



ASAM Practice Pearls Transcript

Addiction Care in Custody: *Trust, Treatment, and Advocacy*

Dr. Stephen Taylor: Welcome back to ASAM Practice Pearls, where we turn clinical expertise into everyday addiction care one conversation at a time. I'm your host, Dr. Stephen Taylor, and before we dive into today's episode, I want to share that the public comment period for the ASAM Criteria 4th Edition Volume 3: Correctional Settings and Community Reentry draft standards is open through August 31st, and ASAM is seeking your input to help refine the standards and decision rules. If you missed the public comment period, be on the lookout for updates on Volume 3's release, tentatively scheduled for early 2028. Now, let's get started.

We're all aware of the opioid overdose crisis. It is a public health emergency that we are actively trying to fix. But one of the most important opportunities to prevent overdose deaths is also, sadly, one of the most overlooked.

For people with substance use disorders, involvement with the criminal justice system is often a critical touchpoint for care. According to the most recent Bureau of Justice Statistics report, approximately 58% of individuals in state prisons and 63% in jails meet criteria for substance use disorder. On top of that, the risk of a fatal overdose is highest immediately after release, with a 41 times greater risk than the general public.

When it comes to opioid overdoses, individuals are 15 to 129 times more likely to die than individuals in the general population. And between 24% and 50% of all fatal opioid overdoses occur among individuals with recent criminal justice involvement.

So, given all that we know, the criminal justice system may be one of the most important, yet underutilized, entry points for addiction treatments and a way to help combat the opioid overdose crisis. So, how do we do that? Well, in today's episode, we will explore what effective addiction care looks like for patients in custody and in their re-entry into the community.

With us today is Dr. Justin Berk, director of the Center for Health and Justice Transformation and an associate professor in the departments of medicine and pediatrics at the Alpert Medical School at Brown University, as well as the former state medical director for the Rhode Island Department of Corrections, which often serves as a national model for MOUD treatment in jails and prisons. This makes him the perfect guest for today's topic. Dr. Berk, Justin, please greet our listeners.

Dr. Justin Berk: Thanks so much for having me. Really happy to be here to talk about a really important topic, and glad this is something that ASAM is taking up as a top priority. So, thanks for having me.

Dr. Stephen Taylor: Let's jump into it, because we have a lot to talk about.

First, the criminal justice system. It's one of the most important touchpoints for people with substance use disorders. What opportunities exist for clinicians to engage patients and prevent gaps in care as they move between hospitals and correctional facilities and the community?

Dr. Justin Berk: This is a population that is super high risk for opioid overdose, and it's one where public health interventions can be super effective. Whether you're a clinician who's working in a jail or a prison or a hospital or a clinic, you're almost certainly seeing someone who is impacted by the criminal legal system. And that may be someone who is actively in custody, recently released, or formerly incarcerated a while back, all of whom have a higher risk of having negative outcomes from substance use disorder.

And this is our charge, as addiction providers or clinicians or anyone who's caring for these people, is how can we improve outcomes? How can we get people on treatment, reducing risk of overdose? And so, what can you do?

So, the easiest is falling back on our evidence-based standards of offering medications for opioid use disorder, finding the right level of care to support the individual in their state of recovery, and, really, I think, planning what the next step is for the individual.

So, if someone's in custody or was on probation or parole and maybe is going to be reincarcerated or is at high risk of being incarcerated, they might need more help, more supports. They might need you to be present. And a lot of that, I think, is something that is the bottom line for any of our marginalized groups, is having to do a little bit more support from the provider because there are just so many barriers that these people face for basic level of healthcare.

Dr. Stephen Taylor: All right. So, here's an experience I've actually had. It's been a while, but I have a feeling we have a few of our listeners who've had this experience.

The clinician walks into a room. You see the patient handcuffed to a hospital bed with a correctional officer present. What are the practical strategies that a clinician can take in that situation to help establish trust and build a therapeutic alliance?

Dr. Justin Berk: We know that internists and different providers have a huge number of exposures to people who are in custody who are actively handcuffed, but the training for these interactions is actually really limited. It's not something you necessarily learn about in medical school or residency. And there are good tips for, I think, how to build rapport with a patient and not be overwhelmed by the situation.

