National Association of State Alcohol and Drug Abuse Directors, Inc.

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Methadone Maintenance Treatment and the Criminal Justice System

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ABSTRACT

This Issue Brief begins with a brief overview of national-level developments during the past eight years concerning methadone maintenance treatment (MMT). These include the unqualified support for MMT from a consensus panel convened by the National Institutes of Health (NIH), the overhaul of Federal regulations regarding the implementation of MMT, and the firm, public support for MMT by national associations and Federal agencies that have critical roles in drug law enforcement and addiction treatment. The Issue Brief explores the current status of MMT in four facets of the criminal justice system: jails and prisons; pre-trial services, probation and parole; reentry initiatives; and drug courts. It touches on the role of buprenorphine in a correctional setting, and concludes with highlights of ongoing initiatives in six States that incorporate the use of MMT in correctional settings and a review of related initiatives.

BACKGROUND

Between 1980 and 2000, the total number of inmates in the United States increased from 501,886 to 2,071,686. The State prison population increased by 318 percent, and the Federal prison population increased by 241 percent. Nearly 1.7 million of the 2 million adults in prison or jail are seriously involved with drugs and/or alcohol (Department of Justice, 2002). During the 1980s many State governments and the Federal government enacted stringent anti-drug laws. These laws largely drove this explosion in incarceration rates in the U.S. (Beck, Karberg, & Harrison, 2002). The increase placed significant pressure on the already-stressed criminal justice system, which was not equipped to address the myriad problems and complexities presented by the drug and alcohol involved population inundating every aspect of corrections (Pollack, Khoshnood, & Altice, 1999). Substance abuse continues among at least some of those offenders after incarceration. About ten percent of all inmates tested for drugs have tested positive (James Wilson, 2000).

A median of 5.8% of adult male arrestees and 6.6% of adult female arrestees tested positive for opiates at arrest in 2000, suggesting that although there is a need for MMT among this segment of the criminal justice population, it is not as significant as other, more urgent health care needs. But at some sites, opioid users constitute a significant number of individuals arrested. In ten of thirty-five urban areas sampled, between 10% and 27% of arrestees tested positive for opiates at arrest (DOJ, 2003), indicating at least a targeted need for this treatment approach. In the early 90s, the Institute of Medicine (IOM) convened a committee of representatives from a range of associated disciplines, charged with reviewing the Federal regulations regarding the provision of methadone maintenance treatment (MMT). The committee's report, issued in 1995, recommended "raising the standard of treatment," by "authorizing greater clinical discretion in medical treatment and reducing the scope of government regulation" (Institute of Medicine, 1995).

In 1997, the National Institutes of Health (NIH) convened a multi-disciplinary panel of experts, who affirmed the large body of research indicating that MMT for opiate addiction represented the gold standard for reducing illicit opiate drug use, reducing crime, enhancing social productivity and reducing the spread of viral diseases such as AIDS and hepatitis (National Institutes of Health, 1997). Concerning the

relationship of MMT to the criminal justice system, the panel noted that "All opiate-dependent persons under legal supervision should have access to [MMT] and the US Office of National Drug Control Policy (ONDCP) and the US Department of Justice (DOJ) should take the necessary steps to implement this recommendation…The unnecessary regulations of methadone maintenance therapy…programs should be reduced…" (NIH, 1997).

Soon after this report was issued, the ONDCP, the DOJ and Health and Human Services (HHS) agreed to new proposed regulations to improve the quality and oversight of MMT. The ONDCP, in partnership with the DOJ, adopted a policy position in support of MMT. This position is reflected in the ONDCP-issued Methadone Fact Sheet, which cites the NIH panel findings in expressing strong support of the role of methadone in the treatment of opiate dependence (ONDCP, 2000). In May 2001, final regulations were implemented that constituted an overhaul of the system, establishing a new MMT program accreditation process managed by the HHS Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (SAMHSA/CSAT) Department of Pharmacologic Therapies (DPT). Designed to provide better program accountability and improved treatment quality, MMT program accrediting bodies now include the National Commission on Correctional Health Care (NCCHC, 2004).

Since the implementation of the final regulations, the Centers for Disease Control (CDC) referenced the NIH panel's findings along with other research in support of the role of MMT in reducing or even stopping intravenous drug use, and the associated transmission of HIV, hepatitis, STDs, and other physical and mental health problems (Methadone Maintenance Treatment, 2002). A second ONDCP Fact Sheet regarding heroin use in the general population noted the role of MMT in heroin addiction treatment, stating that "Methadone…permits the patient to be free from the uncontrolled, compulsive and disruptive behavior associated with heroin addiction (ONDCP, 2003).

These recent regulatory revisions and macro-level endorsements of MMT represent a sea change in both the human services and the criminal justice systems' fundamental attitudes regarding opiate addiction and treatment. They are among several factors influencing the continuing movement of opioid replacement therapy (ORT) in general and MMT in particular into the mainstream of public health care, and health care within the nation's criminal justice system.

