MEMORANDUM

FROM: **Leo Beletsky for the Health in Justice Action Lab, Northeastern University**
TO: **Academy for Justice and CCJ Task Force**
DATE: **August 18, 2019**
RE: **Treating Substance Use and Mental Health Disorders in Correctional Settings**

I. Background: Substance Use, Mental Health, and The Criminal Legal System

Accidental overdose is the leading cause of death for Americans under the age of 50—a veritable national public health emergency.[1] While this issue rightly captivates headlines and the attention of policymakers, fatal drug overdose is only the tip of an iceberg of a far deeper crisis in substance use, suicide, and mental health problems in the United States.

The criminal legal system[2] plays an outsized role in this crisis. An estimated 65% of the 2.3 million people in US prisons and jails have a diagnosable substance use disorder, more than seven times the background rate.[3] Nearly 15% of incarcerated men and 30% of women also have diagnosable mental health disorders.[4] There is broad recognition that, in the context of mass incarceration, correctional institutions act as the de-facto national substance use and mental health safety net. Correctional health efforts to address these health conditions often fall below the medically-accepted standards of care, however.

Using opioid use disorder (OUD) as a case study, this Memorandum examines key barriers and facilitators in aligning treatment behind bars with the best available evidence. It is beyond our scope, however, to address the role of the criminal legal system as a determinant in substance use and mental health outcomes among a large proportion of the U.S. population.[5] For many, this

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[1] U.S. Department of Health & Human Services, *HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis*, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES (Oct. 23, 2017), available at https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html.

[2] The "criminal legal system" consists of a continuum of stages of involvement, from initial police contact to pretrial detention, to incarceration, community supervision, and reentry. See Figure 1 in the Appendix (Intercepts 1-5).

[3] *Behind Bars II. Substance Abuse and America's Prison Population*, CENTER ON ADDICTION AND SUBSTANCE ABUSE (Feb. 2010), available at https://www.centeronaddiction.org/newsroom/press-releases/2010-behind-bars-II; Nearly 15% of men and 30% of women who are incarcerated also have diagnosable mental health disorders. *See Jailing People with Mental Illness,* CENTER ON ADDICTION & SUBSTANCE ABUSE (Feb. 2010), available at https://www.nami.org/learn-more/public-policy/jailing-people-with-mental-illness.

[4] *Id.*

[5] This system governs millions of lives beyond correctional settings: 70% of those classified as comprising the US "correctional population" are under community supervision (i.e. probation, parole, treatment courts, etc.), not behind bars. Even before arrest, many individuals' contact with law enforcement shapes risk behavior and service access outside of the formal control of this system: *see, e.g.,* Leo Beletsky et al., *Police encounters among needle exchange clients in Baltimore: drug law enforcement as a structural determinant of health,* 105 AJPH 1872-1879 (2015). Beyond the individual, this system also has indirect influence on the health status of families and communities.

system does not merely fail to adequately treat mental health and risky substance use—it actually drives the harm.[6]

II. Best Practices for Treating Substance Use and Mental Health in Correctional Settings

A. Conceptual Framework: Sequential Intercept Model

Each phase of involvement in the criminal legal system—from the point of crisis pre-arrest, through detention, and post-release—is an opportunity to address substance use disorder and mental health challenges. This means that criminal legal institutions must: (a) screen and diagnose; (b) treat; (c) monitor and support; and (d) triage individuals to appropriate health care and prevention services. The Sequential Intercept Model provides an apt conceptual framework for how key inflection points can help operationalize necessary health care along a five-phase continuum. With OUD as an illustration, Figure 1 in the Appendix maps out the applicability of this Model to substance use treatment and overdose prevention.[7] The Model can serve as a valuable tool for conceptualizing opportunities to better serve people experiencing any physical, behavioral, and mental health challenges in the criminal legal system.

B. Best Practices for Treatment Behind Bars: The Case of Opioid Agonist Therapy

When it comes to successful management of substance use disorder in correctional settings, where there is a will, there is a way. This is because much is already known about how to diagnose, initiate treatment, maintain care, and transition into the community upon re-entry in these settings. As an illustration, this section highlights the case of substance use treatment using opioid agonist therapy (OAT) within Rhode Island Department of Corrections (RIDOC).

