Journal of Current Medical Research and Opinion

CMRO 09 (03) 4693-4703 (2026)
DOI: **https://doi.org/10.52845/CMRO/2026/9-3-4**
www.cmro.in

CMRO
ISSN (O) 2589-8779
(P) 2589-8760

Original Research

Staffing Resource Use: Medications for Opioid Use Disorder Cost Impact Model in Carceral Facilities

MOUD Cost Impact Model in Carceral Facilities

Chris D. Poole, PhD[1]; Courtney Flynn, MPH[2]; Kristin Kistler, PhD[1]; Stephen Chaplin, BSc[1]; Joris Van Stiphout, MSc[1]; Rashad Carlton, PharmD, MSPH[1]; Meghan L. Thompson, PharmD, PhD[2]; Jessica Jay, PharmD, MS[3]; William Mullen, MPH, PA-C[2]

[1]Cencora, 1 West First Avenue, Conshohocken, PA 19428, USA
[2]Indivior Inc., 10710 Midlothian Turnpike, Suite 125, North Chesterfield, VA 23235, USA
[3]Employed by Indivior Inc. at the time this research was conducted

Abstract

Aims

Medications for opioid use disorder (MOUD) are not widely available within United States carceral settings despite the high prevalence of opioid use disorder. Financial barriers, including staff shortages, represent common obstacles to implementation. A nationally representative survey found that among jails not providing MOUD, nearly half cited inadequate staffing as the primary reason. The purpose of this study was to develop a cost impact model to assess staffing time and costs associated with administering different forms of MOUD within carceral settings.

Materials and Methods

A cost impact model was developed in Microsoft Excel to simulate staff time required to administer MOUD within carceral settings. The model compared methadone, oral buprenorphine, extended-release buprenorphine (BUP-XR; SUBLOCADE* monthly and BRIXADI* weekly or monthly injectable formulations), and extended-release naltrexone (XR-NTX) for treatment of 100 incarcerated individuals per month. Information on clinician and security officer time and responsibilities was compiled using expert opinion, targeted literature reviews, prescribing information, and timestamps from manufacturer MOUD administration videos. Total staffing costs were calculated using a micro-costing approach with US Bureau of Labor Statistics national mean hourly wages for licensed practical nurses and correctional security officers.

Results

Corresponding Author: William Mullen, Indivior Inc., 10710 Midlothian Turnpike, Suite 125, North Chesterfield, VA 23235, USA.

E-mail: william.mullen1@indivior.com

Received: 01.01.2026 | **Revised:** 27.02.2026 | **Accepted:** 06.03.2026 | **Published:** 21.03.2026

The model estimated that monthly SUBLOCADE reduced total staffing hours by 318 hours compared to methadone, 747 hours compared to oral buprenorphine, 192 hours compared to weekly BRIXADI, 1 hour compared to monthly BRIXADI, and 6 hours compared to XR-NTX per 100 patients per month. Corresponding monthly staffing cost reductions ranged from $23 to $22,148 compared to other MOUD formulations.

Limitations and Conclusions

Limitations include reliance on assumptions for certain administration times and escorting procedures, and exclusion of medication acquisition costs. Despite these limitations, long-acting injectable buprenorphine formulations reduce total staffing time and costs compared to other MOUD, potentially helping relieve the operational capacity burden that represents a major institutional barrier to MOUD program implementation in carceral settings.

