# No Missed Opportunities: Criminal Justice Interventions in our National Response to Addiction

October 4, 2018 | Jessica Hulsey Nickel

**Substance use disorders impact every community in the United States.** Every day, nearly 200 Americans die from a drug overdose. Our first responders, law enforcement and criminal justice personnel are increasingly at the center of this issue—from being first at the scene of an overdose to responding to the lack of resources and limited treatment options for individuals with substance use disorders who are in our jails and criminal justice systems.

About 63 percent of people in jail, 58 percent of people in state prison, and 45 percent of people in federal prison have substance use disorders, compared to just 5 percent of the U.S. adult population.[1] And we know that law enforcement and probation see an increasing number of individuals struggling with addiction. With limited services and early detection tools within criminal justice, we miss the opportunity to stop the progression of the disease. Contact with the justice system can provide leverage to overcome the resistance to seeking treatment that is often a symptom of the disease of addiction.

## Early Intervention

Substance use disorders are progressive—the earlier someone starts treatment the better their chances of long-term recovery. By setting up systems to identify people who are struggling with substance use problems and intervening before their problems escalate, law enforcement represents a critical intervention point in reducing both the financial costs and the human suffering that come with substance use disorders.

The current scope of the opioid epidemic and escalation of associated addiction needs nationwide makes it imperative that the criminal justice system reevaluate their response to substance use disorders. New investments and resources should focus on early points of intervention to help prevent individuals with substance use disorders from penetrating deeper into the criminal justice system. “Intercepting” them, a well-established practice in the mental health field, could be easily applied to populations struggling with substance use disorder.

We have an opportunity to align systemic practices with the needs of people who come in contact with the justice system. Interventions for people with treatment needs at points further in the justice system process have been well discussed and articulated. However, diversion decisions that are made during their initial contact with law enforcement and prosecution are less publicized and visible. But it is at these points in the process that we have the greatest opportunity to intervene and direct individuals with a substance use disorder into treatment, which holds the potential for greatly improved treatment outcomes.

In short, we can ‘arrest’ the disease at arrest, directing individuals to the appropriate treatment before the disease and collateral health, social and criminal justice consequences worsen.

## The Sequential Intercept Model for Addiction

The Sequential Intercept Model was developed by Mark R. Munetz, M.D., and Patricia A. Griffin, Ph.D., along with Henry J. Steadman, Ph.D., to provide "a workable framework for collaboration between criminal justice and treatment systems to systematically address and reduce the criminalization of people with mental illness." The model identifies "points of interception," or "opportunities for an intervention" where people with mental illness can be diverted from entering or prevented from penetrating further into the criminal justice system. Ideally, most people will be intercepted at early intervention points, leading to decreasing numbers at each subsequent point.

The points of intercept are:

1. Arrest, including law enforcement and emergency services,
2. Initial detention and hearings,
3. Jail, courts, forensic evaluations and forensic commitments,
4. Reentry from jails, state prisons and forensic hospitalization, and
5. Community corrections and support.

Intercept zero--"Community Services"--was added to the model in 2016 and is designed to connect people in need of treatment with resources before a behavioral crisis begins or at the earliest possible stage of system interaction. Intercept zero includes mobile crisis outreach teams, Emergency Department diversion and police response strategies.[2]

The model also identifies the "ultimate intercept"—a robust and accessible mental health treatment system that prevents an individual's initial engagement with the criminal justice system.

Similarly, a comprehensive strategy for addressing addiction can be realized by implementing: screening, criminal justice diversion policies, medication assisted treatment (MAT) and other treatment programs, and evidence-based programs at each intercept point.

Using a subway line as an analogy, the earliest stops are the initial points of intervention. Getting help for those who are struggling with substance use and preventing them from entering or further penetrating the criminal justice system requires training and resources at the earliest point of contact. Front-loading resources helps to ensure that the number of passengers (or intercepts made) decreases as the subway progresses along the line, diverting people from the criminal justice system into community treatment, improving individual outcomes, and reducing the myriad costs that come with addiction.

