SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

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EXPANDING ACCESS TO METHADONE TREATMENT IN HOSPITAL SETTINGS

Summary

The United States faces an unprecedented challenge in addressing substance use disorders (SUDs) within hospital settings. Recent evidence demonstrates that approximately 12 percent of hospitalizations involve SUDs and that almost a quarter of these admissions involve opioid use disorder (OUD), yet most of these patients do not receive adequate services to address these conditions (Thakrar et al., 2023; Suen et al., 2022). This Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory provides comprehensive information for hospitals and associated healthcare facilities on best practices and recommendations for implementing and expanding methadone treatment services for patients. While this Advisory is focused on methadone treatment for OUD, it also incorporates broader approaches to the care of patients with SUD in hospital settings, given the high prevalence of multiple SUDs, and the commonalities inherent within this category of individual substance-specific diagnoses.

This Advisory aligns with President Trump's Make America Healthy Again (MAHA) initiative and its commitment to addressing the chronic disease epidemic affecting Americans, recognizing that SUDs represent a critical component of our nation's health challenges. Expanding access to methadone treatment for opioid use disorder in hospital settings furthers the focus on evidence-based, transparent approaches to healthcare that prioritize patient outcomes over institutional barriers. The integration of addiction medicine into hospital care exemplifies the whole-person approach to health that MAHA champions, treating SUDs as the chronic medical conditions that they are.

Furthermore, this Advisory embodies MAHA's directive to reduce conflicts of interest and to promote transparency in healthcare delivery. The evidence-based practices outlined here are grounded in rigorous research demonstrating improved patient outcomes, reduced hospital readmissions, and enhanced quality of life. By removing regulatory barriers that have historically prevented hospitals from initiating life-saving treatment of OUD with methadone, and by promoting multidisciplinary, patient-centered care approaches, this Advisory supports MAHA's vision of returning to fundamental health principles that prioritize healing and recovery. The recommendations contained herein support MAHA's goal of empowering healthcare providers with the knowledge and tools necessary to address the full spectrum of their patients' health needs, ultimately working toward a healthier, more resilient America.

Background

Hospital settings present an important but often missed opportunity to initiate and maintain evidence-based treatment for any SUD, particularly OUD. Research consistently shows significant gaps in care delivery. Even after experiencing a nonfatal overdose, only a minority of patients receive medication treatment for an opioid use disorder (MOUD) that could have been started in the emergency department or hospital setting (Larochelle et al., 2018). In a national study of Veterans Health Administration hospitals, only 15 percent of patients with OUD received medication treatment, and fewer than 2 percent received support with linkage to post-hospital discharge services (Priest et al., 2020).

The barriers to providing adequate treatment in hospital settings are substantial. Studies have identified several key obstacles, including stigma (Paquette et al., 2018), gaps in hospital staff knowledge (Wakeman et al., 2017), and racial disparities in access to care (SAMHSA, 2024). However, research also demonstrates that these barriers can be overcome through systematic implementation of evidence-based services.

The development of hospital-based SUD services, often in the form of addiction medicine consultation services, has shown remarkable promise in addressing these gaps. Multiple randomized controlled trials demonstrate significant improvements in patient and administrative outcomes. For instance, Gryczynski and colleagues (2021) found that enhanced hospital SUD services reduced 30-day hospital readmissions from 30 percent to 15.5 percent among patients with SUD.

Underlying Framework for Evidence-Based Practices

42 C.F.R. Part 8 is a federal regulation that describes how methadone can be delivered to patients with OUD. Generally, this is restricted by law to federally accredited and certified Opioid Treatment Programs (OTPs). SAMHSA's regulation includes a provision (42 C.F.R. 8.11(h)(3)), that exempts hospitals from the requirement to obtain certification as an OTP for the "initiation or continuity of medication treatment or withdrawal management of a patient who is admitted to a hospital, long-term care facility… that is registered with the Drug Enforcement Administration as a hospital/clinic, for the treatment of medical conditions other than OUD, and who requires treatment of OUD with methadone during their stay, when such treatment is permitted under applicable Federal law." This is a restatement of 21 C.F.R. § 1306.07(c), which provides that a physician or authorized hospital staff may "administer or dispense narcotic drugs [e.g. methadone] in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction …". The primary diagnosis for care cannot be addiction.

