CIC | DC Corrections Information Council

COUNCIL OF THE DISTRICT OF COLUMBIA
Committee on the Judiciary & Public Safety and Committee on Health
Joint Public Hearing
Bill 22-0459, the "Opioid Abuse Treatment Act of 2017"
December 12, 2017

Testimony of Michelle Bonner
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Good afternoon, Chairman Allen, Chairman Gray, and other members of the Committee on the Judiciary and Public Safety and Committee on Health.

I am Michelle Bonner, the Executive Director of the Corrections Information Council, commonly known as the "CIC." Board members Charles Thornton, Katharine Huffman and Phylisa Carter join me in thanking you for the opportunity to share with you the CIC's observations and thoughts regarding Bill 22-0459, the "Opioid Abuse Treatment Act of 2017."

As you know, the CIC is an independent monitoring body initially established under the *Revitalization Act of 1997*, with its mandate further expanded and detailed in the *DC Jail Improvement Act of 2003*. The CIC is mandated to inspect, monitor, and report on the conditions of confinement in the prisons, jails, and halfway houses where DC residents are incarcerated. This includes over 4,700 residents in over 116 Federal Bureau of Prisons (BOP) facilities and contract facilities in 33 states and the District of Columbia, as well as approximately 2,100 residents in the custody of the DC Department of Corrections (DOC).

Since before 2012, the CIC and advocates for the agency have stressed that the CIC's mandate extends beyond mere inspection of bricks and mortar, to include assessments of programs and services available to DC incarcerated residents, as well as the policies and procedures that govern them. Since 2012, the CIC has inspected 40 BOP prisons, one BOP-contract prison, three halfway houses, and the two DOC jail facilities.

We were all saddened by the news of the two opioid deaths in DOC custody this past spring. In an effort to increase our understanding of how the opioid crisis is affecting corrections and to learn of promising practices to address this crisis, the CIC called upon the expertise of the Drug Policy Alliance (DPA). The CIC also recommended to the DOC that it engage the DPA as well, and DOC officials met with the DPA in October.

From its meeting with DPA's Kaitlyn Boecker, the CIC learned that there are three tiers of responses to the opioid crisis in corrections: interdiction of opioids, detection and

prevention of overdoses, and demand reduction through medically assisted treatment. This third tier – medically assisted treatment or "MAT" – is a promising practice in some jails and prisons in the United States.[1]

At present, the DOC does not provide medically assisted treatment for opioid addiction, except to pregnant women. Instead, those who were receiving medically assisted treatment in the community are weaned off the medication once incarcerated, meaning that they are incrementally given lower dosages until the dosage is reduced to zero.[2] The CDF medical coordinator explained that, for those from the community who were receiving treatment, the treatment schedule while in DOC custody is the following:

- Day one in DOC custody, the inmate will be maintained at the dosage they were on in the community.
- After the first day the inmate is weaned off of the treatment, by reducing the dosage by 5mg every three days.

The DPA explains, "If you stop taking your methadone and return to using street drugs, you can overdose more easily than when you last used. When you stop taking methadone, your body will rapidly develop a lower tolerance for the heroin. As soon as your methadone completely wears off (a couple of days), your tolerance for heroin will be lower than it was when you began taking methadone."[3]

The Bill, as currently proposed, calls for the DOC to provide the community prescription dosage for at least 30 days, and to work with the Department of Health "to ensure that all necessary medications are continued to detained persons in the manner [they] were prescribed." Given that about 69% of women released from jail and about 58% of men released from jail in fiscal year 2017 were detained for fewer than 31 days,[4] the 30-day mark will greatly assist the majority of those released back to the community from jail. Also, for those who are in DOC custody for longer periods of time, the DOC and the DOH can work together for continued treatment, as needed.

