COMBATING THE OPIOID EPIDEMIC UTILIZING MEDICATION ASSISTED TREATMENT

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Disclosures

None of the planners, moderators or presenters of this continuing education activity, have any financial relationships to disclose relating to the content of this activity

Learning Objectives

- Identify intervention strategies and continuity of care to promote better outcomes for SUD individuals reentering the community.
- Identify individuals to build a comprehensive multidisciplinary team model.
- Understand the assessments, screenings, clinical interventions and protocols for offenders used by MA DOC.
- Understand challenges and mitigation regarding implementation of the Pathfinder Program.

Medication Assisted Treatment

What is Medication Assisted Treatment?

- Medicated Assisted Treatment (MAT) combines medications with counseling and behavioral therapies, monitoring, community-based services, and recovery support to treat the bio-psychosocial aspects of alcohol and opioid use disorders.

- MAT ***assists***, not replaces, other treatment and recovery efforts.

FDA Approved Drugs for MAT

Medication	How it Works	Medication Administration	Dosing Frequency	Access to Medication
Methadone	Full Agonist	Pill, Liquid	Daily	Opioid Treatment Program (OTP)
Buprenorphine	Partial Agonist	Pill, Film (placed under the tongue, inside cheek)	Daily	A prescriber with the appropriate waiver
		Implant (inserted beneath the skin)	Every six months	
Naltrexone	Antagonist	Oral	Daily	Any health care provider with prescribing authority
		Extended-release injectable	Monthly	

Why MAT?

- Substance use disorders are overrepresented in the correctional system population
- Decreases incidents of relapse and subsequently reduces recidivism
- Addresses public health crisis related to opioid use and death immediately post-release
- Improves retention in treatment, increases access to health treatment and health education
- Reduced risk of infectious diseases such as HIV/AIDS and Hepatitis C
- Treatment with medication for a period of 12 months or more is recommended if the brain is to repair its ability to regulate stress, pain and mood for sustained abstinence.

MAT vs DETOX

MAT

- MAT helps to counter the negative effects of withdrawal rarely results in long term abstinence.
- MAT has been shown to reduce costs over those who go through straight detox
- MAT is one part of the treatment modality
- MAT offers a physiological and behavioral treatment approach

DETOX

- Detox clears substances of abuse from the body
- Detox adjusts treatment based on individual's physiological response to withdrawal from toxins
- Detox is short term treatment, but preventing relapse is extremely difficult

Evidenced Based vs Belief

- MAT is severely underutilized, including in correctional treatment programs, for practical and philosophical reasons. Prisons/Jails are concerned with contraband and some have found buprenorphine (FDA approved medication) to be a drug of abuse, not promised cure.
- Belief is that inmate detoxed and clean in prison/jail, why encourage him/her to put drugs back into his/her body?
- Being evidence-based means being driven by objective analyses of research. If the data show that medication works to contribute to recovery and public safety, we must set aside personal opinions and bias.

What the experts say

- “When prescribed and monitored properly, medications … are safe and cost-effective components of opioid addiction treatment. These medications can improve lives and reduce the risk of overdose, yet medication-assisted therapies are markedly underutilized.”
- NIDA Director, Nora Volkow, M.D.
- “Our prison policies are failing half of the time, and we know that there are more humane alternatives—especially alternatives that do not involve spending billions more on more prisons—it is time to fundamentally rethink how we treat and rehabilitate our prisoners.” —
- Newt Gingrich, April 7, 2011, 58th Speaker of the House, U.S. House of Representatives

Joint Policy Statement

- American Correctional Association and American Society of Addiction Medicine Release Joint Policy Statement on Opioid Use Disorder Treatment in the Justice System
- MARCH 20, 2018
- Statement supports access to all evidence-based treatment options
- The American Correctional Association (ACA) and the American Society of Addiction Medicine (ASAM) released today a Joint Public Correctional Policy on the Treatment of Opioid Use Disorders for Justice Involved Individuals. The statement includes recommendations to support correctional policy makers and correctional healthcare professionals in providing evidence-based care to those in their custody or under their supervision who have an opioid use disorder.

