

STATE OF THE ART AND SCIENCE

Why It's Inappropriate Not to Treat Incarcerated Patients with Opioid Agonist Therapy

Sarah E. Wakeman, MD

Abstract

Due to the criminalization of drug use and addiction, opioid use disorder is overrepresented in incarcerated populations. Decades of evidence supports opioid agonist therapy as a highly effective treatment that improves clinical outcomes and reduces illicit opioid use, overdose death, and cost. Opioid agonist therapy has been both studied within correctional facilities and initiated prerelease. It has been found to be beneficial, yet few incarcerated persons receive this evidence-based treatment. In addition to not offering treatment initiation for those who need it, most correctional facilities forcibly withdraw stable patients from opioid agonist therapy upon their entry into the criminal justice system. This approach limits their access to evidence-based health care and results in negative outcomes for individuals, communities, and society.

Introduction

Drug overdose is now the leading cause of death for Americans under age 50 [1]. In 2015 alone, there were 52,404 drug overdose deaths in the US, 63.1 percent of which involved an opioid [2]. Due to the criminalization of drug use and addiction, the prevalence of opioid use is overrepresented in incarcerated populations. Among noninstitutionalized Americans aged 12 or older, the 2014 National Survey on Drug Use and Health estimates that 1.8 percent currently engage in nonmedical use of prescription pain relievers or heroin; in contrast, 12 percent of jail inmates report using opioids regularly [3, 4]. The rising tide of deaths due to opioid overdose has been called an epidemic by the Department of Health and Human Services [5]. An epidemic, defined as an outbreak of disease that spreads rapidly and affects many people, is by definition driven by an illness. That the current opioid crisis is due to a medical condition rather than a moral failing or criminal behavior is an important distinction when shaping a response; people with an illness must be treated, not punished.

Increasingly, this sentiment is echoed in comments by leaders in government and law enforcement, many of whom have used the phrase, "We're not going to arrest our way out of" the crisis of opioid overdose deaths [6]. There are a growing number of police-led diversion efforts, such as the "Angel" program in Massachusetts, which connects

patients directly to detoxification or rehabilitation programs [7]. While the changing language and new diversion programs are promising, many people with [substance use disorders](#) still experience incarceration for drug-related charges. In jails and federal and state prisons combined, in 2015 there were 469,545 Americans imprisoned for drug-related offenses [8], and in 2010 there were 1,638,846 drug-related arrests, 82 percent of which were for simple possession [9]. A prospective cohort study of current and former people who inject drugs in Baltimore found that 57 percent experienced at least one incarceration episode during a median follow-up period of 6.75 years and that 67 percent of those experiencing incarceration reported multiple episodes [10]. And a 2004 study estimated that 440,000 people with opioid use disorder are detained in jails annually [11].

Treatment within correctional facilities for opioid use disorder, when it occurs, rarely resembles evidence-based treatment recommendations, and few patients are even seen by a trained professional [12]. Here, I review the evidence supporting the effectiveness of opioid agonist treatment for opioid use disorder and the lack of access to this therapy in correctional facilities. I will then discuss some reasons for limited access to opioid agonist therapy in correctional facilities and the ethical implications of withholding this treatment.

Clinical Evidence Base for Opioid Agonist Therapy

The most effective treatment for opioid use disorder involves maintenance treatment with the opioid agonist medications methadone and buprenorphine [13–15]. Opioid agonist therapy has been both studied as a treatment within correctional facilities and initiated prerelease in numerous US and international settings [16]. Treatment with buprenorphine or methadone has been found to be beneficial, reducing in-prison risk behavior and increasing postrelease treatment retention while reducing ongoing opioid use, overdose, and death [17]. Protection from fatal overdose is particularly important for those experiencing incarceration, as the risk of death from overdose for those within two weeks of release from prison is 129 times higher than that of community residents [18]. The risk of all-cause mortality among people with opioid use disorder is 2–3 times lower while on opioid agonist therapy than while off it [19]. This treatment is potentially lifesaving not only prior to release but also during incarceration. Among incarcerated people, the hazard of all-cause in-prison death during the first four weeks of incarceration was 94 percent lower while on opioid agonist therapy than while not on it [20].

