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A Path to Recovery:

Treating Opioid Use in West Virginia's
Criminal Justice System

Alison Shames and Ram Subramanian

About this report

In the United States, a disproportionate number of people who come into contact with the criminal justice system suffer from opioid use disorder. Key to confronting the opioid epidemic and related deaths is expanding access to a range of treatment options, including all forms of medication-assisted treatment (MAT). This brief looks at how one state—West Virginia—is providing MAT to eligible people in its criminal justice system and how its efforts under the federal Justice Reinvestment Initiative may improve its availability. Drawing primarily on interviews with 13 stakeholders, including representatives from the executive and legislative branch, practitioners from corrections agencies, and their partners who provide community-based health services, the paper summarizes West Virginia's efforts and draws out lessons for other states interested in using MAT to serve and treat those involved in their criminal justice system who engage in harmful opioid use.

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Introduction

Since 2010, 29 states have formally participated in the federal Justice Reinvestment Initiative (JRI)—a data-driven approach to criminal justice reform that seeks to improve public safety, contain corrections costs, and reinvest the savings in crime reduction strategies.¹ Many of the states that participate in JRI have found that substance use and a concomitant lack of treatment services—whether in the community or in institutions—contribute to increasing numbers of people returning to prison for failing to adhere to the terms of their community supervision or for committing a new crime, and are thus significant factors aiding in rising prison populations and correction costs.² An inadequate amount of treatment services for people involved in the justice system is a problem nationwide: according to recent studies, an estimated 58 percent of people in state prison and 63 percent of people sentenced to a local jail met the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for drug dependence or abuse, and fewer than a third received treatment while incarcerated; for people on probation or parole, approximately 40 percent have an alcohol or other substance use disorder, but only a quarter to a third receive related treatment.³ A cornerstone of the legislative reform package in many JRI states is an expansion of and investment in community- and institution-based behavioral health services.⁴

Over the past decade in particular, opioid use has grown faster than that of any other drug in the United States: between 1999 and 2015, the number of overdose deaths involving opioids quadrupled and, in 2016, approximately 33,000 overdose deaths occurred—averaging nearly 100 deaths a day—related to heroin (an opioid) or prescription opioid pain relievers.⁵ People involved in the country's justice systems comprise one group heavily affected by the rising opioid crisis. Up to one-quarter of incarcerated individuals with a substance use disorder have a problem with opioids; what's more, people recently released from incarceration are vulnerable to both overdose and death, especially in the immediate post-release period.⁶ Many acceptable and evidence-based roads to recovery exist, but abundant research increasingly shows that medication-assisted treatment (MAT) is one of the most promising

approaches for effectively treating opioid use disorder.⁷ Unfortunately, MAT is underutilized, particularly in the criminal justice system.⁸

This report focuses on the experiences of one state—West Virginia—and examines how its JRI efforts may intersect with and bolster the state’s response to opioid use among people involved in the criminal justice system. The substance use issues in West Virginia’s justice system are largely tied to the opioid epidemic: the state leads the nation in opioid

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use or dependence with an average per capita rate of 12.9 per 1,000 people and one of the highest rates of death due to drug overdoses, at 41.5 per 100,000.⁹ Over the past several years, West Virginia has built an infrastructure through which MAT is becoming more widely available. Although these embryonic efforts have resulted in some successes by offering MAT to a growing number of system-involved individuals, they have also underscored a number of challenges common to the rollout of MAT in other contexts—challenges that the state’s justice reinvestment work is poised to address. West Virginia’s experiences are relevant not only to justice reinvestment states—many of which also identify substance use and the lack of treatment services as a driver of their prison populations—but to any state attempting to serve and treat people involved in the justice system who suffer from harmful opioid use.

What is MAT?

Medication-assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders, primarily opioid addiction. The U.S. Food and Drug Administration has approved three prescription medications to treat addiction to opioids: methadone, buprenorphine (which, in combination with naloxone—a drug that reverses the toxic effects of opioid overdose—is widely known by its brand name, Suboxone), and naltrexone (which comes in pill and injectable forms; the injectable extended-release form is typically referred to by its brand name, Vivitrol).^a

Both methadone and Suboxone, which are long-acting synthetic opiates, operate as agonists or partial agonists to reduce or extinguish cravings; this means that they attach themselves to and activate the same brain receptors as the addictive substance does and, in doing so, minimize the painful symptoms of opiate withdrawal and block the euphoric effects of other opioid drugs. Methadone is an opioid full agonist offered in pill, liquid, and wafer forms and is taken once a day. Suboxone is an opioid partial agonist (it only partially activates

opiate receptors) and is ingested at home in the form of a film, often referred to as a “strip,” and is taken as prescribed by a medical doctor, often daily.

Vivitrol is an antagonist drug therapy, meaning that it covers rather than attaches to the brain receptor that opiate drugs activate. In doing so, it blocks the euphoric effects of opioids if they are used. (It also reduces the euphoria associated with alcohol, though not some of its other physical effects such as impaired coordination and judgment.) Vivitrol is not used for withdrawal management. It is delivered as an injection by a medical provider once a month.^b

Although research demonstrates that MAT can effectively treat opioid use disorder, it may not be the appropriate treatment for all individuals. Similarly, some individuals may have success with Suboxone but not Vivitrol—and vice versa. Ultimately, an individual with an opioid use disorder must consult with a medical provider who specializes in addiction and decide on the best form of treatment.

^a This report refers to the three MAT drugs as methadone, Suboxone, and Vivitrol.

^b For more information about the medications used in MAT, see Substance Abuse and Mental Health Services Administration, “Medication and Counseling Treatment,” <https://perma.cc/7S8D-DZK3>.

A case study of MAT in West Virginia's criminal justice system

It is widely accepted that MAT is an effective way to treat opioid use disorder. Research demonstrates that MAT can reduce opioid use and thus help decrease criminal activity, increase the likelihood that a person will remain in treatment, reduce the risk of infectious disease transmission, and reduce the risk of overdose mortality.¹⁰ For a number of reasons, MAT is too often unavailable and underutilized: it is estimated that only 10 to 30 percent of U.S. substance use treatment programs offer such treatment.¹¹ While estimates of the number of jails and prisons offering MAT differ widely, it is clear that most people held in these settings do not have access to the medication needed to treat an opioid addiction.¹² Many courts and some probation and parole agencies also reportedly do not refer clients to or allow participants to receive MAT.¹³

Still, there are some indications that MAT is becoming or is likely to become more available broadly in the United States and for people involved in the justice system. On the recommendation of the White House's Commission on Combating Drug Addiction and the Opioid Crisis, in August 2017 President Donald Trump stated his intention to declare the opioid epidemic a national emergency, and the commission made several recommendations aimed at enhancing access to all modes of MAT.¹⁴ An increasing number of policymakers and correctional practitioners are open to incorporating MAT as an integral treatment approach for criminal justice populations, and the topic has begun appearing on the agendas of many specialty webinars and conferences aimed at criminal justice professionals.¹⁵

Against this backdrop, West Virginia offers an interesting case study of how criminal justice reform efforts can strengthen a state's response to opioid use. Although the state's endeavors in expanding access to MAT have not always been well coordinated and are still a work in progress, West Virginia has developed the scaffolding of a system that successfully supports the use of MAT in many of its criminal justice settings. This section reviews the substance use treatment infrastructure that West

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Virginia's JRI legislation created, summarizes some of the ways the state government has demonstrated its support for MAT, and describes some of the MAT programs available in West Virginia correctional facilities and for people in the community who are involved in the justice system.

