MAT Medications in Criminal Justice Settings

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INTRODUCTION TO THE HMA TEAM



HEALTH MANAGEMENT ASSOCIATES



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WEBINAR SPONSOR

- + This webinar is presented under the STR-funded project Expanding Access to Medication Assisted Treatment in County Criminal Justice Systems
- + The project currently supports teams from 23 counties to expand access to at least two forms of MAT in jails and drug courts.
- + Up to 20 additional counties will be eligible to participate in this project in early 2019
- + Information on the project and a library of MAT resources can be found on the project website:
 - + https://MAT inCountyCJ.healthmanagement.com

OBJECTIVES

Participants can....

- + Identify three major medications used to treat opioid disorders
 - + Means of action
 - + Best candidates
 - + Outcomes/effectiveness
- + Understand implications of the use of each type of medication in prisons and jails
 - + Potential for diversion
 - + Prescribing and obtaining the medications
 - + Cost
- Describe best practices to overcome challenges of providing MAT in correctional settings

AGENDA

- + Opioid addiction as a brain disease
- + Treatment objectives
- + Medications
 - + Methadone
 - + Buprenorphine (Sublingual, Injectable and Implantable)
 - + Naltrexone (oral tablets, injectable Vivitrol)
- + Naloxone (Narcan) for treating overdose

Chronic pain

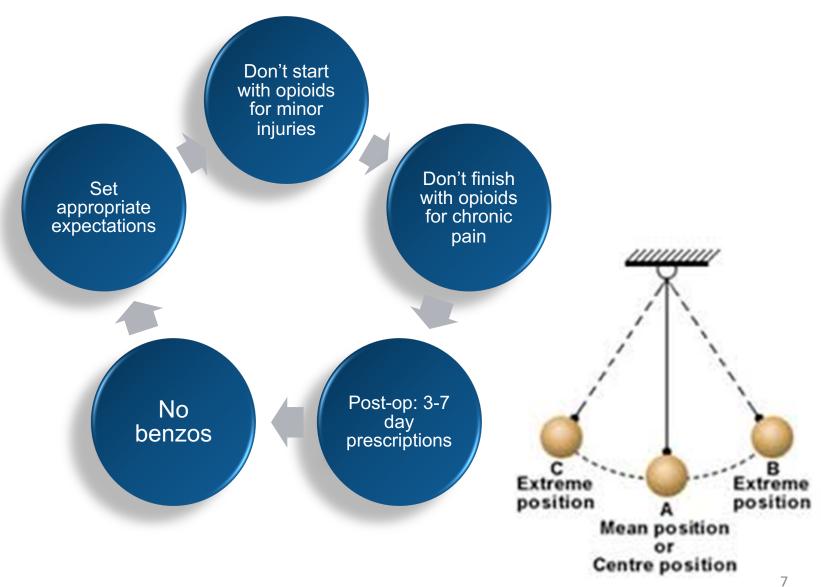
Push by manufacturers for use of opioids in NCCP

Buy-in from the Medical field

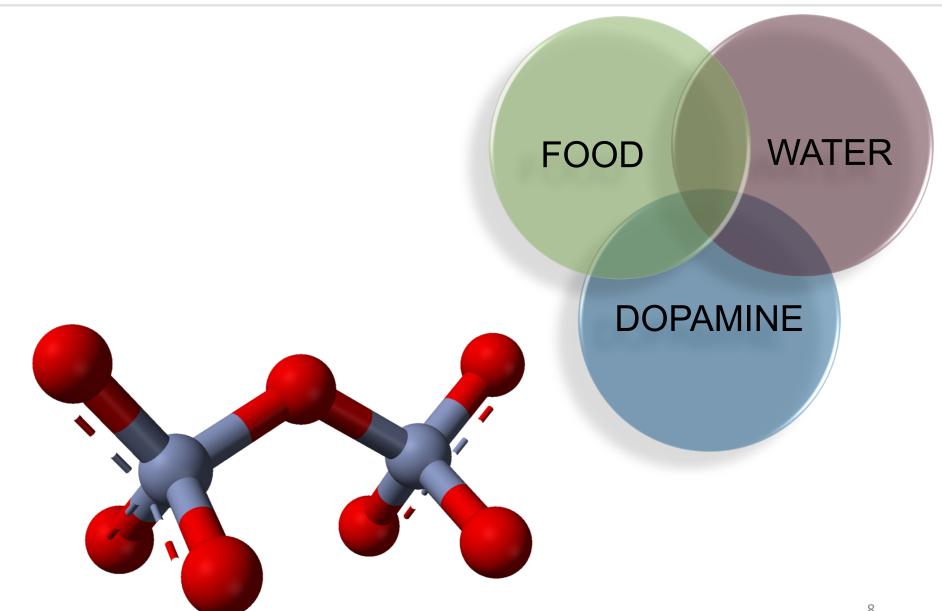
- + Pain as 5th vital sign
- + Expectation of no pain

