STIMULANT USE DISORDERS (StUD) TREATMENT IN CORRECTIONAL SETTINGS:
PRACTICAL STRATEGIES AND TOOLS

DHCS
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HMA

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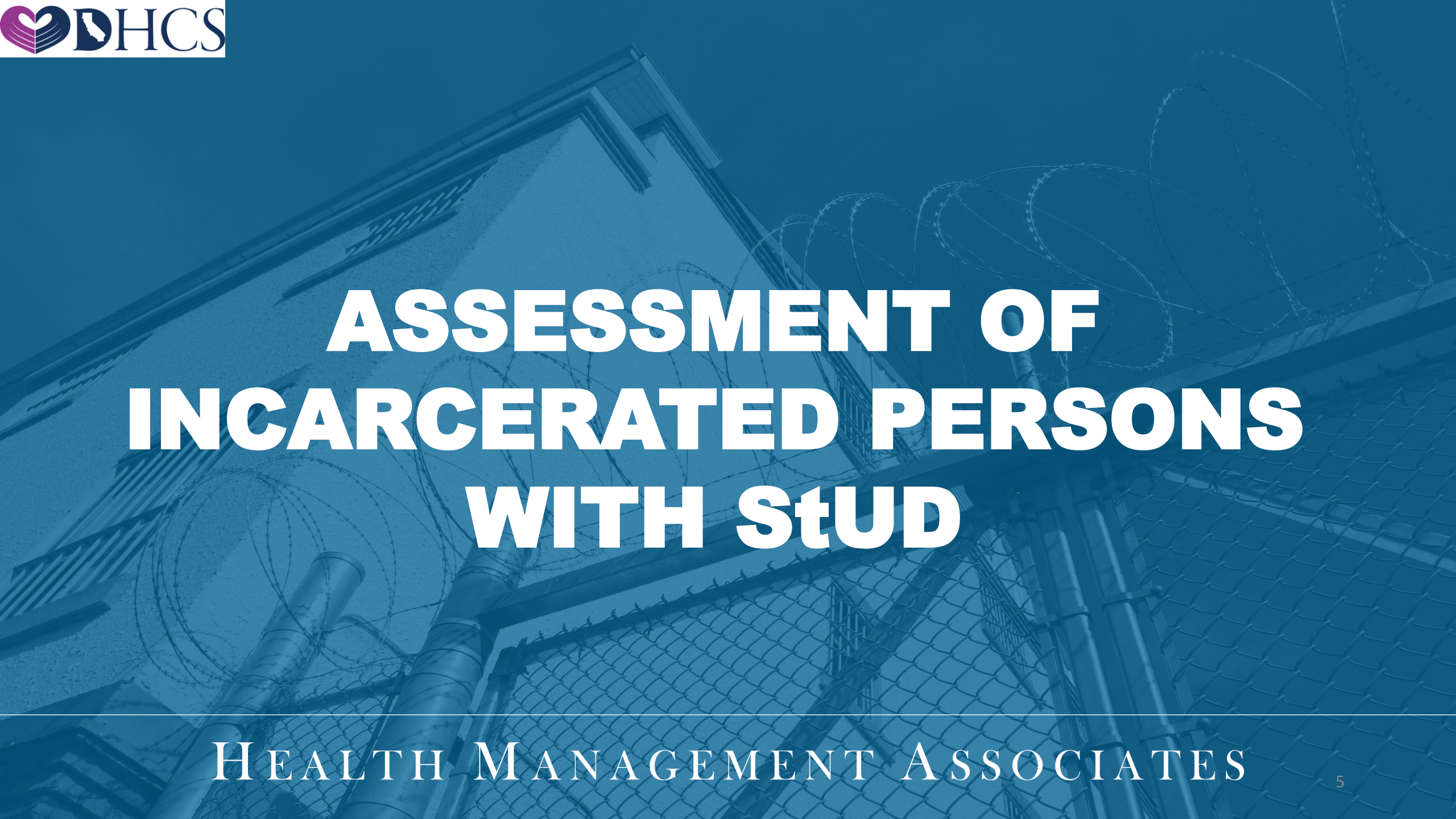
PAST WEBINARS/TRAININGS ON STIMULANT USE DISORDERS (StUD)

