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The U.S. Should Increase Access to Medication for Opioid Use Disorder Among Incarcerated Individuals

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KEY TAKEAWAYS

- Incarcerated individuals are at an increased risk of opioid overdose upon release.
- Healthcare, including access to appropriate treatment for diseases such as addiction, is a Constitutionally protected right.
- Medications such as Methadone and Buprenorphine are proven effective in treating Opioid Use Disorder (OUD). These medications should be offered universally for those suffering from OUD.

Opioid Use Disorder (OUD) is among the most common medical diagnoses for people in jails and prisons. Opioids, such as heroin and Percocet, are narcotic drugs used to control pain and increase feelings of pleasure. Nearly one in seven incarcerated people in the United States have a substance use disorder.[1] Additionally, people leaving incarceration are up to 40 times more likely to have a fatal overdose upon release than the general population,[2] making overdose a leading cause of death for people recently released from jails and prisons.[3] The U.S. government must focus overdose reduction efforts on this exceptionally vulnerable population.

Not only do people with OUD in jails and prisons *need* treatment, but they are entitled to it under the law. The Americans with Disabilities Act (ADA) recognizes individuals with Substance Use Disorder as a protected population. Their civil rights, even while incarcerated, must be upheld.[4]

This brief describes the use of Medication for Opioid Use Disorder (MOUD) and Medication Assisted Treatment (MAT) as a realistic and legally protected approach to reducing overdoses upon exiting incarceration and calls for federal regulation and guidance on the use of MOUD in prisons, jails, and drug courts to ensure each person who needs treatment receives it.

What Is Medication for Opioid Use Disorder (MOUD)?

The gold-standard for treating OUD is medication, and in particular Methadone, Buprenorphine, and Naltrexone.[5] All three are effective at preventing relapse, even without additional treatment. When used in conjunction with therapy and group

counseling, the treatment is referred to as MAT. A person on MAT has a significantly reduced likelihood of experiencing a fatal overdose.[3]

Methadone and Buprenorphine both work by binding to the opioid receptors (the part of the brain that opiates activate when used) to reduce the symptoms of withdrawal and craving after they stop using opioids.[5] This is beneficial because withdrawal symptoms and craving are two major causes of relapse for a person with OUD. If an individual no longer has the painful and debilitating physical symptoms associated with cessation of opioid use, they are less likely to misuse opioids. Both Methadone and the common oral form of Buprenorphine require daily dosages to maintain the beneficial effects.

Unlike Methadone and Buprenorphine, Naltrexone works by blocking the opioid receptors to prevent a person engaged in opioid use from feeling the desired euphoric effect of the drugs.[3] The idea behind this is that a person who does not feel the high from the drug will be less compelled to us it. Naltrexone comes in a short-acting, daily dose form as well as a long-acting injectable form called Vivitrol that can last up to 30 days. For this reason, it is the most common form of MOUD used in correctional settings.

What is the Current State of MOUD Access in Carceral Settings?

Typically, when a person is arrested, they are assessed at intake for medical conditions. If they need medical intervention or treatment for injury or illness, they are sent to a medical wing in the jail, and treatment begins. However, in most jails, if they are diagnosed with acute withdrawal from opiates, the person is simply observed and allowed to painfully withdraw without medical intervention. They are then released to the general population and processed through the justice system as though they do not have a disease at all.

Many prisons offer some form of drug and alcohol addiction treatment, but few offer MOUD.[6] However, MOUD for incarcerated individuals has a beneficial effect not only on health outcomes of the individual, but on community safety and even recidivism.[7] If a person can successfully begin and continue treatment during their time in jail or prison, they are more likely to continue treatment after release.[7] This reduces the chance of relapse, which in turn affects the behavior associated with drug addiction, including criminal activity like property crime.

Unfortunately, the current state of MOUD regulation and access for incarcerated individuals ranges greatly across and even within states.[6] Some states have facilities that offer all three types of medication depending on individual needs and assessment. In Maine, for example, the Department of Corrections has expanded access to MOUD to every individual with OUD housed in a state correctional facility.[8] Other states have very few facilities that offer MOUD to incarcerated populations. For example, Oklahoma (despite having one of the largest inmate populations in the country) offers MOUD in only one county jail with restrictions.[6] In most facilities, access to MOUD is restricted to pregnant women.[9] Additionally, MOUD is typically offered as a continuation of treatment and is only available for individuals who were already engaged in MAT prior to incarceration and who have a current prescription for the medication. Even then, most of the facilities offering continued MOUD expect the treatment to taper after 30 days of confinement. This means that most individuals leaving jail or prison will no longer be actively engaged in medication treatment, increasing their risk of relapse and overdose.

Access to MOUD is Slowly Expanding Across the U.S.

In April of 2022, the Civil Rights Division of the Department of Justice (DOJ) emphasized that MOUD is a civil right for individuals who are incarcerated.[4] As an example of illegal discrimination against a person with OUD, the paper describes a jail inmate being denied access to their MOUD when they are admitted to jail. This brings up a very interesting point: If OUD is a protected disability, and MOUD is recommended for the treatment of this disease, even when incarcerated, why is it not widely available as a medical treatment in every facility?

Some courts have begun to address this issue. For example, in Maine, two different cases have made their way through the court system to decide whether individuals who are incarcerated have a constitutional right to MOUD. In one case, an inmate challenged Aroostook County Jail policy not to allow individuals to maintain their use of MOUD when they enter the jail. The plaintiff claimed that the denial of medication prescribed by a physician would cause pain and potential irreparable harm.[10] The claim was rooted in the Americans with Disability Act (ADA) as well as the 8th Amendment to the Constitution which prohibits cruel and unusual punishment. The court agreed. Affirming a District Court's decision that the inmate was being discriminated against because of her disability, they ordered the jail to provide the "necessary medication". It is important to note, however, that this decision is limited to the individual inmate and only applied to the continued use of previously prescribed medication. The use of MOUD for those who are diagnosed upon intake has not been litigated as of the date of this publication.

However, some progress has been made. Federal facilities are already treating OUD with medication and therapy while incarcerated. The Bureau of Prisons (BOP) and the DOJ have implemented universal screening for OUD to ensure access to MOUD.[11] There is also increased funding designated to expand access to MOUD across all facilities, including certifying BOP pharmacist practitioners to prescribe Buprenorphine, allowing it to be dispensed without contracting to an external specially licensed physician.

The Federal Government Must Create Guidelines for State and Local Jails and Prisons to Ensure Access to MOUD for Inmates

Unquestionably, MAT is the best possible treatment for an individual with OUD. It reduces risk of relapse, illness related to injection drug use, and overdose.[9] With any other disease, an incarcerated person is Constitutionally entitled to adequate treatment.[12] The same should be true for those with the disease of OUD.

To ensure that incarcerated individuals with OUD are treated ethically, facilities need to have clear instructions for their medical and administrative staff on the use of MOUD while incarcerated. This includes education about the benefits and prescribing methods of MOUD. A first step would be a federal regulation requiring state run facilities to comply with the ADA in continuing medications for those with pre-incarceration diagnosis of OUD. Second, state governments should require that individuals entering a carceral setting be screened for OUD upon intake or upon witnessing signs and symptoms of opioid withdrawal and given MOUD by the facilities' medical provider as soon as possible. Appropriate treatment implemented immediately upon intake to a facility and followed up throughout incarceration and upon release could save thousands of lives each year. The federal government has the resources to educate and equip both state and local facility employees with the tools they need to reduce opioid misuse, overdose, and secondary consequences to society.

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