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COVID-19 highlights the pitfalls of reliance on the carceral system as a response to addiction

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ABSTRACT

People who are incarcerated are likely to meet criteria for at least one substance use disorder and need access to treatment. Access to such interventions was limited prior to the COVID-19 pandemic and has almost certainly been restricted further due to implementation of procedures intended to stop the spread of the virus. In this brief commentary, we discuss how COVID-19 has revealed the already tenuous access that people who are incarcerated have to behavioral health services, and the pitfalls of reliance on the U.S. carceral system as a response to addiction.

1. Introduction

The United States incarcerates more of its citizens than any other country in the world. There are approximately 746,000 people in jails and more than 1.2 million in prisons (Sawyer & Wagner, 2020).[1] System-level behaviors and policies determine who is ultimately incarcerated (e.g., policing and enforcement; what is criminalized and how severely; Wildeman & Wang, 2017). Racial/ethnic minorities—especially Black men—are disproportionately incarcerated, as are people with substance use disorders and most other mental illnesses (Fazel et al., 2017). Once incarcerated, people are wholly reliant on these facilities for their health care needs, including substance use treatment.

In this COVID-19 special section commentary, we review the intersecting epidemics of mass incarceration and addiction, and how the pandemic has highlighted the pitfalls of reliance on the carceral system as a response to addiction. We also briefly share our experiences as volunteer service providers[2] in Arkansas' state prison system—which has had recent and nationally unprecedented growth in incarceration—to support this assertion. Throughout, we highlight dual realities: the urgent need for mass decarceration and the urgent need for substance use treatment providers to bring their expertise to carceral systems.

2. Mass incarceration and addiction as intersecting epidemics

The Bureau of Justice Statistics estimates that 58% of people in prison and 63% of people in jail meet diagnostic criteria for a substance use disorder (Bronson et al., 2017), and more than 85% of incarcerated people are substance-involved (CASA, 2010).Yet access to substance use

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[1] For unfamiliar readers, jails house people who have been arrested and are awaiting trial, sentencing, or completion of brief sentences. Prisons house people post-conviction and for longer periods.

[2] The first author (MZ) is a licensed clinical psychologist who has provided various therapy groups for people with substance use disorders in Arkansas' prisons as a volunteer since 2014. She has supervised provision of trauma-focused services within a regional drug treatment court since 2016, and served on the board of directors for one of Arkansas' reentry centers for women from 2018 to 2020. She directs the Health and the Legal System (HEALS) Lab at the University of Arkansas for Medical Sciences, which focuses on the intersections among trauma, mental illness, addiction, and the legal system. She is the recipient of a NIDA-funded Career Development Award focused on identifying factors that affect implementation of evidence-based practices in prisons and the effectiveness of interventions for traumatic stress sequelae, like drug addiction, in these settings. The second two authors (KH, CB) were advanced doctoral student trainees who co-led the services described in the commentary with MZ at the time that this manuscript was written, including efforts to adapt services to the COVID-19 pandemic.

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treatment in carceral settings is limited in the best of times (Belenko & Peugh, 2005; Taxman et al., 2007). About 11% of incarcerated people receive services such as counseling or medication, with addiction-focused peer support (23%) and education (14%) slightly more common (CASA, 2010). Less than 1% of jails and prisons provide medication-assisted treatment (Vestal, 2018), despite that it reduces risk of post-release opioid use by 78% (Moore et al., 2019). The result is that people with substance use disorders leaving incarceration have significantly higher mortality (Chang et al., 2015) and die from opioid overdoses at a rate that is 40 times that of their peers in the two weeks postrelease (Ranapurwala et al., 2018).

3. Carceral settings as COVID-19 epicenters

Since the onset of the COVID-19 pandemic, an already poor situation has gotten worse. Incarcerated people with substance use disorders have high rates of medical comorbidities that elevate risk for COVID-19 mortality and morbidity (Mukherjee & El-Bassel, 2020). Typical confinement conditions and overcrowding impede or prohibit infection control procedures (Barnert et al., 2020; Henry, 2020) and, as of this writing, 43 of the 50 largest clusters in the U.S. were within prisons and jails (The New York Times, 2020).

Many experts—including public health professionals, public defenders, and government officials—have advocated for mass decarceration to effectively curb the spread of the virus nationally (Howell et al., 2020; Ransom & Feuer, 2020; Rich et al., 2020). Individual states, counties, and courts have varied widely in their responses to such calls, from very little change in most state prison systems to some jails having reduced their population by up to 50% (Prison Policy Initiative, 2020). In Arkansas, we have seen similar variability. Our regional jail has reduced their census to a level not seen since 2005,[3] but our state prison system has expedited releases for comparably few.

4. Invisible costs of COVID-19 in carceral settings: implications for addiction treatment

Policies intended to limit the spread of COVID-19 will likely worsen other aspects of health and limit already tenuous access to substance use services for people who remain incarcerated. For example, to reduce the spread of COVID-19 through carceral systems, facilities have eliminated facility access for all but essential staff. Because some combination of facility staff, contracted providers, external volunteers, and/or peers in recovery (Taxman et al., 2007) offer recovery programming, substance use education and treatment almost certainly decreased early in the pandemic. Additionally, many facilities are isolating people within single cells or barracks, effectively suspending internally facilitated group substance use treatment indefinitely.[4]

Research should assess how the severity of restrictions has affected substance use treatment access and the impact of increased isolation due to the pandemic; here, we offer our experiences as a lived example. Our university-based team had been offering multiple therapeutic groups in one prison as volunteers each Friday for nearly three years. Since the pandemic hit, we have had to cease services completely. Our weeks of attempts to transition to televideo failed due to a combination of factors, including inadequate prison staffing support and new quarantine procedures that limited movement within the facility. Even with strong leadership support for innovative ways to continue services, we could not overcome barriers that the facility put in place to manage an outbreak in an institutional setting.

5. Conclusions

While the pandemic is an extreme example of factors that can interrupt addiction treatment in carceral settings, it is not the exception. COVID-19 has simply highlighted the tenuous access that people who are incarcerated have to behavioral health services, and the pitfalls of reliance on the carceral system as a response to addiction. At the same time, substance use treatment providers need to engage with carceral systems now, more than ever, to avoid seeing rates of postrelease overdose and death continue to rise.

This is a unique moment in history for (re)considering our national policies on crime and punishment. It is also a moment that can be leveraged for the public good if those with the power to change systems take the opportunity to do so.

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CRediT authorship contribution statement

MZ conceived of the paper and created an initial outline. MZ, KH, and CB together wrote a preliminary draft during a collaborative writing session, after which MZ took a lead role in refining/revising. All authors contributed to manuscript revisions.

Declaration of competing interest

None.

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[3] Approximately 400 people less than maximum capacity, which is typically reached (Pulaski County Sheriff's Office, 2020).

[4] Notably, in some states that are moving to decarcerate, a lack of access to treatment services is the very thing that is preventing early releases because people are unable to meet the conditions required to be eligible (Widra & Sawyer, 2020).

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