Blind eye to the data

SAFE OPIOID PRESCRIBING

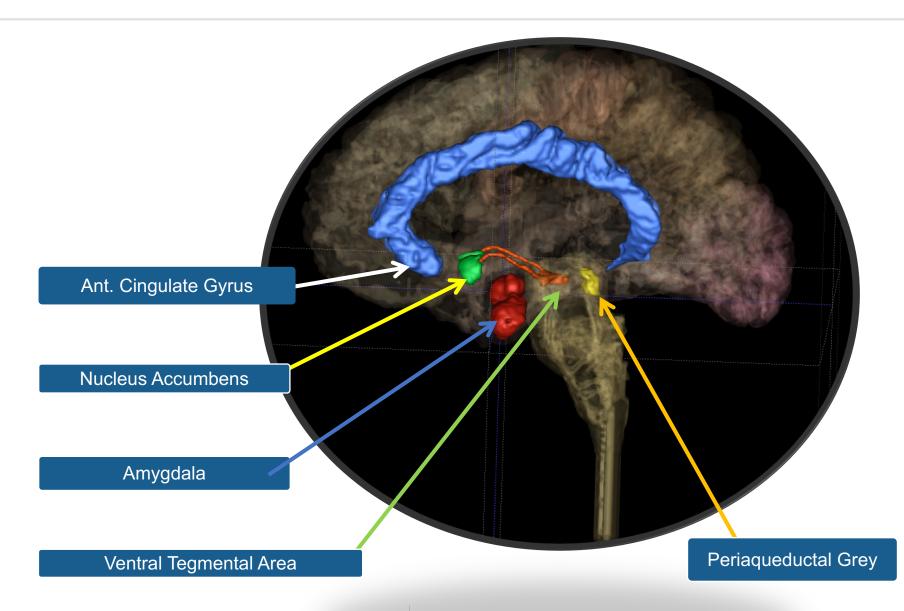


SURVIVAL

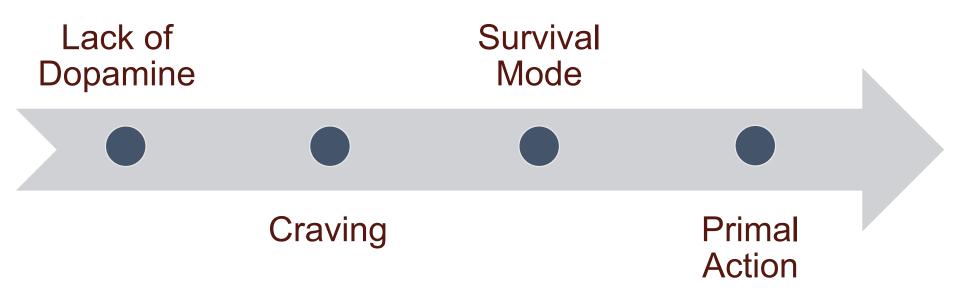




■ **NEUROBIOLOGY OF** ADDICTION



BEHAVIOR



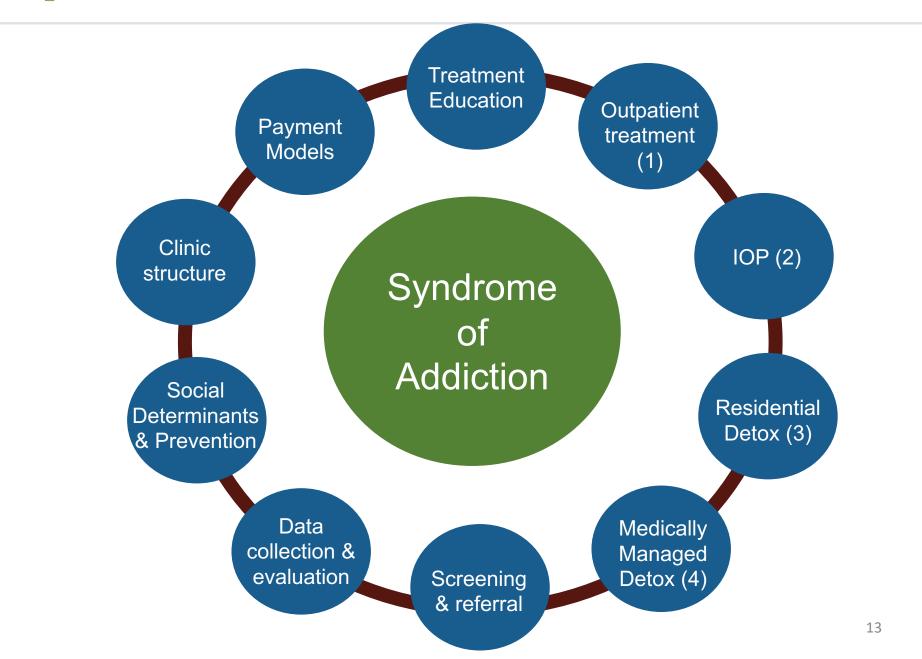
■ **DSM-5** DIAGNOSTIC CATEGORIES

TABLE 1

Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

Category	Criteria
Impaired control	 Opioids used in larger amounts or for longer than intended Unsuccessful efforts or desire to cut back or control opioid use Excessive amount of time spent obtaining, using, or recovering from opioids Craving to use opioids
Social impairment	 Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky use	 Opioid use in physically hazardous situations Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use
Pharmacological properties	 Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

SYNDROME OF ADDICTION



JAILS AND PRISONS HELD TO COMMUNITY STANDARD OF CARE

- + National Commission on Correctional Health Care, American Correctional Association, National Sheriffs Association, and many others have position statements supporting treatment of opioid addiction with all FDA-approved forms of MAT
- + DOJ statement that refusing to treat opioid addiction in corrections is a violation of the Americans with Disabilities Act, current prosecutions underway
- + Refusing to continue treatment of an addiction started in the community is unethical and dangerous
 - + Overdose death following release is 14 times higher
- + Nonetheless, providing MAT in prisons and jails presents some very real challenges. The good news is that there are emerging best practices that address all these challenges.

CATEGORIES OF MAT FOR OUD

METHADONE
full agonist
activates opioid
receptors which
eliminates craving for
other opioids

partial agonist
activates opioid
