

Health, Justice, and Community: Findings from Rhode Island's Health and Justice Research Symposium

JUSTIN BERK, MD, MPH, MBA; ALEXANDRIA MACMADU, PhD; AURIELLE THOMAS, MSc; MICHELLE SUH, MD, MHPE; ELIZABETH LOWENHAUPT, MD; HALEY MCKEE; KYLE CAMPBELL; MICHAEL DILAURO, JD; ANNAJANE YOLKEN, MPH; TIMOTHY OWENS, LMHC, MA; ERIKA PARADIS, MS; SUSAN RAMSEY, PhD; LAUREN M. WEINSTOCK, PhD; JODY RICH, MD, MPH; BRANDON DEL POZO, PhD, MPA, MA; BRENDAN SALONER, PhD

ABSTRACT

On April 17, 2026, the Center for Health and Justice Transformation (CHJT) convened the Rhode Island Health and Justice Research Symposium at Brown University. The event united researchers, clinicians, community advocates, policymakers, and people with lived experience of the criminal legal system to share findings, build connections, and identify shared priorities. This article synthesizes the proceedings of the symposium along five themes: Evidence-Based Interventions, Pressing Tensions, Existing Barriers, Open Questions, and Shared Vision. Across all five, a single thread recurred: Rhode Island's position as a national innovator in carceral health rests not on the agility afforded by its comparatively small size, but on its collaborative relationships and institutional capacity.

KEYWORDS: carceral health; criminal legal; health equity; lived experience; juvenile legal; overdose prevention

BACKGROUND

The United States (US) incarcerates the greatest number of people of any nation globally.¹ This carceral system inflicts disproportionate harm on communities already burdened by poverty, structural racism, and inadequate access to healthcare.^{1,2} Yet within this landscape, Rhode Island (RI) has emerged as a national example for carceral health innovation. RI was the first state to implement a system-wide, comprehensive medication for opioid use disorder (MOUD) program spanning all formulations,³ and the first to officially authorize overdose prevention centers (OPCs)⁴ as a public health intervention that affords people the opportunity to more safely consume drugs without risk of arrest.

On April 17, 2026, the Center for Health and Justice Transformation convened the RI Health and Justice Research Symposium, co-sponsored by the Brown University School of Public Health's Center for Advancing Health Policy Research, its Center for Alcohol and Addiction Studies, and Rhode Island Hospital's COBRE on Opioids and Overdose. The symposium had three goals: to share emerging findings from RI's criminal justice and health research ecosystem; build connections across disciplines, institutions, and sectors; and identify shared priorities for research and policy.

After a welcome from the Director of the Center for Health and Justice Transformation, Dr. Justin Berk, the keynote address was delivered by the Dean of the Brown University School of Public Health, Dr. Francesca Beaudoin, who framed RI's achievements as evidence that cross-disciplinary effort can transform care for incarcerated and justice-involved people. Three panels followed, covering reentry, arrest and pre-trial justice, and juvenile justice, alongside 10 research speed talks presenting findings from ongoing and completed studies based at Brown University and Brown University Health. Closing remarks were delivered by the US Representative for Rhode Island, Gabe Amo, alongside a plenary discussion led by the Associate Director of Behavioral and Social Sciences at the Brown University School of Public Health, Dr. Brendan Saloner.

Rhode Island's successes are often attributed to its small size, which eases coordination across agencies and provides the agility to rapidly implement statewide initiatives with widespread adoption and penetration. This article instead locates the state's success in its collaborative focus and institutional capacity. The symposium's contributions span five areas: Evidence-Based Interventions, Existing Barriers, Pressing Tensions, Open Questions, and A Shared Vision.

1) EVIDENCE-BASED INTERVENTIONS (EBIS)

Across the symposium, Brown-affiliated researchers presented evidence in support of specific interventions that improve health for justice-involved people across the criminal legal spectrum.