In hospital emergency departments, patients often present with a condition other than OUD/SUD. This framework enables hospitals to effectively manage OUD with methadone, both as a home medication for patients already receiving it in the community and as a new medication, when clinically appropriate, for the many patients requiring care for other primary health conditions. Of note, this advisory describes administration of methadone for the treatment of OUD, and is not meant to exclude use of methadone under the three-day rule enumerated in 21 CFR 1306.07(b).[1] It also does not cover the use of methadone for pain management.

[1] 21 CFR 1306.07 (b) states: " Nothing in this section shall prohibit a practitioner, who is not specifically registered [with DEA] to conduct a narcotic treatment program, from dispensing (but not prescribing) narcotic drugs, in accordance with applicable Federal, State, and local laws relating to controlled substances, to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both). Not more than a three-day supply of such medication may be dispensed to the person or for the person's use at one time while arrangements are being made for referral for treatment. Such emergency treatment may not be renewed or extended."

Steps to Improve Care

The first step in addressing OUD or other SUDs in addition to other primary conditions in hospital settings is implementing systematic screening. Research demonstrates significant under-identification of SUDs in hospital settings (Priest et al., 2020). Relying solely on clinical judgment or diagnosis codes misses many patients who could benefit from intervention for SUD, including medication treatment. Implementation research by Tran and colleagues (2021) found that systematic screening procedures identified significantly more patients needing intervention for SUD compared to usual care practices. Their analysis of over 5,000 hospital admissions demonstrated that standardized screening led to almost 30 percent of patients receiving brief intervention for SUD and over 15 percent receiving specialized consultation services.

Once hospitals establish effective screening processes, they need systematic approaches to deliver evidence-based care. Research points to three essential elements for successful implementation. First, hospitals benefit from establishing comprehensive SUD addiction consultation services. These services, studied extensively by Englander and colleagues (2019), have demonstrated significant improvements in treatment initiation rates and post-discharge engagement. Their research showed that patients receiving SUD consultation were significantly more likely to complete post-discharge treatment compared to those receiving usual care.

Second, successful programs should develop collaborative partnerships with community-based providers to ensure continuity of care. Without such partnerships, the benefits of hospital-based intervention may be lost during transitions of care. For example, Marks and colleagues (2019) found that patients receiving coordinated care through established partnerships had significantly higher rates of treatment retention and lower rates of hospital readmission. Further studies demonstrate that patients seen by an addiction consultation service with strong community linkages were more likely to continue to engage in treatment post-hospital discharge (Danovitch et al., 2024).

The third essential element involves integrating SUD care into existing hospital systems and workflows. Rather than creating parallel processes, successful programs embed SUD interventions into standard hospital operations. This integration improves both care delivery and patient outcomes. King and colleagues (2022), for example, demonstrated that integrated programs achieved higher rates of treatment initiation and hospital retention.

Delivering Evidence-Based Care

Hospital-based addiction treatment should prioritize interventions with strong empirical support. The most consistently supported intervention across studies is medication initiation during hospitalization (Danovitch et al., 2024). Successful programs develop protocols for screening, medication initiation, dosing, and management of complex medical conditions. SAMHSA resources such as TIP 63: Medications for Opioid Use Disorder provide comprehensive advice on screening, medication induction, linkage to treatment, as well as follow up and referral after discharge from the hospital.

Given the complexity of SUDs and other health conditions, it is important to form a multidisciplinary team that works with the patient in an individualized and patient-centered manner. Tailoring treatment to the individual using a non-judgmental, shared decision-making approach develops trust and facilitates an open and therapeutic dialogue. In this way, team members include physicians, nurse practitioners, physician assistants, nursing staff, case managers, allied health staff, pharmacists, and peer support workers.

The role of clinical pharmacists has often been overlooked. Importantly, pharmacists can provide essential guidance on methadone dosing, drug interactions, and quality assurance procedures. Similarly, care coordination deserves particular attention. Hospitals achieving the best outcomes typically established formal relationships with community OTPs or other SUD treatment providers,

created clear protocols for care transitions, and employed dedicated staff to facilitate these processes. For example, Bradford and Zavodnick (2021) found that formal coordination services significantly improved rates of successful transition to community-based care for patients with SUD.

