ORIGINAL ARTICLE

Opiate replacement therapy at time of release from incarceration: Project MOD, a pilot program

Michelle McKenzie, MPH
Grace Macalino, PhD
Clair McClung, BS
David C. Shield, BS
Josiah D. Rich, MD, MPH

ABSTRACT

Approximately 7 million people in the United States are in jail, in prison, or on probation or parole, many as a result of drug-related offenses. Individuals who use opiates account for a significant minority of this population. Methadone maintenance treatment (MMT) of opiate addiction is highly effective in reducing drug use, drug-related criminal activity, and risk of human immunodeficiency virus transmission. Recently released inmates are at particularly high risk for overdose and disease transmission. Project MOD (Managing Opioid Dependency) provides services to eliminate logistical and financial barriers to MMT entry immediately on release from incarceration. Such programs provide a promising opportunity to facilitate reentry into the community, combat disease transmission, and reduce recidivism.

Key words: methadone maintenance treatment, opiate addiction, incarceration, rehabilitation

INTRODUCTION

The United States incarcerates more people per capita than anywhere else in the world. The US Department of Justice Bureau of Justice Statistics reports that in 2003, 6.9 million people, or one in 32 adults in the United States, were on probation, in jail, in prison, or on parole.[1] In the 1990s, the United States experienced a 239 percent increase in the number of people in jails and prisons, resulting primarily from the so-called "war on drugs," and a threefold increase in drug-related arrests.[2,3] As a result, an estimated 80 percent of incarcerated individuals have substance abuse problems.[3,4] More specifically, up to 25 percent of inmates report a history of heroin use, and as many as 20 percent report a history of injection drug use (IDU).[5,6]

Given the high prevalence of individuals grappling with addiction in the corrections system, relapse into illicit drug use after incarceration is a substantial problem.[7] The consequences of relapse include increased criminal activity,[7-9] additional risk of human immunodeficiency virus (HIV) infection,[10] overdose death,[11-13] and reincarceration.[14] Fifty-five percent of former prisoners relapse into substance abuse within one month of release from incarceration.[7] This high rate of relapse suggests that although physical dependence on drugs may wane during the relative sobriety associated with incarceration, the behavioral manifestations of addiction and life stressors related to drug use are still present and require treatment. Many incarcerated drug users are addicted to heroin. One study found that a minimum of five years of heroin abstinence considerably reduced the rate of relapse, but 25 percent of participants still relapsed even after 15 years of abstinence.[15] This suggests that even long periods of incarceration and sobriety cannot be considered sufficient for recovery from addiction. Indeed, because heroin can cause physiological changes in the brain, addiction may be a lifelong problem.[16-18]

The goal of opiate replacement therapy (ORT) is to provide long-term stability and medical support for addiction through pharmaceutical replacement. The most common treatment is methadone. Long-term methadone maintenance treatment (MMT) programs have been shown to reduce risks of relapse, criminality, HIV transmission, mortality, and recidivism.[18-22] MMT has also been shown to be more effective at achieving these goals than ORT detoxification programs alone.[23] Although only a few MMT programs exist in prisons and jails around the world, the potential benefits of implementing such programs have been well documented.[24-27] One such effort, Project KEEP, on Rikers Island, New York, has successfully initiated MMT for prisoners, but linkage to aftercare post-release remains a challenge, and many participants report difficulty negotiating community placement in treatment after release.[28,29]

Newly released prisoners are especially vulnerable to the heightened risks associated with relapse into illicit drug use. Satisfying basic survival needs including housing, income, and food, often supercedes their ability to focus on less immediate concerns, such as drug treatment and disease prevention.[30] To alleviate these problems, the Centers for Disease Control and Prevention and the World Health Organization recommend that individuals be provided with prevention programs that would seamlessly transition prisoners to the community.[27,31,32] Relapse into illicit drug use and the accompanying heightened risk of disease merit attention as a target for prevention efforts.

We describe here an ongoing service program designed to provide increased linkage to MMT at time of release from incarceration, and offer our practical experience for others in the opiate treatment community in hopes of encouraging creation of similar programs.

