A New Normal

Addressing Opioid Use through the Criminal Justice System

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From the Director

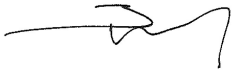
The United States is experiencing an epidemic of drug overdose deaths that cuts across economic, racial, and geographic boundaries—and, despite a fraught election season, even political boundaries. In 2015, an average of 144 people died each day from drug overdoses, including 91 people who died from overdoses on opioids (prescription opioid pain relievers and heroin). In the midst of this devastation, people are struggling to find ways to save the lives of their community members. During the recent presidential campaign, one of the few areas of agreement between the candidates was the need to approach drug use differently, including the use of overdose prevention drugs such as naloxone.

Four decades ago, the U.S. government declared a "war on drugs" with the aim of reducing drug use through tough enforcement policies that mandated long sentences for drug convictions. Defining drug use primarily as a criminal issue helped create a bloated justice system in which up to 65 percent of incarcerated people meet criteria for a substance use disorder but where few people have access to the types of support needed to address their substance use, rebuild their lives, and prevent recidivism.

There is increasing momentum, however, for a smarter, effective, and more compassionate approach to people who use drugs that is grounded in the evidence by incorporating a range of public health strategies, such as alternatives to incarceration, medication-assisted treatment, and overdose prevention. The public health community has long used these approaches—collectively referred to as "harm reduction"—as tools for addressing substance use, but justice-system stakeholders have been much slower to incorporate them into their practice.

This report describes how some jurisdictions—both red and blue—are implementing harm reduction strategies in order to reduce overdose deaths, improve the well-being of justice-system-involved people, and advance the health and safety of their communities. It shares perspectives from stakeholders in law enforcement, the court system, corrections agencies, drug policy, and the community about what strategies are being implemented, how they have overcome barriers, and what work remains to be done.

Communities and government can no longer ignore the harsh realities of the overdose epidemic. This brief aims to facilitate a wider discussion about how we can build a justice system that is equipped to address the harms associated with substance use. We highlight police departments, courts, jails, and prisons around the country that are already applying these principles. Expanding these harm reduction programs to serve more people in more places will strengthen communities and save lives.



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Contents

Introduction

New data from the Centers for Disease Control and Prevention confirm that the United States is experiencing an epidemic of drug overdose deaths that spans the nation and affects people of all backgrounds. Between 2000 and 2015, the overdose death rate increased 163 percent including a 246 percent increase in deaths involving opioids (which include both prescription opioid pain relievers and heroin).[1] In particular, the surge in drug overdose deaths is a major driver of rising death rates among young white adults—a trend that resembles the rise in death rates during the H.I.V. epidemic in the late 1980s and early 1990s.[2] With overdose deaths now overtaking motor-vehicle accidents as the leading cause of injury-related death in the United States, there are budding bipartisan efforts to respond to this urgent public health problem.[3] Notably, in 2016, Congress passed the Comprehensive Addiction and Recovery Act (CARA), which was co-sponsored by both Republican and Democratic senators and expands people's access to treatment, prevents overdose deaths, and increases community prevention efforts.[4] Several of these strategies move away from traditional, abstinence-based approaches—and those that criminalize drug use—toward incorporating principles of harm reduction—a public health philosophy and set of practical strategies that seeks to reduce the negative consequences associated with drug use.

While communities increasingly are adopting harm reduction approaches, criminal justice actors have been slow to incorporate strategies proven to help mitigate the damage caused by drug use. Police, courts, and corrections agencies are well-suited to use these comprehensive approaches because of the sheer volume of contact they have with people who use opioids. (Indeed, law enforcement is often on the front-lines of this crisis, and in many cases have taken the lead in fighting it.) Drug offenses are the most common reason for arrest in the United States, accounting for nearly 14 percent of all arrests in 2015.[5] It is also estimated that up to 65 percent of incarcerated people meet the criteria for substance abuse or dependence.[6] Faced with spiraling rates of overdose and the reality that abstinence-based enforcement approaches have so far failed to stem the tide of drug use, justice professionals are increasingly considering approaches that incorporate harm reduction principles. Even so, most justice professionals have limited training and experience in how to adopt these approaches, resulting in limited use among most law enforcement agencies, courts, jails, and prisons.

Public health and human rights organizations in states from Indiana to Connecticut have been advocating for further uptake of harm reduction practices in the United States for decades, but have only recently targeted efforts toward integrating such interventions in the U.S. criminal justice system. Indeed, there is a need for materials that specifically address the concerns of criminal justice stakeholders and approaches that are attuned to justice settings.

To bridge these gaps, this brief describes several harm reduction strategies currently being

implemented in the criminal justice system and draws on interviews with 14 stakeholders in law enforcement, the court system, corrections agencies, drug policy, and the community in four geographically diverse jurisdictions: New Mexico, New York, North Carolina, and West Virginia. The goal is to help capture current attitudes about the place of harm reduction in the criminal justice system, the feasibility of its widespread use, and what it will take to establish harm reduction as a viable alternative to enforcement-based responses to drug use.

