

The Status of Medications for Opioid Use Disorder (MOUD) Provision in Washington State Jails, 2021



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Executive Summary

Individuals releasing from long-term incarceration are at an increased risk of death, largely due to risk of drug overdose, including opioid overdose. Medications for opioid use disorder (MOUD) reduce the risk of opioid overdose and have been identified as an important intervention to reduce the risk of death for people releasing from incarceration. In 2021, a survey was conducted with Washington State jails to better understand the current use of MOUD and inform funding efforts.

Of the 57 active jails in Washington State, 47 (82%) participated in the survey, representing 98% of all jail residents. Nine jails did not respond to survey requests or were not contacted due to being a very small jail, and one jail refused.

Of those jails responding, the majority screen for opioid withdrawal immediately at booking (n=44, 92%) and this is most commonly done by correctional officers (COs: n=30, 63%; nurses: n=17, 35%). The Clinical Opioid Withdrawal Scale (COWS) was the most commonly reported tool used for opioid withdrawal screening (n=25, 52%). Buprenorphine was used for opioid withdrawal management in 29 (62%) of the reporting jails, whereas 15 (32%) used other prescribed medications, and 3 (7%) used over-the-counter medications or water only. Methadone was continued (i.e., residents with outside prescriptions continued to receive the medication) for all residents at 25 (53%) of the 47 reporting jails with an additional 8 (17%) jails continuing "some" residents on methadone. Most jail respondents (n=45, 96%) continue residents on buprenorphine with an additional 1 (2%) jail continuing "some" residents. Naltrexone is continued by 28 (60%) jails in some formulation with an additional 1 (2%) jail continuing "some" residents. Buprenorphine was initiated at 31 (66%) responding jails, and 16 (34%) jails started people on naltrexone. No jails in Washington State currently were able to start people on methadone. Most jails providing buprenorphine dosed residents daily (n=35, 74%; non-daily "balloon dosing": n=5, 11%).

At release, 25 (53%) of the reporting jails provide MOUD in hand, 11 (23%) jails provide a written MOUD prescription, 3 (6%) arrange for a next-day MOUD appointment, 2 (4%) had variable plans, and 7 (15%) jails facilitated no bridging plan. Almost half (n=23, 49%) of responding jails provide naloxone at release to residents on MOUD.

In summary, most jails use prescribed (opioid or non-opioid) medications to treat opioid withdrawal, but only half use buprenorphine, the standard of care in the community. Although buprenorphine is continued at almost every jail in Washington State, only two-thirds start people on this medication. Methadone is not started in any jail and only half continue this medication. Additional efforts are needed to provide these life-saving MOUD, including increased funding for staff and medications, administrative and legal support.

Background

The Washington State Department of Health describes the widespread use and overdose of opioids* in Washington as a “crisis.”¹ Opioid overdose-related death rates are rising steadily throughout the state² and public health efforts to prevent and address opioid overuse in Washington communities are urgently needed. In 2018, an estimated 53% of people in Washington with opioid use disorder exited the doors of a jail over the course of a year.³

Admission to a jail also presents a risk to die from opioid use disorder (OUD). Indeed, contrary to a longstanding belief in the medical and lay community, forced withdrawal from opioids (“cold turkey”) can be a fatal event in the most severe cases^{4,5}. Washington jail residents have not been immune from such deaths.^{6,7,8,9} Withdrawal induces vomiting, diarrhea, and metabolic hyperactivity (e.g., fast heartbeat, tremor), all of which cause the net loss of fluids and electrolytes. If those fluids and electrolytes are not adequately replaced, patients become dehydrated with imbalance of electrolytes in their blood, severe states of either or both of which can cause death.