Objections to Opioid Agonist Therapy

Despite the evidence, access to these treatments is limited [11, 12]. Reasons for not offering opioid agonist therapy include concerns about [diversion](#) and philosophical objection to the notion of agonist therapy—viewing it as a substitution and thus not as legitimate as abstinence-based recovery [21]. In addition to not initiating treatment for

those who need it, most correctional facilities forcibly withdraw stable patients from opioid agonist therapy upon entry into the criminal justice system [22]. This approach has been shown to decrease community treatment entry [23]. It also functions to detract people with a history of incarceration from engaging in treatment due to fear of subsequent forced withdrawal [24].

The lack of access to opioid agonist therapy in criminal justice settings is due in large part to negative attitudes among correctional staff and leadership about the use of these medications [25]. In a 2008 survey of prison medical directors, the most frequently cited reason for not offering opioid agonist therapy was that they preferred drug-free detoxification [26]. In a study of attitudes towards methadone initiation in prison, a staff member commented, "Why would you re-addict someone after we've cleaned them up?" [27]. A widely held misunderstanding that these medications are "replacement addictions" is a potent driver of stigma [14]. And it is patently false. Addiction is defined by the American Society of Addiction Medicine as compulsive drug use despite harmful consequences [28]. Taking a daily prescribed medication that improves functioning, health, and quality of life, while reducing other drug use and death, does not meet this definition. People taking opioid agonist therapy depend on a daily medication to keep their disease in remission, the same way that people with diabetes, hypertension, hyperlipidemia, hypothyroidism, and nearly every chronic medical condition do. Unfortunately, this persistent stigma against opioid agonist therapy has very real policy implications, as evidenced by the responses of correctional staff cited above. Given the strength of the evidence supporting opioid agonist therapy, incarcerated patients' lack of access to it raises questions about whether the care for people with addiction experiencing incarceration is truly equivalent to the care provided to the general community [29].

Clinical Evidence for Opioid Antagonist Therapy

Few US correctional facilities allow opioid agonist therapy; however, a growing number are supportive of antagonist therapy with extended-release naltrexone. The opioid antagonist naltrexone is the third medication that has been FDA-approved for opioid use disorder and can be considered for people with less severe opioid use disorder and a high likelihood of abstinence [30]. The ongoing crisis of deaths, coupled with the stigma of opioid agonist therapy, has presented a remarkable opportunity for dissemination of extended-release naltrexone and profit for the company manufacturing it [31].

The evidence supporting extended-release naltrexone is weaker than the evidence for opioid agonist therapy. The one US randomized controlled trial conducted with people on probation or parole did show that extended-release naltrexone was more effective than no medication [32]. In this study, opioid-free participants with a stated goal of treatment that did not include opioid agonist or partial agonist treatment were randomized to extended-release naltrexone or to no medication. A relapse event was detected in 43

percent of those in the intervention arm compared to 64 percent in the control arm. In follow-up out to 54 weeks after naltrexone was stopped, there were no differences between the two groups, with 46 percent of participants in both groups having opioid-positive toxicology.

While these findings support ongoing treatment with extended-release naltrexone as a relapse prevention intervention among a carefully selected patient population, they do not support the broad adoption of this medication as the only pharmacological option for people with opioid use disorder in the criminal justice system. As Kevin Fiscella, an addiction specialist who advises the National Commission on Correctional Health Care, opined, "When we have two agents that work [methadone and buprenorphine], why would you not use them? I can't imagine anywhere else in medicine where anyone would use an unproven agent instead of a proven one" [21]. Recent journalism has explored the reasons for such broad support of extended-release naltrexone in the face of relatively little empirical evidence. What was uncovered was an extensive and expensive lobbying effort by the company Alkermes, which makes an extended-release naltrexone. This company's effort appears to have largely targeted criminal justice systems and seems to have used correctional staffs' distaste for opioid agonist therapy to its advantage:

That [extended-release naltrexone] has no street value and no potential for abuse has helped the drug shake some of the skepticism directed toward medication-assisted treatment. For the last several years, the company has marketed the drug heavily to people in the criminal justice system, convincing judges and corrections officials to offer [this drug] to inmates and parolees [31].