I mean, you walk into the exam room, and there's an officer in the hallway with a gun. There's a person who, in someone's mind, has been deemed such a security risk that they have to be tied to a bed. This is a very overwhelming emotional state that you're walking into, and the default is often to defer to the man with the gun, and that's kind

of a reasonable response. But it's not always the thing that can best help our patients, in that there are certain things you can do to build rapport with a patient without always just defaulting to the security officer rather than the patient. Your first responsibility as a clinician is to the patient.

So, what are some things you can do? First and foremost, this is where a lot of trauma-informed care comes in, where you can talk about the patient in very supportive terms, using very specific and thoughtful wording to make sure that you are understanding that person's predicament and you're not using judgmental or stigmatizing language.

One of the pearls that I really like, that I've had mentors teach and try to implement any time this happens, is asking the correctional officer, asking security to uncuff the individual. This is something that almost all the time can be done. The correctional officer does have a discretion to uncuff the individual, and it can dramatically improve, whether it's the physical exam or rapport building. It really makes for a less demeaning situation where you're trying to bond with the patient.

And now, listen, the correctional officer may very well say, "Nope, sorry, Doc. He's staying locked up." You don't have to fight back. I think even just asking that question at the start of the interview can be such an amazing bonding experience where the patient knows that you're trying. That you're interested in their well-being, you're building an alliance with them, and those are little things that can really go a long way for a patient who, otherwise, is not receiving a lot of compassionate care, necessarily, and is not someone who's having, you know, someone trying to be supportive in their day-to-day, and not just being scared and asking short questions and running out of the room as soon as you can.

Dr. Stephen Taylor: So let me get this right. I can help build a rapport with that patient without arguing with the correctional officer who might say no to my request to removing the cuffs?

Dr. Justin Berk: Yeah, you're a doctor. You can do whatever you want. No, but I think that's exactly right. I think those are things where clinicians don't know that they can make that simple request.

And when you have someone in handcuffs, whether it's in the emergency room, whether it's in an outpatient clinic, or in the hospital, there's a huge variation of security levels. You know, this might be someone in a jail setting. It might be someone in a minimum-security setting that's about to get out. It might be someone from a maximum-security facility.

And the correctional officers will have different protocols about who they can and can't uncuff, necessarily. But asking is always something that's allowed. It's often something that can be done, and if not, it's still a very small act of kindness and

consideration that, as providers, we can do that can be really meaningful for the patient.

Dr. Stephen Taylor: So let me ask you this, yes, it's a very different situation working with someone who is in custody. But what about our treatments? Are our treatments going to be different? I mean, we know that medications work in the community, but is there evidence that implementing MOUD in jails and prisons also works? Do we need that evidence? Should we just assume because it works in one setting, it works in the other?

Dr. Justin Berk: Yeah. It's such a good question because, again, we know that buprenorphine and methadone and medications for opioid use disorder, broadly, are these life-saving miracle drugs in the community. But when people are incarcerated, there's an assumption that their drug use is going to stop, and therefore, they don't need these medications.

And most jails and prisons in the United States do not offer medications for opioid use disorder. The majority of facilities do not offer these medications for opioid use disorder, which is kind of wild. When you talk about, this is the population that has such high risk, this is the population that can be such a critical touch point, you would think these are the ones we would want to treat.

And sure enough, there's a lot of research on this, of when you initiate medications for opioid use disorder in jails and prisons, what happens? First and foremost, it reduces opioid overdose. It reduces opioid overdose to such an extent that I think it's hardly comparable to any other medication that we have.

Some evidence shows that there's an 80% reduction in fatal opioid overdoses when you provide methadone for opioid use disorder in a jail setting. In Rhode Island, some of the preliminary data, that our state was a part of, found a number needed to treat of 11 in order to save one life. So, for every 11 people you prescribed buprenorphine or methadone to, one life was saved.

And in the field of medicine, there are so few examples, maybe insulin in type 1 diabetes, but of the medications that we prescribe in primary care settings, in any inpatient or outpatient setting, a survival number needed to treat of 11 is truly a miracle drug. And despite this great evidence, they're not implemented. And that's just for opioid overdose.