Not only is opioid withdrawal a risk for death upon admission to a jail, but opioid overdose is a risk for death upon release from a carceral institution. A study of individuals released from the Washington State Department of Corrections showed that individuals experience an almost 129-fold increase in the risk of death from overdose in the first two weeks after release.¹⁰ Opioids were involved in almost 15% of all post-release deaths.¹¹

Thus, beginning treatment for OUD in jail is strategic harm reduction from a public health standpoint, may help to prevent withdrawal deaths in jail, and may help to prevent overdose deaths after release from jail. The cornerstone of this early OUD treatment is the use of medications (methadone, buprenorphine, and naltrexone), known as medications for opioid use disorder (MOUD). While counseling is a valuable part of OUD treatment, its value accrues over long-term exposure, something that is generally not possible in the jail setting where lengths of stays can be measured in days, if not hours. Further, research shows that not all patients with OUD desire counseling and that medications alone have value in treating OUD in such patients.¹²

*Technically opiates are naturally occurring narcotic substances and opioids are narcotic substances which are partially or wholly synthetic. Both contribute to the current narcotic-related substance use crisis. In line with current usage, we use the term opioid in this report to denote both opiates and opioids.

While jails provide an important venue to provide MOUD, according to the previously cited 2018 report, many jails have limited or no MOUD program.³ To inform funding and legislative efforts, there was a need for data regarding the current status of MOUD provision in Washington's jails. Thus, the purposes of the current survey were to provide data on MOUD practices, barriers to service provision, and fiscal costs to address these gaps in Washington jails.

Methods

Overview

Data on current MOUD practices in jail were collected using a semi-structured survey. Surveys were conducted by two interviewers: a correctional physician with experience treating OUD (MFS) and an advanced graduate student in public health (AB). Interviews were completed between June 2021 and February 2022. This survey was an administrative inquiry to inform government planning and action and thus did not meet the definition of research or require human subjects review.

Survey Development

Survey questions and format were developed with input from experts with experience in jail-based MOUD provision, the HCA (see Appendix A), legislation, and MOUD research. An initial draft then underwent pilot testing with an experienced custody administrator at a facility with an advanced MOUD program, resulting in further modifications. Finally, the interview instrument was refined iteratively over the first two months of interviews, based on participant responses and feedback during the interview process.

The instrument was designed to be used in oral interviews with semi-structured questions and opportunities for clarifying questions based on respondent responses. The final version (see Appendix B) had approximately 50 questions distributed across nine topics: Screening for Withdrawal, Withdrawal Management, Continuation of Community-Prescribed MOUD, MOUD Induction, Counseling, Prescriber, Release Medications, Release Planning and Logistics, and Barriers and Costs.

Interviewers

A correctional physician (MFS) with experience treating OUD conducted 20 interviews. A research assistant (AB) conducted 32 interviews. The research assistant received didactic instruction on jail settings and the delivery of health care in jails, principles of MOUD, and the delivery of MOUD care in the criminal legal setting and participated in a site visit to a jail with a mature MOUD program. The research assistant observed and co-led three interviews conducted by the correctional physician, then conducted two interviews under supervision. The research assistant maintained communication with the correctional physician throughout the survey period to ask questions,

clarify answers, and, where necessary, to have the physician recontact informants directly to clarify answers.

Settings

There are 57 active jails in Washington State, including 38 county, 14 city, 2 inter-jurisdictional, and 5 jail facilities. One additional jail (Oak Harbor) was not active at the time of survey, but instead contracted with another facility. The average daily population across all jail facilities, at year-end 2019, was 11,764. The average length of stay at that time, weighted by each jail's average daily population, was 16.3 days.

Procedures

To initiate recruitment, the Washington Association for Sheriffs and Police Chiefs (WASPC) sent an introductory email to all jails to announce the survey. The survey and interviewers were also introduced at a regular statewide meeting of jail administrators. Jail commanders were then contacted directly via email or phone to complete the survey. Four attempts via email and phone were made to contact a jail before it was considered non-responsive.

Surveys were conducted with jail staff most knowledgeable about the MOUD program and could include corrections staff, health care managers, internal or external MOUD providers, nursing staff, and other substance use or mental health staff. If the initial interviewee indicated that another individual would be able to respond more accurately to certain questions, the interviewee or interviewer contacted that individual. Total interview time (including multiple interviews) per facility was between 30 minutes and 2 hours. Due to the complexity of information and nuanced differences between jails, probing questions and clarifications were unstructured to allow for maximum accuracy of information. Interviews were not recorded; instead, interviewers took detailed notes.

