Providing Methadone in Jails and Prisons: An explanation of a new approach to increase access to methadone in carceral settings

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There are many reasons for correctional facilities to provide addiction treatment to people who enter their facility with opioid use disorders. These include:

- The chances of dying from an overdose are significantly higher for newly released individuals who are not receiving addiction treatment.
- Medications to treat opioid use disorder—particularly methadone and buprenorphine—have been shown to reduce the risk of overdose death.
- Numerous professional associations—including the American Correctional Association, the National Commission on Correctional Healthcare, and the American Society of Addiction Medicine—recommend that jails and prisons provide access to these medications.

Additionally, the Department of Justice recently issued guidance that failure to provide these medications can be a violation of the Americans with Disabilities Act. As a result of litigation, federal courts have required facilities to provide these medications.

Methadone is the most tightly regulated of the three medications used to treat opioid use disorder, and many facilities have struggled to provide it. Traditionally, jails and prisons who want to use methadone have had two options:

1. Become a methadone clinic (also known as an opioid treatment program (OTP) or a narcotic treatment program (NTP))
2. Contract with a methadone clinic to supply the medication

These options are expensive, logistically challenging, and not well-suited to correctional settings.

As described in a recent report released by the Johns Hopkins Bloomberg School of Public Health, jails and prisons have another option for providing methadone to a large fraction of their eligible population: they can rely on the same legal provision that hospitals use to provide methadone without contracting with or becoming a methadone clinic.

Under this Drug Enforcement Administration (DEA) regulation, hospitals can provide methadone to people who are receiving treatment for another physical or mental health condition. Similarly, by registering with the DEA as a "hospital/clinic," correctional facilities can provide methadone to people receiving care for another physical or mental health condition.

This approach should make it significantly easier for correctional facilities to provide methadone. Facilities interested in implementing this approach should consult with their legal staff to ensure that they are in compliance with all applicable federal and state regulations.

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Frequently Asked Questions

1. What are the specific DEA regulations that give correctional facilities the ability to use methadone without contracting with or becoming a methadone program?

The DEA's provision regarding hospitals' use of methadone can be found at 21 C.F.R. § 1306.07(c). This regulation states that hospitals can use methadone "*as an incidental adjunct to medical or surgical treatment of conditions other than addiction.*" Additional guidance on how to apply this provision in correctional settings can be found in the 2000 and 2022 DEA guides for narcotic treatment programs. In the 2000 guidance (p. 32), the DEA stated:

> ***Q. May a Department of Corrections medical staff administer methadone to incarcerated, pregnant, opioid-dependent women during the course of their pregnancy without a separate registration as an NTP?***
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> *A. Methadone may be administered in such circumstances when the following conditions are met. A practitioner, or authorized hospital staff, may administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction. Pregnancy is recognized as a medical condition by both DEA and FDA, and, therefore, this would be considered medical treatment of a condition other than addiction.*
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> *Such medical treatment is allowed "in a hospital" or institutional setting. However, the Department of Corrections must be licensed by both the state and DEA as a clinic, a hospital, or a hospital/clinic. [21 CFR 1306.07(c)].*

In its response, the DEA affirms that correctional facilities can treat pregnant women with methadone. Additionally, the guidance explains that correctional facilities can also administer methadone to people who are receiving treatment for other medical conditions.

This position was reaffirmed in the 2022 guidance (p. 30), where the DEA stated that:

> *A correctional facility may register with DEA as a hospital/clinic. Under a hospital/clinic registration, a physician or authorized hospital staff may administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an* ***incidental adjunct*** *to medical or surgical treatment of conditions other than addiction. (Emphasis in original.)*

2. How does my correctional facility register with the DEA as a "hospital/clinic"?

The process to register with the DEA as a "hospital/clinic" is straightforward. DEA form 224, which is available online, asks for information such as the address of the facility and the DEA license of the provider supervising the clinic. Some jails and prisons may already be registered with the DEA as a "hospital/clinic."

3. Does my correctional facility need to be registered with my state?

Facilities must be in compliance with both federal and state regulations regarding controlled substances; the specific details will vary from state to state. In some states, facilities may need to register with the state as an entity that dispenses controlled substances. Jails and prisons that are providing other controlled substances (opioids, benzodiazepines, etc.) may already have completed the registration processes needed in their state.

In addition to any state regulations regarding controlled substances generally, states may have particular rules regarding the treatment of people with a substance use disorder that facilities must follow.

4. Can my correctional facility use this provision to start methadone treatment for individuals with opioid use disorder?

Yes. Facilities can use this provision to start people on methadone (methadone induction) and to continue the medication for those already in treatment.

5. What should my correctional facility have in place to make this approach work?

As a best practice, correctional facilities that are interested in this approach to treat people with methadone should develop:

a) a protocol outlining which conditions would qualify as a "primary condition" that would make someone eligible for methadone

b) protocols for initiation and adjustment of the methadone dose

c) a protocol for communicating with the patients' community-based methadone clinic, especially around intake (for dose verification) and discharge

d) a relationship with an addiction medicine provider to discuss any challenging cases

e) a plan to periodically review how well the program is working and how it can be improved.

6. Is a correctional facility required to offer all the services that federal regulations require methadone clinics to offer?

No. Under federal regulations, facilities that use the provision discussed here do not need to offer the full spectrum of services that methadone clinics must provide.

7. How would my facility get the methadone?

A facility needs to coordinate with its pharmacy supplier to obtain methadone.

8. What conditions would qualify as a "primary condition" under this provision?

There are no federal guidelines for what qualifies as a "primary condition" under the DEA's regulations and permit the use of methadone. Facilities should have a protocol for their providers to use in making and recording this determination.

9. Can my correctional facility treat someone for opioid use disorder if they're not getting treatment for another condition?

A correctional facility may write to the DEA asking for an exception to the requirement that people receiving methadone are also receiving treatment for other diagnoses. The DEA must grant explicit permission for this exception.

The team at the Johns Hopkins Bloomberg School of Public Health can assist with this correspondence.

10. Where can I go for more information?

This white paper released by the Johns Hopkins School of Public Health contains more details about this approach.

11. My correctional facility would like to start doing this. How do we begin?

While this approach has been laid out in DEA regulations and guides and requires no further special permissions, some correctional facilities have taken the cautionary measure of alerting the DEA at least a month before starting this process to resolve any outstanding questions and minimize confusion. Such correspondence should be directed to the Assistant Administrator of DEA's Diversion Control division, copying the DEA regional office, the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration, as well as any relevant state agencies.

The team at the Johns Hopkins Bloomberg School of Public Health can assist with this correspondence.

12. Who can I contact if I have questions?

Please do not hesitate to contact the Johns Hopkins Bloomberg School of Public Health if you have questions or would like assistance in pursuing this approach: OverdosePrevInit@jh.edu

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