



Community-based methadone maintenance in a large detention center is associated with decreases in inmate recidivism



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ABSTRACT

Because it is not common in the U.S. for jails to allow inmates to continue opioid medications that have been started in the community, we aimed to assess whether inmates maintained on methadone showed different rates of recidivism, lengths of incarceration, and types of offenses than other incarcerated groups. We also analyzed rates of return to home clinics after release. In order to answer these questions this study used extant data from 960 adult inmates in a large metropolitan detention center who were in 1 of 4 groups: general population with no known substance use disorders, alcohol detoxification, methadone maintenance (MMT), and opioid detoxification. Recidivism was assessed for 1 year after release. Data were collected from medical screening forms and jail databases and included demographic variables, dates of admission and release, number of doses and total dosage of methadone if applicable, reason for incarceration, and the date of rebooking and nature of offense, if it occurred. There was a significant difference in time to rebooking, $F(3,956) = 13.32, p = .00$, with the MMT group taking longer to be rebooked (275.6 days) than the opioid (236.3 days) and alcohol detoxification groups (229.3 days), but not the general population group (286.2 days). Survival analysis indicated significantly better survival without rebooking in the MMT and general population groups than the alcohol and opioid detoxification groups. There also were differences in length of incarceration, $F(3,954) = 9.02, p = .00$, with the MMT group being incarcerated longer than other substance using groups; and in misdemeanor vs. felony rebooking offenses, $\chi^2(3) = 31.29, p < .01$, with the opioid detoxification group being more likely to have a felony rebooking than the general or alcohol groups. In a separate analysis, data from 137 MMT clients, who were not precisely the same clients who were involved in other analyses reported in this article, indicated that over 97% returned to their home methadone clinics after incarceration. In summary, inmates who had been allowed to be maintained on methadone started in the community displayed a significantly longer time to be rearrested than inmates undergoing opioid or alcohol detoxification, but not inmates without substance use disorders. When they were rebooked, they were as likely as the opioid detoxification group to be rearrested for felony offenses.

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1. Introduction

Heroin has been ranked highest of illicit drugs in dependence and physical and social harm (Nutt, King, Saulsbury, & Blakemore, 2007). The use of heroin is associated with criminal behavior (Bukten et al., 2011; Gordon, Kinlock, Schwartz, & O'Grady, 2008), and individuals incarcerated in the United States are approximately 10 times more likely to have a history of heroin dependence compared to non-incarcerated individuals (Albizu-García, Caraballo, Caraball-Correa, Hernández-Viver, & Román-Badenas, 2011). Furthermore, opioid-dependent individuals leaving incarceration with heroin or other opioid use disorders are more likely to die from an unintentional drug overdose during the first few weeks after release from jail or prison than the general non-incarcerated population (Gordon, Kinlock, & Miller, 2011).

It is important to clarify the distinction between a jail (AKA detention center) and a prison as they are very different institutions and play a different role in society. Jails are (usually) short-term incarceration facilities that house arrestees. Most arrestees have not been adjudicated and often are in jail for only a day or fewer while awaiting adjudication (which may be a trial or probation, or dropping of the charge). Of those in the jail who have been adjudicated, nearly all are serving sentences of less than a year, although a few can have been in longer. Generally speaking those who are sentenced to terms longer than a year are sent to prison. Jails are therefore characterized by rapid turnover, usually short-term housing of both sentenced and non-sentenced people who have been arrested. Prisons are long-term incarceration for people who have been sentenced by the courts.

In 1965, Dole and Nyswander (1965) established the use of methadone for the treatment of heroin dependence. Since then, methadone maintenance therapy (MMT) as a treatment for opioid use disorders has been found to be effective in decreasing illicit opioid use (Dolan &

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Wodak, 1996), injection drug use (Barnett, Zaric, & Brandeau, 2001), and harms associated with opioid use, such as incarceration and unintentional overdoses (Barnett et al., 2001; Dolan et al., 2003). A recent systematic review (Hedrich et al., 2011) of opioid maintenance treatment (OMT; both methadone and buprenorphine) in prisons indicated OMT during incarceration was associated with reduced heroin use and injection equipment sharing. After release, those who had been on OMT showed a greater probability of treatment entry and retention in treatment. Most studies of any type of opioid replacement treatment with incarcerated individuals have occurred in prisons, but studies of methadone treatment in jails (Magura, Rosenblum, Lewis, & Joseph, 1993), and of a combined jail and prison sample (Rich et al., 2015) have reported several significant positive outcomes.

Despite the evidence of the effectiveness of MMT in community treatment settings and correction institutions around the world, the use of methadone in jails and prisons in the United States is rare (Dolan & Wodak, 1996; Gordon, Kinlock, Schwartz, & O'Grady, 2008; Kinlock, Gordon, Schwartz, Fitzgerald, & O'Grady, 2009; Nunn et al., 2009). A survey of 51 prison systems in the United States found that 57% of those prisons listed the most common reason for not using MMT as the "facility favors drug-free detox over methadone". Such a finding may indicate a persisting stigma associated with the use of pharmacotherapies to treat individuals with opioid use disorders (Nunn et al., 2009). Although such studies in jails and detention centers are nearly nonexistent, a study by Fiscella, Moore, Engerman, and Meldrum (2004) found that of 500 jails contacted, with a 49% response rate, only 12% continued methadone during incarceration; and of those that detoxified inmates from methadone, only 2% used any opioid for detoxification.

