Criminal Justice Barriers to Treatment of Opioid Use Disorders in the United States: The Need for Public Health Advocacy

Expanding access to treatment of opioid use disorder (OUD) is central to addressing the US overdose mortality crisis.

Numerous barriers to OUD treatment are encountered in criminal justice institutions and processes, with which people with OUD are disproportionately involved. OUD treatment access is severely limited in US corrections facilities, with few exceptions. Drug treatment courts, which in principle provide court-supervised treatment as an alternative to prison, have also unduly limited treatment options, particularly medication-assisted treatment.

The voice and expertise of health professionals are urgently needed to remove these barriers and ensure that criminally accused persons are systematically linked to the care they need. (*Am J Public Health*. 2019;109:419–422. doi:10.2105/AJPH.2018.304852)

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In the midst of a declared public health emergency of opioid overdose mortality in the United States, there is a strong consensus among public health authorities and professionals that readily accessible treatment of opioid use disorder (OUD) must be central to the national response. Receiving adequate treatment of OUD in criminal justice institutions is often impossible, which is a matter of grave concern because people with OUD are disproportionately likely to be involved with the criminal justice system.[1] Moreover, those in the criminal justice system are likely to suffer more severe OUD than others living with the disorder.[1] National priorities for expanding treatment, such as the Department of Health and Human Services' plan,[2] do not always include attention to the criminal justice system. The voice and expertise of health professionals are urgently needed in policy considerations of this matter.

In the United States, people convicted of nonviolent, minor drug infractions, including simple possession, can face lengthy prison sentences and sometimes extended pretrial detention. National survey data from 2015 to 2016 indicated that more than half of people with OUD linked to prescription opioids reported some involvement with the criminal justice system.[1] As of 2016, there were an estimated 81 900 persons in federal prison for drug-related offenses (47% of the federal prison population) and 197 200 in state prisons (about 15% of the state prison population).[3] In addition, an estimated 171 000 persons were in municipal or county jails for drug-related offenses, including pretrial detainees.[4] There are no recent estimates of the proportion of these persons who suffer from OUD. A government survey from 2007 to 2009 concluded that 58% of people in state prisons and 63% of sentenced persons in jail had some substance use disorder.[5] At that time, 16.6% of state prisoners and 18.9% of sentenced persons in jail identified themselves as regular users of heroin or other opioids. There is little reason to think that these figures are lower in 2018.

The current policy environment is not favorable to major diversion away from custodial sentences for people accused or convicted of drug crimes, even if they suffer from OUD. In the second Obama term, the Department of Justice made efforts to eliminate mandatory minimum prison sentences for minor drug offenses in the federal system.[6] The federal FIRST STEP Act (H.R. 5682) passed in late 2018 offers limited reduction of mandatory sentences for certain federal drug offenses, but it does not apply to state laws, under which the large majority of drug convictions in the US are made.[7] A number of US states continue to incarcerate people for nonviolent drug offenses at a high rate in spite of evidence that incarceration is not associated with lower incidence of drug-related crime.[8]

It has long been understood that the period immediately following release from prison is a moment of especially high risk of overdose.[9] Forced abstinence or near abstinence during incarceration may diminish physiological tolerance to opioids, making overdose risk acute upon reexposure after release. Although provision of medication-assisted treatment (MAT) during incarceration and link to treatment after release can reduce this risk, these services are rarely available in the United States.[10]

TREATMENT ISSUES

Indeed, the prospects for receiving any treatment of OUD in federal or state prisons or local jails in the United States are

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generally poor. Federal prisons may offer methadone for detoxification, but as a matter of policy they offer methadone as MAT only to pregnant women.[11] They do not offer buprenorphine treatment at all. In 2018, the president called for routine screening of federal prisoners for OUD and for linking those who need it to treatment, but only with naltrexone upon release; there was not a call for expansion of other treatment choices in the criminal justice system.[12] Treatment options in the state prison systems are variable and partial. Only one state (Rhode Island) offers methadone, buprenorphine, and naltrexone to prisoners; one state (Hawaii) offers methadone and buprenorphine; in 16 states, at least some prisons or jails offer naltrexone only, and then often with restrictions as to population (e.g., pregnant women only) or only at the time of release.[13]

The failure to provide MAT to people in the custody of the state does not accord with international standards and guidelines. UN member states have long agreed to the principle that people in prison and pretrial detention have the right to the same range of health services as those offered in the community.[14] The World Health Organization (WHO) recommends MAT in detention settings explicitly as an overdose prevention measure.[15] WHO and the UN Office on Drugs and Crime also recommend that governments do everything possible to ensure that OUD is managed outside the criminal justice system by making maximal use of alternatives to incarceration that facilitate access to treatment, as allowed by law.[16]