Creating a statewide treatment supervision infrastructure

West Virginia embarked on its justice reinvestment process in 2012. Its Justice Reinvestment Working Group found that the biggest driver of recent growth in the state's prison population was the number of people sent to prison from probation or parole—"revoked" for failing to adhere to the terms of their supervision or committing a new crime in the community, often due to substance use and a lack of community-based treatment services. Of probationers who returned to prison in 2010, 62 percent were identified as needing substance use treatment; in 2011, possession or use of alcohol or other drugs was cited in 78 percent of technical parole revocations (noncompliance with the terms of supervision, such as a failed drug test) and 65 percent of revocations for new crimes.¹⁶ Although the working group's final report referred generally to substance use treatment rather than the specific concern of opioid use, it was widely known that the state was grappling with a significant opioid problem.

The resulting legislation, SB 371 (the "Justice Reinvestment Act") was enacted in 2013. The law included a variety of strategies to better address the substance abuse and addiction issues among people involved in the justice system, with the dual goals of saving lives and protecting public safety. Among the strategies were the expansion of drug courts across the state; a new "treatment supervision" sentencing option for felony drug offenders; and implementation of and investment in an array of policies to

strengthen community supervision and expand access to community-based substance use treatment.

People involved in the justice system can now be required to participate in treatment supervision services, pursuant to SB 371, in the following ways:¹⁷

- > **as an alternative to incarceration:** If a sentencing judge determines that significant behavioral health issues are driving a person's criminal behavior, the judge may sentence the person to probation with the condition of treatment services instead of incarceration.
- > **as a condition of parole:** The Division of Corrections may order treatment supervision services as a parole requirement for people being released who demonstrate significant behavioral health needs.
- > **as an alternative to revocation:** If a judge or the parole board concludes that an individual's violation of supervision was driven by behavioral health issues, the judge may order the person to participate in treatment instead of revocation.

In implementing SB 371, the Division of Justice and Community Services (DJCS), in collaboration with the Bureau for Behavioral Health and Health Facilities—a division of the West Virginia Department of Health and Human Resources—created the Treatment Supervision Grant Program, which was designed to strategically and deliberately expand community-based treatment services for people required to participate in treatment under SB 371.¹⁸ The program encourages partnerships between day report centers (which provide case management and program services to people on community supervision) and other local providers in order to provide a comprehensive set of treatment options in each community.¹⁹

After an initial investment of approximately \$3 million—and buoyed by the stabilization of the state's prison population and reported savings and averted costs of nearly \$25 million—West Virginia has to date invested approximately \$15 million in the Treatment Supervision Grant Program.²⁰ Grants are available for day report centers and local providers (independently or in partnership with each other) to support the following services:

- > **Outpatient and intensive support services:** These services include individual, family, or group therapy; individual or group supportive counseling; treatment planning; and targeted case management.
- > **Community Engagement Specialists:** These new staff positions assist people by connecting them with resources related to their substance use issues and other day-to-day needs (such as housing, employment, and benefits); they also help people with the reentry process from correctional facilities back to the community.
- > **Recovery residences:** These residences are considered transitional housing and provide residents with a structured living environment and access to treatment services if they have substance use issues or both a mental health condition and a substance use disorder (often referred to as co-occurring disorders).
- > **Peer Recovery Coaches:** This peer-to-peer service relies on staff members who have managed their own behavioral health challenges and work as coaches. They work directly with participants to help address personal and environmental obstacles to recovery and serve as mentors in the management of their peers' recovery.

Government support for MAT

At the same time that West Virginia set out to implement its justice reinvestment plan for treatment supervision, the governor and legislature continued to address the state's urgent substance use issues, in part by expanding access to MAT for people involved in the justice system and beyond. A range of laws were enacted in 2015 and 2016, including legislation to do the following:

- > **Minimize misuse of MAT by regulating Suboxone clinics (SB 454, 2016).** West Virginia became one of the first states to regulate Suboxone clinics. This law requires such clinics to be licensed by the state, offer counseling in conjunction with the medication, and drug-test patients to ensure its proper use. With these requirements, as well as the state's right to inspect the clinics, collect data, and review their performance, the hope is to minimize the number of clinics misusing the drug and to produce better outcomes for the state's opioid users.
- > **Reduce the number of opioid-related overdose deaths by making naloxone widely available (SB 335, 2015; SB 431, 2016).** West Virginia enacted two measures designed to expand the availability of naloxone, a drug that reverses the effects of an opioid overdose: in 2015, law enforcement officers were explicitly permitted to carry naloxone; and in 2016, a law was enacted that allows pharmacists to sell the medication to individuals without a prescription. Both bills limit criminal and civil liabilities for prescribers and dispensers, as well as for laypeople who administer the drug or possess it without a prescription.
- > **Expand treatment options in criminal justice settings by authorizing pilot MAT programs (HB 2880, 2015; HB 4176, 2016).** In 2015, the West Virginia legislature, by near unanimous votes, authorized the creation of MAT pilot programs for people in the custody of the West Virginia Division of Corrections and those participating in an adult drug-court program. In 2016, the legislature expanded the pilot program to include regional jails.

- > **Increase access to MAT to people involved in the justice system by clarifying related policies.** In recent years, the state supreme court clarified its adult drug-court program policies so that a court could not bar someone from participating in its program on the grounds that the individual was undergoing MAT as prescribed by a competent physician.²¹ To further expand access to MAT, DJCS has directed day report centers to become eligible to bill Medicaid and offer therapy and medical services via telehealth technology—usually secure video—when needed. (Because the state’s probation and parole agencies do not prohibit the use of MAT, those divisions did not issue or restate any formal policies.)

- > **Leverage federal dollars to fund substance use treatment, including MAT.** West Virginia expanded Medicaid coverage to insure additional people under the Affordable Care Act in 2014 and applied in 2016 for a Section 1115 waiver (a state’s request to the federal government to allow the state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules). West Virginia’s Section 1115 waiver seeks to expand the set of substance use disorder treatment services available to Medicaid beneficiaries, and it includes expanded coverage of withdrawal management, short-term residential substance use treatment, enhanced access to outpatient treatment, coverage for methadone, and an initiative to more widely distribute naloxone.²² (The application was still pending in September 2017.)

MAT programs for people involved in the justice system

West Virginia makes MAT available at a number of points in the criminal justice system, including the regional jails and state prisons—and to people on probation or parole through day report centers, other community providers, and recovery residences. (See Figure 1.) This section briefly describes some of these programs. (See “Initial MAT outcomes,” page 16, for a summary of the jail and prison programs’ results to date.)

West Virginia Division of Corrections pilot MAT program

West Virginia's Division of Corrections offers Vivitrol in all state prisons as part of its pilot MAT program, under the parameters outlined below.²³

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|-----------------------------|--|
| Location | All state prisons |
| Mat offered | Vivitrol |
| Funding | The drug manufacturer, Alkermes, covers the cost of the first injection. |
| Eligibility criteria | The program is offered to all people held in state prisons and has no restrictions based on risk level or the type of criminal conviction. |
| Evaluation process | The candidate must be evaluated for and deemed to have a problem with opioids or alcohol (Vivitrol alters the effects of both) by a WVDOC drug treatment counselor and a psychiatrist; be "motivated for treatment" as determined by the counselor; and be drug-free. (Before starting Vivitrol, an individual must be opioid-free for a minimum of seven to 14 days to avoid sudden opioid withdrawal.) Most interested people self-refer or a counselor refers them to the program. The assessment process takes place prior to a person's parole hearing. ²⁴ |
| Program components | The individual receives a Vivitrol injection two or three days prior to release. This program has no therapeutic components. ²⁵ |
| Continuity of care | WVDOC staff assist participants with enrolling in Medicaid (if qualified), identifying local community providers, and scheduling an appointment for the next monthly dose within 28 days of the person's release. |

West Virginia Regional Jail Authority pilot MAT program

The Regional Jail Authority in West Virginia also operates a pilot MAT program using Vivitrol as the therapeutic intervention. The pilot is offered in five of the state's 10 regional jails under the framework outlined below.²⁶