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[1] In addition to the Rikers Island Jail MAT program in New York City, Connecticut has had methadone treatment programs in its jails; Rhode Island offers methadone and buprenorphine (Suboxone) in its prisons, and Vermont corrections has had a methadone program. Pew Charitable Trusts, "At Rikers Island, a Legacy of Medication-Assisted Opioid Treatment," STATELINE, May 23, 2016. http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/05/23/at-rikers-island-a-legacy-of-medication-assisted-opioid-treatment

[2] The World Health Organization suggests the following schedule for dose reduction: "Reduce by 10mg per week until a dose of 40mg per day is reached; from then, reduce by 5mg per week until a zero dose is reached; and dose reduction should occur once a week or less often." World Health Organization, CLINICAL GUIDELINES FOR WITHDRAWAL MANAGEMENT AND TREATMENT OF DRUG DEPENDENCE IN CLOSED SETTINGS, 6 Methadone Maintenance Treatment: 6.5 Ending Treatment (2009), available at https://www.ncbi.nlm.nih.gov/books/NBK310658/. Titration off the medication at a faster rate can result in withdrawal symptoms and increased cravings.

[3] Drug Policy Alliance, ABOUT METHADONE AND BUPRENORPHINE (2nd ed.) (2006), at 24, available at http://www.drugpolicy.org/sites/default/files/aboutmethadone.pdf.

[4] DC Department of Corrections, FACTS AND FIGURES, October 2017, page 25. https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DC%20Department%20of%20Corrections%20Facts%20and%20Figures%20October%202017.pdf

The importance of this continued treatment cannot be overstated. As the DPA indicated, when one stops taking methadone, their tolerance for heroin is lowered. Without the support of methadone, the craving for street heroin could then become even more deadly. In 2007, a Washington State Department of Corrections study showed that those released from incarceration are 12.7 times more likely to die within the first two weeks of release, and the primary cause of death during this time period was drug overdose.[5] More than ten years after this study, the stakes are far more deadly with the presence of fentanyl in street drugs. Regardless of tolerance levels, a small amount of fentanyl can be instantaneously lethal.[6] Therefore, controlling the craving for street drugs through periods of incarceration can save lives if the craving is continuously staved off throughout transition back into the community.

Bill 22-0459 also calls for a Fatality Review Team at the Department of Behavioral Health (DBH), which could be a great tool for measuring the success of medically assisted treatment in DOC facilities, as well as measuring other treatment initiatives of the Bill. The Washington State Department of Corrections 2007 study and the 2001 study of Rikers Island MAT program,[7] while helpful, cannot speak to the unique characteristics of our city's correctional system. If this Fatality Review Team, or another city-sponsored study, could also look at effects of incarceration without treatment upon release and risks of post-incarceration overdose retrospectively, it could comparatively measure the effects of medically assisted treatment upon release, after the Bill's passage and implementation.

While medically assisted treatment would be provided to those identified as having an opioid addiction and as receiving treatment while in the community, there may still be others incarcerated who are using opiates that are not known to the DOC. Since the spring's tragedies, the agency has employed first tier methods to interdict contraband; and its medical staff have access to opioid overdose reversal medication to prevent overdose deaths. (Medical staff successfully reversed the overdose of a man serving a work release sentence, while he was working in the Inmate Reception Center (IRC).) Depending on the availability and location of medical staff, especially on evening shifts, these committees might discuss with the DOC the possibility of giving front-line security staff access to opioid overdose reversal medication as well.[8] This would strengthen the DOC's second-tier response to the opioid crisis.

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[5] Ingrid A. Binswanger, M.D., et al., RELEASE FROM PRISON – A HIGH RISK OF DEATH FOR FORMER INMATES, New England Journal of Medicine, January 11, 2007; 356(2): 157-165. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/

[6] While 30 mg of heroin can kill an adult male, only 3mg of fentanyl is needed to have the same deadly effect. "Why fentanyl is deadlier than heroin, in a single photo," Allison Bond, New Hampshire State News, 9/29/2016, https://www.statnews.com/2016/09/29/fentanyl-heroin-photo-fatal-doses/

[7] The University of Western Michigan studied the Rikers Island program in 2001 and found that up to 80% of releasees continued treatment after release.

[8] The American Society of Addiction Medicine (ASAM) and The National Commission on Correctional Health Care (NCCHC) support the recommendation that both medical and correctional staff receive training in the administration of naloxone via nasal spray. See https://www.ncchc.org/naloxone-for-the-prevention-of-opioid-overdose-deaths.

It is the CIC's goal to provide information and insight that advocates, government officials, decision-makers, and corrections agencies can use to improve the conditions of confinement for incarcerated DC residents. The CIC is grateful for this opportunity to provide information relating to this very important issue today and for the continued opportunity to do so in the future.

Thank you.