ADVOCATES FOR HUMAN POTENTIAL, INC.

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Anne Landry
Chief Counsel
Office of Senator William N. Brownsberger

Re: Correctional programming suggestions

Dear Ms. Landry,

Although I hope to be able to join your Friday meeting, I would also like to share with you and the Commission some written suggestions for correctional programming that stem from what we have learned as the U.S. Department of Justice (DOJ) Bureau of Justice Assistance (BJA) prison and jail drug treatment technical assistance provider. These suggested practices, programming, and protocols are essential to responding to the safety and treatment needs of jail populations. While the task of rationalizing jail budgets and staffing is essential, it is equally important that jails respond appropriately to meet the challenging medical, psychiatric, and related needs of detainees held pending trial or sentenced after conviction.

First, jails should complete a full clinical assessment of each detainee within hours of their entering the facility. This allows jails to identify those detainees who are withdrawing from drugs and alcohol; in need of continuing prescribed opioid, alcohol, or antipsychotic medications; at risk for suicide; in immediate need of hospitalization; and the like.

The Philadelphia Department of Prisons has proven not only that completing clinical intake assessments within 4 hours of jail admission is feasible, having completed 400,000 such assessments since 2008, but also that they provide an essential starting point for meeting detainees' mental and physical health needs.

Last year, Philadelphia jails released more than 3,300 inmates on buprenorphine medication-assisted treatment (MAT), the largest such cohort of any jail program in the country. Jail staff Identify potential MAT candidates in the initial assessment (within 4 hours of admission). These inmates are immediately referred for medical withdrawal management until their symptoms allow for buprenorphine induction, usually with 48 hours. Another 700 inmates, also identified within the first 4 hours, are confirmed to be enrolled in methadone maintenance and are referred for continued methadone maintenance until their release. The Department's intake has also

CORPORATE HEADQUARTERS
490-B Boston Post Road
Sudbury, MA 01776
Phone: 978.443.0055

CALIFORNIA
131 N. El Molino
Suite 380
Pasadena, CA 91101
Phone: 323.431.5617

ILLINOIS
1021 West Adams Street
Suite 303
Chicago, IL 60607
Phone: 312.376.0595
Fax: 833.348.3366

proven effective in dramatically reducing inmate suicides, most of which occur, the research tells us, within the first week in custody (the plurality within the first 48 hours). Those found to be at risk for suicide are automatically scheduled for immediate psychiatric follow-up. (All intake data are immediately entered into an interactive, computerized program.) (www.rsat-tta.com *Jail Medication-Assisted Treatment Begins with Immediate Clinical Intake,* 2020).

Second, jails should adopt and implement protocols for drug and alcohol withdrawal management consistent with current standards of care. While jails often do not have the luxury of administering long-term tapering protocols available in the community, there are 3-day rapid agonist tapering withdrawal programs pioneered by NaphCare, a correctional medical vendor, in several dozen jails across the country. In 2018, the U.S. Food and Drug Administration (FDA) approved the first non-agonist medication specifically to treat the physical symptoms associated with opioid withdrawal, lofexidine. Yet jail medical providers continue to substitute off-label, inferior medications for this purpose, including most if not all of the providers in Massachusetts's jails. People who do not want agonist medications or for whom they are contraindicated should be able to be safety and humanely detoxified, allowing them also, if they desire, to be eligible for naltrexone medication to assist in their recovery.

Third, jails should adopt and implement protocols for the supervision and treatment of individuals on suicide watch. Too many jails continue to rely on isolating inmates on suicide watch in solitary confinement, in harsh conditions; the practice has been found to *increase* risk of self-harm, not contain it. Coordination and communication between security and mental health treatment staffs have also often proven problematic. One method that has been found to be effective: A number of prisons and jails have developed programs to train inmates to prevent suicides among their peers.

Fourth, jails should provide treatment programming for persons with substance use disorders, mental illness, and co-occurring disorders that are also consistent with contemporary standards of care. In 2019, BJA convened a national roundtable of experts, relevant federal and state agency heads, researchers, and practitioners to develop the first national standards for prison and jail drug treatment programming for federally funded Residential Substance Abuse Treatment (RSAT) programs. Revised in January 2021, *Promising Practices Guidelines for Residential Substance Abuse Treatment* (https://www.rsat-tta.com/Files/Re-edited-PPG-RSAT-after-BJA-review_EDITED_REFEREN) offers minimally accepted standards for such programs. These standards, for example, include access to MAT, including antipsychotic medications, for all appropriate inmates. The new generation of long-acting injectable antipsychotic medications for both schizophrenia and bipolar disorder are slowing making their way into corrections and offer superior bridges for continued treatment upon release, much like injectable naltrexone provides a 28-day window post-release for persons to arrange for continuing care in the community. While the opioid epidemic has received the most attention within correctional treatment programming, jails should also provide alcohol use disorder treatment, including access to FDA-approved medications.

