

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

When Medication Treatment for Opioid Use Disorder Gets Disrupted by Extra-Clinical Variables, How Should Clinicians Respond?

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Abstract

Structural and systemic discrimination against people with substance use disorder is pervasive. Clinicians caring for patients receiving medications for opioid use disorders (MOUDs) should plan for possible disruptions of treatment caused by arrests and pretrial confinement in jails. This case commentary suggests that harms caused by such treatment disruption can be mitigated by clinicians who take some of the practical approaches outlined in this commentary to better preserve continuity of care for people receiving MOUD.

Case

MJ has been in a methadone treatment program for 20 years. Moderately high doses of methadone are needed to treat MJ's opioid cravings and are prescribed and managed by Dr D.

MJ does not use other drugs, works full-time, and spends free time with family members. After driving over the speed limit to get to a hospital where their daughter was giving birth, MJ was pulled over and arrested after violating the suspension of their driver's license for past traffic violations. While jailed for nearly 2 days, MJ did not have access to their prescribed methadone; MJ experienced severe withdrawal symptoms and cravings, none of which were treated while they were incarcerated.

MJ's release from jail did not incorporate follow-up appointments for MJ's usual treatment program, and a couple of days after their release, MJ still had not returned to the clinic. Dr D worries that MJ has returned to drug use and wonders what to do.

Commentary

Because of structural discrimination wrought by more than a century of racism, ableism, and classism in prohibitionist drug policy,¹ persons who use opioids have higher rates of criminal legal system involvement than those who do not report opioid use.² As in MJ's case, this involvement may include incarceration in jails (locally operated settings where people are confined before adjudication or sentencing or for sentences of less than a year).³ Although it is difficult to get an estimate of the number of persons with opioid use disorder (OUD) in jails, it was estimated that, between 2007 and 2009 (the most recent period for which these statistics are available), 63% of persons serving sentences in jails

had a substance use disorder (SUD) compared with only 5% of the general adult population.⁴ When left untreated (or when medications are discontinued, as was the case with MJ), persons who are released from jail are more likely to experience overdose deaths on release, with increased risk of drug overdose death being associated with repeat jail bookings.⁵ Conversely, provision of medications for opioid use disorder (MOUD) in jail is associated with an 80% reduction in overdose mortality in the first month post release.⁶

Even short-term incarceration seriously disrupts access to treatment. Many jails and prisons do not provide evidence-based treatment for SUD (such as MOUD) or for alcohol or opioid withdrawal, despite the Supreme Court's interpretations of both the Eighth and the Fourteenth Amendments of the Constitution as obligating states to provide necessary health care to people who are incarcerated and the protections offered such persons under Title II of the Americans with Disabilities Act (ADA).⁷ Persons covered by Medicaid often have their coverage suspended or even terminated upon entry to a carceral setting, leading to further barriers to accessing care upon release.⁸ The futility and cruelty of the continuing War on Drugs produce structures and systems wherein people like MJ and, by association, Dr D, are discounted, disempowered, and silenced.⁹ These consequences are a matter of profound epistemic injustice—both testimonial injustice (when the listener's prejudice against the speaker leads them to discount the speaker's credibility) and hermeneutical injustice (when someone is unable to understand or share their social experience due to a lack of interpretive resources caused by the marginalization of a social group to which the individual belongs).¹⁰ For those who provide SUD treatment like Dr D, oppressive and harm-inducing legal regimes and attendant practices also create moral distress and ethical dilemmas because ethically appropriate care is hampered by the inability (or perceived inability) to execute it—either out of fear of violating the law or due to feeling helpless to intervene when patients are arrested and detained in jails. There are, however, some affirmative steps clinicians can take to mitigate some of the structural harm to their patients who may be experiencing, or newly released from, incarceration.

Withdrawal in Carceral Settings and Legal Protections

People who are incarcerated have constitutional and civil rights to receive medical treatment in many circumstances. The Supreme Court has interpreted the Fourteenth Amendment as guaranteeing substantive due process protections¹¹ to persons awaiting trial and sentencing, and the Eighth Amendment prohibits cruel and unusual punishment¹² for persons convicted of a crime. In *Estelle v Gamble*, the Supreme Court held that “deliberate indifference” to serious medical illness constitutes “cruel and unusual punishment,” requiring that persons in custody receive adequate medical care to prevent “the unnecessary and wanton infliction of pain.”¹³ Additionally, Title II of the ADA prohibits discrimination based on a disability (including SUD) and applies to state and local entities,¹⁴ including jails. People like MJ, who have SUD and are currently receiving MOUD, are protected by the ADA, and jails that fail to arrange for continued treatment are likely in violation of the law. Courts across the country have required jails to continue providing MOUD to persons who become incarcerated.^{15,16,17,18} The Department of Justice, responsible for enforcing Title II and federal constitutional rights vis-à-vis civil rights laws, has explicitly stated that it is an ADA violation for a jail not to allow MOUD continuation.¹⁹

Nonetheless, patients receiving MOUD treatment, like MJ, are too often **forced into withdrawal** by noncompliant jails that refuse to provide continued MOUD treatment upon

incarceration. While courts increasingly find that the ADA and the US Constitution require that jails and prisons offer MOUD, uptake in jails and prisons remains slow.²⁰ The US Department of Justice Bureau of Justice Statistics estimates that only 54% of jurisdictions with jails provided at least one form of MOUD at mid-year 2019.²¹ A 2022 study of a representative sample of US jails found that only 20% provided MOUD to all persons with OUD (as opposed to restricting access to certain categories of persons such as pregnant persons with OUD), and many of the jails did not provide access to all 3 US Food and Drug Administration-approved MOUDs (methadone, buprenorphine, and naltrexone).²²

Even in carceral facilities that provide MOUD, treatment delays may occur while the correctional staff contacts the community MOUD provider to verify prescriptions. These delays can lead to forced withdrawal, which poses health risks, increased risk of suicide, and even death.²³

Since pre-trial detention is short-term incarceration, with many individuals being released once they have been arraigned, clinicians who provide MOUD should create contingencies to allow for continued MOUD treatment while their patients are in custody, especially when the patient is being administered methadone by that prescriber. In fact, the duty to create these contingencies arises, in part, out of the structural inequalities created by the regulation of methadone.

