Opioid Users Are Filling Jails. Why Don’t Jails Treat Them?

Getting methadone in jail gave a Connecticut heroin user a firmer foothold in recovery. But fewer than 1 percent of jails and prisons allow it.

By TIMOTHY WILLIAMS  AUG. 4, 2017

NEW HAVEN — When Dave Mason left jail in October 2015 after his 14th criminal conviction, the odds were good that he would soon end up dead.

A man with a longtime heroin addiction, Mr. Mason was entering one of the deadliest windows for jailed users returning to the streets: the first two weeks after release, when they often make the mistake of returning to a dose their body can no longer handle.

Standing outside the New Haven Correctional Center, clutching his few belongings in a brown paper bag, Mr. Mason appeared precariously close to taking that path. His ride never showed up. He had no money, no contact with his family and nowhere to live.

But instead of panhandling for cash to score drugs, he went to a methadone clinic, determined to stay clean.

Methadone was not a new thing for Mr. Mason, 43. He had been on it before he went to jail for cashing forged checks. But it is almost always banned in jail, increasing the chances of relapse. Of the nation’s 5,100 jails and prisons, fewer than 30 offer opioid users the most proven method of recovery: administering methadone or buprenorphine, according to the federal Bureau of Justice Assistance.
Mr. Mason, though, had been allowed to take his daily dose, in a fledgling program that helped him continue what he says has been his longest period off heroin since his teens.

“It is the key to my success,” he said. “It did what it was supposed to do. It kept me clean.”

For more than a year, the PBS series “Frontline” and The New York Times followed 10 newly released prisoners in Connecticut, including Mr. Mason, as they tried to start over. Though the stories were about the criminal justice system, they were also, inevitably, about addiction — three out of four inmates in Connecticut have a drug or alcohol problem, according to the Department of Correction, and the number who use opioids has soared.

For these 10, there were many setbacks, and what counted as success was modest. Mr. Mason met up with his girlfriend, Dani Herget, who at the time also used heroin; slept outdoors; panhandled for money; and used a wide variety of street drugs. Twice he was ordered into treatment, and once he was sent back to jail. Ultimately, he reunited with Ms. Herget, 21.

But despite his self-destructive tendencies, he says he stayed off heroin and has ultimately been able to moderate his use of other drugs.

Though limited in size, the methadone treatment program is one of numerous changes Connecticut has made to help inmates successfully re-enter society. But for most jails and prisons, such programs are out of the question. Much of the criminal justice system still takes a punitive approach to addiction. Many who work in corrections believe, incorrectly, that treatments like methadone, itself an opioid, allow inmates to get high and simply replace one addiction with another. And many officials say they have neither the money nor the mandate to provide the medications.

“The best way to not get addicted to opioids is to never use them,” said James M. Cummings, sheriff of Barnstable County in Massachusetts, who opposes methadone in jails despite a sharp rise in addiction and overdoses there.

But maintenance treatments like methadone, if uninterrupted, are proven to
reduce arrests and increase employment, and for many with addiction are the only thing that works. In July, a White House commission on opioid addiction called for increasing inmates’ access to addiction medication.

Dr. Kathleen Maurer, director of health services for Connecticut’s corrections department, said it was critical for jails and prisons to treat opioid addictions like chronic diseases, including providing medicine.

“We don’t take away people’s insulin or their asthma inhalers,” she said. “Why should we take away their methadone?”

In the New Haven jail, 35 inmates stand in line every day at 12:30 p.m. to drink the contents of a plastic cup containing a green, bitter fluid, followed by a swallow of a sweet orange drink to wash it down. A corrections officer shines a flashlight beam into their mouths as they leave the room to ensure they have nothing hidden there.

With this dose of methadone, individually calibrated to alleviate cravings without producing a high, these inmates have been spared the torment of detox — a painful process that includes diarrhea, insomnia, severe cramping and hallucinations. But more important, they have less danger of relapse.

Methadone and Suboxone, a combination of buprenorphine and naloxone, work by reducing cravings and preventing withdrawal symptoms. Because they activate opioid receptors in the brain, both drugs can cause a high in large enough doses. Suboxone is already commonly smuggled into lockups, whether to get inmates high or help them avoid withdrawal.

Though people do not die from opioid withdrawal, without proper care they can die from related effects like dehydration. There have been several such deaths, as well as dozens of overdose deaths, in jails in recent years.

Few studies have measured the outcomes of jail-based methadone treatment. But a 2001 study at Rikers Island, which started one of the country’s first jail-based methadone programs in 1987, found participants were less likely to commit new crimes and more likely to continue treatment. And a 2014 Australian study found
fewer overdose deaths after release.

In New Haven, Mr. Mason, who started injecting heroin at age 17, represents an unexpected success, officials say, given the length and severity of his addiction.