Methadone and buprenorphine maintenance therapy, administered orally daily, are established evidence-based therapies for treating OUD. Naltrexone, especially in the extended-release form (XR-NTX), is often preferred among criminal justice decision-makers in the United States, although the clinical evidence for its effectiveness for people with OUD is weaker than for methadone and buprenorphine. One reason for this preference is that naltrexone, an opioid antagonist, has no addictive potential and is unlikely to be diverted to nonmedical use.[17] In 2018, a randomized controlled study comparing XR-NTX with buprenorphine found that patients had greater difficulty initiating XR-NTX than buprenorphine, causing many to relapse.[18] Those who were able to overcome induction problems, however, had 24-week treatment outcomes that were similar to those of patients receiving buprenorphine. There are no long-term clinical trials or observational studies that evaluate and compare the two drugs as treatment options.

Subject matter experts and stakeholders and at least one US senator have expressed concern about the marketing of XR-NTX directly to criminal justice officials, bypassing medical professionals, especially in ways that undermine more established therapies. In 2017, Senator Kamala Harris (D, CA) asked Alkermes, the manufacturer of the brand-name XR-NTX Vivitrol, for details of the marketing efforts that Harris said had led Vivitrol sales to increase from $30 million in 2011 to $209 million in 2016.[19] Noting that Alkermes had spent millions on federal lobbying for Vivitrol, Senator Harris warned that the marginalization of "cheaper and more thoroughly studied treatments" would mean that the national response would be shaped more by the lobbying capacity of industry than by medical science.[19] Vivitrol, which is administered by injection once a month at a retail cost of about $1300 to $1400 per injection,[20] is far more expensive than methadone and buprenorphine.

Harris' letter followed a 2017 open letter signed by 700 medical experts on a similar topic to the then secretary of health and human services, Tom Price.[21] Price had publicly promoted Vivitrol by name and dismissed methadone and buprenorphine as representing just another form of addiction.[22] The open letter noted the large body of evidence on the effectiveness of methadone and buprenorphine and the danger of stigmatizing those established treatments, which have helped millions of people.

DRUG TREATMENT COURTS: PART OF THE SOLUTION?

Not all people with OUD who are involved with the criminal justice system go to prison, or at least not directly. Drug treatment courts (or "drug courts"), usually county or municipal bodies, are meant to offer court-supervised treatment as an alternative to incarceration for cases where drug dependence is deemed to be an underlying determinant of the drug offense. They are supported by the federal government, as well as many state and local governments, and are seen as part of the response to the opioid crisis.[12] As of mid-2018, there were over 3100 drug courts in the 50 states.[23] Rather than the usual adversarial—defense versus prosecution—process of regular courts, drug courts offer programs "generally managed by a multidisciplinary team including judges, prosecutors, defense attorneys, community corrections officers, social workers and treatment service professionals."[23] These special courts should in principle be a mechanism for allowing someone accused of a drug offense to avoid prison and its limited treatment options in favor of a clinically sound treatment program overseen by the court.

In practice, the record of the drug courts in ensuring access to evidence-based OUD treatment has been mixed. A 2013 survey of 103 drug courts in 47 states found that although virtually all of the courts had participants judged to be living with OUD, only 47% said that MAT was available to those participants.[24] Fifty-two percent said that they did not allow methadone as an option for court-supervised treatment as a matter of rules of the court, and 49% said it was not offered for lack of methadone providers in the area. With respect to buprenorphine, 40% of respondents said the court did not permit it and 41% cited the lack of local providers. In 2017, a study by Physicians for Human Rights found that drug courts in three states relied on persons not trained in medicine for diagnosis of OUD and that some judges determined treatment plans without consulting medical professionals.[25] In an earlier study in New York State, treatment providers bemoaned the tendency of some drug court judges to reject MAT out of hand because they saw it as "another form of addiction."[26] In addition, it has been found that in a number of courts, people who are judged to have "failed" treatment are punished by incarceration, which is unlikely to improve access to treatment.[25,27]

Concerned about the denial of MAT in drug courts, the

Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015 announced that federal grant support would not be available to drug courts that deny MAT to "any appropriate and eligible client."[28] SAMHSA also said that drug courts could use up to 20% of this grant support to purchase MAT medicines for clients unable to pay for them. Because many drug courts receive considerable state, county, and municipal funding, the impact of this measure is not clear. It is also not clear whether the federal government will allow drug courts to meet MAT standards by offering XR-NTX only.