JOINT PUBLIC CORRECTIONAL POLICY ON THE TREATMENT OF OPIOID USE DISORDERS FOR JUSTICE INVOLVED INDIVIDUALS

2018-2

Introduction:

Seventeen to nineteen percent of individuals in America's jail and state prison systems have regularly used heroin or opioids prior to incarceration.[i] While release from jail and prison is associated with a dramatic increase in death from opioid overdose among those with untreated opioid use disorder (OUD), there are considerable data to show that treatment with opioid agonists and partial agonists reduce deaths and improves outcomes for those with opioid use disorders.[ii,iii] Preliminary data suggest that treatment with an opioid antagonist also reduces overdose.[iv] As a result, the 2017 bipartisan Presidential Commission on "Combating Drug Addiction and the Opioid Crisis" has recommended increased usage of medications for addiction treatment (MAT) in correctional settings.[v]

Policy Statement:

The American Correctional Association (ACA) supports the use of evidence-based practices for the treatment of opioid use disorders. ACA and the American Society of Addiction Medicine (ASAM) have developed recommendations specific to the needs of correctional policy makers and healthcare professionals. These recommendations will enable correctional administrators and others, such as community corrections, to provide evidence-based care to those in their custody or under their supervision that have opioid use disorders.

ASAM recently published a document entitled *The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*[vi] that includes treatment recommendations specifically for individuals in the justice system. Pharmacotherapy, behavioral health treatment, and support services should be considered for all individuals with OUD that are involved in the justice system.

ACA and ASAM recommend the following for correctional systems and programs:

A. Screening/Prevention

1. Most deaths from overdose occur during the first few days following intake to the correctional facility. Screen all incoming detainees at jails and prisons using screening tools with psychometric reliability and validity that provide useful clinical data to guide the long-term treatment of those with OUD and with co-occurring OUD and mental disorders. Opioid antagonist (naloxone) should be available within the facility and personnel should be trained on its use.
2. Pre-trial detainees screened upon entry that are found to be participating in an MAT program to treat OUD and who are taking an opioid agonist, partial agonist, or antagonist should be evaluated for continuation of treatment on that medication, or a medication with similar properties. There are effective models for continuing treatment with each of these medications in the justice system.
3. Pre-trial detainees and newly admitted individuals with active substance use disorders who enter with or develop signs and symptoms of withdrawal should be monitored appropriately and should be provided evidence-based medically managed withdrawal ("detox") during the period of withdrawal. Validated withdrawal scales help gauge treatment. Several medications have been shown to improve withdrawal symptoms.

B. Treatment

1. All individuals who arrive into the correctional system who are undergoing opioid use disorder treatment should be evaluated for consideration to continue treatment within the jail or prison system. Individuals who enter the system and are currently on MAT and/or psychosocial treatment should be considered for maintenance on that treatment protocol.
2. Treatment refers to a broad range of primary and supportive services.
3. The standard of care for pregnant women with OUD is MAT and should therefore be offered/continued for all pregnant detainees and incarcerated individuals.
4. All individuals with suspected OUD should be screened for mental health disorders, especially trauma-related disorders, and offered evidence-based treatment for both disorders if appropriate.
5. Ideally, four to six weeks prior to reentry or release, all individuals with a history of OUD should be re-assessed by a trained and licensed clinician to determine whether MAT is medically appropriate for that individual. If clinically appropriate and the individual chooses to receive opioid use disorder treatment, evidence-based options should be offered to the individual.
6. The decision to initiate MAT and the type of MAT treatment should be a joint decision between the provider and individual who has been well informed by the trained and licensed clinician as to appropriateness of the therapy, as well as risks, benefits, and alternatives to this medical therapy. MAT should not be mandated as a condition of release. In choosing among treatment options, the individual and provider will need to consider issues such as community clinic or provider location/accessibility to the individual, insurance access or type and medical/clinical status of the individual.
7. Treatment induction for the individuals who choose treatment for opioid use disorder (MAT) should begin 30 days or more prior to release, when possible.