Harm reduction definition

Harm reduction refers to a set of evidence-based public health practices focused on reducing the harms of drug use.[a] This umbrella term encompasses a wide range of strategies, such as nicotine replacement therapy (such as nicotine gum), methadone maintenance treatment for opioid dependence, and supervised injection facilities, among others. What these strategies have in common is an emphasis on promoting personal and community health without an insistence on abstinence. A common critique regarding harm reduction, which has invited resistance to the term, is the belief that non-abstinence-based approaches encourage or condone drug use. However, robust scientific evidence supports the effectiveness of these interventions.[b] As jurisdictions grapple with how best to address overdose deaths, public health, law enforcement, and corrections officials are increasingly recognizing that these interventions are important aspects of the solution.

a The principles of harm reduction have also been applied to other potentially harmful behaviors, such as sex work. See, for example, North Carolina Harm Reduction Coalition, "Safer Sex Work," 2017, http://www.nchrc.org/harm-reduction/sex-work/; and Michael L. Rekart, "Sex-work harm reduction," The Lancet 366, no. 9503 (2005): 2123-2134.

b A. Ritter and J. Cameron, "A Review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco, and illicit drugs," Drug and Alcohol Review 6, no. 25 (2006): 611-624. J.C. Veilleux, , P.J. Colvin, J. Anderson, C. York, A.J. Heinz, Heinz, "A review of opioid dependence treatment: Pharmacological and psychosocial interventions to treat opioid addiction," Clinical Psychology Review 30 (2010): 155-166.

Trends in harm reduction and substance use in the U.S. criminal justice system

There is now widespread recognition in the United States that the punitive drug policies of the early 1990s have failed to deter drug use. Instead, the common stigma around drug use and the risk of facing criminal penalties have discouraged users from seeking help and promoted risky practices that increase rates of infectious disease and death.[7] In turn, over the last decade communities and public officials have increasingly called for an approach to drug use that employs harm reduction principles, making the issue a public health concern rather than one to be managed by the criminal justice system.[8] Various harm reduction strategies can be incorporated at different points in the community and criminal justice system, from pre-arrest to post-reentry. Current strategies include law enforcement-assisted diversion (LEAD), medication-assisted treatment (MAT), distribution of naloxone (an antidote that reverses the effects of opioid overdoses), and syringe exchange programs (SEPs). All of these strategies have an established evidence base and proven viability at different intercepts in the criminal justice system, yet remain inaccessible to large groups of people.[9]

Law Enforcement Assisted Diversion (LEAD)

A small but growing number of jurisdictions across the country are developing law enforcement-led responses to improve health outcomes while protecting public safety. Seattle, for example, established the first LEAD program in 2011 and LEAD has since been launched in four additional jurisdictions; it is in development or under consideration in 39 more.[10] LEAD programs give police officers discretion to divert people involved in illegal activities who have behavioral health needs, such as substance use disorders, to case-management services, where a person can receive a wide range of community-based services including housing, employment support, and/or drug treatment. A three-year evaluation of the Seattle program demonstrated that LEAD participants fared better in multiple ways when compared to control participants who were arrested, taken into custody, and had criminal charges filed against them. LEAD participants were, on average, less involved in the criminal justice and legal systems and had lower associated costs; they were less likely to recidivate in the short-term (six months subsequent to entry) and the long-term (up to nearly three years

subsequent to entry depending on length of program participation); and they were significantly more likely to obtain housing, employment, and legitimate income in the 18 months following their LEAD referral (compared to the month prior to their referral).[11] Such results bolster support for diversion as a part of a comprehensive strategy to minimize the harms caused by substance use.

Medication-Assisted Treatment (MAT)

Experts agree that providing MAT, in combination with appropriate behavioral treatments, can help deter or alleviate drug dependence. A significant body of research demonstrates that medications like methadone and buprenorphine help people remain in treatment, decrease opioid use, and reduce criminal activity.[12] Nonetheless, justice-system actors—particularly courts and corrections professionals—have been slow to integrate MAT. A 2010 national survey of drug courts showed that although 98 percent reportedly had participants with opioid addictions, only 56 percent offered MAT.[13] Meanwhile, a 2008 national survey of prisons found that only 55 percent of facilities offered methadone, only 14 percent offered buprenorphine, and fewer than half referred people to MAT programs upon release.[14]

However, jurisdictions are beginning to respond to these gaps in treatment. Indiana, New Jersey, New York, and West Virginia state legislatures passed bills in 2015 that require drug courts to permit people to receive MAT for substance use disorders; Indiana and West Virginia's bills also make way for corrections departments to offer MAT to people in custody.[15] Furthermore, federal funding for drug courts is now contingent upon making MAT available to participants.[16] This gradual trend toward increasing the availability of MAT for people involved in the criminal justice system sets a new standard for making evidence-based treatment practices available in justice settings, even if implementation challenges remain.

Naloxone Distribution

The distribution and administration of naloxone—an antidote that reverses the effects of opioid overdoses—has gained increasing support in communities, given rising rates of opioid overdose deaths and the fact that naloxone is inexpensive and has no addictive properties. Largely as a result of legal changes, public access to and training in naloxone distribution has expanded dramatically. A 2014 survey by the Harm Reduction Coalition showed that between 1996 and 2014, community-based organizations across the United States provided

training and naloxone kits to over 150,000 laypersons—including people who use drugs, their families and friends, and service providers—and received reports of over 26,000 overdose reversals.[17] By June 2016, 47 states had passed legislation designed to improve public naloxone access.[18]

