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The Effects of the Opioid Epidemic on the Reentry Population

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Introduction

Opiates have long ravaged our nation and state. Opiate addiction deeply cuts into the lives of unwitting individuals of all races and genders. The disease of addiction does not discriminate in who it takes under its complete control. The majority of deaths in New Jersey in the past few years has been due to opiates. There is a direct correlation between recidivism and opiate addiction. It is the goal of this writing to highlight the relationship between the criminal justice system and opiate addiction. There have been measures taken in other states that have proven their worth in battling the opioid epidemic within the criminal justice community. Ultimately, if these measures are applied in New Jersey there will be a dramatic decrease in the number of opioid-related deaths, as well as recidivism.

The reentry population, those who were at once incarcerated, is the population most afflicted by the opioid epidemic. Naturally, this group is the most controlled and easily managed out of every demographic directly suffering from the opioid epidemic due to the constant supervision both in and out of incarceration. A Substance Use Disorder (SUD) is a medical condition in which the use of a substance negatively impacts the ability of an individual to live a healthy and productive life. The pervasiveness of SUDs among those incarcerated is high. Studies estimate that approximately 3/4 of those in New Jersey state prisons suffer from SUDs, and roughly 1/4 of those in state prisons suffer from Opioid Use Disorder. If that substance is an opioid and it similarly, negatively impacts one's life, then the associated condition is referred to as Opioid Use Disorder (OUD) by healthcare providers.[1]Moreover, studies say that the prevalence of SUDs and OUD is similar—if not higher—among the local jail population.[2]

[1] "Mental Health and Substance Use Disorders." Substance Abuse and Mental Health Services Administration (SAMHSA), April 13, 2019. https://www.samhsa.gov/find-help/disorders.
[2] Rich, J. & Satel, S. "Access to Maintenance Medications for Opioid Addiction is Expanding." Slate. 8 May 2018

The link between those suffering from OUD and involvement in the criminal justice system is clearly interrelated. According to the 2018 National Survey on Drug Use and Health, those with OUD were up to 13 times more likely to have criminal justice involvement than those without OUD.[3] The Center on Addiction conducted a 2010 study in which it was found that 65% of all inmates in the United States met the criteria for a Substance Use Disorder diagnosis.[4] According to the New Jersey Department of Health, between 70-80% of those who are incarcerated have Substance Use Disorder (SUD), and 80% of inmates in New Jersey, with SUD were under the influence when they committed their crime; and 75% of inmates with opioid-use disorder relapse within three months of release. [5] These studies suggest that drug use, more specifically, opioid use and recidivism are strongly correlated. More importantly, they imply that if we combat OUD by getting those who are addicted the help that they need and deserve, recidivism should decrease along with the staggering overdose mortality rate.

Background

Opioids have long been a part of American history. Friederich Serturner, a German chemist and pharmacist, endeavored on isolating the alkaloid component from the opium poppy plant in order to provide a new and powerful pain reliever. Eventually he succeeded and dubbed his new discovery, "Morphine." Morphine, and opiates alike, found its first purpose treating the wounded soldiers on the battlefields of the Revolutionary and the Civil Wars. Doctors were impressed with the fast-acting success that opiates had in relieving pain. In 1890, "opiates were sold in an unregulated medical marketplace" and in 1895, approximately 1 in every 200 Americans were

[3] https://www.npr.org/sections/health-shots/2018/07/06/626176621/with-more-opioid-use-people-are-more-likely-to-get-caught-up-in-the-justice-syst
[4] https://www.centeronaddiction.org/newsroom/press-releases/2010-behind-bars-II
[5] https://nj.gov/health/news/2018/approved/20180806a.shtml

addicted to some form of opiate. In 1898 Bayer Pharmaceuticals released its brand of opiate medication under the name "Heroin."[6]

Meanwhile, immigrants from China opened opium smoking parlors across the United States. These parlors thrived from 1870 to 1910, the year that America recognized this disconcerting and problematic trend. The first steps were to educate doctors and pass regulatory laws. In 1914, the United States, along with 33 other nations, participated in the International Opium Commission, which sought to limit the production and importation of opium.[7] In the same year, the Harrison Narcotics Tax Act was passed which imposed a special tax on the sale of opium and its derivatives.[8] The Act also required that those selling opium and its derivatives to register with the federal government as such.

The Harrison Narcotics Tax Act was ultimately replaced in 1961 when the United States decided to participate in the United Nations Single Convention on Narcotic Drugs, a treaty amongst nations setting out to prohibit the worldwide "manufacturing, importation, possession, use and distribution of opioids and other substances."[9] In 1970, President Richard Nixon signed into law the Controlled Substances Act with the ambitious goal of regulating all prescription medication, as well as the flow of illegal drugs. In 1973, the Drug Enforcement Agency was formed and charged with the duty of enforcing drug laws and closely monitoring the chain of custody of prescription medication.