EBI #1: Medication for Opioid Use Disorder (MOUD) in Carceral Settings

In 2017, RI was the first state to implement a system-wide, comprehensive MOUD program in corrections,³ an intervention that led to significant declines in fatal overdose among people with opioid use disorder.⁵ Dr. Josiah "Jody" Rich characterized continuity of addiction treatment at release as a critical clinical transition point: the period immediately following release represents the period of highest overdose mortality risk for people who were receiving MOUD in custody.⁶⁻⁹ This risk is largely preventable when continuity of care is maintained, and mortality is elevated when it is not.^{10,11} Brown researchers have demonstrated a significant

reduction in post-incarceration fatal overdoses following implementation of Rhode Island's statewide jail and prison MOUD program,^{5,12} a replicable model since adopted across the US. Future research can optimize the outcomes of this initiative by determining how to most effectively link people released from incarceration with continuity of care, including studying which formulations of MOUD are most likely to retain recently-released patients in treatment (e.g., extended-release injectable buprenorphine).¹³⁻¹⁵

EBI #2: Overdose Prevention Centers (OPCs)

RI became the first state to legally authorize OPCs, which are spaces where people who use drugs may bring pre-obtained substances to use under trained staff supervision. OPCs are an internationally recognized public health intervention to reduce overdose,^{16,17} build trust,¹⁸ and provide linkages to services and other forms of harm reduction.¹⁹ In January 2025, Project Weber/RENEW began operating the first state-authorized OPC in the country. The Director of Strategy at Project Weber/RENEW, Annajane Yolken, MPH, presented operational data: in approximately 14 months of operation, the OPC recorded 10,071 visits from 819 unique participants, managed 105 overdoses with only two EMS calls for service, and found that 78% of participants would have consumed their drugs alone without access to the site. Notably, 87% of participants were unhoused, underscoring the OPC's role as a point of contact for people largely disconnected from formal health systems, and who would be at elevated risk of arrest as people who use drugs in more exposed, public places, and therefore engaging in riskier and more rushed consumption. This work is being evaluated by researchers at the Brown School of Public Health, led by Dr. Brandon Marshall, through the NIDA-funded SAFER program.²⁰ Additionally, Dr. Brandon del Pozo contributed evidence that New York City's OPCs produced no increase in crime or disorder in surrounding neighborhoods following OPC opening,²¹ and he has made the case that careful site selection in RI contributed to the program's acceptability and success.²² Additional evidence on OPCs is compiled at OPCinfo.org.

EBI #3: Transitions Clinic: Community Health Workers (CHWs) as the Care Model

The RIH Transitions Clinic model pairs formerly incarcerated CHWs with patients recently released from correctional facilities, providing primary care, care coordination, and navigation during the highest-risk window following release. RI's Transitions Clinic has demonstrated the model's local feasibility, while nationally, these models are associated with a 51% reduction in emergency department utilization, a 50% reduction in preventable hospitalizations, hospital stays shortened by nearly a full day, and 25 fewer incarceration days from parole violations in the first year; each dollar invested yields \$2.55 in reduced criminal justice system costs.²³⁻²⁶

EBI #4: Safety Planning to Reduce Suicide Risk at Reentry

National data show that approximately one in five adult suicides occur among individuals recently released from jail.²⁷ Dr. Lauren Weinstock presented findings from her SPIRIT Trial,²⁸ a randomized trial of a Safety Planning Intervention across jail facilities at the Rhode Island Dept. of Corrections (RIDOC) and the Genesee County Jail in Flint, MI. A randomized controlled trial of the intervention found that safety planning reduced subsequent post-release suicide attempts by 55%.²⁹ The intervention is brief, scalable, and well-suited to rapid implementation.

She Thrives: Interdisciplinary Innovation for Justice-Involved Women

Through a collaboration between the People, Place & Health Collective at the Brown University School of Public Health and community-based organization OpenDoors, "She Thrives" is a program that administers GLP-1 agonists as off-label treatment for substance use disorder in justice-involved women. Jacqueline Goldman, MSc, presented early data from 13 participants showing 77% adherence to GLP-1 treatment at eight months, with evidence of reductions in substance use and improvements in housing stability. The program received national media attention, including coverage in *The New York Times*.³⁰ Women's incarceration has grown at twice the rate of men's, yet women remain dramatically underrepresented in correctional health research, a gap this work begins to address.

Therapeutic Interventions Behind the Walls: A Yoga Randomized Controlled Trial

Dr. Lisa Uebelacker presented findings from a yoga pilot at RIDOC, offering evidence that therapeutic interventions delivered inside correctional facilities can produce durable behavioral health benefits that extend beyond the walls.³¹ In the 10-week trial, 40 participants reported using breathing and self-regulation techniques both during sessions and in the facility itself, with high satisfaction and decreased depression and anxiety symptoms, and several reported "staying out of seg" (i.e., avoiding disciplinary segregation) through mindfulness skills acquired in yoga.

