A SPECIAL SESSION WEBINAR

The Office of Correctional Health,
The Coalition of Correctional Health Authorities,
&
The Substance Disorders Committee

Presents

A SPECIAL SESSION WEBINAR
MEDICATION ASSISTED TREATMENT:
EFFECTIVE APPLICATION IN JAILS AND PRISONS

December 1, 2016
PRESENTATIONS

**The Ohio Department of Rehabilitation & Correction’s Naloxone Initiative**

*Stuart Hudson, B.A.*
Managing Director, ODRC Healthcare & Fiscal Operations
Co-Chair, Coalition of Correctional Health Authorities

*Amy Whitmore, R.N.*
Health Planning Administrator 3, ODRC

**Medication Assisted Therapy in Corrections: Some Thoughts**

*Kathleen F. Maurer, M.D., M.P.H., M.B.A.*
Correctional Medical Director and Director of Health and Addiction Services, Connecticut Department of Correction
Chair, Coalition of Correctional Health Authorities Research and Health Outcomes Work Group

**Heroin Epidemic: Need for Community Solutions**

*Randy Shively, Ph.D.*
Director of Research and Clinical Development- Alvis
Co-chair Substance Disorders Committee/ACA
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The Substance Disorders Committee is charged with reviewing and updating all ACA substance disorders standards for the adult and juvenile population. The committee works with other ACA committees to address critical issues and the provision of substance disorder services for the corrections population. The committee is charged to identify exemplary practices in the area of substance disorder services.
RANDY SHIVELY, PH.D.

- Director of Research and Clinical Development, Alvis
- Vice Chair, ACA Substance Disorders Committee

- Licensed psychologist
- Licensed Independent Chemical Dependency Counselor-Supervision
- Board Certified in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders
PROGRAM OVERVIEW

Introductions

Presentations
The Ohio Department of Rehabilitation & Correction’s Naloxone Initiative
Medication Assisted Therapy in Corrections: Some Thoughts
Heroin Epidemic: Need for Community Solutions

Questions

Wrap up
OBJECTIVES

- Identify the need for MAT programs in the correctional field.
- Provide corrections professionals with examples of MAT programs that are in operation today.
- Explain MAT program successes/obstacles and how to measure metrics.
STUART HUDSON, B.A.

- Ohio Department of Rehabilitation and Correction, Managing Director of Healthcare and Fiscal Operations
- Coalition of Correctional Health Authorities (CCHA), Co-Chair
- Responsible for all healthcare operations and the overall ODRC fiscal management
- Served as Deputy Warden, Warden, and Bureau Chief for the Office of Construction, Activation, and Maintenance
Amy Whitmore, R.N.

Ohio Department of Rehabilitation and Correction, Health Planning Administrator 3

- Responsible for planning, directing, organizing, and managing department-wide health care policy/protocol/forms creation, review and revision
- Responsible for auditing and re-inspecting statewide health care services
KATHLEEN MAURER, M.D., M.P.H., M.B.A.

+ Connecticut Department of Correction
  Correctional Medical Director and Director of Health and Addiction Services
+ CCHA Research and Health Outcomes Work Group, Chair
+ Board Certified in Addiction Medicine, Preventive Medicine, and Internal Medicine
+ Developed a system-wide medication assisted therapy program for the Connecticut DOC
+ Interested in facilitating re-entry programs through integration of community and correctional healthcare
The Ohio Department of Rehabilitation & Correction’s Naloxone Initiative

Presented By:
*Stuart Hudson, ODRC Managing Director of Healthcare & Fiscal Operations
*Amy Whitmore, ODRC Health Planning Administrator 3
Objectives:

- Provide an overview of the protocol and use of Naloxone within the Ohio Department Rehabilitation and Correction prison system.

- Provide an overview of the protocol for the distribution of Naloxone from the Ohio Department of Rehabilitation and Correction to Community Residential Centers, Community-Based Correctional Facilities, and Halfway House partners.
Fentanyl-related deaths on the rise
- In 2013: 84
- In 2014: 503
- In 2015: 1,155

Majority of fentanyl seized by Ohio law enforcement is illegally produced/trafficked, not diverted prescriptions

Overall drug overdose deaths in 2015 = 3,050
Current Prison Population = 50,913

- Of the 19,755 ODRC commitments in FY15, 5,329 (27%) were specifically incarcerated for a drug-related offense *(this number only includes commitments who had a drug offense listed as their most serious offense)*