Currently, overdose education and naloxone distribution is less established across the criminal justice system and varies largely by jurisdiction and sector. The number of law enforcement agencies carrying naloxone has increased steadily in recent years—with 1214 law enforcement departments in 38 states carrying naloxone as of December 2016.[19] However, only a few jurisdictions are taking steps to adopt corrections-based overdose education programs or provide naloxone to people as they leave custody—a critical intervention point, given the high rates of drug-related death that occur in the period following one's release from prison. (One study in Washington State found that the relative risk of death from a drug overdose was over 12 times higher for people released from prison as compared with other state residents; the risk of overdose is even greater in the first two weeks after release).[20] In the past year, some efforts have emerged to make naloxone use more widespread for people in custody: the National Commission on Correctional Health Care adopted a policy position supporting increased access to naloxone in correctional facilities and some states are implementing overdose prevention measures for people transitioning from jail or prison to the community. (Examples can be found in jails in Durham County, North Carolina and San Francisco, California, as well as in prisons in New York and Rhode Island, among other locations).[21]

Syringe Exchange Programs (SEPs)

There are additional strategies to reduce the harms associated with drug use that do not necessarily take place at specific criminal justice intercepts but nonetheless require cooperation from criminal justice system actors to ensure that community members have access to needed services. SEPs—also known as syringe service programs, needle exchange programs, and syringe-needle programs—have long been considered a vital resource in curbing the spread of disease and infection among injection drug users; a 2014 survey estimates that 194 SEPs now operate in 33 states.[22] But law enforcement officers may actively discourage the use of these facilities by targeting enforcement efforts around needle exchange sites or using "drug paraphernalia" laws to arrest drug users who are returning used injecting equipment. They also may be unaware of or unfamiliar with the benefits of SEPs, such as a reduction in the number of needle-stick injuries that law enforcement officers experience. Indeed, policing practices in numerous jurisdictions still target SEP participants, despite the proven benefits such programs provide.[23]

Expert insights on the challenges and promise of implementing harm reduction strategies

Focusing on the array of harm reduction strategies currently used in various jurisdictions in the United States, Vera researchers interviewed 14 stakeholders in law enforcement, courts, corrections, drug policy, and the community about how they are responding to opioid-related issues in their communities and about how receptive their agencies and jurisdictions are to harm reduction strategies. For New Mexico, New York, and West Virginia, Vera interviewed stakeholders at both the city and county level: respectively, Albuquerque in Bernalillo County, Ithaca in Tompkins County, and Huntington in Cabell County. For North Carolina, Vera focused on statewide initiatives; interviewees included stakeholders who work across the state and one city-level official.

Methodology

The analysis, observations, and recommendations in this report are based on Vera researchers' review of the literature in the criminal justice, substance use treatment, and harm reduction fields, as well as on interviews with 14 local criminal justice stakeholders from New Mexico, New York, North Carolina, and West Virginia. Vera researchers identified jurisdictions for participation in these interviews based on a combination of the magnitude of the overdose epidemic in the jurisdiction and/or the presence of promising or novel harm reduction initiatives underway in those locations.

At the time of the interviews, West Virginia and New Mexico had the two highest rates of drug overdose mortality in the United States. (Age-adjusted rates of overdose deaths were 35.5/100,000 and 27.3/100,000 respectively). They now rank first and eighth according to the most recent data published by the Centers for Disease Control and Prevention (with age-adjusted rates of overdose deaths at 41.5/100,000 and 25.3/100,000). While New York and North Carolina both have comparatively lower overdose rates (13.6/100,000 and 15.8/100,000), they rank fifth and tenth nationally in the total number of overdose deaths.[a] Both states also have notable initiatives underway. In New York, the city of Ithaca recently released a groundbreaking plan to create a comprehensive health-based approach to drug policy and the state is

expanding overdose prevention within its correctional facilities. In North Carolina, the North Carolina Harm Reduction Coalition has become a national leader in expanding access to naloxone among law enforcement and has a strong record of legislative advocacy for supporting harm reduction approaches.

Once jurisdictions were identified, researchers contacted individuals in those jurisdictions who work in law enforcement agencies, the court system, corrections agencies, drug policy, or the community, and invited them to participate in telephone interviews focused on how their jurisdiction and sector is responding to the opioid epidemic. Researchers contacted 30 individuals and 14 responded and agreed to participate. One or two Vera researchers conducted interviews by telephone with those individuals between February and April 2016. Participants included stakeholders from a range of sectors: five from law enforcement; three from the court system; one from corrections; two who are leading the development of drug policy strategy for their jurisdictions (within a Mayor's Office of Drug Control Policy and a countywide Opioid Abuse Accountability Initiative, respectively); and three who work in the community (one parent advocate and two harm reduction experts).

a. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, "Injury Prevention & Control: Opioid Overdose State Data," February 22, 2017, https://www.cdc.gov/drugoverdose/data/statedeaths.html.

Of those interviewed, most people discussed wanting to shift from a punishment-oriented model to a treatment-oriented model in their jurisdictions' response to people who use drugs; many also reported that they had considered implementing some type of harm reduction practice in their jurisdiction, such as the ones discussed above. Collectively, the interviews revealed four key challenges to integrating harm reduction practices:

- defining and understanding what harm reduction means;
- assessing support for a range of harm reduction strategies;
- changing long-ingrained attitudes about crime and addiction; and
- conceptualizing how big or small a role the criminal justice system should have in the lives of people who use drugs.

Defining and understanding harm reduction

When asked to define harm reduction, stakeholders presented a wide range of answers. Some interviewees mentioned its core principle—reducing the negative effects of drug use—though most did not, and several cited the importance of minimizing disease transmission. Other respondents were quite broad in their definitions, describing harm reduction as a way to save

lives or using the phrase "harm reduction" to signal approaching drug use as a public health issue rather than a criminal justice issue.