PROGRAM DESCRIPTION

Our program, Project MOD (Managing Opioid Dependency), is a five-year, federally funded service initiative that aims to reduce recidivism, improve health, and increase personal stability among opiate-addicted exoffenders through linkage to MMT. Project MOD is housed in the Miriam Hospital, a well-established, nonprofit hospital in Providence, Rhode Island. The project is funded by the Center for Substance Abuse Treatment (CSAT), an agency of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Members of the RI Department of Corrections staff provide referrals for interested inmates with a history of opiate addiction. Recruitment is now almost entirely from jail or prison, but during the startup stage of the project individuals were also enrolled who had been recently released from incarceration. Project MOD staff screen inmates to establish addiction and treatment history and whether MMT is practical (i.e., can the inmate afford it; is there a geographically convenient clinic; is there an existing debt with the clinic; is s/he committed to the rigors of clinic—daily attendance, regular meetings, regular toxicology screens; does s/he have daily transportation, etc.). While clients are still incarcerated, we work with them to facilitate and ensure entry into MMT within 24 to 48 hours of release. These efforts include arranging an appointment with an MMT program, acquiring documentation necessary for clinic entry (i.e., legal identification and social security card), and arranging transportation to the first clinic appointment.

After clients are released and enter a community treatment program, we provide temporary financial assistance for treatment costs (100 percent coverage for 12 weeks and 50 percent for the next 12 weeks). During screening, each client creates an individualized work plan that delineates the steps needed to help ensure payment for treatment costs when program financial assistance ends. Project MOD staff meet with the client several times in the first six months to reassess the plan and provide assistance with job referrals and training, applications for Medicaid or other insurance, and state-subsidized treatment slots. Additionally, throughout program participation, staff provide referrals for healthcare, housing, and other social services. Clinical care is entirely managed by the MMT program staff.

Project MOD has an annual budget of $450,000 in direct costs; the average cost per Project MOD client is $2,665, of which approximately $1,500 amounts to fees paid to the methadone clinics. The remaining costs include personnel, local travel for staff (e.g., to the Department of Corrections, area methadone clinics, the Social Security Administration, the Department of Motor Vehicles, Vital Records in the Department of Health, etc., all of which is service oriented and does not pertain to the evaluation aspects of the project), staff training, transportation assistance for clients (i.e., bus tickets and cab rides for the first clinic visit, when necessary), and assistance with paying for identification cards and birth certificates.

The RI Department of Corrections and all of the state's MMT facilities have been partners in the effort to develop and implement this program. We rely on RI Department of Corrections staff, including discharge planners, medical personnel, and counselors, for referrals. The RI Department of Corrections permits MOD staff to be present during inmate informational sessions, facilitating outreach to potential clients. Collaboration with MMT facilities includes special billing arrangements; providing space for MOD staff to meet with clients; and communicating discharge status, length and dates of treatment, and results of urine toxicology screens (all information is shared only with client's consent). Additionally, methadone clinics have been flexible with appointments, understanding that release dates may change unexpectedly.

Project MOD follows clients for one full year with assessments at baseline, six months, and 12 months. Data are gathered through client self-report, methadone clinic chart review, and RI Department of Corrections records. An interview combining the Addiction Severity Index (ASI) and CSAT-mandated Government Performance and Results Act (GPRA) measures seven general areas: 1) medical status, 2) psychiatric status, 3) substance use, 4) employment/support status, 5) legal status, 6) family history, and 7) family/social relations. Methadone clinic chart review is used to measure clinic attendance, methadone dosing, and urine toxicology results. Review of public corrections records is used to measure reincarceration.