Though there was a very public repression of illegal drugs, the criminal justice system had attempted to specifically address drug users and suppliers. In 1935, the United States opened up

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[6] Erick Trickey, Inside the Story of Americas 19th-Century Opiate Addiction Smithsonian.com (2018), https://www.smithsonianmag.com/history/inside-story-americas-19th-century-opiate-addiction-180967673/ (last visited May 8, 2020).
[7] Nelson, Harry/ Presley, Lisa Marie (FRW), The United States of Opioids: a Prescription for Liberating a Nation in Pain (2019).
[8] Ibid.
[9] Ibid.

the first "drug prison" in Lexington, Kentucky. The Federal Medical Center and became the "ultimate destination for any and all drug addicts for the first half of the 20th century". In the 1920s, approximately half of all convicts were convicted of drug related offenses. Today, the number of prisoners in the United States suffering from SUD is closer to 65%.[10]

Today, approximately 19,000 individuals are incarcerated in a New Jersey State prison and 15,000 individuals are incarcerated in a county or local jail.[11] This means that of the 34,000 inmates currently incarcerated, at least 23,800 are diagnosed with or can be diagnosed with Substance Use Disorder. Approximately, one-quarter of this population is diagnosed with Opioid Use Disorder (OUD).[12] In addition, recently released individuals are more than 129 times more likely to overdose within the first two weeks of their release than that of the general population.

The opioid epidemic is by far the most prevalent internal threat to our state and country. With the death rate accelerating at an alarming speed, State Departments of Health across the nation are left baffled at the thought of a solution. Between 2016 and 2017, New Jersey experienced nearly a 30% rise in overdose deaths (one of the five highest increases in the nation).[13] In 2018, the number of overdose deaths in New Jersey climbed to over 3,100.[14] The flood of synthetic opioids into the drug supply is believed to be a key driver in the rising rates of overdose

[10] Clary Estes, The Narcotic Farm And The Little Known History America's First Prison For Drug Addicts Forbes (2019), https://www.forbes.com/sites/claryestes/2019/11/18/the-narcotic-farm-and-the-little-known-history-americas-first-prison-for-drug-addicts/#73861f7f7b3b (last visited May 2, 2020).
[11] https://www.prisonpolicy.org/graphs/correctional_control2018/NJ_incarceration_2018.html
[12] Rich, J. & Satel, S. "Access to Maintenance Medications for Opioid Addiction is Expanding." Slate. 8 May 2018.
[13] "New Jersey Opioid Summary." National Institute on Drug Abuse (NIDA), May 22, 2019. https://www.drugabuse.gov/opioid-summaries-by-state/new-jersey-opioid-summary.
[14] 2018 NJ Suspected Drug Overdose Deaths. NJ Cares. Department of Law and Public Safety. https://www.njcares.gov/pdfs/2018-NJ-Suspected-Overdose-Deaths-01.14.19.pdf

deaths, with deaths from fentanyl in New Jersey exceeding the national average in recent years.[15][16] The death rate can be partly ascribed to the introduction of fentanyl and carfentanil.

The need for systemic change grows as fast as the opioid death toll. One of the major issues is that access to Medication Assisted Treatment (MAT), such as buprenorphine, naltrexone, etc., is proving to be more difficult in the state of New Jersey than most states in America. Another substantial obstacle is the revocation of Medicaid for all incarcerated individuals. When released, formerly incarcerated individuals are usually released with no health insurance, which makes it exceedingly difficult for them to participate in any MAT, inpatient, and/or outpatient services. Thus a cycle of crime and drug abuse forms for most of those addicted after incarceration as they do not have access to these programs. These individuals will likely obtain their drug of choice through any means possible, even criminal.

The recently released and incarcerated population can greatly benefit from simple, systemic changes. Not only is change needed, but a concurrent and collaborative effort from law enforcement and healthcare professionals is required. It is the purpose of this article to address the major conflicts affecting the reentry population, show model solutions to those conflicts, and recommend solutions to our own problems in New Jersey. Recidivism and crime are closely related to opioid use and therefore will also be positively affected by the implementation of certain solutions. If we can address these barriers, the opioid epidemic in New Jersey will be significantly defaced and overdose rates will decelerate, as we have seen in those states that have already implemented solutions.

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[15] New Jersey Fentanyl Death Statistics. Queried from CDC Wonder API. Data reported as Underlying Cause of Death, ICD-10 codes: X40-X44, X60-X64, X85, Y10-Y14; and Multiple Cause of Death, ICD-10 codes T40.4. https://www.livestories.com/statistics/new-jersey/fentanyl-deaths-mortality.

[16] Curtis, Kaya, Forkey, Katie, Reynolds, Will. 3 Waves of the Rise in Opioid Overdose Deaths. New Jersey Opioid Addiction Report: A Modern Plague. 2018; 9. Accessed November 13, 2018. http://njreentry.org/wp-content/uploads/2018/09/Published_9_24.pdf.

Medication-Assisted Treatment

Issue

Medication-Assisted Therapy (MAT) is a method of Pharmacotherapy. Pharmacotherapy refers to the introduction of new drugs to a patient in order to combat the patient's addiction to opioids, a promising and worthy opponent to the opioid epidemic. Currently, there are three medications approved by the Food and Drug Administration: methadone, buprenorphine and naloxone combined with naltrexone. This is an evidence-based solution to opioid addiction. These medications can affect the brain in two ways: they can activate the same receptors in the brain that opiates do and be absorbed into the bloodstream after a period of time, or they block the same receptors, so that if the person uses opiates, they will not feel the desired effects.[17] Medication-Assisted Treatment has become the "gold standard" in OUD treatment.[18]