The gold standard[8] medical treatment for OUD is maintaining patients on either methadone or buprenorphine. As opioids, these drugs work by reducing cravings, treating withdrawal symptoms, and stabilizing the patient. There is a third FDA-approved drug approved for OUD treatment: injectable extended-release naltrexone (brand name Vivitrol). Together, these three medications are dubbed medication-assisted treatment (MAT).[9] Whereas methadone and buprenorphine are

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[6] For those who come into contact with the criminal legal system, each stage of the process results in cascades of detriment, limiting access to housing, health care, employment, education, and civic participation.

[7] Lauren Brinkley-Rubinstein et al., *Criminal justice continuum for opioid users at risk of overdose*, 86 ADDICTIVE BEHAVIORS 104-110 (2018).

[8] U.S. Dep't of Health & Human Servs, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health 4–10 (2016), available at https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf; *See also* National Sheriffs' Association and National Commission on Correctional Health Care, Jail-based Medication-assisted Treatment: Promising Practices, Guidelines, and Resources for the Field, (Oct. 2018), available at https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.

[9] Calling OUD treatment "medication-assisted" is a misnomer, as medication *is* the treatment. Ancillary modalities, like counseling and group therapy—while helpful to some—have been shown in research to confer no additional benefit on the population level; see U.S. Dep't of Health & Human Servs, *supra note* 8. Some have reframed this acronym to signify "medication for addiction treatment."

opioid agonists because they activate relevant receptors, naltrexone blocks receptor activity and is therefore an antagonist. Since its launch as a treatment for OUD, Vivitrol has demonstrated far inferior overdose prevention and other health benefits compared to OAT.[10] Despite these findings, only Vivitrol had been made widely available in correctional systems.[11]

In the context of the current crisis, a significant proportion of those booked into correctional settings use opioids, either through prescription for pain or substance use treatment, or through the use of illicit drugs. Beyond rapid detox and limited programs for pregnant women, correctional institutions have barred opioid access to both medical and non-medical users. This means that even those presenting with existing prescriptions could not continue their medication regimen. Disruption in opioid use leads to acute withdrawal. While typically not deadly, there have been numerous fatalities inside correctional facilities directly linked to untreated withdrawal.[12] In absence of treatment behind bars, bridging to care in community settings, and lack of overdose education for those returning to the community, the risk of fatally overdosing upon re-entry is astronomical: 40 to 130 times higher than the general population.[13]

Based on successful protocols from Rikers Island jail[14] and numerous international settings, Rhode Island recently became the first jurisdiction to implement a state-wide model for treating OUD in its correctional system. Starting in July 2016, RIDOC began to screen all incarcerated individuals at its unified jail-prison facility, offering those who received a positive diagnosis one of three medications: methadone, buprenorphine, and Vivitrol.[15] Once an individual is stabilized and maintained on their medication, they continue to receive it for the duration of their sentence, and are bridged to prescribers in their community upon release. Pre-release planning also includes overdose education and naloxone distribution to prevent fatal re-entry.

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[10] Sarah Wakeman, *Comparing Medications to Treat Opioid Use Disorder*, Harvard Health Blog (Jan. 3, 2018) available at https://www.health.harvard.edu/blog/comparing-treat-opioid-use-disorder-2018010313021.

[11] Lev Facher, *Trump Opioid Plan Writes in Favoritism to Single Company's Addiction Medication*, STAT News, (Mar. 26, 2018) available at https://www.statnews.com/2018/03/26/trump-opioid-plan-alkermes-vivitrol/.

[12] Julia Lurie, *Go to Jail. Die From Drug Withdrawal. Welcome to the Criminal Justice System.*, Mother Jones, (Feb. 5, 2017) available at https://www.motherjones.com/politics/2017/02/opioid-withdrawal-jail-deaths/; *See also*, Zachary Siegel, *Pennsylvania Man Dies in Jail After Guards Allegedly Ignored his Opioid Withdrawal Symptoms*, The Appeal, (Feb. 5, 2018) available at https://theappeal.org/pennsylvania-man-dies-in-jail-after-guards-allegedly-ignored-his-opioid-withdrawal-symptoms.

