VIEWPOINT

Treating Opioid Use Disorder in Patients Who Are Incarcerated

Quandaries of a Hospitalist

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Related articles

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Mr J is a man in his early 40s with severe opioid use disorder (OUD) who was incarcerated in a county jail shortly before being brought to the hospital for an injection-related infection. As is common for persons who are hospitalized while incarcerated, he was shackled to the bed with guards present. In jail, he had not been screened and treated for OUD using evidence-based medical practices, resulting in severe withdrawal in jail. He then required opioids for analgesia and withdrawal while hospitalized. Mr J was interested in treatment with medication for OUD (MOUD), and buprenorphine was initiated, which is standard of care for treatment of OUD.[1] Mr J expressed gratitude for the medication; buprenorphine relieved his pain and opioid withdrawal symptoms, and helped to control opioid cravings.

Mr J received treatment for the infection with surgical management and prolonged intravenous antibiotics. His main concern was how he could continue MOUD treatment. The hospitalist contacted the jail physician, who confirmed that they had the medical qualifications to continue buprenorphine, but refused to do so citing the county jail policy: MOUD is only prescribed for persons who are court-ordered to receive it or are pregnant and receiving MOUD prior to incarceration. Mr J was devastated by the news. After shared decision-making with the patient, the hospitalist administered extended-release buprenorphine (Sublocade; Indivior), a long-acting monthly injection, to provide MOUD treatment for as long as possible. Extended-release buprenorphine obviates the jail resources required for daily supervised dosing and mitigates the risk of misuse and diversion, a significant concern among jail administration.

> Jails continue to provide medications for other chronic medical diseases, such as hypertension or diabetes, that are potentially fatal if left untreated; [medication for opioid use disorder] should not be left out.

After discharge, the jail transported Mr J to infectious disease and surgery follow-up appointments but refused transport for an addiction medicine appointment for the next extended-release buprenorphine injection.

Unfortunately, Mr J's case is not an anomaly. Untreated OUD often results in serious medical complications that require hospitalization, including life-threatening injection-related infections, such as endocarditis and osteomyelitis, and overdose. Accordingly, hospitalizations related to OUD have increased, and 1 in 9 hospitalized patients currently has an untreated substance use disorder.[2] MOUD, specifically buprenorphine and methadone, reduces mortality; treats withdrawal, cravings, and pain; and decreases infections. Though there has been increasing awareness that MOUD should be offered to all hospitalized persons with OUD, it is not yet universal.[2] Inadequately managed OUD leads to worse outcomes, such as risk of overdose with loss of opioid tolerance, and patients leaving the hospital by patient-directed discharge before their medical condition is stabilized. In addition, 70% of people who use heroin will have encounters with the legal system.[3] Loss of tolerance to opioids during incarceration is associated with increased risk of overdose and death after release.[4] Jails do not routinely continue MOUD or provide linkage to outpatient treatment facilities that can provide MOUD. Continuation and initiation of MOUD for patients who are incarcerated has been associated with increased likelihood of linkage to care after release.[5]

Incarceration and acute medical illness can co-occur, which leads to complex situations for clinicians. Persons who are incarcerated remain in custody when hospitalized. In our experience, there is no interference from jail staff with treatment for injection-related infections and other medical issues; yet the carceral system restricts use of the most medically and cost-effective MOUD treatments. Prior case laws, such as *Pesce v Coppinger* (355 F Supp 3d 35 [D Mass 2018]), outline that discontinuation of MOUD upon incarceration violates the Americans with Disabilities Act (ADA),[4,6] but no case law exists to apply this principle to patients who are hospitalized while incarcerated. Systemwide OUD screening and MOUD initiation for people who are incarcerated decreased overdoses by 12.3% in Rhode Island over 1 year, and Maine experienced a 60% decline in deaths from overdoses after release from jail.[4] Advocacy and reporting potential ADA violations can lead to substantial change (**Box**).

