TREATMENT OF OPIOID USE DISORDER USING MEDICATION-ASSISTED THERAPY IN THE CRIMINAL JUSTICE SYSTEM

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I have no conflicts of interest related to this presentation

Learning Objectives

- Identify barriers to implementation of opioid use disorder and medication-assisted treatment in the criminal justice system and processes for engagement with correctional facilities, law enforcement, and staff
- Discuss specific medications used in the treatment of opioid use disorders, including mechanism of action, side effects, dosing, and barriers to treatment that may impact choice of medication for an individual
- Describe transitions of care for opioid use disorder treatment when an individual is released to an outpatient care setting

Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD)

- Oral Medications
  - Methadone – opioid agonist
  - Buprenorphine – opioid partial agonist
  - Naltrexone – opioid antagonist
- Long-acting injectable medications
  - Buprenorphine subcutaneous
  - Naltrexone intramuscular
- Rescue medications
  - Naloxone intranasal and intramuscular (emergency public use)
  - Naloxone intravenous and subcutaneous (EMS)
- Opioid withdrawal
  - Lofexidine tablets
  - Clonidine tablets

METHADONE

- Available in oral dosage forms in opioid treatment programs
- Illegal to prescribe for OUD outside of licensed treatment programs
- Tablet and liquid formulations
- Daily observed dosing with opportunity to earn "take-home" bottles
- Is an opioid; side effects include sedation, respiratory depression, cardiac arrhythmias
- Drug interactions are possible and should be monitored
  - Some antidepressants and antibiotics
- Long half-life which makes it attractive for once-daily dosing
- May not be found in usual urine drug screening tests – synthetic
- To be eligible for an opioid treatment program, adolescents must have two documented unsuccessful attempts at detoxification within a 12 month period; must have parent/guardian written consent

BUPRENORPHINE

- Available in sublingual/transmucosal dosage forms for office-based prescription if the prescriber is DATA-waivered
- Only sublingual dosage forms due to a lack of absorption of buprenorphine in the stomach
- Partial agonist with a decreased risk of respiratory depression
- Once-daily dosing (usually, frequency may be increased in pregnancy due to faster metabolism)
- Injectable subcutaneous dosage long-acting dosage form – patient must take 7 days of sublingual buprenorphine first
- FDA-approved for ages 16 and older

NALTREXONE

- Opioid antagonist – blocks opioid receptors – called the "abstinence drug"
- Oral dosage form in available, but not recommended for long-term use due to risk of non-adherence
- Long-acting injectable dosage form
  - Must be free of opioids for at least 7 – 10 days to avoid withdrawal
  - Risk of overdose if patient does not return for injections because of decreased opioid tolerance
- Patients must be aware of decreased or lack of effectiveness of pain management
- Liver function tests should be monitored routinely; usually well-tolerated
- Patients must be ready for "abstinence" treatment

TABLE 4. MAT MODELS IN CORRECTIONAL SETTINGS[54]		
#	**Model type**	**Description**
1	Off-site medication administration	Patients are transported to community OTPs, hospitals or other medical providers for medication.
2	On-site medication administration by an external provider	External OTPs or other prescribers administer medication to patients within the correctional setting and under the license of the external OTP/provider.
3	On-site XR-NTX	Correctional health care providers administer XR-NTX within the correctional facility for treatment of OUD.
4	Licensed correctional prescribers provide buprenorphine on-site	Correctional physicians, nurse practitioners or physician assistants who are licensed to prescribe buprenorphine administer it within the correctional facility for treatment of OUD and withdrawal.
5	Facility becomes a licensed OTP	The facility obtains an OTP license permitting use of methadone and buprenorphine for treatment of OUD and withdrawal.
6	Facility becomes a licensed health care facility	State and DEA licensing is obtained entitling the facility to the same exemptions as hospitals for use of methadone or buprenorphine during pregnancy or to ensure treatment of other conditions (e.g., HIV, mental illness).

National Council for Behavioral Health, Medication-Assisted Treatment for Opioid Use Disorders in Jails and Prisons, Jan 2020

Regulatory Requirements to Dispense Each Medication in Corrections

- Naltrexone – not a controlled substance, can be administered in a corrections setting pursuant to a physician's order and availability of the drug from the medical contract/pharmacy
- Buprenorphine – can be administered in a corrections setting if prescribed by a waivered prescriber (physician, nurse practitioner, physician assistant), must be appropriately stored by nursing/medical contract
- Methadone – can only be stored/dispensed in the corrections setting if the jail/prison is an accredited, federally certified opioid treatment program (OTP) (model 5)
  - On-site methadone administration can be provided by an external provider (model 2)

National Council for Behavioral Health, Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons, Jan 2020

Where should services be delivered?

- Models 2, 3, 4, 5
- Centralized location
- Consider security, risk of medication diversion, patient confidentiality, logistics
- Clinical staff to administer medications directly
- Space for both clinical and security staff
- Cameras
- Space for patients to wait and be observed for up to 20 minutes (buprenorphine takes time to dissolve in the mouth)
- If certified as an OTP, federal regulations require confidentiality of SUD treatment records, must have a separate medication line

National Council for Behavioral Health, Medication-Assisted Treatment for Opioid Use Disorders in Jails and Prisons, Jan 2020

