**Court Letterhead**

Dear [Sheriff / Warden / Commissioner / Director] \_\_\_\_\_\_\_\_\_\_\_\_:

I am writing in hope of beginning a collaborative conversation with you and your staff about ways to continue life-saving medications for opioid use disorder (MOUD) for persons detained in your facility.

I am the presiding judge of the \_\_\_\_\_\_\_\_\_\_\_\_ Treatment Court in \_\_\_\_\_\_\_\_\_\_\_\_ County. Our mission is to provide proven, evidence-based treatments in the community in lieu of conviction or incarceration for persons with severe substance use disorders charged with drug-related offenses. I work with a multidisciplinary team of professionals including substance use and mental health treatment providers, probation officers, defense lawyers, prosecutors, and members of law enforcement. Team members share their observations and expertise to ensure that participants attend treatment faithfully, meet their other obligations in the program, and desist from dangerous and unlawful misconduct.

Our participants are tested frequently for drug and alcohol use and come to court regularly for the team to review their progress in treatment and deliver rewards for their accomplishments and sanctions for infractions. Sanctions may include verbal reprimands, increased supervision, curfews, person and place restrictions, community service, or brief jail detention in your facility for more serious technical violations.

Approximately 15% to 30% of adult treatment court participants nationally [OR, IF DATA ARE AVAILABLE –\_\_\_% of our participants] suffer from an opioid use disorder and are at risk for severe repercussions from this illness, including overdose and death, treatment attrition or failure, and new drug-related arrests and incarcerations. Research is clear that medications including naltrexone (e.g., Revia, Vivitrol), buprenorphine (e.g., Suboxone, Subutex), and methadone, along with counseling and social services, improve outcomes substantially for persons with opioid use disorders in the justice system. Proven benefits include increasing treatment attendance and reducing illicit opioid use, overdose risk, and new drug-related arrests and technical violations.[[1]](#endnote-1) Based on this body of evidence, MOUD is endorsed as the generally accepted standard of care for treating opioid use disorders by virtually all leading medical, scientific, and professional treatment organizations, including but not limited to the following:

* National Institute on Drug Abuse (NIDA)[[2]](#endnote-2)
* National Academies of Sciences, Engineering, and Medicine (NASEM)[[3]](#endnote-3)
* U.S. Surgeon General[[4]](#endnote-4)
* Substance Abuse and Mental Health Services Administration (SAMHSA)[[5]](#endnote-5)
* Centers for Disease Control and Prevention (CDCR)[[6]](#endnote-6)
* White House Office of National Drug Control Policy (ONDCP)[[7]](#endnote-7)
* American Medical Association (AMA)[[8]](#endnote-8)
* American Psychiatric Association (APA)[[9]](#endnote-9)
* World Health Organization (WHO)[[10]](#endnote-10)

Evidence is equally clear that requiring inmates to discontinue or change a medication regimen is associated with poor outcomes and a lower likelihood of resuming MOUD after release from custody.[[11]](#endnote-11) Worse, because physiological tolerance to opioids declines during forced abstinence or while taking blockade medications like naltrexone, inmates required to withdraw involuntarily from methadone or buprenorphine face a substantially increased risk of overdose and death if they return to illicit opioid use.[[12]](#endnote-12) This explains, in part, the heartbreaking statistics indicating that **persons with opioid use disorders released from jail or prison are between 10 and 40 times more likely than those in the general population to die of an opioid overdose within the first few weeks after returning to the community.[[13]](#endnote-13)**

As public officials, we also cannot ignore recent case precedent taking note of these alarming statistics and concluding that denying MOUD as a matter of course to jail or prison inmates, whether on post-conviction or pretrial status, is likely to violate the Americans with Disabilities Act (ADA) or Rehabilitation Act and possibly the Eighth Amendment. At least two federal courts have granted preliminary injunctions against jails for routinely denying access to methadone or Suboxone,[[14]](#endnote-14) and federal settlement agreements have been reached in several cases granting access to MOUD for specific plaintiffs[[15]](#endnote-15) or whole classes of plaintiffs.[[16]](#endnote-16) Like you, our court would like to avoid such unpleasant litigation and implement safe and effective practices proven to enhance the health and functioning of our participants and public welfare.

I can assure you that my staff and I will do everything in our power to work collaboratively with your institution to ensure safe and appropriate use of MOUD. Physicians or other lawfully qualified medical providers working with our program are available to provide extended prescriptions or medication doses to your medical staff with instructions for their use. In addition, there are many effective ways to avoid misuse or diversion of medications, such as observed ingestion, random pill counts, and use of abuse-deterrent formulations to name just a few. These and other strategies are described in excellent documents I would like to call to your attention on the use of MOUD in corrections facilities, one published jointly by the National Sheriffs’ Association and the National Commission on Correctional Health Care,[[17]](#endnote-17) and the other published by SAMHSA and the Bureau of Justice Assistance (BJA).[[18]](#endnote-18)

My staff and I would welcome the opportunity to meet with you or designated officials from your facility to discuss this important matter further and begin problem-solving mutually agreeable and feasible ways to address understandable concerns you might have. If you require any additional information or are open to arranging a time to speak, please contact my clerk, \_\_\_\_\_\_\_\_\_\_\_\_, at \_\_\_\_\_\_\_\_\_\_\_\_ to schedule a mutually convenient meeting or phone call. Most Appreciatively and Respectfully,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presiding Judge, \_\_\_\_\_\_\_\_\_\_\_Treatment Court

