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Tip Sheet: Opioid Addiction in Jails and Prisons, Common and Untreated

Stories of people with addiction in jail are grabbing headlines, for the following reasons:

- People addicted to heroin and other substances frequently get arrested, either for the addiction behavior itself, or for acts needed to support the addiction (petty crimes, selling drugs).
- At least one-fourth of people in jails and prisons have an opioid addiction (overall, two-thirds of people in jails and prisons have addictions to alcohol or other drugs).
- While jails and prisons must provide general medical care, very few offer addiction treatment.
- Untreated detox can sometimes lead to death.
- In the four weeks after leaving prison, people are over 129 times more likely to die of a drug overdose than the general population.

Background

Opioid-use disorder is the medical term for the disease of addiction to opioids like heroin, fentanyl, or oxycodone. Untreated opioid addiction involves continued and often escalating opioid use despite negative consequences—physical, social, or economic. In the throes of addiction, people may engage in illegal acts that result in incarceration. At least a quarter of people in US prisons and jails have an addiction to opioids, compared to 1% in the general US population.

Jails and prisons are required to offer health care for all medical conditions. For example, if someone with diabetes were arrested, a jail doctor could not say, “We don’t offer insulin here,” and a judge could not say, “You can avoid jail by getting treatment, but I will decide what treatment you will receive.” People with an addiction are treated quite differently: most jails do not provide medications that have been proven to work. Despite research on the effectiveness of medications by qualified medical professionals, judges frequently mandate medication-free residential treatment

The gold standard to treat opioid addiction is to use one of three FDA-approved medications—methadone, buprenorphine (also called Suboxone), and naltrexone (also called Vivitrol)—in tandem with behavioral treatment, including counseling. But few jails and almost no prisons in the US will start treatment for someone entering incarceration with an opioid addiction. Some jail systems will continue treatment for people who were already enrolled in a program before they were jailed, but most will taper or withhold medication entirely.

People with addiction who are arrested may be left to detox in jail. Many believe that opioid withdrawal is painful but not deadly, so medical treatment is often not given during detox in jail. Yet the symptoms of detox include diarrhea and vomiting, [sometimes leading to severe dehydration and death](#), especially if other drugs and alcohol are on board.

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The highest-risk period for incarcerated people with opioid addiction is immediately after release. The risk of drug overdose death during this time is 129 times greater than in the general population. That's because during time in prison, a person with opioid addiction has gone through a forced withdrawal and spent time without using any opioids. This process lowers a person's tolerance to opioids. Upon release, people are not able to tolerate as much drug as they had in the past. What had been enough drug to cause a "high" is now enough to cause death. As jails and prisons are high-risk places for COVID-19, many began releasing people, especially those with substance use disorders, at the beginning of the pandemic. However, they were released into communities without a support system or job, increasing the chances of relapse.

The same holds true for people who first are incarcerated in county jail, where they detox and then are sent to prison. In almost all prisons, it is easier to get illegal opioids than medical treatment, which means overdose deaths are common in prison as well as outside. Fentanyl — an extremely potent drug — is part of the reason, as it is easy for visitors to smuggle in minute quantities. The drug has even been dropped by drones in prison yards. (Just Google "drone drop opioids prison.")

How Does Treatment Work?

The three FDA-approved medications to treat opioid addiction are methadone, buprenorphine, and naltrexone. Each dramatically reduces the craving for opioids and helps people stop using and stay in treatment. Methadone and buprenorphine work by activating opioid receptors in the brain to calm opioid cravings. These medications can be started while someone is in withdrawal, and they stop the withdrawal process. While methadone and buprenorphine are opioids, they have a very slow onset and slow decline in blood levels, which means they do not work fast enough to give a high. Buprenorphine also works by blocking other opioids, so a high is not felt even if the person uses heroin or other opioids.

Naltrexone is not an opioid. It works by blocking the effect of all opioids. But it cannot be given until someone has gone through the [process of withdrawal](#) and is off all opioid drugs for at least a week. Because withdrawal can cause such serious physical problems including vomiting, diarrhea, severe anxiety, and mental distress ("feeling like you are going to die"), it is more common for people to abandon naltrexone treatment than the other medications.

Opioid addiction is best treated with a long-term, medication-based approach. Only about 1 in 10 people who do not use medication-based treatment stay abstinent at one year, compared to 6 to 8 in 10 using medications. The risk of death in people with opioid addiction who are not on medication is two to three times higher than people who are on treatment. This is why detox and rehab without ongoing maintenance medication are dangerous and not recommended for the treatment of opioid addiction.

