March 2, 2015

Charles Colson Task Force on
Federal Corrections
Washington DC

Re: Medication-Assisted Therapy in Bureau of Prisons

Dear Members of the Task Force:

Thank you for the opportunity to submit testimony regarding the need to increase the availability of medication-assisted therapies (MAT) in federal prisons. Dr. Rich is the Professor of Medicine and Epidemiology at Brown University and founding Director of the Center for Prisoner Health and Human Rights at the Miriam Hospital in Providence, Rhode Island. For more than a decade, Dr. Rich has written extensively on the topic of medication-assisted therapies in prison settings and serves as a clinician and medical advisor to the Rhode Island Department of Corrections. Ms. McLemore is an attorney and Senior Researcher at Human Rights Watch with extensive experience in issues of prison health.

Currently, the policy of the BOP states that "suboxone/buprenorphine will only be prescribed for detoxification, not for pain or maintenance therapy," and methadone is similarly restricted. [i] There is a pilot program underway at several sites that provide naltrexone[ii] for selected prisoners about to be released. This is an important step forward given that the risk of relapse and overdose for prisoners at re-entry is extremely high. [iii] However, given the consensus in the medical community that MAT in conjunction with behavioral therapy is the standard of care for opioid dependence, we urge the Bureau of Prisons (BOP) to accelerate the availability of MAT for opioid-dependent prisoners by 1) expanding sites of field testing for its re-entry initiative and 2) implementing a pilot program for providing maintenance therapy for opioid-dependent prisoners during incarceration.

The scientific evidence for treatment of opiate dependence using the medication-assisted therapies methadone, buprenorphine and the buprenorphine formula Buprenorphine/naloxone (Suboxone) as well as depot naltrexone * is well established. Indeed, a March 2013 report from the US Bureau of Justice Assistance (BJA) reviews this extensive evidence for its appropriateness in criminal justice settings and concludes:

> Medication-assisted treatment for opioid users is associated with reductions in recidivism, incarceration and decreased crime and reduced HIV and Hepatitis C infection (citations omitted). These effects are many times greater (emphasis in original) than the effects of behavioral treatments without medications. Despite all the evidence, MAT remains one of the most under-utilized tools for reducing recidivism. [iv]

The National Reentry Resource Center, cited recently by Attorney General Eric Holder as a reference for corrections policy, also recommends increased use of medication-assisted therapy in correctional settings. [v] In February, 2015 the Office of National Drug Control Policy called MAT combined with behavioral therapy the "standard of care" for opioid dependence and announced that drug courts must make MAT available in order to be eligible for federal funds. [vi]

Significantly, the BOP itself has determined that abstinence-based programs for opioid-dependent prisoners are not effective. In a memo dated March 2014, BOP Medical Director Newton E. Kendig wrote, "Even though our drug treatment programs are very successful for the majority of substance abusers, research has shown that abstinence-based programs similar to ours only offer a 1 in 10 chance of success for opiate-dependent participants." A copy of this memorandum is attached to this submission.

As with any controlled substance in a prison environment, MAT must be carefully administered to prevent diversion. However, direct observation is feasible and is commonly practiced with methadone, buprenorphine and other medications in jails and prisons throughout the world. The National Commission on Correctional Health recommends making medication-assisted therapy

available for opiate dependent prisoners and provides accreditation of facility programs as well as technical assistance. The BJA report notes that proper administration of MAT in prisons has been found to increase security and reduce drug-seeking behavior and contraband among the population. [vii]

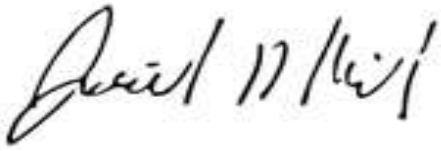
We urge the BOP to revise its policy to make MAT treatment available to prisoners during incarceration. Addiction is a chronic, relapsing disease and many opioid-dependent prisoners inevitably find narcotics in prison and suffer harsh punishment as a result. Human Rights Watch has documented the months, even years, of solitary confinement endured by prisoners in New York State prisons whose relapses are severely punished. [viii]Human Rights Watch is also closely following the case of Gordon Goodwin, a BOP prisoner who suffered serious disciplinary action for relapse, including solitary confinement and loss of family visiting privileges, then was transferred to a high security prison as a result of his "dirty urine" where he was stabbed over the Christmas holidays by another inmate. (An article describing Mr. Goodwin's case authored by Ms. McLemore has been accepted by *Politico* and is forthcoming.) Mr. Goodwin's experience illustrates that the human cost of failing to provide adequate medical care to prisoners dependent on opioids can be tragic, and is no longer acceptable. Where clinical assessment determines it to be appropriate, MAT should be made available during incarceration. This approach conforms to the stated intention of the BOP medical service to "deliver health care to inmates in accordance with proven standards of care without compromising public safety concerns inherent in the agency's overall mission."[ix]

