Medications for Opioid Use Disorder

MOUDs in Jails and Prisons: An Idea Whose Time Has Come?

By Ed Sweeney

We are undergoing a sea change in our criminal justice system regarding the use of FDA-approved Medications for Opioid Use Disorder (MOUD), and all hands are needed on deck to navigate the new course. There is growing consensus in the medical community—including the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the National Commission on Correctional Health Care (NCCHC), as well as the U.S. Department of Justice (DOJ)—that MOUDs (methadone, naltrexone, and buprenorphine) are fundamental to the treatment of opioid addiction and should not be categorically denied in our jails and prisons.

Historically, medical protocols in most jails did not include the use of MOUDs. Such medications were highly regulated by federal agencies, and many states promulgated their own additional legal restrictions. Detainees who had been using them as part of a community-based treatment program could be denied continued access to these medications when placed in detention. MOUDs were not routinely given for the management of withdrawal symptoms. Many drug courts did not support the use of MOUDs; some prohibited their use entirely, while others allowed only some medications and not others. I remember several spirited debates among criminal justice leaders about expanding the use of MOUDs. Sometimes referred to as Medication Assisted Treatment (MAT), MOUD in its many forms warrants increased understanding and effort. Like most things we do, it's complicated.

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An Overview of the Substances Involved

Methadone, a schedule-II controlled substance, is highly regulated and especially challenging for correctional agency use. Although pressure is mounting on the DEA to improve access to methadone in correctional facilities, the current regulatory system prevents jails and prisons from prescribing or administering methadone. Methadone can only be prescribed to combat drug addiction by authorized, DEA-registered methadone clinic providers working for a SAMSHA accredited Narcotic/Opioid Treatment Program (OTP). As of June 2023, there were just over 2,000 OTPs in the United States. Current federal regulations (CFR Title 21, Chapter II, Part 1306, Section 1306.07) allow jail medical practitioners who are not registered with the DEA as a narcotic treatment program to administer, but not prescribe, up to three days' worth of a schedule II medication such as methadone. Hospitals can administer methadone, but only if necessary in treating another serious health condition—for example, providing methadone to a pregnant woman to prevent harm to the unborn child—and not simply to treat a drug addiction. Because of these restrictions, jails have routinely transported pregnant detainees to hospitals to receive methadone in order to avoid withdrawal illness symptoms. Once the associated post-partum is complete, the involved hospital may no longer provide the mother methadone.

Naltrexone is not an opioid or a controlled substance, and doctors do not need any special training or licenses to prescribe it. Naltrexone reduces opioid cravings but cannot be initiated for 10 to 14 days from last opioid use, after withdrawal symptoms are complete. In my experience, Naltrexone is used primarily to help prepare inmates for their transition back into the community. Naltrexone is also used to treat Alcohol Use Disorder.

Buprenorphine is a schedule-III controlled substance that is commonly used in varied opioid treatment medications. Buprenorphine has also historically been highly regulated. Physicians seeking to prescribe and dispense buprenorphine have been required to complete specialized training to qualify for the federal Drug Addiction Treatment Act (DATA) waiver. Waiver requests were submitted to U.S. Department of Health and Human Service, as well as SAMHSA, and required the approval of the U.S. Drug Enforcement Agency (DEA). The federal requirements associated with the waiver included limits on the number of patients and certification related to the provision of patient counseling. The required process was daunting when considering the size and transitional nature of the jail population. I doubt that most jail officials even considered the inclusion of the DATA waiver requirement when preparing their RFPs for medical services; I know I didn't.

According to "New Momentum for Addiction Treatment Behind Bars," a 2018 study released by the Pew Trust, "fewer than 1 percent of more than 5,000 U.S. prisons and jails, housing more than 2 million inmates, allow access to the FDA-approved medication (buprenorphine)." Until recently any broad expansion in the use of buprenorphine seemed unlikely.

Once Restricted, Now Expected

In 2023, section 1262 of the consolidated Appropriations Act removed the federal requirement for the special DATA waiver for the prescribing, administering, and dispensing of schedule III, IV, and V narcotic drugs for maintenance and detoxification treatment, which includes buprenorphine. Additional provider restrictions relating to the provision of counseling were also eliminated, meaning all practitioners with a general DEA license can now prescribe MOUDs containing buprenorphine.

