Our Ethical Obligation to Treat Opioid Use Disorder in Prisons: A Patient and Physician’s Perspective

Curtis Bone, Lindsay Eysenbach, Kristen Bell, and Declan T. Barry

“T here is no way I’m going on methadone. Absolutely no way!” My patient was beyond emphatic. His hands waved wildly as if attempting to swat an onslaught of relentless and horrifying ideas. He squirmed in his worn jeans, “I’ve heard what that stuff does to you and I’m not doing it.” As a newly minted addiction medicine fellow, still in my first month of fellowship, the majority of my days were spent learning the tremendous benefits of buprenorphine and methadone. Some of this learning derived from textbooks, but the facts and figures were reinforced by countless patients whose narratives described these medicines as the critical stepping stone that made it possible to rebuild their lives. This was the first resistance that I had encountered. I questioned with genuine curiosity, “What are your concerns?” The heavy lines on his forehead relaxed and he adopted a calm even tone as he explained, “Listen man, I’ve had plenty of friends on this stuff and they all say the same thing. It’s fine when you’re out, but the minute you get locked up, you’re in for a world of pain.” I felt that I had missed something vital in the conversation. “I’m sorry sir … are you going to prison soon?” He denied any current legal issues but repeated, “If I do get put away, it would be absolute hell. I am not taking that chance.” Surprised by this perspective but still hopeful, I drew upon recent training in motivational interviewing and offered a reflection, “So you recognize that methadone is a good medicine but you won’t start it because you’re concerned you’ll get arrested and you’ll have to go through withdrawal.” He interjected, “Heroin withdrawal is horrible but it lasts just a few days. With methadone I’d be throwing up and with diarrhea for weeks and weeks in a prison cell … Nope. Nope. Nope.” I felt we had a straightforward solution, “so why don’t we start the medicine and then just make sure you stay out of prison?” He looked at me with deep brown eyes set in deep brown skin. “Ps Communities … it just ain’t that easy.”

Completely taken aback by this encounter, I felt driven to better understand my patient and his situation. I was aware that the opioid epidemic has claimed the lives of more than 183,000 individuals since 1999,

Curtis Bone, M.D., M.H.S., is an addiction medicine research fellow at the Yale University School of Medicine and West Haven VA. Lindsay Eysenbach, B.A., is currently a medical student at the Yale University School of Medicine and co-founder of the Yale Addiction Medicine Collaborative. Kristen Bell, J.D., Ph.D., is currently a Lecturer in Law, Associate Research Scholar in Law, and Senior Liman Fellow in Residence at Yale Law School. Declan T. Barry, Ph.D., is a psychologist and an associate professor of psychiatry at the Yale University School of Medicine. He is also the director of research at the APT foundation, a non-profit substance abuse treatment facility in Connecticut.
I was aware that the opioid epidemic has claimed the lives of more than 183,000 individuals since 1999, and is now the leading cause of accidental death in the United States, however, I was surprised to learn that both deaths involving opioids and the rates of incarceration have more than quadrupled in recent decades. Could these statistics be connected? The risk of death due to drug overdose after incarceration is 12.7 times greater for individuals who have been imprisoned when compared to individuals of similar ages in the general population. In Connecticut, 44% of opioid-related deaths occur among individuals formerly detained by the Department of Corrections. A separate study conducted in Washington state showed that the mortality rate among individuals formerly incarcerated was 3.5 times that of the general population, and overdose was the leading cause of death in this cohort. The first few weeks after discharge are the most hazardous, as opioid tolerance is unpredictable after abstinence. While the initiation or continuation of MAT in jails and prisons would both dramatically mitigate this risk of overdose post-release and attenuate opioid withdrawal, opioid agonist therapy is not an option in most prisons.

These statistics are troubling, but why was my patient so certain that incarceration was a foregone conclusion? The criminalization of drugs was a tectonic policy shift that helped position the United States as the world leader in incarceration. Indeed, drug and property offenses are the most common reason for individuals to come into contact with the prison system. America’s addiction to mass incarceration as a response to drug use disproportionately impacts racial and ethnic minorities and people living in poverty. African Americans and Latinos make up approximately one quarter of the U.S. population but comprise more than 50% of the incarcerated population. African Americans alone constitute nearly 1 million of the 2.2 million incarcerated, and are incarcerated at nearly six times the rate of whites. I was beginning to understand some of my patient’s concerns.

Still, I remained confident that methadone was the right treatment for him. I drew upon positive patient experiences and my evenings spent in textbooks to counsel that individuals who take methadone or buprenorphine are actually protected from both the positive and negative reinforcing effects (euphoria and withdrawal) associated with shorter acting opioids. Among those treated, 70% return to school or work, risk of overdose plummets, and risk of viral illnesses such as HCV, HBV, HIV are also reduced. He knew most of this ... and he remained unmoved.

I began to question why he and I were forced into this conversation. Why couldn’t he get treated with methadone if he were incarcerated? Why must he or why must any individual with opioid use disorder (if incarcerated) be forced to weigh the risks of death via HIV, HCV, HBV, or overdose due to heroin or non-medical opioid use against weeks of withdrawal from methadone or buprenorphine in a prison cell (which my patient so colorfully described)?

