Considering the Massachusetts Court Ruling that Jail Must Provide Methadone to Entering Defendant

In December, a federal district court judge in Massachusetts ordered the Essex County Massachusetts jail to provide an entering inmate methadone so that he could continue his successful methadone treatment of the last two years. The individual had failed on the other opioid medications, buprenorphine and naltrexone. He had overdosed and been revived with naloxone multiple times. He and his doctor feared that if he were forced to stop taking methadone for his 60-day jail commitment for operating after revocation, he would relapse and risk death.

The jail offers a sophisticated medical detox program, a model RSAT treatment program that provides injectable naltrexone for those who want it but is not a licensed methadone clinic. However, the sheriff announced he would not appeal the ruling and accommodate the individual even if correctional officers had to drive him to a methadone clinic each day for 60 days.

The ruling has prompted headlines like the following from the Santa Fe New Mexican, "Ruling in Massachusetts opioid treatment case could affect New Mexico." Yes and no. The ruling from a single Federal District Court Judge carries no legal precedent, even among his colleagues on the federal District Court in Massachusetts. However, it will prompt more demand from advocates and other individuals facing jail time and more lawsuits as the American Civil Liberties Union has already lodged similar suits in Maine and Washington so far.

The real issue is ***should*** jails and prisons provide opioid medications for those already on these medications or for those who request them to assist them avoid relapse upon release? The answer is not clear cut one way or the other.

First, it makes little sense for jails and prisons to offer medication that is not available to individuals when they are released and go home. Methadone clinics are few and far between, inaccessible to most persons especially those living outside major cities. Even within cities, many methadone clinics are full, not accepting new patients. Further, in states without Medicaid expansion, and in other states where Medicaid does not cover methadone, the cost of methadone treatment may make it out of reach to many individuals. The same problem exists with buprenorphine. Only certified doctors and other medical personnel may prescribe buprenorphine. They too are in limited supply, nonexistent in most rural and suburban counties. While doctors do not have to been certified to prescribe naltrexone, most doctors do not do so.

Second, it may be problematic to continue individuals on opioid medication if they are unable or unwilling to abide by the rules. Jails are documenting that the majority of individuals entering with prescriptions for methadone or buprenorphine are mixing their prescribed medications with additional narcotics and benzodiazepines. A large Medicaid study across New York documented that a third of persons on agonist medication for opioid treatment were obtaining narcotic prescriptions outside of their maintenance. Both increased doses and mixing of medications can deadly drug overdoses more likely.

Third, polydrug abusing individuals who lack steady employment, housing, and strong family support may not be in a good position to be able to sustain a regimen of daily medication, particularly for buprenorphine. The delivery system for buprenorphine, outpatient through doctors' offices, was not

designed for individuals with high criminogenic needs. Studies increasingly reveal that diversion of this medication is the rule, not the exception.

With studies finding that more than 11,000 children and adolescents were reported to poison control centers for exposure to buprenorphine between 2007 to 2016, the last thing jails and prisons want to be responsible for is increasing that deadly exposure. The recent introduction of injectable buprenorphine may help, but the cost will be prohibitive.

Fourth, the limited number of jails and prisons that induce individuals on methadone or buprenorphine upon entrance are finding most do not continue these medications after release. Their motivation to begin agonist medication appears understandably to be avoidance of the agony of withdrawal from opioids, not a commitment to long term recovery after release. Once released on methadone or buprenorphine, these individuals must either enter detox, withdraw cold turkey, or return to illicit drugs. The retention rate for injectable naltrexone after release is also problematic, although stopping does not result in withdrawal.

Medication-assisted treatment adds value to any drug treatment program. All of the issues raised above can be addressed. But simply providing medication to incarcerated individuals is insufficient and may even be harmful. Jail and prison medication-assisted treatment requires concurrent treatment, support, and tight monitoring as well as seamless transition to comprehensive community aftercare and support upon release. This requires a commitment and increased resources currently unavailable to jails and prison and the many communities where individuals will return.