Keywords: Opioid Use Disorder, Buprenorphine, Cost Impact, Carceral Health, MOUD

Introduction

Medications for opioid use disorder (MOUD) are not widely available within United States (US) carceral settings despite the high prevalence of opioid use disorder (OUD) [1]. The right to MOUD in carceral settings for appropriate patients is protected by the eighth amendment of the US constitution [2], the Americans with Disabilities Act (1990), and associated state laws [3,4]. Financial barriers to MOUD implementation in jails and prisons, such as staff shortages, are common. For example, a nationally representative cross-sectional survey from June 2022 to April 2023 found that among jails that did not provide MOUD (n=830), the most reported reason (49.8%) was lack of adequate staff [5]. Buprenorphine extended-release (BUP-XR) provides an opportunity to reduce staffing time and costs associated with administering MOUD within carceral settings and staffing cost data are reported in this study to help address this data gap. Literature regarding costs of implementing MOUD in carceral settings is limited. Data on direct costs post-release reported in the literature show that costs were not markedly different between exposure to MOUD compared to no exposure to MOUD. One study reported that in the first 12 months after release, there were no statistically significant differences in total Medicaid costs between offering MOUD at intake (either extended-release naltrexone (XR-NTX), buprenorphine, or methadone), and offering no MOUD [6]. Per person per year (PPPY) spending by Medicaid was $15,780 before the MOUD program, compared to $17,316 after implementing MOUD [6]. Inpatient costs were similar before and after exposure to MOUD. However, emergency department (ED) costs were lower for those exposed to MOUD during incarceration ($1,356 versus $1,898 PPPY, $P<0.001$), while non-acute outpatient ($3,878 versus $3,265 PPPY, $P<0.001$) and pharmacy costs ($2,508 versus $1,560 PPPY, $P=0.002$) were higher [6]. To identify key cost drivers, more research and up-to-date data are needed on medical, facility, and societal costs during incarcerations and after community re-entry.

Limited recent studies have evaluated US carceral healthcare spending. A report by PEW Charitable Trusts estimated that median prison healthcare spending was $5,720 per individual across 49 US states (range $2,173 to $19,796) in fiscal year (FY) 2015 [7]. More recently, state prison healthcare operating budgets were reported to be $4.1 billion for FY 2025-2026 in California [8] and $322.7 million for FY26 for persons convicted of a felony in Texas [9]; these are among the states with the largest prison populations. A study evaluating cost savings of telemedicine in North Carolina prison facilities reported that corrections officers earned an hourly overtime rate of $30.05 while transporting incarcerated individuals to and from the hospital [10].

Across six Massachusetts jails, the monthly per-patient cost of implementing and sustaining MOUD (methadone and buprenorphine) induction and maintenance programs was $93–$242; with

similar costs across different MOUD models[11]. An economic evaluation in parallel with a randomized controlled trial in the Philadelphia Department of Prisons estimated that the average cost of XR-NTX treatment given pre-release was $976 per participant[12]. Vermont Department of Corrections (DOC) expanded to include all Food and Drug Administration (FDA)-approved MOUD and reported a cost increase of $1,181.02–$1,248.86 per incarcerated individual per month (not including MOUD cost) [13]. A retrospective, observational cohort study found that among people with OUD in New York City jails, in-jail MOUD treatment was associated with lower risk of overdose mortality (adjusted hazard ratio, HR = 0.20, 95% CI = 0.08–0.46) and a reduction of all-cause mortality risk (adjusted HR = 0.22, 95% CI = 0.11– 0.42) for the first 28 days post-release compared to those who were out-of-treatment [14]. Furthermore, a follow up study reported a higher percent of individuals who received MOUD during incarceration compared to the out-of-treatment group experienced stability after release (defined by a pattern of few subsequent incarcerations, ED visits, or hospitalizations after release) [15]. Another follow-up study reported that the in-jail MOUD treatment group had lower risk of non-fatal opioid overdose ED visits immediately after jail release (adjusted HR 0.49, 95% CI 0.33–0.74) than the no MOUD group[16]. In a retrospective cohort analysis, individuals who received methadone or BUP-XR during their incarceration were less likely to present to the emergency department for any cause at the 28 days following release than those not receiving treatment, after controlling for age, race, sex assigned at birth, preferred language, and housing status (adjusted odds ratio, 95% CI: 0.4, 0.2–0.9; P = 0.036; and 0.4, 0.2–0.7 P = 0.007; respectively) [17].

A previous customizable cost impact tool has been reported in the literature with the goal of estimating the implementation and sustainment costs of numerous MOUD delivery models for carceral facilities[18]. The present model provides carceral facilities with the unique ability to predict the impact of long acting injectable buprenorphine on staffing costs because barriers abound to implementing MOUD in carceral settings, including stigma, fear of diversion, and budgetary restrictions, this cost impact model was developed to help facilities calculate estimated staffing costs based on treating 100 incarcerated persons a month. In this work, staffing time and costs associated with administering different forms of MOUD within carceral settings are reported.

Methods

A novel model framework was developed to assess costs to carceral facilities, and a cost impact model was built in Microsoft Excel to compare staffing time and costs. The model assumed treatment of 100 individuals per month with MOUD, including methadone, oral buprenorphine, injectable BUP-XR (i.e., monthly SUBLOCADE or weekly/monthly BRIXADI), and injectable XR-NTX.