## Innovations

To expand the accordion a bit and dive into each specific criminal justice component of this subway system, what follows are innovative initiatives within the criminal justice system that utilize the leverage of engagement in the system to connect individuals to treatment for SUD.

### Law Enforcement Diversion –

### STEER Program, Montgomery County, Md.

The STEER (**Stop, Triage, Engage, Educate and Rehabilitate**) program in Montgomery County, Md., provides rapid identification and access to treatment for individuals with substance use disorders who are encountered by law enforcement.

STEER's goal is to direct people in need of substance abuse treatment away from jail to an intervention program. Police officers use a screening tool to assess whether a person is a candidate for this deflection program.

Charges can be held in abeyance while the person is seeking services and, if no criminal charges are present, the individual can still be referred to STEER in a prevention contact. The citizen is offered a chance for treatment and help instead of entering into the criminal justice system.

Chief Tom Manger with the Montgomery County Police Department has been an important element of the program's success, along with key program partners that include the State's Attorney, Public Defender, corrections, Human Services and local treatment providers.

As of November 2016, STEER had deflected 133 individuals and has now become part of standard police protocol options for responding to people with substance use disorders. Of the 157 people referred to STEER, as of February 2017, 66 (42%) were assessed and 37 of those assessed (56%) agreed to participate in treatment.

**Law Enforcement Overdose Reversal Response -**

**Arlington Opiate Outreach Initiative, Arlington, Mass.**

The Arlington Massachusetts Police Department began tracking opioid-related overdoses and deaths in 2013 and quickly recognized a growing problem. Working in conjunction with the community, the Arlington Police Department implemented the **Arlington Opiate Outreach Initiative** (AOOI) to prevent multiple overdoses and break the cycle of addiction. The program uses seven steps to tackle the lifecycle of substance use disorders from early stages to recovery and relapse prevention, including:

1) Target most at risk;

2) Widen access to naloxone;

3) Create a partnering relationship with those most at risk;

4) Educate the public;

5) Treatment access;

6) Prevent relapses; and

7) Remove surplus of opiate medications.

Rebecca Wolfe, a Jail Diversion Clinician for AOOI, explains: "This is our attempt to provide a comprehensive police-based response to the opiate epidemic."

Since 2013, AOOI has held over 15 community meetings and events in Arlington, training over 50 people in the community on the use of naloxone. Through this program, over 90 people have been sent to the hospital for treatment and an AOOI clinician has connected with over 56 overdose victims and their families. AOOI has also collected and disposed of over 96,000 unused prescription drugs from the community.

This comprehensive plan is making headway in stemming the tide of opioid overdoses in Arlington. It demonstrates how programs can expand training to reverse overdoses and provide follow-up support after an overdose reversal to use that incident as an access to care opportunity.

**Prosecution -**

**District Attorney's Drug Diversion Program, Essex County, Ma.**

The Essex County **District Attorney's Drug Diversion Program** is a program for young adult, non-violent

offenders with substance use issues. This program seeks to reduce drug misuse and improve public safety by offering treatment rather than prosecute people charged with low-level drug-related offenses. With funding support from the state, the Essex County District Attorney's Office has partnered with a local treatment provider in order to deliver wrap-around services to program participants.

Eligible participants are screened by the District Attorney's Office staff both pre- and post arraignment. Once a person is referred to the program, a Clinical Intake and Assessment Coordinator conducts an intake interview at the courthouse, which involves identifying the individual's immediate safety needs and may include referral to a medical detox program, emergency psychiatric evaluation, an intensive outpatient program, or a residential treatment program. The Intake Coordinator may also help address other emergent issues, such as homelessness or an unsafe home life. Following the initial intake, the case is assigned to a Clinical Case Manager, who will contact the participant the same day and schedule a case management session within a week. The Clinical Case Manager serves as the liaison among the participant, treatment providers, and the District Attorney's Office, and oversees implementation of the participant's individual treatment plan. Based on the individual's unique needs, the Case Manager may help him/her enroll for MassHealth, identify a primary care physician, secure services through the Department of Transitional Assistance, access job placement services, and connect with other supportive services that could contribute to the participant's stability and encourage recovery.

