Good evening Committee Members. My name is Robert Heimer and I am a Professor of Epidemiology and Pharmacology at the Yale Schools of Public Health and of Medicine. In my capacity as an researcher in the field of substance use disorders and their negative consequence, I have two led two studies pertinent to the proposed legislation. Both involve the results of pilot programs that provided treatment with methadone for individuals with opioid use disorder in correctional setting.

The earlier of the two studies was conducted in Puerto Rico in 2003. Las Malvinas, the largest prison on the island was rife with contraband heroin -- three in five prisoners reported access while incarcerated, two in five within the last month. A small pilot program was established to provide daily methadone up to 24 inmate volunteers -- all of whom reported using heroin, validated by urine testing. Contraband heroin use among these inmates during their participation in the pilot was reduced by 95%, measured both by urine testing and self-report. Although the pilot population was subsequently doubled, this successful pilot was terminated when the next election resulted in a change in the Commonwealth’s ruling party.

Similarly, contraband opioids are rife in CT correctional facilities -- but here the major contraband item is suboxone, a wafer-thin formulation of buprenorphine. For the better part of five years, pilot programs to provide medication for opioid use disorder have been operating in the correctional centers in New Haven and Bridgeport. The programs provide continuing treatment with methadone to newly incarcerated individuals who had been receiving methadone in the community prior to being jailed. We are in the midst of an evaluation of the positive and negative impacts of participating in this program comparing individuals who were able to continue, about 40% those eligible (who we will call the cases), with the other 60% who did not continue treatment (who we will call the controls). At this stage of the evaluation we can present preliminary results on overdoses among the cases and controls following their release from custody. Through 2017, there were 36 fatal overdoses among both groups -- 28 among the controls, 8 among the cases. The simplest statistical analysis suggests that continuing to receive methadone was protective, cutting the risk of fatal overdoses by a little more than half. Through 2016, there were 248 episodes in which first responders' efforts prevented fatal overdoses -- 161 among the controls and 87 among the cases. Again, continuing methadone appears protective, cutting the risk of non-fatal overdoses by 15%. Students working with me on this project – Molly Doernberg, Adam Viera, and Alissa Haas – will be
updating these numbers as more recent data on fatal and non-overdoses become available. We expect to release a full report by midsummer.

Unlike Puerto Rico, here in CT we have an opportunity to scale up rather than eliminate effective programs to treat opioid use disorder in the correction system and thereby reduce the negative consequences for individuals once released back into the community. The proposed allocation of $2 million to provide medication-based treatment for fiscal year 2020 with an increase to $6 million for fiscal year 2021 will allow expansion not just for those who become incarcerated while already receiving treatment but will include those not currently receiving treatment for their opioid use disorder. This increase is vital in responding to the state's opioid crisis by moving individuals into evidence-based, gold standard treatment and overcoming the stigmas associated with both the diagnosis and, curiously, the best treatments for the disease.