Although medications for other disorders inmates are taking upon entering incarceration are usually continued with little problem, medication for substance use disorders are a different issue; these medical treatments are discontinued upon incarceration (Fiscella et al., 2004; Milloy & Wood, 2015).

Apart from the unpleasantness of withdrawal, there appear to be negative downstream ramifications of removing inmates who had been on methadone in the community from that medication upon incarceration. Rich et al. (2015) conducted a randomized study with inmates who were allowed to stay on methadone versus those who were removed from the medication. Those who were allowed to stay on methadone were twice as likely to reengage in community treatment as those who were forcibly removed. Magura et al. (1993) reported that those in an in-jail methadone maintenance program were more likely than controls to apply for methadone or other treatment after release, and to be retained in treatment, and that being in treatment was associated with lower drug use and crime.

To inform the practices of jails in treating individuals with opioid use disorders while incarcerated, we were contracted by the county administering the detention center to examine outcomes of those who were enrolled into a methadone maintenance program in the community and continued to receive methadone while in detention, compared with several groups that did not receive methadone while incarcerated. Using retrospective data we examined the recidivism (defined as rebooking into the same facility) rate for the subsequent year after release from this detention center. Four groups were compared: (a) a general population group that had no identifiable substance use disorders, (b) a methadone group composed of those maintained on methadone during incarceration (MMT), (c) an alcohol detoxification group, and (d) an opioid detoxification group. It is important to emphasize that methadone was not started in the detention center. Thus we compared whether a group given continuous methadone: starting on methadone in the community, continuing that methadone in the jail, and living in the community after release; demonstrated less recidivism compared to three other groups that did not receive methadone.

2. Material and methods

This study was reviewed and approved by the University of New Mexico Institutional Review Board.

2.1. Participants

Participants were not enrolled directly into the study, but their individually identified data were used. All 14,962 inmates released between July and December 2011 were eligible for the study from which we drew a sample of 960. This timeframe was chosen so that we could examine rebooking in the subsequent 12 months after release for each inmate. The group of interest was composed of those who had been enrolled into a community-based MMT program at the time of their booking into the detention center in the target interval ($n = 118$), and were continued on methadone while incarcerated. The 3 comparison groups were: (a) a group from the general inmate population ($n = 385$) who were not identified as having a substance use issue, (b) an alcohol detoxification group ($n = 220$), and (c) an opioid detoxification group ($n = 237$). The unequal numbers in each group occurred because the data collection timeframe was based on the relatively small MMT group. The MMT group was composed of all those in the MMT program who had been released in the July – December 2011 index period. Members of the other groups also were selected from all persons released in the index period generated from the detention center's electronic database. Because some individuals were released two or more times during the study period we took the first release to generate an unduplicated list of 14,962 released individuals over the 6 months of the "recruitment (sampling) phase. We randomly chose the study sample from this population of all 14,962 inmates. After determining the percentage of total releases that occurred each month we randomly selected (SPSS Statistics 20) an approximately 20% sample (which approximated reasonably well the percentage of the total releases that occurred each month) by month. This method was used to account for differences in the number of releases by month and resulted in a pool of 2952 people for the 6-month period from which each of the three comparison groups was collected. Each individual in the sample of 2952 released individuals was reviewed, and if the selection criteria were met for one of the comparison groups, the individual became a member of that group. We did not find as many drug/alcohol using clients as we thought we would. This was due partly to rigorous selection criteria where group criteria had to be unambiguously fulfilled. We had no problem collecting the general population group. Final group size was determined by the time it took to collect the MMT group. Recruitment stopped because we were running short of time to complete the contract.

2.2. Procedures

The detention center is administered by the county. All inmates who are booked into the facility are given a permanent, individual number so that any new bookings are referenced back to this number avoiding misidentifications. The county keeps an electronic record of all justice-related information in this database including arrests, reasons for arrest and so on. Health services were provided by a private contractor that conducted their own assessments, health care, and kept their own records separate from the detention center records except for the unique inmate number described above. The MMT program was administered by a local methadone-maintenance provider working under contract with the county. All inmates who received methadone in the detention center had to have been enrolled and active in a community-based methadone facility. No inmates were started on methadone while in the detention center. All inmates were encouraged and aided to return to their home methadone clinic after release from incarceration. Aid consisted of the in-jail methadone contractor contacting a care representative at the inmate's home clinic before release and making sure that clinic knew their patient was to be released. The number of MMT clinics in this city is not so large that providers do not know of each others' existence and they frequently know providers in those clinics.

All inmates who were booked into the jail were triaged by the health-care contractor after initial incarceration paperwork had been

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