I mean, there's also robust data that shows it decreases hep C transmission. There's evidence that it reduces HIV transmission. There's increase in treatment retention upon release. There is a decrease in recidivism and reincarceration. So, this is really a very clearly effective intervention and one that's just not being utilized.

Dr. Stephen Taylor: That is astounding when you think about those numbers and think about the fact that this is so grossly underutilized. But we've established, beyond a shadow of a doubt, this is something we should do.

So now the next question is, how do we do it? What is the way that clinicians should approach initiating evidence-based treatment for patients in custody?

Dr. Justin Berk: Yeah, there's a major gap in implementing research evidence in correctional facilities. We know that even in the community, from a research study to implementation, can take, you know, 10 to 17 years. There's an additional time of uptake in jails and prisons, and we've actually written about this and coined the term 'prison implementation penalty' of this extra time that it takes for evidence to disseminate into jails and prisons.

And so, there's a lot of reasons for this. There's barriers, there's logistical constraints, but I think one of the major challenges is that individuals in jails and prisons are often a very siloed part of the community. People view jails and prisons as something they don't want to think about. They think about, you know, this good guy, bad guy mentality, and forget that 95% of people who are incarcerated are going to return to their neighborhood, to their community. So, it's a population that we need to take care of. But we often, you know, just when public health interventions occur, aren't thinking about the incarcerated population.

And so, what can a clinician do? How can someone help advocate and recognize for this? I think there's a few things. I think one is just simply having this discussion with your colleagues, with policymakers, with other clinicians. It's a time when you see one of these patients, to advocate by doing evidence-based medicine, by prescribing buprenorphine. And if a correctional officer says, "Hey, doc, we don't do buprenorphine," you say, "That's unfortunate. You should. I'm going to prescribe buprenorphine. I'm going to document buprenorphine. I'm going to tell everyone and make it very clear that my recommendation is for this individual to be on buprenorphine, and if your facility is unable or unwilling to do that, there's potential legal liability."

And that's something that does scare, you know, prison administrators. Whereas, if a provider says, "Oh, your facility doesn't do buprenorphine? No problem. We won't prescribe it then," that's where I think we reinforce the status quo and aren't able to help move the needle to get people the evidence-based medicine that they deserve.

Dr. Stephen Taylor: Interesting. So, a couple of things I want to highlight right there. Number one, 95% of people who are in the carceral system will at some point return to their community. And I noticed you didn't qualify that by saying innocent versus guilty or at what state. You just said 95% of people who are incarcerated are going to end up back in the community.

I think that bears repeating and emphasis because that, I think, may fuel and buttress clinicians to do the other thing that you said that I want to highlight, which is go ahead and prescribe what you know is right, even if there's little chance of it being delivered.

The bottom line is, you got to be on record prescribing it for that patient, letting the folks know that this is what you're prescribing, that this is what is the right treatment for the patient, and if they don't prescribe it, they could be incurring legal liability. In other words, you got to be willing to buck the system a little bit. Am I overstating that?

Dr. Justin Berk: No, I think that's exactly right, and you can do it in a way that is not confrontational. It's not yelling at the correctional officer. It's not lecturing the major decision-makers. It's quietly adding a hyphen to your note that says, "Buprenorphine is an evidence-based recommendation. I am prescribing this evidence-based medication." You can say, "I've been informed that it'll not be continued, but I would still highly recommend."

And to your point, this doesn't just apply to medications for opioid use disorder, but other sequelae and other challenges in healthcare delivery. This might be the only time they're assessed or treated for hepatitis C. Don't discharge them to follow up for their colonoscopy outpatient if it's possible to do it tomorrow. If there's an opportunity to do things like injectable buprenorphine in the hospital, these are all really high-yield things that can help someone while you have the ability, and all that you're doing is offering evidence-based care and essentially ignoring the handcuffs and treating the person like a patient. Which is what we should all be doing.

Dr. Stephen Taylor: Oh, that's powerful, and it's very important. You know, I think I've shared with you previously that I did my addiction psychiatry fellowship at Bellevue Hospital in New York City. And on the 20th floor is where Dr. Mark Galanter had his whole addiction treatment mecca, is what I like to call it, where we had the alcohol detox unit, and then down the hall was this, at the time it was called the dual diagnosis unit, and in another part of the hall was a different unit.