If a participant successfully complies with the program for at least six months, then the District Attorney's Office will either decline to prosecute, if the participant was referred pre-arraignment, or file to dismiss the charges, if the participant was referred post-arraignment.  The Clinical Case Manager will make recommendations and referrals to meet a participant's anticipated needs for the six months following Diversion. Community-based services, delivered by the same treatment provider, are always available to former participants should they need additional support after leaving the program.

This program was launched in 2007 by Essex County District Attorney Jonathan Blodgett with assistance from former Massachusetts State Sen. Steven Tolman, in response to a spike in heroin and prescription drug misuse. The Drug Diversion Program is modeled on another, well-established program in the county, which focuses on diversion of juveniles and youthful offenders. Program coordinators were able to leverage the experiences of staff who worked on the existing program to build and implement something new.

Program administrators report that about 60% of participants successfully complete the program, meaning that they finish their treatment program and remain drug-free so that the charges against them are dismissed.

## Courts -

### Opioid Crisis Intervention Court, Buffalo, NY.

Sentencing options available to judges often include treatment-based alternatives to incarceration, and sometimes alternatives to conviction. This includes problem-solving courts like drug courts. There are over 3,000 drug courts in the United States. Drug courts are specialized dockets for those with substance use disorders. These courts typically provide screening and assessments as well as treatment and wrap-around services. These programs have been shown to reduce recidivism rates and drug use, saving thousands of dollars per participant. Recently court-based interventions have expanded to include evidence-based responses to non-fatal overdoses and supervision of individuals with opioid use disorder specifically.

The nation's first opioid court in Buffalo, New York, has gained national attention as a promising model for communities looking for solutions to the opioid crisis. The court partners with local nonprofits to offer treatment for people who might not otherwise be able to afford it.

After going through 30 days of inpatient treatment and detoxification, participants engage in 30 days of outpatient treatment. During that portion of the program, participants are channeled into wrap-around services, including one-on-one and group counseling, and must appear in court daily. The program includes random, regular drug

testing as well as a nightly curfew. Unlike typical drug courts, in which defendants are punished if they relapse, Buffalo's model recognizes setbacks as a part of the recovery process. Upon completion of the program, which generally entails participants going 60 days without using drugs, criminal charges are likely to be reduced or dropped.

The program employs a rapid-response-model — meaning that those who are eligible and willing to participate undergo an immediate assessment and are referred to treatment within hours.

**Jail -**

**Kenton County Detention Center's Jail Substance Abuse Program, Covington, Ky.**

In 2016, Kentucky was identified by the Centers for Disease Control and Prevention (CDC) as the state fifth-hardest hit by the opioid crisis. Kenton County is one of many state regions starved for adequate resources to combat the crisis and provide treatment for those struggling with a substance use disorder. Mirroring the national trend, there has been a significant increase in the percentage of people admitted to the Kentucky Department of Corrections who report having used heroin in the 12 months prior to incarceration.

**Kenton County Detention Center's Jail Substance Abuse Program** (JSAP) provides treatment for residents struggling with substance use disorders and facilitates their transition into community-based care. The program aims to expand and improve substance use disorder treatment pre- and post-release, decrease drug overdose morbidity and mortality, and reduce recidivism related to substance use and relapse. Kenton County employs a multi-faceted biopsychosocial approach to treatment that combines medication; cognitive and behavioral therapies; therapeutic, community living environments; as well as referral to community-based providers upon release.