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|-----------------------------|---|
| Location | Five of the state's 10 regional jails ²⁷ |
| MAT offered | Vivitrol |
| Funding | The drug manufacturer, Alkermes, covers the cost of the first injection. |
| Eligibility criteria | The program is limited to people convicted of a misdemeanor and who are in custody for at least three weeks. ²⁸ (This is because an individual must be opioid-free before taking Vivitrol.) Given the need for a set release date in order to participate, the program is not offered to people who are detained pretrial (many of whom are in jail for either short periods or an uncertain amount of time) or to those convicted of felonies (many of whom are awaiting transfer to a state prison). |
| Evaluation process | Every week, jail counselors review booking/intake information and compile a list of possible participants based on their eligibility with regard to their conviction charge and release date. That list is provided to the medical department, which determines whether anyone listed was assessed during the booking/intake process as having drug addiction issues. The list is then returned to the counselors, who approach potential participants. If an eligible person shows interest, the individual is referred to the medical department to be evaluated by a physician and meet with a psychiatrist for further analysis and to confirm eligibility. |
| Program components | Participants receive a Vivitrol injection two or three days prior to their release. This program has no therapeutic components. |
| Continuity of care | Whenever possible, jail staff schedule the next monthly injection with a community provider on behalf of the participant. They are not always able to do this, however, because the provider often wants prior proof of insurance—and the individual may be uninsured or the jail may not have sufficient information to make that determination. (Jail staff do not assist people incarcerated in jail with Medicaid enrollment.) Jail staff give participants a list of local providers upon their release. |

Day report centers

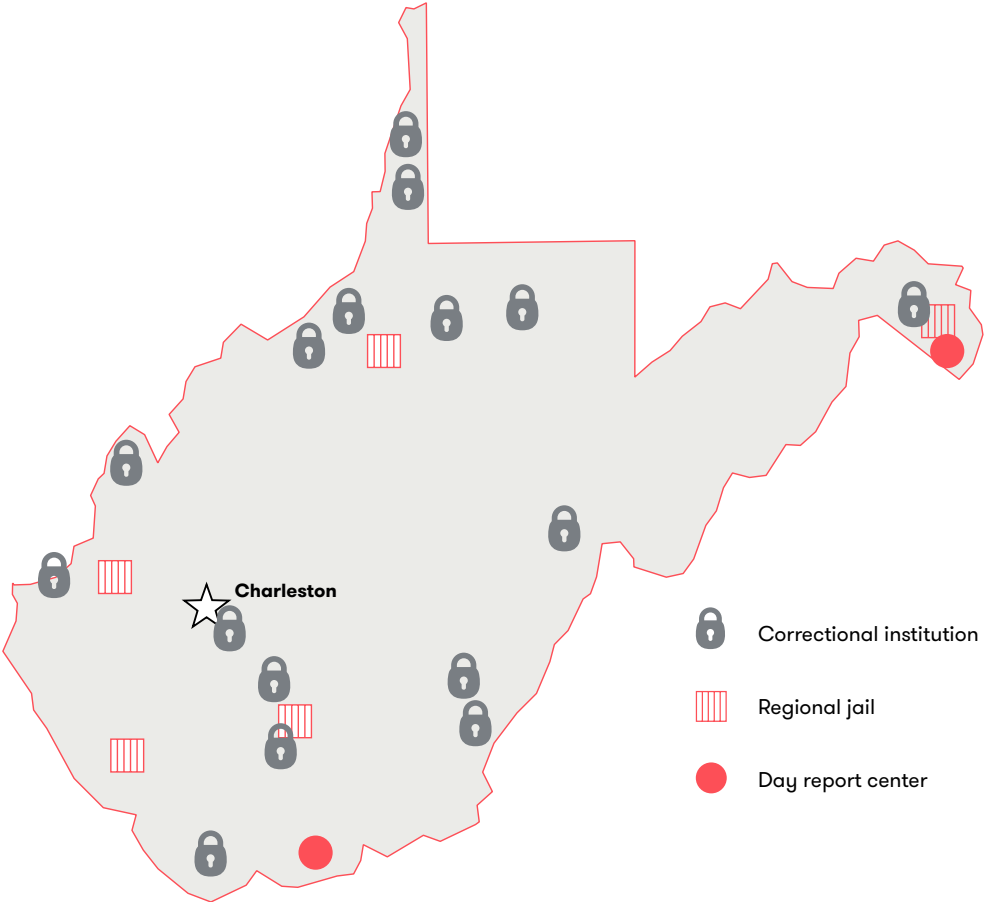
West Virginia also offers MAT, either directly or through an on-site contractor, in two of its day report centers. The components of this program are set forth below.²⁹

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|-----------------------------|--|
| Location | Although many day report centers in West Virginia offer people a choice of MAT referral services, the Jefferson County Day Report Center (JCDRC) is the only such center that directly offers MAT. ³⁰ Mercer County Day Report Center (MCDRC) offers its clients MAT on-site through a contract with Southern Highlands Community Mental Health Center. |
| MAT offered | Both JCDRC and MCDRC (through Southern Highlands) offer Vivitrol. The day report centers refer people to other programs and providers if they wish to receive other forms of MAT (such as Suboxone or methadone). |
| Funding | JCDRC: Medicaid or private insurance is billed for the medication and required therapy sessions. A treatment supervision grant from JRI funds a peer recovery coach, community engagement specialists, and outpatient services. MCDRC: Southern Highlands receives a treatment supervision grant from JRI to rent space from the day report center and employ a case manager. Medicaid or private insurance is billed for the medication and required therapy sessions. |
| Eligibility criteria | Day report centers serve people who are on probation or parole and are assessed as moderate to high risk and are participating in the drug-court program or were convicted of a misdemeanor or a nonviolent felony. Southern Highlands at MCDRC only serves people convicted of felonies. |
| Evaluation process | The Level of Service/Case Management Inventory (LS/CMI), the state-approved risk and needs assessment tool, is conducted with each person referred to the JCDRC or MCDRC, and each person is evaluated by an on-site staff member. If a person presents with an opioid use disorder and seems to want or need MAT, the process is as follows: At JCDRC: The person is referred to the center's addiction specialist, in a consultation conducted via telehealth technology (secure video). ³¹ If the specialist deems the client eligible, the person enters the program. At MCDRC: The person is referred to Southern Highlands and an additional clinical evaluation is conducted; Southern Highlands then refers the client to Bluestone Health Center for a medical consultation. |
| Program components | At JCDRC: A registered nurse who works on-site at the day report center provides the Vivitrol injection. The client receives Medicaid-mandated therapy sessions (four interventions per month, with one intervention a one-on-one session) from the JCDRC. These are group therapy sessions provided by the center and/or individual sessions via telehealth technology with addiction specialists. At MCDRC: Bluestone Health Center provides the Vivitrol injection. The Medicaid-mandated individual and group therapy sessions are led by Southern Highlands on-site at the MCDRC. |
| Continuity of care | Both JCDRC and MCDRC offer a range of evidence-based practices to support their clients' recovery and address their criminogenic needs (personal deficits and circumstances known to predict criminal activity if not changed), such as programs on anger management, criminal and addictive thinking, relapse prevention, peer recovery, and parenting. |

Other programs available to people on probation or parole

People on probation or parole may also access MAT programs through other state-funded community providers or recovery residences, or through private providers. Programs funded by the Treatment Supervision Grant Program are limited to people considered moderate to high risk for recidivism (as assessed by the state-approved risk and needs assessment tool) and convicted of a nonviolent felony; private programs or those funded otherwise are available to people of any risk level and conviction history. The evaluation process typically includes assessments and consultations with qualified therapists and medical professionals. Medicaid requires that all MAT programs include individual and group therapy sessions. The extent to which people are referred to other evidence-based programs that address their criminogenic needs depends on the program and each person's assessed risk level and needs.³²

Figure 1
MAT locations in West Virginia's corrections system



Challenges and solutions

Research has identified a number of barriers that limit the availability and use of MAT. These include a lack of prescribing physicians, as well as alternative treatment ideologies (such as an emphasis on 12-step programs), attitudes and misunderstandings about the nature and use of MAT, and regulatory policies that restrict or forbid MAT use.³³ The criminal justice MAT programs in West Virginia face many of the same challenges. (See “Initial MAT outcomes,” page 16). Based on interviews conducted with West Virginia criminal justice professionals, policymakers, and treatment providers for this report, the state is employing a number of strategies to address these barriers, such as the following:

- > improving access to physicians and therapists (for example, by expanding Medicaid and encouraging day report centers to use telehealth technology);
- > making clear that MAT is not prohibited by the criminal justice system (for example, by authorizing pilot programs and restating MAT policies); and
- > educating relevant stakeholders about MAT (such as providing information directly to people involved in the justice system and facilitating educational meetings with system actors such as judges and prosecutors).³⁴

Providing MAT in a criminal justice setting also presents additional challenges relating to the people served, the circumstances of incarceration, reentry into the community, and supervision. West Virginia’s JRI efforts are helping address many of these challenges and enabling the state to provide MAT to increasing numbers of people in this population.

