LAW AND ORDER

Prisons Are Making America's Drug Problem Worse

Even federal prisons know that their inmates need medication-assisted therapy. So why aren't they changing?

By MEGAN MCLEMORE | March 11, 2015

Lead image by AP Photo.

Today, Gordon Goodwin is in federal prison in Atlanta. Not too many years ago, he was a student at University of North Carolina at Chapel Hill, on track for law school. He enjoyed tennis and mountain biking. Today, his future looks bleak—failed by prison drug treatment policies that even the Bureau of Prisons admits don't work, policies opposed by science and medical professionals, including groups like the World Health Organization.

As criminal justice reform becomes a major topic of conversation in Washington, Goodwin's journey from would-be law student to prison addict is a cautionary tale of how inmates in the bureaucratic federal system are set up to fail—and how those failures ripple through the prison system and waste taxpayers' dollars at a time when both states and the federal government are looking to rein in spending.

Because, unfortunately, Gordon's story—while remarkable—isn't necessarily an outlier.

In 2009, as a 20-year-old history major at UNC-Chapel Hill, he had a bout of kidney stones and became addicted to oxycodone and other opioid painkillers after taking them as prescribed for only one week. By 2011, in an all-too-common transition, Gordon began using its cheaper, more accessible relative: heroin. He went in and out of treatment programs and tried to keep up with his coursework, but his life went into a downward spiral. He started to gamble compulsively, and with debts to repay and a heroin habit to support, he committed three bank robberies between November 2011 and May 2012. After the final incident, Gordon was arrested, pled guilty and received a sentence of 47 months in federal prison for bank robbery.

Gordon's addiction did not disappear once he entered the Federal Correctional Institution in Beckley, West Virginia, a medium-security prison, in March of 2013. In an effort to end his worsening cravings, he completed a prison treatment program and drug education classes. Gordon and his mother, Diana, pleaded with federal Bureau of Prisons (BOP) officials in writing and in person to give him a medication called Suboxone, a form of buprenorphine that his doctor had prescribed before he entered federal custody to block his craving for drugs. The officials refused. As a matter of policy, the BOP does not provide buprenorphine, methadone or other medication-assisted therapies (MAT) for opioid addiction—a policy that has had disastrous consequences for Gordon and the roughly 15 percent of all U.S. inmates that have a history of heroin addiction.

It's a policy that even the Bureau of Prisons admits doesn't work—and one with an obvious negative outcome.

Opioid dependence is a chronic, relapsing disease, and Gordon eventually found narcotics in prison. Drug-related incidents followed, including a failed urine test result that sent him to solitary confinement for 45 days and led to the loss of visiting privileges, including visits with his family, for one year. Gordon appealed those sanctions; "I have done everything I can to get better," he said. The appeal was denied and because of his drug use he was transferred to a high security prison. Over the Christmas holidays, Gordon was stabbed by another prisoner and is now awaiting transfer to another unit, his future uncertain.

After two decades of rapidly rising incarceration rates—rates that continued to rise even as crime sat at record historic lows—America today has nearly 2.2 million adult inmates in local, state and federal jails and prisons, including about 300,000 who have a history of heroin addiction. The BOP spends $110 million annually on drug treatment programs for approximately 80,000 inmates identified as dependent on narcotics. But for the 10,000 or so federal inmates dependent on heroin or other opioids, millions of those dollars are currently spent on outdated, ineffective approaches that wrongly prohibit medication-assisted therapies—approaches that, in other words,fail to help prisoners addicted to opioids during their sentence and ultimately return them afterwards to society as addicted as they were when they went into jail.

It doesn't have to be that way. A recent study of opioid-dependent inmates leaving Rikers Island jail in New York City showed that nearly nine out of ten inmates who were not medicated relapsed within a month, as opposed to just 2 out of 5 inmates who were on medication-assisted treatment. The difference to society between those two numbers—in terms of health outcomes, reduced crime, and improved employment stability—is huge.

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Science notwithstanding, the U.S. criminal justice system has resisted medication-assisted therapy, with only a few large urban jails (e.g. New York City, San Francisco, Albuquerque) and a handful of state prisons such as those in Rhode Island and Vermont opting to use it. Yet most major correctional experts, including the U.S. Bureau of Justice Assistance (BJA), the National Re-Entry Resource Center and the National Commission on Correctional Health Care, all recommend increasing the availability of medication-assisted therapy for opioid dependence in the country's jails and prisons. The U.S. Bureau of Justice Assistance (BJA) recently concluded that the effects of MAT are "many times greater" than behavioral therapies without medications.