Interviewees were asked to reply to questions based on the status of their MOUD program in December 2019. This time was chosen due to changes in jail bookings, staff availability, and jail operations, due to the COVID-19 pandemic. For example, during COVID there have been fewer patients admitted to the jails, resulting in a proportional decrease in the number of patients with OUD and only those charged with serious crimes were being booked. Additionally, to varying degrees, many jails were forced to redirect limited staff and other resources away from OUD management to handling the COVID crisis. Thus, MOUD services during COVID-19 may not accurately reflect normal operations.

Results

Forty-eight (84%) jails completed the survey, representing 11,553 (98%) of all 11,764 jail residents in Washington State. Eight jails did not respond to recruitment efforts and one jail refused to

complete the survey. At the time of surveys, 14 (29%) of the 48 responding jails received any grant funding for their MOUD services.

Opioid Withdrawal

Screening. Most jails screened residents for risk of withdrawal from opioids immediately at booking (n=41), with others within 24 (n=4) or 72 hours (n=1), and one jail reporting that they did not screen. Screening for opioid withdrawal was most commonly done by a correctional officer (n=30; nurse: n=17; no one: n=1) and using the Clinical Opioid Withdrawal Scale (COWS; n=25). One jail reported using the WOWS,* one used vital signs only to screen opioid withdrawal, and 21 said they did not use any formal tools.

Monitoring. Residents were most commonly monitored for opioid withdrawal by healthcare staff (n=21). Other jails used corrections officers only (n=17) or a combination of healthcare staff and correctional officers (n=8); 2 jails did not monitor.

Management. Twenty-nine jails used buprenorphine for opioid withdrawal management, including initiation of buprenorphine (n=9), only a buprenorphine taper (n=10), or both initiation and taper depending on the resident (n=10). An additional 15 jails used other prescribed medications (not buprenorphine), and 3 used over-the-counter medications to manage opioid withdrawal. One jail did not respond to the question about how opioid withdrawal was managed.

MOUD Continuation and Initiation for Opioid Use Disorder

Screening for Opioid Use Disorder. While screening for withdrawal identifies most patients with opioid use disorder, some patients have the disorder but without physical dependence (i.e., without the risk of experiencing physiologic withdrawal symptoms if the substance is discontinued). Almost half of reporting jails screened all residents for opioid use disorder (n=23), with 15 of 23 happening at booking and 8 screening at a later time. Of the remaining jails, 8 screened for opioid use disorder only when asked by a resident and 17 screened no one.

Continuation. Jails reporting continuation and initiation of MOUD are provided in Table 1. Methadone was continued for all residents at 25 of the 48 reporting jails (52%) with an additional 8 (17%) jails continuing "some" residents on methadone. Most jails respondents (n=45, 94%) continued residents on buprenorphine with an additional 1 (2%) jail continuing "some" residents. Naltrexone was continued by 28 (58%) jails in some formulation with an additional 1 (2%) jail continuing "some" residents.

*Wilcox Opioid Withdrawal Scale, a non-validated scale used at the Salt Lake County Jail.

Initiation. Buprenorphine was initiated at 31 (65%) responding jails and 16 (33%) jails started people on naltrexone. No jails in Washington State are currently able to start people on methadone.

Table 1. MOUD provision in N=47 reporting jails.

	Methadone	Buprenorphine	Naltrexone
Continuation	All = 25 Some = 9 Switch to bup = 6 No plan = 4 Discontinue = 6	All = 44 Some = 1 Discontinue = 2	All = 16 Some = 1 Oral only = 11 No plan = 14 Discontinue = 5
Initiation	0	Sublingual = 29 Injectable = 2	Oral = 9 Injectable = 7

Notes. Bup = buprenorphine.

Buprenorphine Dosing

Of the 44 jails that either continue or initiate residents on oral buprenorphine for OUD, 33 (75%) dose daily and 5 (11%) use an alternate dosing regimen (“balloon” dosing 3-4 times a week). The remaining six (14%) jails did not provide an answer to dosing frequency of buprenorphine. Sixteen (36%) of the jails continuing or initiating buprenorphine had no maximum dose, 4 (10%) had a maximum dose of 24mg, 14 (31%) a maximum dose of 16mg, and 4 (9%) a maximum dose of 8mg per day. Three of the jails with maximum doses, however, stated that the maxima only applied to induction, with no maxima for continuation. Seven jails did not provide an answer to maximum daily dose of buprenorphine.

