Key:

T = Dr. Thomson

T: A significant number of people involved in the criminal justice system have a substance use problem. Providing treatment saves between $2 and $6 for every dollar spent, and it's very important that both the inmates and other stakeholders in the criminal justice system understand that forced abstinence during incarceration is not treatment, nor is it recovery.

Throughout this presentation, I'll be using the term "inmate" to signify that population of criminally and justice-involved people who are currently incarcerated.

As many as 65 percent of inmates in the federal prison system have a substance use disorder. Very often, many of these people have co-occurring mental health issues as well, such as depression, anxiety, or psychotic disorders. Many of them have significant histories of trauma. We understand that it is very important that we provide an integrated approach to treatment, where we can treat the inmate whole-person, to make sure that we address all of their treatment needs in order to successfully support their re-entry to society.

The Bureau provides a multi-system treatment approach, consisting of drug education, outpatient drug treatment, residential treatment, and most recently, medication-assisted treatment. Drug education is a series of classes that provides education regarding substance use and its effects and serves to help identify inmates with a need for further programming. Drug education is required when inmates have a history of substance use documented in their pre-sentence investigation report, when inmates have a history of violating terms of supervised release or community placement due to drug use, when their drug use contributed to their instant offense, and also when they have a judicial recommendation for drug treatment. Drug education is provided within 12 months of the inmate's initial incarceration.

The non-Residential Drug Abuse Program provides non-residential treatment for inmates who may not have enough time left to participate in RDAP, or who might just not have an interest or a need to participate in our more intensive drug abuse treatment program. It is intended for inmates with longer sentences who are earlier in their sentence and may still be struggling with substance use treatment needs during their incarceration. Non-residential drug treatment meets for 90 to 120 minutes per week for 12 to 24 weeks. The most well-known drug treatment program in the Bureau of Prisons is, of course, the Residential Drug Abuse Program, sometimes called RDAP, or the 500-hour drug treatment program.

The Residential Drug Abuse Program was originally developed in 1989 and has been refined over time to incorporate best practices in substance use treatment. There are currently 83 RDAPs in 72 Bureau institutions and one contract facility. We have residential drug abuse programs to address treatment needs for special populations, including female inmates, inmates with mental health issues, and inmates who require programming in Spanish.

The Bureau's theoretical model of change is Cognitive Behavioral Therapy -- CBT. It's intended to reduce anti-social peer associations, promote positive relationships, increase self-control, self-management and problem-solving, and end drug use. The Challenge Program is another residential unit-based program developed for inmates in high security settings, otherwise known as penitentiaries. We understand that successful re-entry to the community happens when inmates' treatment needs are carried through to the halfway house or on home confinement. In order to accomplish this, we have a wide network of contracts to provide mental health, substance use and sex offender treatments to inmates who are in halfway house or on home confinement. Inmates who do not volunteer for drug abuse treatment in the institution may request drug treatment to support their re-entry into society.

In an effort to address the ongoing opioid epidemic, the Bureau of Prisons is implementing medication-assisted treatment of inmates with opioid use disorder. Medication-assisted treatment is the use of medications in conjunction with counseling and behavioral therapies to provide a whole-person approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these offenders, and for some people struggling with addiction medication-assisted treatment can help sustain recovery.

A common misperception is that addiction is a choice or a moral problem, and all you have to do is just stop using drugs. But nothing could be further from the truth. The brain actually changes with addiction, and it takes a good deal of work to get it back to its normal state. The more drugs or alcohol you've taken, the more disruptive it is to the brain. These brain changes, coupled with severity of withdrawal, make it really difficult for a person with opioid use disorder to engage in traditional treatment, even after they have been incarcerated for a period of time. Formerly incarcerated individuals are 40 times more likely to die of an opioid overdose within two weeks of release from prison, regardless of the length of their sentence, so it's important that we provide a full range of treatment options for these individuals.

Evidence-based treatment strategies for substance use disorder include Cognitive Behavioral Therapy, individualized treatment that target each person's unique treatment needs, and a therapeutic community to help these folks learn the skills that they need to return to society. It's also critically important that we provide wrap-around services for these people, that we provide treatment that starts during their

incarceration, carries through their placement in halfway house or on home confinement, and extends right through to supervised release. Fortunately, the Bureau's drug treatment programs are uniquely situated to do just that.

