal legal system in the preceding year.³⁹ However, as of 2018, less than 1% of jails and prisons in the United States offered MOUD,⁴⁰ despite the fact that the leading cause of death following incarceration is overdose.⁴¹ While incarcerated, without regular access to opioids, an individual's opioid tolerance decreases, leading to the increased risk of overdose. One study found that in the two weeks following release, people who had been incarcerated in state prisons were 129 times more likely to die from an overdose compared to the general public.⁴² Further, upon release from jail, individuals whose MOUD was discontinued while incarcerated are less likely to reenter treatment.⁴³ Studies have shown that post-release mortality was almost 6 times lower for those whose MOUD was continued, versus those who were forced to withdraw.⁴⁴

A lack of access to MOUD and the trauma of incarceration for individuals with OUD further increases the likelihood of opioid overdose risk after release. In the OUD population, risk factors such as high rates of uncontrolled pain, HIV, high rates of chronic disease, physical assaults, elevated risk of suicide, poverty, having multiple stigmatized identities, race, disrupted social networks and supports, interruptions in care, depression, anxiety and PTSD can negatively influence post-release opioid-related overdose mortality.⁴⁵

Evidence also shows that providing MOUD to incarcerated people reduces deaths from overdose. The Rhode Island prison system expanded access to MOUD and saw a 61% reduction in post-release overdose deaths.⁴⁶

The National Sheriff's Association and National Commission on Correctional Healthcare have noted many benefits to providing MOUD in a carceral setting including "stemming the cycle of arrest, incarceration, and release associated with substance use disorders (SUDs)," "contributing to the maintenance of a safe and secure facility for inmates and staff," "reducing costs," among other benefits.⁴⁷

The Disparate Impact on Racial and Ethnic Minorities

Access to MOUD in jails and prisons is also a racial justice issue, given the confluence of the lack of access to treatment and higher rates of incarceration among people of color. While OUD is often thought of as a problem more prevalent among white people, since 2015, overdose deaths have been increasing most rapidly among communities of color.⁴⁸ The pandemic continued to disproportionately worsen health outcomes for racial and ethnic minorities, and a recent study found that Black people had a higher overdose mortality rate than white people for the first time since 1999.⁴⁹

In the 1970s, as opioids and crack cocaine were devastating the Black community, the U.S. government's response was the "War on Drugs." This government policy resulted in the incarceration of Black people for drug-related offenses at a much higher rate than white people, causing massive disruption in Black communities.⁵⁰ The effects of the War on Drugs are still felt today. In 2017, although Blacks/African Americans represented 12% of the U.S. adult population, they made up 33% of the sentenced prison population.⁵¹

For decades research has clearly demonstrated poorer health outcomes for racial minorities in this country.⁵² These outcomes are partly due to less access to health care due to higher rates of unemployment or over-representation in employment without employer-provided health insurance.⁵³ However, racial disparities in health outcomes are not solely the result of these structural barriers. "Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled."⁵⁴

Inequities in access to healthcare in the community also impact access to MOUD in jail for people of color. As explained further below, the vast majority of jails will only provide someone MOUD if they were previously receiving it, if at all. As a result, a person's ability to access MOUD prior to incarceration has a significant impact on their ability to receive it while incarcerated. This is one of many reasons why encouraging more jails to focus on induction in addition to continuation is important.

MOUD IN PENNSYLVANIA JAILS

Methodology

This descriptive study aims to understand the state of Medication for Opioid Use Disorder (“MOUD”) in Pennsylvania’s county jails. Information on access to MOUD in jails was obtained from 62 jails through the Pennsylvania Right-to-Know Law, reports from more than 75 of the Pennsylvania Institutional Law Project’s clients, and publicly available jail oversight board meeting minutes.

People are held in county jails in Pennsylvania prior to trial and sentencing, or because they have a short sentence. Unlike in some states where there is a unified county jail system and programs are consistently implemented throughout, in Pennsylvania, each county jail is operated independently. Not all Pennsylvania counties have their own jail, and instead may send people to jails in other counties.

The Right-to-Know Law requests sought information dating back to 2018, including written policies regarding MOUD, numbers of people receiving MOUD, any written materials relating to MOUD, and other documents. The Pennsylvania Institutional Law Project (“PILP”) also received information from its clients regarding the provision of MOUD in jails. Lastly, PILP obtained information from published meeting minutes of jail oversight boards, as well as notes taken from attendance at jail oversight board meetings. This information represents the state of MOUD in Pennsylvania as of the point in time when this data was collected in March 2021-April 2022.

Collecting data in this manner posed a variety of challenges to getting a clear picture of the provision of MOUD in Pennsylvania jails. Most jails do not have a written policy which makes explicit their policy regarding MOUD. Almost all jails provided at least some data regarding people receiving MOUD, but even this information did not necessarily clarify the jail’s policy. PILP used the information available to best categorize each jail. The criteria for the specific categories are described further below.

Summary of Findings

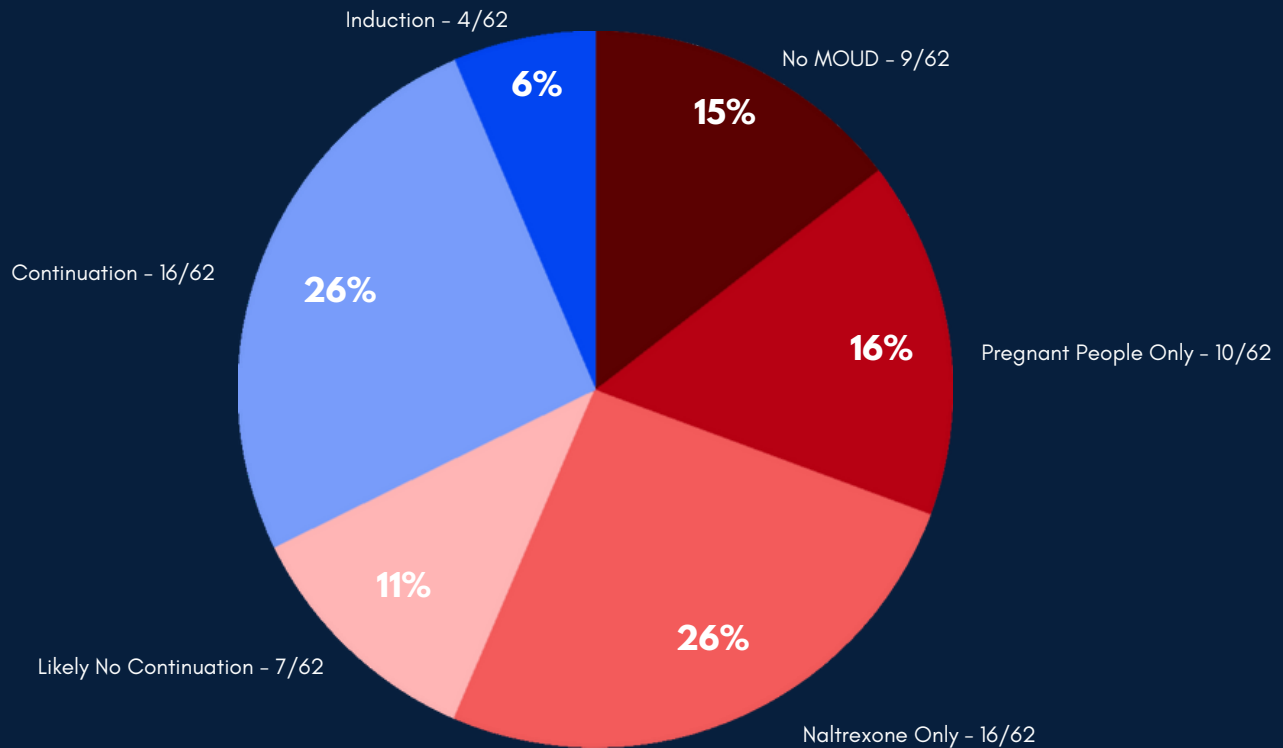
Based on the documentation obtained, here is a summary of the findings:

- 15% (9 of 62) jails offer no MOUD at all.
- 53% (33 of 62) jails offer only the least effective form of MOUD or offered MOUD to a very limited number of people.
- 26% (16 of 62) of jails provide continuation.
- 6% (4 of 62) of jails provide induction.
- 32% of jails offer a partial agonist taper to individuals going through detoxification.