However, access to MAT is difficult for the reentry population due to obstacles such as not having insurance. An investigative report by The New York Times found that fewer than 31 out of the over 5,100 prisons and jails in the country offer these medicines to inmates.[19] For those who are sporadically identified as having OUD, only two state prisons--Mid-State (for men) and Edna Mahan (for women)—and few local jails offer MAT. Even in the prisons and jails that do offer MAT, the ability to provide it is limited by the failure to screen and treat co-occurring conditions, such as hepatitis, that could complicate the medical treatment of OUD. Officials currently estimate

[17] Kate Sheridan et al., How effective is medication-assisted treatment for addiction? STAT (2017), https://www.statnews.com/2017/05/15/medication-assisted-treatment-what-we-know/ (last visited May 4, 2020).
[18] Medications for Addiction Treatment (MAT); https://www.shatterproof.org/treatment/MAT
[19] Williams, Timothy. "Opioid Users Are Filling Jails. Why Don't Jails Treat Them?" The New York Times. The New York Times, August 4, 2017. https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html.

that less than 800 out of 1900 individuals currently incarcerated are on MAT (likely over 25% of whom have OUD and nearly 75% of whom have some form of SUD).[20]

Not providing MAT to those suffering from OUD can result in death. Victoria Herr, an individual diagnosed with OUD, was arrested in 2015 when police found drugs in her vicinity after raiding her boyfriend's apartment. She admitted to the intake staff at the Lebanon County Correctional Facility that she used at least ten bags of heroin a day and feared the withdrawal process. While awaiting her court date, her withdrawal symptoms began on March 27 and she was brought to the medical unit where she was given adult diapers, Ensure protein shakes and water. She was not given any Medication-Assisted Treatment and died several days later from dehydration.[21] Had she been given any form of Medication-Assisted Treatment, her symptoms of vomiting and diarrhea would have been curtailed and fluids may have been retained. Though this is an extreme case, thousands upon thousands of inmate's experience symptoms just like Ms. Herr's every day and are without the help of Medication-Assisted Treatment.

Model Solutions

The Rhode Island Department of Corrections (RIDOC) contracted with CODAC Behavioral Healthcare --the state's largest and oldest nonprofit outpatient treatment provider for OUD—to screen individuals for OUD upon incarceration, provide evidence-based interventions,

[20] Lilo H. Stainton, "State Expands Addiction Treatment for Prisoners," NJ Spotlight, last modified August 9, 2018, https://www.njspotlight.com/stories/18/08/08/state-expands-addiction-treatment-for-prisoners/.
[21]https://www.usnews.com/news/healthiest-communities/articles/2018-10-24/county-pays-nearly-5m-over-heroin-withdrawal-death-in-jail

and ensure continued treatment upon release.[22] They had to develop a dependable way to provide MAT to those incarcerated and upon their release, which included access to all three FDA approved medications. A study by Greene and colleagues published in the Journal of the American Medical Association finding a 60.5% decrease in the risk of opioid overdose death upon release as a result of these implementations.[23] Rhode Island is amongst few others that is perceived as a formidable opponent to the opioid epidemic.

In Massachusetts, officials launched a Medication Assisted Treatment program in Franklin County Jail where an estimated 40% of the 220 inmates suffered from OUD.[24] Franklin County experienced a 35% decrease in opioid overdose deaths since the inception of the MAT program. It is the only county in Massachusetts that offers MAT to inmates and has experienced a decrease in deaths due to opioids.[25]

In California, officials in Sacramento County launched a pilot program in the county jail to help combat the negative effect opioids were having in their county. Inmates were able to receive a naltrexone injection five weeks prior to their release and then once again one week prior to their release.[26] The effects of this injection block the effects of opioids for approximately 30 days, as well as subside cravings and withdrawal symptoms. Three weeks after release, a reentry officer must ensure that the individual has an appointment to receive his or her third shot of naltrexone in the community.[27] The reentry officer continues to check in with the individual and confirms that he or she can receive additional shots of naltrexone every month for up to six months post-release.

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[22] Howard, Lauranne. "Substance Abuse Treatment Services." State of Rhode Island: Department of Corrections. Accessed August 16, 2019. http://www.doc.ri.gov/rehabilitative/health/behavioral_substance.php.
[23] 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. doi:10.1001/jamapsychiatry.2017.4614
[24] Philip Marcelo, "Jails, prisons slowly loosen resistance to addiction meds," Associated Press, last modified August 7, 2018, https://www.apnews.com/c594ad1b9a3a4dcd8b3bcf30bc1a4157.
[25] Ibid.
[26] "Jail-Based Medication-Assisted," [Pages 7-24].
[27] Ibid.

Based on the outcomes of the initial pilot project, the initiative was expanded and made available to all eligible individuals in Sacramento County Jail.[28]

Recommendation

New Jersey can build on the momentum of President Trump at the federal level to implement a public health approach to the problem, using the funds that have been made available to them through recent landmark pieces of legislation, including the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act.[29] New Jersey was recently awarded $7,433,765.00 by the federal government for their efforts in the fight against the opioid epidemic.[30] This money should be able to cover the expense of providing Medication Assisted Treatment to those who are incarcerated and diagnosed with Opioid Use Disorder. Medication Assisted Treatment being introduced pre-release has been shown, in states such as Rhode Island and Massachusetts, to improve the likelihood of recovery sustainability post-release.