MMT has value to society and to the criminal justice system in terms of cost-effectiveness and offender health care. Research demonstrates that MMT is cost effective, especially when compared to the costs of incarceration. While MMT costs about $4,000 per person each year (Rosenbaum, et al. 1996), incarceration in U.S. prisons has an average annual cost of $ 22,279. (Camp & Camp, 2001).

Numerous studies have demonstrated that MMT reduces drug use and criminal activity among opiate addicts, "with effects many times the size of hospital-based detoxification, drug-free outpatient treatment, and residential treatment" (Marlowe, 2003, referencing Platt, et al., 1998).

METHADONE MAINTENANCE IN FOUR FACETS OF THE CRIMINAL JUSTICE SYSTEM

The following section explores the current status of MMT in four facets of the criminal justice system: jails and prisons; pre-trial services, probation and parole; re-entry programs; and drug courts.

Jails And Prisons

Jails are city or county operated facilities used to detain newly arrested persons, those waiting to appear before a judge to be formally charged with an offense, those detained prior to or during their trial, and those sentenced to short sentences of less than two years in confinement. Prisons at both the State and Federal levels typically house persons who have been convicted and sentenced to longer periods of confinement (Bureau of Justice Statistics, 2005).

As entry points into the correctional system, jails are most likely to confront acute drug and alcohol withdrawal among arrestees. Prisons may confront withdrawal following the sentencing of a person who has been previously free on bail (Peters, 1993).

NCCHC standards for drug treatment in jails indicate "screening [should be] performed by health-trained or qualified health care personnel on all inmates immediately upon their arrival at the jail system." The standards further specify that "it is extremely important to explore fully the inmate's ... alcohol and other drug withdrawal potential," and provide appropriate treatment. (NCCHC, 1996). The Federal Bureau of Prisons Clinical Practice Guidelines (CPGs) for Drug and Alcohol Detoxification also recommend careful screening practices and echo these concerns, noting the high prevalence of substance abuse disorders in arrestee and inmate populations, and the need for safe and effective treatment of withdrawal (detoxification) (Federal Bureau of Prisons, 2000). The NCHCC standards and the Federal Bureau of Prisons CPGs detail procedures for detecting the presence of a substance use disorder, and also recommend detoxification protocols.

The Federal Bureau of Prisons CPGs for Drug and Alcohol Detoxification recommend continuing MMT in the case of arrestees and inmates who are already engaged in MMT and who are pregnant. However, the guidelines advocate detoxification "with or without" methadone, even for "short-stay" inmates. The guidelines recommend clonidine as an appropriate methadone alternative for detoxifying inmates, noting that the provision of MMT is restricted to facilities licensed to provide it.

The SAMHSA Office of Applied Studies (OAS) 1997 Survey of Correctional Facilities (SAMHSA/OAS, 2000) results indicated that 87% of Federal prisons, 67% of State prisons, and 64% of jails conducted assessment for treatment need (the term treatment as used in this study included MMT and opiate detoxification). Correctional institutions provided detoxification services in the following percentages: 16% of Federal prisons, 8% of State prisons, and 28% of jails. The report noted that about 40% of facilities nationwide provided on-site substance abuse treatment services (including MMT). These data were supported by a national survey of jail inmates conducted by the DOJ. Among the inmates who admitted

abusing drugs or alcohol at the time of their offense, only one percent reported receiving detoxification services. (Wilson, 2000)

A recent survey of the medical directors of prisons in all 50 States and the Federal system asked them to describe their attitudes and practices regarding MMT (Rich et al., 2005). Of the 40 respondents (having jurisdiction over 88% of prisoners) 48% reported the use of methadone-supported treatment, predominately for pregnant inmates and/or for detoxification (as recommended in the Federal Bureau of Prisons CPGs). 8% of respondents reported referring opiate-dependent inmates to methadone programs upon their release from prison.

These data reflect a gap between the recommendations articulated in the field's own practice guidelines, and the reality of current practices. There are several factors contributing to the existence of this gap. It was noted earlier in this paper that stricter drug laws enacted in the 1980s caused a dramatic increase in prison and jail populations, comprised largely of individuals engaged in substance abuse. Increased funding for jails and prisons has been outpaced by need (DOJ, 2001). For some jails and prisons, the percent of arrestees and inmates who need opiate detoxification and MMT is so small it may be difficult to justify the expenditure of resources on accreditation and treatment in the face of other, more pressing health care priorities (BJS, 2003).

But some studies indicate that lack of understanding of the nature of addiction and of MMT may also contribute to this gap in MMT medical services in prisons and jails. In a study designed to validate an instrument for discovering the attitudes on the part of those who staff jails towards prisoners who are engaged with MMT, researchers administered the survey to 114 jail staff in a newly-constructed jail in a large metropolitan center. The jail offers MMT to inmates. They found that staff members had strong and polarized opinions about MMT. Medical staff and older, more educated security staff were supportive. Younger non-medical staff showed less support, as well as less knowledge concerning MMT. Many of the respondents in the latter group described animosity towards drug addicts in general, and lumped MMT participants with all offenders into a single criminal group. Others expressed a philosophical aversion to substituting one drug for another, indicating a lack of understanding of the fundamental difference between the pharmacodynamics of methadone and of heroin. This group also expressed concerns about diversion of medication and the potential they believed this represented for security breaches, a concern that is not supported by the research data (McMillan & Lapham, 2005).

