TESTIMONY OF:

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Hearing Examining the Effectiveness of Medication-Assisted Treatment Programs in New York's Prisons and Jails

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My name is Kelsey DeAvila and I am a Jail Services Social Worker at Brooklyn Defender Services. BDS provides multi-disciplinary and client-centered criminal, family, and immigration defense, as well as civil legal services, social work support and advocacy in nearly 35,000 cases in Brooklyn every year. As part of our representation, BDS dedicates staff, including myself, to provide direct services and advocacy for our clients while they are incarcerated in New York City jails in pre-trial detention, serving sentences of less than a year, or returning from New York State Department of Corrections and Community Supervision (DOCCS) prisons upstate. I thank the New York State Assembly Committees on Alcoholism and Drug Abuse, Health, and Corrections, and in particular Chair Rosenthal, Chair Gottfried, and Chair Weprin, for considering our comments in support of guaranteed access to Medication-Assisted Treatment (MAT) in New York's prisons and jails.

Background

Throughout New York State, rates of arrest and prosecution for simple drug possession remain high, as does the incidence of prosecutors overcharging for behaviors linked to substance use disorder. Likewise, state prisons and local jails are largely populated with people who struggle with addiction. According to an August 2015 Status Report of the Mayor's Task Force on

Behavioral Health and Criminal Justice, more than 85% of people in New York City jails were believed to have substance use disorders.[1] Similarly, an estimated 83% of people in New York State prisons had some substance use treatment needs, according to the most recent DOCCS report. [2] Indeed, despite the rhetoric from law enforcement officials that "we cannot arrest and jail our way out of the overdose epidemic," that remains a topline strategy across our state, particularly for Black and Latinx people and people in poverty.

Prisons and jails were never intended to serve as medical facilities. Conditions inside are fundamentally ill-equipped and inappropriate to delivering a high standard of care. Decarceration while investing in healthy *communities* must remain the primary goal. Ending unnecessary arrests and discriminatory bail practices, adopting sentencing and discovery reform, and establishing a robust framework to divert people in need of treatment would all contribute to this end.

All that said, while people with substance use disorder continue to be detained and incarcerated, the government has an obligation to provide the best possible medical care to meet their needs. This includes MAT, or the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide holistic treatment of substance use disorders. Research has shown that MAT can cut the mortality rate among addiction patients by a half or more.[3] MAT in jails and prisons and other public health approaches to tackling opiate addiction should be expanded across jurisdictions, according to best practices of community-based healthcare. **To that end, BDS supports A8774B (Rosenthal)/S8914A (Rivera), which requires DOCCS and local jails to establish comprehensive substance use disorder treatment programs, including MAT.** The bill also sets forth requirements for transitional services to help people during and after re-entry, when risks of fatal overdose are heightened. Crucially, the bill prohibits prison and jail administrators from blocking people from life-saving treatment due to infractions of the infamously arbitrary and unfair correctional disciplinary systems. It also prevents the issuance of disciplinary infractions, which can trigger prolonged and dangerous solitary confinement, for positive drug screenings upon intake into the drug treatment program.

Substance Use Disorder and Treatment in NYC Jails

Our clients' experiences suggest that Health and Hospitals Corporation and the New York City Department of Correction (DOC) have addressed various challenges with mixed results. The agencies should be acknowledged for their efforts to safely manage substance abuse and addiction among people in custody. Prompt screenings for alcohol withdrawal appear to function well to avoid possibly fatal withdrawals. The substance abuse program A Road Not Taken (ARNT) offers people struggling with addiction an opportunity to be housed among peers and

[1] Mayor's Office of Criminal Justice, First Status Report of the Mayor's Task Force on Behavioral Health and Criminal Justice (2015), https://www1.nyc.gov/assets/criminaljustice/downloads/pdfs/BHTF%20First%20Status%20Report%208.15.pdf.
[2] Corr. of New York, Fact Sheet: Substance Abuse Treatment in New York Prisons (2011), https://www.correctionalassociation.org/resource/substance-abuse-treatment-in-new-york-prisons.
[3] German Lopez, There's a Highly Successful Treatment for Opioid Addiction. but Stigma Is Holding It Back, Vox, Oct. 18, 2017 at , https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone.

receive programming geared to support their efforts to stop using drugs.[4] We believe there are best practices to be gleaned from these programs which should be evaluated for use in other jurisdictions.

However, drug treatment programs in City jails have critical flaws that must be rectified. A common barrier is the Security Risk Group classification. People designated as alleged gang members, based on no standard of evidence and with no meaningful opportunity to appeal, are denied access to program-based services supporting people with substance use disorders. Likewise, treatment can be terminated due to disciplinary infractions, including for drug use, which is nonsensical and dangerous. Both of these bars to treatment impact young people, people with mental illness, and others who are particularly vulnerable. They send a message that some lives are worth saving, and others are disposable.

The Key Extended Entry Program (KEEP) in New York City jails facilitates detox and manages methadone treatment for opiate-dependent people. Unfortunately, people facing state prison time are excluded from KEEP because state prisons do not offer methadone. The obvious solution here is that the state prison system should offer methadone treatment and other MAT, particularly in this era of skyrocketing opioid overdose deaths. In the interim, it is important to recognize that many people face state prison time "on paper" although there is little real chance they will be sent to state prison. As cases proceed through plea bargaining, prosecutors wait until pleas are entered to withdraw the most serious charges, despite all parties involved being aware that prison time is not a likely outcome. One collateral consequence of this practice is that many people who need methadone treatment are excluded from KEEP. More honest prosecutorial practices would benefit public safety, as people maintained on methadone are more likely to continue treatment in the community and avoid relapse.

