Early Effects of COVID-19 on Programs Providing Medications for Opioid Use Disorder in Jails and Prisons

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Objectives: To describe how the novel coronavirus (COVID-19) pandemic has affected opioid agonist treatment (OAT) programs in jails and prisons.

Methods: In May 2020, we conducted an online survey of 19 carceral systems that provided methadone and/or buprenorphine treatment for incarcerated populations before COVID-19. Eleven survey items examined challenges and changes to these programs as a result of the pandemic. Sixteen of 19 programs (84%) responded to the survey.

Results: Ten out of 16 systems reported downsizing their OAT programs. Seven of 16 systems made changes to medication dispensation processes. Half of systems report challenges implementing physical distancing (n = 8), and/or obtaining personal protective equipment (n = 8). In 13 out of 16 systems some OAT program participants were released early due to COVID-19 infection risk.

Conclusions: Jails and prisons with existing OAT programs have curtailed their operations in the context of the COVID-19 pandemic. Given the robust evidence base around OAT for treating opioid use disorder and averting overdose deaths, guidance is needed on maintaining and ramping up medication access as carceral facilities grapple with implementing COVID-19 mitigation.

Key Words: COVID-19, criminal justice, opioid use disorder

Jails and prisons are at the epicenter of the novel coronavirus (COVID-19) pandemic in the United States. By April 2020, several thousand cases existed among incarcerated individuals, likely an underestimate due to limited reporting and testing. High incarceration rates, limited ability to physically distance, inadequate medical services, and elevated rates of high-risk conditions contribute to the difficulty in controlling COVID-19 in carceral settings.

COVID-19 arrives during another public health emergency, the opioid crisis. Incarcerated populations are at elevated risk for opioid use disorder and are more than 100 times more likely to die of overdose immediately after release compared to the general population. Providing incarcerated individuals with opioid agonist treatments (OAT), like buprenorphine and methadone, could dramatically improve treatment and mortality outcomes, yet these medications remain widely stigmatized. A small number of US carceral facilities offer comprehensive OAT programs, though recent litigation, legislation, and support from national associations promote increased access.

As carceral facilities grapple with COVID-19, their ability to sustain OAT programs is uncertain. Accordingly, we conducted a survey of existing carceral OAT programs to assess how COVID-19 was affecting these programs.

METHODS

We fielded an online survey to carceral systems (n = 19) that were initiating methadone and/or buprenorphine maintenance treatment before COVID-19 (excluding those systems that were solely providing OAT for individuals already using OAT at arrest or for withdrawal management). Our sample included 14 county jail systems and 5 state-level systems (ie, prisons or unified systems). Systems were identified as potentially initiating OAT via the Substance Abuse and Mental Health Services Administration’s Buprenorphine Practitioner Locator and Opioid Treatment Program Directory, news reports and expert sources. The presence of a program that initiated methadone or buprenorphine treatment was confirmed via an interview conducted as part of a prior study to understand the structure of carceral OAT programs, which was deemed not human subjects research by the Johns Hopkins Bloomberg School of Public Health Institutional Review Board.

Data collection occurred May 5 to 20, 2020. Targeted respondents, including wardens, sheriffs, medical directors, and other leadership from each system, were sent a recruitment email and 2 reminders. The survey instrument included 11 questions about changes and challenges to OAT programs.
due to COVID-19. Measured changes included: program scale, medication dispensation processes and reentry protocols. Measured challenges included those related to staffing, space, and supplies. Challenges were measured on a 5-pt Likert scale and collapsed into dichotomous variables. See Supplemental Digital Content, http://links.lww.com/JAM/A206 for full survey instrument.

RESULTS

Of the 19 eligible systems, 16 (84%) responded to the survey. Twelve of 16 responding systems were jails, and 4 were state-level systems. Six systems were from the Northeast Census region, 5 from the South, 4 from the West, and 1 from the Midwest.

Ten of 16 systems reduced the scale of their OAT programs due to COVID-19, and 6 reported no changes in scale (Fig. 1). These changes included discontinuing enrollment of all new participants or particular groups, such as individuals requiring transport to community opioid treatment programs. Seven of 16 systems reported changing medication dispensation processes, including limiting frequency of assessments and changing the physical location of dispensation. Among these 6 systems, 4 changed dispensation processes to increase physical distancing. All systems reported...
that OAT was continued for program participants placed in isolation due to a suspected or confirmed COVID-19 diagnosis.

