

SIGN OF THE TIMES: PART I

Opioid Addiction and Criminal Justice Systems: Opportunities to Break the Cycle of Incarceration

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Mr. Robinson is a 60-year-old man with HIV infection who came to see me several days after his release from state prison where he had served a five-year sentence for crimes related to heroin addiction. He was healthy, stable, on combination anti-retroviral therapy for HIV, and had completed an abstinence-based substance abuse treatment program in prison. Having maintained abstinence while incarcerated, Mr. Robinson was confident that he would avoid heroin relapse after release. He was getting older and was tired of the stressful lifestyle that using heroin demanded. He planned to move in with his sister who lived out of town and distance himself from the triggers and temptations of New York City. Knowing the high rates of relapse to heroin use following release from incarceration, I offered him buprenorphine maintenance treatment, but he respectfully declined.

For the growing number of Americans with opioid use disorder—2.3 million in 2010—the cycle of incarceration and recidivism is far too common. In a typical scenario, chronic opioid use leads to physical tolerance, which increases demand for opioids, which often leads to petty crime or drug sales to acquire money to buy more opioids. Annually, it is estimated that one third of heroin users, or 250,000 Americans, pass through correctional facilities. More than half of prisoners with substance use disorders have prior incarcerations, which highlights the urgent need for interventions during and following incarceration to prevent relapse and recidivism.

During incarceration, few opioid users receive opioid agonist treatment, such as methadone or buprenorphine, which is the most effective treatment for opioid use disorder. Although 28 state prison systems offer methadone maintenance treatment in some settings, methadone is rarely offered except with concomitant pregnancy or chronic pain. Less than 0.1% of incarcerated Americans with opioid use disorder are estimated to receive agonist treatments. Consequently, opioid abuse often continues during incarceration, with prisoners (or staff) smuggling opioids into facilities. In New York between 1996 and 2005, at least 27 prisoners died of drug overdoses while in custody, but the greatest risk of overdose occurs following release. Within three months of release from prison, rates of opioid relapse can be as high as 75%, and many opioid users report cravings and relapse immediately upon release. Because opioid tolerance decreases with less frequent opioid use during incarceration, resumption of opioid use in amounts similar to those used before incarceration can lead to overdose. The mortality rate in the two-week period following prison release is 12 times higher among former prisoners than the general population, with the leading cause being drug overdose. Between 1999 and 2010 in Washington state, 15% of deaths among former prisoners were attributable to opioid overdose.

My research has focused on understanding why opioid users do or do not seek treatment, including opioid agonists, following release from incarceration. In a qualitative

study of formerly incarcerated individuals with opioid use disorder, we asked about barriers and facilitators of post-incarceration addiction treatment, and several common themes emerged. Nearly all participants had experienced adverse conditions following release, which often contributed to relapse, including housing instability, challenges with employment, and constant exposure to substance use. Regarding opioid agonist treatments, participants feared becoming physically dependent on medications, which they often perceived as a step backward in recovery. Interestingly, participants feared physical dependence because it would result in a painful withdrawal if medications were withheld in the future (i.e. during incarceration). Overall, participants believed that willpower was most important for recovery and were confident that they would maintain abstinence. These findings have implications for treatments offered during incarceration and following release.

Correctional facilities need to do more to prepare inmates with opioid use disorder for release. Current treatment paradigms during incarceration only focus on medication-free approaches, but programs should educate inmates about agonist treatments and link them to treatment sites following release. Several randomized controlled trials have demonstrated that, prior to release from prison, initiating methadone or buprenorphine increases entrance into addiction treatment and reduces opioid use following release. Therefore, pre-release opioid agonist treatment

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should be offered, even if some opioid users would prefer to remain medication free. Because of the high rate of overdose soon after release, distribution of naloxone rescue kits could save lives, and pilot interventions in correctional settings have demonstrated feasibility. Additionally, long-acting naltrexone, an opioid antagonist that does not cause euphoria and only requires monthly injections, is a promising pre-release treatment option. At the very least, identifying inmates at high risk for relapse and providing discharge planning and linkage to aftercare is a high priority.

As general internists, we can also improve medical care for formerly incarcerated individuals in

several ways and possibly break the cycle of incarceration. Transitions clinics create a medical home for formerly incarcerated individuals and work with the criminal justice system to facilitate linkage to care following release from incarceration. Using community health workers who were formerly incarcerated can improve engagement in care while serving this population, and community-based organizations can help address competing needs, such as lack of housing, that contribute to relapse. Transitions clinics can offer office-based buprenorphine treatment or naltrexone and screen patients for relapse and referral to addiction specialists. Treating mental health conditions, which are often comorbid with opioid use

disorder, may also prevent reincarceration. Physicians can also familiarize themselves with naloxone prescribing for prevention of opioid overdose.

Ultimately, my concern that Mr. Robinson would overdose was unfounded, but unfortunately he did relapse to heroin use. As we discussed his challenges in adjusting to post-prison life, he told me about his heroin use and interest in initiating buprenorphine maintenance treatment. Mr. Robinson has continued follow-up for HIV care and has maintained abstinence from illicit opioids. Although the risks of relapse and overdose remain, he is fully engaged in medical care and doing his best to break the cycle.

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