Addressing Opioid Use Disorders in Criminal Justice: Medication-Assisted Treatment

Lily Gleicher, MS, PhDc

Research Analyst, Illinois Criminal Justice Information Authority

Key Topics

- Defining Substance Use Disorders (SUDs) & Opioid Use Disorders (OUDs)
- Discussing Stigma
- Medication-Assisted Treatment (MAT)
- MAT Efficacy (Justice-Involved Populations)
- MAT Challenges and Concerns

First…

TEXT **ICJIACIC194** TO **22333** TO JOIN

USED TO POLL AUDIENCE ABOUT DIFFERENT TOPICS THROUGHOUT THE PRESENTATION ***ANONYMOUSLY.***

Opioid use disorder (OUD) is a moral issue.

FALSE!

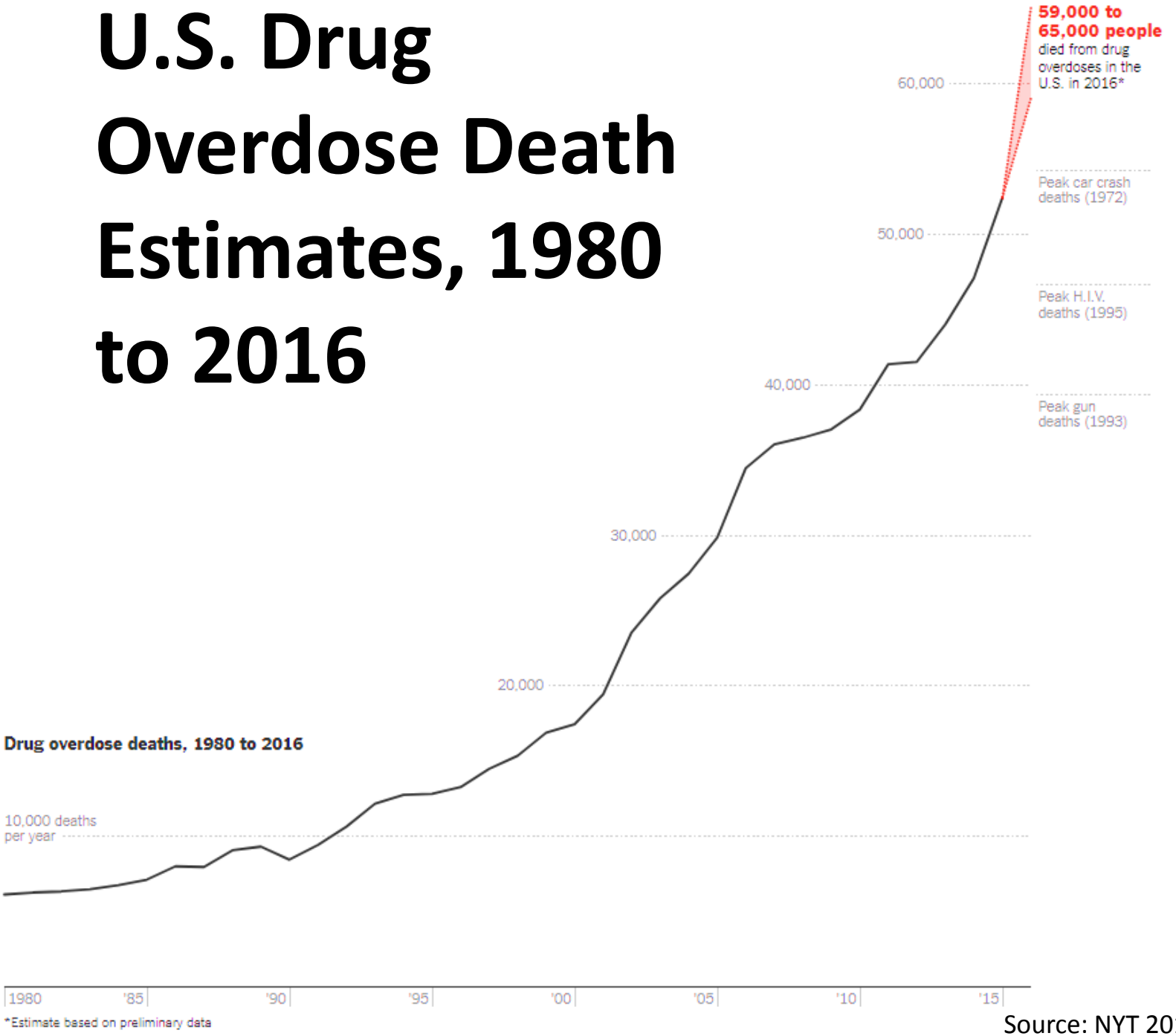
- **Chronic, relapsing condition**
- Despite negative consequences feel **compelled** to continue
- **Brain disease**—affects brain's anatomy and chemistry
- Risk factors—genetic, environmental, and behavioral