It should be noted that, to be effective, jail MAT programming must include seamless transition to continuing care and medical access in the community. Studies of correctional MAT retention rates for released inmates find the majority do not continue sufficiently to promote long-term recovery. Jails must identify and work with community medical and treatment providers, including Opioid Treatment Programs (OTPs), to prevent inducing inmates on medication that is

not readily accessible in the community or without the concurrent treatment and support programming needed to encourage its retention.

While persons held pending trial may not be able to complete treatment programming that research suggests must be at least 90 days to have any lasting effect, jails in Essex County, Massachusetts and Louisville, Kentucky have both pioneered short-term programming that stabilizes detainees with substance use disorders, inducts them as appropriate on medication, and promotes their suitability for subsequent non-custodial sentencing (see *Diverting Defendants to Treatment: Model Pretrial Jail Programming for Withdrawal Management and Opioid Medication-Assisted Treatment*, https://www.youtube.com/watch?v=vb4GC4NyccI&feature=emb_title).

Fifth, jails should negotiate, monitor, and better enforce contracted care with their medical and mental health providers. Rather than rely on each jail separately negotiating with medical and mental health contracted providers, the jails should join together to increase their ability to negotiate with and hold contractors accountable to deliver treatment consistent with contemporary standards of care. Currently, when it comes to correctional medicine, it is a seller's market, with limited available options among a small array of often inadequate providers. Perhaps by joining together, the jails collectively can negotiate and enforce better contracted care. At the very least, jails can agree upon metrics to determine minimal standards for contracted care providers so that they can better monitor the delivery of care within their facilities and hold providers accountable.

Sixth, there should be independent oversight of jail safety and health care. There is little oversight of jails, even when people die. According to the American Jail Association, fewer than 20 of the nation's 3,100 plus jails have any independent oversight. Twenty-four states have a government body that exercises some regulatory power over jails; a few conduct fatality reviews. However, most such state oversight has been shown to be tepid at best, with little influence to ensure jails correct deficiencies identified by these bodies. What little jail oversight that exists is usually the result of wrongful jail death lawsuits, but these are typically resolved years after the deaths occurred.

After the death of George Floyd, pending lawsuits, picked up by the media, revealed that inmates in Minnesota's jails also had died while being restrained by jail staff gasping that they could not breathe. Although the Minnesota Department of Corrections was charged with enforcing standards and licensing jails, it had consistently failed to do so. The Commissioner ended up replacing the official in charge of jail inspections and licensing and announced the Department would reinvestigate all 56 jail deaths that had occurred since 2015.

The recent report from the U.S. Department of Justice Civil Rights Division and the U.S. Attorney's Office for the District of New Jersey on their investigation of the Cumberland County Jail (CCJ) in Bridgeton, New Jersey provides a useful template for oversight (https://www.justice.gov/usao-nj/press-release/file/1354736/download). The findings reveal the essential metrics for acceptable jail health and safety programming. They can be discerned in the three major findings reported:

1) CCJ staff acted with deliberate indifference to inmates experiencing opiate withdrawal and particularly vulnerable to suicide by failing to provide medication-assisted treatment.

2) Poor screening, classification, and suicide prevention protocols demonstrate the ccj's deliberate indifference to inmates at heightened risk of self-harm.

3) Systemic deficiencies in CCJ's mental health services continue to place prisoners at risk of harm.

These systemic deficiencies included (1) inadequate mental health staffing, (2) haphazard and deficient treatment of prisoners with mental illness, (3) inappropriate restraint of prisoners in behavioral health emergencies, (4) minimal access to higher levels of mental health care, (5) the CCJ policy's denial of mental health professionals' clinical autonomy, (6) poor coordination between mental health and custody staff, and (7) deficient quality assurance and contract oversight.

Massachusetts is fortunate to have jails run by sheriffs whose principal duty is to administer its jails. As the Commission understands, the challenge they face is enormous as jails have become, by default, the largest detoxification programs and the largest mental health holding facilities in the country. They also represent, unfortunately, the largest missed opportunity to begin to turn around the lives of the highest-risk and most impoverished, marginalized, medically and mentally fragile populations in the country. Our work providing technical assistance to prison and jail substance abuse treatment programs over the past decade has shown that this challenge can be met. The above recommendations, we believe, should assist with Massachusetts jails' efforts.

Sincerely,

Andrew Klein

ANDREW R. KLEIN, Ph.D.
Senior Scientist for Criminal Justice
Advocates for Human Potential, Inc.

H: 627-325-4477