Costs included in the model were the staffing costs directly attributable to running a MOUD program. The population in the model is adults aged over 18 incarcerated in the US in state, federal, and county jails.

Model Inputs and Data Sources

To develop the original model, a targeted literature review was conducted using Ovid MEDLINE, Emcare (via Ovid), Embase, Econlit, and EBM Reviews databases to identify previous economic and program evaluations of MOUD programs within carceral settings. Stakeholders (e.g., a correctional medical director, a clinical advisor, and researchers) were engaged to provide feedback on model components, usability and to inform decision-making in MOUD coverage within carceral settings.

Staffing costs

Staffing costs for MOUD program administration were disaggregated between medical costs for drug administration and security costs for escorting incarcerated individuals and delivering medication. Average hourly wages were sourced from Occupational Employment and Wage Statistics for licensed practical nurses[19] and security officers[20].

Administration of methadone was assumed to take 45 seconds per patient using an automated dispensing system. For oral buprenorphine, it was assumed based on literature that 10 out of 15 minutes are spent placing it under the patient's tongue, allowing the necessary time for absorption of the medication for a group of 10 incarcerated persons at a time and two security officers' for the observation and escorting steps[18].

Timestamps from administration videos of injectable MOUD available on each manufacturer's website were used to estimate administration time per step listed in the respective products' Prescribing Information instructions for use ***Figure 1***

Table 1 Program Administration Costs summarizes the hourly cost and number of staff used in the base case. For injectable BUP-XR products and XR-NTX, additional time is required to prepare worksheets, to collect the drug, and to check and release the incarcerated individual. However, unlike methadone and oral buprenorphine, observation and completion (i.e., ensuring the patient finished oral administration, such as completely drinking a cup of water after dosing) are not needed for the injectable MOUD formulations Table 2.