Initial MAT outcomes

Since March 2015, when the WVDOC pilot Vivitrol program launched, and through May 31, 2017, 266 people were referred to and deemed eligible for the program.^a More than 80 percent of them (218 people) did not participate in the program, for reasons including being denied parole (26 percent), deciding against participation (51 percent), or other explanations (22 percent).^b People reported that they decided against participating for one or more of the following reasons:

- > They were concerned about side effects or medical problems and complications involving Hepatitis C;
- > Family members had concerns about (or refused to allow) the use of MAT therapy;
- > They believed they had overcome their addiction; or
- > They had personal preferences against completing the required psychotherapy component.

According to one of the directors of the pilot program, another reason people said they did not want to take Vivitrol was because of a continuing desire to use alcohol or other drugs.^c (See “What is MAT?,” page 4, for more about Vivitrol’s effects.)

Of the 74 participants who received a Vivitrol injection from WVDOC, there was a significant drop-off rate in treatment after their release. Only 14 people completed three months of treatment; only six remained in treatment after six months; and only one individual continued with treatment after 11 months. The reasons given for stopping treatment included switching to a different MAT, reported side effects, inaccessibility of a treatment provider, conflicts with a work schedule, insurance issues, or a lack of transportation.

The West Virginia Regional Jail Authority’s program—which started only in March 2017—has had similar results. As of July 27, 2017, of the 123 identified eligible candidates, 39 people agreed to participate, 28 of whom received their first injection. (The remaining 11 were waiting for an injection, which is given two or three days prior to release.) According to one of the directors of the pilot program, the reasons eligible people chose not to participate included fear of needles, an addiction other than opioids, and a desire to continue using alcohol.^d The regional jails do not collect any post-release data on the program participants. Given that they were convicted of misdemeanors and are not placed under any form of community supervision, such data collection would be difficult.

^a Dr. Merideth Smith, “Lessons from a Corrections Opioid Treatment Program,” (data on WVDOC MAT program results presented at the National Correctional Industries Association, Southeast Regional Conference, White Sulphur Springs, WV, October 25, 2016). See also “Addiction Treatment Pilot Program (HB 2880 and HB 4176), Executive Summary and Annual Report,” July 1, 2017, provided to the authors by Dr. Rahul Gupta, commissioner, West Virginia Department of Health & Human Resources, Bureau for Public Health.

^b These were largely administrative or technical reasons, including transfer to another facility or to work release; a detainer or a discharge to another state; medical complications; and insufficient time to complete the process. See Dr. Merideth Smith, “Lessons from a Corrections Opioid Treatment Program” (2016).

^c Ibid.

^d Ashley H. Bennett, director of programs, West Virginia Regional Jail Authority, phone interview by Alison Shames, August 1, 2017.

Using community engagement specialists and peer recovery coaches

West Virginia’s Treatment Supervision Grant Program was the result of extensive research, deliberate planning, and comprehensive consultation. Through this process, certain services were targeted for funding. Two of them—the services of community engagement specialists and peer recovery coaches—are proving critical in the delivery of MAT programs. Staff in these positions can help educate people involved in the justice system about MAT and provide a personal connection that may encourage them to continue treatment after their release from jail or prison.

Education

Research demonstrates—and the experiences in West Virginia confirm—that misconceptions about MAT remain a primary obstacle to increasing access to and use of the treatment.³⁵ A key hurdle is to educate people involved in the justice system, as well as their support networks, about MAT. Regardless of whether people are in custody or are under supervision in the community, they elect to participate in a MAT program and cannot be forced to do so. Although a court or parole board may include as a condition of sentencing or supervision that a person must attend a substance use treatment program, they do not usually mandate the type of treatment and cannot—in any instance—require that someone submit to a particular form of medical treatment. Given the purely voluntary nature of MAT, if a goal of a criminal justice system is to encourage participation, it must provide people information to help them understand their options and make knowledgeable treatment decisions.

Although West Virginia relies on traditional means to educate individuals—such as videos and other educational materials provided by Alkermes, the manufacturer of Vivitrol, as well as written materials that the Division of Corrections created—the state also uses other strategies.³⁶ The peer recovery coaches and community engagement specialists, funded by the Treatment Supervision Grant Program, can and do play an important role in educating people involved in the justice system and their colleagues in the criminal justice system about MAT. This is consistent with the experiences of correctional facilities in other U.S. jurisdictions, which report that participation among incarcerated people increases as they receive positive feedback from their peers.³⁷ West Virginia’s day report centers, community providers, and recovery residences may also call on peer recovery coaches to help educate clients about MAT in the community. The role of the coach is to promote and help sustain peers’ recovery by, among other things, serving as a guide and mentor and helping them find resources and strategies for treatment and recovery. Indeed, DJCS recommends that all applicants who receive funding from the grant program be trained about MAT.

A warm handoff

A central challenge for those offering MAT in the custodial setting is to ensure continuity of care after people are released. The jails and prisons in West Virginia rely on a number of strategies to improve the likelihood that someone will continue MAT upon release. For instance, the facilities

take steps to connect people participating in the Vivitrol program with a treatment provider in the community. Essential elements of WVDOC's pilot program include identifying a local MAT provider and scheduling an appointment for participants 28 days after their release. Because the regional jails in West Virginia face distinct challenges—largely due to the transient nature of the populations they serve—this can be complicated. Although staff working on the jails' pilot Vivitrol programs attempt to make appointments for program participants after their release, requirements such as proof of insurance make this difficult. When these obstacles arise, participants are given, minimally, the names of local MAT providers in the communities to which they are returning. But this may not be enough to ensure participants' treatment retention and completion.

The WVDOC maintains that a “warm handoff” to someone in the community may bring about better outcomes.³⁸ Connecting participants prior to their release (either in person or by phone) to a local community engagement specialist or peer recovery coach, for instance, could provide a personal tie for people being released and may make it more likely that they remain committed to their treatment. Correctional facilities may also wish to consider putting participants in their Vivitrol program in touch with a local community-based behavioral health specialist or treatment provider to whom they will be referred after their release. Another option is for the WVDOC to coordinate more closely with parole staff and ensure that when participants report to a parole office for the first time, they meet with a specialist or contract therapist who discusses the Vivitrol program, reviews future appointment dates, and provides whatever supports are needed to encourage them to continue MAT. This is especially needed for those who are assessed as lower risk of recidivism and are thus ineligible for MAT at the day report centers (where services target people assessed as medium to high risk).

Prioritizing the use of evidence-based supervision practices

The adoption and use of evidence-based supervision practices is essential to improving the results of MAT programs in the justice system. Although the justice professionals, policymakers, and treatment providers interviewed for this report expressed strong support for MAT, some noted the particular challenges of making Suboxone available to system-involved people. Many had stories about frequent diversion and misuse of the medication—such as people

using, selling, or trading it—including anecdotes of someone dealing Suboxone in a treatment provider's parking lot. As such, it comes as no surprise that law enforcement officers perceive MAT as a problem, not a solution.