At about the same time the US Department of Justice (DOJ) began to target facilities that continued to withhold treatment, in some cases suing correctional and judicial entities who had policies in place prohibiting or restricting the continuation of MOUDs, under the Americans with Disabilities Act (ADA), which ensures that people in recovery from opioids and other drugs are protected.

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As interpreted by the DOJ, the ADA requires that jails and prisons individually assess the medical needs of people with disabilities and not categorically restrict or deny access to FDA-approved opioid use disorder medications that many need to effectively treat their disability. Science-driven and data-informed approaches to the opioid crisis are important priorities for the Civil Rights Division of the DOJ.

The ADA does not protect individuals using drugs illegally. This prohibition includes illegal drug use recent enough to support a reasonable belief that the use is current, or that continuing use is a real and ongoing problem. However, there is one poorly defined exception: a person who is currently engaging in the illegal use of drugs can't be denied healthcare or rehabilitation services because of that current use if they would otherwise qualify for these services. Taking MOUD or other opioids legally prescribed by a doctor for a valid purpose is not considered to be current illegal drug use when they are taken as directed.

In February 2024 in my home state of Pennsylvania, the DOJ announced a settlement with the Unified Judicial System resolving allegations that the court system violated the ADA by preventing individuals under supervision from taking lawfully prescribed medication to treat their opioid use disorder (OUD). As part of a separate settlement with the DOJ, Allegheny County, Pennsylvania has agreed to offer treatment with any FDA approved medication for OUD to all individuals booked into the Allegheny County Jail for whom such treatment is medically appropriate. Similar settlements of DOJ actions were reached in other states including Massachusetts and Kentucky.

Some settlements are going even farther in their responsive approach. In December 2023, the Big Sandy Regional Jail Authority agreed to offer all individuals with OUD the option to receive treatment with any FDA-approved MOUD, even if they were not being treated with that medication before their incarceration.

How These Changes Affect Your Facility

As you might imagine, the demand for MOUDs is growing rapidly, and supply problems are a new and unanticipated reality.

Here are some recommendations for making sure your facility or agency is ready to meet a rapidly evolving set of mandates:

Review all written documents prepared by governing officials (RFPs, professional service contracts, policy, formulary limitations, etc.) relating to medical services, to make sure that you do not have any written policy or directive that categorically prohibits or restricts the provision of any MOUD. If you find any such documentation, reissue it, and note the removal of the former language. Jails and courts should not use incentives, rewards, or punishments to encourage or discourage individuals from receiving any FDA-approved OUD medication.

Discuss this topic openly and extensively with your medical service provider(s). Make sure that it is understood that the continuation or initiation of FDA-approved MOUDs is to be made based on an individualized medical assessment. Jail medical providers can change or discontinue an individual's use of a particular OUD medication when doing so is based on an individualized determination by a qualified medical professional. If the conversation results in a required renegotiation of financial terms, due to formulary changes, work it out expeditiously.

Recognize that your medical provider may not be able to facilitate the continuation of methadone during incarceration. The barriers to achieving SAMHSA accreditation to become an OTP are huge. Some large urban jails have successfully partnered with established methadone clinics to allow identified detainees to continue their opioid treatment while incarcerated, but those situations are far from the norm. Expect that your pharmacies may not provide the three-day methadone treatment, because many won't fill methadone scripts for anyone other than OTPs or hospitals. As such, medical documentation of having tried to initiate the regimen is important. Secondly, medical staff should document that they have contacted the methadone clinic who was providing service for the new detainee and ask if they are willing to continue to provide the methadone and maintain patient contact via telemedicine. If the methadone clinic provider is not willing to do so, document the effort.

In the fight against addiction, a paradigm shift is welcome. Now that you know, you'll know better.

Here is a link to FAQs from the Substance Abuse and Mental Health Services Administration (SAMHSA) regarding the buprenorphine DATA Waiver Elimination (MAT Act): https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act ■