Psychosocial support represents another essential component, as these services improve treatment engagement and support long-term recovery. However, providing these services in a person-centered manner is an important principle. This means assessing and considering a person's stage of change, incorporating the patient's goals and priorities into the care plan, and applying a shared decision-making approach (Prochaska et al., 1992). It is crucial to support a patient's preferences for medication as part of a patient-centered approach to treatment. By tailoring plans to align with patients' unique needs and preferences, healthcare providers can foster a therapeutic alliance, optimize treatment efficacy, and ultimately contribute to more successful and sustainable recovery.

As for formal counseling services, most hospital systems are going to be limited in the extent to which they can offer formal counseling services to patients admitted to medical or surgical units. In long-term care facilities (LTCFs) offering formal SUD counseling may be more realistic. However, the evidence-base provides limited direction on the type of counseling that might be optimal for different patients, and at different stages of treatment and recovery progression, in these clinical settings.

Increasingly, hospitals and emergency departments are incorporating peer recovery specialists as key members of the multidisciplinary team caring for hospitalized patients with SUD. Studies of peer support in hospitals and emergency departments have found high acceptability of services provided by people with lived experience and signs of positive outcomes (Liebling et al., 2021; Treitler et al., 2024).

Implementing Clinical Services

Successful implementation requires careful attention to clinical protocols and procedures. Hospitals must develop specific approaches for medication initiation, ongoing adjustments, and care transitions. Research provides guidance for several key areas:

- ***Medication initiation should follow evidence-based protocols while allowing for individualization based on patient needs.*** For example, hospitals with standardized protocols achieve higher rates of successful medication initiation and retention in treatment (Trowbridge, et al., 2017). Recent review articles, such as Caring for Hospitalized Adults with Opioid Use Disorder in the Era of Fentanyl and Rapid Methadone Induction in a General Hospital Setting: A Retrospective, Observational Analysis provide actionable advice that is particularly relevant in the age of fentanyl.
- ***Hospitalized patients receiving methadone, who also need pain management, require the creation of specific protocols that clarify the need for additional analgesia to treat acute pain*** (Sand et al., 2024). The importance of multidisciplinary and planned care among those being treated with methadone and who experience acute or chronic pain cannot be overstated. SAMHSA's TIP 63: Medications for Opioid Use Disorder and Advisory: Opioid Therapy in Patients with Chronic Noncancer Pain who are in Recovery from Substance Use Disorders provides further recommendations.
- ***Care coordination procedures should begin early in hospitalization***. If a patient is already in treatment, the hospital team should request patient permission to follow up with the OTP or community provider, and prior to discharge, communication should be undertaken to ensure that the patient can continue to receive care in community-based services. Successful approaches establish clear protocols for communicating with

community providers, including compliance with applicable rules (particularly 42 CFR part 2 and the Health Insurance Portability and Accountability Act).

- ***Patient engagement strategies, such as development of trust between patients and hospital providers, are important.*** Clinical approaches that actively work to build trust, such as using consistent communication, shared decision-making, and attention to patients' individual goals and needs have achieved better outcomes (King et al., 2022).
- ***Caring for people with OUD is empowering for the provider and patient.*** Expanding skills and knowledge through learning about medications to treat OUD, initiating or continuing OUD medications, and engaging with other resources provide a practical way to help a growing number of individuals. Recent legislative and regulatory changes require that licensed practitioners applying for or renewing their Drug Enforcement Administration (DEA) registration must attest to one time receipt of eight hours of education on the treatment of SUDs. This represents an opportunity for health systems to provide appropriately certified education on the topic that aligns with their organizational goals and mission. In this way, all practitioners become partners in providing whole person care.

Quality Measurement and Program Success

Research demonstrates the importance of systematically measuring outcomes to ensure quality and drive improvement. Successful initiatives track several key metrics that correlate with long-term patient success.