- Learning Collaborative Session: Stimulant Use Disorders (9-23-2020): https://vimeo.com/461962089/a7a34a3756
- Webinar: The Neuroscience of Stimulant Use Disorders (10-7-2020): https://vimeo.com/466218120/4a1c71c3b2
- Webinar: Behavioral Interventions for Justice-Involved Individuals with Stimulant Use Disorders: Part I (4-27-2021): https://vimeo.com/542751375/30a3c368af
- Webinar: Behavioral Intervention for Justice Involved Individuals with Stimulant Use Disorders: Part II (5/3/21): https://vimeo.com/545545293/617c92f860

What we will discuss today

1) Assessment of Incarcerated Persons with StUD
2) StUD Treatment Considerations during Incarceration
3) Continuous Quality Improvement
4) Re-entry considerations



ASSESSMENT OF INCARCERATED PERSONS WITH StUD

HEALTH MANAGEMENT ASSOCIATES

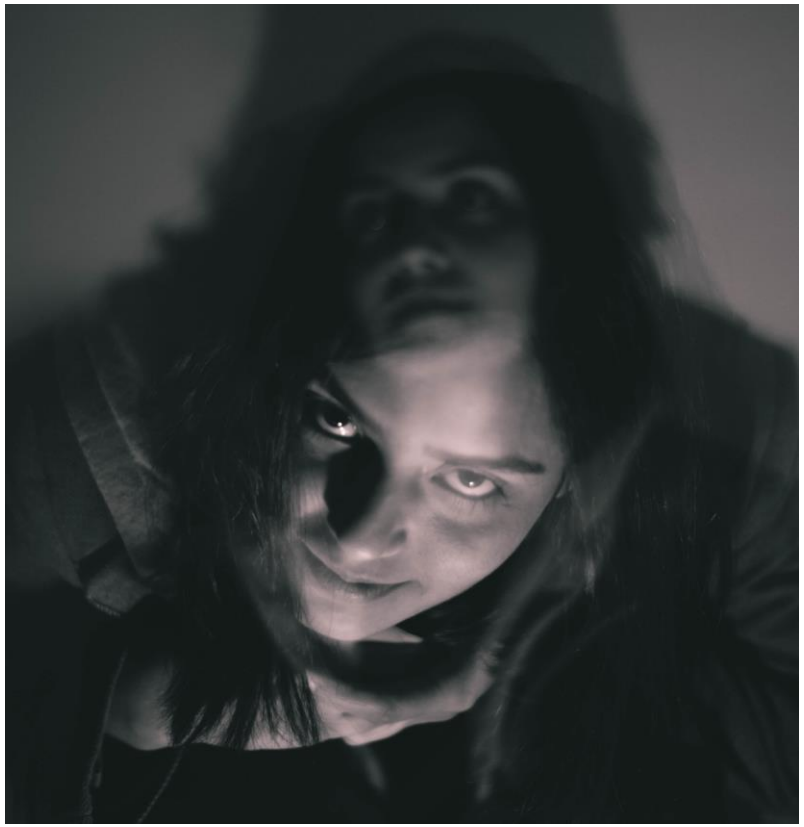
CASE

Mary is a “frequent flyer” at X County Jail, CA. Her primary drug of choice is methamphetamine.

She is usually loud and hostile when first booked into jail. All custody and health staff know her by name.

They tend to roll their eyes when they see her, but call her by her first name, and will remind her that she “knows the drill” and needs to cooperate if she wants extra food and a quiet cell.

She stays anywhere from one night to six months when she is arrested.



MARY'S TREATMENT EXPERIENCE IN THE JAIL

Mary is reminded to drink plenty of water, but when she complains of the bad tasting water, staff shrug their shoulders. She is housed in the general population when cooperative.

She was evaluated by a jail psychiatrist once when showing signs of psychosis at time of booking, such as internal preoccupation, and tangential speech.

However, by time she was evaluated, these symptoms had diminished without medication. She was diagnosed with Substance Induced Psychosis and was not referred again.

There is a Seeking Safety group in the female dorm that meets once per week for 12-week cycles.