PRELIMINARY RESULTS AND PRACTICAL EXPERIENCE

Between May 2003 and September 2004, we enrolled

217 clients. At baseline, clients were 64 percent male, 70 percent Caucasian, 13 percent Latino, and 11 percent African American. In the 30 days before assessment, many reported being unstably housed: 13 percent were homeless, 14 percent were institutionalized (prison or jail), and 53 percent stayed with friends or family. Many struggled with mental health issues that persisted for at least two weeks in the 30 days before assessment—30 percent had serious depression; 38 percent had anxiety; and 33 percent had difficulty understanding, concentrating, or remembering. Only 11 percent had received inpatient, outpatient, or emergency mental health treatment. Illicit and polydrug use was substantial: 90 percent of clients reported illegal drug use in the last 30 days. The most common drug was heroin (81 percent), followed by cocaine (43 percent). Notably, 73 percent also reported recent illicit drug injection, and 38 percent reported sharing syringes and other paraphernalia.

Of the 217 enrolled clients, 175 had completed six months in the project by September 2004. Approximately one-half (46 percent, n = 81) were still in treatment at six months. Of the 54 percent (n = 94) who left MMT, we have completed six-month interviews for 79. Of those, 38 percent were discharged owing to their inability to pay for treatment costs, 34 percent were discharged owing to reincarceration, and 25 percent left on their own against staff advice. Overwhelmingly, project participants reported that they would have been unable to enter MMT without the assistance provided by the project.

The quantifiable results to date are promising, and our subjective experiences reflect that as well. For instance, attitudes at the RI Department of Corrections initially fell in line with many other correctional and substance abuse treatment settings that stigmatized MMT as "just another drug," and total abstinence the only worthwhile goal. Attitudes toward methadone as a viable treatment option have gained considerable ground in the last two years, however, and the RI Department of Corrections has been a true partner in developing and implementing Project MOD. This is evidenced in part by the array of staff in all of the security facilities from whom we receive referrals, by our invitations to speak before the parole board, and by our regular involvement in discharge planning meetings and training.

Tight-knit collaboration with the methadone treatment facilities has likewise been crucial and productive. Special billing arrangements, transferring between clinics, and clinic discharge and re-entry have all gone smoothly. Each of the clinics has been welcoming of project staff and helped to facilitate our meeting with clients. Although not all clinics were accustomed to working with recently released inmates, they have trained staff regarding the federal regulations that specify slightly different entry criteria for those individuals. Likewise, clinics accommodated last-minute rescheduling of appointments that occurred as a result of sudden changes in prison release dates. In short, the clinical and correctional staffs' investment in providing services for this population has been crucial to ensure prompt treatment entry.

Our results are preliminary. We plan to examine many outcomes, including risk behaviors (self-reported drug use and injection behaviors, urinalysis results from chart review), reincarceration (incarcerated for old offense) versus recidivism (incarceration for new offense), length of stay in treatment, and length of time between prison release and clinic initiation.

DISCUSSION

Project MOD is one of few projects to provide linkage to MMT and funding support for individuals recently released from incarceration. The vision behind Project MOD is that linking individuals to treatment, covering treatment costs, and assisting with referrals for other needs contributes to the stability clients need to sustain long-term treatment. Preliminary evidence supports this vision. We have reached this underserved population and provided support for entering and continuing treatment. We have formed strong partnerships with the RI Department of Corrections and community methadone programs that lay the groundwork for further development of this program.

Financial assistance

Although considerable effort goes into arranging all the logistical details for treatment initiation and providing medical and social service referrals, it is clear that the project's most desired service is temporary financial assistance. This is not surprising, because a significant barrier to methadone treatment is the cost. For example, in Rhode Island, the cost of MMT programs averages more than $80 per week. As a result, MMT is not feasible without stable employment or assistance through a third-party payer.

Financial discharge

Although approximately one-half of Project MOD clients remained in treatment at six months, treatment was interrupted for one in five clients owing to their inability to pay at the end of MOD financial assistance. In general, this is a suboptimal outcome, because heroin-addicted patients who undergo short-term MMT frequently relapse. Since the project's inception, we have been aware of the possibility of financial discharge and have addressed this problem in the following ways:

- pre-enrollment emphasis on the possibility of

financial discharge to clients thinking about entering treatment and completing a work plan with each client to develop concrete steps toward paying for treatment when the project no longer does so; and

- working with clients to pursue third-party payers (e.g., Medicaid, state-subsidized treatment slots) and referrals for job training and placement (although these resources are scarce).