Treating prisoners under current medical standards of care is not only better policy but a legal obligation. Prison health care is an activity subject to the obligations set forth in the ADA.[x]Federal courts have consistently found drug-dependent individuals to meet the criteria for "disability" under the ADA.[xi]Denial of a medication prescribed in the community for prisoners during incarceration violates the Act's prohibition against discrimination based on disability, particularly when it is pursuant to a blanket policy prohibiting a specified course of medical treatment for affected individuals.[xii]"Reasonable accommodation" is required on an individual basis under federal law. [xiii]

Further, forcing prisoners into withdrawal from medication, creating a risk of relapse and subsequent punitive action in prison, particularly when prison officials themselves have acknowledged the failure of their current treatment approach, can violate the Eighth and Fourteenth Amendments of the US Constitution's prohibition against cruel and unusual punishment as "deliberate indifference to a serious medical need."[xiv] A failure to provide adequate medical care can be unconstitutional when it involves an "unnecessary or wanton infliction of pain." [xv]In addition, the United States is a party to the International Covenant on Civil and Political Rights (ICCPR) which guarantees to all persons the right to life, and to be free from cruel, inhuman or degrading treatment; and if deprived of their liberty to be treated with humanity and with respect for the inherent dignity of the human person.[xvi] Under the ICCPR, governments must "provide adequate medical care under detention." [xvii]

Medication-assisted therapy in conjunction with behavioral therapy is the standard of care for opioid dependence, and the BOP has recently acknowledged the inadequacy of its current treatment approaches. It is time for this to change, and we respectfully urge the Task Force to recommend that the BOP accelerate its availability of medication-assisted therapy to prisoners dependent on opioids both during incarceration and upon re-entry to the community. We stand ready to provide any assistance or information that might be helpful in relation to this topic. Thank you very much for your consideration.

Respectfully submitted,



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[ii] US Bureau of Prisons Health Services, National Formulary, 2012, p. 16.

[ii] In the interest of full disclosure, Dr. Rich is a stockholder in Alkermes, a company that produces a depot-naltrexone formulation.

[iii]Ingrid Binswanger et al., "Release from Prison-A High Risk of Death for Former Inmates," *New England Journal of Medicine* , vol. 356(52), 2007, p. 157.

[iv] US Bureau of Justice Assistance, "RSAT Training Tool: MAT for Offender Populations," March 10, 2013, http://www.rsat-tta.com/Files/Trainings/FinalMAT (accessed March 2, 2015), p. 5.

[v]National Reentry Resource Center, "Key Resources," http://csgjusticecenter.org/reentry/issue-areas/substance-abuse/ (accessed March 2, 2015).

[vi]Jason Cherkis, "Federal Government Set to Crack Down on Drug Courts That Fail Addicts," *Huffington Post*, February 5, 2015, http://www.huffingtonpost.com/2015/02/05/drug-courts-suboxone_n_6625864.html (accessed March 2, 2015).

[vii] US Bureau of Justice Assistance, "RSAT Training Tool: MAT for Offender Populations," http://www.rsat-tta.com/Files/Trainings/FinalMAT, pg. 8.

[viii] Human Rights Watch, *Barred from Treatment: Punishment of Drug Users in New York State Prisons*, March 2009 http://www.hrw.org/sites/default/files/reports/nyprisons0309webwcover_0.pdf.

[ix] "BOP Patient Care Policy 6031.03," August 23,2012, http://i2.cdn.turner.com/cnn/linkto/pdf/6031_003.pdf (accessed March 2, 2015).

[x]42 U.S.C. 12132; Pennsylvania Department of Corrections v. Yesky, 524 US 206 (1999).

[xi]See, e.g. *MX Group Inc. v City Of Covington*, 293 F.3d 336 (6th Cir. 2002).