But a couple of floors up from us in Bellevue Hospital was what was called, then, the prison unit. And it wasn't uncommon to go down in the elevator and see a very large person with a very large gun, or at least it appeared to be large, escorting an even larger person, handcuffed, who was obviously a patient in that prison unit.

And so, the idea, when you say that it isn't right to necessarily yell at the corrections officer, I have to confess that never occurred to me. It just wasn't something I ever considered doing, was yelling at those guys.

But I will say that it is very important for us all to think in terms of going on ahead and doing the advocacy that is involved in just doing our jobs, just prescribing what we

know is right, or doing what we know is right for the patients that are under our care, who happen to be in the carceral system.

I think that's very important, and I think it's worth noting that that is a form of advocacy, is it not?

Dr. Justin Berk: What a beautiful form of advocacy. You know, just doing the job and recognizing how jarring that visual, that you mentioned in the elevator, might be, and recognizing our own implicit biases when we're walking into that room and feel uncertain.

Those are the things that we have to be thoughtful of and not let the reflex of just wanting to get in and out of the room, the reflex of deferring to the man with the gun to take control, but to say, "No, I am a trained clinician. My duty is to the patient. I'm going to do everything I can for the patient." And that is the most core form of advocacy, and actually can go a really long way, in part, because that's not what every provider is going to do in that situation

Dr. Stephen Taylor: Yeah, unfortunately. Well, here's another thing that you said that I want to come back to. Back to that 95%, which, still, I think, is something we need to keep in mind.

What that also means is that 95% of those folks will have a time when they are discharged from the carceral setting. What about if we are not convinced, or we are convinced perhaps, that they will not be able to access what we want them to access once they're discharged? What if it's not going to be guaranteed that they'll get MOUD, or whatever other evidence-based treatment that they need, once they're discharged? What should we do?

Dr. Justin Berk: This is a tough question that I wish there was an easy answer for, because this is something that is challenging. When someone leaves incarceration, even if they were lucky enough to be at one of the facilities offering treatment, they go back to a community where there are a lot of collateral consequences of their incarceration. Their Medicaid might have been suspended and is causing a whole challenge to getting back on health insurance. They might need vital documents, like an ID, which can be very challenging. Transportation, housing.

You know, if you are incarcerated and get out one Tuesday, the first thing in your mind is probably not, "You know who I want to see is my addiction doc." But you got to catch up with your family. You got to find a job. You got to figure out where you're going to stay that night. And so, all of these are major challenges at the time of re-entry that makes that period so high risk. And so, what can you do?

I think, again, there's some advocacy level on a lot of the policymakers who are involved in ASAM or know people who are doing this kind of public health work.

There's an opportunity to really ensure this is a population that people are talking about and supporting.

I think, as a clinician, keeping all these challenges in mind. When your patient no-shows for their clinic appointment, don't just assume that they'll reach out if they need you. But this is where all these alternative models of delivery can be really helpful, where peer recovery specialists or community health workers or push initiatives rather than pull initiatives to meet people where they're at and to help them where they're at. It does require some extra work because the patients have a lot more barriers than your typical patient.

And so, these are the things that, I think, there's an advocacy level at the policy, but also just advocacy level in your day-to-day of going the extra mile to support these patients.

Dr. Stephen Taylor: Now, look, we know what stereotypes are. We know that there's probably a stereotype in many people's minds that folks who end up in the carceral system, at some point or another, may have violated a rule or two. They may be people who are not likely, necessarily, to follow all rules.

So, therefore, when we think about the carceral setting and people who are in that setting, we think about medication diversion. It's a common concern, as often cited as a barrier to offering or continuing medication treatment in correctional settings. But how should clinicians approach conversations about diversion, and what practical safeguards can be implemented without restricting access to care?

Dr. Justin Berk: This is such a good question because if you have a conversation with a correctional officer or prison warden, they might even say, "Yeah, buprenorphine, methadone are great, but doc, like the diversion is out of control. It's a major issue. People are selling it, they're coercing it. It causes a problem because it causes a black market, and a black market leads to violence in a jail or prison."

And I'd say, certainly, there is some truth to this. What research has shown is that the perceived amount of buprenorphine or methadone diversion is far greater than the actual level of diversion, but diversion certainly occurs, and I think there's different reasons. That may be untreated withdrawal. That may be wanting to self-medicate.

