

Public Comment Submitted to the House Resolution 590 Task Force Hearing, October 18, 2016
333 Market St, Hearing Rooms A &B, Harrisburg PA

TO: Secretary Tennis, and the Task Force members

By: Gail Groves Scott, MPH (gscott@usciences.edu, 215-596-7636)
Health Policy Fellow in Addiction Studies, University of the Sciences in Philadelphia

RE: Access to Addiction Treatment

The public health reasons why Medication-Assisted Treatment (MAT) for opioid use disorders should be made available to individuals incarcerated in our county jails and participating in our state drug courts.

Thank you for allowing me the time to present comments to the Task Force. I will make a brief summary of my research, and submit a written copy. I also have a 2-page Policy Brief with references, a one-page copy of a research poster presentation, and a legislation fact sheet. I ask that these be included in the public record, and can make copies available to audience members here today on request.

I am a post-master's Fellow doing graduate research and training in Addiction Studies at the University of the Sciences in Philadelphia, where I work in the department of Health Policy and Public Health, within the Mayes College of Healthcare Business and Policy.

I am here today to share with you what I learned in a research project I started last year, to **examine opiate use disorder treatment policies in two criminal justice settings: drug courts and county jails.**

I don't need to tell this task force that substance disorder treatment must be available in criminal justice settings if we are to solve the public health problem of this opioid epidemic.

You are also well aware that the federal government and Governor Wolf have a goal to expand access to Medication-Assisted Treatment (MAT). MAT reduces death rates, decreases the spread of infectious disease, lowers rearrests and incarceration, and is cost-effective for tax payers. A comprehensive literature reviews have found that MAT is superior to behavioral therapies alone in retaining people in treatment. Care must be individualized, but for the appropriate person with opiate use disorder -- treatment with methadone, buprenorphine or naltrexone must be offered, if we are to turn around the current health crisis, where 10 people a day are dying of opiate overdoses.

However, I wonder if the Task Force members are fully aware of the **lack of access to MAT** in almost all the jails and probably half of the drug courts in the Commonwealth?

Were you aware that if a person who is dedicated to recovering from their opioid use disorder, and starts a program of counseling and methadone or buprenorphine medication, but then has an encounter with criminal justice and is incarcerated --- or is unable to make bail, even for a few days --- will almost always have to go through forced withdrawal from their prescribed medication?

JAILS: 90% of the jails in the U.S. require people to discontinue opioid agonist MAT medications, often abruptly, triggering painful withdrawal. From my assessment (2015 data), almost everyone entering jails in South-Central PA will go through forced withdrawal from their prescribed methadone or buprenorphine; that appears to hold true throughout almost all jails in the Commonwealth (based on media reports, and interviews with providers, however I was not able to do a survey of all the jails).

The one exception is for pregnant patients. Women who are pregnant are usually allowed to stay on methadone or buprenorphine (to decrease the risk of a miscarriage if she goes through withdrawal,) and if physically dependent on illicit opioids she may be provided a way to start treatment with medication. **The fact that our jails *can* manage to provide MAT to *some* patients, speaks to the fact that this can be done logistically.**

Keep in mind, that more than half the people in our jails have not been sentenced, and are detained for a short period -- the average is 21 days. So many of the people incarcerated in county jails will not be staying a year or more, where they would transfer to a state prison. (It may be appropriate, to gradually taper people off of MAT if they are incarcerated for long periods, such as a year or more, under our system limitations today-- re-engaging them in MAT on community re-entry).

Why is this a public health problem? **Forced withdrawal policies** in jails for people on methadone or buprenorphine treatment **is not only inhumane, and considered medically unethical by experts worldwide—it is also completely inconsistent with public health goals.**

PUBLIC HEALTH IMPLICATIONS:

- 1) **RETENTION IN TREATMENT:** Multiple studies have shown that forced withdrawal will deter re-engagement in treatment post-incarceration.
- 2) **RELAPSE / MORTALITY:** Interrupting therapy can cause a life –threatening relapse on reentry to the community. *Mortality for persons released from jail or prison is 8-12 times higher than that of the general population.* One large study showed the risk of overdose death the first week after release from prison was *129x higher* in the first week.
- 3) **HEALTH RISKS:** Withdrawal is a risk factor for suicide in jails, and it increases risky behaviors that spread disease and cause behavioral problems. Complications connected to opiate withdrawal can be life-threatening and have caused deaths in jails across the country and here in PA.