However, even among jails which have a stated policy of providing continuation or induction, PILP found that there are many barriers to incarcerated people actually receiving treatment. Some jails provide continuation only under specific criteria, such as if it is court-ordered or if the medical staff approve continuation for the individual. However, eligibility criteria for medical staff approval may be unclear or not stated in the policy.

Induction is almost non-existent, causing individuals who were not in a treatment program prior to their incarceration to go through withdrawal or to seek medication illicitly. These and many other challenges to receiving MOUD are discussed further below. In many instances, the experiences of incarcerated individuals did not reflect the policies submitted by the jails.

BREAKDOWN OF JAIL MOUD PROGRAMS



Categories of MOUD Offered

Each Pennsylvania jail has been placed into one of the categories below delineating the circumstances under which MOUD is provided.

NO MOUD • 15% (9 of 62 jails)

This category is for jails which do not provide any of the FDA-approved medications for opioid use disorder, under any circumstances. These jails require everyone with OUD entering the jail to go through withdrawal. They may provide some medication to relieve the symptoms associated with withdrawal. It is possible that they transfer individuals in particular circumstances (such as pregnant women) to another jail where they can receive treatment.

Some jails that do not provide MOUD provide other forms of treatment which, on their own, are less successful, such as peer support groups including Alcoholics Anonymous and Narcotics Anonymous, or group or individual therapy.

Jails which were placed in this category did not provide any policy regarding MOUD or data showing that anyone had received MOUD.

PREGNANT PEOPLE ONLY • 16% (10 OF 62 JAILS)

Jails in this category only provide MOUD to pregnant people. Once the child is born, the mother is taken off MOUD and forced to go through withdrawal.

For jails that are not a licensed Opioid Treatment Program (“OTP”) or do not have providers on staff able to prescribe MOUD, there are several options for how they may provide MOUD. Sometimes pregnant individuals are transported to an outpatient center in the community where they are assessed at least once a week by a physician and receive methadone. Methadone doses for the remainder of the week for an individual require a security set-up called a “carry-pack” that is filled and locked by the outpatient treatment center staff in the presence of the jail transporting officer. The jail transporting officer signs a receipt for the locked carry-pack on a methadone chain-of-custody form. At other jails, pregnant people are transported to an OTP daily to receive their medication.

In instances where a pregnant individual does not have a verifiable prescription for MOUD at the time of their incarceration, the individual is transported to a hospital or is evaluated by a certified physician to administer methadone. Placing a pregnant person on methadone when they have no history of being in a methadone treatment program requires close medical and fetal monitoring.

FROM OUR CLIENTS

J.M. & S.S.

J.M. was 71-years old when he was incarcerated in a county jail in Western Pennsylvania. At the time of his arrest, J.M. had been in active recovery for over two years and taking a daily dose of methadone. During intake, J.M. informed medical staff of his prescription but was told, "We don't give methadone here. We give detox meds." J.M. suffered through severe withdrawal symptoms for weeks, exacerbated by his advanced age.

S.S. had a similar experience on the opposite side of the state. Prior to his incarceration, S.S. had been in a local treatment program for a year, receiving methadone. Despite providing methadone to pregnant women at this jail, they would not provide it to S.S. Instead, he was forced to undergo withdrawal and suffered severe symptoms for weeks. After S.S. was released from jail, he re-entered treatment but continued to suffer post-acute withdrawal symptoms for months until his dose of methadone could be tapered up to the dose he was receiving prior to his incarceration.



NALTREXONE ONLY • 26% (16 OF 62 JAILS)

Jails in this category provide only one type of MOUD, naltrexone (often Vivitrol), to non-pregnant people. Jails that fall into this category may provide other forms of MOUD to pregnant people, as described above. Frequently, jails that provide naltrexone only do so when the individual is close to their release date.

In some jails, an individual must apply to receive the medication, can only do so after they have a release date, and also must meet other criteria. One jail requires that an individual successfully complete all group therapy sessions and show commitment to abstinence to the satisfaction of the program coordinator to qualify for Vivitrol injection. Another jail requires that an individual be a resident of the county where the jail is located to receive Vivitrol.

LIKELY NO CONTINUATION • 11% (7 OF 62 JAILS)

Based on the data provided, jails in this category appear to offer agonist MOUD to very limited numbers of people who are not pregnant. However, we do not have information regarding why those individuals were able to receive MOUD and given the low numbers of people receiving agonist MOUD, it is difficult to determine if everyone who has a MOUD prescription is receiving their medication.

Jails in this category also provide agonist MOUD to pregnant people and naltrexone to non-pregnant people.

CONTINUATION • 26% (16 OF 62 JAILS)

Jails in this category provide agonist MOUD to non-pregnant people who enter the jail with an active, verified prescription for MOUD. Continuation is also sometimes referred to as maintenance.