Mary was told during orientation that she can fill out an inmate request form to attend the group, but since she is hostile when first arrested, she turns it down, and no one tries to engage her further.

Mary does not ask for help getting into a program upon release, and is released to the street, since she does not pose a safety risk.

POLL QUESTION

Mary was referred, evaluated, and told how to request to be in a therapeutic group. Was this amount of outreach adequate?

Answers:

- ❑ YES
- ❑ NO

CHATTERFALL

If you answered “NO”:

What is one additional intervention that could be done to improve Mary’s treatment in the jail?

INITIAL ASSESSMENT

Assess for physical symptoms

- Skin infections
- Heart problems
- Lung problems
- Throat problems
- Tooth decay

For more information, please see “Stimulant Use Disorder” session from 9/23/2020 Learning Collaborative: https://vimeo.com/461962089/a7a34a3756

Medication:

- There is no FDA approved medication for Stimulant Misuse
- However, there are medications for associated behavioral issues, e.g.
  - Antipsychotics: Substance-induced psychosis can be treated with antipsychotics
- **These medications will NOT reduce cravings related to stimulant dependence**

StUD TREATMENT CONSIDERATIONS DURING INCARCERATION: INTEGRATION, COHORTING, & SUICIDE RISK ASSESSMENT

INTEGRATED CARE

- Often clients will be referred to either substance use treatment or mental health treatment
- When someone has been misusing stimulants, hard to know which is primary. Being at risk for one puts a patient at risk for the other.
- Integrated care assumes that a person identified as needing SUD treatment also should be assessed for mental health treatment
- Coordination between mental health and substance use providers leads to more effective care.
- In a jail, there already are three type of providers in one building (health, mental health, and SUD). **Why not one treatment plan?**

INTEGRATED CARE: MAKING IT WORK

- At first glance, this can seem challenging
- If not implemented effectively, integrated care can be a drain on staff time (more meetings) or possible duplication of efforts (suicide risk/mental health/SUD screens done by multiple departments)

PLEASE REPLY IN CHAT:

What are some successes you have had implementing an integrated care model in your facility?

COHORTING

- Is it possible in your jail to cohort people who are withdrawing from stimulants?
- Rather than starting a behavioral health intervention, supportive housing is a good way to start engagement
- Reasons:
  - Greater observation
  - Quiet hours for increased sleep
  - Extra food trays
  - Hydration station
  - Planned and structured exercise time

SUICIDE RISK ASSESSMENTS

- Suicide accounts for 30% of jail deaths
- Someone in jail is more than 3x as likely to die by suicide than the general population, including prison.
- Although many jails have put into place suicide prevention programs, the rate of suicide in jails has increased. Stats available indicated an increase in jail suicides between 2008 and 2018.
- Suicide happens early after incarceration. Most detainee who completed suicide had been in jail for nine days or less, as compared to 17 days for all causes of death.

Source: Carson, E.A. (2021) Mortality in Local Jails 2000-2018- Statistical Tables
https://bjs.ojp.gov/content/pub/pdf/mlj0018st.pdf

METHAMPHETAMINE USERS AND SUICIDE

- Methamphetamine users who use meth intravenously are 80% more likely to attempt suicide than non-IV users.
- In general, people with substance use disorders are 10 to 14 times more likely to die by suicide.
- Combination of this tendency, along with higher rate of suicide in jail, makes this population higher risk.

Source: Hypse, J. (2018) Suicide rates between methamphetamine users who inject versus non-injectors; J Addict Res Ther 2018, Vol 9(2): 359

Does your jail currently conduct suicide assessment on all intakes?

- Yes
- No
- Not sure

SUICIDE RISK ASSESSMENT

- Suicide risk assessment should be a part of intake.
- Consider whether you have staff available to provide a risk assessment on all incarcerated persons.
- Is there regular training on suicide risk for all staff?
- Is there a clear referral process for suicide risk assessment by a qualified mental health professional?

SUICIDE

- While suicide risk assessments are effective in identifying incarcerated persons at risk for suicide at the time of booking, this is not enough.
- Many incarcerated persons will not admit to suicidal ideation for fear of being placed on restrictive suicide precautions.
- Providing programs which allow for continuous intervention allows for ongoing assessment of suicidal ideation.

