Written Testimony in Support of SB 846
Finance Committee
Maryland Senate
February 27, 2019

Richard Bruno, MD MPH
on behalf of MedChi, Maryland State Medical Society
and the Maryland Public Health Association

The above-named organizations support this bill because it is desperately needed among our incarcerated population in Maryland. In fact, over 50% of state prisoners meet criteria for substance use disorder, but less than 1% receive medication assisted treatment (MAT), the standard of care.[1] This means there is a huge gap that leads to diversion, recidivism, and relapse. This causes unnecessary suffering, poor outcomes, and worsens an already dangerous public health crisis.[2] Three years ago, the Rhode Island Department of Corrections created an MAT program in their prison system, leading to a 12% decrease in post-incarceration overdose deaths just one year after implementation.[3] This bill aims similarly to expand access to critical medications that help people who are actively using.

I'd like to tell you about three patients, the first is a 45-year-old man, who has been using heroin for nearly 20 years. He had gotten in trouble with law enforcement recently and was sentenced to some time in jail. Upon entry, his substance use disorder was not recognized, he was forced into withdrawal (which probably violated his 8th amendment right against cruel and unusual punishment), and he suffered needlessly without access to Medication-Assisted Treatment—such as methadone (a full opioid agonist), Suboxone (a partial opioid agonist), or Vivitrol (a long-acting opioid antagonist). Upon his release, he began using again, but no longer had a tolerance built up. He overdosed and I never saw him again.

My second patient is a 38-year-old man who has been prescribed Suboxone for a few years. Suboxone is a combination of two medications—buprenorphine, which is a partial agonist of opioid receptors that decreases cravings, and naltrexone, which blocks opioid receptors so that even if he did use heroin or oxycodone again it wouldn't have an effect. This medication, in combination with substance abuse counseling and a supportive team of addiction service providers has led to dozens of my patients finding work, supporting their families, and not turning to the street everyday. Unfortunately, relapse can sometimes be a part of the process, and he also ran into some trouble with the law, leading to arrest and incarceration. However, despite alerting medical staff at the jail that he was on Suboxone, he was denied this critical

---

[1] Bronson J, et al. (2017). Bureau of Justice Statistics: Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009. https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf
[2] Bone C, et al. (2018). Our Ethical Obligation to Treat Opioid Use Disorder in Prisons: A Patient and Physician's Perspective. J Law Med Ethics. 2018 Jun;46(2):268-271. doi: 10.1177/1073110518782933.
[3] Green TC, Clarke J, Brinkley-Rubinstein L, et al. Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. JAMA Psychiatry. February 2018. doi:10.1001/jamapsychiatry.2017.4614

medication and forced into painful withdrawal. In jail, he was sometimes able to attain smuggled Suboxone, placing himself at risk of further sentencing, just to avoid further withdrawal.

Lastly, when my 55-year-old patient was released after 20 years in prison, he could have turned back to the street drugs that had led to his initial conviction, but instead recognized the worsening plight it has been taking on his city, and decided to become a peer recovery specialist in order to help others through the difficult journey of recovery—an evidence-based approach to recovery. If HB 116 had been law, he would have been able to get that peer recovery specialist training while in prison and had a job waiting for him upon re-entry.

We have learned over decades of failed drug policies that we cannot incarcerate addiction out of people. Medication-Assisted Treatment is more successful than drug-free detoxification. The social, medical, and economic benefits of providing MAT to inmates during incarceration and linkage to MAT upon release is well known.[4] As a society, we must recognize the role of evidence-based interventions such as MAT, and expand access to populations that are at high risk of overdose and death. Thank you for considering this life-saving bill, and please feel free to contact me if I can be of further assistance.

---

[4] Nunn A, Zaller N, Dickman S, Trimbur C, Nijhawan A, Rich JD. Methadone and buprenorphine prescribing and referral practices in US prison systems: results from a nationwide survey. Drug Alcohol Depend. 2009;105(1-2):83-88. doi:10.1016/j.drugalcdep.2009.06.015.