U.S. DHHS (2016); Catalano et al. (2012); Stone et al. (2012); Shek et al. (2012); Viner et al. (2012); NIDA (2014)

Examining Our Biases

SAMHSA (2018)

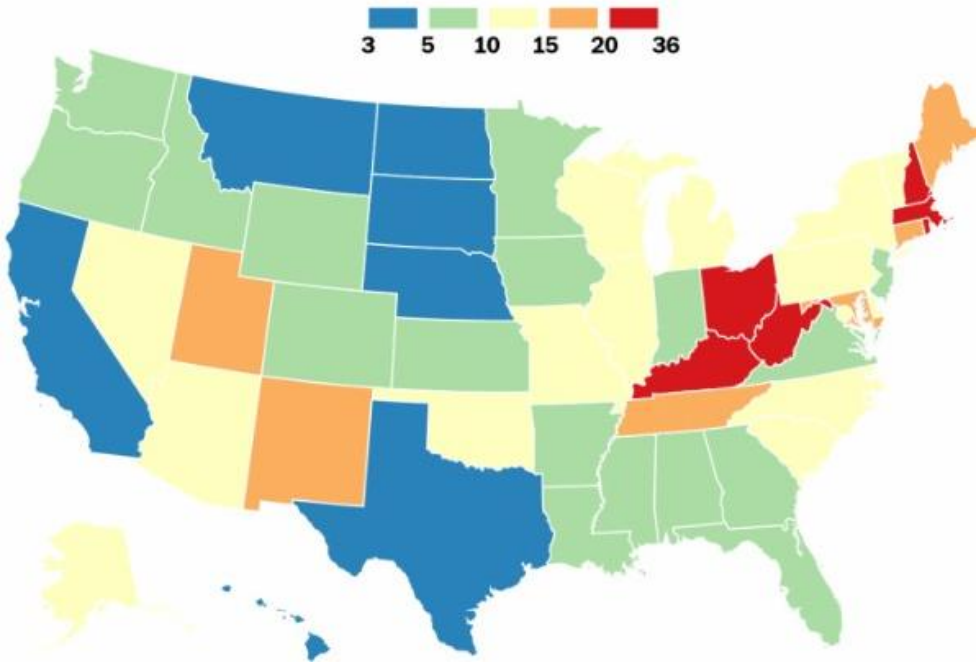
U.S. Drug Overdose Death Estimates, 1980 to 2016