[13] Binswanger, *supra* note 8; An Assessment of Opioid-Related Overdoses in Massachusetts 2011-2015, Mass. Dep't of Pub. Health (Aug. 2017), available at https://www.mass.gov/files/documents/2017/08/31/data-brief-chapter-55-aug-2017.pdf; *See also:* Leo Beletsky, et al, Fatal Re-Entry: Legal and Programmatic Opportunities to Curb Opioid Overdose among Individuals Newly Released from Incarceration, 7 NORTHEASTERN UNIVERSITY LAW JOURNAL 155 (2015).

[14] Christine Vestal, *At Rikers Island, a Legacy of Medication-Assisted Opioid Treatment*, Pew Charitable Trusts, (May 23, 2016) available at https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/05/23/at-rikers-island-a-legacy-of-medication-assisted-opioid-treatment.

[15] Traci Green et al., Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment In A Statewide Correctional System, JAMA Psychiatry (Apr. 1, 2018), available at https://www.ncbi.nlm.nih.gov/ pubmed/29450443. Very few patients in this program opted to receive Vivitrol.

The outcomes of RIDOC's science-based approach are impressive. For every 11 patients treated, researchers estimated they prevented one fatal overdose. A preliminary evaluation of the first year of the RIDOC program showed a 61% reduction in fatal re-entry.[16] Demonstrating the role of incarceration as a driver of population-level overdose risk, the corrections program contributed to an estimated 12.3% reduction in overdose for the entire state.[17]

III. Removing Barriers to Effective Substance Use Treatment in Correctional Settings

Rhode Island's treatment program is just one illustration of a correctional system successfully implementing a high-quality science-based treatment protocol. As with other substance use and mental health domains, however, there remains a significant gap between evidence and practice when it comes to addressing substance use and mental health in correctional settings. Nationwide, only a few dozen jails and prisons currently offer OAT maintenance.[18] The federal level lags furthest behind, with not a single facility in the Bureau of Prisons providing OAT maintenance (excepting very limited programs for pregnant women). This gap exists for many reasons; this section enumerates only the most significant barriers, along with key measures to address them (for a summary, see Table 1 in the Appendix). Beyond their relevance to OUD, these barriers suppress the quality of other addiction and mental health services across the Sequential Intercept continuum.

Attitudes constitute one major impediment. Corrections officials and the broader law enforcement community tend to hold sentiments reflective of general stigma and lack of understanding of OAT, including conflating dependence and addiction to opioids and conforming to their definitions of "sobriety."[19] Research shows that abstinence-based approaches to "treatment" lead to elevated rates of overdose and death post-release.[20] Changing the hearts and minds of correctional opinion leaders has been difficult, but recent state-level legislation,[21] litigation,[22] and other levers have begun to shift attitudes in a space where powers of persuasion have long failed.

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[16] Lurie, *supra* note 12.

[17] Accidental Overdose Deaths Occurring in Rhode Island by Month/Year, STATE OF RHODE ISLAND DEP'T OF HEALTH (Aug. 14, 2019), available at http://www.health.ri.gov/data/drugoverdoses/.

[18] Timothy Williams, *Opioid users are filling jails: Why don't we treat them?*, NEW YORK TIMES (Aug. 4, 2017) available at https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html.

[19] Substance Abuse and Mental Health Services Administration, *SAMHSA's Working Definition of Recovery*, SAMHSA (Feb. 2012), available at https://store.samhsa.gov/system/files/pep12-recdef.pdf.

[20] Legal Action Center, *Legality of denying access to medication assisted treatment in the criminal justice system*, LEGAL ACTION CENTER (2011) available at https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf; https://onlinelibrary.wiley.com/doi/full/10.1111/add.13193.

[21] Office of Governor Charlie Baker and Lt. Governor Karyn Polito, *Governor Baker Signs Second Major Piece of Legislation to Address Opioid Epidemic in Massachusetts*, COMMONWEALTH OF MASS. (Aug. 14, 2018), available at https://www.mass.gov/news/governor-baker-signs-second-major-piece-of-legislation-to-address-opioid-epidemic-in.