Funding has been provided to the New Jersey Department of Corrections to guarantee that every inmate with OUD can receive this treatment. However, corrections officials are experiencing a "paradigm shift" in the treatment of incarcerated individuals.[31] Some New Jersey jails and prisons may have the resources to implement a MAT, but wardens and top officials still have bias and misinformation about the positive effects of this treatment. Furthermore, not every jail and prison have addiction screening services, therefore it is unknown who can benefit from this treatment.[32]

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[28] Ibid.
[29] Bonamici & Suzanne, H.R.34 - 114th Congress (2015-2016): 21st Century Cures Act Congress.gov (2016), https://www.congress.gov/bill/114th-congress/house-bill/34 (last visited May 4, 2020).
[30] CADCA, https://www.cadca.org/comprehensive-addiction-and-recovery-act-cara (last visited May 4, 2020).
[31] Lilo H. Stainton, State Expands Addiction Treatment Programs in County Jails NJ Spotlight (2019), https://www.njspotlight.com/2019/09/19-09-22-state-expands-addiction-treatment-programs-in-county-jails/ (last visited May 4, 2020).
[32] Ibid.

Health Insurance Discrepancies

Issue

Individuals in reentry are some of the most medically and socially complex patients of the healthcare community. As a result, the formerly incarcerated face several barriers to reliable and sufficient access to healthcare. Upon incarceration, inmates often do not receive a broad array of medical screenings, such as hepatitis testing. Nearing release, individuals often do not receive a comprehensive physical test nor a physical Medicaid card (and much less education on when, where, and how to use health insurance). They may receive no more than a couple-week supply of their medications, or referrals to community healthcare providers. These oversights may create further difficulties after reentry including difficulty such as navigating the healthcare system, obtaining integrated care to meet mental and physical health needs and sharing health records with multiple community-based providers. A closer look at practices in the months and weeks before release, however, bring four barriers to this care into perspective.

First, many individuals are released without the complete applications for those eligible for Medicaid as they near release, even though state prisons and county jails are required to do so. Even if they were able to do so, determining where to mail the Medicaid card can be challenging since those who have served long sentences often do not have a well-established mailing address. In such instances, officials may instruct the card to be mailed to a social services office within the county. As a result, individuals often navigate the weeks before and after release without effectively securing a Medicaid card. Without a Medicaid card or insurance details in hand, their

ability to access healthcare suffer. Experts suggest release from incarceration without a Medicaid card is a major contributor to high recidivism among those with Substance Use Disorder (SUD).[33]

Second, prescriptions provided upon release – known as bridge prescriptions – are often for less than one-month of medicine without refills.[34] The same dynamic applies to other mental and physical health needs. These limited courses of asthma, diabetes, or seizure medications require an individual to secure insurance, establish care, and attend a primary care or specialist appointment in short order to maintain therapeutic levels of their medications. While this can be challenging under even the best of circumstances, it can be significantly more so for those who were not provided a physical Medicaid card upon release.

Third, knowing where and when to go to continue care is challenging. Navigating the healthcare system is difficult, especially when providers may not accept your insurance. There is even greater difficulty for those who have spent significant time incarcerated. Moreover, past interactions with healthcare providers are less than therapeutic due to the stigma surrounding incarceration—real or perceived—that may affect health professionals or perverse incentives within the correctional system that may discourage seeking healthcare. In the absence of a referral and instruction on where to seek care, too many individuals nearing release do so without having a clear sense of what to do in terms of their health.

Fourth, for those individuals who do manage to overcome these barriers, they do so only to discover that the healthcare provider does not have access to his or her medical records during incarceration creating gaps in his or her records. These significant gaps in medical records increase the risk of a medical error due to incomplete information.

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[33] "Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System", in Council of State Governments Justice Center, [Pages 22-25], last modified December 2013, https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf.

[34] "Prison Health Care Costs and Quality." The Pew Charitable Trusts. October 2017. Accessed August 15, 2019. http://www.pewtrusts.org/~/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf.

Ultimately, these challenges—the need for a Medicaid card, longer-term prescriptions, referral to a community based provider, and access to correctional healthcare records—are not unique to New Jersey. Several states have found effective solutions. Studies have shown—as a result of these barriers—that nearly 90% of those incarcerated end up seeking care in the emergency room rather than a primary care clinic upon release,[35] that one in twelve end up hospitalized within 90 days,[36] and that many do not have health insurance even months after release.[37]

Model Solutions

Ohio has installed the Medicaid Pre-Release Enrollment Program, which arranges for incarcerated individuals to attend a peer-led Medicaid pre-enrollment session 90 days before they are released. In this session, incarcerated individuals learn the benefits of Medicaid, how to apply for Medicaid, the application process, and the important distinctions between the five managed care plans that are available. [38]

In the pre-enrollment class, inmates are educated on health insurance, but may choose to opt-out. The follow-up enrollment class provides inmates the opportunity to sign Medicaid Authorizations, provide forwarding addresses, and sign a Release of Information form. Afterwards, it is determined whether or not the inmate is eligible and if so, the inmate is enrolled

[35] Trotter Ii, R. T., Camplain, R., Eaves, E. R., Fofanov, V. Y., Dmitrieva, N. O., Hepp, C. M., … Baldwin, J. A. (2018). Health Disparities and Converging Epidemics in Jail Populations: Protocol for a Mixed-Methods Study. JMIR research protocols, 7(10), e10337. doi:10.2196/10337

[36] "Incarceration and Health: A Family Medicine Perspective." American Academy of Family Physicians (AAFP), March 18, 2019. https://www.aafp.org/about/policies/all/incarcerationandhealth.html.