Current Community Supervision population = 37,579

Number of inmates participating in Recovery programs in FY16

- Approximately 8,811 in formal treatment
- Approximately 9,536 in supported recovery services-oriented programs (AA/NA/self-help peer groups/etc)
Project Dawn

- Community-Based Naloxone Distribution Model
  - Ohio’s first Overdose Reversal Project
  - Over 1,000 pharmacies in 79 of Ohio’s 88 counties now offer naloxone without a prescription

- Abetting Illicit Drug Use?
  - Evidence suggests prescription naloxone does not reduce the disincentives to reduce drug use/seek treatment
  - Evidence suggests that surviving an overdose is a traumatic event that is likely to induce remorse and self-reflection; a study of injection drug users found that 1 in 4 sought drug treatment within 30-days after their last overdose

- Cost Comparison
  - Project Dawn kit costs $77.93
  - Average in-patient treatment charge for Ohio overdose-related hospital stays costs approximately $10,488.00
Inside the Fence...

Project Dawn

- In October 2014, ODRC institutions began stocking Project Dawn kits on-site, incorporating them into the institutional Medical Department’s emergency bag.
  - Project Dawn kits are provided through ODRC’s contract mail-order pharmacy, the Ohio Department of Mental Health’s Pharmacy Service Center

- A Project Dawn Overview lesson plan and PowerPoint presentation was developed by the ODRC Bureau of Medical Services and utilized to train all institutional clinical staff on:
  - Recognizing an overdose
  - Responding to an overdose
  - Naloxone Administration Procedures
Inside the Fence...

➢ Project Dawn

- Since inception, ODRC Medical Departments have utilized 95 Project Dawn Kits within the prisons

- Administration of Narcan resulted in 80 overdose reversals
  • 13 Narcan administrations did not result in reversal due to lack of opioids in the patients’ system
  • 2 Narcan administrations did not result in reversal in patients’ with opioids in their system
Outside the Fence...

ODRC protocol developed for the training, access and use of naloxone effective 7/1/16

- Community-Based Correctional Facilities (CBCF)
  • A secure facility providing 24-hour living accommodations and programming for persons referred/admitted by the Ohio Common Pleas Court

- Correction Community Residential Centers (ComRC)
  • An ODRC-licensed facility housing lower-risk, lower-need adult offenders under the supervision of the ODRC Adult Parole Authority

- Halfway Houses (HWH)
  • A private non-profit agency licensed residential facility with a current contract with ODRC
Protocol reviews the following:
- Indications for Naloxone Use
- Precautions, Contraindications & Adverse Reactions of Furnishing Naloxone
- Administrative Requirements, Labeling, Storage and Record-Keeping
- Staff Training Requirements

Significant Ohio Board of Pharmacy Resolution
- Facility Directors/Executive Directors/Chief Operating Officers of CBCF/ComRC/HWH may serve as the Responsible Person on the Category II Terminal Distributor of Dangerous Drugs License until March 31, 2017
References


Medication Assisted Therapy in Corrections: Some Thoughts

Kathleen F. Maurer, M.D., M.P.H., M.B.A.
Why MAT in Corrections

Substance use disorders overrepresented in corrections

Community standard of care

Current Practice places offenders at risk for overdose and death

Current practice complicates return to treatment
1. Disease of Addiction Over-Represented in Corrections

- Disease of addiction over-represented in corrections
  - CT DOC – 75%-85% of population has substance use disorder requiring treatment
  - Primary drugs of choice in male population CT DOC—4th Quarter 2015
    - Alcohol—31%
    - Marijuana—30%
    - Opioids—23%
  - Criminal justice system offers an opportunity for treatment for this population

Data source CT DOC Addiction Services—2.11.16 for 4th quarter 2015. Courtesy of Deborah Henault and Jaime Richardson.
Drug of Choice Female Offenders: York Correctional Institution, Niantic, CT

Offender Drug of Choice--York CI
2015-2016

Bar chart showing the drug of choice for female offenders at York CI for the years 2015-2016.
Control Spread of Infectious Diseases

- HCV and HIV both involve IDU as infectious mechanism
- Treatment of HCV and HIV limits spread in the community
- Harm reduction methods including treatment of IDU with MAT is standard of care for treatment of heroin substance use disorder and limits re-infection and spread of HCV and HIV in the community
3. Community Standard of Care
Cravings generally not extinguished by time spent in jail or prison

After a short period of time, addicted persons lose tolerance

Patients addicted to opioids frequently seek the drug soon after release

Same dose without tolerance increases risk for overdose and death
CT Accidental Drug Deaths – OCME* and OPM**