All systems made follow-up community appointments for program participants before COVID-19. Thirteen of 16 systems continued to make follow-up appointments with the same process used pre-pandemic, 2 used a different process and 1 discontinued making follow-up appointments. Two of 16 systems did not have policies that released individuals early due to COVID-19 risk. Of the systems that did have an early release policy, 13 reported that some OAT program participants had been released early, and 1 reported no OAT program participants being subject to early release.

Finally, half of systems reported having challenges maintaining an adequate number of clinical staff (n = 8) and/or finding space to permit physical distancing while dispensing medication (n = 8). Fewer than half reported challenges obtaining enough personal protective equipment for staff (n = 5), and/or buprenorphine or methadone (n = 1).

**DISCUSSION**

Overall, this survey finds that OAT programs in carceral settings downsized during the COVID-19 pandemic, which is concerning given evidence that OAT provision in jails and prisons is associated with reduced mortality and improved treatment outcomes postrelease. Downsizing these programs during the pandemic further restricts already limited access to these first-line, opioid use disorder treatments for incarcerated populations, who continue to experience highly elevated risk of overdose. Downsizing of community OAT programs due to COVID-19 has also been reported, with providers pointing to multiple causes: patients’ relapse or delaying treatment due to fear of infection, social distancing requirements and the need to furlough staff to maintain financial solvency. This may further reduce OAT access in jails and prisons that rely on these programs for medication distribution and further elevate overdose risk for incarcerated populations immediately after release.

Some programmatic changes during COVID-19 were driven by regulations around OAT dispensation. For example, carceral systems that were not licensed opioid treatment programs reported no longer being able to transport individuals to community-based opioid treatment programs for required face-to-face methadone initiation. Loosening of regulatory restrictions around the provision of OAT, such as allowances of telehealth appointments and medication delivery and increases in allowed take-home dosages, has occurred throughout the pandemic. These regulations may impact access to OAT and reentry protocols in carceral settings. For example, telemedicine may help alleviate some COVID-19-related challenges with having community opioid treatment programs provide OAT within jails and prisons. These regulatory changes might also be applicable to the expansion of reentry services: such as using telemedicine to establish relationships with community providers who can prescribe take-home medications immediately upon release. However, specific guidance for carceral settings is needed to fully implement these regulatory changes, particularly in the context of limited budgets and telehealth capacity. Furthermore, the prohibition of using Medicaid to cover most medical services during incarceration may limit community providers’ ability to coordinate reentry services with jails and prisons.

A vast majority of programs applied early release policies to OAT program participants, which is an important step in mitigating the effects of COVID-19 and addressing the broader harmful effects of mass incarceration. Reentry services that reduce the risk of COVID-19 complications and opioid overdose postrelease, such as connections to housing, community OAT providers and harm reduction services, are particularly important to consider in this context. Capacity for these services was already limited before COVID-19 and is likely further threatened by the pandemic.

Only half of programs reported challenges finding space to implement physical distancing and having enough personal protective equipment. This is unexpected given the limited physical space and medical resources often present in carceral settings. It is unclear the extent to which systems are adhering to Centers for Disease Control and Prevention COVID-19 mitigation guidance for carceral facilities, which recommend widespread access to hygiene supplies, increased physical space between incarcerated individuals, and use of protective equipment for individuals with contact with a suspected COVID-19 case.

These results should be taken in the context of several limitations. The sampling frame did not include the full universe of OAT programs based in carceral settings, which is unknown. Many programs that were initially identified only offered OAT maintenance or OAT to a very limited population, such as pregnant women, and therefore did not meet study inclusion criteria. Furthermore, survey responses may be subject to social desirability bias, particularly given negative press coverage on COVID-19 response in carceral settings. Respondents were ensured confidentiality to mitigate this concern. Efforts to triangulate these findings with other data, particularly views of incarcerated individuals, should be considered. However, these results provide the first empirical evidence on the early impact of the COVID-19 pandemic on OAT programs in jails and prisons.

**CONCLUSIONS**

The COVID-19 pandemic has resulted in the downsizing of programs to provide OAT treatment in jails and prisons. By threatening access to life-saving medications, the COVID-19 pandemic poses an additional threat to an already vulnerable and highly marginalized population. Efforts must be made to bolster OAT programs and further evaluate the pandemic’s impact on overdose and treatment outcomes.

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**REFERENCES**