A number of US cities have adopted Law Enforcement Assisted Diversion (LEAD), a program that offers people accused of drug infractions a diversion from prosecution that, unlike drug courts, is managed outside the justice system. Though not explicitly crafted as an alternative to drug courts, LEAD may be seen in that perspective. Pioneered in Seattle, Washington, the LEAD program enables police who encounter drug infractions to divert the accused person to "community-based, trauma-informed care systems," recognizing that drug infractions may be "driven by unmet behavioral health needs."[29] The services that are offered can help people address unstable housing, untreated mental illness, and other determinants of poverty and exclusion. Unlike drug courts, LEAD does not require people to enter a guilty plea for the infraction in question; they are not automatically arraigned. Seattle's LEAD was run as a randomized pilot for the first years to enable comparisons between those diverted to LEAD services and controls managed normally in the criminal justice system. LEAD participants were 58% less likely than were controls to be arrested several years after entering the program.[30] In an 18-month follow-up, they were more likely to be in stable housing and have regular employment.[31] As of July 2018, LEAD programs were operational or on the verge of being launched in 30 cities in 17 states.[29] Other cities are exploring the program for the future.

CONCLUSIONS

Many people with OUD will continue to be involved with the criminal justice system in the United States, whether in corrections facilities, on probation or parole, or in drug courts. Criminal justice involvement is a barrier to treatment of OUD in that prisons, jails, and pretrial detention facilities rarely offer any—let alone the optimal—treatments, and many drug courts limit MAT.

Medical and health professionals have the expertise and credibility that position them well as advocates for measures that would reduce impediments to OUD treatment in the criminal justice system. In particular, their advocacy voice is needed toward the following objectives:

- Ensuring that health policymakers and practitioners in state, county, and municipal corrections agencies have access to training, information, and support to enable them to introduce at least the range of OUD treatments that are available in the general population.
- Improving access to all proven forms of OUD treatment through drug courts, including ensuring that there are adequate numbers of MAT providers for drug courts who can work with drug court staff to ensure that treatment options and plans are implemented with the approval of medical personnel.
- Ensuring that promotion and use of XR-NTX do not undermine access to methadone and buprenorphine in drug courts or other treatment settings.
- Reducing prison sentences and use of pretrial detention for minor, nonviolent drug offenses.
- Exploring the LEAD program and other efforts to link criminally accused people with OUD systematically to the health and social services they need.

All of these measures would contribute to reducing important barriers to OUD treatment and thus to reducing the risk of overdose mortality. None is likely to be achieved without strong and authoritative public health advocacy. AJPH

CONFLICTS OF INTEREST
There are no conflicts of interest.

REFERENCES

1. Winkelman TNA, Chang VW, Binswanger IA. Health, polysubstance use, and criminal justice involvement among adults with varying levels of opioid use. *JAMA Netw Open*. 2018;1(3):e180558.

2. US Dept of Health and Human Services. HHS response: 5-point strategy—better prevention, treatment & recovery services. Available at: https://www.hhs.gov/opioids/about-the-epidemic/hhs-response/better-access/index.html. Accessed June 23, 2018.

3. Carson EA. *Prisoners in 2016*. Washington, DC: Bureau of Justice Statistics; 2018.

4. Sentencing Project. Fact sheet: trends in US corrections. Washington, DC. 2018. Available at: https://sentencingproject.org/wp-content/uploads/2016/01/Trends-in-US-Corrections.pdf. Accessed June 27, 2018.

5. Bronson J, Stroop J, Zimmer S, Berzofsky M. *Drug Use, Dependence and Abuse Among State Prisoners and Jail Inmates, 2007–2009*. Washington, DC: US Dept of Justice, Bureau of Justice Statistics; 2011.

6. US Dept of Justice. In Milestone for Sentencing Reform, Attorney General Holder announces record reduction in mandatory minimums against nonviolent drug offenders [media statement]. February 17, 2015. Available at: https://www.justice.gov/opa/pr/milestone-sentencing-reform-attorney-general-holder-announces-record-reduction-mandatory. Accessed June 28, 2018.

7. H.R. 5682 — 115th Congress: Formerly Incarcerated Reenter Society Transformed, Safely Transitioning Every Person (FIRST STEP) Act, 2018. 2018. Available at: https://www.govtrack.us/congress/bills/115/hr5682. Accessed January 22, 2019.

8. Pew Charitable Trusts. More imprisonment does not reduce state drug problems [brief]. Available at: http://www.pewtrusts.org/-/media/assets/2018/03/pspp_more_imprisonment_does_not_reduce_state_drug_problems.pdf. Accessed June 28, 2018.

9. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157–165.

