

Opioid Use Disorder Treatment in Correctional Settings

Position Statement

The National Commission on Correctional Health Care (NCCHC) recommends that prisons, jails, and detention centers enact the following steps to provide access to and continuity of medications for opioid use disorders (MOUD¹) approved by the Food and Drug Administration (FDA) in order to prevent overdose deaths and save lives.

1. Establish MOUD programs that involve universal opioid use disorder (OUD) screening upon entry, offering treatment with MOUD, and ensuring MOUD treatment continuity upon entry and on discharge in coordination with community MOUD treatment providers.
2. Provide individuals who screen positive for OUD with diagnostic and psychosocial assessments, including confirmation of OUD, evaluation for mental health conditions and social needs, and appropriate referrals for behavioral health treatment, psychosocial counseling, and postrelease care.
3. Establish partnerships and memorandums of understanding with community opioid treatment programs (OTPs) and buprenorphine providers so that (a) people receiving MOUD treatment upon entry can continue their current regimen while in custody, (b) people not engaged in treatment may opt to have MOUD initiated during their incarceration when appropriate, and (c) people receiving MOUD during incarceration and those who wish to initiate treatment at the time of reentry receive appointments with community treatment providers along with adequate supplies of MOUD, with a backup plan if appointments are canceled or delayed.
4. Partner with prerelease programs such as those funded through Medicaid reentry (1115 waiver) programs, local “bridging clinics,” and telehealth programs that facilitate engagement in community treatment programs, including OTPs and office-based buprenorphine programs.
5. Provide education to correctional health and custody staff in the science and treatment of OUD, including the fact that OUD is a chronic illness requiring patient education, appropriate counseling, treatment with medication, and appropriate monitoring during MOUD administration. Training should also address stigma and implicit bias, and include the locations of and proper administration of opioid reversal medications.²
6. Establish policies and procedures that ensure that all people living with OUD are offered choices regarding MOUD available in the community. Ensure that people currently receiving MOUD continue to receive it, and those not previously engaged in treatment are provided with treatment. This process includes appropriate counseling about OUD, patient management, recovery groups, risks associated with discontinuing medications, how continued treatment with MOUD can save lives, continuation of treatment in the community, discharge planning and care coordination, and use of opioid reversal medications.
7. Screen for pregnancy among all people who could become pregnant and are living with OUD. Withdrawal from opioids should be especially avoided in pregnant people. They should be offered pregnancy-appropriate MOUD (i.e., methadone or buprenorphine) in the absence of a strong patient preference for injectable naltrexone. Clinicians with expertise in perinatal MOUD should provide treatment during pregnancy. Initiation of MOUD during pregnancy may require hospitalization. Other opioid medications, such as

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acetaminophen with codeine, hydrocodone, and oxycodone, are not alternatives to MOUD and should not be substituted for appropriate medication treatments.

8. Ensure that adolescents living with OUD have access to health care professionals experienced in MOUD and psychosocial interventions that are developmentally appropriate. Treatment provided should be consistent with state laws regarding consent, adhere to confidentiality, and involve family or guardians when possible.
9. Seek out resources, including technical assistance, to help establish effective programs. This may involve partnerships with community MOUD treatment health care professionals, on-site buprenorphine prescribing by clinicians licensed by the Drug Enforcement Administration (DEA), or becoming licensed as a health care facility allowing for adjunctive use of methadone or as an OTP (see table for more information).

Discussion

Deaths from opioid overdoses were estimated at 54,700 in 2024, down from a peak of more than 80,000 in 2023. These deaths are largely preventable. OUD is a chronic, treatable illness and a disability recognized by the Americans with Disabilities Act that is best treated in the community. Court systems and attorneys should be educated about alternatives to incarceration, such as drug courts and pretrial diversion, that can better promote recovery and are more appropriate than incarceration for some individuals.

Fifteen percent of people screened upon jail admission have OUD. Prevalence of OUD is only slightly less in state prisons than in jails. Thus, correctional facilities have important roles to play in ensuring appropriate treatment for people with this chronic illness. Scientific evidence has firmly established that treatment with MOUD saves lives. By providing access to MOUD and behavioral treatment based on national standards, prisons, jails, and detention facilities can reduce deaths, improve long-term health outcomes, reduce recidivism, and minimize litigation.

The current FDA-approved treatments are buprenorphine (for patients ≥ 16 years) and naltrexone and methadone (for patients ≥ 18 years). The American Society of Addiction Medicine (ASAM), the National Academies, and the National Governors Association recommend that all FDA-approved MOUD be available within carceral facilities. See the table for options for implementing MOUD in correctional settings.

Although medication alone is effective for the treatment of OUD, its efficacy is enhanced when used in combination with appropriate behavioral interventions that address underlying psychological contributors to OUD, as well as co-occurring mental health conditions. Assessment and treatment of people's behavioral health and social resource needs are a critical part of comprehensive treatment plans for people living with OUD. Support groups such as Narcotics Anonymous and other mutual support groups (e.g., non-faith based groups) can also provide benefits for recovery. Such counseling and support groups are important parts of treatment, but medication alone is strongly recommended even if counseling is unavailable. Appropriate screening for opioid use and OUD, along with thorough counseling on treatment options by appropriately trained health care professionals, can help identify those who would benefit most from engaging in medication-assisted and behavioral treatment.