Our office had a recent case where a BDS criminal defense attorney tirelessly advocated for her client, who had a history of substance use, to partake in the ARNT program in hopes of reducing his stay in jail. His attorney worked with his parole officer and the District Attorney, both of whom ultimately agreed to reduced jail time as long as our client participated in the program. It was not until our office put in a request with Correctional Health Services and explained the court agreement that we were told the request was denied due to our client's high classification, a classification resulting from a 2007 incarceration where DOC identified him as gang affiliated. He is no longer in a gang. Yet due to the time it takes to appeal such classifications to the Department of Correction and the Bronx DA, our office was not able to move forward with the court agreement. Our client wanted nothing but to participate and turn his life around. He has struggled in the past but this time he saw a real opportunity where he was given a chance and because of an specious identification designation that was clearly outdated, he was denied that opportunity.

Participation in these programs can and do impact people's ability to fight their criminal case in court, both in helping them overcome their disorder and participate more effectively in their own defense, and in demonstrating to the court their commitment to change. Correctional Health Services should make their programming available to all who may benefit medically. Situating

[4] Selling, D., Lee, D., Solimo, A., Venters, H. (2015), 'A Road Not Taken: Substance Abuse Programming in the New York City Jail System', in: Journal of Correctional Health Care 21(1) pp. 7-11

access to treatment and medical decision-making as the exclusive domain of healthcare providers, not DOC, is essential.

Relatedly, we are concerned about the knee-jerk embrace of Vivitrol among corrections officials as an alternative treatment for opiate addiction. Any such decision should be made by medical professionals, on a case-by-case basis, depending on the particular patient's circumstances, rather than for penalogical reasons. Although the drug claims to block an individual's opioid receptors in long-lasting doses, we are dubious about the drug's effectiveness in treating addiction *sustainably.* It is our position that tackling addiction must address root causes that lead people to use drugs in the first place – poverty, trauma, desperation, and other factors. We urge the state to maintain a critical perspective on drugs peddled as a "magic bullet" for addiction. Rather, we support committing greater resources to treatments that have been subjected to adequate study and been found to sustainably manage opiate addiction, prevent overdoses and improve public health.[5]

Delivering Healthcare in a Security-Driven Environment

The predominance of security in correctional institutions inhibits access to all manner of healthcare, including MAT. For example, when a facility goes on lockdown for security reasons, all movement may be halted, sometimes for extended periods. This means no one is able to go to the clinic, leading to delays care. Even when facilities are operating as designed, security interference in access to care and treatment decisions is a common occurrence.

In New York City jails, every incarcerated person must be escorted by a correctional officer to and from the clinic. As uniformed staff are often occupied with other tasks, or otherwise unwilling to help, escort shortages frequently result in missed appointments and treatment delays. One sensible fix to overcoming the inevitable competing demands on correctional staff is to more wisely balance staffing to include roving medical escort posts during day-shifts who are not assigned to other tasks. We believe this could be achieved at present staffing levels through more efficient staff management, ensuring adequate escorts, and limiting instances in which staff are pulled away from crucial security positions. More fundamentally, ending facility-wide lockdowns is necessary to improve access to health care.

Beyond their role as escorts, **correctional officers serve in many respects as gatekeepers to medical care, which poses serious dangers to the well-being of people in custody**.

Continuity of Care in Re-Entry

Others testifying today will certainly offer more comprehensive recommendations to improve continuity of substance use disorder treatment during re-entry. Nevertheless, I would like to highlight a few of the recurrent issues handled by our Re-Entry Unit, some of which could be relatively easily addressed. In addition to connecting people with MAT facilities in the community, **DOCCS should proactively discharge people with a copy of their essential medical records,** without requiring individuals to make a pre-discharge request for those

[5] *See* Goodnough, A., and Zernike, K., 'Seizing on opioid crisis, a drug maker lobbies hard for its product', The New York Times, 11 June 2017.

records. That simply change would help to avoid delays in securing treatment in the community and would likely minimize confusion and administrative burdens created by processing records requests.

Furthermore, bureaucratic missteps can inhibit access to care upon discharge and should be prevented. Despite welcome efforts to enroll people in Medicaid prior to discharge, people are frequently released on inpatient Medicaid status, rather than outpatient status. In practical terms, this limits the range of services available to hospital care. Our re-entry specialists find it takes days to weeks to correct this relatively straightforward error. In the meantime, people are unable to access the full range of services available through the health-home system, relying instead on emergency rooms, thereby further draining public health resources.

Additionally, our clients' experience suggests that DOCCS does not do enough to educate people to navigate the complex and intimidating healthcare system awaiting them in the community. A first step to resolve this issue would be to **better incorporate healthcare staff and navigators into the pre-release process**. This process should offer opportunities for people close to discharge to ask questions of healthcare providers who can provide guidance on managing their health conditions once out of prison. This is especially important for people with substance use disorder.

Conclusion

BDS is grateful to the Assembly for hosting this critical hearing and shining a spotlight this issue. Thank you for your time and consideration of our comments. We look forward to further discussing these and other issues that impact our clients. If you have any questions, please feel free to reach out to Jared Chausow, our Advocacy Specialist, at 718-254-0700 ext. 382 or jchausow@bds.org.