Governor's Criminal Justice and Substance Abuse Cabinet

Report to Governor Peter Shumlin

December 15, 2014

In accordance with Executive Order 02-14, effective 6/17/14

Submitted by Co-Chairs **TJ Donovan**, Chittenden County State's Attorney, and **Tom Huebner**, President and CEO of Rutland Regional Medical Center, on behalf of the Cabinet:

Paco Aumand Deputy Commissioner, VT Dept. of Public Safety
James Baker Police Chief, Rutland City Police Dept.
Bob Bick Director of Mental Health and Substance Abuse Services, Howard Center
Harry Chen Acting Secretary, VT Agency of Human Services
Barbara Cimaglio Deputy Commissioner, Alcohol & Drug Abuse Programs, VT Dept. of Health
Tris Coffin U.S. Attorney, U.S. Dept. of Justice
Rachel Feldman Chief of Staff, Lt. Governor's Office
Patrick Flood CEO & Executive Director, Northern Counties Health Care, Inc.
Keith Flynn Commissioner, VT Dept. of Public Safety
Patricia Gabel State Court Administrator, VT Judiciary
Karen Gennette Executive Director, Crime Research Group, Inc.
Bram Kranichfeld Executive Director, Dept. of State's Attorneys and Sheriffs' Association
Mary Kay Lanthier Supervising Attorney, Office of the Defender General
James Leene Law Enforcement Coordinator, U.S. Dept. of Justice
Mike Leyden Deputy Director EMS, VT Dept. of Health
Roger Marcoux Sheriff, Lamoille County Sheriff's Dept.
Jeff McKee Director of Psychiatric Services, Rutland Regional Medical Center
Mary Alice McKenzie Executive Director, Boys and Girls Club of Burlington
George Merkel Police Chief / President, Vergennes Police Dept. / VT Police Chief's Association
David Mickenberg Attorney, Mickenberg, Dunn, Lachs & Smith PLC
Andy Pallito Commissioner, VT Dept. of Corrections
Annie Ramniceanu Director of Pretrial Services, VT Dept. of Corrections
Judy Rex Executive Director, VT Center for Crime Victim Services
Bobby Sand Governor's Liaison to Criminal Justice Programs
Max Schlueter Senior Research Associate, Crime Research Group, Inc.
Phil Scott Lt. Governor
Richard Sears VT State Senator
Amelia Silver Development Director, Sunrise Family Resource Center
Tom Simpatico Chief Medical Officer, Department of Vermont Health Access
Jane Stetson Chair, D-H Partners for Community Wellness
John Treadwell Chief, Criminal Division, VT Attorney General's Office
Matthew Valerio Defender General, Office of the Defender General
Chris Winters Director of Professional Regulation, VT Secretary of State's Office

BACKGROUND:

The Governor's Criminal Justice and Substance Abuse Cabinet was created by Executive Order Number 02-14, codified as 3 V.S.A. app. § 3-61, dated June 17, 2014.

The Order sets forth the following charge for the Cabinet:

The Cabinet shall be advisory to the Governor and shall meet at the call of the Chair or Co-Chairs, but no less than three times annually. The responsibilities of the Cabinet shall include, but not be limited to:

A. Consulting at least annually with the Center for Criminal Research Statistics, recovery centers, community and family services organizations, state agencies and departments, law enforcement, and other relevant individuals and organizations, to obtain and review data relevant to the Cabinet's charge;

B. Monitoring the progress of state and local programs, including plans to implement initiatives related to reductions in the volume of drug-related crime, increased availability of treatment options, and increased substance abuse prevention resources;

C. Meeting as requested by the Chair or Co-Chairs to coordinate and discuss statewide and local efforts to combat drug abuse and drug-related crime; and

D. Reporting to the Governor on December 15 of each year regarding: (1) recommendations regarding resource, policy, and legislative or regulatory changes, and (2) progress made under state and local programs.

The Cabinet may designate sub-committees as necessary. The Cabinet shall receive administrative support from the Department of Public Safety and Governor's Office.

The full Cabinet met in Montpelier on September 30, 2014, November 5, 2014, and December 11, 2014.

The full Cabinet created four Subcommittees:

(1) Nalaxone

(2) Treatment

(3) Unified Pain Management

(4) Prevention

The Subcommittees met on various dates and in various locations to formulate recommendations for the full group.

Pursuant to Section II(D) of Executive Order 02-14, the Cabinet submits the following recommendations, proposed by the following four Subcommittees, to the Governor:

RECOMMENDATIONS:

NALOXONE SUBCOMMITTEE

David Mickenberg, Chair
Keith Flynn
Bram Kranichfeld
Mike Leyden

Scope Statement:

Vermont should be working to expand awareness, outreach and access to Naloxone for users, families, and third parties that come into contact with users (e.g., community-based organizations, health centers, etc.).