In addition to saving lives, treatment also positively affects behavior. Decades of experience show that people maintained on methadone are less likely to engage in criminal activity. Multiple studies also show that both methadone and buprenorphine treatment reduce the risk of HIV and hepatitis C.

Why Isn't Treatment More Widely Used in Jails and Prisons?

Many people do not understand the need for medication to treat opioid addiction and see it as “replacing a drug with a drug.” The stigma against medication treatment is so strong that people with addiction often choose to try to go “cold turkey” on their own. Some 12-step programs and other substance use treatment programs historically have looked down on people using medication as “not really sober.”

Lawyers, judges, and other people working in the criminal justice system may take a dim view of medication treatment. Jail and prison staff worry that methadone and buprenorphine might be diverted from patients to others for recreational use. Diversion is much more common in settings where treatment is not widely available, such as jails and prisons, as described above.

Racism plays a role as well. Black and Latinx people are much more likely to be arrested, incarcerated, given long sentences, and denied parole compared to white people. Even though addiction to opioids is more common among white people, people of color are less likely to get effective treatment.

What Is Being Done to Expand Treatment in Criminal Justice Settings?

Real-world research demonstrates that treatment of opioid addiction with methadone, buprenorphine, or naltrexone can be safely and effectively delivered in jails and prisons. Rhode Island's unified jail/prison system has been a leader in this area. Post-incarceration overdose deaths [dropped by 60% within a year](#) of starting its treatment program. This reduction in deaths was so significant that it contributed to a 12% decrease in overdose deaths in Rhode Island's total population while the rest of the US was experiencing escalating overdose death rates.

California's prison system announced in late 2018 that it would overhaul its approach to addiction treatment, including using medications for opioid addiction, and started treating people in prison with methadone, buprenorphine, and naltrexone. Over 30 of California's counties, representing over 80% of California's population, are actively working to build treatment programs using medications in their jail systems, as part of a [broader statewide effort](#) to expand medication treatment for addiction across health care settings, including primary care clinics, emergency departments, hospitals, and mental health clinics. The state-wide effort has seen some successes: 22,000 previously untreated Californians with opioid addictions received care and the program created 650 new locations where patients can receive MAT. However, this is hard work, as people in correctional systems often have negative attitudes about buprenorphine and methadone, as they have seen it smuggled into jails and sold. Programs need to figure out how to give it safely, so it is not diverted to others: a common tool is to require people to chew crackers and get mouth checks after they get their meds, so they can't pocket the medication in a cheek and sell it later.

Lawsuits are putting pressure on jails and prisons to step up. The US District Court of Massachusetts ruled that a jail's refusal to provide methadone treatment to a man who was about to be sentenced violated the Americans with Disabilities Act and the Eighth Amendment prohibition of cruel and unusual punishment. This is one of many lawsuits settled in favor of patient's civil rights: just as jails and prisons are required to give effective health care for other medical conditions, they must also provide treatment for people with addiction.

While COVID-19 has had devastating effects on justice-involved persons, it has allowed for the development of new pathways of treatment. While it used to be very difficult to have enough doctors available to prescribe Buprenorphine to patients, the rise in telehealth due to COVID-19 has allowed for doctors to easily reach patients via iPads and prescribe medications. Telehealth allows them to see many more patients without having to be physically present.

Case Example

Lisa used heroin for over a decade and had been arrested and jailed many times for drug possession and petty theft charges. Each time she went to jail, she had a painful detox — days of agonizing full-body pain, vomiting, and feelings of despair. Each time she vowed she would stop using, but when she was released, the feelings of craving were so overwhelming that she couldn't stop herself. Sometimes it seemed automatic — she found herself with a needle in her arm without remembering how it got there. One time a judge mandated her to 30-day residential treatment. She asked about Suboxone since it had worked for a friend, but she was told that if Suboxone was found in her urine test, she would be sent back to jail. Finally, after another arrest, she found out she was pregnant and was told that methadone treatment was available. She seized the opportunity. For the first time in her life, she could think clearly. Her brain wasn't ruled 24/7 by powerful cravings for heroin. She wanted a different life for her baby, and on release Lisa stayed in treatment, enrolled in counseling, and got some help from social services to get into a safer environment. Her baby was born healthy. She credits her baby — and the chance to get treatment that works — for saving her life. And she knows that had she not made the choice to get help, her baby would be in foster care.

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