Offenders who are enrolled in methadone maintenance programs at the time of their arrest are rarely allowed to continue treatment. This was made evident in the 245 responses of the 500 jails queried to a survey, which specifically asked about management of opiate dependency among arrestees/inmates enrolled in methadone programs (Fiscella, Moore, Engerman & Meldrum, 2004). This survey found that although 62% of respondents said there was an MMT program in their community, only 27% reported contacting the MMT programs regarding dose. Very few jails provided continuous treatment for inmates on methadone, except for pregnant inmates. For detoxification purposes, very few (2%) jails used methadone or other opiates; roughly half of jails provided clonidine for withdrawal symptoms, 30% used only ibuprophen or acetaminophen, and 20% reported providing no symptomatic treatment. Moderately large jails and those located in the South and Midwest were significantly more likely to continue methadone-based treatment after arrest. Very large jails, those in which opiate-dependent arrestees/inmates were 6-10% of the population, were significantly more likely to use recommended detoxification protocols.

The advent of NCCHC accreditation authority may eventually reduce the significance of the barriers reflected in this data. But the initial stages of implementation of accreditation in correctional settings may also present some unique challenges regarding the need to educate officials concerning accreditation requirements and accreditation processes (J. Stanley, personal communication as the representative for NCCHC, on the CSAT/DPT and SMA conference call, December 15th, 2005). As more correctional settings come to terms with the need to be accredited in order to provide MMT, and also evaluate the resources available to them for meeting requirements for accreditation, existing treatment protocols may be subject to internal review. However, the potential that NCCHC accreditation authority represents is illustrated in the discussions at the end of this paper highlighting MMT programs in correctional settings in six States.

Pre-Trial Services, Parole And Probation

Pretrial Services

Testing and treatment for drug and alcohol use are conditions that courts can impose in cases involving defendants who are known to abuse drugs or alcohol, after the defendants arrest and before they are brought to trial. Since the Pretrial Services Act of 1982 (Pub. L. No. 97-267) made the delivery of pretrial services mandatory in each judicial district, pretrial services officers often play a key role in arranging substance abuse treatment, including MMT. These officers also monitor the behavior of defendants who are released pending trial, and are responsible for enforcing court-imposed conditions of pretrial release including drug testing and treatment (Mahoney, Beaudin, Carver, Ryan, Hoffman, 2001).

Pretrial detainees or newly arrested persons who are in jail pending arraignment (the formal reading of the charges) or trial (due to the inability to post bail) are at highest risk for acute drug or alcohol withdrawal. The risk of withdrawal complications is heightened by the presence of co-morbid conditions. Opiate dependent persons have high rates of concurrent illness including HIV and hepatitis C infection, pneumonia, and endocarditis (infection involving the heart valves) (O'Connor & Kosten, 2000). Furthermore, symptoms from opiate withdrawal may mask symptoms of life-threatening conditions such as sepsis (blood infection), pneumonia, myocardial infarction (heart attack), appendicitis or even alcohol withdrawal (ASAM, 2000).

The picture is further complicated by the fact that there are many reasons for someone in withdrawal from opiates to attempt to conceal symptoms during pretrial services. Delaying the arraignment is feared (Kay, 1991). Revealing physical or psychiatric ailments can make an arrestee vulnerable to other arrestees. Raising any type of health issue prior to or during arraignment may negatively impact bail and detention determination. Arrestees who do decide to ask for help for opiate withdrawal related symptoms during the pre-trial process might be stigmatized by the criminal justice system. They may even be held in custody because they may be viewed as being at risk for losing control, being dangerous, or being more likely to get needed treatment in jail than in the community (Slutsky, 1975).

There are some indications of an emerging recognition that the denial of appropriate detoxification services to pre-trial detainees poses serious constitutional questions. Failure to detoxify pretrial detainees could, under certain circumstances, qualify as deliberate indifference to a serious medical need and constitute punishment without trial – the standard for finding a violation of the Eighth

Amendment prohibition against "cruel and unusual punishment" (*Ruiz v. Estelle* 429 U.S. 97, 106 [1976], a class action suit which addressed a prisoners right to “adequate medical and mental health care”) and the prohibition in the Fourteenth Amendment against deprivation of a person's liberty without "due process of law” (Fiscella, Pless, Meldrum & Fiscella, 2004).

