VCJR Vermonters for Criminal Justice Reform

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Written Testimony
(submitted November 27, 2023)
Vermonters for Criminal Justice Reform (VCJR)
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MOUD in Vermont Correctional Facilities (H. 222)

Background

- Vermont is the nation's leader in providing full access to medications used to treat opioid use disorder (MOUD) in correctional facilities (Act 176, 2018)
- Many Vermonters become involved in the criminal justice system because of their struggle with opioid use disorder --in fact, most incarcerated Vermonters are living with opioid use disorder
- About 60% of incarcerated people in Vermont correctional facilities are prescribed medications to treat opioid use disorder, including buprenorphine and methadone
    - Context: 90% of people incarcerated in Vermont prisons receive some kind of medication; 70% receive mental health medication; average number of medications per person is 5.5
- The Vermont Department of Corrections (DOC) operates one of the largest and most important MOUD drug treatment programs in the state
- The DOC MOUD program is an important part of the continuum of drug treatment services in Vermont

- KEY: Vermont's provision of MOUD in correctional facilities is the best in the country, but there is still room for improvement in terms of treatment retention both during periods of incarceration and upon release

Benefits

- Treatment for opioid use disorder in Vermont correctional facilities is an important form of r**ehabilitation** and **crime prevention**
- Buprenorphine and methadone are critically important, life-saving medications that cut overdose deaths in half or more
    - An academic study found that Vermont's implementation of full access to MOUD in Vermont correctional facilities resulted in an **over 60% reduction in overdose deaths** following release from Vermont prisons AND
    - **Increased continuation of care after release**

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Other benefits include:

- Excellent **"case finding"** due to universal screening for OUD resulting in treatment initiation within Vermont prisons (prior to 2018, treatment MOUD induction was not available in prison)
- Improved continuity of MOUD treatment during periods of incarceration (research shows uninterrupted MOUD treatment for 5 years or more results in the best treatment success) (prior to 2018, continuation of MOUD treatment was limited to 30 days – 6 months regardless of medical need)
- **Less suffering** caused by preventable withdrawal symptoms (can lead to death)
    - Less contraband
    - Less illicit opioid use within prisons
    - **Improved safety and order** within prisons
    - Increased focus on recovery from opioid use disorder
    - Improved outcomes broadly following release

Limiting Factors

The Vermont Department of Corrections (DOC) has much to be proud of in successfully implementing an MOUD program that is so important to the public health and public safety of Vermont communities. However, the success of the program is currently limited by:

- **Inconsistent coordination of MOUD** for individuals reentering the community after release from incarceration (gaps in MOUD following release are common)
- **Interruptions in MOUD treatment during periods of incarceration** (this contributes to gaps in MOUD following release)

Other factors limiting success of the program:

- an extreme, ineffectual and dangerous **focus on policing of low-risk diversion of mostly tiny amounts of buprenorphine** (observed dosing by corrections officers, mouth checks, strip searches, living unit searches, "dragging to the hole," solitary confinement, isolation in "dry cells," suspension of medical confidentiality and due process, disruption in the doctor/patient relationship, discontinuation of life-saving medication) **that is resulting in high-risk interruptions in treatment participation**
- **involuntary discharge from MOUD treatment as a punishment for possession/diversion**
- **stigma-based opposition to the program** among some corrections staff
- the unnecessary and harmful **enmeshment of security staff (many who oppose MOUD treatment) in medical care** for opioid use disorder
- Lack of adequate direct provider/patient communication

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- Issues with the effectiveness of the "med slip" system and medical grievance system

Recommendations

The Joint Legislative Justice Oversight Committee should identify continuity of MOUD treatment as a **public health and public safety priority** and recommend that the House Committee on Human Services and Senate Committee on Health and Welfare take legislative action to improve retention in uninterrupted MOUD treatment during periods of incarceration and re-entry (this includes continuity of care during transitions from the community into correctional facilities, during periods of incarceration and during transitions from incarceration back into the community) as follows:

1. Direct DOC and Wellpath to prioritize continuous MOUD treatment and avoid dangerous and destabilizing interruptions in MOUD treatment (both during periods of incarceration and upon release)

2. Direct DOC and Wellpath to conduct a comprehensive review of policies and procedures and make changes necessary to prioritize continuous MOUD treatment (which has been shown to save lives) and to severely limit involuntary discharge from MOUD treatment (which has been shown to put lives at risk)

3. Direct DOC to review cases in which individuals were released without a scheduled medical appointment and medication sufficient to bridge them until a scheduled medical appointment to identify opportunities for improvement

4. Direct DOC to implement a protocol for individuals who are released from incarceration without medication and without a medical appointment with a community MOUD provider (call 211 or HelpLink to be connected with a Wellpath MOUD on-call provider and/or JHC/VCJR)