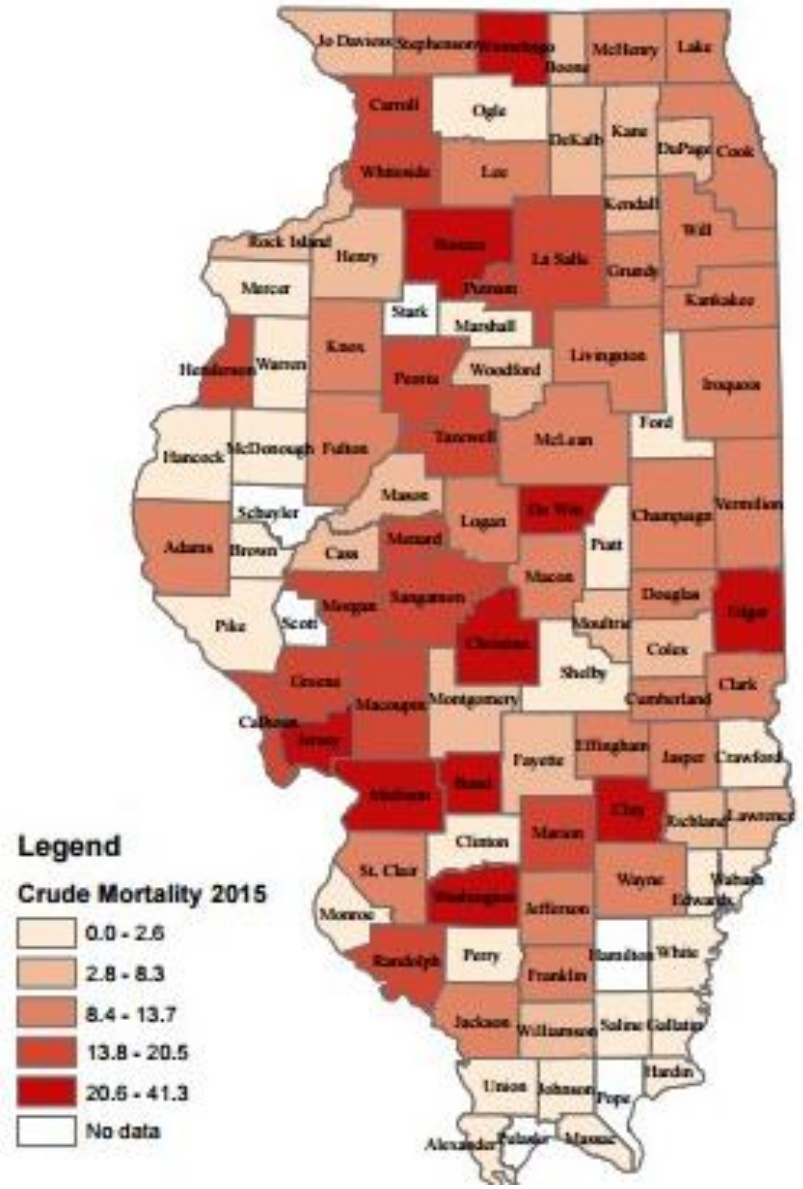


Source: NYT 2017

Opioid Death Rate, 2015

Per 100,000 pop.





Source: CDC WONDER

WHAT ARE SUBSTANCE USE DISORDERS AND OPIOID USE DISORDERS?

Substance Use Disorders

... “occur when the recurrent use of alcohol and/or drugs causes **clinically and functionally significant impairment**...” (SAMHSA, 2015)

- impaired control
- social impairment
- risky use
- pharmacological criteria

SUDs are characterized by…

- Inability to consistently **A**bstain
- Impairment in **B**ehavioral control
- **C**raving or increased "hunger for drug or rewarding experience
- **D**iminished recognition of one's behavior and impact on self and others
- Dysfunctional **E**motional response