A robust body of evidence has demonstrated the feasibility and benefits of providing MOUD in correctional settings, including a striking mortality benefit. People living with OUD who are not receiving MOUD have up to

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40 times higher risk of dying from overdose in the first 2 weeks following their discharge compared to the general population. MOUD significantly reduces postdischarge overdose deaths; one state showed a two-thirds reduction in statewide opioid overdose deaths when its correctional system made MOUD available in custody. A modeling study showed that 1,840 lives could be saved annually if all people living with OUD received appropriate MOUD in jails and prisons. Although the prevalence of OUD is similar by race and ethnicity, Black and Brown people are more often incarcerated and more often have their treatment interrupted by incarceration; thus, people of color are at a potentially higher risk for needing MOUD treatment in carceral settings.

Providing OUD treatment and addressing diversion to individuals while incarcerated also promotes engagement in and continuity of treatment in the community after discharge, especially when linkages to community treatment and services are facilitated. Providing MOUD in correctional facilities also offers an opportunity to evaluate untreated mental health conditions that may be contributing to OUD. Although both methadone and buprenorphine treatment pose some risk for diversion in correctional facilities, evidence suggests that overall rates of illicit drug use often decline following the introduction of MOUD and disciplinary problems decrease. Current evidence in the context of high fentanyl prevalence shows that higher (≥ 16 mg/day) dosing of buprenorphine improves retention in care in the community. Similarly, long-acting injectable MOUD minimizes diversion and may improve retention.

People living with OUD who are incarcerated should have the choice to receive MOUD or undergo medically supervised withdrawal. Involuntary withdrawal discourages engagement in community treatment, increases the risk for substance use during incarceration, and increases the risk for accidental overdose death during incarceration and after discharge. If, after education about the benefits of treatment, patients decline MOUD and choose withdrawal, then withdrawal (if moderate or greater) should be accomplished using buprenorphine by tapering doses based on an opioid withdrawal scale. Pregnant people in particular should have timely access to MOUD and avoid withdrawal during pregnancy and postpartum due to fetal and maternal risks.

Opioid reversal medications available within facilities and provided at discharge (in the person's property or via e-prescribing) can prevent overdose death. These steps should be accompanied by training in its use for patients and their family/friends. Partnering with local public health agencies may offset the costs of opioid reversal medication and offer opportunities to provide visitors with opioid reversal medication and training in its use. Discharge planning should begin at admission to facilitate linkages to community MOUD treatment. Correctional health advocates/liaisons can facilitate access to MOUD in community settings by arranging appointments, facilitating the exchange of health information, and developing backup plans if community linkage fails. Evidence-based models for coordinating care have demonstrated feasible workflows and describe roles and protocols.

MOUD treatment during pregnancy benefits the patient and fetus and should be done by clinicians trained and experienced in managing OUD during pregnancy. Buprenorphine and methadone are preferred, given their proven reduction in overdose deaths and longer retention in treatment. Injectable opioid reversal medication is an option for patients who prefer it, although any opioid withdrawal symptoms in pregnancy require additional monitoring. Psychosocial support and prerelease linkage to appropriate medical, behavioral, and social services in the community are beneficial for patients released during pregnancy and are critical during the postpartum period, when risk of opioid overdose death increases substantially. Infants exposed prenatally to any opioid are

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at risk for neonatal opioid withdrawal syndrome (NOWS), commonly called neonatal abstinence syndrome (NAS). These infants should be monitored and treated by pediatric clinicians trained and experienced in its management. Treatment with buprenorphine is associated with a lower risk of NAS and higher birthweight compared with methadone.

Although methadone and extended-release naltrexone are FDA-approved for individuals 18 years and older, data related to adolescents is limited. These medications appear to be safe and effective for both populations. Buprenorphine is FDA-approved for adolescents 16 years and older and requires only a DEA license to prescribe.³ Methadone generally can be administered only through a licensed and certified OTP. (NCCHC accredits carceral facilities as OTP.⁴) Notably, methadone can be administered to manage OUD outside of an OTP only under two limited circumstances:

- a) Under the DEA three-day rule, up to a three-day supply can be dispensed to bridge the patient until methadone can be obtained.⁵ This three-day supply cannot be extended.
- b) If the facility obtains a DEA license as a health care facility, it is permitted to use methadone for adjunctive use, such as pregnancy or treatment of another condition.⁶ Facilities seeking such a license should discuss it with their local DEA office and ensure compliance with state regulations.

Injectable extended-release naltrexone is not a DEA-controlled substance. However, it requires appropriate clinician training, and the patient must undergo medically supervised withdrawal before administering. The Bureau of Justice Assistance and the National Institute of Corrections have national guidelines for medically supervised withdrawal. To date, evidence concerning retention in treatment and reduction of overdose deaths is weaker for injectable naltrexone than for buprenorphine and methadone.