The program began as a pilot in 2015 with 70 men who had a substance use disorder. Jason Merrick, MSW, CADC, director of inmate addiction services at the detention center, launched the pilot based on a program he created with Terry Carl, the Kenton County Jailer who conducted extensive research on similar programs in corrections departments throughout the state.

When the pilot at Kenton County Detention Center proved a success, Merrick worked to expand the program within the detention center and sought sustained funding. This was secured in 2016, when legislation passed allowing state tax dollars to be spent on JSAP for county inmates.

The Kenton County Detention Center is licensed by the state as a residential Alcohol and Other Drug Entity (AODE), with a client capacity of 125 (providing for about 90 men and 35 women). Programming includes a diverse array of therapies as well as education, 12-Step programs and life-skills training. While the majority of participants in the JSAP program engage voluntarily, some are court-ordered to attend or referred by the state. All participants are assessed for program eligibility by trained staff upon entry. The program operates at full capacity but can accommodate interested parties within 10 to 14 days.

Medications are used in conjunction with cognitive and behavioral therapy for detoxification, stabilization and maintenance. These services are specialized for pregnant women. Once participants with an opioid use disorder have completed 30 days of therapeutic programming, they can volunteer to receive injectable naltrexone (Vivitrol®), an antagonist medication that helps to prevent relapse. Residents who qualify are educated about the medication and given their first two injections 60 days before being discharged. Prior to their release, participants are connected with a clinician who helps them enroll in Medicaid and connects them with a community provider to ensure continuity of treatment. Upon release from the detention center, participants are often taken to the community provider for an intake evaluation.

"A brick and mortar inpatient treatment facility is going to cost millions, maybe even tens of millions of dollars to build, and we already have that. We have the beds, we have the food—it's a state-of-the-art facility and everyone

is here being taken care of. All we had to do was plug in these social services. It was a no-brainer and an easy fit. The entire jail staff is determined to change the way we view and respond to addiction," explains Merrick.

In 2016, a Kentucky Department of Corrections study of JSAP participants from Kentucky jails, prisons and community corrections facilities who were interviewed 12 months post-release found:

- 56.0% had not been re-incarcerated.
- 82.3% were living in stable housing.
- 66.9% were employed.
- 78.2% reported providing financial support to their children.
- 56.6% did not use any illicit substances in the year since release.
- 73.4% attended 12-Step meetings.

Treatment participants noted positives about JSAP participation, including...

- 83.2% felt better about themselves as a result of treatment.
- 80.0% received services they needed to get better.
- 79.4% considered the treatment program to be successful.

Cost offset analysis indicated that...

- For every $1 spent on Kentucky corrections-based substance abuse treatment there is a $4.52 cost offset.[3]

## Prison -

## Pennsylvania's Medication Assisted Treatment (MAT) Pilot Program

Pennsylvania's Medication Assisted Treatment (MAT) Pilot Program For Justice-Involved Individuals is a program focused on achieving better outcomes for individuals experiencing substance use issues who are reentering society following a period of incarceration within a Pennsylvania Department of Corrections (PA DOC) facility. PA DOC and Secretary John Wetzel take seriously their responsibility for addressing the barriers to their inmates' success post-incarceration. This means addressing the fact that about 2/3 of individuals entering PA DOC custody have a substance use problem that unless decisively addressed during incarceration, would likely contribute to future involvement with the criminal justice system.

PA DOC decided to try a different approach to keeping incarcerated individuals sober and away from drugs. For other diseases, such as diabetes, medication is a normal part of treatment. Medication assists people in becoming and staying healthy, but for some reason medication had not been translated into an approach at DOC for the treatment of those with the disease of addiction. It took the step of recognizing at the system level that addiction is a disease, not a crime, and that its traditional approach to addressing alcohol and drug addiction was not sufficient. Medication-assisted treatment is considered the gold standard of care for opioid use disorders and has been shown to decrease the risk of relapse and increase the likelihood that an individual will remain engaged in treatment. There are three FDA-approved medications for treating opioid use disorder—methadone, buprenorphine, and naltrexone.