Decarceration as Public Health: The Rhode Island Training School

At the national level, some of the most robust evidence for decarceration in the field focuses on youth detention. Brown Economist Dr. Anna Aizer's causal analysis of juvenile justice outcomes drew national attention, including a recent feature on *The New York Times Daily* podcast.³² Using a natural experiment of random assignment to different judges, Dr. Aizer isolated the causal effect of detention on life-course outcomes. Incarceration was associated with long-term harms: fewer than 1% graduated high school

by age 19, and 44% were incarcerated by age 25.³³ Judicial detention decisions about juveniles can shape education, employment, health, and future legal-system involvement well into adulthood.

Against that backdrop, the Rhode Island Training School (RITS) offers a case study in decarceration as a public health intervention. The reduction in the RITS population over recent decades has been accompanied by investments in therapeutic programming, educational continuity, and mental health services. Dr. Elizabeth Lowenhaupt, medical and psychiatric director of RITS and past board president of the National Commission on Correctional Health Care, has helped set national standards for the health care of incarcerated youth, linking local practice to national standard-setting in ways that give RI's reforms broader significance.

Across this work, RI's progress was attributed to a collaborative, interconnected network of institutions and community organizations [Table 1].

Table 1. Select institutions and community organizations in Rhode Island's health and justice ecosystem.

Resource	Description
Center for Health and Justice Transformation (CHJT)	Symposium convener; hub linking research, clinical services, and community partnerships.
Collaborative Justice-Involved Research and Training (CJRT) Program	NIDA-funded program training investigators in HIV, substance use, and health equity for justice-involved populations.
Rhode Island Department of Corrections (RIDOC)	Site of the statewide MOUD program; longstanding partner in correctional health research.
Brown University	Research infrastructure supporting this work, including CAHPR and CAAS.
Project Weber/RENEW	Operates the first state-authorized OPC in the country; largest harm reduction organization in the state.
Rhode Island Freedom Collective	Grassroots organization of people with lived experience; provides Welcome Back Packs and peer support at release.
OpenDoors	Reentry support provider for formerly incarcerated Rhode Islanders; community partner in the She Thrives program.
Rhode Island Hospital Transitions Clinic	Community health worker-centered reentry model connecting released individuals to health and social services.
Justice Assistance	Nonprofit providing community-based supervision, diversion, and reentry services.
Committee on Racial and Ethnic Fairness in the Courts	Rhode Island Judiciary body working to identify and reduce racial and ethnic disparities in the courts.
Diversion Court	Rhode Island's drug diversion and recovery court; active 20 years, routing individuals with substance use disorders toward treatment rather than incarceration.

Abbreviations: CAAS = Center for Alcohol and Addiction Studies; CAHPR = Center for Advancing Health Policy Research; MOUD = medication for opioid use disorder; NIDA = National Institute on Drug Abuse; OPC = overdose prevention center.

2) EXISTING BARRIERS

Several concrete but addressable barriers were discussed.

Nursing Home Discrimination and Compassionate Release

A statewide “secret shopper” study of all 74 licensed Rhode Island nursing homes examined availability for individuals granted parole through compassionate release. The study found that facilities were 3.41 times more likely to reject admission for an incarcerated patient. After disclosure of a serious-offense history, facilities were 11.39 times more likely to reject, rendering approximately 90% of Rhode Island nursing homes effectively unavailable to this population.³⁴ As presenter Dr. Michelle Suh noted: “People will remain incarcerated because no nursing home will take them.” This problem is not unique to RI: individuals 55 and older are the fastest-growing segment of the incarcerated population (a 400% increase from 1993 to 2013),^{35,36} carrying healthcare costs roughly three times higher than younger incarcerated persons.³⁷

Telephone and Connectivity Access at Release

The reentry panel of the symposium identified guaranteed access to a working cell phone and data plan as a critical necessity at time of release. Without it, individuals cannot contact family, navigate service systems, access benefits, reach healthcare providers, or apply for employment, and even well-designed clinical interventions become very difficult or impossible to utilize.

Juvenile Detention Policies

RI has not established a minimum age for juvenile incarceration, meaning children of any age can be held in a detention facility; approximately 30 other states, including Texas, have established minimum ages.³⁸ A related structural barrier is that incarceration is sometimes the only available pathway to treatment, mental health services, or stable housing for justice-involved youth with serious behavioral health needs, a failure of the surrounding system that is taken up as a distinct ethical tension below.