In response to the fact that one-fifth of MOD clients have undergone financial discharge, despite these continued efforts, we have recently adopted the strategy of offering the choice of a four-month treatment episode—eight weeks ramping up and maintaining a therapeutic dose, and an approximately eight-week taper—the cost of which is fully covered by Project MOD. Although far from optimal, this option may provide protection and stability during the initial transition back into the community. Additionally, a completed short-term treatment episode may be a steppingstone to longer-term treatment in the future.

Comparison of public costs

Although MMT costs are a barrier for many individuals, it may be cost effective at the policy level in comparison to the costs of incarceration. The average annual cost of incarceration is at least $22,630 per inmate in state or federal prison.[33] Conversely, the annual cost of MMT (based on average costs at Rhode Island clinics of $75 to $90 per week) is approximately $4,420. There may be additional costs in supporting individuals recently released from incarceration, such as social services and governmental support (e.g., welfare, food stamps, etc.). As individuals stabilize in MMT, however, many are able to secure employment, obviating the need for some social services. Therefore, an emphasis on substance abuse treatment could mean governmental savings over the costs of incarceration and offsetting of social service costs.

Limitations

The results we present here are primarily from practical operational experience, meant to inform other agencies interested in providing similar services. Because this is a service initiative, the outcomes that we report may not be generalizable to all incarcerated opiate-addicted individuals. For instance, there was a selection bias because all our clients sought out MMT services. We had contact only with those who were specifically interested in MMT and needed assistance in accessing that treatment. Also, MMT is not appropriate for all people who use heroin.

Currently, minorities are under-represented in our client population. Although whites account for 70 percent of our clients, they make up only 50 percent of the incarcerated population.[34] Although there are not accurate numbers regarding race of heroin users in Rhode Island, a reasonable indicator would be new HIV infection rates and IDU-related HIV infection rates, both of which indicate a higher percentage of minority IDUs than are represented in the Project MOD sample.[35] This discrepancy, in part, reflects under-representation of minorities in Rhode Island methadone clinics, where whites comprised 80 percent of patients treated for heroin addiction in 2003.[36] We are attempting to address this problem by collaborating with local minority service organizations to increase the diversity of our outreach.

Our efforts for recruiting women have been more successful, owing in large part to our collaboration with the Women's Division at the RI Department of Corrections. We seek to recruit women to represent at least one-third of our clients. This is the ratio consistently reported in the literature for heroin users in the community. This is also the ratio of men to women being treated in Rhode Island for heroin addiction, although it is a considerable over-representation of women as compared to their numbers in the prison population (6 percent).[34,36]

CONCLUSION

The demand for linkage and funding support through Project MOD underscores the public health importance of facilitating continuous and sustained care during the transition from prison to the community. The intense cooperation with the RI Department of Corrections and MMT programs facilitated by Project MOD has produced promising results. Nearly one-half of our baseline clients remained in treatment at six months, and even those who were discharged received important protection from relapse during the high-risk period immediately after incarceration. Overwhelmingly, our clients reported that they could not have entered MMT without assistance from Project MOD. Through analysis of our six- and 12-month assessments, we hope to demonstrate that immediate MMT linkage and funding at time of release from prison decreases recidivism and improves health and personal stability, thereby improving the community's health. Data from small demonstration projects such as Project MOD may be helpful in convincing policymakers, correctional administrators, and the general public of the merits of this approach.

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Michelle McKenzie, MPH, The Miriam Hospital, Providence, Rhode Island
Grace Macalino, PhD, Tufts-New England Medical Center, Boston, Massachusetts.
Clair McClung, BS, The Miriam Hospital, Providence, Rhode Island.
David C. Shield, BS, The Miriam Hospital, Providence, Rhode Island.
Josiah D. Rich, MD, MPH, The Miriam Hospital and Brown University Medical School, Providence, Rhode Island.

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