Recognizing this gap led to the creation of the Medication Assisted Treatment (MAT) reentry pilot program at PA DOC's SCI-Muncy facility. Prior to leaving prison or confinement, PA DOC provided Vivitrol injections to a pilot cadre of female reentrants at the SCI-Muncy facility who were returning to Allegheny,Dauphin or Philadelphia counties. This was followed up post-reentry with both a monthly shot and cognitive behavioral therapy to reduce likelihood that they would lapse back into substance misuse. Researchers from Penn State University critically evaluated the initiative and were able to give the recommendation that PA DOC could expand the program to males at additional selected facilities across the state. Those sites were ultimately chosen based on data from the

PA Physician General.

To implement the program, PA DOC relied on social workers at each SCI and Regional Office of Community Corrections who interacted with drug and alcohol staff inside the SCIs, medical staff and community corrections staff. Social workers also served as the link to external stakeholders, such as staff at the PA Board of Probation and Parole (PBPP), treatment providers and other associated service providers.

PA DOC is working closely with Correct Care Solutions (CCS), which currently provides health care to the system, to establish the expansion of MAT beyond the initial pilot group. Approval will require further coordination with the Pennsylvania Department of Drug and Alcohol Programs (DDAP) Division of Drug and Alcohol Program Licensure, the U.S. Drug Enforcement Agency (DEA) and the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

Additionally, PA DOC hired a statewide coordinator of MAT services through the PA DOC Bureau of Treatment Services (BTS). The coordinator provides TA and training to site coordinators (such as social workers) and also liaises with Bureau of Community Corrections (BCC), PBPP points of contact, Single County Authorities (SCAs) and treatment and other service providers.

There is no national consensus on how best to provide MAT inside corrections facilities from a clinical perspective. As such, staff in the field, at treatment facilities and those at Community Contract Facilities (CCFs) expressed varying levels of support for MAT in general. For example, staff at treatment facilities, many of whom found recovery from their own addiction through abstinence, strongly favored that model instead of MAT. In addition, individuals who received MAT were sharply criticized by the 12-step community. These examples suggest that securing broader buy-in of MAT is a challenge that will need to be addressed continuously and differently for different members of the stakeholder community.

Some obstacles that remain to be overcome include educating individuals and their families about the dangers of substance use and its role in causing people to become justice-involved in the first place. Once individuals are incarcerated, education is also required to continue to promote MAT as a positive method by which to achieve better outcomes for individuals once they are released.

Ultimately, PADOC views MAT as a "tool in the toolbox," a potent one that can be used to help people successfully reintegrate into society – especially during the important first post-incarceration year – without the anchor of addiction.

## Conclusion

The current opioid crisis has elevated national conversations around addiction and spurred much-needed reforms throughout the myriad systems that deal with individuals with substance use disorders first-hand. This moment in time can feel harrowing—but for those of us working tirelessly to sustainably curb the tide of the crisis through systemic change, it also provides a unique opportunity to re-envision how addiction can and should be addressed.  Criminal justice systems play a critical role in this, particularly when we focus on early interventions and real diversion to treatment and services.

[1] Jennifer Bronson, Jessica Stroop, Stephanie Zimmer & Marcus Berzofsky, *Drug Use, Dependence, And Abuse Among State Prisoners And Jail Inmates, 2007-2009,* Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice (2017), http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5966.

[2] *The Sequential Intercept Model Brochure,* Policy Research Associates (2017), https://www.prainc.com/wp-content/uploads/2017/08/SIM-Brochure-Redesign0824.pdf

[3] Staton-Tindall, M., McNees Winston, E. (2016). Criminal Justice Kentucky Treatment Outcome Study (CJKTOS) FY16 Report. http://cdar.uky.edu/cjktos/Downloads/CJKTOS_FY2016_Final%20Report.pdf

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