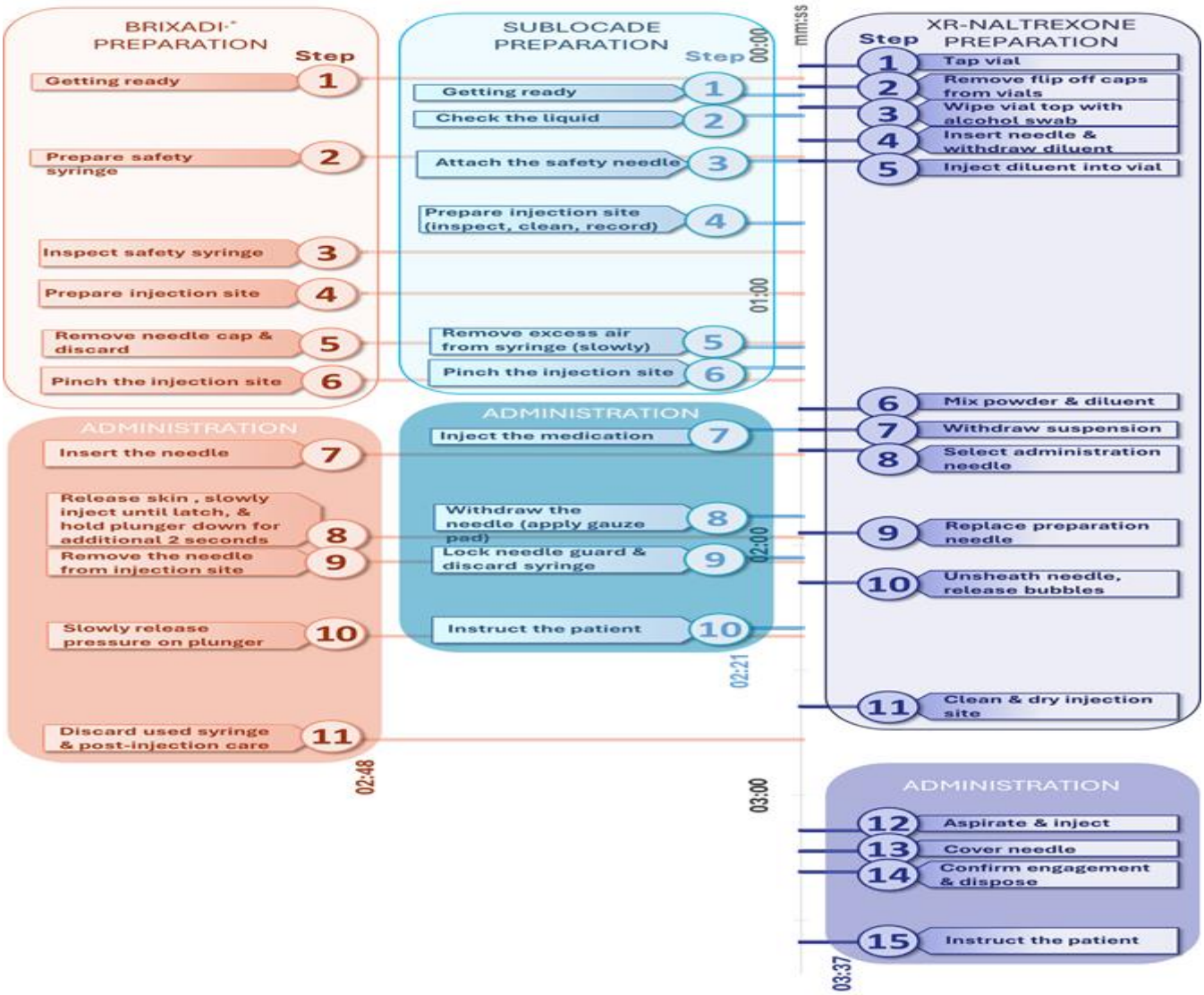

Figure 1 Timing of Preparation and Administration Steps for Extended-Release Buprenorphine and Extended-Release Naltrexone (from manufacturer demonstration videos [30–32]

* Note: The weekly BRIXADI formulation may be administered four times per month and could be administered 2–3 times in the first week of treatment depending on the needs of the patient. The values shown are only for one injection.

Table 1 Program Administration Costs

	Hourly wage	Number of staff
Medical		
Licensed Practical Nurse	$30.84	1
Security officer		
Escorting offender	$28.27	2
Medication delivery	$30.84	1

Table 2 Resource Use (in minutes) Assumptions Required for Dosing, Preparation, and Administration of Medications for Opioid Use Disorder

	Methadone	Oral buprenorphine	BRIXADI (XR-buprenorphine)		SUBLOCADE (XR-buprenorphine)	XR-naltrexone
			Weekly*	Monthly		
Clinician ($30.84 per hour)						
Prepare worksheet	0	0	4.6	4.6	4.6	4.6
Drug collection	0	0	2.2	2.2	2.2	2.2
Check and release	0	0	1.02	1.02	1.02	1.02
Administration	0.75	10†	2.80	2.80	2.35	3.62
Observation	15	15†	0	0	0	0
Completion	5	5†	0	0	0	0
Security officer ($30.84 per hour dispensing, $28.27 escorting)						
Escort patients	3.6	3.6	3.6	3.6	3.6	3.6
Dispensing	41.5	60†	20.34	20.34	20.34	22.87

* Note: The weekly BRIXADI formulation may be administered four times per month and could be administered 2–3 times in the first week of treatment depending on the needs of the patient. The values shown are only for one injection.

† For a group of 10 incarcerated persons at a time[18]

XR: extended-release

Results

Table *3* and Figure 2) compared to methadone (318 less hours), oral buprenorphine (747 less hours), BUP-XR/BRIXADI weekly (192 less hours), BUP-XR/BRIXADI® monthly (1 less hour), and XR-NTX (6 less hours).

The model estimated lower total staffing costs per month for BUP-XR/SUBLOCADE (Figure 3) compared to methadone ($9,750 less), oral buprenorphine ($22,148 less), BUP-

The model estimated lower total staffing hours per month for BUP-XR/SUBLOCADE (

XR/BRIXADI weekly ($5,815 less), BUP-XR/BRIXADI monthly ($23 less), and XR-NTX ($195 less).

Preparation and administration of long-acting injectable MOUD (**Figure** *1*) is similar; however, each BUP-XR/SUBLOCADE injection takes on average less time to prepare and administer than BUP-XR/BRIXADI weekly or monthly (by 27 seconds) or XR-NTX (by 1 minute, 16 seconds).