   Link to recent Seven Days article about joint project between Johnson Health Center and Vermonters for Criminal Justice Reform (a new community-based project currently being used to help address gaps in MOUD treatment following release from incarceration)

5. Direct DOC to assess and improve the functioning and quality control of the "med slip" and medical grievance systems to allow incarcerated patients to be more effectively proactive in MOUD coordination prior to release (and perhaps create a "hotline" priority process for ensuring MOUD continuity via the tablet messaging system)

6. Direct DOC to partner with an academic research institution to conduct a functional assessment of buprenorphine possession and diversion in Vermont correctional facilities

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and identify the factors driving possession/diversion in Vermont correctional facilities

7. Direct DOC to partner with community stakeholders to create a Buprenorphine Diversion Prevention and Mitigation Plan to reduce the need for and incidence of buprenorphine possession and diversion in Vermont correctional facilities

8. Direct DOC and Wellpath to fully implement the Buprenorphine Diversion Prevention and Mitigation Plan

9. Direct DOC and Wellpath to maintain MOUD patients on the buprenorphine dosage level prescribed at the time of incarceration or document a medical consultation with the community prescriber (with the patient's permission) and the medical reason for a change in dosage in the medical record (perhaps by amending 28 V.S.A. §801 further as in Act 153 (2018))

10. Direct DOC to limit penalties for buprenorphine possession or diversion in correctional settings and implement a therapeutic response that prioritizes uninterrupted MOUD

11. Direct DOC to eliminate involuntary discharge from MOUD as a punishment for or response to buprenorphine possession or diversion and instead implement a problem-solving process followed by a therapeutic behavioral health response

12. Direct DOC to partner with an academic research institution to conduct an independent evaluation of outcomes for individuals who were involuntarily discharged from MOUD treatment while incarcerated over the last 3 years

13. Direct DOC and Wellpath to re-assess all currently incarcerated individuals who were involuntarily discharged from MOUD while incarcerated and promptly offer each patient an opportunity to immediately resume MOUD treatment (or document why MOUD is currently medically contraindicated)

14. Direct DOC to enhance MOUD program data collection and reporting

15. Direct DOC to ensure a clear separation between medical and non-medical staff functions, and facilitate medical privacy

16. Eliminate prior authorizations for buprenorphine to allow individuals who are released from incarceration to remain on Subutex or generic equivalents and to remove barriers to MOUD providers prescribing effective doses greater than 16mg

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Discussion

Prioritize continuous MOUD treatment and avoid dangerous and destabilizing interruptions in MOUD treatment

The current hyper-focus on policing low risk buprenorphine possession/diversion in correctional settings and hyper-willingness to punish alleged possession or diversion by interrupting MOUD treatment is a deadly by-product of stigma. We know this because it is not based in science and increases harm. A first step in addressing stigma in this context is to recognize, accurately describe and acknowledge the relative safety risks of buprenorphine diversion versus involuntary discharge from MOUD treatment.

Diversion of very small amounts of buprenorphine creates a theoretical risk to unknown others while involuntary discharge from MOUD treatment in response to diversion concerns results in an immediate, disproportionate and direct harm to the safety and wellbeing of the individual buprenorphine patient, who is under the direct care of the MOUD provider. DOC and Wellpath should affirm that DOC and Wellpath MOUD providers owe a legal and ethical duty of care to their individual MOUD patient, must prioritize the health and safety of their individual MOUD patient, and should not make medical decisions based on speculative concerns relating to limited, mostly theoretical potential risks to others.

Legislators should consider directing DOC and Wellpath to conduct a comprehensive review of policies and procedures and make changes necessary to prioritize continuous MOUD treatment (which has been shown to save lives) and to severely limit involuntary discharge from MOUD treatment (which has been shown to put lives at risk).

Legislators should consider directing DOC and Wellpath to re-assess all currently incarcerated individuals who were involuntarily discharged from MOUD while incarcerated and promptly offer each patient an opportunity to immediately resume MOUD treatment (or document why MOUD is currently medically contraindicated)

Limit penalties for buprenorphine possession or diversion in correctional settings

The Vermont legislature eliminated criminal penalties for possession of personal use amounts of buprenorphine without a prescription in community settings in recognition of the important role non-prescribed buprenorphine plays in filling gaps in access to prescribed buprenorphine, preventing withdrawal symptoms and drug cravings, reducing overdose deaths and leading people with opioid use disorder to seek MOUD treatment (Act 46, 2021). An academic research study found the policy beneficial and the Vermont legislature removed a sunset provision earlier this year (Act 22, 2023).