[22] JB Nicholas, *Drug Treatment is Reaching More Prisons and Jails*, THE APPEAL (Jul. 31, 2019), available at https://theappeal.org/a-shot-over-the-bow-to-all-jails-and-prisons/.

Another chief concern among decisionmakers is security and diversion, stemming from the current popularity of buprenorphine as a contraband drug in many institutions. These concerns are exaggerated and misconstrued, however, as evidenced by a quickly growing number of facilities offering methadone and buprenorphine in the US and abroad that have successfully established protocols for medication access without documented detriment to facility security environments.[23] Ultimately, providing appropriate medication to those who need it reduces the unmet demand for contraband in correctional settings, with the potential to improve—rather than worsen—safety and the occupational environment for correctional officers and other staff.[24]

Policies that restrict where and when these medications can be prescribed create additional roadblocks. Jails and prisons can only provide methadone if they formally register with the Drug Enforcement Administration (DEA). Many facilities lack the resources and desire to meet DEA's burdensome requirements for opioid treatment programs (OTPs). Similarly, prescribers must obtain an "X-waiver" from the DEA in order to prescribe buprenorphine; patient caps further limit prescriber ability to meet demand, especially in correctional settings.

Another key barrier is the cost of care and insurance coverage. Medicaid accounts for the majority of reimbursements for OAT costs and the vast majority of individuals in correctional settings are Medicaid-eligible. People inside correctional settings are not covered by Medicaid or Medicare because of the "inmate exception."[25] Absent federal financial participation, correctional OAT programs can supplement direct health budget appropriations with block grants and other external funds. The exception policy does not apply to coverage for people under community supervision.[26] It may be amenable to incremental reform through the 1115 Medicaid waiver process; ultimately, it should be repealed.[27]

Treatment access is also often lacking in the communities where people are returning post-incarceration. This is because too few providers are available to prescribe, lack of insurance

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[23] American Academy of Psychiatry and the Law, *AAPL Practice Resource for Prescribing in Corrections,* JAAPL (2018), available at http://jaapl.org/content/jaapl/46/2_Supplement/S2.full.pdf.

[24] "Increasing, not limiting, buprenorphine treatment may be an effective response to the diversion of buprenorphine." *Economic Impact Analysis of Implementation of the Provision of the Comprehensive Addiction and Recovery Act of 2016 Relating to the Dispensing of Narcotic Drugs for Opioid Use Disorder [Docket No. DEA-450],* DRUG ENFORCEMENT ADMINISTRATION & U.S. DEPARTMENT OF JUSTICE (Jan. 2018), available at https://docs.house.gov/meetings/IF/IF14/20180517/108343/HMKP-115-IF14-20180517-SD004.pdf.

[25] Kevin Fiscella, Sarah Wakeman, and Leo Beletsky. *The Inmate Exception and Reform of Correctional Health Care*, 107 *AJPH* 384 (2017); See also U.S. Department of Health & Human Services Centers for Medicare & Medicaid Services, *To facilitate successful re-entry for individuals transitioning from incarceration to their communities*, CMS (Apr. 28, 2016), available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf, for extensive description of federal regulations on FFS and eligibility for justice-involved individuals.

[26] The exception policy does not apply to coverage for people under community supervision. See, e.g. Arizona Health Care Cost Containment System Justice Ambulatory Project, available at https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/Justice_webpage.pdf; see also U.S. Department of Health & Human Services Centers for Medicare & Medicaid Services, *supra* note 23.

[27] *See* Office of Governor Charlie Baker, *supra* note 21.

coverage and other financial barriers, and regulatory and other hurdles to OAT provision. For instance, some jails had coordinated with mobile methadone units to meet returning individuals directly post-release to facilitate treatment initiation, but the DEA has imposed a moratorium on such mobile programs.[28] Without adequate treatment in the community, people receiving treatment inside have few options of staying on course upon their release; in absence of options, they may return to street drug use and experience heightened risk of overdose and death. Overdose education and naloxone distribution upon re-entry are critical to mitigating this risk.[29]

Even where there is access to treatment, the conditions of community supervision frequently bar returning individuals from accessing OAT and punish them for experiencing relapse.[30] This may be expressly through policies of parole boards, through practices of judges or community supervision staff, or through conditions imposed by transitional housing and other programs.[31] Reforming community supervision systems to play a supportive rather than punitive and coercive role can help facilitate recovery and avert negative outcomes, including death.