Respondents lacked clarity about the spectrum of strategies that could fall under the umbrella of "harm reduction." Only three of the 14 people with whom Vera spoke were able to describe a full range of harm reduction techniques for drug use—from LEAD, to MAT, to naloxone distribution, to SEPs, and supervised injection facilities. Others were unaware of the range of options or admitted they were not familiar enough with the evidence base to support currently using a particular technique.

Assessing support for different harm reduction strategies

When Vera researchers asked stakeholders more specifically about harm reduction strategies currently being used within the justice system, it became clear that there is a continuum of comfort with different harm reduction techniques. The use of naloxone and MAT are illustrative examples. All jurisdictions discussed in this brief have state laws that provide civil and/or criminal immunity to licensed healthcare professionals for the administration of naloxone.[24] Almost all interviewees supported community-based naloxone distribution, often described as an inevitable response to the worsening opioid overdose epidemic or as a technique for which there is mounting peer pressure to endorse.

However, several interviewees reported lingering resistance to law enforcement carrying or administering the antidote in the jurisdictions where they are based. Interviewees described a lack of resources or bandwidth for police departments to take on added responsibilities, a feeling that the service may not be necessary if fire departments and EMTs were already carrying naloxone, and a continuing concern about liability since police officers are not medical professionals.[25] In terms of distribution in jail or prison, Ray Bunce, captain of the Corrections Division in the Tompkins County Sheriff's Office, recognized the importance of providing overdose education and facilitating access to treatment for people who used drugs, but opposed the practice of naloxone distribution upon release from jail. He cited what some research shows to be a commonly shared misconception—that equipping drug users with naloxone incentivizes riskier using behavior.[26] He also noted the challenge of distribution in jail settings, since delivering effective behavioral health services requires rapport between providers and patients, which is inherently challenging in a transient environment. Moreover, many jails lack the staffing and resource capacity to adopt new programs, and have organizational cultures resistant to harm reduction approaches.[27] Even with these barriers, there are examples of jail-based MAT programs nationwide, including a program that has been in operation in the New York City jail since 1987.[28]

The use of MAT in drug courts and in correctional facilities was much rarer in Vera's sample,

often due to legal, logistical, or capacity issues. Even as laws change to expand the use of MAT in drug court and federal funding for drug court becomes contingent on allowing access to MAT, wide-scale implementation and accessibility of such programs is dependent on a host of factors. Indeed, courts must address practical and cultural barriers to using MAT by adapting supervision and monitoring practices, developing relationships with treatment programs and prescribing physicians, ensuring that decisions about access to medication are solely the responsibility of trained clinicians, and educating drug court staff about the use and efficacy of MAT.

Voices from the Field: On harm reduction, naloxone distribution, and MAT

"We approach it as a public health issue and not a [criminal justice] issue… To put it in a nutshell, the stance I take is that it's got to be as easy to get into treatment as it is into jail." – Gwen Wilkinson, former district attorney (Tompkins County, New York)

"Naloxone distribution has a little bit of a domino effect. As an agency, we have initiated the use of naloxone statewide to multiple law enforcement jurisdictions. The agencies that are currently not using naloxone are falling like dominos because the heroin and opioid problem is so severe that there is little choice but to approach this epidemic differently… Do you really want your municipality to be the last domino to fall to make a progressive change that could prevent people from dying from overdoses in your community?" – Ronald Martin, harm reduction policing advocate (North Carolina)

"We're getting all these front-running therapy services [services given to people in drug court], helping you get a job, get connected with your family, helping you get an education, helping you get housing. How do we know that you're learning any of these things to move forward? Really how we can make sure we can keep them drug free?" – Patricia Keller, judge (Cabell County, West Virginia)

Changing attitudes about crime and addiction

Although leaders in the criminal justice field increasingly are recognizing the limitations of traditional criminal justice approaches to drug use, interviewees admitted they face

challenges when it comes to changing attitudes and implementing practical change. They commonly described how their own attitudes toward drug use and addiction have evolved because of their increasing proximity or even personal connection to people confronting the opioid epidemic. Indeed, the rising numbers of people dying from drug overdoses and the fact that drug arrests continue to be the leading cause of arrest in the United States has changed attitudes and perhaps even diminished stigma around people with substance use disorders.[29] Robert Childs, a harm reduction expert in North Carolina, observed what he called a "sea change" in law enforcement due to the fact that most everyone now knows someone who has been affected by the opioid epidemic. The result is that there is more support—at least theoretically—for treatment-oriented solutions.

However, even as interviewees acknowledged that broad attitudes are changing and softening, they also noted that there remains resistance to changing practice on the ground. For example, Joseph Ciccarelli, the police chief of Huntington, West Virginia, described how some police officers can be resistant to LEAD programs because they perceive them as "feel good kind of programs" (see below for "Voices from the Field: On treatment, new models, and old policing methods"). For North Carolina, Mr. Childs cited how some communities are hesitant to implement LEAD because they fear they won't look tough on crime if they divert people to services rather than arrest them. But other interviewees spoke about confronting more deep-seated beliefs about drug use and addiction. Nan Nash, chief judge in New Mexico's 2nd District Court, explained that allowing MAT in drug courts would appear to be a "very radical approach" to some people, even if they can articulate the theory that addiction is a disease, because of deeply ingrained beliefs that anyone can stop using drugs if they just work hard or have enough will power. Thus, despite evidence showing that MAT can aid in recovery, giving people drugs to treat drug addiction may fly in the face of the abstinence-only model on which drug courts traditionally have been based; it asks people to reframe what addiction means and how it can be managed.