Buprenorphine tablets were the most common formulation, including 20 jails providing buprenorphine-only tablets and 6 providing the buprenorphine+naloxone tablets. Eight jails provided buprenorphine+naloxone film, and one jail provided injectable buprenorphine. Jails were permitted to list more than one formulation.

When asked about crushing buprenorphine tablets (e.g., which may reduce risk of medication diversion and/or is thought to decrease time to observe medication absorption), 20 of the 26 jails responding to this question reported crushing tablets some (n=1) or all (n=19) of the time. Six (13%) jails said they did not crush buprenorphine tablets.

OUD Counseling

Two (4%) jails reported that OUD counseling is offered to all residents, 17 (35%) jails provide it upon request, 5 (10%) jails only provide it to residents in the MOUD program, 4 (8%) jails provide it to anyone with an OUD, 20 (42%) jails do not provide OUD counseling to anyone, and 9 jails did not answer this question. The most common type of OUD counseling provided was individual counseling (n=11), group counseling (n=7), Narcotics Anonymous (n=6), and brief counseling (n=6). Fewer jails provide Residential Substance Abuse Treatment for State Prisoners (RSAT, a DOJ program) (n=1), peer services (n=1), or counseling via an electronic kiosk (n=1).

Medications at Release

Of the jails reporting, 21 (44%) provided naloxone at release, two (4%) jails provided it to some people, and 25 (52%) jails did not provide naloxone at all. Of jails providing doses, most provided 2 doses (n=19; 40%).

Most jails provided MOUD medications at release (n=25, 52%), while 11 (23%) jails provide a written prescription, 3 (6%) jails set people up with a next-day appointment, and 2 (4%) jails had variable protocols. Seven (15%) jails did not provide any MOUD at release.

Challenges

Jails reported a number of challenges implementing and expanding MOUD programs. Barriers related to prescribers were noted by multiple jails, including provider stigma toward MOUD, insufficient availability of X-waivered prescribers, and DEA limits on number of patients receiving buprenorphine. Jails also commented that a lack of community resources, especially local Opioid Treatment Programs (OTPs), made it difficult to offer MOUD.

Conclusions

Most jails use prescribed (opioid or non-opioid) medications to treat opioid withdrawal, but only half use buprenorphine, the standard of care in the community. Although buprenorphine is continued at almost every jail in Washington State, only two-thirds start people on this medication. Methadone is not started in any jail and only half continue this medication. Additional efforts are needed to provide these life-saving MOUD, including increased funding for staff and medications, administrative and legal support.

Dedication

This study is dedicated to the memory of John McGrath. John was a key partner in designing and implementing this study. He was supportive of the study from the beginning, provided input into its design and provided invaluable facilitation for accessing jail personnel. The study would not have been possible without him.

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Appendix A

Full-scale MOUD program

(From HCA RFA No. 2021HCA42)

- FDA approved medication for opioid use disorder (MOUD) must be available and offered to all incarcerated individuals who present with OUD at intake. Individuals with OUD may decline MOUD at any time, but ongoing discussions on MOUD may be offered.
- Methadone, buprenorphine, injectable long-acting naltrexone – all should be offered unless the availability of methadone through an opioid treatment program (OTP) is not within reasonable driving distance from the jail and may also be dependent on the availability of buprenorphine providers in the community.
- MOUD must be continued for those who are already taking MOUD upon entering the facility. It is continued using the same medication, at the same dose unless ordered otherwise by the prescriber based on clinical need (documented in the patient’s medical record). Methadone may be transitioned to buprenorphine if the jail is not a licensed opioid treatment program (OTP) and the nearest OTP is not within reasonable driving distance from the jail. The presence of other illicit or controlled substances should not result in discontinuation of MOUD (consistent with the 2020 ASAM National Practice Guideline for the Treatment of Opioid Use Disorder).
- Assessing for opioid use disorder (OUD) and risk of acute withdrawal must be done upon intake. The incarcerated individual must be educated on treatment choices and the process for continuation of access to MOUD, during incarceration, and upon release. (See resources for validated tool suggestions.)
- Individuals entering the facility who are physically dependent on opioids, must be offered MOUD treatment; forced withdrawal (including withdrawal using buprenorphine or methadone) is not acceptable unless the patient elects MOUD treatment with naltrexone, in which case withdrawal is clinically required. Use of other medications (clonidine, anti-emetics, anti-diarrheal, analgesics) may be used as adjuncts or may be used in place of opioid agonist or partial agonist if the individual so chooses, but they may not be the only withdrawal treatment available.
- Methadone and buprenorphine must be administered daily or more frequently. “Balloon” dosing is unacceptable. Healthcare providers should assess each case individually for frequency of doses.
- Discharge Planning and Reentry Coordination