Tall and lean with missing front teeth and a limp, Mr. Mason avoids giving detailed answers to questions about his life and frequently contradicts himself. He is chronically homeless, and has become an expert in surviving on the street, subsisting for years by panhandling and theft. He knows where to go for free meals and where on the street to buy benzodiazepines to combat his anxiety. He has committed to memory the schedules of certain police officers who will arrest him at the slightest provocation.

He has been in jail more times than he remembers — for credit card theft, shoplifting and multiple probation violations, among other charges.

But he said being able to continue using methadone while in jail had helped convince him that it was time to try to change.

“Everybody has to hit a turning point where you can’t picture your life with or without drugs,” he said. “You’re at this spot. You know you can’t use anymore, but you don’t know how not to use anymore.”

Connecticut jails were not even allowed to dispense methadone in 2013, when Dr. Maurer, the prison medical director, saw a report that drug overdose deaths in the state had more than doubled over the previous six years. Forty percent of the victims were former inmates.

Dr. Maurer spent months helping persuade state lawmakers to change the law. Then she had to convince the warden.

Like many jail officials, Jose A. Feliciano Jr., the New Haven jail warden, was skeptical. “I thought, ‘That’s another substitute for heroin,’” he said.

But even he had been personally touched by the problem: Two of his relatives had been heroin addicts who died of AIDS. And one of his three children is
recovering from addiction.

“To say that’s something that didn’t influence me would be a lie,” he said. “Not until it impacts people close to you do you understand. It’s incredible how quickly it can overtake a person.”

Initially, Mr. Feliciano opposed the disruption that methadone handouts would surely cause. “But the more I talked to Dr. Maurer, the better I understood that it is an opportunity to let them live a clean life,” he said. “These individuals at some point in time are going to leave these walls. When people run out of drugs, they’re going to start stealing, committing crime.”

Officials say the treatment has shown promise in reducing fatalities and making inmates more likely to continue treatment once they are released, and Mr. Feliciano said the behavior of addicted inmates improved.

“I can tell you the climate around these people is better than it had been before,” Mr. Feliciano said.

But attitudes have not completely shifted, and methadone is still viewed as a privilege. Inmates can be kicked out of the program for any disciplinary infraction.

Karen Martucci, a spokeswoman for the Department of Correction, said the state had a responsibility to maintain order and enforce rules. “It’s also important to recognize that methadone has a contraband value in a correctional environment,” she said.

When Mr. Mason landed back in jail on a probation violation, he got in a fight and was rejected from the program, forcing him into methadone withdrawal, considered far more more agonizing than heroin withdrawal.

“It should be illegal,” he said. “They shouldn’t be able to put a dude through that.”

Severe budget shortfalls have limited the program to just two of the state’s 15 jails. It is open only to those who were already taking methadone when they were arrested.
And unlike Rhode Island and Vermont, which offer methadone and Suboxone, Connecticut offers only one option that may not work for everyone.

A growing number of jails, especially in rural areas, have opted to treat inmates not while they are in jail, but on the way out, giving them a one-time shot of a newer medication, Vivitrol, as they are released. Vivitrol, which unlike methadone and Suboxone is not a narcotic and has no street value, blocks opioid receptors in the brain, making getting high nearly impossible. It is far more expensive, and far less proven, than methadone and Suboxone, but its manufacturer often gives it to jails free. Its effect lasts about a month.

Even in Connecticut, inmates say, prejudices against methadone persist.

“The D.O.C. hates the methadone program,” a friend and jailmate of Mr. Mason’s said when they met on the street and compared notes. “They make fun of us and stuff. They’re like, ‘Oh, you junkies, go get your juice.’ Then they put all our names on the board so everybody in the dorm knows who’s on methadone.”

But for the first time in years, Mr. Mason has allowed himself to envision a future free of heroin — and along with it, the hustles and thefts necessary to support an addiction.

After his release — and over a period of several months — Mr. Mason painstakingly reduced his methadone intake to the point that he has been able to switch to the less powerful buprenorphine. The new medication, he said, allows him to think more clearly.

He has never held a steady job, and his days are often spent watching hours of television with Ms. Herget. He takes medication for severe anxiety and other mental health problems.

But he has begun to talk of finding work, saying he would like to become a drug counselor.

Sometimes, he expresses reservations about a relationship with another recovering addict.

“I just don’t want to be with a wife who shoots dope,” he said. “I’m a heroin
addict. It’ll take like that for me to fall in love with it again. And then, nothing else matters.”

But Ms. Herget’s pull on him is strong, and at other times, he speaks of marriage.

“I’m excited to live a decent life, be the man Dani needs and deserves,” he said. “I’m grateful to be there for my girlfriend. I can spare her 20 years of living hell.”

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