For example, in Monroe County, New York, in the two days following her arrest, a woman died in jail from pneumonia secondary to untreated opiate withdrawal. The New York State Commission of Corrections final report concluded, “had adequate medical evaluation and treatment been afforded, her death would have been prevented” (Flanigan, P. 2001

Probation and Parole

The organizational structures of State probation/parole agencies vary widely from State to State. In some States these functions are highly centralized, with a single State agency responsible for all probation/parole functions, while in other States these functions may be decentralized, or even the complete responsibility of single or multi-county agencies. Probation/parole may be located in either executive or judicial levels of government. In a few States, the probation/parole structure varies among jurisdictions and includes both levels (State and county) and/or both branches (executive and judicial) of government. The roles and responsibilities of these agencies, and their general practices concerning collaboration and consultation with community-based resources also vary widely from State-to-State (Krauth & Linke, 1999).

While emphasis in the public arena has been placed on overcrowded jails and expanding the capacity of our prison systems to accommodate the increase in population that has occurred over the last two decades, the reality is that the majority of offenders involved in the correctional system (58%) are being supervised at any given time by probation/parole officers (Mumola, 1998).

Seventy-eight percent of released prisoners enter into some type of conditional supervision status in this widely diverse system. In the 1970s, the average caseload for a parole officer was 45 parolees - then considered ideal. By 2001, the average caseload for a parole officer had risen to 75 parolees, with most parolees (80%) receiving only nominal supervision, (defined as a face-to-face meeting with the parole officer for about 15 minutes once or twice a month) (Travis, Solomon & Waul, 2001).

Probation officers assigned to monitor offenders sentenced to probation-only or to a combination of jail time and probation carry even larger caseloads than parole officers. In a study of the sources of stress on probation officers in nine sites around the country, the Department of Justice identified burdensome paperwork, difficult deadlines, and an average caseload of 139 probationers per probation officer as the most significant sources of stress (Finn & Kuck, 2003). It was reported in one State that 65 probation counselors were required to monitor an average of 363 offenders each (Carbone & Herzog, 2001).

Because of these and other circumstances, probation/parole officers may be only peripherally aware of MMT as a viable treatment option, if they consider it at all. In a 1995 Department of Justice study of the drug treatment programs offered to a representative sample of probationers across the country, it was found that, of people on probation receiving drug treatment, and regardless of prior drug use, MMT was one of the least common among drug treatment programs made available to probationers. In

this 1995 study only .3% of probationers received MMT yet a mean of approximately 6% of arrestees tested positive for opiates in 2000 (DOJ, 2003).

Research indicates that a collaborative approach combining community-based drug treatment with on-going criminal justice supervision produces the best outcomes. The essential elements of such a program includes: treatment in the community; opportunity to avoid a criminal record or incarceration; close supervision (such as random weekly urinalyses); and certain immediate consequences if the offender deviates from the rules of participation in treatment (offenders agree to specific sanctions and rewards) (Marlowe, 1998). MMT programs would seem to fit readily into that paradigm; daily visits make supervision and drug testing easier to administer. Since they are located in the community, the MMT clinic's services can be conducted in consultation and collaboration with probation related services, including employment services and mental health treatment.

But there is still sometimes resistance to probationers participating in MMT during their probationary period. In one recent, highly publicized case, a woman placed on six months house arrest and three years probation was instructed by her probation officer to "detox" from methadone within six months. The probationer attempted to comply with this order, even against the advice of the health care professionals at the MMT provider program. Eventually, however, she began to experience severe withdrawal symptoms, and the center began increasing her doses. When her probation officer heard of this, she was immediately jailed, and the circuit court judge revoked her probation, ordering her to spend three years in prison (American Civil Liberties Union, 2004). Although the case was resolved to the defendant's satisfaction, the judge did not modify his stance against MMT during probation.

Reentry

Reentry initiatives focus on continuity of care as the offender transitions from a correctional setting into society. The Council of State Governments Reentry Policy Council issued a report (Report of the Reentry Policy Council, April 2005) that clearly describes the critical importance of substance abuse treatment as a component to re-entry initiatives, and identifies methadone maintenance treatment as part of the continuum of medication assisted treatment.

This report spurred the introduction of bills in both the House (H.R. 1704) and the Senate (S. 1934) that are referred to as "The Second Chance Act." The House Subcommittee on Crime, Terrorism, and Homeland Security heard testimony in support of the Second Chance Act of 2005 on November 3, 2005.

The House bill does not reference medications assisted treatment; neither does it prohibit such treatment. The companion Senate bill contains the following language in regard to medications assisted treatment:

"Section 3621(e)(5)(A) of Title 18, United States Code, is amended by striking `means a course of' and all that follows through the semicolon at the end and inserting the following: `means a course of individual and group activities and treatment, lasting at least 6 months, in residential treatment facilities set apart from the general prison population, which may include the use of pharmacotherapies, where appropriate, that may extend beyond the 6-month period;'"

In February 2006, the House Judiciary Subcommittee on Crime, Terrorism and Homeland Security began receiving testimony from various stakeholders, and passed its version on February 15th. The Full Committee Hearing has not yet been scheduled.