- Provide at least 2 doses of naloxone and naloxone training to all incarcerated individuals with OUD upon release.
- Schedule the first community appointment with a treatment facility.
- Provide – in hand upon release and at no cost to the individual – sufficient doses of MOUD to bridge patient until scheduled MOUD follow-up appointment at community treatment facility (does not apply to patients treated with injectable MOUD).
- Individuals who are at risk of being released directly from court are informed, prior to going to court, that they may request to be transported back to the jail by staff to receive these medications prior to going home.
- In situations where an appointment cannot be made, e.g., after-hours bail-out, resident is given enough medication to last until the next available appointment at the community treatment facility. If that date is unknown, the individual is given a minimum of a 7-day supply.
- 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, the individual is informed that he/she may either return to the jail in the morning to receive bridge medications or, if no medical staff are present the following day, will have a prescription for the same bridging medication called to a local pharmacy, at no cost to the individual.

Appendix B Version 6.10.21 c

Introduction

You may have heard from John McGrath at WASPC and Dr. Stern that WASPC is trying to get good reliable information about Medication for Opioid Use Disorder or MOUD provided by WA jails (some people still call it MAT, but we are trying to move away from calling it MAT in order to move away from the notion that medication is auxiliary to treating OUD and rather an essential element of treatment, so we are calling it MOUD) We know that there a lot of jails that are finding it challenging to provide a full MOUD program. The Legislature also is aware of that and allocated about \$10M to help the jails meet the need for MOUD. Because we know that some jails are not there yet, WASPC is conducting this survey today to help inform how that \$10M is spent.

Chances are that you'll be able to answer a lot of these the questions, but if you are not, we can get them at a later date or might ask you to connect us with someone else who can answer the questions.

Jail _____ **Name/Role of jail administration** informant _____ **Date** of interview _____
Name/Role of clinical informant _____ **Date** of interview _____

What was the **ADP (pre-COVID)**?

Average **length of stay (pre-COVID)**?

Is the MOUD program funded through a grant? _____

If yes, which grant? _____ How much? _____ How long is the grant for? _____

1. Opiate Withdrawal (WD)

- a. Is there any formal screening for risk of WD?
- b. How do you screen for risk of WD?
 - i. Who conducts the screening?
 - ii. When is screening done?
 - iii. approx # of people who screen + for WD per month
- c. How is the decision made of who gets monitored for WD and for how long they get monitored?
 - i. Who monitors (CO, nurse, other)
 - ii. What monitoring tool (COWS, SOWS, WOWS, other)?
 - iii. How often are individuals monitored?
- d. Does this all happen the same way 24/7? (If not, what changes when?)

2. WD management

- a. Which treatments are used?
 - i. Cold turkey (no meds)
 - ii. Symptomatic treatment – fluids (Gatorade), over the counter medication (Tylenol, ibuprofen)
 - iii. Symptomatic treatment – prescribed medication (clonidine, nausea meds (Ondansetron [Zofran], promethazine [Phenergan], prochlorperazine [Compazine])
 - iv. Bupe taper (get dosing schedule)
 - v. Bupe initiation and maintenance without WD
 - vi. other
- b. Does this all happen the same way 24/7? (If not, what changes when?)
- c. Which patients receive one of the Bupe options above?
 - i. pregnant only
 - ii. anyone who asks (Opt-in)
 - iii. offered to everyone who is eligible (Opt-out)
 - iv. other
- d. Which formulation of bupe do you offer?
- e. Does this all happen the same way 24/7? (If not, what changes when?)
- f. Where are patients housed?
 - i. separate living unit
 - ii. mixed in general population

Now we are going to switch gears and talk about when a patient arrives with a MOUD prescription from the community...