Percent change 2012 – 2015: All deaths: 98%, heroin deaths: 138%

Source: OCME, CT DOC
*Office of the Connecticut Medical Examiner
**Office of Policy Management
Former Inmate Overdose Deaths by Month After Release--2015

OD Deaths per month after DOC release

5. Current Practice Complicates Return to Treatment

- Typical practice is to “detox” patients from methadone or other MAT pharmaceuticals.
- Upon release, when methadone or other MAT pharmaceutical is not offered, patients may have difficulty returning to MAT provider—delay in getting seen and other barriers may exist.
- Likelihood of returning to MAT provider is markedly reduced when patients are not inducted or treated with MAT during incarceration or upon release.
Questions to think about when starting a MAT program

1. Who to treat?
2. Where to treat?
3. How to treat?
4. When to treat?
5. What medications to use?
6. What to measure?
Who to Treat?

- Criminal justice perspective
  - Pre-trial detention—jailed population for unified systems
  - Sentenced
    - Pre-release or other (throughout period of sentence)

- Medical Perspective
  - Persons entering on MAT
  - Initiating new MAT for those with opioid use disorder

- Establish program criteria
Program Criteria

**CLINICAL**
- Existing methadone patient
- Within 5 days of last dose
- Verification by methadone OTP
- Agreement with program rules
- Mandatory weekly counseling
- Random urine testing
- Must stay at NHCCC

**CUSTODY**
- Unsentenced with bond <$50,000
- Sentence < 2 years
- Medical/Mental Health Score <4
- No profiles with staff or inmates
- No protective custody
- No SRG affiliation
Comparison of Referred and Treated Patients
May 31, 2016

BCC
- Treated: 502
- Referred: 198

NHCC
- Treated: 739
- Referred: 450
Where to treat?

- Single or few facilities
  - May require movement of inmate patients
  - Not always straightforward in a custody situation
  - May complicate re-entry processes
  - May be advantageous as resources can be concentrated

- Many or all facilities
  - Consider MAT maintenance and induction as another form of health care
  - Simplifies re-entry
Connecticut Correctional System OST Programs

Proposed Induction and Treatment Center
How to Treat?

- Treatment Model
  - In house treatment staff
  - Contracted vendor(s)
  - Hybrid—e.g., in house staff initiate screening and assessment process and hand off to vendor

- Considerations dependent upon
  - Substance use disorder treatment in house capability
  - Resource availability
  - Medical staff knowledge of, or interest in, learning treatment modalities
  - Types and availability of contract providers
When to Treat?

- Maintenance therapy on entry
  - Continue maintenance treatment or manage withdrawal
  - With multiple available agents, may add a level of complexity to care

- Initiate therapy
  - Upon admission or shortly thereafter
  - In pre-release phase—2 to 4 to 6 weeks prior to release from prison
  - In the community immediately upon release

All of this is dependent upon patient wishes/preferences
What Medication(s) to Offer?

- Function of many variables
  - Culture of your management, system and facilities
  - Interest and capability of in house health care providers/vendors
  - Mix and character of community providers that can support treatment on re-entry
    - May have to help build community provider network
  - Medicaid and private insurance coverage
  - Appreciation and tolerance for regulation, audits, etc.
  - Patient preference
  - Cost
MAT Cost

- Methadone
  - Requires annual physical examination, confirmation of program participation, new program enrollment, possibly new PE and dosage confirmation, random drug testing, counseling
  - In Connecticut Medicaid re-imbursement is bundled and ranges from ~$75/patient/week to ~$100+/patient/week
  - For example, induction program for 6 to 8 weeks prior to release at $75/patient/week would be $450 to $600 per patient
What To Measure?

- Process Metrics—decide what is important to you about the process itself
  - Time from identification to treatment or intake to treatment
  - Screening efficiency
  - Compliance with regulations
  - For maintenance, number with medication confirmation on day of intake
- Outcome Metrics—decide what is important to you and your management
  - # screened compared to number treated
  - Impacts on Re-arrest/Recidivism
    - % Re-arrested in 30 days, 90 days, etc.; % Re-incarcerated
  - Time to community engagement (re-engagement)
  - Connect to care rate
  - Impact on facility management (# DRs)—more important in jail population
Recidivism Rate--90 Day

Recidivism - 90 Days

- Not Arrested: 89%
- Arrested: 11%

Slide courtesy of RNP, Shelton, CT, 2016
Lessons Learned

- Ideally MAT needs to follow patients from jail to prison and through release and re-entry for continuity of care
- There are challenges to data collection across agencies
- Factors affecting the ability to expand on site program capacity
  - Court Schedules
  - Sentencing
  - Facility Space
  - Security Needs
  - Resources
Facility staff originally not in favor of such a program have articulated the many benefits they see in the program.