Table 3 Total Staffing Hours to Treat 100 Incarcerated Persons

Medication	Total Monthly Hours	Clinician, Hours	Security, Hours
Methadone	381	138	244
Oral buprenorphine	810	150	660
XR-buprenorphine (BRIXADI)			
Weekly	254	71	184
Monthly	64	18	46
XR-buprenorphine (SUBLOCADE)	63	17	46
XR-naltrexone	69	19	50

XR: extended-release.

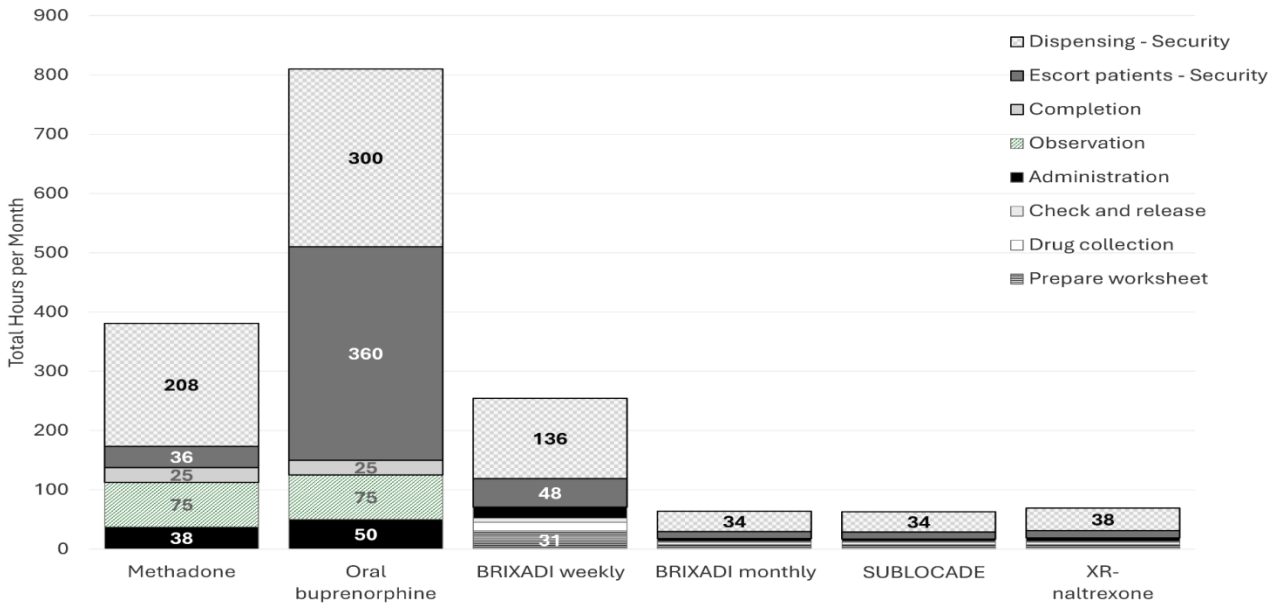

Figure 2 Total Monthly Staffing Hours by Task to Treat 100 Incarcerated Persons

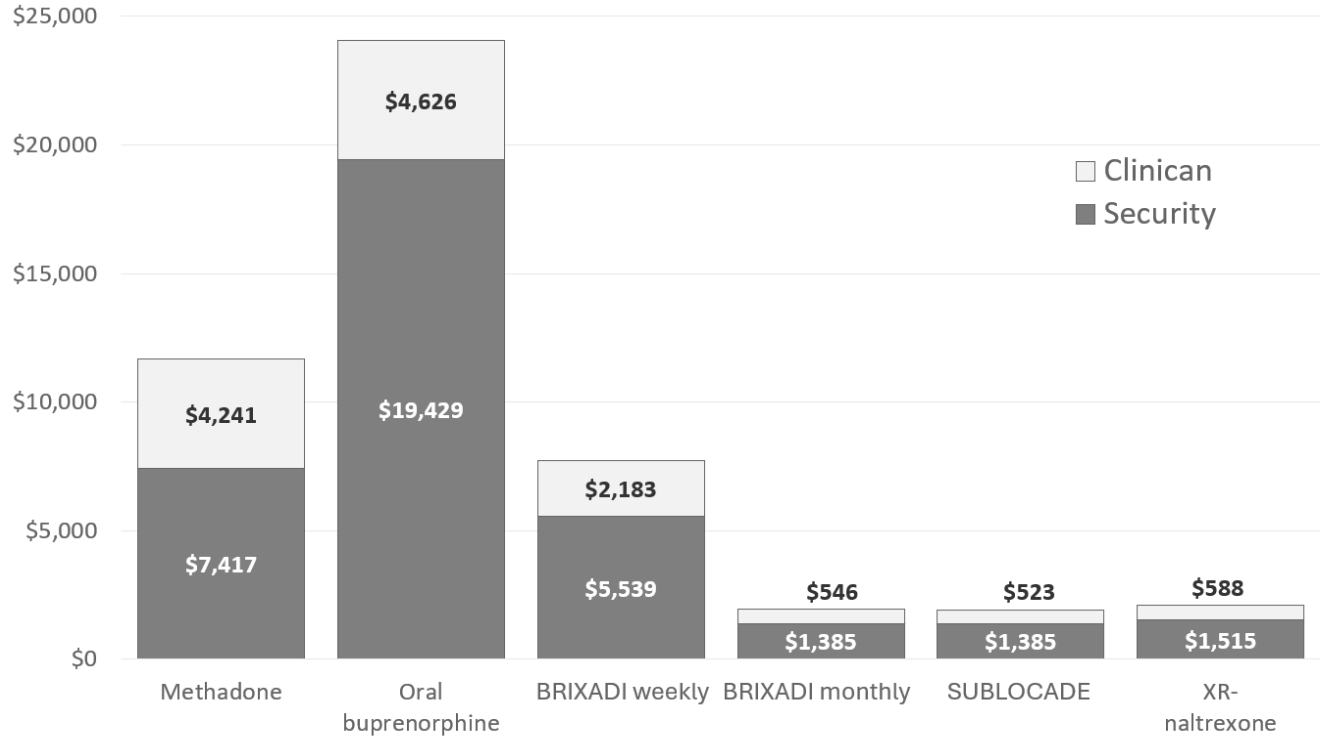

Figure 3 Total Staffing Cost per Month to Treat 100 Incarcerated Persons

Discussion

The reduction in staff hourly costs associated with SUBLOCADE use can positively impact the fiscal challenges faced by jails and prisons. For instance, the hours saved in escorting patients for dosing can reduce overtime expenses. Long-acting injectable buprenorphine products reduce total staffing time and costs compared to other MOUD, possibly helping relieve the operational capacity burden of jails and prisons which is a major institutional barrier to the implementation of MOUD programs within carceral settings[21,22]. The results of our study show that the model estimated total staffing time and cost per month to treat 100 incarcerated persons with BUP-XR/SUBLOCADE was reduced by approximately 1 to 747 hours and approximately $23 to $22,147 compared to other MOUD.

A systematic review of ten studies with 819 participants showed that BUP-XR is feasible, safe, and cost-effective in carceral settings (e.g., reduced drug use, re-incarcerations, and overdose risks while maintaining or improving treatment retention rates)[23]. The article concluded that BUP-XR is a promising alternative for correctional populations and called for efforts to expand access and address barriers like daily dosing requirements and improve treatment continuity post-release[23]. Another systematic review of 16 studies with 3,403 participants aimed to assess the effectiveness of BUP-XR and XR-NTX for those incarcerated or released in the past 3 months[24]. There was preliminary evidence that initial medication costs are offset by savings in staffing, security, and healthcare; as BUP-XR became increasingly used, the per-patient costs for methadone and SL-BUP increased and total costs were most sensitive to treatment administration time[25].

Publications of cost-effectiveness analyses of programs providing MOUD during incarceration have reported various measures of effectiveness: quality-adjusted life years (QALYs)[12,26]; opioid-free years[12]; reduction in incarcerated days[27]; and negative opioid tests[28]. Incremental cost-effectiveness ratios (ICER) were reported in three studies[12,26,28].