[37] Mallik-Kane, Kamala, and Christy A. Visher. "Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration." Urban Institute Justice Policy Center, February 2008. https://www.urban.org/ sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF.

[38] Jesse Jannetta, Jane B. Wishner, and Rebecca Peters, "Ohio's Medicaid Pre-Release Enrollment Program," in Urban Institute, last modified January 2017, https://www.urban.org/sites/default/files/publication/88051/ohio_medicaid_1.pdf..

in a Managed Care Plan, If not, they have the option to appeal Medicaid's decision. The inmate is then given a Medicaid card when released.

Recommendation

Connecting the formerly incarcerated to a health care plan is key to ensuring success and safety while simultaneously reintegrating them back into society while recovering from Substance Use Disorder. By integrating care for inmates, communication flows more freely between doctors and their patients, in addition to simplifying care for those with multiple mental and physical conditions. Organizing pre-enrollment and enrollment sessions for Medicaid at least sixty days prior to release with the support of the Department of Human Services, changing the Medicaid enrollment process behind the wall to be opt-out instead of opt-in, and providing a physical Medicaid card to individuals at the time of release are all essential measures to be taken. In providing insurance to those being released, addiction treatment will be more attainable and recidivism will ultimately decrease.

For Those Addicted While Incarcerated

Issue

The prevalence of Substance Use Disorder diagnoses among those behind the wall is extremely high. Studies estimate that approximately three-quarters of those in state prisons suffer from Substance Use Disorders, and roughly one-quarter of those in state prisons suffer from Opioid Use Disorder. Moreover, studies suggest that the prevalence of Substance Use Disorders and Opioid Use Disorders is similar-if not higher-among the local jail population. The Bureau of Justice Statistics estimates that approximately two-thirds of those in county jails suffer from some

form of Substance Use Disorder [39] and other experts find that as many as four out of five individuals in jail may have been under the influence of a substance, increasingly an opioid, when violating the law. [40] Addiction treatment for the incarcerated are sorely lacking despite the clear need for such services.

There is no standardized and universal approach to screen inmates for Substance Use Disorder upon intake to prison or jail. Statistical evidence indicates that upwards of three quarters of the state prison population has an acute familiarity with drugs and alcohol. Considering the scope of addiction within the incarcerated population, the clinical assessment, treatment, and provisions of ongoing monitoring in accordance with SAMSHA "best practices" ought to be provided.[41] Even in those prisons and jails that do offer Medication-assisted treatment, the ability to provide it effectively appears to be limited by the failure to screen and treat co-occurring conditions such as hepatitis that could complicate the medical treatment of Opioid Use Disorder.

Model Solutions

One of the best studied examples of such efforts come from the previously mentioned Rhode Island. The agreement between the Rhode Island Department of Corrections and CODAC Behavioral Healthcare was developed in order to screen individuals for Opioid Use Disorder upon incarceration, provide evidence-based interventions, and ensure continued treatment upon release. Central to their approach was establishing reliable and expansive access to MAT to those incarcerated upon release, including access to buprenorphine, methadone, and naltrexone.

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[39] "Jail-Based Medication-Assisted Treatment," in the National Commission on Correctional Health Care, [page 5], last modified October 2018, http://www.ncchc.org/filebin/Resources/jail-based-mat-ppg-web.pdf.
[40] Lilo H. Stainton, "State Expands Addiction Treatment for Prisoners," NJ Spotlight, last modified August 9, 2018, http://www/njspotlight.com/stories/18/08/08/state-expands-addiction-treatment-for-prisoners/.
[41] SAMHSA publishes guidance on clinical best practices using medication-assisted treatment to combat the opioid epidemic, SAMHSA.gov (2018), https://www.samhsa.gov/newsroom/press-announcements/201802150200 (last visited May 4, 2020).

In *Coleman v. Brown*, the United States District Court for the Eastern District of California ordered that defendants remedy Eighth Amendment violations, such as not providing the proper treatment for mentally ill prisoners. The court found that seriously mentally ill inmates were being punished by correctional officers in order to control the symptoms displayed by these inmates. Furthermore, some inmates were segregated from the rest of the population and unable to receive the mental health treatment that they required. Plaintiffs successfully brought an Eighth Amendment violation suit against the California Department of Corrections and the court ensured that defendants remedied these issues. The court stated that "failure to properly consider the mental state of class members requires the court to act."[42]

In *Smith v. Aroostook County*, the United States District Court for the District of Maine ruled that denying effective treatment for Opioid Use Disorders violates the Americans with Disabilities Act. Plaintiff reported being in recovery for nearly ten years and was prescribed buprenorphine, a common Medication Assisted Treatment. Prior to being prescribed the medication, Smith had relapsed approximately 20 times. Since being on the medication, she has not relapsed once. When the plaintiff began serving her 40-day sentence, the jail refused to provide her with the Medication Assisted Treatment that she had been previously prescribed. This was a clear violation of the Americans with Disabilities Act because the jail, denied treatment and discriminated against the plaintiff, who suffers from the disability of Opioid Use Disorder, and her chance of experiencing withdrawal symptoms, as well as relapse, overdose, and death increased. [43]

Recommendation

[42] Coleman v. Brown, 28 F.Supp.3d 1068 (2014).
[43] Smith v. Aroostook County, 376 F.Supp.3d 146 (2019).