The criticism about Suboxone reveals a key challenge faced by those offering MAT in the justice system: the treatment addresses an individual's opioid use, but does not respond to the person's remaining criminogenic factors—those needs that are most directly linked to high-risk, crime-producing behavior. Thus, while it is important to make MAT available in the justice system, it is equally important to continue providing effective supervision services aimed at behavioral change, particularly to people assessed as having a higher risk to reoffend and by targeting the four criminogenic needs most amenable to change: antisocial behavior, antisocial personality factors, antisocial cognitions/attitudes, and antisocial peers.³⁹

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While it is important to make MAT available in the justice system, it is equally important to continue providing effective supervision services aimed at behavioral change.

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West Virginia's justice reinvestment bill emphasized the adoption of evidence-based practices to more effectively manage correctional populations. For instance, research demonstrates that supervision and intervention resources are used to best effect with those who pose the highest risk to public safety (and conversely that assigning low-risk individuals to intensive supervision and programming can be counterproductive). Therefore, SB 371 identified assessment as being critical to identifying the target population that facilities and day report centers are intended to serve. The bill required that:

- > the WVDOC must assess all persons transferred to their custody for criminogenic risk and need factors;
- > DJCS must train staff at day report centers on the use of a standardized risk and needs assessment measuring general criminal recidivism; and

- > day report centers must primarily serve people assessed as moderate to high risk of reoffending.

Additionally, the Treatment Supervision Grant Program requires and incentivizes day report centers and community treatment providers to prioritize evidence-based practices. For example, grantees are required to be trained not only on the use of the state-approved risk and needs assessment tool (the LS/CMI), but also about a number of evidence-based programs. These include the following:

- > a daylong introductory workshop on “what works” in behavioral health treatment programs for people on community supervision, based on research and evidence-based principles;
- > motivational interviewing: a collaborative, empathetic, and respectful style of engaging with people that aims to facilitate motivation for change and includes asking open-ended questions, avoiding arguments, and using reinforcing change talk and reflective statements;
- > Thinking for a Change: a program that uses cognitive-behavioral strategies to recognize and change criminal thinking; and
- > Cognitive Behavioral Interventions for Substance Abuse: a program that teaches individualized cognitive-behavioral strategies to avoid substance use.⁴⁰

The Division of Justice and Community Services, which administers the Treatment Supervision Grant Program, is also using the Evidence-Based Correctional Program Checklist (known as the CPC) to measure the extent to which day report centers and treatment providers are adhering to evidence-based practices.

The infrastructure created by SB 371, particularly through the Treatment Supervision Grant Program, provides a foundation for success. The Jefferson County Day Report Center offers a range of services and programs that reflect this foundation. JCDRC staff have received the mandatory trainings on correctional interventions, risk and needs assessment, case planning, motivational interviewing, and cognitive-

behavioral treatment approaches. Case managers conduct a comprehensive risk and needs assessment, prepare a responsive case plan, and then supervise each individual accordingly. Indeed, JCDRC staff use assessment results to help determine whether MAT generally—and which form of MAT specifically—is most appropriate for a client. JCDRC staff understand that MAT is a tool to help manage addiction, and that an individual must address many other factors to make and sustain behavioral change. When MAT is paired with complementary interventions—for example, those targeting antisocial thinking—efforts to reduce recidivism are more likely to succeed.

Using state funding to leverage federal funding

People have greater access to treatment when they are not financially responsible for the program's services. To maximize the impact of state funding, West Virginia takes advantage of available federal funding for substance use programming. Like 30 other states and the District of Columbia, West Virginia expanded Medicaid in recent years to insure additional people under the Affordable Care Act.⁴² To further leverage federal dollars and minimize the cost to the state and its residents, as mentioned, West Virginia also applied for a Section 1115 waiver with the goal of building a more comprehensive network of care across the state to more effectively prevent and treat substance use disorders.⁴²

Expanding access to Medicaid is critical to making MAT more widely available to people involved in the justice system. Because the medication costs alone often reach more than \$1,000 per month, MAT is unaffordable to those without health insurance.⁴³ Although Medicaid enrollment numbers are not available for people involved in the justice system, some state officials have estimated that 80 to 90 percent of those incarcerated in state prisons are likely eligible for expanded Medicaid after release, making it a key vehicle for increasing treatment coverage for members of this population once they return to the community.⁴⁴ Although WVDOC staff help eligible people enroll in Medicaid as part of their discharge planning, the state's jails do not have this capacity. West Virginia's regional jails may wish to examine the experiences of other jurisdictions whose jails have programs to assist people with Medicaid enrollment.⁴⁵ Alternatively, the day report centers and other providers that receive state treatment supervision grant funds to support a community engagement specialist or peer recovery coach might consider enlisting these staff members to assist clients with Medicaid enrollment.

Another strategy to leverage federal dollars to support substance use treatment services would be a directive to all day report centers from DJCS's Community Corrections Subcommittee to become eligible to bill Medicaid. This would expand the services that day report centers can provide directly, including MAT programs. As noted previously in this report, Jefferson County Day Report Center is the only center of its kind to directly provide MAT on-site; this is because it can bill Medicaid for services rendered.

Conclusion

Millions of Americans—many of whom come into contact with the criminal justice system—suffer from opioid use disorder. Expanding access to a range of treatment options, including all forms of MAT, is key to confronting the opioid epidemic and preventing related deaths. Although historically MAT has not been available or used sufficiently—and has sometimes been prohibited in criminal justice settings—this may be changing.

West Virginia is just one example of a state that is taking steps to address opioid use, in particular by expanding access to MAT to people in its criminal justice system. These nascent programs in West Virginia's justice system face a number of common challenges, however. Among them are persistent stigma and misperception attached to opioid addiction generally and MAT specifically; preferences for abstinence-based drug treatment approaches rather than pharmacological treatment of opiate addiction; and regulatory and administrative policies or practices that impede the wider adoption of MAT, such as weak or nonexistent referral policies.

West Virginia's ongoing justice reinvestment efforts may prove critical in addressing these challenges and, in doing so, may improve the availability and success of MAT for people involved in the system, both in the community and in institutions. The infrastructure that JRI provides, particularly through the state's Treatment Supervision Grant Program, can help make sure that all interested parties—individuals who use opioids, community-based providers, and justice system stakeholders—have the information and tools to receive, provide, or expand effective evidence-based care. Given that the nation's opioid epidemic shows no signs of abating, the need for such progress is all the more urgent.