But there's also, almost certainly, some opioid-naïve individuals who are trying to access that medication for some type of buzz, especially to escape the unpleasant situation that they're in, in that jail and prison is not fun. And therefore, having some other way to escape that, as we see with any substance use disorder with people who are facing trauma, is very common.

What I will say is that medication diversion in jails and prisons occurs. It occurs with buprenorphine. It even occurs with methadone, which requires a lot of creativity, but it happens. But there's diversion of gabapentin. There's diversion of bupropion.

There's diversion of cyclobenzaprine. And these are medications that often are not diverted in the community, I think, because people don't really receive a recreational benefit. But in jail and prison, I think it demonstrates, you know, a level of desperation where people are really in unpleasant settings.

And so, just like diversion of these medications, yes, it is bad. It is something that can be dangerous. It is not something you want to promote. But it's also something you have to weigh against the benefits.

Everything is a risk-benefit calculus, and these miracle drugs that have relatively low, especially buprenorphine, low risks of overdose or medication complications is something that I think is often overplayed and comes up in conversations a lot, and just has to be weighed by the enormous amount of benefit that these medications offer.

Dr. Stephen Taylor: That's so true. I'm going to touch on the period immediately after release from a carceral setting. Obviously, we've mentioned that it's one of the highest risk periods for overdose and treatment disengagement. But how can clinicians help support a smooth transition and improve continuity of care and reduce risk? Is there anything more that we haven't already touched on in that regard?

Dr. Justin Berk: I think thinking about wraparound services and how you can support some of the social work needs of the individual, meeting the patient where they're at and going the extra mile to really kind of help them navigate care and support them in that really high-risk period.

I think those are the two biggest things, is just really trying to find ways to support patients in unique ways because that is a major challenging time.

Dr. Stephen Taylor: All right, Dr. Berk, is there anything else that you want our listeners to know about today's topic before we jump into some lightning round questions?

Dr. Justin Berk: Yeah, I think one of the things is some of the other challenges that come up when taking care of a patient who's in custody status. There's a lot of confusion about things like health privacy. And while correctional officers have to ensure security of patients and for healthcare staff, it does allow for privacy, and you can ask a correctional officer to step away from the bedside or to talk softly to a patient to support their privacy.

Decision-making is a common question that we get, and incarcerated patients do have full autonomy. And if they're unable to make decisions, then their next of kin is that surrogate decision-maker. The correctional officers or prison staff should not be making medical decisions.

And then one of the other things you can do with discharge planning, you might not know what the jail or prison facility offers. Call up the provider. Call up the jail and prison. They'll give you the number—have the med student call. I guarantee you the prison physician is going to be very pleasantly and pleased to talk to someone about the care of one of their incarcerated patients, because often when they get someone back, they get the after-visit summary. They may not even have a discharge summary yet. They have no idea what just happened in that hospital. And so, having someone call to create these connections and continuity of care can be a great way, again, to really just make sure that your patient is getting the best care, both in your clinical facility, but also when they go back to their correctional facility.

Dr. Stephen Taylor: All right, it is time for our lightning round. I'm going to shoot these questions at you. I'm going to ask for really quick responses. Are you ready?

Dr. Justin Berk: I'm ready. Let's do a lightning round.

Dr. Stephen Taylor: All right. Question number one. Jail versus prison. What are the most important clinical differences that clinicians should know?

Dr. Justin Berk: Most people think jail and prison are the same thing. They're not. Jails are for short sentences, often under a year. They're run by city and county most of the time. Prisons are longer sentences run by the state.

Therefore, jails are going to have a very short length of stay, so it's a lot of acute issues, including intoxication, withdrawal, trauma. These are things where you're going to see the patient for a week or two tops, and you got to take care of their immediate needs.

Prison population has a lot more chronic conditions, an aging population, COPD, cancers. Very different population to treat medically.

Dr. Stephen Taylor: For clinicians who don't regularly work in correctional settings, what are the most important things they should understand about how healthcare is delivered in jails and prisons?

Dr. Justin Berk: It is very different depending where you are. A rural jail in North Dakota is going to be very different than a large prison in Texas, which is going to be very different than Rikers Island.