receptors in the brain,
but to a much lesser
degree, which reduces
craving for other opioids

antagonist
blocks opioid receptor
without activating it
which eliminates opioid
effect if opioids are taken

METHADONE AGONIST

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WHO IS APPROPRIATE FOR METHADONE?

- + Patients with greater than a year of OUD
- + Patients who have been injecting opioids
- + Patients who have transportation available
- + Patients with a more severe OUD

■ METHADONE – GENERAL REGULATIONS FOR

OPIOID TREATMENT PROVIDER (OTP) / NARCOTIC TREATMENT PROGRAM (NTP)

Delivered via observed dosing through licensed NTP/OTP Once patient is stable and after 6 weeks, can give take-home doses (varies by state)

NTP/OTP highly regulated by federal and state government

Many requirements for treating patients

LICENSED METHADONE CLINIC REQUIREMENTS



- + Required counselling for substance use disorders (not synonymous with psychotherapy for mental health issues)
- + Documented full treatment planning
- + Diversion control processes
- + Drugs screens (urine, oral swabs). Drug testing for confirmations if necessary.
- + Urine collections may be observed or unobserved.
- + Call backs for both random urine drug screens (UDS) and to check that any take home medications are accounted for

The most studied of the three medications

Retention in treatment is the main outcome and has ranged between 60 and 80% among RCTs

Possibly due to combination of high intensity treatment and medication

Still standard of care for patients with Severe Opioid Use Disorder

RETENTION IN METHADONE TREATMENT IS ASSOCIATED WITH:

- Reduction in the use of illicit drugs
- Reduction in criminal activity
- Reduction in needle sharing
- Reduction in HIV infection rates and transmission
- Reduction in commercial sex work