[xii]A complete discussion of the obligations under US law to provide medication-assisted therapy, is available in the report from the Legal Action Center, "Legality of Denying Access to Medication-Assisted Therapy in the Criminal Justice System," December 2011, http://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf (accessed March 2, 2015).

[xiii]Title II of the ADA requires government agencies to make reasonable accommodation to polices, practices and procedures to avoid discrimination. 28 CFR 35.130 (b) (7).

[xiv]*Estelle* v. *Gamble*, 429 US 97 (1976).

[xv]*Gregg* v.*Georgia*,428 US 153,173 (1976).

[xvi]International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc. A/6316 (1966), 999 UN T.S. 171, entered into force March 23, 1976, ratified by the US on June 8, 1992, arts. 6, 7, 10(1).

[xvii]*Pinto* v. *Trinidad and Tobago* (Communication No. 232/1987) Report of the Human Rights Committee, vol. 2, UN Doc A/45/40, p. 69.

Sent to Public 3-14-14

MEMORANDUM FOR EXECUTIVE STAFF

FROM: Linda T. McGrew, Assistant Director
Reentry Services Division

RADM Newton E. Kindig, Assistant Director
Health Services Division

DATE: March, 2014

SUBJECT: Medication-Assisted Treatment Field Trial
(Information Paper)

Historically in the Bureau of Prisons our method for providing substance abuse treatment has been through the Residential and Non-Residential Drug Abuse Treatment Programs. Over 35,000 inmates participate in these programs each year. Even though our drug treatment programs are very successful for the majority of substance abusers, research has shown that abstinence-based programs similar to ours only offer a 1 in 10 chance of success for opiate-dependent participants. Studies have demonstrated that Medication-Assisted Treatment (MAT), combined with substance abuse counseling, is an evidenced-based practice which provides more successful treatment outcomes for individuals with a history of opioid (heroin) dependence.

Overview of the Issue:

In support of this best practice, and as part of a national initiative, the President's Office of National Drug Control

Policy (ONDCP) is eager for the BOP to move forward with providing MAT for inmates with a history of opioid dependence.

Given the Bureau's desire to provide the most effective evidence-based treatment, combined with the ONDCP initiative to increase treatment of opioid dependence through the use MAT, the Bureau has a need to explore the use of MAT both inside our institutions and in the Residential Reentry Center (RRC).

The Suggested Response:

As an initial step in defining the use of MAT in the BOP, the Reentry Services Division (RSD), in collaboration with the Health Services Division (HSD), would like to conduct a field trial of providing MAT in one or more of the three institutions (FMC Carswell, FCI Fort Worth, FCI Seagoville) located in the Dallas Metroplex. To this end, a multi-disciplinary team was created to determine the operational procedures necessary to conduct the trial. The team consists of individuals from Psychology, Health Services, and Community Treatment. The recommendations of the team are presented in the following description of the field trial. All operational procedures incorporated into this field trial are currently covered by existing policies.

If approved by the Executive Staff, the field trial would begin this summer. We anticipate a small number of inmates in the Metroplex institutions will meet all of the field trial criteria. That is, they must be within a few months of releasing to a metroplex RRC, have an opioid use disorder, be in good health, and volunteer to participate in the trial. Since FCI Fort Worth and FMC Carswell both have BOP psychiatrists on staff, we will initially focus on these two institutions to obtain field trial participants.

Inmates who meet the criteria and volunteer will sign an informed consent to participate. They will be given a medication called naltrexone which helps patients overcome opioid addiction by blocking the drugs' euphoric effects. Naltrexone will be provided via a once-monthly extended-release injectable marketed under the trade name Vivitrol. The U.S. Food and Drug Administration (FDA) approved extended-release injectable naltrexone in October 2010 to treat people with opioid dependence.

After being screened by medical staff, and signing the appropriate releases, they will receive two injections of Vivitrol while at the institution. One will occur five weeks from release and the second will be given one week before being released to the RRC. The monthly injections will continue during their six months in the RRC or home confinement. The Vivitrol injections will cost approximately $700 per injection for a total of $5,600 per participant. Along with the medication they will also be offered substance abuse counseling. This will be provided by psychology staff in the institution and by contract treatment providers when they are released to the RRC.

The progress of the participants during the field trial will be closely monitored by the multi-disciplinary team. Upon completion of the field trial, the results will be assessed and a decision made regarding submission of an Executive Staff Paper to address the use of MAT in the BOP.