The residential treatment facilities referenced are those funded by the "Residential Substance Abuse Treatment for State Prisoners" (RSAT) program. The RSAT program was established under the Violent Crime Control and Law Enforcement Act (Pub.L.No.103-322,§ 1901), and is administered by the Bureau of Justice Assistance (BJA). The program was created "to help
States and units of local governments develop, implement and improve residential substance abuse treatment programs in State and local correctional and detention facilities." (Harrison & Martin, 2003) All 50 States, the District of Columbia and the five Territories receive RSAT funding for services that must be coordinated with the State Alcohol and Other Drug Abuse Agency. The Senate language may help to more clearly allow for the possibility of RSAT funding in support of MMT for those in residential/correctional settings.

Drug Courts

Drug courts are an alternative to probation and/or incarceration, reducing recidivism and returning offenders to society in productive roles (GAO, 2005). Drug courts provide intensive, community-based treatment and case management for drug offenders in lieu of prosecution or incarceration. Decisions in drug courts are based on performance in treatment, rather than on legal aspects of the case. Begun in Miami in 1989, drug courts have been implemented in some format in all 50 States, the District of Columbia, and Puerto Rico. As of December 31, 2004, there were 1,621 drug courts operating in the United States (Huddleston, Freeman-Wilson, Marlowe & Roussell, 2005).

Contrasting this model with earlier strategies for diversion to treatment highlights the benefits of drug courts. For example, as drug court participants noted in a 2002 survey of 6 drug courts, the authority of the judge to mete out swift and certain justice was an important feature of their compliance with program requirements–in most situations, the probation/parole officer does not hold this necessary authority (Goldkamp, White, & Robinson, 2002).

The National Drug Court Institute (NDCI) and the National Association of Drug Court Professionals (NADCP) have weighed in heavily in favor of MMT in a Fact Sheet prepared for drug court practitioners (NDCI, 2002). In a 1999 survey of 212 adult drug courts, 82% of the drug courts studied referred offenders to drug detoxification facilities, but only 39% of these included MMT as a referral resource (Peyton & Gossweiler, 2001). There are some practical issues that influence the drug court judges' ability to incorporate MMT into the court's addiction treatment continuum. For example, one barrier may be related to MMT availability as a treatment option. Drug courts in urban (50%) or mixed (44%) settings where MMT is available in the community were more likely to use MMT than those in suburban (29%) or rural (14%) settings where it is not as available. Those drug courts with more than 150 participants were more likely to include referral to MMT.

Judges' attitudes towards MMT may vary from drug court to drug court. On one end of the spectrum are judges who are familiar with MMT as a proven treatment option, and who incorporate MMT into the court's addiction treatment continuum. On the other end are judges who may completely reject the evidence regarding MMT efficacy and efficiency, viewing opiate addiction as a purely social problem best

resolved by imposed abstinence while the offender is in the correctional setting. One study noted that fourteen drug court judges responding to a survey specifically prohibited the use of MMT (Cooper, 1997).

In an open letter to her colleagues regarding medications assistance treatment in general, the Executive Director of the National Drug Court Institute, Judge Karen Freeman-Wilson, commented, "the review of our positions regarding the use of pharmacotherapies will require us to examine our own opinions and biases. Early in my career as a drug court judge, I announced that methadone had no place in my court. When my position was challenged, I did some homework and learned that the use of drugs to address opiate addiction was often necessary in assisting our clients in their efforts towards sobriety. In fact, for many of them it was a matter of life and death. Our team also became committed to assuring that pharmacotherapies were used appropriately in our court" (National Association of Drug Court Professionals News, 2004).

BUPRENORPHINE IN CORRECTIONAL SETTINGS

Buprenorphine's efficacy in treating opiate dependence and opiate withdrawal has been proven through numerous clinical trials, but its effectiveness in a real-world correctional setting has not been well established in this country (Gowing, Ali and White, 2002). France has been providing opiate addiction and dependence treatment using buprenorphine in a correctional setting since 1996 (Durand, 2001). In a retrospective analysis of over 3,600 medical files of French prisoners, researchers compared the effectiveness of methadone, buprenorphine, and abstinence treatment. Compared to abstinence-based treatment, both buprenorphine and MMT resulted in reduced recidivism rates (Levasseur, Marzo, Ross, Blatier, 2002).

Buprenorphine is an attractive alternative to MMT in correctional settings for a range of reasons. Diversion of buprenorphine is reduced through the co-formulation of Naloxone, an opiate agonist, and buprenorphine, called Suboxone. It cannot be injected without precipitating acute withdrawal. Even taken alone, buprenorphine itself, at high doses can precipitate withdrawal because it binds to the m-receptor with greater affinity than heroin (Fudala, Jaffe, Dax, Johnson & Teal, 2000).

Since Suboxone and Subutex (buprenorphine-only) are classified as Class III controlled substances, they can be prescribed by specially trained general practitioners (Drug Addiction Treatment Act, 2002). Treatment with buprenorphine is not as tightly regulated as MMT, making it simpler to incorporate in a variety of correctional settings, thereby expanding access.