One of the things that we have learned is critically important in working with this population is to assess suicide risk. The suicide rate among those people with opioid use disorder is six times greater than the general population suicide rate. We also work very hard to address co-occurring substance use treatment needs, and to promote an integrated care for people with opioid use disorder and co-occurring disorders. These people have high rates of victimization, poverty and homelessness, and if we don't address those treatment needs, the successful likelihood of re- entry is negatively impacted. In implementing a medication -assisted treatment program, there are certain barriers that must be addressed. For example, there are high rates of misunderstanding and stigma towards drug addiction, individuals with opioid use disorder, and the use of medications to treat opioid use disorder. There's inadequate education of professionals responsible for working with patients with opioid use disorder, including treatment providers and law enforcement. Current regulations around methadone and buprenorphine make it difficult to prescribe those medications to the extent that we need in the Bureau of Prisons, and we are working with our partners to mitigate that.

There's a fragmented system of care for people with opioid use disorders and current financing and payment options. The Bureau of Prisons is working hard to address myths associated with medication-assisted treatment. For example, one common myth is that medication-assisted treatment is simply trading one addiction for another. Nothing could be further from the truth. When we conceptualize opioid use disorder as a chronic brain illness, which it is, it makes sense that medication would be the first line of treatment. Another myth is that medication-assisted treatment is only for short-term use; that someone who enters our custody with an existing medication-assisted treatment plan would be removed from that treatment plan as soon as possible. Again, that is not considered consistent with standards of care. Inmates who come into our system with existing medication- assisted treatment plans may need to be maintained on those treatment plans throughout the length of their incarceration.

A common myth that we find in correctional settings is that MAT will make our institutions less safe, that somehow medications that are intended for patients with diagnosed opioid use disorders will find their way out through diversion to the compound. Again, what we find is that when people are getting the treatment they need, it actually reduces the demand for contraband drugs in our institutions.

Some people believe that medication-assisted treatment is a bad moral choice, and this is grounded in the moral model of addiction, where people who use drugs are somehow bad, or made poor choices and deserve to be punished for their behavior. Often these people believe that medication-assisted treatment is inferior to complete and

unassisted abstinence, and may say, "I've known people who could stop using opioids without help. MAT is only for the weak." While it's true that some people may be able to top using opioids without the assistance of medication, that is not the case for many people. And it is important that we provide as much support to individuals with opioid use disorder in achieving recovery as possible.

Some of the specific concerns about medication-assisted treatment in a correctional setting include concerns about diversion. Will these inmates, for example, cheek the medication, or hide the medication elsewhere, take it back to their units and sell it? There are also concerns about drug-seeking behaviors and a lack of resources to administer a medication-assisted treatment program effectively. Many of our staff say we already provide drug treatment we don't need medication-assisted treatment. And there are, in fact, policy limitations. But I'm proud to say the Bureau of Prisons is working hard to educate staff and inmates about the benefits of medication-assisted treatment, address the myths and establish security procedures that reduce the likelihood of diversion and drug-seeking behaviors.

In 2019, the Bureau of Prisons began delivering medication-assisted treatment to inmates who were transitioning to halfway house in the Boston area. The Boston area had a strong tradition of effective drug treatment supports for inmates who were transitioning back to society, and medication-assisted treatment was no different. In 2019, we have broadly expanded medication-assisted treatment throughout the entire agency. Inmates who were nearing transition to halfway house and who have a history of opioid use disorder are evaluated for medication-assisted treatment to help support their re-entry. We are also now continuing inmates who enter our custody on established medication- assisted treatment programs. Inmates in the Bureau of Prisons who demonstrate a need for medication-assisted treatment are evaluated on a case-by-case basis.

It's useful to consider a case that illustrates our integration of substance use, mental health and trauma treatment. Inmate Smith is a 30-year-old woman who entered our custody approximately 18 months ago. She has a significant history of mental health problems, including anxiety, depression, and some fairly serious suicide attempts. Inmate Smith also has a significant history of opioid use disorder and reported that she used heroin on an IV basis for approximately seven years before her incarceration.

Upon entering our custody, we conducted an evaluation of Inmate Smith's treatment needs, and determined that she would be best served by participating in the dual diagnosis Residential Drug Abuse Program. She has been participating in that program for the last six months, and I'm pleased to say that she has reported a significant reduction in mental health symptoms. Inmate Smith will begin medication-assisted treatment in approximately three months, as she prepares for re-entry to society. We believe that the combination of mental health, substance use and medication-assisted

treatment provide Inmate Smith with the best opportunity for supported positive re-entry.

One of the ways the courts can be particularly helpful is by providing us as much information as possible about the offenders that are coming our way. Most commonly, we look to the pre-sentence report for that information, and it is really helpful when that pre-sentence report provides detailed information regarding an inmate's substance use history.

Thank you very much for your time today.