Many of the people in Vera's sample asserted that, despite increasingly progressive attitudes, change would have to be incremental in their agency or jurisdiction and should be approached cautiously. Interviewees discussed the importance of knowing their audience when advocating for the use of new approaches. Whether people are moved by the human cost of overdose, the financial cost of drug addiction and incarceration, or the framing of substance use as a public safety or public health problem, stakeholders stressed that there is something in this for everybody—that the current system is so broken that there is inevitably some common goal despite different justifications for it. In the words of harm reduction policing advocate Ronald Martin, "Anything you can do to change the temperature one degree is like a win for your organization." Such comments suggest there is a very pragmatic aspect to the work of changing justice system responses to drug use. Even without broad agreement on the nature of addiction, justice stakeholders may agree on the viability of trying harm reduction approaches.[30]

Voices from the Field: On personal connections and changing beliefs

"Even though it is fairly well-established that drug abuse—and alcoholism for that matter—are diseases, there is still a notion, just a sort of deep-seated subconscious feeling, that you can get a hold of it if you're really dedicated to getting a hold of it. There isn't a person who doesn't know somebody who has become sober—you know, conquered their addiction—so there's this belief that, well, if one person can do it, anyone can do it… So, I think that there is your rational mind and then there's this nagging subconscious [feeling] that if you really wanted to do it, you would do it, so why are you giving folks an out? Why are we making it easy for them not to do it? It just in some ways goes against the grain of our model, which is a model that expects people to change their behavior." – Nan Nash, chief judge (2nd District Court, New Mexico)

"I think, as a law enforcement agency, we're here to serve a community and the national motto of protect and serve. I think protection means more than arrest, means more than deterring crime; we're a community partner and this is a social issue that affects many families for many years. I know of families that are dealing with multiple addictions within the home, and they've had 10 to 15 years of waiting for the phone call that their child has OD-ed on a drug." – Brad Shirley, police chief (Boiling Spring Lakes, North Carolina)

"Now all of a sudden, when the opiates came in, that wasn't just 'that part of society'; that was your family; that was your neighborhood. Everybody knows somebody that's been touched by it…You have to understand that it's not a moral decision they're making. It's in your family; it's in your neighborhood…It's in your home now; it's in your church; it's in your office." – Jim Johnson, director, Mayor's Office of Drug Control Policy (Huntington, West Virginia)

"We had a few people who were like, 'Why are we bringing them back? That's natural selection's way of getting rid of these problems. Let them die.' But it didn't take long for them to realize that this could be your kid; this could be your neighbor; this is happening to the lawyers; it's happening to professionals; it's happening to everyone in your community." – Patricia Keller, judge (Cabell County, West Virginia)

Right-sizing the criminal justice response

While there is growing recognition that harm reduction principles are an essential component of any community's response to drug use, there are still a range of questions about the appropriate role for the criminal justice system in responding to drug use. For example, if the current or old model is broken, what should the new model look like? Even if there is

increasing momentum for adopting harm reduction approaches in the justice system and even if more people agree that the standards of care in the justice system should match those of community care, when is it appropriate for the criminal justice system to be the pathway to treatment, and when is it more appropriate to keep people out of the criminal justice system altogether? What role can criminal justice leaders play in advocating for increased resources for a stronger public health infrastructure to respond to issues rooted in addiction and poverty, and a smaller role for law enforcement, courts, and corrections?

Interviewees were especially reflective in describing the traditional roles their agencies have played in relation to drug use as well as their ambivalence about what a new approach could look like. Court system actors described increasing recognition of the limits of a model that places more emphasis on punishment but were unsure of what a better model would look like. For example, Gwen Wilkinson, the former district attorney in Tompkins County, New York, acknowledged that while her office is mandated to prosecute crime, she sought to integrate harm reduction approaches when applying the law. Judge Nash of New Mexico described how judges easily recognize the need for additional, non-punitive approaches, but also admitted that many lack knowledge about the efficacy of alternatives, especially those that are not abstinence-based.

Police were equally open about the limitations of their traditional approach to drug use and addiction, but all echoed the sentiment that there is no simple solution to confronting the drug epidemic in their communities, short of re-envisioning the role of police. This is not an easy task given the hard work of changing attitudes described above and the reality that different criminal justice stakeholders will invariably be driven by competing priorities or incentives and may operate with varying degrees of knowledge of, or enthusiasm for, alternatives. But the very fact that leaders in law enforcement are starting to articulate questions about the appropriate role of their agency in responding to drug use indicates there are opportunities for conversation about how to define the potential new roles of the various criminal justice actors who find themselves responding to a worsening drug epidemic.

Notably, a wider role for the police, prosecutors, or judges in responding to drug use—even through the adoption of innovative treatment alternatives and harm reduction approaches—may reinforce the idea that people must enter the criminal justice system in order to get needed health treatment, particularly in places where there is an absence of community-based treatment or services, therefore increasing the number of people who get arrested. For example, Huntington, West Virginia police chief Ciccarelli described having more success with post-arrest diversion than pre-arrest diversion, in part because he believes that the mechanism of arrest often serves as the necessary entrée to recovery for many people—a "wake-up call" of sorts—and keeps officers from feeling that they're enabling immoral activity. (See below for "Voices from the Field: On treatment, new models, and old policing methods.")

