The US overdose crisis intensified during the COVID-19 pandemic, leading to over 93,000 provisional overdose deaths in 2020. Rising deaths were primarily driven by a steep increase in overdoses related to synthetic opioids (eg, fentanyl) and psychostimulants (eg, methamphetamine). The majority of individuals with opioid use disorder (OUD) will experience at least 1 episode of incarceration, typically in a county jail. Most jails do not provide the medications for OUD widely accepted as first-line treatment (ie, buprenorphine, methadone, and naltrexone), which contributes to high rates of overdose mortality after release from jail. Medications for OUD are effective treatments during incarceration and have been associated with substantial reductions in overdose deaths after release. However, treatment retention and continued abstinence after release remain challenges for jails that offer medications for OUD. In this context, longer-acting formulations of medications for OUD hold promise as effective tools for people with OUD transitioning to the community from jail but have not been extensively evaluated in this setting. In their article, Lee and colleagues provide critically needed information about the feasibility of extended-release buprenorphine (XRB) and preliminary outcomes of XRB treatment compared with daily sublingual buprenorphine (SLB) for individuals transitioning from jail to community.

In this comparative effectiveness study, Lee and colleagues document the acceptability and feasibility of implementing XRB in New York City jails. Patients found XRB to be an acceptable treatment option, particularly when continued XRB administration could be guaranteed in the community. Although preliminary, this study also demonstrated promising treatment retention and substance use data among individuals who received XRB. While practitioners should be cautious in interpreting the results of this pilot study, the doubling of treatment retention among individuals who received XRB compared with those who received SLB suggests the field may be on the cusp of a remarkable advance in OUD treatment for individuals involved in the criminal justice system as data from larger trials become available. There were also substantial benefits for jail administrators: daily medical visits decreased dramatically for individuals who received XRB, and there was no documented diversion of XRB in the treatment program. These benefits may ease implementation for many jails given that personnel and safety concerns related to medications for OUD are cited as frequent barriers.

Should the preliminary outcomes reported by Lee and colleagues be substantiated in fully powered studies, barriers to implementing XRB in most jails will need to be overcome. This study was conducted in NYC jails, facilities staffed by health care professionals that have been pioneers in OUD treatment in jail settings for decades with existing linkages to relatively well-resourced community sites. Rural areas, where physical distance creates additional barriers, and areas of the US with less experience prescribing medications for OUD will face logistical challenges in implementing XRB protocols and ensuring follow-up after release. Many community clinics and treatment centers do not offer XRB, creating challenges for correctional health care teams who wish to offer XRB to patients and continue it after release. Finally, social determinants of health, like homelessness and unemployment, will create additional barriers to retention for many patients, which could be mitigated through additional coordination on release.

Important policy barriers will also make expanding XRB treatment to more jails challenging. Federal law prohibits the use of Medicaid during periods of incarceration and requires facilities to...
either suspend or terminate Medicaid upon admission.7 Thus, jails would be required to pay for XRB, typically $1500 or more per dose, from fixed budgets. Given rates of OUD in the criminal justice system, it is unlikely jails would have the funding needed to meet demand. In addition, suspension or termination of Medicaid during incarceration often creates delays in activating insurance and is likely to create challenges in obtaining XRB after release. While Medicaid 1115 waivers provide a potential strategy for states to expand access to medications for OUD in jails, the strategy is onerous, time-limited, and geographically heterogenous, a suboptimal approach amid a national overdose crisis. Federal regulations for the prescribing, distribution, and storage of XRB will also be difficult for many jails to manage. Technical assistance will be required to help jails navigate federal regulations and required safety protocols for administration of XRB.

The overdose crisis continues unabated in the US and disproportionately affects individuals with criminal justice involvement. Lee et al5 present promising pilot data that suggest potentially substantial benefits of XRB compared with SLB for both patients with OUD and correctional health care systems. Future studies will be needed to clarify the effectiveness of XRB in the jail setting. Regardless of future findings, patients experiencing incarceration should continue to have access to all FDA-approved formulations of medications for OUD and have the opportunity to make an informed decision about their medication after discussion with a health care professional. Given the overlap of criminal justice involvement and opioid use, the US will not be able to address the overdose crisis without engaging the criminal justice system in a public health-oriented strategy. The findings in this pilot study are a promising step toward identifying strategies to reduce the risk of overdose and death among people with criminal justice involvement.

ARTICLE INFORMATION

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REFERENCES