IV. North Star: From Harm Production to Harm Reduction

The Sequential Intercept Model is valuable for conceptualizing measures to address health and other issues among individuals in the criminal legal system. But this linear framework obscures the reality that system involvement is often cyclical. Untreated substance use and mental health challenges, poverty, barriers to employment and education, isolation, intrusive government surveillance, and racism are among the factors driving the cycle of vulnerability.

To stop this cycle, "off-ramps" must be built to divert individuals to supportive structures and services. This begins in the community—at Intercept 0—where measures like Law Enforcement Assisted Diversion (LEAD) and OAT can help avoid system involvement now and prevent it in the future.[32] Given the multiple cascades of harm, the ultimate goal must be to minimize system contact whenever possible.

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[28] Meredith Cohn & Andrea K. McDaniel, *Van Parked Outside of Baltimore Jail Offers Drug Treatment*, The Baltimore Sun, (Jan. 3, 2018) available at https://www.baltimoresun.com/health/bs-hs-addiction-treatment-van-20171212-story.html.

[29] Michael Curtis et al., *Acceptability of prison-based take-home naloxone programmes among a cohort of incarcerated men with a history of regular injecting drug use,* 15 HARM REDUCT. J. (2018).

[30] Brief on Behalf of the Massachusetts Medical Society et al. as Amici Curiae, *Eldred v Massachusetts*, 101 N.E.3d 911 (No. SJC-12279) (2017), available at http://www.massmed.org/advocacy/eldred-amicus-brief-final/ .

[31] Maria Cramer, *Legislators seek to bar judges from sending drug users who relapse to jail,* BOSTON GLOBE (Mar. 17, 2019), available at https://www.bostonglobe.com/metro/2019/03/17/legislators-seek-bar-judges-from-sending-drug-users-who-relapse-jail/qNWRWdvmYOL4ETfWBho0VM/story.html.

[32] U.S. Department of Justice National Institute of Corrections, *LEAD: Law Enforcement Assisted Diversion*, NIC (2015), available at https://nicic.gov/lead-law-enforcement-assisted-diversion; See also Susan E. Collins et al., *Seattle's Law Enforcement Assisted Diversion (LEAD): program effects on recidivism outcomes*, 64 EVAL. PROGRAM PLANN. 49-56 (2017). Instead of arresting people who use drugs, sex workers, and other marginalized people for minor offenses, LEAD connects them with case workers who assess their needs and link to services outside of the criminal legal system. A 2017 evaluation of the program found that

Off-ramps should never lead into a ditch, however. In most jurisdictions, policing and criminal legal budgets have long outpaced investment in community-based services. As a result, many communities lack adequate quality substance use and mental health treatment, affordable housing, meaningful employment, and other supportive mechanisms that can help avert contact with the criminal legal system.

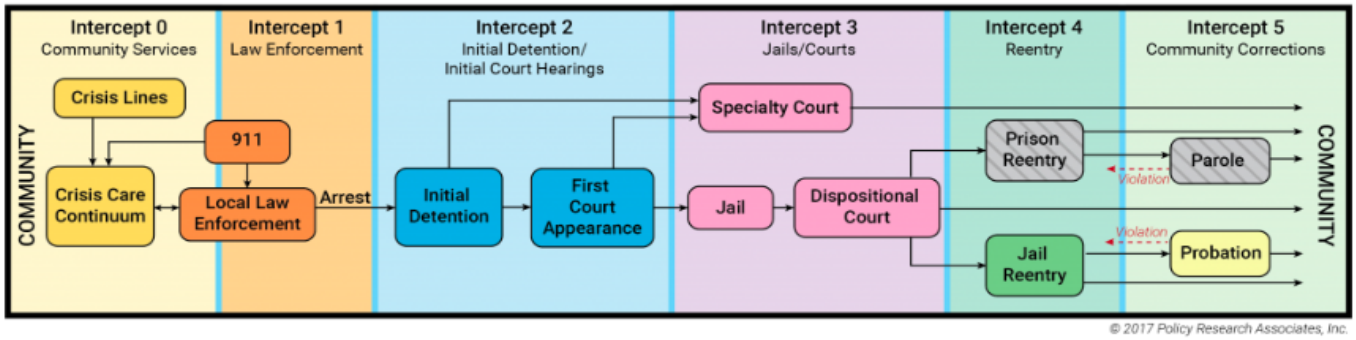
This has assured that the criminal legal sector is not just the safety net of last resort, but is the only governmental system many vulnerable people can reliably access. In the short term, urgent improvements to health and other services inside correctional and other criminal legal system components are needed to reduce their harm. Longer-term, investing in *bona fide* public health policies and measures of social support will help reduce the reliance on coercive and punitive systems to address the substance use and mental health crisis in our society.[33]