- Reduction in the number of reports of multiple sex partners
- Improvements in social health and productivity
- Improvements in health conditions
- ☑ Retention in addiction treatment
- ☑ Reduction in suicide
- ☑ Reduction in lethal overdose

METHADONE FORMS

- + Dose formulation is usually liquid, or 40 mg tablet wafers and/or 5 mg pills
- + 10 mg pills may not be provided by OTPs
 - 10 mg pills found on the street were therefore initially prescribed for pain, not dispensed by OTPs.
 - This has allowed the CDC to state clearly that the vast majority of diverted methadone is not coming from OTPs

METHADONE PARTICULARS

- + As the dose goes up, so does retention in treatment
 - + Best dose range 90-120 mg
 - + Not considered therapeutic until at least 60 mg per day
- + Common misunderstanding: if you are on methadone you are covered for pain
 - + Methadone for pain is 3x/day
- + Illegal to write prescription for methadone to treat OUD unless covering a gap in treatment under "emergency prescribing"
 - + This allows jail providers to prescribe methadone for up to 3 days while arrangements for longer term treatment through OPT are established

METHADONE IN JAILS AND PRISONS

- + Provider can write up to 72 hours of emergency methadone while community arrangements are made; must verify dose with NTP
- + Correctional settings can be licensed OPTs larger facilities especially
- Correctional settings can have Medication Unit on site under authority of licensed NTP
 - + Can store stock methadone (rather than doses that are patient-specific)
- + NTPs can bring patient-specific doses to jail every day
- + Jail can transport detainee to NTP site for daily dosing
- Potential for diversion low based on patient's need but high based on coercion
 - + Urine screens important to verify ingestion
- Most facilities use separate medication line, based on who is administering the medication (i.e., on-site staff or OTP staff) and storage requirements

CAVEATS

Not available in many rural areas

Despite having the best outcomes, it has the highest level of stigma

Requires good geographic association to patients

Hard to get patients off after a few years of treatment

Any provider
authorized to
prescribe controlled
substances can
prescribe
methadone for
treatment of pain

BUPRENORPHINE PARTIAL AGONIST

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BUPRENORPHINE

- + Approved in the 1990s for pain via an injectable form
- + Approved in 2000 for use in maintenance treatment for OUD
- **+** Now Multiple Forms
 - Sublingual tablet (under the tongue, dissolves very slowly)
 - Sublingual film (under the tongue, dissolves slowly)
 - Buccal Film (between gum and cheek, dissolves immediately)
 - Sublingual oral dissolvable tablet
 - Implantable rods (last six months)
 - Long acting injectable (last 30 days)

■ WHO IS APPROPRIATE FOR COMMUNITY BUPRENORPHINE?

POSITIVE DSM 5
WITH A SCORE OF
2 OR GREATER

POSITIVE DAST (6 OR GREATER) FOR OPIOIDS

CAN MAKE IT TO CLINIC FOR EVALUTION

CAN AFFORD THE MEDICATION

■ WHO CAN PRESCRIBE BUPRENORPHINE FOR OUD?



- + Physician takes 8 hour course
- + Nurse Practitioner or Physician Assistant takes 24 hour course
- Apply for DATA 2000 ZX Waiver from Drug Enforcement Agency
 - + 30 patients in first year then can apply to go to 100
 - + Can be allowed up to 275 patients under certain circumstances
- + Any provider authorized to prescribe controlled substances can prescribe buprenorphine for treatment of pain, without a waiver

OUTCOMES AT
1 YEAR HAVE
RANGED FROM
45% TO 65%
USING THE
SUBLINGUAL
MEDICATION

HIGH DEGREE
OF VARIABILITY
IN THE
DELIVERY
MODELS AND
PATIENT
SEVERITY

BUPRENORPHINE IN JAILS AND PRISONS

- + Must be started within 48 hours of intake to prevent withdrawal
- + Potential for diversion low based on patient's need but high based on coercion
 - + Urine screens important to verify ingestion
- May use separate medication line because of lengthy time required for drug to dissolve
- + Buvenex film dissolves immediately on cheek
- + Injectable form is expensive
 - + Eliminates movement and diversion



Buccal film that dissolves immediately has extremely low diversion potential; may be optimal for prison/jail