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Non-prescribed buprenorphine plays similar roles in Vermont correctional facilities. This is especially true in the current context where individuals often experience gaps in MOUD treatment upon incarceration resulting in severe withdrawal and where too many patients have their MOUD treatment taken away in response to possession/diversion concerns (often without any real evidence or due process). We know from testimony from union representatives and PRIN surveys that a large percentage of corrections staff do not support MOUD treatment. Incarcerated patients report that DOC staff sometimes make derogatory comments about MOUD patients. And incarcerated patients say they sometimes feel targeted by DOC staff who they have come to believe are looking for opportunities to get them discharged from MOUD treatment.

Given this context and the life and death importance of continuous access to buprenorphine for many individuals with opioid use disorder, legislators should consider directing DOC to forego criminal and disciplinary penalties for diversion or possession of small amounts of buprenorphine within correctional facilities (as is consistent with removal of criminal penalties for possession of personal use amounts of buprenorphine without a prescription in community settings) and refer individuals who may have diverted or possessed buprenorphine for assessment for opioid use disorder and treatment options counseling. In the alternative, DOC should implement the above for first and second incidents of buprenorphine diversion or possession, a restorative process for the third incident and graduated sanctions for additional incidents. Legislators should consider directing DOC and Wellpath to eliminate involuntary discharge from buprenorphine treatment as a response to buprenorphine possession or diversion.

Conduct a functional assessment of buprenorphine possession and diversion in Vermont correctional facilities and create a plan to reduce the need for buprenorphine possession and diversion in correctional settings

While possession or diversion of non-prescribed buprenorphine is low risk and has important benefits, every effort should be made to allow incarcerated patients to get their medical needs met through continuous access to prescribed buprenorphine. Legislators should consider directing DOC to work with academic researchers to study the factors driving possession/diversion of buprenorphine in Vermont correctional facilities and use that information to create a plan to reduce the need for buprenorphine possession and diversion in correctional settings.

After talking to hundreds of justice-involved people with opioid use disorder, VCJR staff anticipate that researchers will find that the following factors contribute to possession/diversion of non-prescribed buprenorphine in correctional settings:

- Key factor: Existence of a pool of untreated or undertreated individuals who are self-medicating to treat extremely painful symptoms of withdrawal and unmanageable drug

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cravings, to avoid using much more dangerous substances like fentanyl, to reduce overdose risk, and to maintain physical and mental functioning

Other contributing factors:

- Delays in timely access to MOUD to limit withdrawal symptoms at the time of entry into incarceration
- Under-dosing (prescribing less medication than the person was receiving in the community and/or less than is necessary to eliminate withdrawal symptoms and manage cravings)(de facto capping of dosages at 16mg regardless of medical need)
- Delays in medication adjustments
- Refusal to accommodate the need for "split dosing" to allow more than once per day dosing as needed to manage withdrawals symptoms and cravings
- Interruptions in MOUD treatment caused by dose reductions or involuntary discharge from MOUD treatment in response to real or perceived medication diversion
- Sleep issues/disorders
- Mental health issues/disorders
- Economic incentive (lack of economic resources to meet basic needs)
- Peer pressure/coercion
- Desire for mood alteration/euphoria

Identify and implement buprenorphine diversion prevention and mitigation measures

Legislators should consider directing DOC to partner with community stakeholders to create and implement a Buprenorphine Diversion Prevention and Mitigation Plan to minimize the need for and incidence of buprenorphine possession and diversion in Vermont facilities.

After working with many incarcerated MOUD patients over a period of many years, VCJR staff recommend that prevention and mitigation measures should include directing DOC and Wellpath to:

- Eliminate gaps in MOUD treatment when people become incarcerated (to prevent withdrawal symptoms and unmanageable drug cravings, and eliminate a need to self-medicate with non-prescribed buprenorphine)
- Maintain MOUD treatment during periods of incarceration and avoid discontinuing MOUD treatment in response to diversion/possession (to eliminate a need to self-medicate with non-prescribed buprenorphine)
- Eliminate formal or informal caps on buprenorphine dosages to ensure individualized dosing assessment, fidelity to best practices and (to reduce the need for patients to supplement their prescribed buprenorphine with non-prescribed buprenorphine)

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- Accommodate those who would benefit from a split dosing schedule (to reduce the need for patients to attempt to implement self-help split dosing by diverting their own medication for later personal use)
- Eliminate dose reductions in response to concerns related to use of non-prescribed substances beyond any period of acute intoxication (to reduce the need for patients to supplement their prescribed buprenorphine with non-prescribed buprenorphine)
- Create separate MOUD housing units to eliminate the risk of diversion of OUD treatment medications to individuals who do not already have OUD
- Allow incarcerated individuals to schedule standing mental health or substance use disorder counseling appointments and maintain an ongoing therapeutic relationship with an individual mental health or substance use counselor (including via in-person visits or telehealth with community providers)(allow for Medicaid billing or grant funding for community providers)
- Improve the functioning of the "med slip" and medical grievance systems

Enhance MOUD program data collection, reporting and evaluation

Legislators should consider directing DOC to improve data collection and reporting related to MOUD treatment in Vermont correctional facilities. This should include collecting and reporting data relating to gaps in MOUD access upon entry into the facility and upon release from incarceration. This should also include collecting and reporting data relating to dosage reductions, dosage increases and involuntary discharge from MOUD during periods of incarceration.