Logistics in a Central Location

- Central location is preferred
  - If using the housing areas, plan for safe transportation of medications and patient records
  - Cohorting people taking MAT into one housing unit does not allow for patient confidentiality
- Will need computer(s) for electronic medical record and pharmacy records
- Both methadone and buprenorphine can be given once daily
  - Consider daily morning dosing with time built in for observing each patient after dosing
  - May need additional staff time for seven days/week dosing
- Telepsychiatry may be used for prescribing and dose changes; requires adherence to state and federal regulations

https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies#

Medication Storage

- Models 4 & 5 – in-house MAT provision
- Must be stored in locked cabinets
- Routinely counted
- Return missed doses to the locked cabinets
- If Model 5 (in-house OTP)
  - Follow DEA Narcotic Treatment Program Best Practices Guidelines
  - Safes, steel cabinets, vaults constructed to withstand entry attempts
  - Must weigh less than 750 lbs, be bolted or cemented to the floor/wall
  - Must have an alarm system, change security codes frequently
  - Perimeter alarm and hold up alarms recommended
- Must have refrigeration storage for injectable naltrexone and buprenorphine

https://www.deadiversion.usdoj.gov/pubs/manuals/narcotic/part7/index.html#1

ACCESSIBILITY OF CONTROLLED SUBSTANCES

- DELIVERY MUST BE ACCEPTED ONLY BY A LICENSED PRACTITIONER EMPLOYED BY THE FACILITY OR OTHER AUTHORIZED INDIVIDUAL DESIGNATED IN WRITING
- PATIENTS MUST WAIT IN AN AREA PHYSICALLY SEPARATED FROM THE CONTROLLED SUBSTANCE STORAGE AND DISPENSING AREA
- METHADONE AND BUPRENORPHINE MAY BE DISPENSED ONLY BY:
  - LICENSED PRACTITIONER
  - RN OR LPN UNDER THE DIRECTION OF A LICENSED PRACTITIONER
  - PHARMACIST UNDER THE DIRECTION OF A LICENSED PRACTITIONER
- STORAGE AREAS MUST BE ACCESSIBLE ONLY TO AN ABSOLUTE MINIMUM OF AUTHORIZED EMPLOYEES

https://www.deadiversion/usdoj.gov/pubs/manuals/narcotic/part7/index.html#1

Dispensing Medication in Community Corrections Settings

- Designate a "medication room"
- Prescribed medications are stored here and medication-related activities take place her:
  - Preparing for dispensing
  - Medication counts (controlled substances)
- A medication cart is the most common storage modality
- Each drawer is assigned to an individual
- A medication administration record must be used that is for each individual person and their medications
- Person dispensing must document that the patient took their medication using their initials
- Missed medications must be documented if the individual is not present to receive their medication at the designated time
- Preventing diversion

KEY CONSIDERATIONS

- Multidisciplinary treatment teams
  - Behavioral health and criminal justice professinals
  - Shift from "abstinence-only" to inclusive treatment of substance use disorders
  - Ongoing staff training and education – including stigma training and recognition
- Work with community providers
  - Necessary for building relationships for re-entry treatment
- Data and information sharing
  - Be able to work with many partners – stakeholders, community-based social service and treatment providers
  - Adhere to HIPAA, ensure that privacy laws are not too restrictive and limit information sharing

SAMHSA, MAT in the Criminal Justice System: Brief Guidance to the States, 2019

Re-entry support, health care coverage, continuity of care

- Comprehensive re-entry planning to ensure access to care, medications, treatment upon release
  - Also consider housing, employment, daily activities, support system
- If loss of health care insurance (Medicaid, commercial insurance) upon incarceration:
  - Re-enrollment prior to release – may need to start this process early
  - Important for continuity of care
  - Be aware of coverage for MAT for health insurance plans, including Medicaid
    - Indiana – broad access to MAT in both Fee for Service and Managed Care Entities
    - Prior authorizations in Medicaid generally limited to drug-specific prescribing information
- Continuity of care
  - If an individual already receives treatment from a community-based provider, consider policies allowing this to continue during incarceration
  - Incarceration should not disrupt MAT and other treatments
  - Link jail MAT participants to community providers prior to release
  - Embrace recovery as the desired outcome

SAMHSA, MAT in the Criminal Justice System: Brief Guidance to the States, 2019

American Society of Addiction Medicine: 2020 Focused Update

- High concentration of at-risk people, stress of incarceration, loss of tolerance to opioids with length of incarceration, withdrawal = risk of adverse consequences
- OUD treatment should not stop with incarceration
- Federal law requires that incarcerated people be treated for health problems
- All FDA-approved medications for OUD should be available to incarcerated people
- Choice of medication should be based upon the individual's needs
- Treatment with methadone or buprenorphine while incarcerated leads to significant reductions in deaths from overdose in the time after release and reduces re-incarceration rate
- Collaboration with community partners is important
- Naloxone kits should be available in corrections settings; individuals and families should be educated about how to administer and naloxone kits should be offered upon release
- All incarcerated individuals should be screened for OUD
- Individuals should not be subjected to forced opioid withdrawal or be forced to switch from agonist (methadone or buprenorphine) to antagonist (naltrexone) treatment
- A combination of medication and psychosocial treatment should be offered, but medication should not be withheld if the individual declines psychosocial treatment

American Society of Addiction Medicine – 2020 Focused Update, Dec 2019

Conclusion

- Use of MAT has been shown to decrease the risk of overdose after release and to decrease the rate of re-incarceration
- Barriers to treatment exist in the corrections setting, including physical barriers to development of MAT programs and stigma
- Policies and procedures, as well as physical space, should be developed and implemented to support MAT in corrections settings
- Treatment guidelines recommend that all forms of MAT be available where possible
- Forced withdrawal or MAT medication switch is discouraged
- Community partnerships for continuity of care, as well as health insurance and support systems, are important for successful recovery