However, multiple studies have established the need for psychosocial and healthcare services in conjunction with opiate replacement therapy, including therapy using buprenorphine. Without that protocol, and regular testing for the use of other drugs, the effectiveness of opiate replacement therapies is dramatically reduced. (Friedmann, Lemon & Stein, 2002) (Desland & Batey, 1991). Opiate replacement therapy using buprenorphine does not have this protocol as firmly established in a community setting. This is an important component to the success of opiate replacement therapy (Nurco, Hanlon and Kinlock 1991).

In terms of the associated stigma, treatment with buprenorphine faces many of the same obstacles as treatment with methadone. They share a lack of acceptability, and the idea that one addictive drug is being

replaced with another. Access to treatment with buprenorphine is restricted in several ways. Although the 30 patient cap on a group practice was lifted in August 2005, there is still a 30 patient cap on physician practice. Placing these limits was part of the initial strategy to limit diversion of buprenorphine as it was introduced in this country. However, only about 3,000 physicians are currently qualified to treat patients with buprenorphine, and there is an estimated 3.5 million patients who need treatment (Porter, 2005). The general limited access that those released from correctional institutions generally have to primary health care may also prevent access to treatment as much as the limited number of slots for MMT currently does (Blankenship, Bray and Merson, 2000).

MMT IN CORRECTIONAL SETTINGS: SIX STATES

The development of jail-based programs is a promising indication for the future of MMT for those who are incarcerated. In this section, we review the long established program in Rikers Island, New York, and some newer programs that have been or are in the process of being established in five additional States.

Rikers Island, New York

The first in-jail MMT in the country was initiated in 1987 in New York City Rikers Island Correctional Facility. It was launched both to address the issue of overcrowding and as an AIDS prevention initiative. Known as the Key Extended Entry Program (KEEP), it was jointly developed by the New York City Department of Corrections and the New York Office of Alcohol and Substance Abuse Services. It was specifically developed to help heroin users make the transition from a jail methadone program to local programs (Smith-Rohrberg, 2004).

KEEP enables addicts charged with misdemeanors to be maintained on a stable dose of methadone during their stay at Rikers (averaging 45 days) and to be referred at release to dedicated slots in participating community methadone programs. Thirty-five percent of KEEP-eligible heroin addicts admitted to Rikers are enrolled in a methadone program at the time of their arrest; KEEP enables them to continue receiving medication while in jail to encourage return to their community clinic after release. For the 65 percent of addicts who are not in treatment when arrested, KEEP is intended to be a route into long-term community drug treatment. The objective is to break the cycle of illicit drug use and criminal recidivism (Magura, Rosenblum, Joseph, 1992).

KEEP performs approximately 18,000 detoxifications and 4,500 admissions for MMT per year. Of those methadone treatment patients discharged to the community, mostly to outpatient KEEP programs, 74-80% report to their designated program (all KEEP patients are given an outside referral upon discharge). Recidivism rates reveal that 79% of KEEP patients were incarcerated again only once or twice during a recent 11-year period. Finally, KEEP data point to the importance of dedicating slots in the community for released inmates and maintaining them on sufficient blocking doses to eliminate the craving for heroin (Tomasino et al., 2001).

Bernalillo County, New Mexico

In February 2004, Bernalillo County, New Mexico opened the nation's first public-health office inside a county jail, and announced that, along with other preventive services such as immunizations, HIV testing, and counseling, the clinic would pilot MMT (Bernalillo County, NM, 2004). The pilot MMT program was designed for inmates who are enrolled in a methadone treatment program at the time of their arrest. A third party will evaluate the program for its "effectiveness as a harm reduction approach to reduce some of the crime and disease associated with heroin abuse" over a two year period.

The program is the result of the findings of a task force convened in 2002 by the Behavioral Health Services Division of the New Mexico Department of Health to address the problem that inmates on MMT entering the county's correctional system were not receiving continued MMT in the jail. These inmates were forced to undergo opiate withdrawal syndrome during their period of incarceration for periods (from 48 hours to over one year).

The public health clinic and MMT pilot implementation coincided with the construction of a new jail that houses 2,500 inmates. Clinic services also include infectious disease control (through health education, immunizations, tuberculosis skin testing, and a sexually transmitted diseases clinic), and family planning.

The pilot provides a unique opportunity to examine the impact of MMT on jail inmates and jail operations as the program develops and evolves. The study population is comprised of all persons admitted to the jail who are enrolled in MMT prior to arrest. The pilot will compare outcomes between the pre-program-implementation inmates and those admitted after the jail MMT is implemented. The Behavioral Health Research Center of the Southwest will analyze the data, focusing on the number of visits for medical services associated with opiate withdrawal syndrome and other conditions; behavioral misconduct and rule infraction rates; and post release readmission rates (recidivism).

The pilot project research is being led by the Center's Director, Sandra Lapham, M.D., M.P.H. (Robert Wood Johnson, 2004). New Mexico Department of Health public relations office director Deborah Busemeyer noted that the program opening was delayed until November 2005, but that they are in the process of planning a press release concerning the progress of the initiative, slated for March 6, 2006 (Personal communication, January, 2005).