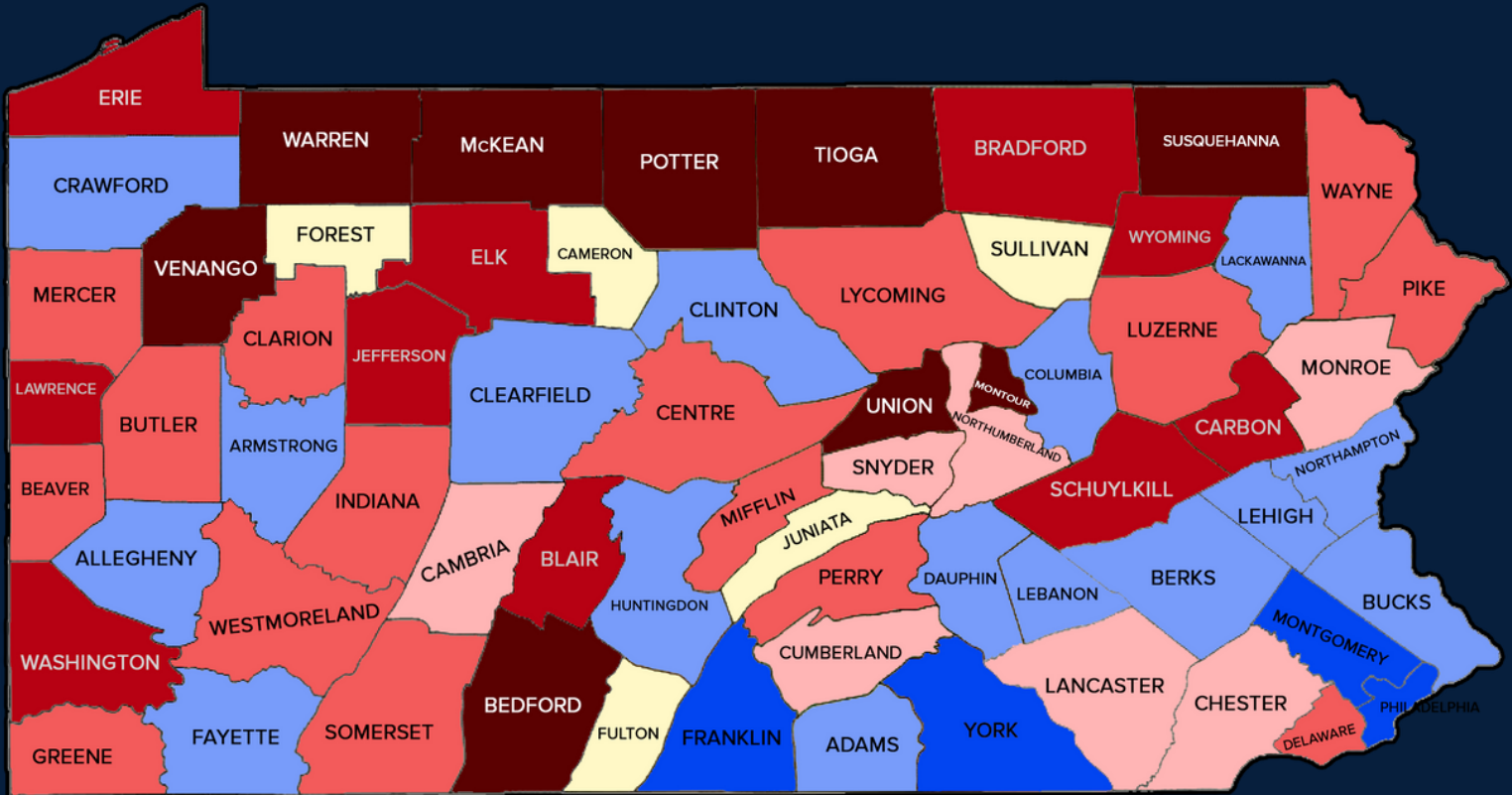
Even at these jails, there are significant challenges that prevent people from receiving MOUD. Written policies include limitations on who receives continuation, and incarcerated people have reported a host of issues with these programs, discussed further below.

Jails in this category also offer agonist MOUD to pregnant people, regardless of whether they have an active prescription, as well as naltrexone to anyone who does not have an active prescription.

INDUCTION • 6% (4 OF 62 JAILS)

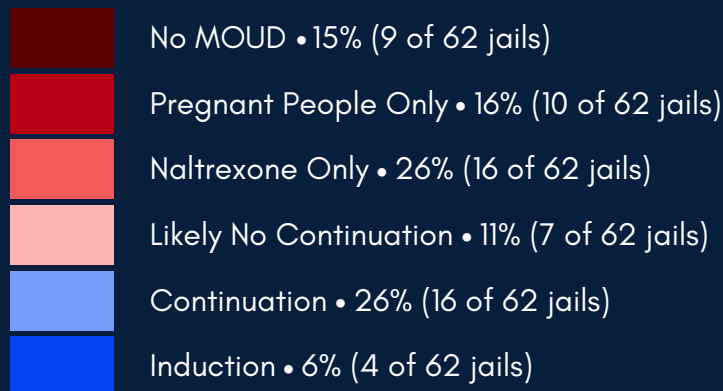
Jails in this category offer agonist MOUD to at least some non-pregnant individuals who did not have an active prescription from prior to their incarceration. These programs are by far the most expansive. Some offer treatment to all people with OUD who enter the jail, others offer induction on a more limited basis with unclear criteria as discussed further below.

WHERE IS MOUD OFFERED IN PENNSYLVANIA?



** Counties in yellow do not have county jails within their borders

Key



MOUD Program Challenges

As explained above, the fact that a jail offers MOUD, even if it offers continuation or induction, does not mean that everyone who needs MOUD receives it, or even that everyone who was on MOUD pre-incarceration receives it. Below is a more in-depth discussion of issues raised by PILP's clients and identified in jail policies and other documents.

1. Unclear or Unfounded Eligibility Criteria

Many of the official jail policies state that MOUD will be provided after an evaluation by a health care provider, but there are no criteria stated as to how that provider will evaluate eligibility for MOUD. This sets up a system in which it is entirely unclear who receives MOUD in jail and who does not.

In other cases, the criteria for receiving MOUD are wholly unrelated to medical need. In one example, an individual with OUD can be disqualified from continuing MOUD if they do not reside in the county in which the jail is located or if they have a drug treatment court violation. Some jails rely on grants to fund MOUD and will restrict medication only to those who reside in the county and will return to the county upon release.

FROM OUR CLIENTS

S.R.

S.R. was incarcerated in a county jail in Central Pennsylvania. He repeatedly requested to participate in the MOUD program. While his medical records show that he was reviewed for the MOUD program, medical staff made comments that he needed to demonstrate more "motivation" to be sober, rather than claiming an "entitlement." S.R. never received MOUD at this county jail.

Medical care at the jail where S.R. was incarcerated was provided by PrimeCare Medical. Despite the fact that "motivation to be sober" is not one of the listed criteria in PrimeCare Medical's policy, the requirements for the program are vague enough that it allows providers to make these types of judgments.

Another county jail's policy states that an incarcerated person seeking Vivitrol must have "good institutional adjustment." This vague policy statement also allows providers, and other jail staff, to determine a person's medical care based on a subjective judgment about their behavior.



FROM OUR CLIENTS

J.C.

J.C. was incarcerated in a large, urban Pennsylvania county jail. During intake, she provided information about her Suboxone prescription. She also signed a release that would allow the jail to confirm her prescription. The jail delayed processing this information, so, for weeks, she did not get her medication. During that time, she suffered through withdrawal and was put at significantly increased risk of relapse.

2. Delays

Even at jails with continuation policies, there is often a delay, sometimes days or weeks long, as the jail works to verify an individual's MOUD prescription. Given that an individual will begin to experience withdrawal within 12 to 24 hours from the last time they ingested opioids, this delay is significant and causes unnecessary suffering.

3. Inappropriate Punishment

In some jails, individuals are removed from the MOUD program because of a non-medication related misconduct. For example, if a correctional officer believes that an individual did not follow their orders or responded to a correctional officer in a disrespectful manner, these behaviors are considered misconducts. As punishment, the incarcerated individuals will be taken off MOUD. In addition to being denied MOUD, these clients are punished further by being forced to go through withdrawal while in solitary confinement or restricted housing.

One jail provided a list of individuals who were disqualified from their MOUD program and included the reason they were disqualified. This list included reasons such as “disciplinary action for lying to staff” and “disciplinary action for disrespecting staff and lying.”

4. Screening Urine Tests

Screening urine tests are frequently used by jails to determine whether incarcerated people are taking illegal substances and can be a basis for jails’ discontinuing someone’s medication or imposing a variety of other punishments. However, the instructions for these tests generally indicate that they are for screening only, and when they show a positive result, the sample should be sent to a lab which can perform a more accurate test for confirmation.

A recent report by the Inspector General of New York investigated the practice in the New York State Prisons of using screening tests, and found that the use of screening tests alone without a confirming test inappropriately served as the basis for a variety of punishments, which included solitary confinement, delaying parole hearings, and denying family visits.⁵⁷ The Inspector General report found a high rate of false positives by the screening drug tests, and the report noted that a positive result could be triggered by substances such as the artificial sweetener Stevia, and an over-the-counter antacid.⁵⁸ The Inspector General found that as a result of these faulty tests, more than 1,600 were unjustly penalized.⁵⁹

This highlights the problems that can result if screening drug tests serve as a basis to remove people from MOUD.