1. *See., e.g.,* Substance Abuse and Mental Health Services Administration (SAMHSA). *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings* (2019). (HHS Pub. No. PEP19-MATUSECJS). <https://www.samhsa.gov/resource/ebp/use-medication-assisted-treatment-opioid-use-disorder-criminal-justice-settings> [↑](#endnote-ref-1)
2. National Institute on Drug Abuse. *Principles of Drug Addiction Treatment: A Research-Based Guide* (Third Edition) (2020), https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface; and Principles of Drug Abuse Treatment for Criminal Justice Populations (2014), <https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide/principles> [↑](#endnote-ref-2)
3. National Academies of Sciences, Engineering, and Medicine. *Medications for Opioid Disorder Save Lives* (2020), <https://www.nap.edu/catalog/25310/medications-for-opioid-use-disorder-save-lives> [↑](#endnote-ref-3)
4. SAMHSA, U.S. Office of the Surgeon General. *Facing Addiction in America: The Surgeon General’s Spotlight on Opioids* (2018), <https://www.ncbi.nlm.nih.gov/books/NBK538436/> [↑](#endnote-ref-4)
5. SAMHSA. MAT Medications, Counseling, and Related Conditions web page, <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions>; and TIP 63: *Medications for Opioid Use Disorder* (2020), <https://www.samhsa.gov/resource/ebp/tip-63-medications-opioid-use-disorder> [↑](#endnote-ref-5)
6. Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. *Medication-Assisted Treatment for Opioid Use Disorder* (2019), <https://doi.org/10.26616/NIOSHPUB2019133> [↑](#endnote-ref-6)
7. Executive Office of the President, Office of National Drug Control Policy. *Medication-Assisted Treatment for Opioid Addiction* (2012), <https://obamawhitehouse.archives.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf> [↑](#endnote-ref-7)
8. American Medical Association. Medication-Assisted Treatment web page, [https://www.ama-assn.org/topics/medication-assisted-  
   treatment](https://www.ama-assn.org/topics/medication-assisted-treatment) [↑](#endnote-ref-8)
9. American Psychiatric Association. Medication-Assisted Treatment for Opioid Use Disorder web page, <https://www.psychiatry.org/psychiatrists/education/signature-initiatives/model-curriculum-project-for-substance-use-disorders/medication-assisted-treatment-for-opioid-use-disorder> [↑](#endnote-ref-9)
10. World Health Organization. *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* (2009), <https://www.who.int/publications/i/item/9789241547543> [↑](#endnote-ref-10)
11. *See, e.g.,* Rich, J. D., et al., Methadone Continuation Versus Forced Withdrawal on Incarceration in a Combined US Prison and Jail: A Randomised, Open-Label Trial (2015), Lancet 386(9991):350–359. <https://doi.org/10.1016/S0140-6736(14)62338-2> [↑](#endnote-ref-11)
12. *See* Green, T. C., et al., Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System (2018), *JAMA Psychiatry* 75(4):405–407. <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2671411> [↑](#endnote-ref-12)
13. *See, e.g.,* Merrall E. L., et al., Meta-Analysis of Drug-Related Deaths Soon After Release from Prison (2010), *Addiction* 105(9):1545–1554, <https://doi.org/10.1111/j.1360-0443.2010.02990.x>; Binswanger, I. A. et al., Release from Prison—A High Risk of Death for Former Inmates (2007), *New England Journal of Medicine* 356:157–165, <https://www.nejm.org/doi/full/10.1056/nejmsa064115>; Rosen, D. L., et al., All-Cause and Cause-Specific Mortality Among Men Released from State Prison, 1980–2005 (2008), *American Journal of Public Health* 98(12):2278–2284, <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2007.121855>. [↑](#endnote-ref-13)
14. *Pesce v. Coppinger,* 355 F. Supp. 3d 35 (D. Mass. 2018); *Smith v. Aroostook County,* 376 F. Supp. 3d 146 (D. Maine), *aff’d,* 922 F.3d 41 (1st Cir. 2019). [↑](#endnote-ref-14)
15. *DiPierro v. Hurwitz,* No. 1:19-cv-10495-WGY (D. Mass. 2019); *Smith v. Fitzpatrick* (D. Maine 2018); *Crews v. Sawyer* (D. Kan. 2019); *Sclafani v. Mici* (D. Mass. 2019); *Godsey v. Sawyer* (W.D. Wash. 2019). [↑](#endnote-ref-15)
16. *Kortlever v. Whatcom County* (D. Wash. 2018). [↑](#endnote-ref-16)
17. National Sheriffs’ Association and National Commission on Correctional Health Care. *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* (2018). <https://www.ncchc.org/filebin/Resources/Jail-Based-MAT-PPG-web.pdf> [↑](#endnote-ref-17)
18. SAMHSA and BJA. *Medication-Assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion* (2019). <https://store.samhsa.gov/product/mat-inside-correctional-facilities-addressing-medication-diversion/PEP19-MAT-CORRECTIONS> [↑](#endnote-ref-18)