In addition to developing a universal and standardized approach to address all Substance Use Disorder diagnoses in correctional facilities, providing all who are diagnosed with a clinically appropriate individualized treatment plan, and increasing access to counseling and wraparound services, I believe claims under the Americans with Disabilities Act and the 8th Amendment should be explored just as they were in *Coleman v. Brown.* By not providing mentally ill patients and those who suffer from OUD, the New Jersey Department of Corrections could face an Eighth Amendment violation lawsuit and be ordered to provide sufficient treatment to all those who suffer from OUD as well as SUD.

Litigation like *Smith v. Aroostook County* should be mirrored in New Jersey to ensure that all of the prisoners suffering from Substance Use Disorder, and/or Opioid Use Disorder, are able to receive Medication Assisted Treatment, while incarcerated. Other avenues, such as establishing agreements between all correctional facilities and providers in the respective communities, should also be explored as well as allowing the recently-released to better coordinate care prior to release.

For Those Addicted and Recently Released

Issue

Incarcerated individuals with Substance Use Disorder are 129 times more likely to overdose and die within the first two weeks of their release than those from the general population. This is in large part due to the challenges in obtaining addiction treatment after release. Chief among these challenges is the dearth of the high-quality addiction treatment and recovery services in the community. Reports by the New Jersey Department of Human Services and New Jersey Advance Media estimate that between 40 and 50 % of the demand for these services is unmet. For

those in reentry, the scarcity of high-quality programs and providers is further complicated by the fact that few accept Medicaid (the health insurance that those in reentry are most likely to have).

Model Solutions

One of the most promising approaches has been the hub-and-spoke model. Vermont first developed this model that focused on establishing "hubs" capable of treating and coordinating care for such individuals with complex addiction needs. Vermont has since established nine "hubs" across the state that had staff with substantial experience in treating addiction, dispensed Medication Assisted Treatment daily, held daily counseling sessions, and provided intensive case management for management. Hubs also serve as an epicenter for "spokes" in the community—often primary care offices—that provide general medical care but also employ staff that have received additional training in nursing, counseling, and caring for those in recovery and who could prescribe Medication Assisted Treatment.

The management of addiction treatment has begun to mirror the organizational approach of how many other complex conditions are treated, such as cancer. Early analyses of the hub-and-spoke model found that patients reported a 96% decrease in opioid use as well as a reduction in overdoses, family conflicts, and mood symptoms like anxiety, anger, and depressions.[44] The number of individuals waiting for treatment in Vermont declined.[45] While the number of patients actively receiving treatment at hubs increased. Individuals with Medicaid, in particular, reported

[44] "Hub & Spoke Model Evaluation 2017," Vermont Department of Health, last modified 2017, http://www.healthvermont.gov/sites/default/files/documents/pdf/adap_HubSpokeEvaluationBrief.pdf.
[45] "Opioid Use Disorder Treatment Census and Wait List," Vermont Department of Health, last modified March 2019,http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_OpioidUseDisorderTreatmentCensusandWaitList.pdf.

better access to treatment and care while emergency department visits and police arrests related to opioid use dropped by 90%.[46]

Recommendation

Implementing a hub-and-spoke model with hubs available in each county is important to achieve two goals: 1) Empowering and supporting pharmacists to provide maintenance dosing of MAT with specialist support on call; and 2) Establishing opioid treatment providers who are open twenty-four hours a day and seven days per week.

Smaller rehabilitation centers, that offer limited addiction treatment services, must contract with bigger hospitals. Hubs serve as a regional headquarters of which satellite treatment centers are attached. The satellite treatment centers are community-based and are located in the vicinity of the hub. In exchange for referring patients to the hospital, or "hub", the hospital will provide consultation and training to the smaller centers, as well as a broader array of treatment services that the smaller center can utilize for their patients. This necessitates a free-flow of patient information in order for this model to enjoy the same success as it did in Vermont. Open communication between all providers regarding an individual patient lowers the chance of human error in providing treatment.

There are other problems that need solutions to help to those addicted and recently released. The most practical and helpful of those would be adequate recovery housing, which is addressed in the next section. The lack of adequate supportive housing options for those who are just being released is a major contributing factor to both relapse and recidivism.

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[46] "Hub & Spoke Model Evaluation 2017," Vermont Department of Health, last modified 2017, http://www.healthvermont.gov/sites/default/files/documents/pdf/adap_HubSpokeEvaluationBrief.pdf.