FROM OUR CLIENTS

S.B.

S.B. was removed from the MOUD program in a Pennsylvania state prison when a random urine test showed the presence of an unauthorized medication, even though another urine drug test taken the same day showed a negative result for this medication.

5. Alleged Diversion

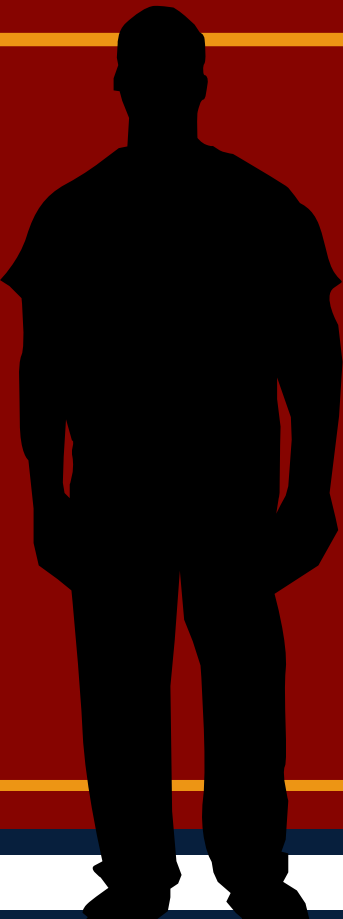
A significant number of PILP clients across several different jails and prisons report being denied MOUD due to unfounded accusations of diversion of medication. Many report that after being accused of diversion, even if no medication is found during a search, there is no recourse to challenge the accusation. They simply no longer receive their medication.

Examples of actions that caused people to be accused of diversion and removed from MOUD include fast or sudden movements during the medication line, dropping the medication and quickly retrieving it before it touches the floor, having their hands out of place while standing in the medication line, or part of the Suboxone strip breaking off in the cup when asked to drink water before the Suboxone medication has dissolved.

These situations are problematic because people can be denied their MOUD without any due process, and diversion appears to be frequently used to rationalize withholding this medication. Importantly, research demonstrates that “illicit use of buprenorphine decrease[s] as individuals ha[ve] access to treatment,” suggesting that the solution to diversion is not taking people off MOUD, but putting more people on it.

FROM OUR CLIENTS

P.J.



P.J. had been receiving Suboxone for the past 6 months while incarcerated at a large urban county jail. While he stood in the medication line to receive Suboxone, another person accidentally stepped on his foot. P.J. bent down in pain, and then was accused by prison staff of taking another person's Suboxone. He and the other person were searched. Despite no Suboxone being found, he was not allowed to receive that day's dose, was removed from the MOUD program, and was forced to withdraw.

P.J.'s story reflects the experiences of dozens of other incarcerated people who have been removed from their medication for supposedly diverting it (i.e., taking it to use or sell later). Frequently, there is no investigation to confirm this is true. Some incarcerated people believe they are accused of diverting as retaliation. Many are forced to painfully withdraw without assistance.

6. Improper Administration

In addition to the outright denial of MOUD, there are also concerns regarding its administration. These include correctional officers without healthcare training or licenses administering MOUD, or clients missing their medication due to lack of staffing.

Further, some clients have reported that they are forced to drink water immediately after applying the Suboxone strip under the tongue, not allowing for adequate absorption time. Proper administration of Suboxone includes drinking water prior to application of the Suboxone strip under the tongue to help with absorption of the medication. Once the strip is placed under the tongue, the mouth is to remain closed for four to eight minutes until the film is completely dissolved.⁶¹ Patients are instructed not to chew or swallow the medication because the medication is not effective if ingested instead of absorbed.⁶² The ineffectiveness of the medication due to improper administration may lead individuals to diverting medication by keeping a piece of the film to be taken later in the day to help them sleep. Improper administration causing withdrawal has also resulted in some individuals using additional medication from the illicit market in the jail.

7. Dosing

Multiple PILP clients report that jails limit their dose of Suboxone to 8 mg or less per day. To be effective, buprenorphine must be given at a sufficiently high dose. Some treatment providers wary of using opioids have prescribed lower doses for short treatment durations, leading to the failure of buprenorphine treatment and the mistaken conclusion that the medication is ineffective.⁶³

Suboxone is indicated for the maintenance treatment of OUD and the recommended target dosage of suboxone is 16 mg per day.⁶⁴

Other Issues

1. Attitudes of Jail Personnel

The attitudes of jail personnel present challenges to providing MOUD to incarcerated individuals.⁶⁵ Incarcerated people have reported that correctional officers frequently refer to them with derogatory labels like “dope heads,” “junkies” or “the Suboxone gang” and harass them by announcing publicly their OUD diagnosis. Some jail personnel appear to believe that it is appropriate to impose “extrajudicial punishment of [incarcerated] people for their societal misdeed and therefore believe [incarcerated people] should experience the ‘natural consequences’ of their actions; that is, opioid withdrawal.”⁶⁶

There is still widespread failure of jail officials to recognize OUD as a medical disorder resulting from chemical changes in the brain. Many officials, especially in jails where no form of MOUD is provided, favor “cold turkey” withdrawal and abstinence as the goal of treatment.

2. The Illicit Market

To avoid withdrawal symptoms, incarcerated individuals may continue to buy drugs from the illicit market. Illicit market purchases lead to drug-related deaths and a high risk of HIV and hepatitis C transmission from needle sharing.⁶⁷ Incarcerated individuals have reported that due to the lack of access to MOUD, people openly purchase Suboxone paying a high cost and incurring debts for an 8mg strip of Suboxone that a person will cut into pieces to last for up to six days.

Purchasing Suboxone from the illicit market subjects the buyer to the risk of receiving a misconduct for having contraband. Illicit market purchasing can cause individuals to serve additional time in jail or prison, lose jobs, spend time in solitary confinement, be subjected to strip searches, or lose visitation and phone privileges. In addition to these collateral consequences, individuals purchasing medication on the illicit market are often forced to suffer through withdrawal multiple times if they cannot always afford to purchase their medication.

A.Z.

In order to avoid suffering through withdrawal, A.Z. purchases Suboxone on the illicit market in prison. This causes him and his family and friends significant stress, due to the high cost of purchasing Suboxone this way. A.Z. relies on the financial support of close friends to purchase suboxone. One friend works a second job to help A.Z. get his needed medication. A.Z. constantly worries that if he is cut off from his medication, he will have to go through debilitating withdrawal. He also worries about potential risks to his personal safety due to the significant debts he incurs by purchasing Suboxone on the illicit market.

Withdrawal Protocol

If there are circumstances in which withdrawal is necessary, tapering by using slowly decreasing doses of MOUD is the standard of care.⁶⁸ “[M]ethadone and buprenorphine are more effective in supporting an individual through the process of withdrawal than just providing comfort medications.”⁶⁹ This study found that 32% of jails (20 of 62) provide some formulation of buprenorphine taper for withdrawal.⁷⁰

Some clients have reported that the method used by the jail does not decrease the medication dosage over a period of days, but the taper only consists of one or two doses of buprenorphine. For example, on admission to the jail, the individual will be told that they will receive Suboxone for the next three days only, and then will be given “comfort” medications to ease the symptoms of withdrawal.