Source: Boring, Alice (2013) http://www.ncianet.org/suicide-prevention-in-correctional-facilities-reflections-and-next-steps/

SUPPORTING STAFF

1

In order to implement any correctional health policy, you must have healthy and committed staff

2

Working with staff on self-care and compassion resilience is an important part of treatment

DON'T FORGET ABOUT STAFF BURNOUT

- Be aware of burn-out:
  - Research demonstrated that burn out is higher among highly motivated individuals
  - One study which looked specifically at substance use counselors in corrections found that burn-out is more common when there is:
    - Higher perceived danger,
    - Less administrative and or emotional support,
    - Lack of physical space
    - role ambiguity and a
    - lack of clarity around the mission of the organization.

Source: Garner, B (2007) International Journal of Offender Therapy and Comparative Criminology

CHATTERFALL

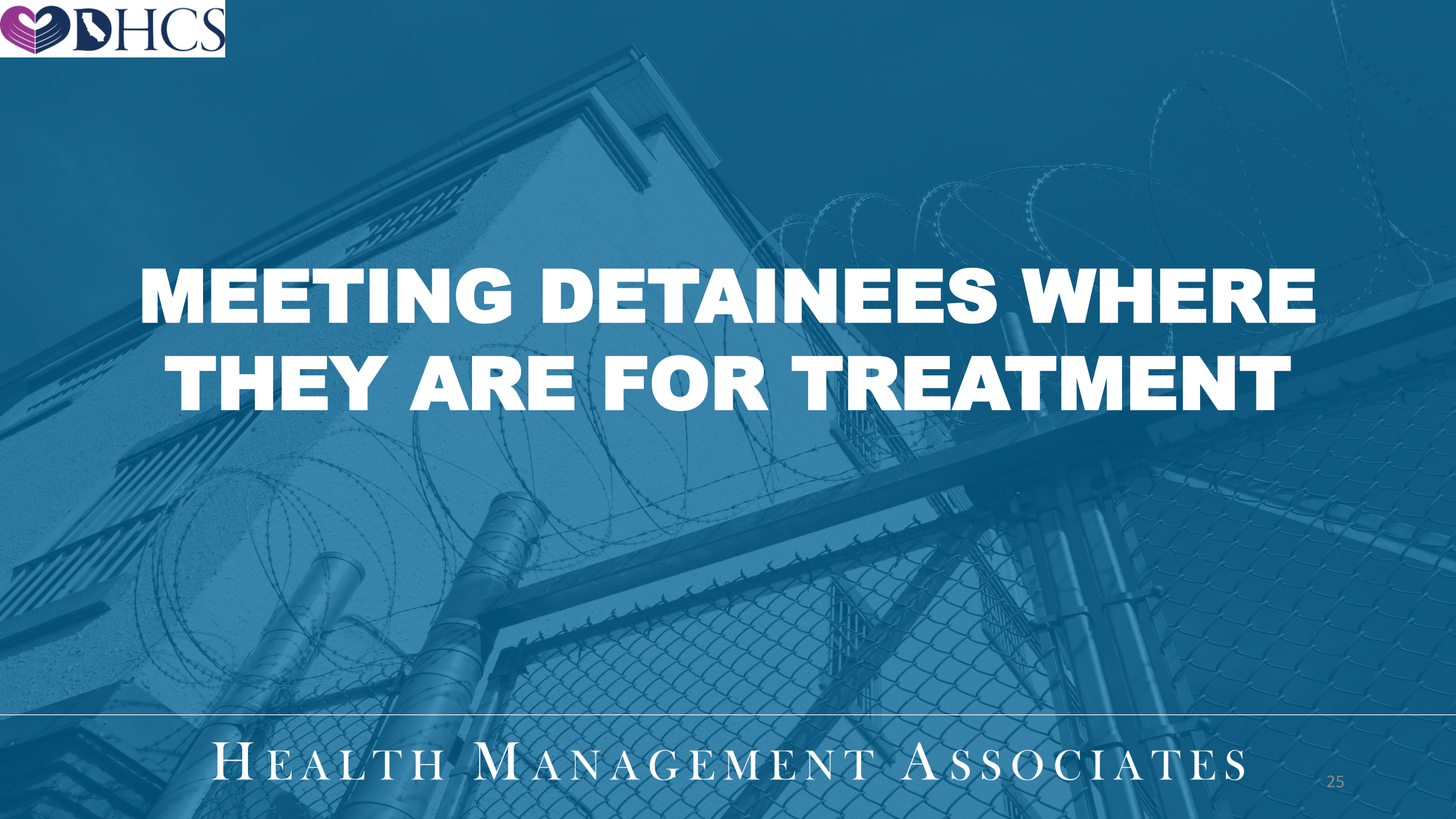
How can you re-energize yourself and your team to work with this population?