3. If patient arrives with **active community MOUD prescription**, what happens?

a. Methadone?

- i. continue without break
- ii. continue after break due to +Utox
- iii. stop
 1. taper (how)
 2. abrupt
- iv. Criteria for making above decision (e.g. verification in PMP, recency of Rx, Utox for bupe, Utox for another substance, expected length of stay)
Does this all happen the same way 24/7? (If not, what changes when?)

b. Buprenorphine?

- i. continue without break
- ii. continue after break due to +Utox
- iii. stop

1. taper (how)
2. abrupt
- iv. Criteria for making above decision (e.g. verification in PMP, recency of Rx, Utox for bupe, Utox for another substance, expected length of stay)
Does this all happen the same way 24/7? (If not, what changes when?)

c. Naltrexone?

- i. continue without break
- ii. continue after break due to +Utox
- iii. stop
 1. switch to oral (how)
 2. abrupt
- iv. Criteria for making above decision (e.g. verification in PMP, recency of Rx, Utox for bupe, Utox for another substance, expected length of stay)
Does this all happen the same way 24/7? (If not, what changes when?)

4. Induction on MOUD before release

- a. Besides screening for WD, is there any OUD screening?
 - i. Who is screened for OUD?
 - ii. When screened?
- b. Who is eligible for induction on MOUD before release?
 - i. Is there anyone who does not go through detox before they are induced (i.e. go straight from street drugs to MOUD?)
 - ii. Of those eligible, who is actually induced? (In other words, are they inducing everyone who is eligible?)
 - iii. When during their stay does it start?
 - iv. Approximately how many new inductions were there per month pre-COVID?
- c. What meds are offered? (bupe, methadone, naltrexone)
 - i. For bupe, what formulation?: film; sublingual tablet; transdermal patch (Butrans®); implantable (Probuphine®); subcutaneous depot (Sublocade®); buprenorphine tablet; buprenorphine/naloxone tablet
 1. For tablet, whole or crushed?
 2. for sublingual/buccal preparations, is the patient given a time limit for absorption?
- d. Frequency of bupe dosing (daily versus 3x/week)
- e. What is maximum daily bupe dose (or equivalent, if 3x/week)

5. SUD counseling

- a. Is there any SUD-specific counseling offered?
- b. Who is offered counseling?

- c. What is offered (including group/individual, how often)?
- d. Who provides it?

6. MOUD provider

- a. Internal (i.e. contract or jail employee) or External (i.e. community-based)?
 - i. If external, role of external provider (e.g., initial assessment and recommendation, regular assessment for dosage adjustment, frequency of assessments, etc.)

7. Release meds

- a. Naloxone?
 - i. How many doses?
- b. MOUD bridge until community appt
 - i. meds-in-hands or script?
- c. Does this all happen the same way 24/7? (If not, what changes when?)

8. Release – How is OUD after-care supported?

- a. warm hand off (e.g., jail or navigator drives to community agency, community agency picks up at jail)
- b. arrange appt in the future
- c. follow up/reminder calls
- d. other/none
- e. Does this all happen the same way 24/7? (If not, what changes when?)

9. Barriers/costs

- a. Barrier (during normal times and now during COVID) and cost for each barrier (if cost is driven by patient volume, record average cost per patient)
 - i. Medications
 - ii. Health care staff
 - iii. Custody staff
 - iv. Housing
 - v. Lack of community provider
 - 1. Bupe
 - 2. Methadone
 - vi. other
- b. # patients/month (during normal times and now) affected by the barrier if cost is based on patient volume

10. Do you have any additional information you'd like to add?

11. Requests for detail/further information requested of informant that they have agreed to provide after interview:

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