Several interviewees said they wanted to provide interventions for people struggling with drug addiction outside the criminal justice system, but were unable to do so because pre-

arrest or community care options are limited or nonexistent. In Huntington, West Virginia, for example, the Women's Empowerment and Addiction Recovery Program is a vital pathway to treatment for women who engage in sex work and have a substance use disorder, but it is only open to women arrested on felony charges. Access to treatment is thus dependent on deep criminal justice involvement, which brings a host of long-term collateral consequences such as limited access to employment, public benefits, or participation in civic life.

Voices from the Field: On treatment, new models, and old policing methods

"I can inform my approach to prosecutions and investigations with an eye to having the best public safety outcome I can—and that is legitimately a decline in the numbers of addicted people—by putting them in touch with treatment." – Gwen Wilkinson, former district attorney (Tompkins County, New York)

"The criminal justice system has embraced this model… the carrot [and] stick model and we understand that model because we understand being a stick, but ok, that helps some people, but what else is out there? What else can and should we do?… I need to have more information about the efficacy of [harm reduction] programs but from what I understand… those programs offer a potential avenue that the system has to consider." – Nan Nash, chief judge (2nd District Court, New Mexico)

"I think that all of these 'feel good' kind of programs will always…raise concerns…We can keep doing what we've been doing for the last 50 years that hasn't worked or we can do something different. Quite frankly, [police] are paying the consequences of criminal activity. So, I think from that standpoint it's a little more powerful to the average policeman on the street to say, 'If they have a needle on them, I don't care if they got it from the health department harm reduction program; if they're shooting heroin, you charge them with it. You let the judge worry about what's going to happen and that's when you get them into diversion and into the treatment program.' To some degree the policeman contents himself that he's not enabling anybody. That he's doing his job. Those arrests are halfway to recovery for some people. Those citations are a mechanism for a wake-up call." – Joseph Ciccarelli, police chief (Huntington, West Virginia)

Conclusion

The knowledge and attitudes of these select criminal justice stakeholders suggest that although the opioid overdose epidemic has created a key moment for shifting the paradigm of how the United States responds to substance use—away from criminalization and toward a public health approach that incorporates principles of harm reduction—there remains a number of significant obstacles to overcome. These obstacles include the still nascent understanding about what harm reduction means and how it can be incorporated into the justice system; a range of opinions about the spectrum of techniques appropriate for integration; deeply held beliefs about the nature of addiction and viable avenues for recovery; and legitimate questions about the appropriate role of the justice system in responding to drug use. To best address these obstacles and help interested jurisdictions introduce harm reduction strategies, it is clear that the justice system requires at least three avenues of work:

1. The launch of a more visible campaign to raise awareness and build a cadre of credible messengers who can attest to the value of a public health approach in the criminal justice system;

2. The dissemination of practical guidance for jurisdictions on how to implement evidence-based harm reduction strategies across different criminal justice intercepts (such as toolkits for implementing evidence-based approaches from pre-arrest to post-reentry; case studies from jurisdictions that have implemented strategies with success; and the provision of technical assistance during implementation); and

3. The development of a research program evaluating the implementation of harm reduction approaches in criminal justice settings (such as implementation studies that follow jurisdictions as they build the capacity for data collection, tracking, and evaluation of the evidence-based approaches they apply).

Without this work—that is, the creation, testing, and dissemination of concrete models, ideas, and tools for integrating harm reduction across the system and right-sizing the role of the justice system in the lives of people who use drugs—this promising moment could be squandered. But stakeholders interviewed were optimistic that a new model for responding to drug use—one based in principles fundamental to public health—is possible.

As Judge Nash said, “Once you get caught up in the criminal justice system, your ability to

lead a normal life—normal being defined as, 'I have a job, I pay my rent, I have a place to live, and I live my life'—is more and more difficult." Transforming the criminal justice system from a "life-interruption model" to an avenue for increased recovery options necessitates that the system be capable of proving evidence-based care—a standard that includes embracing harm reduction. And as long as criminal justice stakeholders remain frequent first and second responders to people in crisis, they must develop a robust set of strategies for responding to substance use that goes beyond arrest and incarceration. In the words of Kenneth Burner, West Virginia state coordinator of the Appalachia High Intensity Drug Trafficking Area, they must, "embrace the fact that there's going to be a new normal in the United States."

Endnotes

1. Rose A. Rudd et al., "Increases in Drug and Opioid Overdose Deaths — United States, 2000-2014," Morbidity and Mortality Weekly Report 64, no. 50 (2016): 1378-1382; Rose A. Rudd et al., "Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010-2015," Morbidity and Mortality Weekly Report, no. 65 (2016): 1445-1452, DOI: https://perma.cc/UXB2-AGB4. Prescription opioids are medications that relieve pain by reducing the intensity of pain signals reaching the brain. Medications falling within this class include hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine (e.g., Kadian, Avinza), codeine, and related drugs. Heroin is an opioid drug that is synthesized from morphine. See National Institute of Drug Abuse, "What are opioids?" November 2014, https://perma.cc/D7AH-LVYZ; and National Institute of Drug Abuse, "Drug Facts: Heroin," October 2014, https://perma.cc/K9BN-27MK

2. Haeyoun Park and Matthew Bloch, "How the Epidemic of Drug Overdose Deaths Ripples Across America," *The New York Times*, January 19, 2016, http://www.nytimes.com/interactive/2016/01/07/us/drug-overdose-deaths-in-the-us.html.