WAYS TO PROVIDE SUPPORT TO TREATMENT PROVIDERS

When caring for ourselves and other treatment providers, we support compassion resilience, as opposed to compassion fatigue.

Ways to support your colleagues:

- Regular communication
- Supportive supervision
- Remind staff about self-care
- Model self care behavior
- Ongoing focus on quality management and quality improvement
- Celebration of successes/positive outcomes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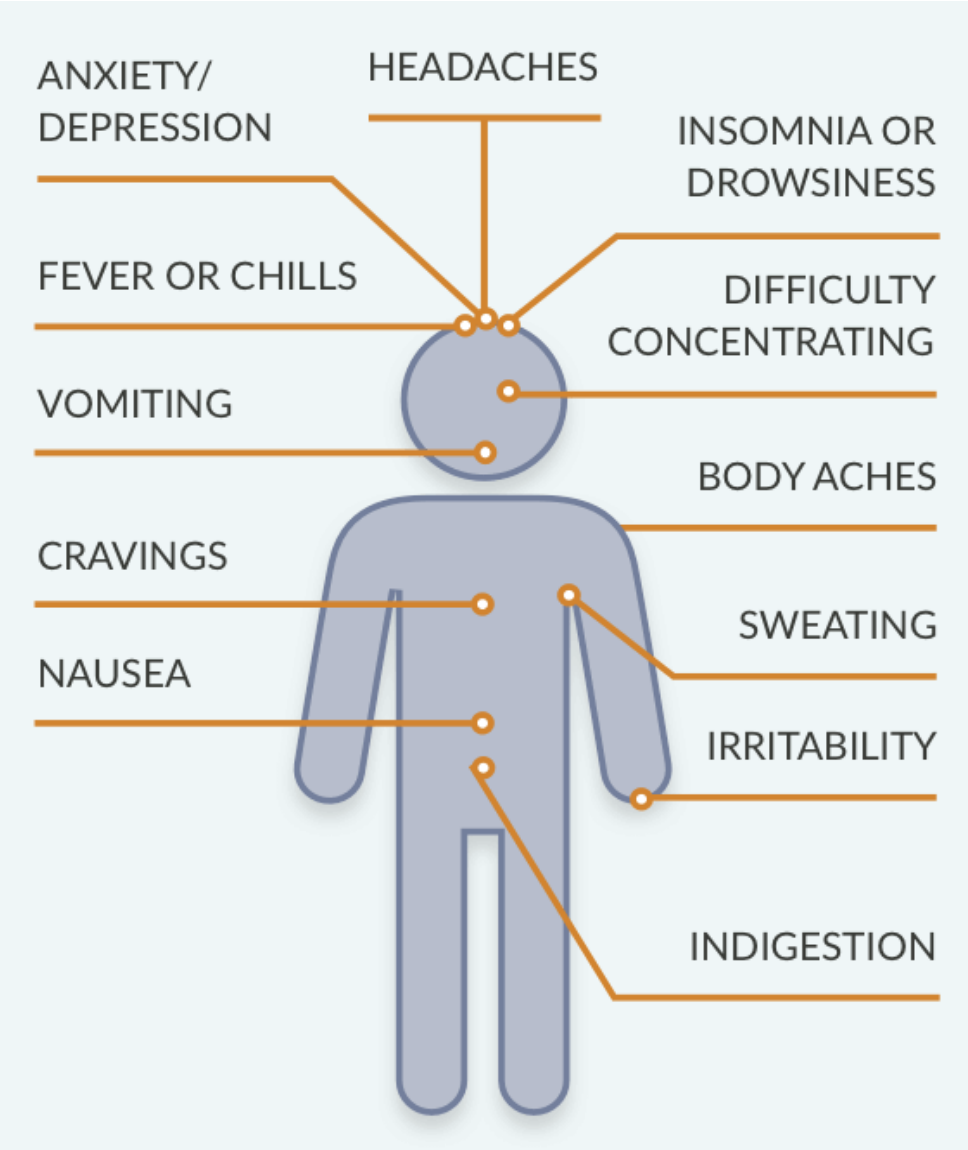
MEETING DETAINEES WHERE THEY ARE FOR TREATMENT
HEALTH MANAGEMENT ASSOCIATES