- 4) **CIVIL & HUMAN RIGHTS:** Emerging legal opinions view forced withdrawal as a civil rights violation under the American Disabilities Act (ADA) and it is possibly unconstitutional. Painful forced withdrawal is viewed as inhumane and medically unethical.

We know that neither punishment or forced abstinence “cures” addiction.

Criminal justice policies banning MAT medications largely originate from an outmoded view of substance disorders as a “moral failing” rather than a bio-psychosocial disease.

Many corrections staff believe that medications are “a crutch” or “treating a drug with a drug” and aren’t aware that **empirical evidence supports MAT over behavioral therapies alone.**

In my policy brief I review the ways jails *can* provide MAT for persons already taking MAT when incarcerated. They are doing this already for pregnant women. Jails can contract with nearby OTPs (opioid treatment programs). Or the jail physician or medical contractor can prescribe buprenorphine on-site.

Changes in federal regulations are making this even easier in 2016—there are new higher patient limits for prescribers, and now physician assistants and nurse practitioners (PA’s and CRNP’s) will be able to get certified to prescribe buprenorphine. As a schedule 3 medication, it is also possible for physicians to call in a verbal order to a jail nurse, i.e. call in a new prescription for buprenorphine, just as they do now for psychiatric medications that are controlled substances.

Drug Courts:

I’ve focused on jails, due to the limited time to present today, but access barriers seen in jails also exist for adjudicated persons in diversion programming like drug courts. More than half of all drug courts in the U.S. do not allow participants to be on MAT as a matter of policy. This is true in most PA counties as well. This is contrary to the recommendations of national experts; it’s not evidence-based or properly individualizing treatment. But as I noted in my research findings, jails and drug courts are connected – people go back and forth between these systems—so if jails change, it will make it easier for drug courts to change.

Managing Opioid Withdrawal for all persons in jail, including those on illicit opioids:

In addition—another big issue, which I will not be able to fully address here—is the issue of properly managing opioid withdrawal in jails for ALL persons who are going through withdrawal—including people who were on illicit opioids (heroin or non-prescribed pain medications) or those who were taking prescribed opioid pain medications. I brought with me two new articles authored by corrections physicians, both published just this summer. They say that the new world of opiates in 2016 is much different than it used to be, and advise that withdrawal protocols must be changed and opioid withdrawal managed differently in jails:

“[In jails] we now have more patients coming in on opiates, the prescription strength of opiates is substantially stronger, illegal opiates are now of much higher purity, and

opiate withdrawal is more clinically severe and can frequently result in death if not managed appropriately” (Wilcox, 2016).

Attempts to divert medications are always a concern in jails, but security risks can and have been managed.

One of the problems is that county jails – like the Dauphin County Prison -- are not run by the state, they are supervised, managed and funded by local governments. The health care is managed by a contracted medical provider. While our state prison system is already working on a plan to expand access to MAT, under Secretary John Wetzel, the DOC has limited ability to influence county jails.

Policy Change:

Yet the Commonwealth has a number of options to drive change.

These include the following:

- Education efforts
- Legislation
- Regulatory Action
- Funding Support

Education efforts have been shown to work. (There is some good news; I am hoping to expand my research to gather better data, but I am seeing some readiness to change, especially in drug courts, but in a few jails as well (i.e. Philadelphia’s prison system).

In neighboring states, last year legislators passed laws *requiring* drug courts to allow access to all medications approved for opiate use disorders under a healthcare provider’s direction — buprenorphine, methadone and naltrexone. I am submitting to the Task Force a Legislation Fact Sheet I wrote in 2015 summarizing the New York law.

Thank you for allowing me to present this information. I welcome your questions or comments today, and would be happy to meet in the future to review details of my research in this area.

Wilcox, T. (2016) Managing Opiate Withdrawal: The WOWS Method, *Correct Care: Summer 2016*, National Commission on Correctional Health Care, Chicago, IL. Retrieved from <http://www.ncchc.org/filebin/CorrectCare/30-3-WOWS.pdf>

Attachments:

- 1) Policy Brief: Ending Forced Withdrawal Policies in Jails (April 2016) (2pp)
- 2) An examination of opiate use disorder treatment policies in two criminal justice settings (May 2016)
- 3) Legislation Fact Sheet: New York Bills A6255B-2015 (Rosenthal) and S4239B-2015 (Murphy) (2015)