C. Reentry and Community Supervision Considerations

1. All individuals returning to the community who have an OUD should receive education and training regarding unintentional overdose and death. An opioid antagonist (naloxone) overdose kit or prescription and financial means (such as insurance/Medicaid) for obtaining the kit may be given to the individual, along with education regarding its use.
2. When possible, an opioid antagonist (naloxone) and overdose training should include the individual's support system in order to provide knowledge about how to respond to an overdose to those who may be in the individual's presence if an overdose does occur.
3. Immediate appointment to an appropriate clinic or other facility for ongoing treatment for individuals returning to the community with substance use is critical in the treatment of opioid use disorder. As such, ideally the justice involved population's reentry needs should be addressed at least 1 to 2 months prior to release in order to avoid any interruption of treatment.
4. Reentry planning and community supervision should include a collaborative relationship between clinical and parole and/or probation staff including sharing of accurate information regarding MAT.
5. Parole and probation staff should ensure that residence in a community-based halfway house or similar residential facility does not interfere with an individual's treatment of OUD with MAT.

D. Education

1. Scientifically accurate, culturally competent, and non-judgmental training and education regarding the nature of OUD and its treatment should be provided to all justice system personnel including custody officers, counselors, medical personnel, psychologists, community supervision personnel, community residential staff, agency heads and leadership teams.
2. This training should include education about the role of stigma involving substance use disorders and the subtle but very real impact that stigma has on those suffering from substance use disorders and those treating them.

This Joint Public Correctional Policy was unanimously ratified by the American Correctional Association Delegate Assembly at the 2018 Winter Conference in Orlando, FL. on Jan. 9, 2018.

[i] BJS. (2017, June). Special Report. Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009.
[ii] Binswanger IA, Blatchford PJ, Mueller SR, and Stern MF. Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009. Ann Intern Med 2013 Nov 5; 159(9): 592–600.
[iii] Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ 2017;357:j1550
[iv] Lee JD, Friedmann PD, Kinlock TW, et al. Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders. N Engl J Med 2016;374:1232-42.
[v] https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf
[vi] ASAM. National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (ASAM, 2015).

Intervention Strategies

Challenges

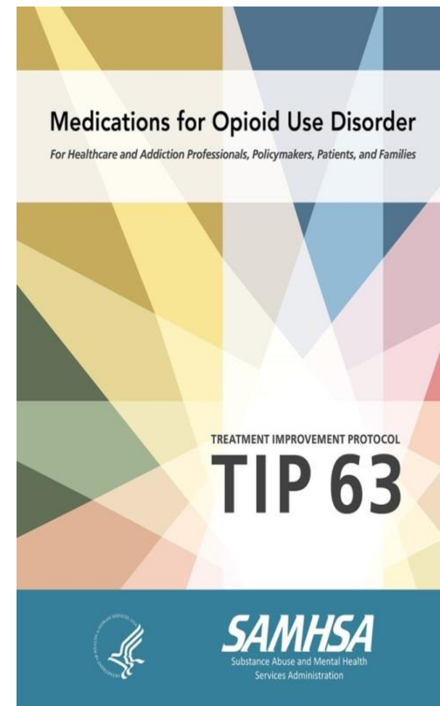
- Culture Change for Correctional System
- Resources – Staffing, Security, Physical Pla
- State and Federal Regulations
- Induction to Relapse
- Reentry
- Recidivism
- Community Engagement

Challenge: Culture Shift

The use of Medication Assisted Treatment shifts prison based substance use treatment from a strict evidence based public safety model to a hybrid that incorporates the elements of a public health approach.