INITIAL PHASE OF TREATMENT

Stimulant withdrawal symptoms can last 2-3 weeks or more

- Decline in energy and cognitive functioning
- Fatigue
- Depression
- Anxiety
- Stomach cramps
- Sweating
- Cravings

The engagement opportunity at this time is to address these symptoms



NOT THE BEST TIME TO START A MANUALIZED TREATMENT GROUP!

- There are many evidence based psychosocial treatments
- However, **TIMING IS EVERYTHING**!
- Imagine having someone invite you to a full hour of group where you have to be able to listen, contribute meaningfully, and sit still . . .

HOW TO ENGAGE

- Effective engagement is critical
  - Trauma Informed Principles (Be kind to the client - Be kind to yourself)
  - Motivational Interviewing (Empathy and Ambivalence to Change)
  - Be aware of your own judgments, stigma, and bias
  - Engage the client where they are now

"People will forget what you said. People will forget what you did.
But people will never forget how you made them feel."
– Maya Angelou

BREAK OUT SESSION 1

Discuss Mary's experience at County X with the information that has been provided

- What opportunities do you see with Mary to improve engagement and support stability while she is incarcerated?
- What is County X doing well right now?
- What could they do to improve?

BEYOND WITHDRAWAL: REVIEW OF TREATMENTS

In previous webinars we have discussed evidence-based treatments, including:

- Motivational Interviewing
- Community Reinforcement Approach
- Contingency Management
- Cognitive Behavioral Therapy

These are available on the website at:

Webinar: Behavioral Interventions for Justice-Involved Individuals with Stimulant Use Disorders: Part I (4-27-2021): https://vimeo.com/542751375/30a3c368af

Webinar: Behavioral Intervention for Justice Involved Individuals with Stimulant Use Disorders: Part II (5/3/21): https://vimeo.com/545545293/617c92f860

Webinar: Brief Interventions Everyone - Not Just BH Staff or Clinicians! - Can Use to Support SUD Recovery and Personal Wellness Webinar (6-9-2021): https://vimeo.com/561389521/dab67c8bbd

WHAT THEY ALL HAVE IN COMMON

ADDITIONAL CONSIDERATIONS

The length of the treatment episode is a Protective Factor against relapse. Therefore, it is important that treatment is initiated and maintained throughout

Questions:

- What can be done to engage clients with treatment as early as possible – an invitation once every six weeks to participate in group is insufficient
- How can you use the principles of Motivational Interviewing and work from the stages of change apart from manualized groups?
- Think beyond the "usual suspects" for MI: Who from the jail team can engage with Motivational Interviewing

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4550209/

FACTORS THAT SUPPORT TREATMENT ENGAGEMENT

Captive Audience

Motivated by Legal Consequences

Boredom – Willing to initiate treatment to deal with the monotony of jail

BARRIERS TO TREATMENT IN JAILS

- Lack of Trust
- Cognitive Issues
- Long Withdrawal Recovery Period
- Space
- Scheduling
- Staff Resources

SUPPORTING EFFECTIVE TREATMENT

- To effectively provide treatment in jails
  - Identify staff resources
  - Consider whether there can be reinforcements (Contingency management)
    - If so, what would be the target behaviors?
    - Is attendance enough (possible reinforcements)?
    - Participation (possible reinforcements, and participation measures)?
    - Be creative! Positive reinforcement can come in many forms, especially in a tightly controlled environment

SOME EXAMPLES OF REINFORCEMENT

We know treatment works!