Long-acting injectable MOUD offers potential advantages in the carceral setting. Extended-release buprenorphine can remove the barriers of staffing, security, and diversion concerns, and the need for immediate follow-up postrelease. The monthly injection is more efficient than a daily medication pass, reducing staffing needs for both custody and health staff. Particularly in jails, where release dates can be unpredictable, extended-release buprenorphine can allow people an extended bridge to access treatment and establish care postrelease. A “shot for the road” provides days to weeks of continuous medication release, serving as potential protection from overdose and return to use during the vulnerable postrelease period. Although medication cost can be a barrier, early studies show benefits and adherence in a transient population. At this time, safety data is insufficient to recommend long-acting injectable buprenorphine in pregnancy, but research is ongoing.

Considerations for the treatment of adolescents include the importance of engaging youth and family in treatment as much as possible, incorporating psychosocial interventions alongside any pharmacological interventions, recognizing and addressing complex issues of confidentiality and consent especially in the juvenile justice system, recognizing and treating the likely co-occurring psychiatric conditions, accessing developmentally appropriate interdisciplinary treatment programs whenever possible, and identifying and addressing underlying medical (e.g., chronic pain), social, and developmental needs that may be contributing to the OUD. ASAM’s National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use includes treatment in correctional facilities and options for using MOUD with adolescents. Laws regarding age of consent for MOUD treatment for adolescents vary by state.

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Health care professionals in carceral settings should follow ASAM guidelines when treating people with OUD. From a legal perspective, OUD is a protected disability under federal law. Recent court rulings have affirmed the right of people with OUD in jails and prisons to receive MOUD. Useful guides for implementation include NCCHC's Jail Guidelines for the Medical Treatment of Substance Use Disorders 2025 and Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit from the National Council for Mental Wellbeing. Despite the established benefits and feasibility of providing MOUD in custody, available evidence shows that many correctional facilities do not provide access to MOUD, provide MOUD only in limited circumstances, or, in some cases, do not even continue community-initiated MOUD. To facilitate community return, the Assess, Plan, Identify, and Coordinate (APIC) model offers guidance for transitional care and care coordination.

Table. Options for Providing MOUD in Correctional Facilities

- a) Transport patients to community OTPs or a hospital (sometimes done during pregnancy) for medication dosing. OTPs may request waivers to use takeout doses to minimize transport.
- b) Partner with community OTPs for dosing of patients within the facility. In this case, dosing is performed under the community OTP's license.
- c) Encourage providers to provide training and prescribe buprenorphine for both maintenance and medically supervised withdrawal (for patients declining maintenance buprenorphine or methadone).
- d) Obtain an OTP license for the facility. This permits the use of methadone and buprenorphine for both treatment and withdrawal. (Note: NCCHC accredits facilities for OTPs.⁴)
- e) Obtain DEA licensing as a health care facility.⁶ This entitles the facility to the same exemptions as hospitals for adjunctive use of methadone or buprenorphine in the management of pregnancy or other conditions. However, state restrictions may vary.

Notes

1. For more information on MOUD, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) at <http://www.samhsa.gov/medication-assisted-treatment>.
2. See NCCHC's position statement on Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths, <https://ncchc.org/naloxone-for-the-prevention-of-opioid-overdose-deaths>. Nalmefene is available only under its brand name, Opvee®, and is more expensive. It has a mechanism of action similar to that of naloxone, but has been less studied and less used for overdose. It also has a longer duration of effect with potential for protracted withdrawal.
3. Buprenorphine is the only opioid agonist-type drug that clinicians holding a DEA license can prescribe (outside of an OTP) to treat OUD in any patient, regardless of pregnancy. There is no longer a requirement for an X waiver or for additional training.
4. NCCHC OTP Accreditation Program for Correctional Facilities. Opioid Treatment Programs. <https://ncchc.org/programs/opioid-treatment-programs-accreditation>
5. The three-day rule permits administration of one dose per day of a narcotic such as methadone for up to three days "while arrangements are being made for referral for treatment." Furthermore, providers may

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request an exception that would permit dispensing a three-day supply to patients for such “bridging.”
[https://www.deadiversion.usdoj.gov/drugreg/Instructions-to-request-exception-to-21-CFR-1306.07\(b\)-3-day-rule-\(EO-DEA248R1\).pdf](https://www.deadiversion.usdoj.gov/drugreg/Instructions-to-request-exception-to-21-CFR-1306.07(b)-3-day-rule-(EO-DEA248R1).pdf)

6. Correctional facilities may apply to the DEA for licensing as a hospital/clinic that would allow “incidental” treatment of OUD with methadone. Specifically, DEA regulations state that “a physician or authorized hospital staff may administer or dispense methadone in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction” (21 CFR 1306.07(c)). The primary diagnosis for care cannot be addiction. Correctional facilities using this regulatory provision are not registered with DEA as an OTP and are not required by SAMHSA to offer the full suite of services that OTPs provide. See <https://library.samhsa.gov/sites/default/files/oud-correctional-facilities-pep25-02-005.pdf>.

Note: This statement replaces Substance Use Disorder Treatment for Adults and Adolescents, adopted in 2016 and expired in 2021.

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POSITION STATEMENT

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