Endnotes

- 1 For information about the initiative, see U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, “Justice Reinvestment Initiative,” <https://perma.cc/295X-8KAL>.
- 2 For example, justice reinvestment working groups in Alabama, South Dakota, and Utah found that the behavioral health needs of people involved in their states’ justice systems went largely unmet and contributed to rising prison admissions. See the Council of State Governments Justice Center, *Justice Reinvestment in Alabama: Analysis and Policy Framework* (New York: CSG, 2015), <https://perma.cc/BBN4-Q5E6>; South Dakota Criminal Justice Initiative, *South Dakota Criminal Justice Initiative: Final Report*, (Pierre, SD: South Dakota Department of Corrections, 2012), <https://perma.cc/Z3R5-BZPQ>; and Utah Commission on Criminal and Juvenile Justice, *Justice Reinvestment Report* (Salt Lake City: Utah Commission on Criminal and Juvenile Justice, 2014), <https://perma.cc/7GFM-MQ9E>.
- 3 Among people in state or local custody who met the DSM-IV criteria for drug dependence or abuse, 28 percent of people in state prison and 22 percent of people in local jails said they received drug treatment or participated in a program since admission to the facility where they were incarcerated when surveyed. See Jennifer Bronson, Jessica Stroop, Stephanie Zimmer et al., *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009* (Washington, DC: Bureau of Justice Statistics, 2017, NCJ 250546) 3, 13. Regarding probation and parole, see Substance Abuse and Mental Health Services Administration (SAMHSA), “Trends in Substance Use Disorders Among Males Aged 18 to 49 on Probation and Parole,” *The NSDUH Report* (Rockville, MD: SAMHSA, 2014), <https://perma.cc/E6AY-AMZM>.
- 4 Nancy LaVigne, Samuel Bieler, Lindsey Cramer, et al., *Justice Reinvestment Initiative State Assessment Report* (Washington, DC: Urban Institute, 2014) 2, 10, <https://perma.cc/C97C-QUJ6>; and Samantha Harvell, Jeremy Welsh-Loveman, Hanna Love, et al., *Reforming Sentencing and Corrections Policy*, (Washington, DC: Urban Institute, 2016) 14, 25, <https://perma.cc/R6DQ-VQBE>.
- 5 For the increase in deaths involving opioids, see Centers for Disease Control (CDC), “Drug overdose deaths in the United States continue to increase in 2015,” n.2, <https://www.cdc.gov/drugoverdose/epidemic/index.html>; Rose A. Rudd, Noah Aleshire, Jon E. Zibbell, et al., “Increases in Drug and Opioid Overdose Deaths — United States, 2000-2014,” *Morbidity and Mortality Weekly Report* 64, no. 50 (2016), 1378-1382, <https://perma.cc/JP6A-ABGG>; and Rose A. Rudd, Puja Seth, Felicity David, et al., “Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010-2015,” *Morbidity and Mortality Weekly Report* 65, nos. 50 and 51 (2016), 1445-1452, <https://perma.cc/BHL3-HNKK>. Prescription opioids are medications that relieve pain by reducing the intensity of pain signals reaching the brain. These include hydrocodone (brand name Vicodin), oxycodone (Percocet), morphine (Avinza), codeine, and related drugs. Heroin is an opioid drug that is synthesized from morphine and is classified by the federal government as a Schedule I controlled substance, meaning it is a drug with no currently accepted medical use and a high potential for abuse. See National Institutes of Health, National Institute of Drug Abuse, “Opioids” November 2014, <https://perma.cc/XET3-7PY5>. For the federal drug schedule, see 21 U.S.C. §812, <https://perma.cc/R73Q-7QKC>.
- 6 For the proportion of people incarcerated with an opioid use disorder, see Seena Fazel and Jacques Baillargeon, “The Health of Prisoners,” *Lancet* 377, no. 9769 (2011), 956–65, <https://perma.cc/9CYC-GTXU>. For research about risk of overdose death after release, see Ingrid A. Binswanger, Patrick J. Blatchford, Shane R. Mueller, et al., “Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends from 1999 to 2009,” *Annals of Internal Medicine* 159, no.9 (2013), 592-600, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5242316>. For drug-dependent persons, transitions such as hospital discharge and discontinuation of drug treatment have been associated with increased mortality. Enforced abstinence, as is typical in prisons because of administrative prohibitions, may be associated with counterintuitive effects on future mortality. Also see Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, et al., “Release from Prison—A High Risk of Death for Former Inmates,” *New England Journal of Medicine*, 356, no. 5 (2007) 157-65, <https://perma.cc/V89R-NESP>.
- 7 For example, see Catherine A. Fullerton, Meelee Kim, Cindy Parks Thomas, et al., “Medication-Assisted Treatment with Methadone: Assessing the Evidence,” *Psychiatric Services* 65, no. 2 (2014), 146-157, <https://perma.cc/MJ3J-X662>. This is a systemic review of evidence demonstrating that methadone can have a positive impact on treatment retention, illicit opioid use, mortality, and criminality. Also see Cindy Parks Thomas, Catherine A. Fullerton, Meelee Kim, et al., “Medication-Assisted Treatment with Buprenorphine: Assessing the Evidence,” *Psychiatric Services* 65, no. 2 (2014), 158-170, <https://perma.cc/B8VL-8VPX>; and Timothy W. Kinlock, Michael S. Gordon, Robert P. Schwartz, 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, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2803487>.

- Also see Robert P. Schwartz, Jan Gryczynski, Kevin E. O’Grady, et al., “Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009,” *American Journal of Public Health* 103, no. 5 (2013), 917-922, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670653>. This study found a 37 percent decline in the average annual number of heroin overdose deaths after MAT became available in 2003.
- 8 For more on the use of MAT through drug courts, see, for example, Harlan Matusow, Samuel L. Dickman, Josiah D. Rich, et al., “Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes,” *Journal of Substance Abuse Treatment* 44, no. 5 (2013), 473-480, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602216>; for more on MAT in jails, see, for example, Kevin Fiscella, Andrew Moore, Judith Engerman, et al., “Jail Management of Arrestees/Inmates Enrolled in Community Methadone Maintenance Programs,” *Bulletin of the New York Academy of Medicine* 81, no. 4 (2004), 645-654, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3455924/pdf/11524_2006_Article_332.pdf; for more on MAT in prisons, see, for example, Amy Nunn, Nickolas Zaller, Samuel Dickman, et al., “Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems: Results from a Nationwide Survey,” *Drug and Alcohol Dependency* 105, nos. 1 and 2 (2009), 83-88, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2743749>.
 - 9 For West Virginia’s rate of past-year opioid abuse or dependence, see Christopher M. Jones, Melinda Campopiano, Grant Baldwin, et al., “National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment,” *American Journal of Public Health* 105, no.8 (2015), e55-e63, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504312>. For West Virginia’s 2015 drug overdose data, see Centers for Disease Control and Prevention, “Drug Overdose Death Data,” <https://perma.cc/8LSS-EJZ3>.
 - 10 See Fullerton, Kim, Parks Thomas, et al., 2014; Parks Thomas, Fullerton, Kim, et al., 2014; Kinlock, Gordon, Schwartz, et al., 2009; and Schwartz, Gryczynski, O’Grady, et al., 2013.
 - 11 For a summary of the barriers preventing MAT from being more widely available, see Legal Action Center, *Confronting an Epidemic: The Case for Eliminating Barriers to Medication Assisted Treatment of Heroin and Opioid Addiction*, (New York: Legal Action Center, 2015) 4, notes 13 and 14, <https://perma.cc/8UUN-5S2C>. For the availability of MAT, see U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration–Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions, *Expanding the Use of Medications to Treat Individuals with Substance Use Disorders in Safety-Net Settings*, (Rockville, MD: SAMHSA-HRA, 2014), <https://perma.cc/65KR-EM59>. This report cites a 2011 study finding that less than 30 percent of U.S. substance use treatment programs offer MAT. Also see the White House Commission on Combating Drug Addiction and the Opioid Crisis, August 2017, <https://perma.cc/G858-RUZY>; this letter states that “approximately 10 percent of conventional drug treatment facilities in the United States provide MAT for opioid use disorder.”
 - 12 For estimates of the number of jails and prisons offering MAT, see Alison Knopf, “Treatment Behind the Walls: States Gather to Share Information,” *Addiction Professional*, August 4, 2016 (reporting that as of its publication date, a dozen prisons and more than 100 jails provided MAT), <https://perma.cc/3YC2-6J86>; Beth Schwartzapfel, “A Better Way to Treat Addiction,” *The Marshall Project*, March 1, 2017 (reporting that only 23 jails and four state prison systems offered Suboxone, and upward of 150 jails and prisons offered Vivitrol), <https://perma.cc/J854-43TV>; and Nunn, Zaller, Dickman, et al., (2009) (reporting survey results that found only 55 percent of facilities offered methadone, only 14 percent offered buprenorphine, and fewer than half referred people to MAT programs upon release). This is out of approximately 5,000 prison and jail facilities in the United States. For the number of prison facilities, see James J. Stephan, *Census of State and Federal Correctional Facilities, 2005* (Washington, DC: Bureau of Justice Statistics, 2008), 1, <https://perma.cc/5MC5-XWSV>. For the number of jail facilities, see James Stephan and Georgette Walsh, *Census of Jail Facilities, 2006* (Washington, DC: Bureau of Justice Statistics, 2011), 2, <https://perma.cc/Z3L4-D7EP>.
 - 13 See Matusow et al., 2013; findings of a 2010 national survey of drug courts found that while nearly all respondents had participants with opioid addictions, only 56 percent offered MAT. Also see Peter D. Friedmann, Randall Hoskinson, Jr., Michael Gordon, et al., “Medication-Assisted Treatment in Criminal Justice Agencies Affiliated with the Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS): Availability, Barriers & Intentions,” *Substance Abuse* 33, no.1 (2012), 9-18, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3295578>. Conditions of release—whether to pretrial supervision, probation, or parole—are set by judges and parole boards and are often long lists of standardized conditions that apply to everyone. A common condition, particularly for longtime alcohol or other drug users, is a requirement to remain abstinent while on supervision. See Peggy McGarry, Alison Shames, Allon Yaroni, et al., *The Potential of Community Corrections to Improve Safety and Reduce Incarceration* (New