King County, Washington State

Modeled on KEEP at New York's Rikers Island, two jails in King County, Washington (in Seattle and Kent) are implementing a $350,000 pilot project called the Jail-based Opioid Dependency Engagement and Treatment Program (JODET), which will provide methadone to heroin and other opioid-dependent inmates, including those not already enrolled in MMT programs. The initiative is being funded by King County, in cooperation with the Washington State Department of Health and Social Services - Division of Alcohol and Substance Abuse, Washington State Board of Pharmacy, and the federal Drug Enforcement Administration. JODET participants will be eligible for a 12-day, medically supervised withdrawal course of methadone and, if charged with only a misdemeanor offense, may be inducted into MMT while still in custody.

In addition to dispensing methadone, treatment services will include assessment and documentation of opioid-dependence, chemical dependency treatment counseling, discharge planning, and case

management from a Master's-level social worker who will be physically located in the jail as well as on-site medical and psychiatric services. Inmates participating in MMT will receive a voucher for MMT for use once the recipient has been released from jail Some of the primary purposes of JODET include reducing recidivism to drug use, criminal activity, and jail stays as well as provision of humane care for opioid-dependent inmates. JODET implementation is targeted for July 1, 2006.

Orange County, Florida

The decision to permit MMT in the Orange County jail system was an outgrowth of problems associated with two people who were arrested and ultimately died while incarcerated in the Orange County Correctional Facility. The individuals were not MMT patients but were addicted to street narcotics when arrested and were undergoing withdrawal under the correctional facility's prevailing detoxification protocols, which at the time, did not include using methadone. The incidents involving the two individuals gained much attention in the local press, which ultimately resulted in a call for action and a change in the way such inmates were handled relative to their addiction.

The State Methadone Authority was initially called upon by Orange County officials to assist the county in working on a plan to correct deficiencies in the system. Following a series of meetings with numerous stakeholders including local methadone programs, the DEA, State Board of Pharmacy, State licensure personnel, county officials, and others, the foundation was laid for corrective action.

The Center for Drug Free Living (The Center), one of Florida's long standing substance abuse agencies and a provider of MMT services, took the lead on working directly with Orange County and other MMT's to craft a proposal and a protocol for dosing patients involved in MMT's who are arrested and incarcerated. After many months a formal agreement was developed in which the Center served as the HUB methadone program through which all patient transactions would occur with county officials.

Very generally, under the agreement, county jail authorities notify the Center when an MMT patient is incarcerated. All patients who are incarcerated are transferred from the MMT they were attending at the time of their arrest to the Center, unless the incarcerated patient was already a patient at the Center. Center staff then transport the medication to the jail daily and Center staff medicate the patient at the jail.

There is a formal agreement between the Center and Orange County for this arrangement and it is also based on approval by the DEA and State Authority.

Baltimore, Maryland

The Center for Substance Abuse Research at the University of Maryland found that a third of men arrested in Baltimore, and nearly half of all women arrested in Baltimore, had used heroin within the month before their arrest (Citation). The National Institute on Drug Abuse (NIDA) funded a five-year $500,000 pilot study that offered Opiate Replacement Therapy (ORT) to inmates at the Metropolitan Transition Center, a State prison pre-release facility, in the three months prior to their release, then referral to community-based treatment post-release.

The pilot was initiated using levo-alpha-acetyl-methadol (LAAM). LAAM is marketed as Orlaam and was approved by the FDA in 1995. It is a synthetic narcotic similar to methadone in its effect, but it acts in the body for 48 to 72 hours – methadone acts for 24 hours. The pilot was implemented both within the prison setting and upon release to an ORT program in the community. Later in the study, participants who reported to the community-based clinic upon release were switched to methadone because of the cardiac arrhytmia associated with LAAM.

The pilot followed 398 inmates. Participants were randomly assigned to either LAAM maintenance, which included weekly group drug abuse educational counseling in addition to medication, or to a control group. At the conclusion of the jail-based treatment, experimental participants who passed a physical examination and signed a second consent to initiate maintenance treatment were eligible to receive LAAM maintenance (later methadone mainteneance) provided by a Baltimore community-based ORT program both during and following their incarceration. Control participants received no intervention in prison other than usual correctional programming. Outcomes monitored were re-admission to drug abuse treatment; re-arrest; re-incarceration; frequency of heroin use (reported); frequency of other illegal activity (excluding illicit drug use and/or possession); and average weekly income obtained from illegal activities.

Although the study had some weaknesses, outcomes were strong enough to justify a second study, currently underway, to provide a more definitive test of prison-based MMT. This study will "compare the efficacy of three treatment conditions: 1) initiation of methadone maintenance and drug abuse counseling in prison with transfer to community-based methadone maintenance with the same provider upon release from prison; 2) provision of drug abuse counseling, but not maintenance treatment, in prison, with transfer to the same provider for methadone maintenance treatment upon release from prison; and 3) provision of drug abuse counseling, but not maintenance treatment, in prison, with information on how to access drug abuse treatment in the community upon release" (Kinlock, T.W., 2005).