Despite many fears, only 2 incidents occurred in New Haven in the first year.

Cap waiting list creates need for detox or induction.

Treatment model very effective for criminal justice population.

Corrections agencies need robust research and data analysis capacities.

Never underestimate the role of stigma, or the power of education!
Heroin Epidemic: Need for Community Solutions

Randy Shively, Ph.D.
Co-chair Substance Disorders Committee/ACA
Director of Research and Clinical Development- Alvis
15% of the over 2 million jail and prison inmates have histories of heroin dependence.

Few inmates receive substance disorder treatment in prison or immediately upon release—release is most vulnerable time for use and relapse.

Heroin users have high rates of relapse, criminal behavior, HIV infection and OD death.

Frank Vocci, 2011- partnership at drugfree.org
“Addiction has three main characteristics that cause it to be a disease. First, it has a lifelong course characterized by frequent relapses, cross addiction and a common set of behavioral changes. Second, like other chronic medical disorders, genetics plays an important role in determining who is at risk to become addicted. Finally, there are effective medications that treat drug addiction by blocking the rewarding effects of drugs and decreasing drug cravings”

New York Times
Dr. Sack, Opinion Pages, 2016
Addiction is not a choice- it is a disease

- Addicts can not turn off brain’s natural desire for dopamine
- Biological, emotional, social and spiritual symptoms of addiction
- Addicts are accused of choosing their fate, but there is little freewill involved in addiction
- Both genetic and environmental factors
  
  Harry Haroutunian, 2013, Being Sober
No Test for Addiction

“No test can reveal if an inmate is addicted or abusing opioid medication----screening is based on good history, observation, and interpretation of an inmate’s behavior”

Webster and Dove, 2007
Heroin Users Multiplying

- 2011: 200,000 tried Heroin for the first time
- 2014: 700,000 admitted using the drug

What is the increase costing us?
- 16,000 lives annually
- Healthcare costs 72 billion annually
- Increase in criminal offenses
Before mid 1990’s few doctors prescribed narcotics for pain

Pressure from pharmaceutical industry, regulatory agencies and medical boards changed culture of pain management

Zero pain became an expectation culturally leading to the “fifth vital sign” required in medical charts
Path to Heroin

- Patient takes a pain pill for a nagging pain from an accident
- Patient starts to like the feeling from the medication
- Takes more than prescribed and runs out of prescription and doctor refuses to write more
- Physical dependence on opioids, withdrawal symptoms, cravings, compulsive behaviors
- Patient realizes heroin is much cheaper than original pain medicine
Heroin: Epidemic In the Making

- Inexpensive High-doses from Mexico
- Easily Obtained on Streets
- Often laced with dangerous substances, i.e., Fentanyl - Ohio epidemic - Dayton, Ohio - Fentanyl - 50-100X more powerful = huge spike in deaths
- Health hazards associated with needle sharing
Relapse is Highly Probable with no MAT

- More than half of heroin-addicted prisoners relapse within a month of their release. 
  Nunn, et al, 2009

- Most prisons do not provide referrals for substance abuse treatment for prisoners on release—high rates of recidivism and detrimental impact on community health.
What can corrections do?

- Realize that Narcan only can prevent death, it does not treat addiction
- Address trauma: Behind a lot of the heroin addiction is client’s emotional pain- trauma- this needs to be addressed, i.e., Trauma Informed Care
- Engage community: The hope to combat addiction, especially drugs which kill, takes a community response = shared responsibility
- Provide evidenced-based treatment to those addicted to substances
Prevalence of Trauma

NO previous screening, assessment or treatment for trauma (Mueser et al., : Frueh et al., 2012)

UNTREATED!

- 90% of all mental health clients have been exposed to trauma (and most have actually experienced multiple trauma (Goodman, Rosenberg, Mueser)
- 75% of women and men in Substance Abuse treatment report abuse and trauma history (SAMHSA/CSAT, 2000)
- Nearly 8 out of 10 female offenders with a mental illness reports having been physically or sexually abused
- Nearly 1 out of every 20 male offenders report being sexually abused ...(PREA, presentation, 2015) Rape & Helplessness due to “No ESCAPE”
Most states are developing policies, practices and services to meet the needs of people that have been affected by trauma including helping to prevent retraumatization.