As a testament to the effectiveness of this strategy, the brand name of this drug and variations on it now appear in more than 70 bills and laws in 15 states [31].

Ethical and Legal Considerations

In 1976, the US Supreme Court ruling in *Estelle v Gamble* found that deliberate indifference to a prisoner's serious illness constitutes cruel and unusual punishment, violating the Eighth Amendment [33]. Importantly, this ruling has advanced the quality of correctional health care for most medical conditions though not necessarily for the [treatment of addiction](#) [34]. An ethical challenge unique to physicians working within criminal justice settings is that the patient's well-being is not the sole driver of treatment. Physicians working within correctional facilities are caught in a "dual loyalty conflict" wherein the punitive aspect of the correctional facilities' mission and the best interest of their patients often oppose each other [35]. These ethical conflicts are present not only within jails and prisons but also in drug courts. A 2013 survey found that only 34 percent of US drug courts report permitting initiation of opioid agonist therapy in some circumstances, including continuation of treatment for those on agonist

therapy [36]. In a study of clinicians who work with drug courts, respondents felt that the reason judges don't allow methadone is because of their personal biases against methadone as a valid treatment. One clinician commented, "Methadone always has this stigma associated with it.... People can't think of it as medicine" [37]. The clinical implications of these biases can be grim. A judge in New York ordered a defendant taken off of methadone treatment, stating that it does not enable a person "to actually rid him or herself of the addiction." The man subsequently died from overdose [38].

The combination of preferential use of opioid antagonist therapy despite its limited scientific support in comparison with methadone and buprenorphine, the lack of access to opioid agonist therapy initiation for those who need it, and the forced withdrawal of stable patients upon entry into the criminal justice system is ethically concerning. This approach ignores [respect for patient autonomy](#), limits access to evidence-based health care, and results in negative outcomes for individuals, communities, and society. The example of drug court judges mandating withdrawal from successful opioid agonist therapy raises additional concerns in situations in which a judge is making life-or-death clinical decisions. It also highlights how treatment for addiction is approached differently from any other medical illness. Imagine if a judge required that a person with diabetes stop insulin therapy and instead be treated with diet and exercise because he or she didn't "believe" in medication treatment for diabetes.

Conclusion

In light of the scientific evidence, withholding effective medical treatment with opioid agonist therapy from people with addiction is ethically questionable in any context. To do so during a public health crisis that disproportionately affects people experiencing incarceration is unconscionable. Truly addressing the crisis of opioid-related deaths as an epidemic will require strategies guided by science, not ideology. Ongoing practices of incarcerating people for drug-related crimes in the first place deserve scrutiny. In the meantime, those under any form of correctional supervision should be encouraged to start, and should not be prevented from starting, potentially lifesaving opioid agonist treatment. Physicians have a role in advocating for change in both the criminalization of addiction and access to evidence-based, community standards of care for people under correctional supervision. In the face of growing evidence of the deadly impact of the status quo, there is arguably a moral imperative to advocate for such change.

References

1. Katz J. Drug deaths in America are rising faster than ever. *New York Times*. June 5, 2017. https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html?_r=0. Accessed June 13, 2017.