Challenges: Resources

- Federal and State Regulations
  - OTP
  - SAMHSA: TIP 63: Medications for Opioid Use Disorder
- Local State Jurisdictional Policies
- ACA
- Correctional System Regulations
- Physical plant
- Fiscal impact
- Staffing
- Location
- Operational Impact

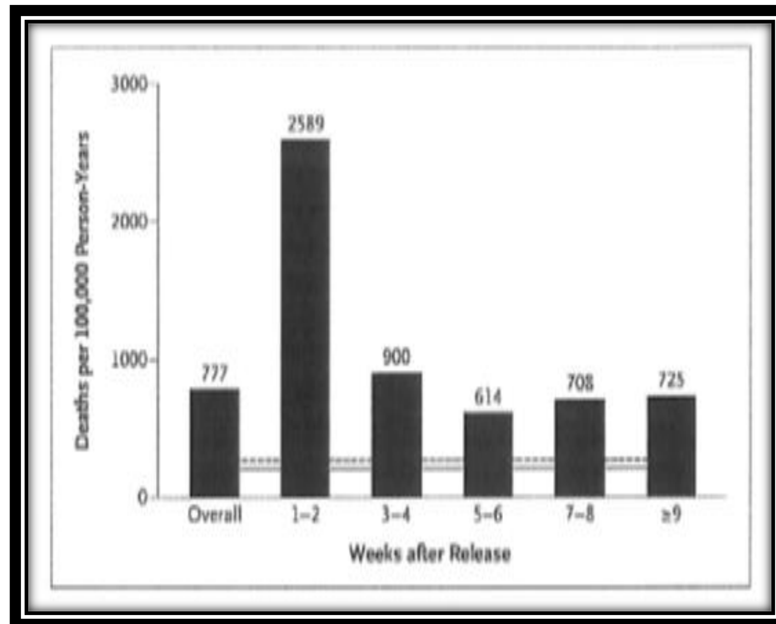


Challenge: Reentry

- Alcohol and drug addiction are major drivers of recidivism that affect up to 70% of offenders; 50% with substance/alcohol use disorders relapse within a month of release.
- Aftercare is effective
- Aftercare with MAT is more effective

Reentry Death Rate from Drug Overdose

- Within 2 weeks of release, ex-inmates are nearly 129 times at greater risk for death by drug overdose than the general population of same demographics.



Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. Release from prison-a high risk of death for former inmates. N Engl J Med. 2007;356(2):157–165.

Implementation

Assessments, Interventions and Protocols

- Initial Intake and Assessment
- Self Report and Verification
- Texas Christian University (TCU) Drug Screen (TCUD)
- Drug Abuse Screening Test, DAST-10
- Mental Health Screening
- Addictionologist Assessment

Multidisciplinary Team Model

- ✓Correctional Staff
- ✓Counselor
- ✓Medical Provider
- ✓Reentry –Probation, Parole
- ✓Family and Friends
- ✓Religious Groups
- ✓Community Clinical Partners (MAT/OTP, Doctor, Mental Health Provider)
- ✓Employer
- ✓Housing Manager
- ✓Community Case Worker
- ✓Medicaid, Medicare, Department of Public Health, Police Department, Courts

Offender needs to be included in his/her own plan to be successful

Recovery Support Navigators (RSNs)

- Recovery Support Navigators (RSN) coordinate with Medical Discharge Planners to facilitate referrals to community based clinics and assist in the development of the inmate's post release substance use treatment plan. This may include linkages to faith based organizations, mentors, parole and probation.
- These staff play a key role in developing a community network of providers and volunteer agencies to assist the offender once released into their community.
- Strengthening existing partnerships with community-based agencies and creating new ones improves the continuity in our continuum of care model in an effort to sustain reentry success and reduce recidivism.

RSNs – Family Engagement

- RSNs discuss the importance of family and social support networks;
- Offenders complete a Release of Information form for all family/support persons he/she would like to have contacted.
- During the offender’s last appointment prior to release, the Recovery Support Navigator facilitates a phone call between the client, family/support person, and Recovery Support Navigator to discuss release planning.