Acute symptoms of withdrawal often begin within 12 hours of the last opioid use for short-acting opioids such as heroin and oxycodone, peaking within 24–48 hours, and lasting for 3 to 5 days. For long-acting opioids such as methadone, withdrawal symptoms generally emerge within 30 hours of the last drug use and may last up to 10 days, but in some cases may last up to 6–8 weeks or longer. Most jails’ withdrawal protocols do not address the fact that acute withdrawal from methadone is more severe and lasts longer than withdrawal from buprenorphine or illegal drugs and requires different medications and increased dosages.

Many people believe that withdrawal from opioids is an acute event that is over within a matter of weeks. **On the contrary, post-acute withdrawal symptoms can continue for weeks to months, and sometimes years.**⁷¹ About 90% of OUD patients experience post-acute withdrawal symptoms, characterized as impairments that can persist for weeks or months and fluctuate in severity.⁷²

Discharge Planning and Re-entry

This study found that 65% of jails (40 of 62) provided discharge planning in the form of providing information on community services and re-entry programs.

However, few jails provide re-entry planning with case managers or nurse navigators. On-site case managers or nurse navigators can ensure that individuals have treatment program appointments scheduled, arrange for individuals to receive a 3-day supply of medication upon release, coordinate health insurance re-enrollment, and submit housing applications.

Lack of Data Collection by Jails on Race and Ethnicity

In an effort to determine the impact of race and gender on MOUD access, each county jail was requested to provide data on: (1) the number of people incarcerated in the jail, broken down by race and gender; and (2) the number of incarcerated people with OUD broken down by race and gender. Almost every jail responded that information regarding the race and gender of incarcerated people with OUD was not tracked, or that they had no documents with this data.

Medical Vendors

This study found that 60% of jails (37 of 62) have outsourced all healthcare for incarcerated people, including provision of MOUD. Almost all of the jails (34) with a medical vendor providing their healthcare use the same company, PrimeCare Medical. These vendors, and PrimeCare Medical in particular, appear to have a general set of policies which they provide to all the jails with which they contract. One of PrimeCare Medical's MOUD policies is written very generally, and it is unclear as to the actual policy implemented at each specific jail. This posed a challenge in determining each jail's specific procedures.

The PrimeCare Medical policy titled "Medically Supervised Withdrawal and Treatment" states, "Written policies shall exist addressing the management of patients, including pregnant patients, on methadone or similar substances. Patients entering the facility on such substances shall have their therapy continued, or appropriate treatment for methadone withdrawal syndrome is to be initiated."

Of the jails that do not provide MOUD, none of them contract with a medical vendor.

PENNSYLVANIA DEPARTMENT OF CORRECTIONS

Prior to January 2018, the Pennsylvania Department of Corrections (“DOC”) (the state prison system) only provided MOUD to pregnant incarcerated people, and only during their pregnancy. In January 2018, the DOC began providing Vivitrol for non-pregnant incarcerated people being released from prison and oral naltrexone for new intakes with short minimum sentences.⁷³

In June 2019, the DOC expanded their MOUD offerings and began providing Suboxone continuation. Suboxone is only available to new intakes who have a verified prescription for MOUD. New people entering the DOC on methadone or those who were not enrolled in a treatment program are evaluated on a case-by-case basis. This policy raises several issues:

1. Incarceration Prior to 2019: Individuals who were incarcerated at the DOC before the June 2019 expansion of the MOUD program do not have access to MOUD, regardless of whether they received MOUD prior to their incarceration.

2. Lack of Availability of Methadone: Methadone is not available to non-pregnant people in the DOC, regardless of whether they were receiving it prior to their incarceration.

FROM OUR CLIENTS

B.B.

B.B. had been successfully receiving treatment in a methadone program when she was about to be sentenced. She was most likely to go to the Pennsylvania Department of Corrections (DOC), where methadone is not available to people who are not pregnant. As a result of the DOC’s policy, B.B.’s doctors decided to transition her from methadone to Suboxone. The process of transitioning from one medication to another takes weeks and requires the patient to slowly taper off methadone before Suboxone is slowly introduced. It must be done carefully, or it can cause a severe form of withdrawal.

FROM OUR CLIENTS

N.R.

N.R. has a twenty-five-year history of OUD. She was incarcerated at a county jail for thirty days before being transferred to a Pennsylvania state prison. On the day her incarceration began, she received her daily dose of 90 mg of methadone. However, the county jail where she was first incarcerated did not offer MOUD. Later, the state prison denied her MOUD because on the day she was transferred to state prison, her last dose of Suboxone was 30 days prior to her transfer. N.R. was denied MOUD because the jail she came from did not provide MOUD to non-pregnant people.

3. Prior Incarceration in a Jail Not Offering MOUD: Individuals who were in a treatment program in the community prior to being incarcerated in a county jail, but who then enter county jail which does not provide MOUD, are often not eligible to receive MOUD even though they had a prescription pre-incarceration. More recent policy documents indicate that this practice recently changed, but multiple PILP clients reported this issue.

LEGAL LANDSCAPE

Federal courts are increasingly recognizing several legal claims when an individual who was previously on MOUD is denied MOUD while incarcerated. Several cases on behalf of individuals denied MOUD by a jail or prison despite having an active MOUD prescription have successfully argued that the jail or prison violated the Eighth Amendment's prohibition on cruel and unusual punishment, the Fourteenth Amendment's Due Process clause, the Americans with Disabilities Act, and the Rehabilitation Act.

The cases thus far have focused on the legal right to continuation, but these same legal principles should apply to induction. Jails have an obligation to treat other medical conditions, diabetes for example, regardless of whether the individual was receiving treatment prior to their incarceration. The same is true for OUD.

Constitutional Claims

The Eighth Amendment's prohibition on cruel and unusual punishment requires jails to provide adequate medical care to incarcerated people. To state a constitutional claim based on inadequate medical care, an incarcerated individual must establish that prison officials were deliberately indifferent to their serious medical needs.⁷⁴ Deliberate indifference is "a conscious disregard of a serious risk," and it exists where a prison official "act[s] or fail[s] to act despite his knowledge of a substantial risk of serious harm."⁷⁵

The Fourteenth Amendment provides those same, if not greater protections, to individuals who are incarcerated pre-trial.⁷⁶

Several courts have acknowledged that OUD and withdrawal from opioids are serious medical needs. In recent cases, courts have acknowledged that failure to continue MOUD for an individual who was receiving it before entering jail could constitute deliberate indifference. *See, e.g., Strickland v. Delaware Cty.*, No. 21-4141, 2022 U.S. Dist. LEXIS 71347 (E.D. Pa. April 19, 2022); *P.G. v. Jefferson Cty.*, No. 21-388, 2021 U.S. Dist. LEXIS 170593, at *10-11 (N.D.N.Y. Sept. 7, 2021); *Smith v. Aroostook Cty.*, 376 F. Supp. 3d 146, 160 (D. Me. 2019); *Pesce v. Coppinger*, 355 F. Supp. 3d 35 (D. Mass. 2018); *see also Rokita v. Pa. Dep't of Corr.*, No. 340 M.D. 2020, 2022 Pa. Commw. LEXIS 44 (Pa. Commw. Ct. April 12, 2022).