- York: Vera Institute of Justice, 2013), 11-14, <https://perma.cc/6LQW-AC44>. Note however, that this is changing. The Substance Abuse and Mental Health Services Administration announced in 2015 that drug courts funded by federal grants would no longer be allowed to tell drug-court participants to stop taking medications to treat opioid use disorders. See, for example, SAMHSA Treatment Drug Courts Request for Applications (RFA) No. TI-15-002, <https://perma.cc/43W7-GK82>. Also see Novus Detox, “New York Joins the List of States Ruling Drug Courts Must Allow Med-Assisted Treatment or Lose Federal Funding,” September 2015, <https://novusdetox.com/new-york-joins-the-list-of-states-ruling-drug-courts-must-allow-med-assisted-treatment-or-lose-federal-funding/>; and Jason Cherkis, “Kentucky Reforms Drug Court Rules to Let Heroin Addicts Take Prescribed Meds,” *Huffington Post*, April 17, 2015, <https://perma.cc/LB7K-SR9Y>.
- 14 White House Commission on Combating Drug Addiction and the Opioid Crisis, 2017.
- 15 For example, see 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), 13, <https://perma.cc/N5AP-PZWB>; Advocates for Human Potential, Inc., Treatment Alternatives for Safe Communities, and AdCare Criminal Justice Services, Inc., *Residential Substance Abuse Treatment Training and Technical Assistance: Prison/Jail Medication Assisted Treatment Manual* (Sudbury, MA: AHP, 2016), <https://perma.cc/MC8L-W8Q4>, a manual that describes four correctional institutions that implemented MAT programs; Timothy Williams, “Opioid Users Are Filling Jails. Why Don’t Jails Treat Them?” *The New York Times*, August 4, 2017, www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html?mcubz=3&_r=0; Andrew Joseph, “One State Takes a Novel Approach to Opioid Addiction: Access to Treatment for All Inmates,” *STAT*, August 3, 2017, <https://perma.cc/4MQ4-MHVV>; Christine Vestal, “Helping Drug-Addicted Inmates Break the Cycle,” the Pew Charitable Trusts, *Stateline*, January 13, 2016, <https://perma.cc/JYC2-YBZZ>. Also see the website of the Advocates for Human Potential, Inc.’s Residential Substance Abuse Treatment (RSAT) Training and Technical Assistance, a program funded by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. The program assists state and local governments develop and implement substance use treatment programs in state, local, and tribal correctional and detention facilities. Jail or prison MAT tours and training are included on the agenda for its annual 2017 RSAT Training, at <https://perma.cc/VY4T-HPPS>; and “Medication Assisted Treatment in Jails and Community-Based Settings,” a webinar hosted by the Council of State Governments Justice Center, <https://perma.cc/79SR-RE55>.
- 16 The Council of State Governments Justice Center, *West Virginia’s Justice Reinvestment: Strengthening Community Supervision, Increasing Accountability, and Expanding Access to Substance Use Treatment* (Washington, DC: CSG, 2014) 2, <https://perma.cc/53HH-UMHN>.
- 17 See West Virginia Division of Justice and Community Services (DJCS), “Request for Proposals, Treatment Supervision Implementation,” released November 2, 2015, 7, provided to authors by DJCS.
- 18 West Virginia Division of Justice and Community Services, *Reducing Recidivism and Promoting Recovery: West Virginia Implementation Plan for Treatment Supervision* (2014), <https://perma.cc/WT5E-CQCG>.
- 19 *Ibid.*
- 20 Samantha Harvell, Jeremy Welsh-Loveman, Hanna Love, et al., *Reforming Sentencing and Corrections Policy: The Experience of Justice Reinvestment Initiative States*, (Washington, DC: Urban Institute, 2016) 41, <https://perma.cc/TWW8-U3QV>.
- 21 Robert L. McKinney II, counsel for the Division of West Virginia Probation Services, phone interview by Alison Shames, July 28, 2017. In February 2015, the White House’s Office of National Drug Control Policy announced that the federal government would not fund drug courts that cut off access to medication-assisted treatments. See note 13.
- 22 “West Virginia Proposed Medicaid Section 1115 Waiver Application: Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders,” September 19, 2016, <https://perma.cc/3WDT-VLG3>.
- 23 The WDOC pilot program was authorized by HB 2880 (2015) and is governed by § 62-15A of the Code of West Virginia. Information in this chart was sourced primarily from Dr. Merideth Smith, director of clinical services, PSIMED CORRECTIONS, LLC (the provider of mental health and psychiatric services to West Virginia Division of Corrections), through a phone interview by Alison Shames, July 14, 2017.
- 24 People do not receive any “good time” credits for participating in the program and the parole board has no formal policy of looking favorably upon participation. “Good time” refers to the amount of time on good behavior in jail or prison—often demonstrated by participation in treatment or programming—that can be used to shave time off of custodial sentences.