3) PRESSING TENSIONS

Beyond discrete barriers, the symposium surfaced tensions that the field will have to confront directly.

Officer Awareness of Drug-Seizure Harms Versus the Mandate to Enforce

Dr. Brandon del Pozo presented findings on the consequences of drug seizures: arresting indi-

viduals for drug sales ultimately increased overdose and harm rather than reducing it. His Police Opioid Seizure Temporal Risk (POSTeR) model demonstrated that seizures biologically and behaviorally increase exposure to fatal overdose,³⁹ a finding quantitatively demonstrated in a related study using data from Indianapolis.⁴⁰ Officers interviewed in RI acknowledged that seizures likely increased overdose risk, and understood the reasons why, but felt institutionally compelled to respond to community frustration with visible drug use, illuminating the gap between individual awareness and systemic behavior and the need for diversion pathways that give officers genuine alternatives to arrest.⁴¹ Dr. Del Pozo characterized policing as a structural determinant of health, with direct implications for law enforcement reform.⁴²

Incarceration as De Facto Treatment for Youth

Panelists confronted the problem that incarceration is sometimes the only available pathway to treatment, mental health services, or stable housing for justice-involved youth. When carceral settings become the primary point of access to these supports, panelists argued, the policy response must be to fund community alternatives, not to accept detention as a de facto treatment pathway, or as one of the unintended benefits of incarceration.

The Risk of People With Lived Experience (PWLE) Tokenism

The commitment to including PWLE carries its own tension: even if properly motivated, inclusion can amount to tokenism, or participation that is symbolic rather than meaningful and well-integrated, or sought for the appearance of legitimacy rather than to solicit and incorporate the expertise it represents.⁴³ The challenge is to distinguish genuine integration, in which PWLE shape research questions, program design, and advocacy priorities, from participation that leaves existing power and research and practice hierarchies untouched.

4) OPEN QUESTIONS

Alongside this evidence, the symposium surfaced questions in the field that require careful deliberation. Three stood out.

Q1: How Can Decision-makers Best Incorporate Meaningful Partnership With PWLE in Program Initiatives?

Across every session, presenters and panelists stressed that academic expertise alone is insufficient to fully understand or effectively address the health harms of incarceration. PWLE hold knowledge that cannot be generated in a laboratory or extracted from administrative data.

Kyle Campbell of the RI Freedom Collective illustrated the value of lived expertise through the “parking lot problem:” the cascade of logistical and emotional demands a

recently released person faces the moment they step out of a facility and into the parking lot. In the critical first 72 hours following release, individuals face a cascade of logistical and emotional demands with little institutional support.⁴⁴ Campbell described the life-skills gaps that incarceration creates or exacerbates (e.g., how to use a smartphone or otherwise utilize emerging technologies, navigate a mental health system, find housing, prepare for a job interview). He stressed how people leaving incarceration often carry a diminished sense of self-worth, i.e., self-stigma, and how essential it is to affirm that they are deserving of support, dignity, and care.⁴⁵ What remains unresolved is how to move from well-intentioned inclusion to genuine structural integration—that is, how to build PWLE expertise into the design of research and programs from the outset, rather than incorporating it after key decisions have already been made.

Q2: How Can Interdisciplinary Work Be Leveraged to Make Positive Change?

A recurring insight was that the criminal legal system, and its health consequences, cannot be understood or addressed through any single disciplinary lens. Education, economics, policing, judicial decision-making, housing policy, and public health were all discussed as foundational challenges that affect health outcomes well before and after incarceration itself. From the Watson School, Dr. Benjamin Buka and Dr. Chloe Haimson presented research on “sundown towns:” communities with a demonstrated history of racial exclusion predict modern prison-town status at 1.5–2x odds ratios, arguing that the geography of incarceration is itself a product of structural racism. The open question is how to facilitate genuine collaboration across disciplines so that their distinct bodies of knowledge inform one another to create deep, contextualized knowledge.

Q3: How Can Evidence-Based Interventions Be Scaled and Sustained?