LEAD reduced recidivism rates by 60%, and that participants were less likely to be charged with a felony in the long-term. LEAD originated in Seattle, Washington in 2011 and has since been replicated in over two dozen cities across the country.

[33] Leo Beletsky, *America's Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis*, __UTAH LAW REVIEW__ (2019), available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3185180.

APPENDIX

Figure 1. Sequential Intercept Model Applied to Opioid Use Disorder



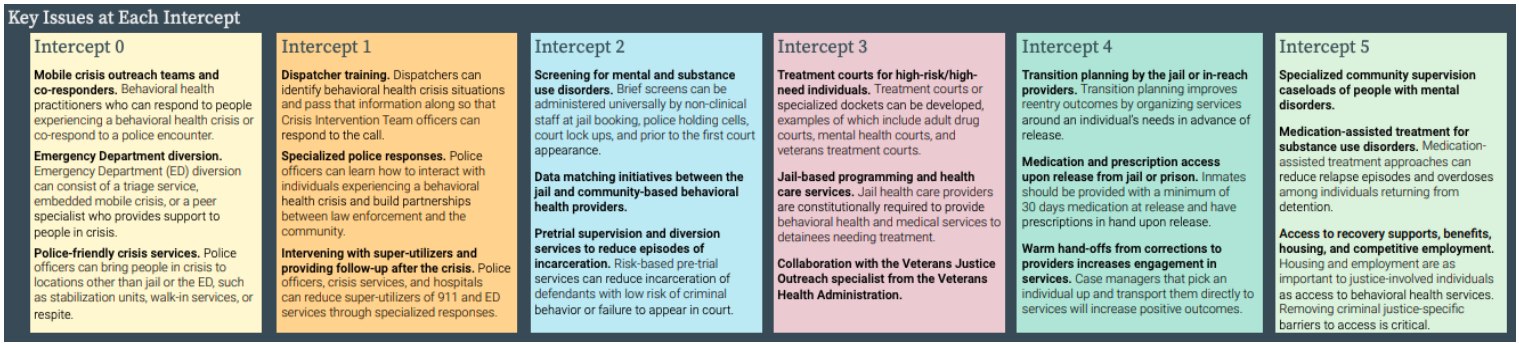


Figure 2. Barriers and Facilitators to OUD Treatment & Overdose Prevention Behind Bars

Issue	Barriers	Facilitators
Funding	• Limited appropriations • "Inmate exception" • Termination of coverage	• End the "inmate exception" • Suspension instead of termination • Pre-release insurance reinstatement • 1115 Waiver to allow back-billing
Security/ liability	• Diversion of buprenorphine • Misuse of buprenorphine • Naloxone's prescription status	• Adequate treatment access • Protocols from successful programs • Standing orders and OTC status for naloxone
Treatment capacity	• X waiver requirement • Regulation of OTPs • Moratorium on mobile methadone	• Support prescriber training • End the X Waiver • Ease regulation of OTPs • Administrative action to end moratorium on mobile methadone
Stigma	• Negative attitudes on OAT • Legislation, marketing favoring Vivitrol • Community supervision policies	• Training and detailing decisionmakers on OAT • Litigation using ADA and 8th Amendment • Legislation to require OAT behind bars • Consent decree provisions • Funding contingent on systems change