NALTREXONE ANTAGONIST

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PATIENTS WITH A
HIGH DEGREE OF
MOTIVATION
(DOPAMINE)

PATIENTS WHO
HAD POOR
RESULTS WITH
METHADONE OR
BUPRENORPHINE

PATIENTS LEAVING THE CRIMINAL JUSTICE SYSTEM WITH A HISTORY OF OUD & AUD

REGULATIONS: NALTREXONE



- + No Federal regulations inhibit the use
- + Some payer restrictions make it difficult to obtain the long acting injectable form
- + Newer implants not FDA approved

THE LEAST
STUDIED OF THE
THREE
MEDICATIONS

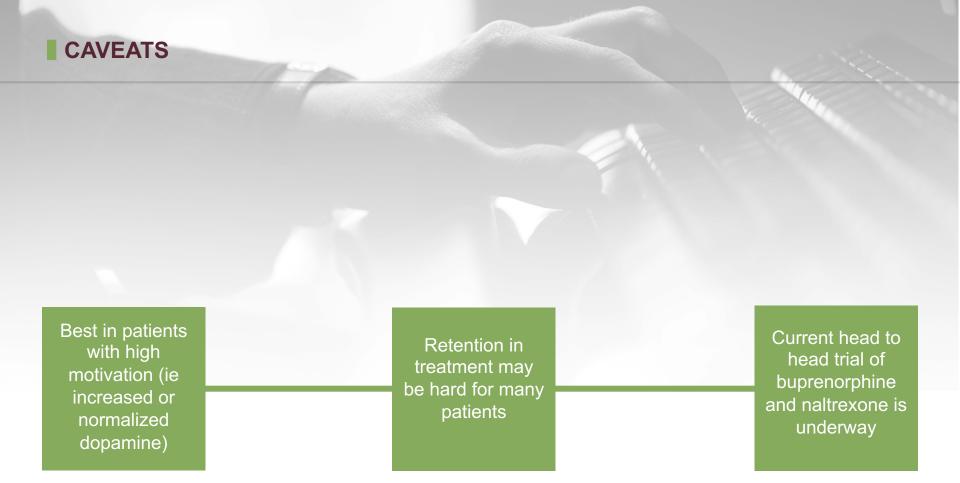
RETENTION IN
TREATMENT IS THE
MAIN OUTCOME AND
HAS RANGED
BETWEEN 23-60%
DEPENDING
ON STUDY

INJECTION HAS
BETTER
RETENTION THAN
ORAL PILLS

IMPLANT SEEMS
TO SHOW
PROMISE
HOWEVER NEEDS
MORE STUDY

NALTREXONE IN JAILS AND PRISONS

- + Must conduct drug screening before starting; cannot start if opioids are in use
- + Can convert from injectable (in the community) to oral form while in jail
 - + Restart injectable at release (if release planning supports this)
- + Little potential for diversion



CONCLUSIONS



- + Methadone and Buprenorphine seem to have no difference if efficacy whether patient is injecting or using oral opioids
- + Up to 58% of patients on methadone maintenance want to be drug free and 85% of those are open to Naltrexone
- + Naltrexone is underutilized in patients who are motivated and/or in the criminal justice system
- + So, every patient needs treatment customized to his/her needs

■ WHAT TO DO WHEN PEOPLE ON MAT TEST POSITIVE FOR OTHER DRUGS.....

- + Possibly not receiving sufficient dose of MAT
- + Possibly diverting MAT and using other drugs
- + Relapse is expected in OUD recovery process
- + Other....

NALOXONE / NARCAN

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NALOXONE/NARCAN FOR OPIOID OVERDOSE

- + Data on overdose deaths after incarceration
- + Increase in in-custody deaths from fentanyl-laced illicit drugs
- + Naloxone should be in every health care jump bag
- + Naloxone should be readily available to custody officers
- All health care and custody staff should be trained to use naloxone
 - + It's easy, fast, fool-proof and you can't do it wrong
- + CA Dept of Health Care Services giving \$22 million in free naloxone kits jails eligible for unlimited amount
- All detainees with OUD should receive naloxone kit at release lots of examples on how to operationalize
- Best practice: Jail makes naloxone and training available to all visitors
- + Best practice: Naloxone is available in all drug court settings

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