Through recent legislature or executive orders, all jails and prisons in Rhode Island, Vermont, New York, Maryland, and Massachusetts provide MOUD.[7] Per the US Substance Abuse and Mental Health Services Administration and the American Society of Addiction Medicine guidelines, MOUD is the standard of care for patients with OUD due to its clear benefits including reduced mortality, particularly with buprenorphine or methadone treatment.[1] Yet jails and prisons in most states only offer extended-release naltrexone,[7] the only

Box. Clinician Resources on the Americans with Disabilities Act (ADA)

Educational resources on the ADA and the protections it offers for patients with opioid use disorder
- American Civil Liberties Union (https://www.aclu.org/issues/prisoners-rights)
- Legal Action Center (https://www.lac.org/)
- Jail & Prison Opioid Project (https://prisonopioidproject.org/)

Offices at which reports of potential ADA violations can be filed
- Americans with Disabilities Act (https://www.ada.gov/)
- US Department of Justice Civil Rights Division (http://civilrights.justice.gov)
- Offices of the US Attorneys (https://www.justice.gov/usao)

MOUD that has not been shown to reduce mortality among persons with OUD. In states that do not mandate best medical practice for MOUD treatment of patients who are incarcerated with OUD, physicians treating hospitalized persons who are incarcerated can experience significant moral distress. When the carceral system prohibits a physician from carrying out the professional duty to do no harm (consistent with nonmaleficence), particularly when treatment (1) is desired by the patient (consistent with autonomy), (2) reduces the effects of opioid withdrawal and cravings (consistent with beneficence), and (3) when such treatment is not a limited resource (consistent with justice), the carceral system imposes a violation of medical ethics.

The presence of shackles and guards in hospital rooms clearly communicates the person who is incarcerated has lost rights to liberty and privacy, and one might assume that Mr J would not be permitted to make decisions with respect to his health care. In fact, people who are incarcerated have a constitutional right to health care, yet our case demonstrates that evidence-based treatment for OUD is often excluded. The Eighth Amendment prohibits cruel and unusual punishment. The Supreme Court has upheld withholding of health care as cruel and unusual punishment in multiple cases, reiterating that incarcerated patients deserve access to the same standard of medical care that is available to the general public. Case settlements like *Pesce v Coppinger* in 2018 in Massachusetts have shown that withholding methadone from people who are taking MOUD prior to incarceration is a violation of the rights granted by the Eighth Amendment.[6] Withholding medications (buprenorphine and methadone) for a chronic medical disease (OUD) and forced withdrawal from opioids is cruel and medically not appropriate. The Fourteenth Amendment provides equal civil and legal rights to all citizens under the law. Carceral institutions that withhold MOUD demonstrate "deliberate indifference"[6] to a chronic medical disease resulting in constitutionally inadequate medical care.

Mr J has since completed his jail sentence and is currently not engaged in treatment for OUD. He has had multiple emergency department visits related to complications of OUD, including a near-fatal opioid overdose. The emergency department has given him information for an addiction walk-in clinic, but he has not established care again. Had Mr J been allowed to continue MOUD while incarcerated, additional morbidity and health care utilization may have been avoided.

Barriers to initiation of life-saving MOUD among hospitalized persons who are incarcerated are not commonly discussed, and we hope to shed light on this phenomena. Our case highlights violations of medical ethics, constitutional amendments, and the ADA. Most attention has been focused on the ADA noncompliant policies of not allowing MOUD to continue upon incarceration[4]; however, hospitalizations are an opportunity to engage patients who are incarcerated in care and offer treatment for OUD.[2] Patients with OUD who are incarcerated deserve the same standard of care that is available to the general public. Physician advocacy for this patient population can address many barriers. Physicians need to educate themselves on the ADA as it applies to patients with OUD taking MOUD, start MOUD for patients who are incarcerated and become hospitalized often for medical consequences of untreated OUD, and advocate for jails and prisons to both initiate and continue MOUD. Jails continue to provide medications for other chronic medical diseases, such as hypertension or diabetes, that are potentially fatal if left untreated; MOUD should not be left out.

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