Recovery Housing Inadequacy

Issue

Individuals suffering from Substance Use Disorder who were recently released from incarceration are often hard-pressed to find a safe environment to call home. The housing deficiency affects the individual's health, well-being, and safety and directly causes a foundational instability, often leading to an increase in both recidivism and relapse. Formerly incarcerated individuals suffering from Substance Use Disorder have different needs upon release, and it is crucial that housing options accommodate those needs whether they involve sober-living, abstinence-focused models, harm reduction, or Housing First models. Both the National Council for Behavioral Health and the Department of Housing and Urban Development recommend that "housing options are available for people at all stages of recovery, including people who continue to use drugs or alcohol."[47]

In New Jersey, as many as 8 out of 10 inmates have been diagnosed with Substance Use Disorder, and 3/4 of the approximate 40,000 inmates statewide are expected to relapse within the first three months of release. A large cause of this mass relapse is the inability to locate affordable transitional housing and find a safe and recovery-conducive environment. [48]

[47] "Recovery Housing Policy Brief." HUD Exchange, n.d. https://files.hudexchange.info/resources/documents/Recovery-Housing-Policy-Brief.pdf.
[48] Stainton,Lilo H. "State Expands Addiction Treatment for Prisoners." State Expands Addiction Treatment for Prisoners-NJ Spotlight, August 9, 2018. http://www.njspotlight.com.stories/18/08/08/state-expands-addiction-treatment-for-prisoners/.

According to the U.S. Interagency Council on Homelessness, nearly 50,000 people a year enter homeless shelters directly following release from correctional facilities.[49] The reentry population are nearly ten times more likely to be homeless than the general public, and to add insult to injury, those who are homeless are 11 times more likely to get arrested or face incarceration than the general population.[50] Facing homelessness while suffering from OUD and SUD is extremely daunting. Homelessness, addiction, and criminal justice involvement are inextricably linked, and studies suggest that drug addiction is a primary cause of homelessness.[51][52] Recidivism rates are higher among new entrants unable to find stable, affordable housing upon release. Because of the effective criminalization of homelessness, simply being homeless can land an individual back in prison. In many municipalities and counties, law enforcement agencies aggressively enforce "offenses" such as sleeping, "camping," sitting, or lying down in public spaces; panhandling and begging in public; loitering, loafing, and vagrancy; public urination and food sharing; sleeping in vehicles; and other low-level offenses that are more visible when committed in public. Many laws and policies that effectively criminalize homelessness are implemented at the local level, but states can enact and enforce legislation to prohibit such criminalization. Several states and territories, including Rhode Island, Illinois, Connecticut, and Puerto Rico, have enacted Homeless Bill of Rights legislation to protect individuals from police harassment and guarantee their freedom to move freely in public places.[53]

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[49] United States Interagency Council on Homelessness, Connecting People Returning from Incarceration with Housing and Homelessness Assistance (Washington, D.C.: March 2016), 1.

[50] National Law Center on Homelessness & Poverty, Housing Not Handcuffs: Ending the Criminalization of homelessness in U.S. Cities (Washington, D.C.), 19.

[51] Glasser, I. and Zywiak, W.H. (2003). Homelessness and substance misuse: A tale of two cities. Substance Use and Misuse, 38(3-6), 551-576.

[52] Andrew M. Fox, Philip Mulvey, Charles Max Katz, and Michael Shafer, "Untangling the Relationship Between Mental Health and Homelessness Among a Sample of Arrestees," Crime and Delinquency 62, no. 5 (May 2016): 592–613.

[53] "No Safe Place: The Criminalization of Homelessness in U.S. Cities." National Law Center on Homelessness & Poverty, February 2019. https://nlchp.org/wp-content/uploads/2019/02/No_Safe_Place.pdf.

Model Solutions

In Massachusetts, a coalition of nonprofit agencies has set out to inspect and certify the vast amount of sober living homes in the state. Massachusetts Association for Sober Housing, part of the nonprofit coalition responsible for running the certification program, offers incentives for private owners of sober living facilities to receive certification. Receiving certification means ensuring that homes implement regular drug and alcohol testing, adhere to strict zero-tolerance policies, provide habitable living environments, carry adequate insurance, and other best practices. Massachusetts passed legislation that mandates the monitoring and voluntary certification of Massachusetts sober homes.[54]

These requirements are an important example of ensuring that programs purporting to be sober-living environments have adequate oversight. However, many states, such as California, have recognized that Housing First provides an important alternative to sober-living as well as equal promulgation of both models to ensure that individuals have the opportunity to pursue the path to recovery pertinent to the individual's situation. In several studies, Housing First programs, including Recovery Kentucky, serving chronically homeless individuals have been shown to decrease alcohol and drug use.[55] Also, Housing First transitional housing models across the United States have reported a remarkable recidivism rate of 12 %.[56] Recovery Kentucky currently

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[54] "Certification" Massachusetts Alliance for Sober Housing (MASH), n.d. https://mashsoberhousing.org/certification.

[55] Collins, Susan E., Daniel K. Malone, Seema L. Clifasefi, Joshua A. Ginzler, Michelle D. Garner, Bonnie Burlingham, Heather S. Lonczak, et al. "Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories." American Journal of Public Health 102, no. 3 (2012): 511–19.; "What Works - Housing First." University of Wisconsin School of Medicine and Public Health, March 7, 2019. http://whatworksforhealth.wisc.edu/program.php?t1=109&t2=126&t3=89&id=349.https://doi.org/10.2105/ajph.2011.300403.

[56] Return to Nowhere The Revolving Door Between Incarceration and Homelessness, www.texascjc.org/system/files/publications/Return%20to%20Nowhere%20The%20Revolving%20Door%20Between%20Incarceration%20and%20Homelessness.pdf. Accessed 7 Mar. 2020.

operates 14 facilities across the state that are solely dedicated to the treatment of substance use and Opioid Use Disorders and providing a safe transitional environment for those in the reentry population. As a result of these transitional homes, 2,000 individuals have a safe place to call home.