Continuing methadone initiated prior to incarceration was found to be cost-effective at a willingness-to-pay (WTP) threshold of >$70,000

per QALY, compared to forced withdrawal from methadone during incarceration[29]. Methadone was found to be cost-effective when measured in terms of reducing recidivism: for each decrease of 1 day incarcerated due to recidivism, methadone during incarceration was estimated to have a 95% probability of being cost-effective at a WTP threshold of $116 per incarcerated day, compared to no methadone[27].Cost-effectiveness literature results for XR-NTX are conflicting; there is little evidence to suggest that XR-NTX was cost-effective when measured as ICER per QALY. XR-NTX was more costly and did not lead to additional QALYs when offered at intake compared to no MOUD during incarceration[26], or when offered just prior to re-entry vs after re-entry[12]. However, when measured as opioid abstinent years, XR-NTX offered at re-entry was estimated to be more effective than XR-NTX after re-entry, with 95% probability of being cost-effective at a WTP threshold of at least $49,000 per abstinent year[12].

Notwithstanding the heterogeneity in the way that cost-effectiveness is reported in the literature for MOUD during incarceration, the evidence identified above indicates that MOUD leads to better outcomes within reasonable WTP thresholds. However, consensus is needed on how to measure the benefits of MOUD, (e.g. QALYs, opioid-free years, or recidivism) for decision-makers to draw appropriate conclusions from the data.

This study must be considered in the context of its limitations and assumptions. Firstly, due to lack of data for clinician time for preparing worksheets, data collection, and check and release for BUP-XR and XR-NTX, they are assumed to be the same as preparation of oncology treatments (deemed to be as complex). Administration time for MOUD were based on assumptions and a micro-costing exercise and actual administration times may be different. Data on escorting patients were only available for treatment with oral buprenorphine; assumptions were made for methadone, BUP-XR, and XR-NTX. Finally, the model did not include the cost of medications.

Conclusion

Long-acting injectable buprenorphine reduces total staffing time and costs compared to other MOUD, possibly helping relieve the operational capacity burden of jails and prisons which is a major institutional barrier to the implementation of MOUD programs within carceral settings. In this cost-impact model, BUP-XR/SUBLOCADE reduced total staffing time by approximately 1 to 747 hours and decreased staffing costs by approximately $23 to $22,148 compared to other MOUD when modeling a sample of 100 patients over one month.

Acknowledgments:

This research was funded by Indivior Inc. and conducted by Cencora. Writing and editorial support was provided by Claire Daniele, PhD, of SciPubSupport, LLC with financial support from Indivior Inc. Review and publication support was provided by Maher Abdel-Sattar, PharmD, MS, FAMCP, a full-time employee of Indivior Inc.

Author Confirmation Statements:

Chris D. Poole contributed to conceptualization, data curation, methodology, validation, visualization, data analysis, writing- original draft, and supervision

Courtney Flynn contributed to the conceptualization, data curation, methodology, validation, visualization, data analysis, writing – original draft, writing - review & editing, and supervision.

Kristin Kistler contributed to data curation, methodology, validation, and writing-original draft, writing- review & editing.

Stephen Chaplin contributed to conceptualization, data curation, methodology, validation, visualization, data analysis, writing- original draft, and writing- review & editing

Joris Van Stiphout contributed to data curation, methodology, validation, visualization, writing-original draft, writing- review & editing

Rashad Carlton contributed to conceptualization, data curation, methodology, validation,

visualization, data analysis, writing- original draft, writing- review & editing, and supervision

Meghan Thompson contributed to the data curation, methodology, validation, visualization, data analysis, writing – original draft, and writing - review & editing.

Jessica Jay contributed to methodology, validation, visualization, and writing - review & editing.

Will Mullen contributed to the conceptualization, methodology, visualization, writing – original draft, writing - review & editing, funding, and supervision.

Disclosures:

This research was funded by Indivior Inc. Authors CDP, KK, SC, JVS, and RC are full-time employees of Cencora, which was contracted by Indivior Inc. to conduct this research. Author WM is a full-time employee of Indivior Inc. Authors CF, MLT, and JJ were full-time employees of Indivior Inc. at the time this research was conducted.

Ethics Approval/IRB Statement

This article is a secondary data analysis using previously published and/or publicly available data, therefore it does not require ethical approval (or IRB review/oversight) as it does not involve the collection of new data from human participants. All data used were de-identified and obtained from publicly accessible sources, and the original studies obtained all necessary informed consents and ethical approvals.

Data Availability Statement

The Excel model on which this manuscript is based is available from the corresponding author upon reasonable request.

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