Can incarcerated persons be offered reinforcement for participating in treatment?

Examples:

- Extra recreation time
- Extra time to use tablets
- Commissary (think about how this can be funded)

CONTINUOUS QUALITY IMPROVEMENT

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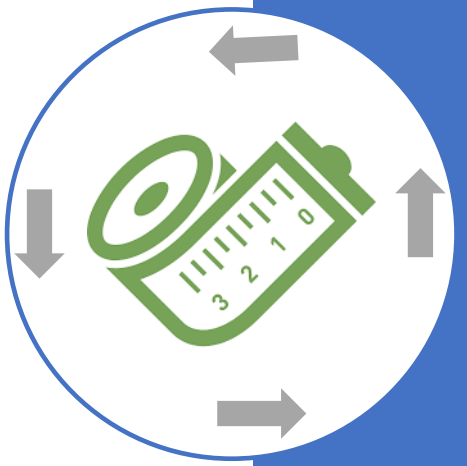
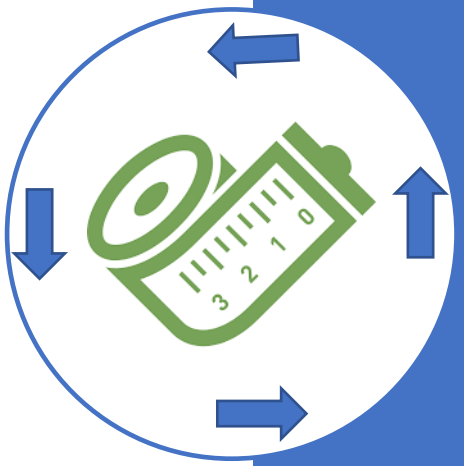
- How do you know your treatment is working? Need to be able to “make the case”
- Why is this important?
  - Behavioral therapies can be considered extras or "just being nice" to inmates
  - Providing treatment means more work for everyone, including custody staff
  - An ability to show that your treatment works helps to address barriers and limitations on treatment as well as addresses burnout among staff – seeing results is great for morale!