Beyond the correctional world, the World Health Organization, UNAIDS, the United Nations Office on Drug Policy, and the National Institute on Drug Abuse (NIDA) all agree that people dependent on heroin and other opioids should have access to

medication-assisted therapy. In a recent publication, NIDA stated, "Taking these medications as prescribed allows patients to hold jobs, avoid street crime and violence, and reduce exposure to HIV." The White House Office of Drug Control Policy calls MAT combined with behavioral therapy the "standard of care" for opioid dependence and recently announced that drug courts, which offer treatment as an alternative to prison for some criminal offenders, will be required to offer MAT in order to continue to receive federal dollars.

Nevertheless, despite the evidence to the contrary, the Federal Bureau of Prisons prohibits such treatments entirely for "routine" (non-detox) purposes. Corrections officials frequently cite security concerns to justify denying buprenorphine and methadone therapy to inmates, fearing the medicine will be diverted to other prisoners—despite the fact that these issues can be resolved with tighter security measures and closer staff supervision (the prison systems of Western Europe, Scotland, Canada and even Iran can attest to that).

The federal Bureau of Prisons even lags behind Congress: In April 2014, 16 U.S. Senators wrote to Attorney General Eric Holder urging the Department of Justice to support increased availability of medication-assisted treatment for opioid addiction in correctional settings.

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Gordon's transition from college student to painkiller patient to heroin addict is a typical story amid the ongoing opioid epidemic that began in the U.S. in the 1990s. According to the U.S. Centers for Disease Control (CDC), over-prescription of oxycodone, morphine and other opioids for pain contributed to a quadrupling of overdose incidents from both licit and illicit opioids in the U.S. in the last decade. When the Food and Drug Administration tightened their regulations for prescription painkillers in response to this increase, many patients moved to heroin, a cheaper and more readily available alternative. Since 2007, the number of people reporting heroin use in the past year has nearly doubled to 620,000. And many users, of course, end up in prison, where misguided policies—like the prohibition of medication-assisted treatment for addicts—make their shot at recovery and rehabilitation significantly more difficult.

In a recent letter to Human Rights Watch addressing Gordon's condition, the BOP stated that Gordon's sentencing report indicated that he had "abused" Suboxone (a form of buprenorphine that reduces the likelihood of overdose) in the past, but did not explain what would constitute "abuse." The BOP's policy prohibits routine use of Suboxone, and its drug treatment experts recommended that Gordon participate in a variety of abstinence-based programs.

But the BOP itself is well aware that such abstinence-based programs are largely ineffective. In an internal memorandum dated March 2014 obtained through a FOIA request filed by Gordon's mother, the BOP acknowledged that "research has shown that abstinence-based programs similar to ours only offer a 1 in 10 chance of success for opiate-dependent participants." The memo concluded that the Bureau should consider launching pilot programs to implement what they called the "best practice" of medication-assisted therapy. Since then, the BOP has implemented a "field test" re-entry initiative for prisoners about to be released. It's an important step, but one that benefits only a small number of inmates who are on their way out of the system.

Under U.S. law, prisoners must establish that in refusing to provide medication-assisted drug treatment officials have been "deliberately indifferent" to their serious medical needs if they are to pursue civil rights claims; most lawsuits have been unsuccessful to date, but given the growing evidence that abstinence-based therapies alone are not effective, this legal landscape is likely to change in the future.

The BOP told Human Rights Watch that addiction medicine "is evolving" and the Bureau "continues to monitor developments" in relation to medication-assisted therapy. But this isn't really true: MAT is now recognized as an essential element of the standard of care for opioid dependence, and the human cost of further delay is neither appropriate nor acceptable. Inmates like Gordon are denied medication, and then punished for the relapse that is nearly inevitable.

Once a low risk inmate with a documented drug problem, Gordon is now considered to be a "disciplinary threat" and awaits transfer after having been stabbed in a high-security prison. Gordon committed the serious crime of bank robbery, but his prison sentence alone was supposed to be the debt he repaid to society. Now, he pays with the deprivation of medical care, an increased likelihood of contracting HIV and the stress of fearing for his safety on a daily basis. His chances of surviving in prison—not

to mention rehabilitation and a successful return to the community—would be greatly increased if the federal Bureau of Prisons gave him—and thousands of others—the care he truly needs.

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Additional credits:

Lead image by AP Photo.