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- 25 Although not required by the Vivitrol program, the West Virginia prison system does offer substance use treatment (including intensive treatment such as the Residential Substance Abuse Treatment program established by the federal government, as well as Narcotics Anonymous and Alcoholics Anonymous meetings) to people assessed as needing it. For more on the program requirements, see Bureau of Justice Assistance, “Residential Substance Abuse Treatment for State Prisoners (RSAT) Program,” (Washington, DC: BJA, 2005, NCJ 206269), <https://perma.cc/G8K3-UAJE>.
- 26 The regional jail pilot program was authorized by HB 4176 (2016) and is governed by the same West Virginia statutes (sections 62-15A-1, 2, and 3) that govern the WVDOC program. The West Virginia Regional Jail and Correctional Facility Authority operates and maintains a system of 10 regional jails, with each jail designated to serve specific counties. Regional jails typically serve people being held pretrial and those convicted and sentenced to terms of one year or less. People sentenced to the Division of Corrections also may be held in regional jails while awaiting transfer to the state correctional system. For more information, see the West Virginia Regional Jail & Correctional Facility Authority website at <https://perma.cc/ZG6L-JW4J>. Information in this chart was sourced primarily from Ashley H. Bennett, director of programs, West Virginia Regional Jail Authority, through a phone interview by Alison Shames, August 1, 2017.
- 27 The regional jail pilot program began on March 20, 2017, and currently operates at five regional jails: North Central, Eastern, Southern, Southwestern, and Western.
- 28 The three-week requirement also provides the jail sufficient time to conduct an assessment to determine whether people have a problem with opiates or alcohol, as well as time for them to be opioid-free for seven to 10 days, to avoid opioid withdrawal symptoms. Some participants are granted five days of “good time” if their sentence allows such credit.
- 29 Information about Jefferson County Day Report Center was sourced primarily from Ronda Eddy, director, Jefferson Day Report Center, Inc., through a phone interview by Alison Shames, July 5, 2017; information about the MAT program offered at Mercer County Day Report Center was sourced primarily from Tina R. Borich, chief clinical officer, Lisa Jones, chief executive officer, and Sheila R. Chandler, director of Substance User Services, Southern Highlands Community Mental Health Center, through a phone interview by Alison Shames, August 21, 2017.
- 30 The main reason Jefferson County has the only center currently offering this program is that it is eligible to bill Medicaid.
- 31 Providing accessible treatment services to people in rural areas is a problem common to many jurisdictions. See, for example, Alison Shames and Ram Subramanian, *Remote Access: Using Video Technology to Treat Substance Users on Probation and Parole in South Dakota* (New York: Vera Institute of Justice, 2016), 2, <https://perma.cc/RR4W-TAFF>; Jennifer D. Lenardson and John A. Gale, *Distribution of Substance Abuse Treatment Facilities Across the Rural-Urban Continuum* (Portland, ME: Muskie School of Public Service, University of Southern Maine, 2007), 1, <https://perma.cc/GY5P-QJPF>; and Karen Van Gundy, *Substance Abuse in Rural and Small Town America* (Durham, NH: University of New Hampshire, Carsey Institute, 2006), 26, <http://scholars.unh.edu/cgi/viewcontent.cgi?article=1006&context=carsey>. The Jefferson County Day Report Center advocates using telehealth technology to make qualified addiction specialists available to its clients. Telehealth not only makes a prescribing physician more accessible to the center’s clients, but it brings a higher level of expertise to the program. It is only through telehealth that Jefferson County Day Report Center can make qualified addiction specialists available to this population.
- 32 Phone interviews by Alison Shames with Dorse Sears, senior justice programs specialist, West Virginia Division of Justice and Community Services, July 6, 2017 and August 9, 2017; Robert Arnold, director of WVDOC Parole Services, August 3, 2017; and Ronda Eddy, director, Jefferson Day Report Center, Inc., July 5, 2017.
- 33 See Paul M. Roman, Amanda J. Abraham, and Hannah K. Knudsen, “Using Medication-Assisted Treatment for Substance Use Disorders: Evidence of Barriers and Facilitators of Implementation,” *Addictive Behaviors* 36, no. 6 (2011), 584–589, www.ncbi.nlm.nih.gov/pmc/articles/PMC3087632; SAMHSA-HRA, 2014; and Leah Pope, Chelsea Davis, David Cloud et al., *A New Normal: Addressing Opioid Use in the Criminal Justice System* (New York: Vera Institute of Justice, 2017), <https://perma.cc/VD9R-DACT>.
- 34 For example, the Jefferson County Day Report Center recognized the need to educate its key stakeholders (including judges, prosecutors, and supervision officers) broadly about substance use treatment. The director of the day report center convened the justice system actors and invited the center’s addiction specialist—the same doctor who meets with participants via video technology to assess them and prescribe MAT—to present information to the group about addiction, substance use disorder, the opioid epidemic, and opioid disorder treatment strategies, including detailed information and supportive research about MAT.

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- 35 See Steven Belenko, Matthew Hiller, and Leah Hamilton, “Treating Substance Use Disorders in the Criminal Justice System,” *Current Psychiatry Reports* 15, no. 11 (2013), www.ncbi.nlm.nih.gov/pmc/articles/PMC3859122; and SAMHSA-HRSA, 2014, 4.
- 36 Interview with Dr. Merideth Smith, 2017. These materials target common misconceptions about Vivitrol and address other concerns. The WVDOC reports that one reason people gave for not participating in the Vivitrol program is that their family would not allow them to have MAT or advised them against it. In response, the WVDOC is planning to create written materials designed to be shared with the families and support network of incarcerated people, similar to materials developed for the Pennsylvania Department of Corrections to support its Vivitrol program, with a range of educational materials designed for different audiences, including friends and family of people involved in the system. See Advocates for Human Potential, Inc., 2016, Appendix B: Pennsylvania Department of Corrections MAT Expansion Plan, 12-13.
- 37 Ibid. For example, see the section on Barnstable House of Correction, 6.
- 38 Interview with Dr. Merideth Smith, 2017.
- 39 Not all criminogenic needs equally influence an individual’s probability of re-offending. Of the eight widely recognized criminogenic needs, experts explain that “the top four (history of anti-social behavior, anti-social personality factors, anti-social cognitions/attitudes, antisocial peers) have the most significant impact on future recidivism and should be considered the primary intervention targets.” It is further recommended that when substance use is identified as central to a person’s criminal behavior, it should become a primary target, but the other top needs should also be addressed. Research also demonstrates that an offender’s risk level is more likely to decline when a greater number of needs is addressed. See Frank Domurad and Mark Carey, *Implementing Evidence-Based Practices: Coaching Packet* (Center for Effective Public Policy, 2010), 18, <https://perma.cc/ZA54-MM4S>; Donald A. Andrews, James Bonta and J. Stephen Wormith, “The Recent Past and Near Future of Risk and/or Need Assessment,” *Crime & Delinquency* 52, no. 1 (2006), 7-27, <https://perma.cc/W42B-EDLR>; and Donald A. Andrews, “Principles of Effective Correctional Programs,” in *Compendium 2000 on Effective Correctional Programming*, edited by Laurence L. Motiuk and Ralph C. Serin (Ottawa: Correctional Service of Canada, 2007).
- 40 West Virginia Division of Justice and Community Services, “Reducing Recidivism and Promoting Recovery: West Virginia’s Implementation Plan for Treatment Supervision” (2015), <https://perma.cc/G9QA-2RRG>.
- 41 The Medicaid program in West Virginia now serves more than 660,000 residents, approximately one-third of the state’s population. More than 200,000 people enrolled in Medicaid since it was expanded in 2014. See West Virginia Department of Health and Human Resources (DHHR), *Creating a Continuum of Care for Substance Use Disorder Treatment in West Virginia: A Medicaid Section 1115 Waiver Proposal* (Charleston, WV: West Virginia DHHR, 2016), <https://perma.cc/XDM5-EXG6>.
- 42 Ibid.
- 43 Without insurance, Vivitrol can cost \$1,000 to \$1,400 per injection; Suboxone or generic buprenorphine can range from \$100 to \$800 per month. See Rachel Dissell, “Vivitrol, Suboxone and Methadone: What We Know About Medicines Used to Treat Opioid Addiction,” *The Plain Dealer*, April 30, 2017, www.cleveland.com/metro/index.ssf/2017/04/vivitrol_suboxone_and_methadon.html.
- 44 Christian Heiss, Stephen A. Somers, and Mark Larson, *Coordinating Access to Services for Justice-Involved Populations* (New York: Milbank Memorial Fund, 2016), 6, <https://perma.cc/434J-3ML3>.
- 45 In Connecticut, the Department of Corrections (which, as a unified system, holds people in custody who are pretrial and those sentenced to state custody) collaborated with the Department of Social Services and adapted an intake-based Medicaid application process. See Kamala Mallik-Kane, Akiva Liberman, Lisa Dubay, et al., *Using Jail to Enroll Low-Income Men in Medicaid* (Washington, DC: Urban Institute, 2016). <https://perma.cc/8PDM-2LPC>.

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For more information about this report, contact Ram Subramanian, editorial director, at rsubramanian@vera.org.

For more information about Vera's technical assistance under the Justice Reinvestment Initiative, contact Nancy Fishman, project director at Vera's Center on Sentencing and Corrections, at nfishman@vera.org.

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Vera Institute of Justice
233 Broadway, 12th Fl
New York, NY 10279
T 212 334 1300
F 212 941 9407

Washington DC Office
1111 14th St., NW, Ste 920
Washington, DC 20005
T 202 465 8900
F 202 408 1972

New Orleans Office
1307 Oretha Castle
Haley Blvd., Suite 203
New Orleans, LA 70113
T 504 655 6277

Los Angeles Office
707 Wilshire Blvd., Ste 3850
Los Angeles, CA 90017
T 213 223 2442
F 213 955 9250