And so, knowing where people are being sent to your facilities, what correctional facilities they're coming from, and understanding what their facilities are is going to be really important in this continuity of care because there can be a huge number of heterogeneity in healthcare services based on facility.

Dr. Stephen Taylor: Third one, OUD gets a lot of attention in jails and prisons, but what about other substances? Alcohol withdrawal, stimulant use disorder, emerging substances? What are some quick must-knows for clinicians?

Dr. Justin Berk: This is really, really important. Alcohol withdrawal is an enormously high-risk situation in a jail. A lot of jails do not have adequate supports to monitor and treat alcohol withdrawal. And there are individuals who are coming in with substance use disorder, including alcohol use disorder. And so are, therefore, at high risk for pretty bad outcomes of alcohol withdrawal. It's one of the leading causes of death in jails. Often requires making sure you have that right level of care appropriate to the severity of the withdrawal.

You mentioned stimulant use disorder. One of the baseline treatments for a stimulant use disorder, contingency management, really doesn't exist in jail and prisons. It's pretty tough to do. We need more treatment options to help people who are coming into jail and prisons, especially now that we see stimulant use disorder on the rise.

Emerging substances, absolutely one of the biggest one is K2 synthetic cannabinoids. It's becoming a major emerging issue. A lot of it is getting sprayed onto paper. There's a couple articles about it—there was actually a New York Times daily podcast just actually did something on this. But it can be smuggled through the mail. And so, some jails facilities now are discontinuing access to physical mail to avoid this contraband coming in. But that has real implications, and I think is a good model of how health and justice intersect, where now kids aren't getting their hand-drawn colored images from their children because there's no more physical mail in some jails as a way to crack down on synthetic cannabinoids. And so, this is a major thing.

As far as quick must-knows for clinicians, I think going back to reiterate the 95% of people that are coming back. These are your community members. These are your neighbors. These are people who are on the front lines of a lot of the public health interventions that we need to be targeting.

When you see someone in custody in any level of treatment facility, thinking about, "How can I best help this person?" And trying to overcome those feelings of overwhelm or intimidation and coming up with a collaborative way to support your patient.

Dr. Stephen Taylor: Thank you, sir. That's a great last question for our lightning round, and first main practice pearl that you want people to take away from this episode.

In addition to that one, what are some of the other main practice pearls or action items that our listeners should take away from this episode?

Dr. Justin Berk: You know, I reflect a lot on a quote that's attributed to Dostoevsky, that you can judge a society by looking at its jails and prisons. And I think in some

way you can judge a clinician by how they care for someone that has otherwise been marginalized by society, and there's no better litmus test than someone who's in custody.

And so, this is an opportunity for clinicians to really show the best humanistic care that addiction medicine and medicine has to offer.

And so, when you see someone in custody, I think making those attempts at therapeutic alliance of asking for the handcuffs to be removed, of helping to expedite workup, whether it's getting the extra labs or trying to keep the patient overnight so they can get their colonoscopy rather than deferring to outpatient, or doing the workup to initiate hepatitis C treatment, you know, considering injectable medications for opioid use disorder, trying to do more aggressive PT while someone is in the hospital so that their needs are met. These are all things that can help provide humanistic care to the person in front of you.

And really, there's a beautiful advocacy to doing your job of advocating for evidence-based medicine while they're in your care, of documenting the need for evidence-based medication. These are all things that can actually go a really long way for a patient that otherwise isn't always receiving the most compassion and support.

And so, it's an easy way, when you're in the exam room, to offer kindness, compassion, and buprenorphine. It's a great combo that can go a really long way for people in custody.

Dr. Stephen Taylor: Love it. What a trio. Dr. Justin Berk, thank you for enlightening me and our listeners on this incredibly important topic.

So, listeners, ASAM offers free treatment court education, mentoring, and resources. If you're looking for more information on SUD in the correctional setting, check out ASAM's online course: Treating Substance Use Disorder in Jails and Prisons. Or, for shorter education, check out ASAM's Clinical Tips videos on this topic.

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Thank you for listening, and we will see you next time on ASAM Practice Pearls, where we turn clinical expertise into everyday addiction care, one conversation at a time.