Statutory Claims

The Americans with Disabilities Act ("ADA") and the Rehabilitation Act ("RA") also provide protections to incarcerated people who were previously receiving MOUD. The standard for establishing a claim under these statutes is the same. A plaintiff (the person bringing the lawsuit) must establish that they are a qualified individual with a disability who was precluded from participating in a program, service, or activity, or otherwise was subject to discrimination, by reason of their disability.⁷⁷

Plaintiffs can demonstrate disability discrimination in several ways, for example, where adverse actions are motivated by prejudice and fear of disabilities, or by failing to make reasonable accommodations for a plaintiff's disabilities.⁷⁸ Often, in cases where an incarcerated person is denied MOUD, both types of discrimination are present.

It is well-established that an individual with OUD who is in treatment or recovery is "a qualified individual with a disability."⁷⁹ Individuals who are denied MOUD while incarcerated are most clearly precluded from the jail's medical services, but also often unable to participate in other programs or activities due to symptoms of withdrawal and uncontrolled OUD, such as exercising, taking part in group activities, and eating.

Jails with a blanket policy against providing MOUD to incarcerated people have a policy which is discriminatory against people with OUD on its face because they fail to consider the individual medical needs of the incarcerated patient. These jails also discriminate against individuals with OUD by failing to provide them with a reasonable accommodation. Providing MOUD may require jails to adjust some of their policies or practices regarding providing other medications, but under the ADA, such an accommodation is required as long as it is reasonable.⁸⁰

The United States Department of Justice ("DOJ"), which is tasked with enforcing the ADA, also recently issued guidance making clear that removing an individual from MOUD violates their rights under the ADA. The DOJ's guidance explains that the ADA "prohibits discrimination against people in recovery from opioid use disorder ("OUD") who are not engaging in illegal drug use, including those who are taking legally-prescribed medication to treat their OUD."⁸¹ The guidance also includes the following example of an ADA violation:

"A jail does not allow incoming [incarcerated people] to continue taking MOUD prescribed before their detention. The jail's blanket policy prohibiting the use of MOUD would violate the ADA."⁸²

State Law Claims

In some cases, medical malpractice claims under state law are also appropriate. These claims are brought against medical providers, and, to prevail on this claim, a plaintiff must only establish that the care provided fell below the standard of care.⁸³

RECOMMENDATIONS

Provide all forms of MOUD to incarcerated people with OUD

- All jails and prisons should provide access to all medications for opioid use disorder, regardless of whether a person has a verified prescription. Assessments should be individualized to each patient's needs. The medications provided should include agonists, partial agonists, and antagonists.

Provide induction of MOUD

- All jails and prisons should provide induction (starting a prescription) of MOUD, even if a person has been using illicit opioids. This would improve treatment outcomes, reduce recidivism, and address racial, ethnic, and socioeconomic inequities and disparities in access to healthcare, housing, transportation, and insurance.

Decrease barriers to treatment

- Minimize barriers to MOUD for people with OUD upon entry to the jail. This includes eliminating arbitrary barriers or restrictions to MOUD access, such as mandatory psychosocial screening; lengthy assessments before treatment; abstinence goals rather than harm reduction practices; residency requirements; and arbitrary tapering timelines.
- Low barrier MOUD also maintains people in active recovery.

Follow the medical ethical guidance of “Do No Harm”

- Medical providers and incarcerated patients should have the opportunity to discuss and develop a plan to maintain active recovery, focused on evidence-based care. Forced withdrawal and an expectation of abstinence cause direct harm due to the pain and suffering associated with withdrawal, and indirect harm by causing patients to practice risky behaviors to get medication to treat their disease.
- All healthcare providers credentialed to administer MOUD should receive annual or regular training on the proper administration of medications for opioid use disorder.
- Results from instant urine drug screen tests should not be relied upon without a certified laboratory urine test to confirm the result.
- Ensure that only licensed, or appropriately certified health care staff administer MOUD, rather than correctional officers who are not medically trained.

Provide alternative modes of MOUD where necessary

- When a jail staff member suspects an individual of diversion, the incarcerated person should receive due process.
- Because MOUD is a necessary medication, people should not be removed from MOUD for diversion or alleged diversion. If concerns about diversion are founded, the jail or prison should consider alternatives that would still maintain the person's treatment with MOUD.

Never remove someone from treatment for a disciplinary reason

- For other diseases and chronic conditions, medications are not stopped for disciplinary purposes. MOUD is not different from other medications, and it should not be taken away as a punishment.

Use agonist taper

- An agonist taper is the standard of care and should be used in all circumstances if detox is medically necessary.
- Additionally, if someone must be detoxed, ensure that during the process, a validated assessment tool is used.

Track key data, including by race, ethnicity, and gender

- Jails should include information related to MOUD in their data tracking, including demographic, racial, and ethnic data for individuals with OUD, information about who is detoxed and why, and types of MOUD administered.

Educate staff regarding the realities of OUD as a chronic disease

- Jails should provide training to all staff about the science of OUD, including its chronic nature; the success of MOUD as a treatment; and in particular, its benefits in a correctional setting.

Ensure the quality of MOUD programs by establishing and tracking quality indicators

- The medical care system in the community has a robust system of data tracking and development of corrective action plans to ensure the quality of medical services provided. Collected data could include information on missed doses and/or removals from the MOUD program.

Improve discharge planning including the use of nurse navigators

- Jails should partner with hospital systems and place hospital case managers on site at jails to provide discharge planning prior to release. A skilled case manager will help reduce the risk of post-release opioid-related overdose mortality by addressing the social determinants of health and well-being. Case managers and nurse navigators can assist in identifying and addressing the effects of disrupted social networks/support, poverty, interruptions in health care, access, incarceration-related stigmas, and an exacerbation of underlying psychiatric and substance use disorders.

Direct opioid litigation settlement funds to jails and prisons

- Jails require funding to implement successful MOUD programs. As jails are on the front lines of the overdose epidemic, the funds available from the opioid litigation settlements should be directed there to maximize the impact on stemming the tide of the overdose epidemic.

RESOURCES

Several organizations have created resources which can assist jails in implementing the recommendations discussed here. These toolkits and other resources are available in Appendix B.

CONCLUSION

Opioid use disorder is a chronic disease that has devastated communities across Pennsylvania. The medical community has established that treatment with agonist Medication for Opioid Use Disorder (MOUD) is the standard of care and leads to better outcomes. In contrast, forced withdrawal and detoxification create physical and mental pain and increase the risk of overdose. Despite this, our review of the jails in Pennsylvania demonstrates that many jails only offer agonist MOUD in limited situations. Several jails offer no access to MOUD at all. Even jails that provide some MOUD have issues within their MOUD programs. By providing full access to MOUD, jails and prisons can be a critical part of the solution in addressing this epidemic that has impacted communities all across Pennsylvania and the country.