Structural Inequity and Contingency Planning

For people with OUD, one structural driver of continued barriers to appropriate care is the long-standing legal segregation of treatment of opioid use disorder from the rest of health care—which serves the expressive function of further **stigmatizing people with OUD** and communicates that their treatment is inherently different, dangerous, and warrants exacting legal control.²⁴ Such excessive regulation is discordant with evidence of the safety and broad efficacy of MOUD.²⁵ While restrictions have been relaxed in recent years, especially regarding buprenorphine prescribing, methadone remains highly regulated when used to treat OUD.²⁴ Unlike buprenorphine, which can be prescribed in an outpatient setting,²⁴ methadone is generally provided by registered opioid treatment programs (OTPs).²⁶

Most patients must report daily to the OTP in person to take their methadone dose in the presence of OTP staff.^{26,27} Due to the shortage of OTPs, some patients have to travel long distances to receive their daily doses.²⁷ As a result, some patients must navigate transportation, childcare, and work schedules to receive their methadone dose at the OTP—making it difficult for patients to attend school, maintain stable employment, and otherwise manage their lives.²⁸ While “take-home doses” are now increasingly allowed due to changes in regulations,^{24,26} OTPs have significant latitude in determining when to allow take-home doses. Recent studies suggest that even when patients receive take-home doses, they are often for only 1 to 2 days.^{24,26,27}

Since MJ appears to be a “stable patient” (as defined by federal law²⁹), Dr D could ensure that MJ has the maximum allowable take-home doses in their jurisdiction. Although having take-home doses on hand is no guarantee that the jail will agree to administer them, it decreases some administrative hurdles. Take-home doses provide evidence of MJ’s enrollment in a methadone program and prescribed dosage and even allow for the medication to be brought immediately on-site. Furthermore, upon release, MJ will have their take-home doses to continue treatment.

Planning for Disruption, Incarceration, and Transition

Dr D's patients are part of a highly stigmatized group by virtue of both their diagnosis and the medication used to treat OUD.³⁰ They may have multiple additional marginalized identities (eg, disability other than SUD, race, prior criminal system involvement), which increases the risk of enhanced police surveillance and future criminal legal system involvement and incarceration (often for matters that would not lead to incarceration for those with more privilege). These social and structural determinants of health lead to health **inequities and injustice**, and physicians have an ethical obligation to address them.³¹ In addition to providing the maximum allowable take-home doses, therefore, Dr D can take several steps to plan for periods of treatment disruption caused by incarceration.

First, Dr D should consider advance care planning for the possibility of treatment interruption, including interruptions caused by criminal legal involvement, with patients like MJ. Such a plan would allow both Dr D and the patient to prepare for and minimize treatment disruptions. For example, Dr D could provide patients with a signed letter to keep on hand if they are incarcerated. The letter could include a brief treatment summary, up-to-date medication and dosage information, and emergency contact information for Dr D so that the institution can reach out for additional relevant medical information for the purposes of treatment. Federal privacy law allows the sharing of information with correctional institutions for treatment purposes with consent and without consent by court order to prevent "substantial risk of death or serious bodily harm" under the Health Insurance Portability and Accountability Act (HIPAA).³² Of note, special care must be taken to avoid secondary disclosure of information of any recent use of illegal drugs (by, for example, notating it in patient histories).

Second, Dr D and the medical team can build a relationship with the local jail and the jail's correctional health care practitioner to understand and possibly improve the jail's process for care continuation. More specifically, Dr D could find out what information a patient would need to provide the jail, how Dr D could quickly deliver the verifications the jail requires, and ways in which Dr D could facilitate dose administration if a patient becomes incarcerated. If needed, the jail's physician could be reminded that federal regulations allow any physician with a Drug Enforcement Administration license to prescribe controlled substances to dispense methadone for up to 3 days to prevent persons with OUD from experiencing withdrawal during treatment transitions.³³

Third, in MJ's case, Dr D can report the jail to the Department of Justice, Civil Rights Division, for violating MJ's civil rights by failing to properly screen MJ for OUD and failing to provide MJ with necessary medical care.³⁴ The reports often form the basis of investigations of ADA violations, leading to practice changes or even enforcement actions.³⁵

Additionally, Dr D can join national advocacy efforts to **improve laws and policies** that continue to harm people with SUD, especially those who are members of already marginalized groups. Many health professional organizations, for example, provide advocacy tools and training for their members. For patients like MJ, Dr D should advocate for policies that make MOUD more accessible to incarcerated populations, including through the reform of Medicaid exclusions that would allow persons who are incarcerated to remain on Medicaid if eligible, requiring jails to provide access to all 3 forms of MOUD, encouraging clinician education about the ADA and robust enforcement of existing civil rights laws, and supporting legal changes that expand access to MOUD—

such as the changes to methadone regulation²⁴ and continued federal permissions that allow for telehealth access to buprenorphine.³⁶

In sum, the unfortunate reality is that Dr D—and others who provide MOUD—should expect and plan for treatment disruptions, such as the one experienced by MJ, and strive to incorporate in their treatment plan strategies to help reduce the harm caused by systematic and policy failures, such as the ones experienced by MJ.

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