The partnership between Kentucky Housing Corporation (KHC), the Department of Local Government (DLG) and the Department of Corrections, Low Income Housing Tax Credits from KHC worth $2.5 million have been allocated for construction costs. The DLG has secured $3 million from DLG's Community Development Block Grant program for operational costs. In addition to these funds, the Department of Corrections has allocated $5 million to be used for operational costs as well.[57] There has also been substantial support from each community and municipality that each Recovery Kentucky transitional home has been built in.

Recommendation

To help alleviate the homelessness-recidivism connection, New Jersey should adopt a Homeless Bill of Rights like many states have done already. Passing a Homeless Bill of Rights will lessen the criminalization of homelessness and safeguard homeless individuals' ability to move freely, exercise their basic civil rights and civil liberties, experience equal treatment under the law, and access public programs and amenities.

No matter the approach, or whether the housing is transitional or permanently supportive, it is critical that recovery-focused housing ensure fidelity to the chosen model. The administration of the recovery housing should also match these programmatic commitments. For instance, a

[57] Kentucky Housing Corporation (KHC), Kentucky Housing Corporation, http://www.kyhousing.org/Specialized-Housing/Pages/Recovery-Kentucky.aspx (last visited May 8, 2020).

sober-living environment must have adequate oversight: where the model emphasizes abstinence, the state licensure process should ensure that staff and programmatic operations adhere to stated goals (e.g. requiring live-in staff to undergo a more stringent vetting process to make sure they are well-versed in recovery models or ensuring that all sober-living facilities maintain Narcan (naloxone) on premises in case of emergency). For non-abstinence-based Housing First programs, housing and supportive services should not be predicated on sobriety, minimum income requirements, lack of criminal record, or completion of treatment.[58]

Faith-based organizations can also provide assistance to those reintegrating into society after being incarcerated. As pillars of the community, these organizations are the front-line of bringing persons back into their own communities. These organizations can provide assistance through their local connections, community contacts, and other services to assist those returning to the community meet their housing needs.

Fundamentally, all inmates should be required to have a legitimate address to call home prior to their release. Parolees in New Jersey are required to have an address to be released to the State Parole Board's supervision, however this requirement should span across all inmates that are being released. Supportive housing should include "outreach and engagement workers, a variety of flexible treatment options to choose from, and services to help people reintegrate into their communities" and "include substance abuse services would help homeless people treat their addictions and re-establish residential stability."[59]

To better reintegrate those who have SUD, the Division of Community Affairs should be designated and charge with the task of ensuring that programs have adequate oversight to necessitate resident compliance with project policies and that life-saving treatments such as

[58] "Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation." United States Interagency Council on Homelessness, September 2016.
[59] National Mental Health Association. "Ending Homelessness for People With Mental Illnesses and CoOccurring Disorders." Apr. 2006. Available from http://www.nmha.org.

Narcan, are available on the premises. Furthermore, the relevant state authorities should be designated in order to guarantee that any Housing First programs are adhering to the model and minimizing all barriers to reentry.

Conclusion

For any substantial progress to be made in the fight against the opioid epidemic, New Jersey must address the aforementioned problems with solutions that have been proven to work in other states. Inmates being released in New Jersey, are often released without any prospect of employment, without anything addressing their Substance Use Disorders, much less a method of obtaining and paying for whatever treatment they can pursue.

Many of those incarcerated suffer from opioid withdrawals, as well as mental cravings, and extreme dehydration. If they are incarcerated in any prison other than Mid-State Correctional Facility in Fort Dix, New Jersey, many inmates may not be provided Medication Assisted Treatment or even screened for an addiction disorder. The gold standard in treating Opioid Use Disorder is Medication Assisted Treatment. By starting their Medication Assisted Treatment while incarcerated, and continuing upon release, the reentry population has a defense against relapse and therefore recidivism. Providing Medication Assisted Treatment is a proven solution that is evidence by the Rhode Island Department of Corrections.

Lack of health insurance continues to be a major factor contributing to recidivism and relapse for the reentry population. Medicaid would be the most popular option for those being released and the fact that they are not provided with Medicaid cards, or even a working

understanding of how, when, and why applying for Medicaid is imperative for their overall well-being is extremely troubling. By providing an education and an actual Medicaid identification card, those reentering society are given a head start in treating not only their Substance Use Disorder, but their overall physical well-being. It is imperative that the incarcerated population, and everyone involved in the criminal justice system, receive treatment both in custody and upon release. The continuity and consistency of treatment can easily be achieved if the proper channels are utilized while the individual is still being supervised.

New Jersey may enjoy a similar 96% drop in opioid use if they employ the same methods as in Vermont. The hub-and-spoke model has saved the lives of many of those suffering from Opioid Use Disorder. Such a model of integrated and coordinated care is essential for those trying to successfully reintegrate back into society.

Between 70-80% of those who are incarcerated have a Substance Use Disorder, and in New Jersey, 80% of inmates with Substance Use Disorder (SUD) were under the influence when they committed their crime; and 75% of inmates with opioid-use disorder relapse within three months of release. With statistics like these, it is hard to refute the importance of leveling whatever obstacles there are for the addicted individuals who were formerly incarcerated. Ultimately, the road of successful recovery should be devoid of all obstacles in the way of the reentering individuals.