Decision makers and legislators have implemented or are moving towards restructuring to include a trauma informed approach, many mental and medical professionals feel that this is a global emergency and that these actions are needed at the provider, local, state and advocacy levels.
“In settings like substance use disorder treatment and jails or prisons, where it is very likely that the majority of clients are dealing with the mental health consequences of trauma, it is best to apply trauma-informed principles, as a “Universal Precaution,” at every client encounter possible and at every level of care, whether or not trauma screening is available”.

Nicole Miller (2011)
Minimize practices that accentuate authoritarian practices while teaching respect for FAIR, FIRM and CONSISTENT use of authority.

All staff are aware of the behaviors that are commonly associated with a history of trauma and respond in ways that maintain institutional and individual stability.

Sharing of information between staff to minimize unnecessary repetition of the story.

Includes security staff and institutional leadership in the training of correctional officers.

Evaluates the results of current practices on the stability of the inmates in custody.

Implements Evidenced-Based Trauma Support Services with appropriately trained staff.
Collaborative Ways Communities Can Tackle the Heroin Epidemic

Huma Bashir, EdD., PCC-S., LICDC
Assistant Professor, Clinical Mental Health Counseling

John Conteh, EdD., LPC (PA), ACS, NCC
Assistant Professor, Clinical Mental Health Counseling

Wright State University
Department of Human Services

Addiction Studies Institute Conference
July 21, 2016
Sponsored by:
The Ohio State University
Wexner Medical Center
Roles of Partners

- Wright State University - provide funding for renewable grants
- East End Dayton - Provide Collaborative resources within the community
- Dayton Mediation Center - Dayton Mediation Center facilitators support participants to talk about their experience of struggling with heroin addiction, what's hard about stopping opiate use, and honor and respect what is hard about changing this behavior and finding motivation to change rather than giving them advice, shaming them, or trying to force them to change
- Project Dawn - Education & training, Narcan Kits
- Families of Addicts - Personal experiences
“Conversation for Change” Sessions

- Community and university-based partnership
- Utilizes a non-confrontational intervention called “Conversations”
- Conversations target individuals who have specific opiate addictions and opiate crime related offenses such as theft, burglary, or overdose
- Uses Motivational Interviewing to discuss education, counseling, and treatment options
Collaborative-Based Partnership

- Wright State University – Dr. Huma Bashir, Dr. John Conteh, Dr. Mary Huber, & Students (university partnership)
- Dayton Police Department – Major Brian Johns (Law Enforcement)
- East End Community – Emily Surico (Local Community Agency)
- Dayton Mediation Center
- Project Dawn
- MAT Nurse
- Families of Addicts
- Syringe Exchanges
Data: Participation

Data: Ohio Medicaid and ADAMHS board of Montgomery County

Total Attendees 285

Attendees with MH/AD treatment History (active or close cases): 78
Attendees who accessed treatment after call-in day event: 41
Ways to Develop a Similar Program

1. University grant initiating partnership
2. Introduce a collaborative-based partnership between a university, a local agency, and law enforcement to increase awareness and preventive interventions for opiate addictions
3. Non-confrontational intervention called "conversation for change" and Motivational Interviewing
4. Participants are those who have opiate addictions and are at risk of an overdose. Family members are also encouraged to participate in the conversation for change
Alvis- Power Program-Residential

- Capacity of 20
- 4 month program
- Partnership with Ohio State Talbot Hall and Adult Probation
- Vivitrol shot monthly and 22 hours of weekly treatment
References

- National Institute on Drug Abuse. 2014. Drug addiction treatment in the criminal justice system. (drugabuse.gov)
- SAMHSA. 2012. Medication-assisted treatment for Opioid Addiction in Opioid Treatment Programs. TIP 43, U.S. Dept. of Health and Human Services
QUESTIONS
CLOSING REMARKS
An email will be sent out to all participants following this webinar:

- In order to receive CME credit, you must follow the link in the email and complete an evaluation and quiz with a score of 85% or higher.

- In order to receive CE nursing credit, you must follow the link in the email and complete the evaluation.

- All attendees are encouraged to follow the third link in the email to evaluate today’s presentation.

If you require assistance, please contact Mike Miskell at michaelm@aca.org or (703) 224-0048.
THANK YOU FOR ATTENDING

To replay the webinar, please visit the Correctional Health Resource Center by Clicking Here

Special Thank You to the entire Substance Disorders Committee for making this webinar possible.