Rhode Island

Although their MMT initiative dos not include MMT in a correctional setting, the Rhode Island program does focus on what may be the most important aspect of jail-based MMT, the transition to community-based MMT. Project MOD (methadone opiate dependency), initiated in May 2003, links recently released ex-offenders to MMT in the community.

Heroin-users represent a substantial sub-population of the Rhode Island correctional system, comprising about 17% of all arrests in Providence and Kent counties (Boutwell and Rich, 2005). Potential subjects, screened by staff at The Miriam Hospital, Providence, are recruited at the Rhode Island Department of Corrections. There, they work with a counselor to make logistical arrangements for MMT entry upon release. The State provides partial financial assistance for their participation in MMT for 24 weeks. Subjects were followed for twelve months, with follow-ups occurring at six-month intervals.

As of January 2005, the program had enrolled 217 subjects and completed 167 six-month interviews for an 87% follow-up rate. 52% of these subjects were still engaged in MMT at the end of the first six-month interval. These subjects reported increased employment rates, and reduction in drug use and

related risk behavior. Clients remaining in treatment at 12 months showed higher employment rates and greater reduction in heroin use, drug injection, and needle sharing than those who left treatment earlier (between six and twelve months).

These data suggest that linkage to MMT upon release, including short-term payment for methadone, is a valuable intervention that "reduces illicit drug use and related risk behaviors, and increases overall stability among former inmates re-entering the community." (McKenzie et al., 2005).

RELATED INITIATIVES

With funds from the Robert Woods Johnson Foundation Innovators Award program and a Mallinckrodt grant, the American Association for the Treatment of Opioid Dependence (AATOD) is working with the Legal Action Center (a public interest law firm) in five States (Arizona, Florida, Maryland, New York and Vermont) to evaluate laws and policies and to develop guidelines to overcome obstacles and increase access to MMT in jails and prisons. AATOD is also working with the American Probation and Parole Association, the American Jail Association and the National Drug Court Institute to survey attitudes and concerns regarding MMT and to develop educational materials targeted at criminal justice professionals. The results of this and other initiatives may serve to further develop and cement this fundamental shift in attitude towards MMT on the part of those who administer and staff the many aspects of the criminal justice system. This situation is beginning to change, as the Federal government funds the development of national standards for MMT in correctional institutions, as well as demonstration projects in various correctional settings, and as State officials increasingly realize the need to replicate the models that have developed.

CONCLUSION

Even a brief review of the history of Federal legislation regulating the sale and use of opioids reveals the societal dilemmas presented by opioid addiction. Legislation and the application of various regulations swing widely between largely uncompromising attempts to "crack down" on the illegal sale and use of opioids, and making provisions for the effective treatment of those caught up in the equally uncompromising web of opiate addiction. The combined impact of definitive research, revised Federal regulations, and uniform support at the Federal level for MMT as the most viable option available seems to be closing the gulf between clinical guidelines and political and fiscal realities.

A carefully planned, targeted approach to connecting opioid addicts involved in the criminal justice system with methadone treatment and other types of opioid replacement therapy seems the most likely strategy for maximizing the impact of limited resources. There are several factors to consider in developing this approach:

1) Although opiate abuse and addiction is a national problem, research indicates that some areas of the country have higher rates of use than others. Initial efforts should focus on those areas where data indicate a significantly high prevalence of opiate use among those who become involved in the criminal justice system.

2) Health care resources for those in the criminal justice system are limited. The need for MMT cannot compete effectively with other, more pressing health care needs. The "added value" of MMT in regard to its potential to reduce a variety of health care costs and to improve outcomes must be adequately demonstrated. The promotion and dissemination of research that clearly shows the relationship between MMT and improved outcomes (reduced recidivism, for example) and reduced health care costs might be effective.

3) Some criminal justice settings are better suited for intervention that others. Although there are opportunities at every point in the continuum, MMT has strong allies in the nation's drug courts. It makes sense to strengthen these and other existing relationships among sympathetic criminal justice professionals, building a track record of success that can then be "marketed" to other aspects of the system.

4) The disease of addiction already bears a heavy stigma, and opiate addiction is certainly no exception to this phenomenon. Promotion of MMT and its concomitant treatment protocols as a solution would be a valuable component to campaigns that seek to address issues related to stigma. Such a campaign would confront head-on the widespread belief that MMT is simply substituting one drug for another.

5) Society is not inclined to be sympathetic or supportive of those who become involved in the criminal justice system. The stigmas associated with addiction are closely tied with those associated with criminal justice involvement for many reasons. Including referral to MMT programs for offenders who are transitioning back into society would demand the close collaboration of both systems. The promotion of "best practice" models that demonstrate the possibilities presented by such partnerships would be valuable to the nation as a whole.

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NASADAD is a private not-for-profit educational, scientific, and informational organization that was established in Washington, D.C. in 1971 to represent Directors of State Alcohol and Drug Abuse Agencies. NASADAD's basic purpose is to foster and support the development of effective alcohol and other drug abuse prevention and treatment programs throughout every State. NASADAD serves as a focal point for the examination of alcohol and other drug related issues of common interest for both State and Federal Agencies.

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