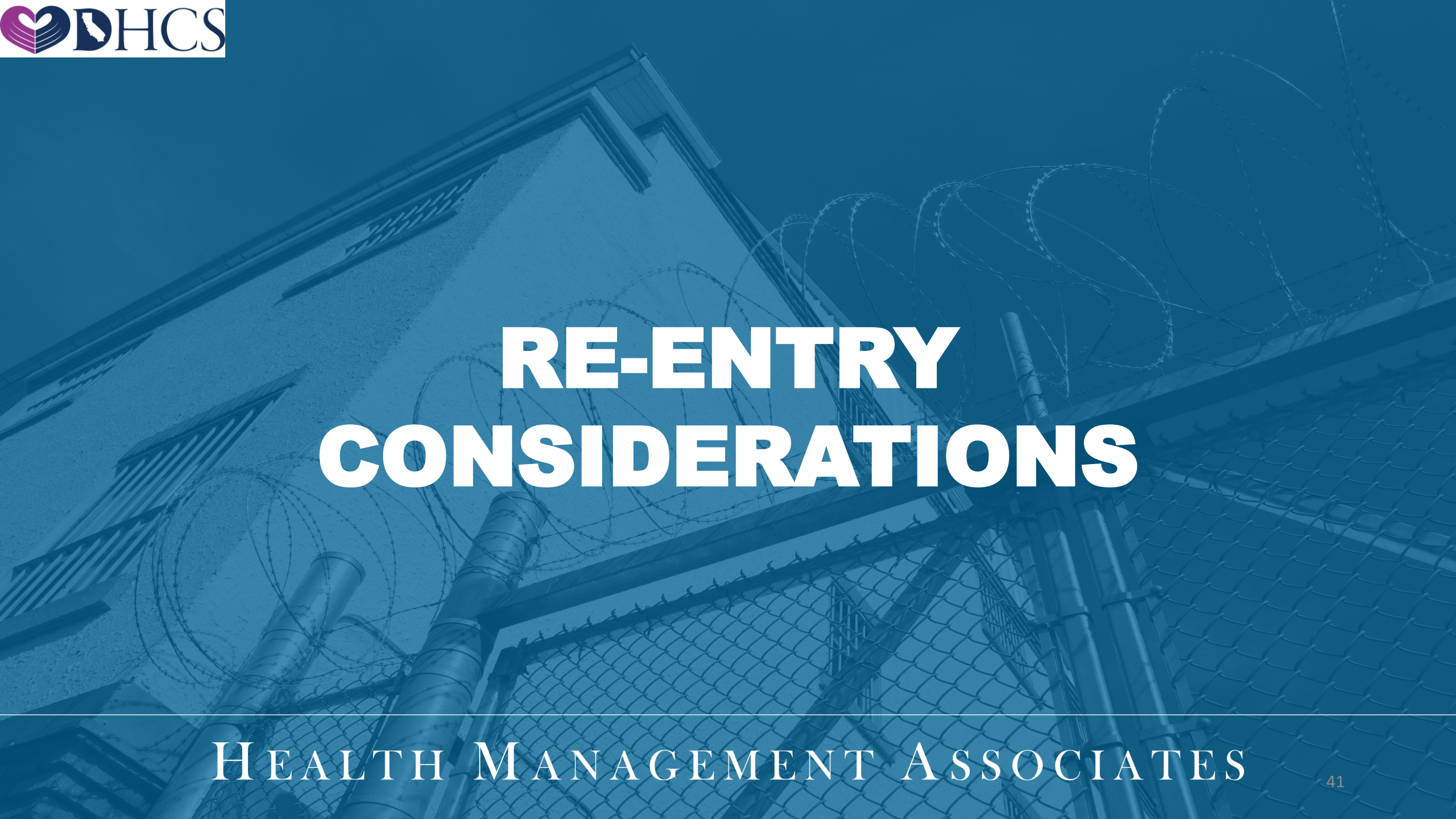
CONTINUOUS QUALITY IMPROVEMENT (CONSIDERATIONS)

- Decide on a metric
  - Pre/Post Tests
  - Reduced Behavioral Write-ups
  - Recidivism



CHATTERFALL

What other metrics and behavioral measures can be used to assess or indicate your treatment is working?



RE-ENTRY CONSIDERATIONS

PROTECTIVE FACTORS

- Over 60% of StUD clients relapse
- Protective Factors are:
  - Length of indexed treatment
  - Participation in self-help groups after the treatment episode
- QUESTION
  - How can this be arranged prior to release?
    - Reentry Referrals to Treatment
    - In-reach services to support engagement with community providers
    - Working with probation so that treatment is a part of supervision
    - Consistent treatment approach and curricula from jail to community

Source: Brecht, M and Herbeck, D. (2014) Time to relapse following treatment for methamphetamine use: a long-term perspective on patterns and predictors Drug Alcohol Depend. 2014 Jun 1; 139: 18–25.

REINFORCING SUCCESS

- What can be in place during incarceration to reinforce protective factors?
  - Educate clients
  - Knowledge sharing: collaboration among in-custody and community providers
  - Engagement with Probation

REINFORCING SUCCESS

- Consider what you have learned and accomplished with implementing MAT for Opioid Use Disorder
- Broad lessons RE: Change Management and Integrated/Evidence Based Care apply to StUDs as well, even if treatment approaches vary
  - Identifying a responsible team
  - Engaging Champions, Ambassadors and Allies
  - Creating a Community Standard of Care with the jail as a part of the community safety net

BREAK OUT SESSION 2

QUESTION:

- What do you see as a possible/realistic goal for the improvement of StUD treatment in your jail over the next six months?
- What are the obstacles?
- How can you address those obstacles?

POLLING QUESTIONS

1. Overall, today's training was:
   A. Very useful
   B. Somewhat useful
   C. Not very useful
   D. Not useful at all

2. The material presented today was:
   A. At the right level
   B. Too basic
   C. Too detailed

CONTACT US

FOR ANY QUESTIONS OR COMMENTS

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