The field has strong evidence that certain interventions work, but limited understanding of how to implement them at scale and sustain them. Sustainability questions sit within a broader pattern documented across carceral health. While an estimated 17 years elapse before research evidence reaches routine clinical practice in the community, adoption in jails and prisons is slower still, a delay authors have previously termed the “prison implementation penalty.”⁴⁶

Implementation science offers a structured response, using established frameworks to identify contextual barriers, match strategies to them, and measure outcomes such as fidelity, acceptability, and reach. RI’s progress illustrates that the penalty is not fixed: the interventions described above advanced not because the barriers were absent but because coalitions, funding pathways, and sustained evaluation were brought to bear against them. In this way, RI can be viewed as the preliminary grounds for initiatives that can be implemented and scaled in larger state settings.

5) A SHARED VISION

The symposium's closing plenary, with remarks from US Representative Gabe Amo and discussion led by Dr. Brendan Saloner, crystallized a shared agenda for the future.

Broader Collaboration and Coalitions

No single discipline, institution, or intervention is sufficient. The expansive, cross-cutting nature of the criminal legal system demands cross-cutting responses across its intercepts, with community-engaged work at every stage: pre-arrest diversion, pretrial, during incarceration, upon release, and during community supervision. Building and sustaining connections across disciplines, institutions, and sectors is itself a core part of the work.

Rhode Island As a Replicable Model Built on Collaboration

Rhode Island's concentration of research expertise, strong community partnerships, justice-focused training pipeline through CJRT, and sustained relationships among academic institutions, RIDOC, and state agencies have created a durable ecosystem for advancing health in justice settings. The symposium demonstrated that rigorous, community-engaged, policy-relevant research is not only feasible in justice-involved settings, but can directly inform practice and systems change.

Rhode Island's small size may facilitate coordination, but size alone does not explain its success. The essential ingredient is sustained institutional collaboration: shared priorities, trusted relationships, meaningful involvement of people with lived experience, and infrastructure that connects research to policy and implementation. These conditions are not unique to Rhode Island; they can be intentionally cultivated elsewhere. Rhode Island, therefore, offers more than a collection of successful initiatives; it provides a replicable model for building the partnerships and capacity needed to improve health, advance equity, and transform systems of care for people affected by the criminal legal system.

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Authors

Justin Berk, MD, MPH, MBA, Brown University Health | Center for Health and Justice Transformation.

Alexandria Macmadu, PhD, Department of Epidemiology, Brown University School of Public Health.

Aurielle Thomas, MSc, Division of Infectious Diseases, Department of Medicine, The Miriam Hospital, Providence, Rhode Island.

Michelle Suh, MD, MHPE, Department of Emergency Medicine, Brown University Health.

Elizabeth Lowenhaupt, MD, Department of Psychiatry and Human Behavior, Brown University Health.

Haley McKee, Rhode Island Policy Advocate.

Kyle Campbell, Rhode Island Freedom Collective.

Michael DiLauro, JD, Just Criminal Justice Group, LLC.

Annajane Yolken, MPH, Project Weber/RENEW.

Timothy Owens, LMHC, MA, Rhode Island Training School.

Erika Paradis, MS, Center for Health and Justice Transformation.

Susan Ramsey, PhD, Brown University Health and Warren Alpert Medical School of Brown University, Department of Psychiatry and Human Behavior and Medicine.

Lauren M. Weinstock, PhD, Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Providence, RI | Center of Excellence for Suicide Prevention, Canandaigua VA Medical Center, Canandaigua, NY.

Jody Rich, MD, MPH, Brown University Health | Center for Health and Justice Transformation.

Brandon del Pozo, PhD, MPA, MA, Brown University Health | Center for Health and Justice Transformation.

Brendan Saloner, PhD, Brown University School of Public Health.

Disclosures

Funding: Research reported in this publication is supported in part by the National Institute of General Medical Sciences of the National Institutes of Health under grant number P20GM125507 (COBRE Center on Opioids and Overdose). Additional work referenced here is supported by the National Institute on Drug Abuse (K01DA056654, R25DA037190, CJRT), the National Institute of Mental Health (U01MH106660, SPIRIT; P50MH127512, NCHATS), and the National Center for Complementary and Integrative Health (R34AT010172). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Author Contributions: Contributions are reported using the CRediT taxonomy. All listed authors meet the four authorship criteria of the International Committee of Medical Journal Editors (2018 revision). Presentation at the symposium was not treated as a basis for authorship; presenters whose work is described but who did not contribute to this manuscript are named and cited in the text but are not listed as authors.

Correspondence

Justin Berk, MD
justin_berk@brown.edu