3. Robert Wood Johnson Foundation, *The Facts Hurt: A State-by-State Injury Prevention Policy Report* (Washington, D.C.: Robert Wood Johnson Foundation, 2015).

4. Congress, "Comprehensive Addiction and Recovery Act of 2016," https://perma.cc/5L6J-

WJ67.

5. Federal Bureau of Investigation, *2015 Crime in the United States*, https://perma.cc/EP6K-QXPD.

6. National Center on Addiction and Substance Abuse at Columbia University (CASA), *Behind Bars II: Substance Abuse and America's Prison Population* (New York: CASA, 2010).

7. Joanne Csete et al., "Public Health and International Drug Policy," *The Lancet* 387, no. 10026 (2016): 1427-1480; Global Commission on Drug Policy, *The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic*, May 2013, https://perma.cc/2LTD-BQZX; and Ernest Drucker, "Drug Prohibition and Public Health: 25 Years of Evidence," *Public Health Reports* 114, no. 1 (1999): 14-29.

8. There are various—and often overlapping—ways to describe the emerging set of approaches for responding to drug use across intercepts in the criminal justice system. These include the "four-pillar approach" and the "public health approach to drug use." See, for example, Donald MacPherson, *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*, (City of Vancouver: April 24, 2014), https://perma.cc/5AZ3-SLBV; American Public Health Association, *Defining and Implementing a Public Health Approach to Drug Use and Misuse*, Policy Statement Number 201312, November 5, 2013, https://perma.cc/7SMX-UGXQ; and Tracy Pugh et al., *Blueprint for a Public Health and Safety Approach to Drug Policy* (New York: New York Academy of Medicine and Drug Policy Alliance, 2013).

9. Safe Injections Facilities (SIFs) are a somewhat common harm reduction strategy in countries such as the Netherlands, Germany, Canada, and Norway. Several stakeholders in Ithaca, New York, including the mayor, have publicly announced plans to create a SIF, as part of their four-part plan to combat overdose. See City of Ithaca, *The Ithaca Plan: A Public Health and Safety Approach to Drugs and Drug Policy,* https://perma.cc/V25U-EFUM. However, this is not a tactic that has gained traction in most jurisdictions as it remains controversial. See, for example, William A. Jacobson, "Does Ithaca really need a government-run heroin shooting gallery?" *Legal Insurrection*, February 23, 2016, https://perma.cc/57HS-44MN.

10. See the Lead National Support Bureau, http://www.leadbureau.org/.

11. Susan E. Collins, Heather S. Lonczak, and Seema L. Clifasefi, *LEAD Program Evaluation: Recidivism Report* (Seattle: University of Washington Harm Reduction Research and Treatment Center, 2015); Susan E. Collins et al., *LEAD Program Evaluation: Criminal Justice*

and Legal System Utilization and Associated Costs (Seattle: University of Washington Harm Reduction Research and Treatment Center, 2015); and Susan E. Collins et al., *LEAD Program Evaluation: The Impact of LEAD on Housing, Employment and Income/Benefits* (Seattle: University of Washington Harm Reduction Research and Treatment Center, 2016).

12. Catherine Anne Fullerton et al., "Medication-Assisted Treatment with Methadone: Assessing the Evidence," *Psychiatric Services* 65, no. 2 (2014): 146-157; Cindy Parks Thomas et al., "Medication-Assisted Treatment with Buprenorphine: Assessing the Evidence," *Psychiatric Services* 65, no. 2 (2014): 158-170; and Timothy W. Kinlock et al., "A randomized clinical trial of methadone maintenance for prisoners: Results at 12 months post-release," *Journal of Substance Abuse Treatment* 37, no. 3 (2009): 277-285.

13. Harlan Matusow et al., "Medication Assisted Treatment in U.S. Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes," *Journal of Substance Abuse Treatment* 44, no. 5 (2013): 473-480.

14. Amy Nunn et al., "Methadone and Buprenorphine Prescribing and Referral Practices in U.S. Prison Systems: Results from a Nationwide Survey," *Drug and Alcohol Dependence* 105 (2011): 83-88.

15. New Jersey S2381 (2015); New York AB 6255 (2015); Indiana HB 1304 (2015); and West Virginia HB 2880 (2015).

16. Sally Friedman and Kate Wagner-Goldstein, *Medication Assisted Treatment in Drug Courts: Recommended Strategies* (New York: Center for Court Innovation, 2015).

17. Since 2008, the Harm Reduction Coalition has maintained a database of organizations providing naloxone kits to laypersons; Eliza Wheeler et al., "Opioid Overdose Prevention Programs Providing Naloxone to Laypersons—United States, 2014," *Morbidity and Mortality Weekly Report* 64, no. 23 (2015): 631-635.

18. A corresponding trend is for jurisdictions to pass "Good Samaritan" laws that encourage bystanders to summon emergency responders in the event of an overdose without fear of arrest or other negative legal consequences. See The Network for Public Health Law, *Legal Interventions to Reduce Mortality: Naloxone Access and Overdose Good Samaritan Laws* (St. Paul, MN: The Network for Public Health Law, 2016), https://perma.cc/4PUG-HTHZ; and Rebecca Silber, Ram Subramanian, and Maia Spotts, *Justice in Review: New Trends in State Sentencing and Corrections 2014-2015* (New York: Vera Institute of Justice, 2016).