Proposed Initiatives:

1. **Public awareness press event:** Increase earned media awareness of the current success of celebrating at a press event the over 100 reversals that have taken place in Vermont since starting the pilot program. Include U.S. Attorney, State's Attorney, Department of Health, Legislators, community-based organizations and others at a press conference hosted by the U.S. Attorney to raise public awareness.

2. **Public Service Announcements:** Do statewide PSA's about how to access Naloxone and highlighting the "Just Call" message related to overdoes, consistent with Vermont's Good Samaritan law. The U.S. Attorney's office has agreed to sponsor these PSA's and can develop with the VT Department of Health.

3. **Law enforcement outreach:** State government should do increased outreach to all municipal and county law enforcement to carry and be trained in Naloxone. Department of Public Safety will take the lead in this outreach.

4. **User Outreach:** Work with Department of Health and other relevant agencies to continue efforts to educate the user community, through community based organizations, about Naloxone availability and our Good Samaritan law. VT Department of Health would lead.

5. **Encourage Naloxone in school infirmaries:** Work with Agency of Education, local school boards, and others to encourage schools to carry Naloxone in school nurses offices.

Statutory Changes:

1. **Encourage the FDA through any and all means available to make Nalaxone available over the counter.** This could take the form of outreach through the National Governor's Association; a joint letter of the Governor, Congressional Delegation, and other concerned officials, as well as other states; and/or a joint resolution of the General Assembly endorsed by the Governor.

2. **Advocate for coverage of prescribed Naloxone by all health care payers.**

TREATMENT SUBCOMMITTEE

Bob Bick, Chair
Patricia Gabel
Mary Kay Lanthier
Andy Pallito
Amelia Silver
Tom Simpatico

Scope Statement:

Opiate use disorders should be addressed within a chronic disease model that reflects treatment that is consistent with patient needs. Within the context of financial, community, and workforce resources, and given the significant, negative and continuing economic and social impact of opiate addiction, Vermont must continue to work toward maximizing timely access to treatment and treatment supports.

Proposed Initiatives:

1. **To increase access to timely medication assisted treatment, the Hubs must be provided with resources necessary to accommodate insured and uninsured active users.** When prescribing Burprenorphine, there must be sufficient Spoke community (primary care) physicians to refer to. ADAP, DVHA and existing Hub & Spoke providers need to continue to evolve standardized practices and viable reimbursement protocols. Greater engagement with the FQHC and hospital affiliated physicians will support this initiative. Removing barriers for community physicians may be facilitated by including enhanced "push" reporting of patients receiving opiate prescriptions, enhanced utilization of the Vermont Prescription Monitoring System, and continued support for case management support to facilitate successful utilization of community physician practices.

2. **The State should continue to expand treatment capacity at DOC to maximize continuity of care.** Engagement with and coordination between DOC staff, existing Hubs, and DOC's healthcare provider has begun within the context of pilots that will help define costs and challenges. Implementation of both short- and long-term maintenance protocols should be considered on a patient-need basis and Return On Investment should be considered based on recidivism and bed utilization costs, among others. Costs should be part of the DOC base budget on an ongoing basis which may necessitate legislative action.

3. **ADAP, DVHA, DOH, DCF, and DOC should review and pilot initiatives that take advantage of changing and developing technology to maximize access and use of limited resources.** For example, the advantages of the use of tele-medicine to observe offsite dosing can free existing treatment slots more quickly. In addition, the use of electronic dosing wheels may reduce patient travel times and permit more timely transitioning to employment.

4. **The need for and provision of treatment for an opiate use disorder requires a range of treatment intervention options that should include long-term residential treatment and expanded access for permanent housing supports.** Currently residential options are extremely limited and the consideration for an examination of current bed need and enhanced options should be considered. This may result in restructured existing resources or consideration for additional options within the community. These

programs offer the potential to enhance pre-trial diversion programs as well as expedite discharge of inmates from, DOC custody.

THE UNIFIED PAIN MANAGEMENT SUBCOMMITTEE

Barbara Cimaglio, Chair
Tris Coffin
Jeff McKee
John Treadwell
Chris Winters

Scope Statement:

The Unified Pain Management Sub-Committee is charged with reviewing the status and content of the Vermont Department of Health proposed regulation of uniform treatment guidelines for patients receiving opiates for chronic, non-cancer pain. The Sub-Committee will also work to ensure that the various practitioner boards adopt policies that are consistent with the VDH guidelines.