References

- ¹ Kyle Kampman & Margaret Jarvis, *American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, 9 J. Addict. Med. 358 (2015), https://journals.lww.com/journaladdictionmedicine/Fulltext/2015/10000/American_Society_of_Addiction_Medicine_ASAM_3.aspx.
- ² The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5") is generally considered the authoritative guide to the diagnosis of mental disorders by the medical community.
- ³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (2013).
- ⁴ *Id.*
- ⁵ R. Douglass Bruce & Rebecca A. Schleifer, *Ethical and Human Rights Imperatives to Ensure Medication-Assisted Treatment for Opioid Dependence in Prisons and Pre-trial Detention*, 19 Int. J. Drug Pol'y 17 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2366202/>.
- ⁶ Thomas R. Kosten & Tony P. George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, 1 Sci. & Prac. Persp. 13 (2002), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2851054/>.
- ⁷ *Id.*
- ⁸ Bruce, *supra* note 5.
- ⁹ U.S. Department of Veterans Affairs, *Identifying and Managing Opioid Use Disorder (OUD): A VA Clinician's Guide* (2020), https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/OUD_Provider_ProviderGuide_IB10933.pdf.
- ¹⁰ Bruce, *supra* note 5.
- ¹¹ Press release, Ctr. for Disease Control and Prevention, Nat'l Ctr. for Health Stat. *U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020 – But Are Still Up 15%*. (May 11, 2022), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.
- ¹² Nat'l Inst. on Drug Abuse, *Pennsylvania: Opioid-Involved Deaths and Related Harms* (April 3, 2020), <https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/pennsylvania-opioid-involved-deaths-related-harms>.
- ¹³ Pennsylvania Medical Society, *Addressing PA's Opioid Abuse and Overdose Crisis* (2017), https://www.pamedsoc.org/docs/librariesprovider2/pamed-documents/opioid-hod-slide-deck_dr-gallagher-final.pdf?sfvrsn=96899d48_2.
- ¹⁴ Brian King, Ruchi Patel, & Andrea Rishworth, *Assessing the Relationships Between COVID-19 Stay-at-Home Orders and Opioid Overdoses in the State of Pennsylvania*, *Journal of Drug Issues*, 51 J. Drug Issues 4 (2021), <https://journals.sagepub.com/doi/10.1177/00220426211006362>.
- ¹⁵ Nat'l Inst. on Drug Abuse ("NIDA"), Nat'l Inst. of Health, *Medications to Treat Opioid Use Disorder Research Report*, (Dec. 2021), <https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-opioid-use-disorder-treated-in-criminal-justice-system>.
- ¹⁶ *Id.*
- ¹⁷ National Academies of Sciences, Engineering, and Medicine, *Medications for opioid use disorder save lives* (2019), <https://nap.nationalacademies.org/read/25310>.
- ¹⁸ The American Medication Association, *Medications to Treat Opioid Use Disorder (MOUD)*, <https://www.ama-assn.org/topics/medications-treat-opioid-use-disorder-moud>.

References (continued)

- ¹⁹ Press Release, U.S. Dept. of Health and Human Services, *HHS Expands Access to Treatment for Opioid Use Disorder* (Jan. 14, 2021), <https://www.hhs.gov/about/news/2021/01/14/hhs-expands-access-to-treatment-for-opioid-use-disorder.html#:~:text=%22The%20medical%20evidence%20is%20clear,use%20disorder%2C%22%20said%20Adm.>
- ²⁰ U.S. Food and Drug Admin, *Information about Medication-Assisted Treatment (MAT)*, <https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat#:~:text=There%20are%20three%20drugs%20approved,with%20counseling%20and%20psychosocial%20support.>
- ²¹ See NIDA, *supra* note 15.
- ²² Substance Abuse and Mental Health Services Admin., U.S. Dep't Health and Hum. Serv., *Medications for Opioid Use Disorder: For Healthcare and Addiction Professionals, Policymakers, Patients, and Families*, TIP 63 (2021), https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-02-01-002.pdf.
- ²³ American Society of Addiction Medicine (“ASAM”), *National Practice Guidelines for the Treatment of Opioid Use Disorder*, 11 (2020). <https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline>.
- ²⁴ Sarah E. Wakeman, et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder* (2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032>.
- ²⁵ NIDA, *supra* note 15.
- ²⁶ University of Illinois for Healthline, *Methadone, Oral Tablet 1*, (2020), <https://www.healthline.com/health/drugs/methadone-oral-tablet#important-considerations>.
- ²⁷ NIDA, *supra* note 15.
- ²⁸ See 28 Pa. C.S. § 715.29.
- ²⁹ See, e.g., George W. Hill Correctional Facility, *Local Operating Procedure, No. J-F-04, Medically Supervised Withdrawal and Treatment, Methadone Pick up SOP* (March 1, 2019).
- ³⁰ NIDA, *supra* note 15.
- ³¹ *Id.*
- ³² Substance Abuse and Mental Health Serv. Admin., U.S. Dep't Health and Hum. Serv., *FAQ's About the New Buprenorphine Practice Guidelines* (2021), <https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner/new-practice-guidelines-faqs>.
- ³³ NIDA, *supra* note 15.
- ³⁴ *Id.*
- ³⁵ *Id.*
- ³⁶ Wakeman, *supra* note 24.
- ³⁷ NIDA, *supra* note 15.
- ³⁸ Ctr. on Addiction, *Behind Bars II: Substance Abuse and America's Prison Population*, (2010), https://www.prisonlegalnews.org/media/publications/natl_center_on_addiction_prisoner_substance_abuse_report_2010.pdf.
- ³⁹ Christy K. Scott, et al, *The impact of the opioid crisis on U.S. state prison systems*, 9 Health & Justice 17 (2021), <https://healthandjusticejournal.biomedcentral.com/articles/10.1186/s40352-021-00143-9#citeas>.

References (continued)

- ⁴⁰ Christine Vestal, *New Momentum for Addiction Treatment Behind Bars*, Stateline, (April 4, 2018), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars>.
- ⁴¹ Paul J. Joudrey, et al., *A Conceptual Model for Understanding Post-Release Opioid-related Overdose Risk*, 14 *Addict. Sci. Clin. Pract.* 17 (2019), <https://doi.org/10.1186/s13722-019-0145-5>.
- ⁴² Ingrid A. Binswanger et al., *Release from prison—a high risk of death for former inmates*, 157 *New Engl. J. Med.* 157 (2007).
- ⁴³ American Society of Addiction Medicine, *Public Policy Statement on Treatment of Opioid Use Disorder in Correctional Settings*, (2020), <https://www.asam.org/docs/default-source/public-policy-statements/2020-statement-on-treatment-of-oud-in-correctional-settings.pdf>.
- ⁴⁴ Michael Linden et al., *Prisoners as Patients: The Opioid Epidemic, Medication-Assisted Treatment and the Eighth Amendment*, 46 *J. L. Med. & Ethics*, 252, 257 (2018), <https://pubmed.ncbi.nlm.nih.gov/30146987/>.
- ⁴⁵ Joudrey, *supra* note 41.
- ⁴⁶ Traci C. Green, et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 75 *J. Amer. Med. Assoc. Psych.* 405 (2018), <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2671411>.
- ⁴⁷ The National Sheriff's Association and National Commission on Correctional Healthcare, *Jail-Based Medication-Assisted Treatment Promising Practices, Guidelines, and Resources For The Field* (Oct. 2018), <https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf>.
- ⁴⁸ Joseph R. Friedman and Helena Hansen, *Evaluation of Increases in Drug Overdose Mortality Rates in the US by Race and Ethnicity Before and During the COVID-19 Pandemic*, 79 *J. Amer. Med. Assoc. Psych.* 379 (2022), <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2789697>.
- ⁴⁹ *Id.*
- ⁵⁰ Substance Abuse and Mental Health Services Administration, *The Opioid Crisis and The Black/African American Population: An Urgent Issue* (2020), https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf.
- ⁵¹ *Id.*
- ⁵² David R. Williams and Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21 *Health Care Finance Review* 75 (2000), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/>.
- ⁵³ *Id.*
- ⁵⁴ Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003), https://www.ncbi.nlm.nih.gov/books/NBK220358/pdf/Bookshelf_NBK220358.pdf.
- ⁵⁵ Each county in Pennsylvania (except Philadelphia) has a jail oversight board which has the duties and responsibilities of overseeing the jail operations and the health and safety of the incarcerated people. See 61 Pa. C.S.A. §§ 1721-1728.
- ⁵⁶ 42 Pa.C.S. § 9762
- ⁵⁷ State of New York Offices of the Inspector General, *Investigation of New York State Department of Corrections and Community Supervision Incarcerated Individual Drug Testing Program* (Jan. 2022), https://ig.ny.gov/system/files/documents/2022/01/doccs-microgenics_2764.316.2019_alb_report_20220103.pdf.