2. Rudd RA, Seth P, David F, Scholl L. Increases in drug and opioid-involved overdose deaths—United States, 2010–2015. *MMWR Morb Mortal Wkly Rep*. 2016;65(5051):1445–1452.
3. Substance Abuse and Mental Health Services Administration (SAMHSA). Behavioral health trends in the United States: results from the 2014 National Survey on Drug Use and Health. HHS publication SMA 15–4927. <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>. Published September 2015. Accessed August 2, 2017.
4. Chandler RK, Finger MS, Farabee D, et al. The SOMATICS Collaborative: introduction to a National Institute on Drug Abuse cooperative study of pharmacotherapy for opioid treatment in criminal justice settings. *Contemp Clin Trials*. 2016; 48:166–172.
5. US Department of Health and Human Services Office of the Surgeon General. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: US Department of Health and Human Services; November 2016. <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>. Accessed August 2, 2017.
6. Arsenault C. Natick chiefs: “we’re not going to arrest our way out of the opioid epidemic.” *Natick Patch*. July 31, 2016. <https://patch.com/massachusetts/natick/natick-chiefs-were-not-going-arrest-our-way-out-opioid-epidemic>. Accessed July 19, 2017.
7. Schiff DM, Drainoni ML, Bair-Merritt M, Weinstein Z, Rosenbloom D. A police-led addiction treatment referral program in Massachusetts. *N Engl J Med*. 2016;375(25):2502–2503.
8. The Sentencing Project. Trends in US Corrections. <http://sentencingproject.org/wp-content/uploads/2016/01/Trends-in-US-Corrections.pdf>. Updated June, 2017. Accessed July 18, 2017.
9. Federal Bureau of Investigation. Crime in the United States, 2010. <https://ucr.fbi.gov/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/persons-arrested>. Accessed August 2, 2017.
10. Genberg M, Astemborski J, Vlahov D, Kirk GD, Mehta SH. Incarceration and injection drug use in Baltimore, Maryland. *Addiction*. 2015;110(7):1152–1159.
11. Fiscella K, Pless N, Meldrum S, Fiscella P. Alcohol and opiate withdrawal in US jails. *Am J Public Health*. 2004;94(9):1522–1524.
12. Mumola CJ. Substance abuse and treatment, state and federal prisoners, 1997. US Department of Justice Office of Justice Programs Bureau of Justice Statistics; January 1999. <http://csdp.org/research/satsfp97.pdf>. Accessed June 19, 2017.
13. Bart G. Maintenance medication for opiate addiction: the foundation of recovery. *J Addict Dis*. 2012;31(3):207–225.
14. Volkow ND, Frieden TR, Hyde PS, Cha SS. Medication-assisted therapies—tackling the opioid-overdose epidemic. *N Engl J Med*. 2014;370(22):2063–2066.

15. World Health Organization. *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*. Geneva, Switzerland: World Health Organization; 2009.
http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf. Accessed on June 19, 2017.
16. Wakeman SE, Rich JD. Addiction treatment within US correctional facilities: bridging the gap between current practice and evidence-based care. *J Addict Dis*. 2015;34(2-3):220-225.
17. Hedrich D, Alves P, Farrell M, Stöver H, Møller L, Mayet S. The effectiveness of opioid maintenance treatment in prison settings: a systematic review. *Addiction*. 2012;107(3):501-517.
18. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157-165.
19. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550.
<http://www.bmj.com/content/357/bmj.j1550.long>. Accessed June 19, 2017.
20. Larney S, Gisev N, Farrell M, et al. Opioid substitution therapy as a strategy to reduce deaths in prison: retrospective cohort study. *BMJ Open*. 2014;4(4):e004666. <http://bmjopen.bmj.com/content/4/4/e004666>. Accessed August 2, 2017.
21. Vestal C. At Rikers Island, a legacy of medication-assisted opioid treatment. *Stateline*. May 23, 2016. <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/05/23/at-rikers-island-a-legacy-of-medication-assisted-opioid-treatment>. Accessed on June 19, 2017.
22. Fiscella K, Moore A, Engerman J, Meldrum S. Jail management of arrestees/inmates enrolled in community methadone maintenance programs. *J Urban Health*. 2004; 81(4):645-654.
23. Rich JD, McKenzie M, Larney S, et al. Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomised, open-label trial. *Lancet*. 2015;386(9991):350-359.
24. Maradiaga JA, Nahvi S, Cunningham CO, Sanchez J, Fox AD. "I kicked the hard way. I got incarcerated." Withdrawal from methadone during incarceration and subsequent aversion to medication assisted treatments. *J Subst Abuse Treat*. 2016;62:49-54.
25. Friedmann PD, Hoskinson R Jr, Gordon M, et al; Mat Working Group of CJ-DATS. Medication-assisted treatment in criminal justice agencies affiliated with the criminal justice-drug abuse treatment studies (CJ-DATS): availability, barriers, and intentions. *Subst Abus*. 2012;33(1):9-18.
26. Nunn A, Zaller N, Dickman S, et al. Methadone and buprenorphine prescribing and referral practices in state and federal prisons: results from a nationwide survey. *Drug Alcohol Depend*. 2009;105(1-2):83-88.