10. Green TC, Clarke J, Brinkley-Rubinstein L, et al. Postincarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system. *JAMA Psychiatry*. 2018;75(4):405–407.

11. US Federal Bureau of Prisons. Detoxification of chemically dependent inmates: clinical guidance. 2014. Available at: https://www.bop.gov/resources/pdfs/detoxification.pdf. Accessed June 25, 2018.

12. White House. President Donald J. Trump's initiative to stop opioid abuse and reduce drug supply and demand [fact sheet]. Available at: https://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-initiative-stop-opioid-abuse-reduce-drug-supply-demand. Accessed June 25, 2018.

13. Lopez G. How America's prisons are fueling the opioid epidemic. *Vox*. March 26, 2018. Available at: https://www.vox.com/policy-and-politics/2018/3/13/17020002/prison-opioid-epidemic-medications-addiction. Accessed June 25, 2018.

14. UN General Assembly. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), doc. no. A/C.3/70/L.3, 2015. Available at: http://www.refworld.org/docid/56209cd14.html. Accessed September 4, 2018.

15. World Health Organization Regional Office for Europe. Preventing overdose deaths in the criminal-justice system (updated version). 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf?ua=1. Accessed October 4, 2018.

16. World Health Organization, UN Office on Drugs and Crime. Treatment and care for people with drug use disorders in contact with the criminal justice system: alternatives to conviction or punishment (pre-launch version). Available at: https://www.unodc.org/documents/UNODC_WHO_Alternatives_to_Conviction_or_Punishment_2018.pdf. Accessed October 4, 2018.

17. US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration. Naltrexone [online fact sheet]. Available at: https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone. Accessed July 1, 2018.

18. Lee JD, Nunes EV, Novo P, et al. Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial. *Lancet* 2018;391(10118):309–318.

19. Harris K (US Senator). Letter to R. Pops, CEO of Alkermes (Waltham, MA). November 6, 2017. Available at: https://www.harris.senate.gov/imo/media/doc/Letter_to_Alkermes.pdf. Accessed June 25, 2018.

20. GoodRx. Vivitrol [online price guide]. Available at: https://www.goodrx.com/vivitrol. Accessed July 1, 2018.

21. Abraham AJ, Acker CJ, Adelman-Mullally T, et al. Open letter to Health and Human Services Secretary Tom Price. May 17, 2017. Available at: https://www.documentcloud.org/documents/3723472-Tom-Price-Letter-Re-MAT.html. Accessed June 27, 2018.

22. Valverde M. What HHS Secretary Tom Price said about opioid addiction treatment. *PolitiFact*. May 26, 2017. Available at: http://www.politifact.com/georgia/article/2017/may/26/what-hhs-secretary-tom-price-said-about-opioid-add. Accessed June 27, 2018.

23. US Dept of Justice, Office of Justice Programs. Drug courts. May 2018. Available at: https://www.ncjrs.gov/pdffiles1/nij/238527.pdf. Accessed June 27, 2018.

24. Matusow H, Dickman SL, Rich JD, et al. Medication assisted treatment in US drug courts: results from a nationwide survey of availability, barriers and attitudes. *J Subst Abuse Treat*. 2013;44(5):473–480.

25. *Neither Justice Nor Treatment: Drug Courts in the United States*. New York, NY: Physicians for Human Rights; 2017.

26. Csete J, Catania H. Methadone treatment providers' views of drug court policy and practice: a case study of New York State. *Harm Reduct J*. 2013;10(1):35.

27. Sevigny EL, Fuleihan BK, Ferdik FV. Do drug courts reduce the use of incarceration? A meta-analysis. *J Crim Justice*. 2013;41(6):416–425.

28. US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration. Grants to expand substance abuse treatment capacity in adult and family drug courts. RFA no. TI-15-002. 2015. Available at: https://www.samhsa.gov/sites/default/files/grants/pdf/ti-15-002.pdf. Accessed June 28, 2018.

29. Law Enforcement Assisted Diversion (LEAD) National Support Bureau. LEAD: advancing criminal justice reform in 2018. Available at: https://www.leadbureau.org. Accessed July 1, 2018.

30. Collins SE, Lonczak HS, Clifasefi SL. Seattle's Law Enforcement Assisted Diversion (LEAD): program effects on recidivism outcomes. *Eval Program Plann*. 2017;64:49–56.

31. Clifasefi SL, Lonczak HS, Collins SE. Seattle's Law Enforcement Assisted Diversion (LEAD) Program: within-subjects changes on housing, employment, and income/benefits outcomes and associations with recidivism. *Crime Delinq*. 2017;63(4):429–445.