Legislators should consider directing DOC to partner with an academic researcher to conduct an independent evaluation of outcomes for individuals involuntarily discharged from MOUD treatment over the last 3 years. Additional evaluation should include outcomes related to gaps in MOUD treatment upon entry into a correctional facility or following release from incarceration.

Create a clear separation between medical and non-medical staff functions, and facilitate medical privacy

One of the most important and beneficial steps legislators could take to improve the effectiveness of the MOUD program in Vermont correctional facilities is to direct DOC to create a clear separation between medical and non-medical staff functions. Currently, non-medical (security) staff are directly present during dosing and monitor for suspected medication diversion. This is not necessary for medical staff safety and denies incarcerated patients medical privacy. Incarcerated patients report that some non-medical staff are openly hostile to MOUD treatment and sometimes falsely accuse people of attempted diversion –often resulting in involuntary discharge from life-saving MOUD treatment.

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Security staff often issue a DR (disciplinary report) for suspected diversion (either in the context of the dosing process or completely outside of medical processes and settings). These reports appear to be shared with the medical provider and sometimes results in involuntary discharge from MOUD treatment --even before the DR review process is completed and even when the alleged diversion was unrelated to prescribed medication (such as possession of buprenorphine introduced from outside the facility). Sometimes the DR review process finds that the alleged diversion is unsubstantiated and the DR is "dropped," but the harm caused by an interruption in MOUD treatment has already occurred. Even when the DR is "dropped," some patients are denied the opportunity to immediately resume MOUD treatment.

Legislators should direct DOC to require non-medical staff to remain outside of the area where MOUD treatment implementation occurs to allow for private meetings between MOUD staff and patients unless security staff are called to respond to a specific security emergency. Legislators should require that diversion monitoring in the medical setting must be implemented by medical staff and that diversion concerns in the medical setting must be addressed by medical staff through problem-solving and a therapeutic behavioral health response.

Medical providers should prioritize continuous MOUD treatment and avoid dangerous and destabilizing interruptions in MOUD treatment in response to diversion concerns. In the rare event that a patient is subject to involuntary discharge from MOUD treatment because of possession/diversion concerns, legislators should require the prescribing medical provider to:

- Have a direct conversation with the patient about diversion concerns
- Identify and document patient concerns that may be contributing to diversion risk (low dosing, the need for split dosing, the need to consider other forms of MOUD, financial need, mental health issues, sleep issues, coercion)
- Engage in problem solving with the patient and document a plan to address patient concerns and limit future diversion risks
- In the event the diversion plan is unsuccessful, assess for treatment with Sublocade (once-monthly buprenorphine injection) or similar medication formulations that limit diversion risk (or document the reason why this option was medically contraindicated)
- Educate the patient about the risks/benefits/potential barriers to methadone treatment and offer a methadone treatment assessment (or document why methadone treatment is medically contraindicated)
- Maintain standard buprenorphine treatment unless and until a transition to a lower risk buprenorphine formulation or methadone treatment is completed
- Implement longer MOUD tapers to limit unnecessary suffering and to avoid creating conditions that are likely to result in self-medicating behavior

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- Document in the patient's medical record how an interruption in MOUD treatment is in the best medical interest of the patient
- Document what steps would need to happen and what conditions would need to change in order for the patient to resume MOUD treatment and explain the rational for requiring these steps or changes in conditions
- Resume MOUD treatment as soon as possible

Legislators should direct DOC to limit correctional staff to monitoring for contraband in non-medical areas and limit the response to possession of contraband to the seizing of the contraband and implementation of the process outlined above (referral for OUD assessment and treatment options counseling).

Conclusion

The Vermont Department of Correction's MOUD treatment program for incarcerated people with opioid use disorder is the best in the nation. The program is hugely important and beneficial. Certain limiting factors are currently preventing Vermont from realizing the program's full public health and public safety potential. Addressing these limiting factors is well worth legislative time and attention.

The Joint Legislative Justice Oversight Committee should identify continuity of MOUD treatment as a **public health and public safety priority** and recommend that the House Committee on Human Services and Senate Committee on Health and Welfare take legislative action to improve retention in uninterrupted MOUD treatment during periods of incarceration and re-entry. This includes continuity of care during transitions from the community into correctional facilities, during periods of incarceration and during transitions from incarceration back into the community.