Proposed Initiatives:

1. Continue to review VDH regulations and make recommendations.

2. Collaborate with Office of Professional Regulation to educate board's representatives about the regulation.

3. Work with boards to assist in creating specific policies for their profession.

4. Continue to support boards in the development of education and training about appropriate treatment policies.

Statutory Changes:

No statutory changes at this time; any regulations or policies will be enacted by VDH and OPR boards.

PREVENTION SUBCOMMITTEE

Patrick Flood, Chair
TJ Donovan
Rachel Feldman
Roger Marcoux
Mary Alice McKenzie
Annie Ramniceanu
Judy Rex
Phil Scott
Jane Stetson

Scope Statement:

The prevention subcommittee believes investments in intervention(s), public awareness/education and more robust communication across systems will help prevent addiction and provide for improved and increased services to those that suffer from addiction and create a roadmap for a healthy and informed citizenry.

Proposed Initiatives:

1. **Require the Criminal Justice Capable Core Team to report on progress in "mapping resources" pursuant to Act 195.**

2. **Urge the Attorney General to review and/or consider joining litigation against the pharmaceutical industry for unfair and deceptive practices, and encourage Vermont's health care providers, including state agencies and those with whom they contract, to cooperate with the Attorney General in his efforts to obtain relevant information needed to evaluate possible litigation against the opioid manufacturers.**

3. **Ask AHS to study the viability of Nurse Home Partnerships, specifically identify the organization for each county that could provide the service and the funding mechanism.**

4. **Ask DCF to review and change its policy of declining to investigate reports/allegations made against pregnant women for substance abuse.** Research possible alternatives in connecting with at risk women.

5. **Require universal screening (SBIRT) for all high risk pregnancies.**

6. **Advocate for a federal waiver/change to federal law to allow mid-level practitioners to prescribe maintenance medication.**

7. **Revise Act 264 to broaden the definition "severe emotional disturbance" to include drug and alcohol abuse.** This will allow for more school-based interventions. "Child or adolescent with a severe emotional disturbance" means a person who:

a. exhibits a behavioral, emotional, or social impairment that disrupts his or her academic or developmental progress or family or interpersonal relationships;

b. has impaired functioning that has continued for at least one year or has an impairment of short duration and high severity;

c. is under 18 years of age, or is under 22 years of age and eligible for special education under state or federal law; and

d. falls into one or more of the following categories, whether or not he or she is diagnosed with other serious disorders such as mental retardation, severe neurological dysfunction or sensory impairments:

    i. Children and adolescents who exhibit seriously impaired contact with reality and severely impaired social, academic and self-care functioning whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre and whose emotional reactions are frequently inappropriate to the situation.
    ii. Children and adolescents who are classified as management or conduct disordered because they manifest long-term behavior problems including developmentally inappropriate inattention, hyperactivity, impulsiveness, aggressiveness, anti-social acts, refusal to accept limits, suicidal behavior or substance abuse.
    iii. Children and adolescents who suffer serious discomfort from anxiety, depression, irrational fears and concerns who symptoms may be exhibited as serious eating and sleeping disturbances, extreme sadness of suicidal proportion, maladaptive depending on parents, persistent refusal to attend school or avoidance of non-familial social contact.

8. **One Child at a Time pilot project.** Studies have shown that the children of addicts and the children of adults who participate in the drug trade are more likely to become addicts and/or to be incarcerated at great rates than the general population. We recommend that the children who meet these risk factors receive special supports based on the positive behavioral assets that are present in their lives. We recommend that a pilot project be authorized and funded to facilitate early identification of at risk children and the creation of a case management focused program of support. The case manager would be responsible for identifying the positive attitudes, aptitudes and interests of each child. Based on those strengths a plan of support would be created and implemented for each child. The plan of support would be updated continuously as the child develops. The case management approach is a long-term, strength based approach that allows the child to develop aspirations, strength and resiliency. The pilot project's design, implementation and outcomes will be documented and studied for effectiveness with the goal of developing best practices such that the pilot can be replicated throughout Vermont in many different child and youth serving settings.

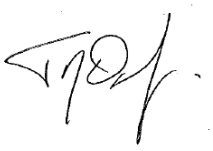
<u>Statutory Changes</u>:

1. Revision of Act 264 as noted above.

NEXT STEPS:

The above reflect the recommendations of the Cabinet for 2014. The Cabinet looks forward to continuing to meet in 2015.

For the Governor's Criminal Justice and Substance Abuse Cabinet:



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T.J. Donovan, Co-Chair

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Tom Huebner, Co-Chair