Statement of Dr. Homer Venters
at
NEW YORK STATE
ASSEMBLY COMMITTEE ON ALCOHOLISM AND DRUG ABUSE
ASSEMBLY COMMITTEE ON HEALTH
ASSEMBLY COMMITTEE ON CORRECTION

Good morning Chairpersons Rosenthal, Gottfried, Weprin and esteemed assembly members. My name is Dr. Homer Venters and I appreciate the opportunity to provide testimony. I am the former Chief Medical Officer of the NYC jail system and had the great honor to lead that system through significant reductions in mortality and morbidity as well as eliminating the use of for-profit health vendors in favor of a public model. I now serve as the Senior Health and Justice Fellow for Community Oriented Correctional Health Services (COCHS), a nonprofit that works to bring evidence-based care to persons with justice involvement around the nation. I am very happy to provide brief comments today in support of medication assisted treatment (MAT) in places of detention. My comments will focus on three areas that I believe merit your attention, 1) Securing access to MAT throughout incarceration 2) Broadening oversight and funding of correctional health and 3) Designing a regional model of care and treatment that meets the needs of rural New York counties.

Securing access to MAT throughout incarceration

As the Chief Medical Officer of the NYC jail system, I have seen first-hand the stabilizing impact that MAT can have on the health of individuals, their ability to maintain healthy relationships, employment and housing. MAT also lowers mortality behind bars, not only for overdose deaths but for overall mortality.[1] Health and correctional staff alike benefit from having detainees engaged in effective treatment because it allows for other health problems to be

addressed more reliably. For those of you familiar with the intake pens of jails and prisons, many people who come into these teeming and chaotic settings may be in the midst of withdrawal and/or imminent overdose from illicit use. Their early identification and treatment not only improves their individual health outcomes, it can also greatly reduce the prevalence of symptoms like nausea, vomiting and headache which may be incorrectly attributed to withdrawal but really indicate fatal medical emergencies like diabetic ketoacidosis, heart attack, stroke or intestinal perforation. I have seen all of these permutations as a physician and without MAT, we ask security staff to do an almost impossible job of assessing detainees for signs of distress. The need for MAT is also clear in the post-release period. Data from jails and prisons reveal the terrifying increases in mortality in the weeks after release, largely driven by drug overdose.[2] Providing evidence-based treatment before release, including MAT, is critical to eliminating these deaths, which form a forgotten subset of the opioid crisis.

There is progress in widening access to MAT, but implementation has been inconsistent and lacking an evidence-based approach. The New York State Department of Corrections has made important progress regarding MAT with a pilot program that allows parole violators to continue their methadone and this is an important first step in providing ethical and evidence-based care to state prisoners. The larger problem of lack of access to MAT for persons transferring to the New York State prison system persists, however, even when persons are stable and receiving MAT in a jail setting such as NYC. Vermont has also passed new legislation relating to MAT but unfortunately, the bill has been implemented in a manner that limits the 'medical necessity' of MAT to the final weeks of incarceration. Denial of evidence-based and mortality-reducing care is not acceptable and the use of a 'medical necessity' label to justify this denial is inappropriate.

We would not accept such a denial of care for diabetes, heart disease or schizophrenia. New York should avoid repeating this error in implementing MAT inside jails and prisons. From the standpoint of medical evidence and medical ethics, there is no doubt that persons in jails and prisons should have access to MAT throughout their incarcerations.

Broadening oversight and funding for correctional health

One critical barrier to wide adoption of evidence-based substance use treatment has been the lack of Federal funding for health services behind bars, owing to the 'inmate exclusion' in the social security act of 1965. This prohibition has left correctional administrators with the daunting task of providing care for a cohort of detainees with ever increasing prevalence of substance use, mental health and Hepatitis C diagnoses without access to adequate funds and expertise. For NYC and other large urban jails, substantial commitments through city tax levy have allowed correctional health services to attempt to seek a community level of care. For rural county jails and many state prisons, this has not been possible. Many of us were part of an important effort in 2015 to seek a waiver from the Centers for Medicare & Medicaid Services to use Medicaid dollars for some care in jails and prisons relating to re-entry, which stalled after the presidential election. Re-engaging with that effort and pursuing new opportunities provided by the recently passed Federal opioid bundle give us hope that we can finally break down the barrier between funding of community and correctional health services, a longstanding goal for improving correctional health.[3]