I tried to consider this question from a systems perspective. Feasibility and cost are often the primary barriers to implementation of reasonable initiatives. I was reassured to learn that there are systems that do offer agonist therapy to select incarcerated individuals. According to a survey of medical directors of state and federal prison systems, 55% offer methadone to inmates in some situations, and a handful offer buprenorphine treatment. The outcomes, not surprisingly, are incredibly strong. Treating and retaining individuals with opioid use disorder in methadone maintenance treatment while incarcerated is associated with reduced mortality, lower rates of re-incarceration, and reduced hepatitis C infection. Moreover, agonist therapy is financially advantageous. It returns 12-14 dollars for every dollar spent. But despite these
positive outcomes, a large share of prisons offer neither methadone nor buprenorphine, and of systems that do offer methadone, over half reserve treatment exclusively for pregnant women. The fact that multiple institutions (even if they are a vast minority) have managed to offer these medications suggests tremendous opportunity.

Why might some prisons offer MAT while others do not? A study of 50 criminal justice systems across the United States found that staff objections were a significant factor in agencies that did not provide MAT for maintenance therapy, and these agencies tended to be more likely to endorse the statement “MAT just substitutes one drug for another.” Or as one official interviewed in a similar study stated, “facilitating addiction seems inconsistent with the mission of incarceration.”

Bioethicists have argued that treatment of opioid use disorder with MAT is ethical from the perspective of various domains including beneficence, non-maleficence, autonomy and distributive justice. Ludwig et al argue that commitment to beneficence and non-maleficence requires correctional facilities to use MAT in order to prevent the spread of infectious diseases as well as the withdrawal syndromes of incarcerated individuals upon entry into a facility. Furthermore, as Ludwig et al argue, the principle of autonomy demands access to MAT, as removing this option impinges upon an individual’s ability to make a fully informed decision. Leadership from the National Institute of Drug Abuse (NIDA) has expressed similar views. In its “Principles of Drug Abuse Treatment for Criminal Justice Populations,” NIDA states: “Findings show unequivocally that providing comprehensive drug abuse treatment to criminal offenders works, reducing both drug abuse and criminal recidivism ... As such, it is a matter of public health and safety to make drug abuse treatment a key component of the criminal justice system.” Thus, the more appropriate question is whether it is ethical for the criminal justice system to withhold MAT to incarcerated individuals with an opioid use disorder. As I empathized with my patient’s dilemma (and that of any person with opioid use disorder who becomes incarcerated), I felt reassured when I learned that the United States actually offers prisoners protection against cruel and unusual punishment or “equivalence of care” under the Eighth Amendment of the U.S. Constitution. However, I was equally disappointed to discover that this principle has been ineffective in securing adequate treatment for addiction. The failure of the justice system to ensure treatment remains troubling.

Failure to treat addiction in criminal justice settings not only reduces the chance of recovery in individuals with the disorder, it also may negatively impact the communities they return to. The negative impact is likely to be disproportionately borne by low-income communities and communities of color. When incarcerated individuals are released, on average they return to communities with fewer resources which already face public health threats such as higher prevalence of HIV and HCV. An analysis of data provided by the Bureau of Justice Statistics showed that the median annual income of incarcerated people was $19,185 prior to their incarceration, 41% less than their non-incarcerated peers. Could the increased risk of HIV and HCV in low resource communities relate to systemic failure to offer treatment to incarcerated individuals with opioid use disorder? How might the risk of HIV, HCV and HBV, from prison exposure impact a reunited couple? How might children or a family dynamic be impacted by the morbidity and mortality associated with failure to treat opioid use disorder in prisons? Children with parents who have an untreated substance use disorder show higher rates of problem behavior and emotional and mental health issues, including substance use disorders. Unfortunately, failure to treat opioid use disorder in prisons disproportionately impacts children from minority communities. Nationally 1 in every 14 children has a parent in prison, that rate is 1 in 9 among black children. And how might failure to treat opioid use disorder in prison impact non-incarcerated individuals with opioid use disorder? Patients who had been on MAT for opioid use disorder prior to incarceration share stories regarding the horrific experience of going through methadone withdrawal in a prison cell. This may create a barrier for prospective patients (including my patient and many others I have since cared for) to entering MAT. Thus, failure to provide MAT in prisons places both prisoners and their non-incarcerated peers at elevated risk of adverse health outcomes associated with untreated opioid use disorder.

The patient I described in the introduction ultimately chose not to engage in our MAT program. The perceived risk of incarceration and withdrawal were too great for him. Now equipped with a better understanding of the shortcomings within the medical and legal system, which he knew all too well, I understand his choice. However, I continue to worry for his safety, his family, and his community. But we are called to do more than to worry. This is a system and a reality that demands change. Continued indifference towards failure to treat opioid use disorder with MAT in the prison system will contribute to growth of the opioid epidemic and the hepatitis C epidemic, and will allow HIV to continue to flourish in low resource and minority communities. Failure to address this issue in
prisons will result in preventable disease and death among incarcerated people and people in communities with high concentrations of formerly incarcerated people. Health care professionals, legal professionals, and legislators have a moral obligation to address the failures of the past and work to bring treatment into our criminal justice systems.

Note
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References