RSNs Post-Release

- 90 Day Meeting Procedure and Expectations
-
- Month 1: Requires a minimum of three points of contact per week with at least one of those contacts being a face-to-face meeting.
- Month 2-3: Requires a minimum of three points of contact per week. At least one point of contact per week should be a face-to-face meeting when possible. Face-to-face contact is required at a minimum of bi-weekly.
- Month 4-12: Requires a minimum of 2 points of contact per month with at least bi-monthly face-to-face contact.

RSNs Community Support

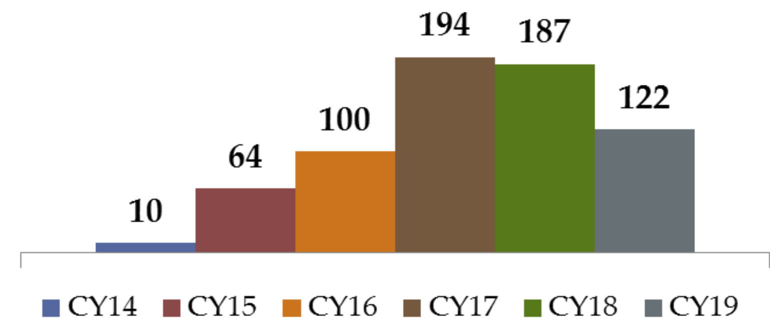
- Clients are assessed monthly and the following areas are discussed:
- Status of employment
- Housing
- Physical health and mental health
- Children/family and support network
- Substance use needs
- Any other essential areas used to assess success in the community.

Medication Assisted Treatment Reentry Initiative (MATRI)

Since the MA DOC inception in September 2014:

- 4,945 offenders have been screened for MATRI;
- Of those screened, 4,539 (92%) of offenders meet the Department's eligibility criteria;
- To date, 677 offenders received a pre-release Vivitrol injection;
- Approximately 77% of offenders who received a pre-release Vivitrol injection engaged in some form of treatment post-release.

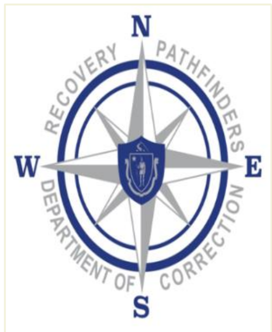
MATRI Completions by calendar year



Recovery Pathfinder Program

Mission

The Recovery Pathfinder Program provides support and advocacy for those individuals civilly committed under a section 35 as they begin the process of recovery, health and wellness in the community.



Recovery Pathfinder Program

Established in October 2018, the Recovery Pathfinder Program begins while offenders are inside the facility and facilitates offender transitions to community based services up to six months post-discharge.

Within the facilities Pathfinders:

- Offer services to every individual during their commitment.
- Pathfinders facilitate weekly Recovery Planning Groups to engage with their clients, build rapport and provide education on recovery.
- Pathfinders have an in-person meeting with clients 24-48 hours prior to discharge.
- Pathfinders develop an Individualized Wellness Plan (IWP) for each client.
  - Client goals, objectives and services are all identified by the offender for their specific path to recovery. The IWP is person-centered and considers the individual's physical, mental, emotional and faith/spiritual aspects of their recovery.

Recovery Pathfinder Program

Family Support Group

- A program offered for the supportive networked community of civil commitments in the Recovery Pathfinder Program. The Family Support Group is offered in the community.
- Families are welcome to attend regardless of their loved ones progress or level of participation in the program.

Pathfinder Statistics

412 currently enrolled in the program;

- 304 in field
- 108 in facility; MASAC / HCSD

Program enrollment rate: over 55%.

Facilitating weekly admission groups at MASAC and HCSD

Active involvement in Family Support Groups

Sobriety reported – September 2019:

- Less than 30 days: 27
- 30 to 60 days: 41
- 60 to 120 days: 57
- 120 days: 51

QUESTIONS?

Thank You!

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