Access to MAT is part of a larger discussion about whether and how we care for persons in jails and prisons. For decades, the quality and scope of care behind bars has been left to the

responsibility and discretion of security services. Sherriff's and Commissioners of Correction are neither trained nor funded to design evidence-based health services, yet this is the mandate they have been given. For MAT to be adopted successfully in these settings, we need to broaden the purview of the State and local Departments of Health and Mental Health to include all health-related services. This is the surest way to bring community standards of care regarding diabetes, heart disease, cancer, injuries and other health concerns to those who pass through jails and prisons. In addition, a broad oversight of correctional health services by health departments will ensure the appropriate use of epidemiology and medical ethics to safeguard the health of vulnerable populations. One mandate of community health settings is to find and address disparities by race, age, gender, sexual orientation and other factors. This type of analysis is rare in correctional settings and requires both the skill and the will to promote health of New Yorkers wherever they are located. By conducting this type of analysis in the NYC jails, we found very concerning racial disparities in mental health engagement and use of solitary confinement that led us to design new custodial and health interventions.[4] Involving independent health departments in correctional health will also promote honest discussions about the health risks of incarceration itself. Far too often, death, injury and trauma behind bars is thought to be the product of the health problems of the incarcerated. This is not true, and these health outcomes reflect an interaction between the health risks of these institutions, and some intrinsic risk factors of the incarcerated.[5] Sexual assault, traumatic brain injury, solitary confinement, death from alcohol withdrawal; these are examples of health risks that jails and prisons may impart to the incarcerated, and until we properly address these as systematic risks, we will continue to struggle to meet our obligation to the health of New Yorkers.

Designing a regional model of care and treatment that meets the needs of rural New York counties

Many of the innovations from NYC are difficult to implement outside an urban area but it is clear that the health services in jails and prisons remain largely disconnected from community care. This disconnect leads to missed opportunities for improving health and reducing recidivism and the financial burdens of our criminal justice system. County-level efforts to stem the tide of opiate overdose deaths and implement alternatives to incarceration could be greatly enhanced by development of regional models that integrate community with correctional health services. One of our most successful programs in the NYC jail system involved utilizing jail-based re-entry team, who routinely linked our jail-based patents to community care, with significant improvements in health and housing outcomes while reducing community costs.[6]

We adapted these teams to dedicate time towards facilitating alternatives to incarceration, with hundreds of successful cases each year. These diversions were effective for some, but we analyzed the churn of people who cycle in and out of jail most frequently, we found they have incredibly high rates of substance use and housing concerns.[7] The next program designed to address these needs was the NYC justice involved supportive housing (JISH) pilot, a multi-agency collaboration that partners with community based organizations to place eligible participants in 120 permanent supportive housing units and provide support services. This program has reported improvements in three areas that are central to the success of addressing opiate and other substance use concerns; fewer returns to jail, less shelter use and improved health outcomes.[8]

Our experience at COCHS is that challenges to this type of integrated model can be greatly reduced with leadership by State-level agencies and actors, including legislators such as yourselves. Our efforts to make MAT and re-entry services accessible to the incarcerated and to implement evidence based behavioral health and supportive housing services in the community should be part of an integrated mission to improve health across New York. To make this a reality, a demonstration project that leverages Federal and State funds and pools resources to create a regional health and re-entry resource could be of great benefit, not only for county jails but for parolees and other state prisoners who are likely to fare better with supportive housing and addiction treatment. Designing a regional pilot that spans the continuum of diversion, jail, prison and re-entry with any eye towards integrating evidence-based treatment and supportive housing could greatly enhance the health, community engagement and resource allocation for persons with justice involvement in rural areas of New York. It could also help create meaningful alternatives to investing millions of dollars to rebuild crumbling county jails and state prisons. COCHS is eager to engage with you and other New York stakeholders to help drive this critical work.

In closing, I believe that MAT is an essential component of providing evidence-based and ethical care for persons with justice involvement. MAT should be available to persons who meet the clinical criteria for treatment, without regard to their location in jail or prison or the time remaining in their incarceration. MAT can be effective in reducing death and reducing recidivism if we can develop re-entry services that also promote alternatives to incarceration, and commit to supportive housing. In order to make these gains, we must all work together to broaden the oversight and funding linked to these essential services, or risk creating another

ineffective silo behind bars. We also need to devise specific strategies to make MAT, supportive housing and other evidence-based innovations a reality for rural New York counties. I thank you for your time and commitment to these important issues and would be happy to answer any questions.

Citations

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