References (continued)

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ NIDA, *supra* note 15.

⁶¹ Medication Guide | SUBOXONE® (buprenorphine and naloxone) Sublingual Film (CIII), 5 (2021), <https://www.suboxone.com/pdfs/medication-guide.pdf>.

⁶² *Id.*

⁶³ NIDA, *supra* note 15.

⁶⁴ U.S. FDA, *Full Prescribing Information for Suboxone Prescribing*, 3, (2010), https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022410s0001bl.pdf.

⁶⁵ Curtis Bone et al., *Our Ethical Obligation to Treat Opioid Use Disorder in Prisons: A Patient and Physician's Perspective*, 46(2) *J. Med. Ethics*, 268 (2018), <https://pubmed.ncbi.nlm.nih.gov/30146992>.

⁶⁶ Bruce, *supra*, note 5.

⁶⁷ Bruce, *supra*, note 5.

⁶⁸ *Id.*

⁶⁹ ASAM, *supra* note 23.

⁷⁰ This number includes all jails who indicated that they provided a buprenorphine to one or more people. Many of these jails provided the buprenorphine taper very infrequently.

⁷¹ UCLA Semel Institute for Neuroscience and Human Behavior (2021), *Post-Acute Withdrawal Syndrome*, https://www.semel.ucla.edu/dual-diagnosis-program/News_and_Resources/PAWS.

⁷² *Id.*

⁷³ Pennsylvania Department of Corrections, *Medication Assisted Treatment (MAT)*, <https://www.cor.pa.gov/About%20Us/Initiatives/Pages/Medication-Assisted-Treatment.aspx>

⁷⁴ See *Farmer v. Brennan*, 511 U.S. 825, 835 (1994); *Estelle v. Gamble*, 429 U.S. 97, 103–06 (1976) (“[T]he incarcerated individual must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs.”).

⁷⁵ *Farmer*, 511 U.S. at 842.

⁷⁶ See *Kingsley v. Hendrickson*, 576 U.S. 389, 400 (2015); *Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979); *Hubbard v. Taylor*, 399 F. 3d 150, 167 n.23 (3d Cir. 2005).

⁷⁷ *Furgess v. Pa. Dep't of Corr.*, 933 F.3d 285, 288–89 (3d Cir. 2019).

⁷⁸ *Taylor v. Phoenixville Sch. Dist.*, 184 F.3d 296, 306 (3d Cir. 1999).

⁷⁹ 28 C.F.R. § 35.108(b)(2); see also *A Helping Hand, LLC v. Baltimore Cty., Md.*, 515 F.3d 356, 367 (4th Cir. 2008) (“Unquestionably, drug addiction constitutes an impairment under the ADA.”); *P.G.*, 2021 U.S. Dist. LEXIS 170593, at *10-11 (“Plaintiff counts as an ‘individual with a disability’ because he has been diagnosed with opioid use disorder and is participating in a supervised rehabilitation program[,] [and] is also ‘eligible’ to receive medical services while he is incarcerated.”).

⁸⁰ See *Strickland*, 2022 U.S. Dist. LEXIS 71347; *P.G.*, 2021 U.S. Dist. LEXIS 170593; *Smith*, 376 F. Supp. 3d at 160; *Pesce*, 355 F. Supp. 3d at 35; see also *Rokita*, 2022 Pa. Commw. LEXIS 44.

⁸¹ U.S. Department of Justice, Civil Rights Division, *The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery* (April 5, 2022), https://www.ada.gov/opioid_guidance.pdf.

⁸² *Id.*

⁸³ See *Toogood v. Owen J. Rogal, D.D.S., P.C.*, 573 Pa. 245, 254 (2003) (“Thus, to prevail in a medical malpractice action, a plaintiff must establish a duty owed by the physician to the patient, a breach of that duty by the physician, that the breach was the proximate cause of the harm suffered, and the damages suffered were a direct result of the harm.”)

Appendix A

County	No MOUD	Pregnant People Only	Naltrexone Only	Likely No Continuation	Continuation	Induction	No Jail	Notes
Adams					x			
Allegheny					x			
Armstrong					x			
Beaver			x					
Bedford	x							
Berks					x			
Blair		x						
Bradford		x						
Bucks					x			
Butler			x					
Cambria				x				
Cameron							x	
Carbon		x						
Centre			x					
Chester				x				
Clarion			x					
Clearfield					x			
Clinton					x			
Columbia					x			
Crawford					x			
Cumberland				x				
Dauphin					x			
Delaware			x					In February 2020, the Delaware County Jail Oversight Board passed a resolution stating its intention to expand its MOUD program.
Elk		x						
Erie		x						
Fayette					x			
Forest							x	
Franklin						x		
Fulton							x	
Greene			x					
Huntingdon					x			
Indiana			x					
Jefferson		x						
Juniata							x	People arrested in Juniata county are held in Mifflin county.
Lackawanna					x			The responses from Lackawanna County indicate that the county intends to start an induction program.
Lancaster				x				
Lawrence		x						
Lebanon					x			
Lehigh					x			
Luzerne			x					
Lycoming			x					
McKean	x							
Mercer			x					
Mifflin			x					
Monroe				x				
Montgomery						x		
Montour	x							
Northampton					x			
Northumberland				x				
Perry			x					
Philadelphia						x		
Pike			x					
Potter	x							
Schuylkill		x						
Snyder				x				
Somerset			x					
Sullivan							x	
Susquehanna	x							
Tioga	x							
Union	x							
Venango	x							
Warren	x							
Washington		x						
Wayne			x					
Westmoreland			x					
Wyoming		x						
York						x		
Total	9	10	16	7	16	4	5	
%	15%	16%	26%	11%	26%	6%		

Appendix B

Resources:

For jails looking to make a change and provide this necessary medical care, there are several resources available:

Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources For the Field by the National Sheriff's Association National Commission on Correctional Health Care

- <https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf>

Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning & Implementation Toolkit by the National Council for Behavioral Health and Vital Strategies

- <https://www.vitalstrategies.org/wp-content/uploads/2020/01/Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Jails-and-Prisons.pdf>

ACLU Report: Over-Jailed and Un-Treated

- <https://www.aclu.org/report/report-over-jailed-and-un-treated>

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THE PENNSYLVANIA INSTITUTIONAL LAW PROJECT

The Pennsylvania Institutional Law Project's (PILP) mission is to ensure equal access to justice for the shocking number of indigent incarcerated and institutionalized people within Pennsylvania whose constitutional and other rights are being violated. We recognize the formidable number of barriers to resources and specialized knowledge that institutional legal issues require. Our organization was created for the purpose of contributing this access and unique expertise. PILP provides civil legal assistance free of charge and is committed to ensuring that the most marginalized members of our community behind bars are afforded their constitutionally protected rights.

VITAL STRATEGIES

Vital Strategies helps governments strengthen their public health systems to contend with the most important and difficult health challenges. They design solutions that can scale rapidly and improve the lives of millions of people. Vital Strategies' mission is to work in partnership to reimagine evidence-based, locally driven policies and practices to advance public health.

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