Hospitals should track the number of patients who are identified as having an SUD in addition to their other health conditions and the rate of patients who initiate medication treatment as part of their overall hospital care. Care transitions also require particular attention in quality measurement. Managing and monitoring follow through on consultation services and transitions to treatment in the community are known to be effective in reducing the rates at which patients decide to leave the hospital prematurely and in improving the rates at which patients followed through on referrals to continue treatment post-hospital discharge (Marks et al., 2019).

Hospital utilization patterns can be useful to measure the effectiveness of addiction consult services and can also demonstrate the financial return on investment. Gryczynski and colleagues (2021) conducted a randomized trial showing that SUD consultation services reduced 30-day hospital readmissions from 30 percent to 15.5 percent. This dramatic improvement in readmission rates demonstrates the potential impact of well-designed programs.

Ensuring Program Sustainability

Building sustainable hospital-based SUD services requires attention to several key factors identified through research. Successful models establish clear organizational support, develop sustainable staffing patterns, and create systems for ongoing quality improvement.

Institutional commitment plays a crucial role in SUD service sustainability. Hospitals with strong administrative support achieved better implementation outcomes as support helps to overcome barriers in a timely way (Danovitch et al., 2024). Administrative support also includes establishing a budget for the respective consult service, ensuring appropriate billing and coding is incorporated into the hospital's electronic health record system, and analyzing income and expenditures.

Staffing must balance comprehensive care with operational efficiency. Analysis of successful initiatives reveals several viable approaches. Some models rely primarily on dedicated addiction specialists, while others integrate SUD care into existing hospitalist services. Calcaterra and colleagues (2022) studied a model using hospitalists with specialized addiction training, supported by social workers. Their analysis demonstrated this approach could effectively deliver evidence-based care while maintaining operational efficiency.

Data collection and quality improvement activities support ongoing SUD service development. Wakeman and colleagues (2021), for example, found that systematic tracking of outcomes helped identify areas for improvement, while also demonstrating their value. Models using data-driven improvement approaches achieved better patient outcomes and greater institutional support.

Conclusion

Hospitals are well positioned to address significant treatment gaps for patients with SUDs. The evidence reviewed in this Advisory demonstrates that systematic implementation of facility-based addiction treatment services, including methadone treatment, can significantly improve patient outcomes. Successful models combine several key elements: comprehensive screening, addiction consultation services, robust community partnerships, and integrated care delivery systems.

While implementing these services requires careful planning and resources, research demonstrates their substantial benefits in terms of improved patient care, reduced readmissions, and better treatment engagement. The strategies outlined in this Advisory, supported by extensive research evidence, provide a roadmap for hospitals seeking to expand access to methadone and other evidence-based treatments for SUDs.

Resources and Support

SAMHSA provides extensive resources to support implementation of hospital-based OUD treatment with methadone. These include clinical guidance documents, training materials, and technical assistance.

- **Treatment decisions are person-centered.** It is crucial to support a patient's preferences for medication as part of a patient-centered approach to treatment. By ensuring informed consent and tailoring treatment plans to align with patients' unique needs and preferences, healthcare providers can foster a therapeutic alliance, optimize treatment efficacy, and ultimately contribute to more successful and sustainable recovery trajectories. For more information on treating opioid use disorders, see SAMHSA's TIP 63: Medications for Opioid Use Disorder. Information on treating stimulant use disorders can be found in TIP 33, and information on treating alcohol use disorder is available in Advisory: Prescribing Pharmacotherapies for Patients With Alcohol Use Disorder. Information on treating co-occurring disorders can be found in TIP 42.
- **The Providers Clinical Support System.** The Providers Clinical Support System (PCSS) is a SAMHSA-funded national training program on SUDs, especially alcohol use disorder, and opioid use disorder. The Providers Clinical Support System - Medications for Opioid Use Disorders (PCSS-MOUD) provides free training, guidance, and mentoring to multidisciplinary healthcare practitioners on the prevention, diagnoses, and treatment of OUD. This training meets the DEA requirements for eight-hour training to obtain a new or renew a DEA registration.
- **Peer workers**, or nonclinical professionals with lived experience in behavior change and recovery from SUD, can support people on their recovery journeys by providing education, advocating for people in recovery, sharing resources, teaching skill-building, and mentoring. For more information about peer workers, see SAMHSA's webpages on peers.

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