27. McKenzie M, Nunn A, Zaller ND, Bazazi AR, Rich JD. Overcoming obstacles to implementing methadone maintenance therapy for prisoners: implications for policy and practice. *J Opioid Manag.* 2009;5(4):224.
28. American Society of Addiction Medicine. Definition of addiction. <https://www.asam.org/quality-practice/definition-of-addiction>. Adopted April 11, 2011. Accessed June 14, 2017.
29. Larney S, Dolan K. A literature review of international implementation of opioid substitution treatment in prisons: equivalence of care? *Eur Addict Res.* 2009;15(2):107-112.
30. Substance Abuse and Mental Health Services Administration (SAMHSA). Clinical use of extended-release injectable naltrexone in the treatment of opioid use disorder: a brief guide. <http://store.samhsa.gov/shin/content/SMA14-4892R/SMA14-4892R.pdf>. Revised February 2, 2015. Accessed June 19, 2017.
31. Harper J, Allen B, Wroth C. A drugmaker tries to cash in on the opioid epidemic, one state law at a time. *NPR.* June 12, 2017. <http://www.npr.org/sections/health-shots/2017/06/12/523774660/a-drugmaker-tries-to-cash-in-on-the-opioid-epidemic-one-state-law-at-a-time>. Accessed on June 14, 2017.
32. Lee JD, Friedmann PD, Kinlock TW, et al. Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. *N Engl J Med.* 2016;374(13):1232-1242.
33. Rosenfeld J. The origin of prisoner's rights: *Estelle v Gamble* 429 US 97; 75-929 (1976). *Natl Law Rev.* September 16, 2016. <http://www.natlawreview.com/article/origin-prisoner-s-rights-estelle-v-gamble-429-us-97-75-929-1976>. Accessed June 19, 2017.
34. Taxman FS, Perdoni ML, Harrison LD. Drug treatment services for adult offenders: the state of the state. *J Subst Abuse Treat.* 2007;32(3):239-254.
35. Allen SA, Wakeman SE, Cohen RL, Rich JD. Physicians in US prisons in the era of mass incarceration. *Int J Prison Health.* 2010;6(3):100-106.
36. Matusow H, Dickman SL, Rich JD, et al. Medication assisted treatment in US drug courts: results from a nationwide survey of availability, barriers and attitudes. *J Subst Abuse Treat.* 2013;44(5):473-480.
37. Csete J, Catania H. Methadone treatment providers' views of drug court policy and practice: a case study of New York State. *Harm Reduct J.* 2013;10:35. <https://harmreductionjournal.biomedcentral.com/articles/10.1186/1477-7517-10-35>. Accessed August 2, 2017.
38. Szalavitz M. Every drug court should allow methadone treatment. *New York Times.* July 20, 2015. <https://www.nytimes.com/2015/07/20/opinion/every-drug-court-should-allow-methadone-treatment.html>. Accessed August 2, 2017.

Sarah E. Wakeman, MD, is the medical director for the Massachusetts General Hospital Substance Use Disorder Initiative in Boston, where she is also program director of the

Addiction Medicine Fellowship, medical director of the Addiction Consult Team, and co-chair of the Opioid Task Force. She is also an assistant professor of medicine at Harvard Medical School and a clinical lead of the Partners Healthcare Substance Use Disorder Initiative. Her research interests include evaluating models for integrated substance use disorder treatment in general medical settings, recovery coaching, physician attitudes and preparedness related to substance use disorder, and screening for substance use in primary care.

Related in the *AMA Journal of Ethics*

[Addiction, 12-Step Programs, and Evidentiary Standards for Ethically and Clinically](#)

[Sound Treatment Recommendations: What Should Clinicians Do?](#), June 2016

[The AMA Code of Medical Ethics' Opinions Related to Health Care for Incarcerated People](#),
September 2017

[Communicating with Patients about Harmful Behaviors](#), January 2008

[How Should a Health Care Professional Respond to an Incarcerated Patient's Request for a Particular Treatment?](#), September 2017

[Shared Responsibility: Massachusetts Legislators, Physicians, and An Act Relative to Substance Use Treatment, Education, and Prevention](#), September 2016

[Teaching about Substance Abuse](#), January 2008

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

**Copyright 2017 American Medical Association. All rights reserved.
ISSN 2376-6980**