19. North Carolina Harm Reduction Coalition, "Law Enforcement Carrying Naloxone,"

https://perma.cc/69T5-58GM. There is also increased federal support for law enforcement agencies to establish naloxone programs. See, for example, National Training and Technical Assistance Center, Bureau of Justice Assistance, "Law Enforcement Naloxone Toolkit," https://perma.cc/B4RW-F4FW.

20. Ingrid A. Binswanger et al., "Release from Prison – A High Risk of Death for Former Inmates." *New England Journal of Medicine* 356 (2007): 157-165; and World Health Organization, *Preventing overdose deaths in the criminal-justice system* (Copenhagen, Denmark: World Health Organization, 2014).

21. National Commission on Correctional Healthcare, *Position Statement: Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths* (Chicago: NCCH, 2015); North Carolina Harm Reduction Coalition, "Durham Jail First in South to Provide Naloxone to Released Inmates," May 22, 2015, https://perma.cc/Z9RX-TAFC; Lauren Enteen et al., "Overdose Prevention and Naloxone Prescription for Opioid Users in San Francisco," *Journal of Urban Health* 87, no. 6 (2010): 931-941; Howard Zucker et al., "Overdose Prevention for Prisoners in New York: A Novel Program and Collaboration," *Harm Reduction Journal* 12 (2015): 51; and Traci C. Green et al., "Two cases of intranasal naloxone self-administration in opioid overdose," *Substance Abuse* 35, no. 2 (2014):129-132.

22. World Health Organization, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injection Drug Users* (Geneva: World Health Organization, 2004); and American Foundation for Aids Research (amfAR), "Syringe Services Program Coverage in the United States – June 2014," https://perma.cc/8W9N-67AN.

23. David Cloud and Chelsea Davis, *First Do No Harm: Advancing Public Health in Policing Practices* (New York: Vera Institute of Justice, 2015).

24. As of July 2016, 46 out of 50 jurisdictions had naloxone access laws passed. See Law Atlas, *Naloxone Overdose Prevention Laws Map*, https://perma.cc/S2JE-QD27.

25. A review of the literature on liability around naloxone administration suggests that the risk for a law enforcement officer or their employer is low. In nearly all states, laws exist that specifically provide extra liability protections for law enforcement officers. Furthermore, the majority of the states that now have naloxone access laws provide for civil and criminal immunity for any person administering naloxone in good faith. See Law Atlas, "Naloxone Overdose Prevention Laws" map, https://perma.cc/D7ST-DMUQ; and Bureau of Justice Assistance, *Law Enforcement Naloxone Toolkit*, https://perma.cc/MQW5-K4LL.

26. Nancy Worthington et al., "Opiate Users' Knowledge About Overdose Prevention and

Naloxone in New York City: A Focus Group Study," *Harm Reduction Journal* 3, no. 1 (2006): 19-26; and Michael A. Yokell et al., "Opioid Overdose Prevention and Naloxone Distribution in Rhode Island," *Medicine and Health, Rhode Island* 94, no. 8 (2011): 240-242.

27. Peter D. Friedmann, Faye S. Taxman, and Craig E. Henderson, "Evidence-based treatment practices for drug-involved adults in the criminal justice system," *Journal of Substance Abuse Treatment* 32, no. 3 (2007): 267-277; and Peter D. Friedmann et al., "Medication-assisted treatment in criminal justice agencies affiliated with the criminal justice-drug abuse treatment studies (CJ-DATS): availability, barriers, and intentions," *Substance Abuse* 33, no. 1 (2012): 9-18. To address these concerns, jail administrators can partner with community harm reduction organizations and local health departments to plan and implement overdose education and prevention programs. For example, the Harm Reduction Coalition has developed a manual to assist local leaders working to get programs off the ground. See Eliza Wheeler et al., *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects* (New York: Harm Reduction Coalition, 2012).

28. Christine Vestal, "At Rikers Island, a Legacy of Medication-Assisted Opioid Treatment," *The Pew Charitable Trusts*, May 23, 2016, https://perma.cc/NRY7-TRZ4.

29. Although a full examination of the changing demographics of overdose deaths is beyond the scope of this paper, it is relevant to note that the conversation around treatment-oriented solutions to the opioid epidemic has expanded at the same time that the epidemic has impacted more white people from rural and suburban communities. From 1999 to 2014, the rate of overdose for white people ages 25 to 34 increased fivefold, and tripled among those 35 to 44 years old. See Gina Kolata and Sara Cohen, "Drug Overdoses Propel Rise in Mortality Rates of Young Whites," *The New York Times*, January 16, 2016, http://www.nytimes.com/2016/01/17/science/drug-overdoses-propel-rise-in-mortality-rates-of-young-whites.html.

30. For example, as an evidence-based approach, medication-assisted treatment resonates with people who understand addiction as a disease. Because MAT has been shown to be associated with reduced recidivism, it can also appeal to stakeholders who are primarily concerned with improving public safety and reducing costs. See Amy Nunn et al., 2011; and Nicole Egli et al., "Effects of Drug Substitution Programs on Offending among Drug-Addictions: A Systematic Review," *Campbell Systematic Reviews* 5, no. 3 (2009).