ASAM

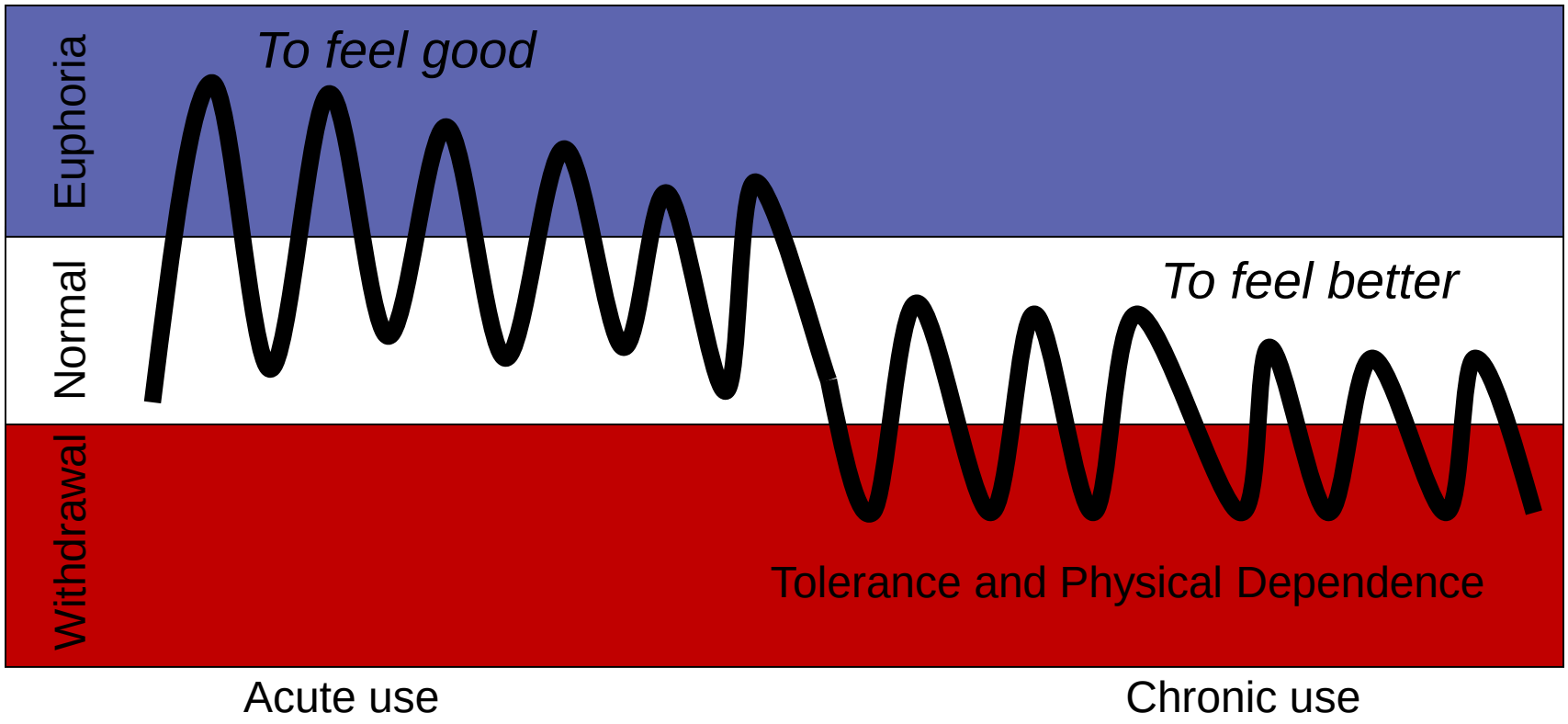
Continued regular use of opioids will lead to…

- **Tolerance** or diminished effects of same dose of drug over time
- **Physical dependence-** withdrawal symptoms upon abrupt cessation of use

With high-dose opioid use, some may be at risk for:

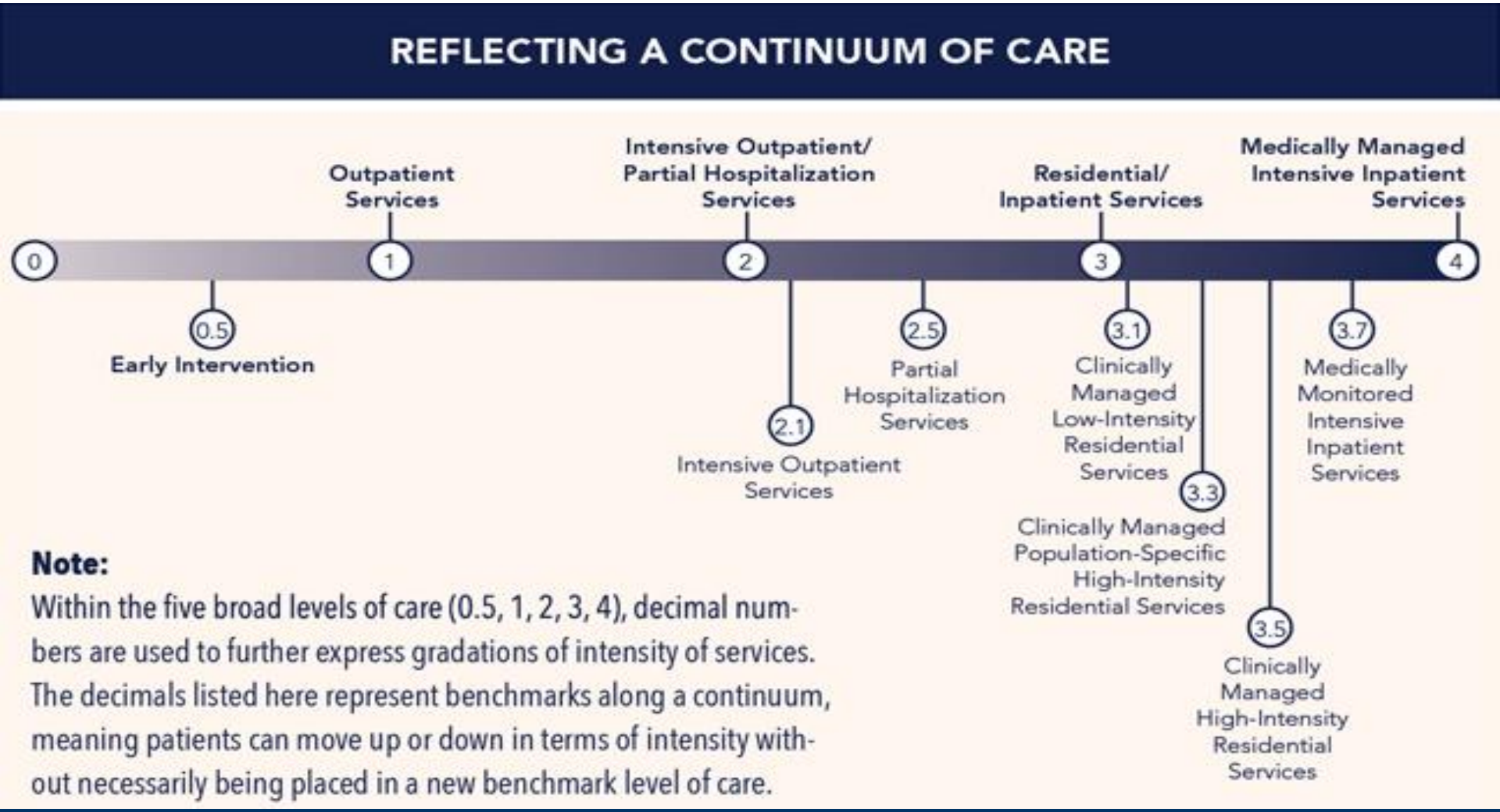
- **Opioid use disorders** diagnosed by a set of behaviors as outlined by clinical diagnostic criteria

Chronic Opioid Use



Source: SAMHSA

ASAM Level of Care



Source: ASAM

Important to note…

Detox is **NOT** treatment and actually **increases risk** of overdose without linkage to next level of care

Public Health Approach

- Addressing frequent, recurring problem throughout population
- Can be:
  - Prevented
  - Treated
  - Managed
- Based on scientific evidence
- Patient-centered care

Evidence-Based Addiction Treatment: National Principles of Care

	1	Universal screening for SUDs across medical care settings
	2	Rapid access to appropriate SUD care
	3	Personalized diagnosis, assessment, and treatment
	4	Continuing long-term outpatient care
	5	Concurrent, coordinated care for physical and MH
	6	Access to fully trained BH professionals
	7	Access to FDA-approved medications
	8	Access to non-medical recovery support services

Arsenault, 2018 (presentation); Shatterproof.org

WHAT IS MEDICATION-ASSISTED TREATMENT (MAT)?

Using medication for OUD is just replacing one drug with another.

FALSE!

- Buprenorphine (e.g. Suboxone) and methadone are ***highly studied, validated medical therapies***
- All major health organizations support, acknowledge methadone and buprenorphine (Suboxone) as the **"gold standard"** for treating OUDs (and AUDs)
  - WHO, SAMHSA, NIDA, UNODC, UNAIDS, CDC
  - WHO indicates methadone and buprenorphine on its list of essential medicines for adults
- Dosage does not result in a "high"

WHO (2009); D'Annu et al. (2014); Bellin et al. (1999); ASAM (2015)

Abstinence is the only option for successful or "real" recovery.

FALSE!

- Treatment and recovery should be an **individualized** process
- **Most effective** OUD treatment includes:
  - Medication
  - Behavioral therapy (CBT), individual counseling
  - Peer recovery support*
- Not all individuals will want to use medication—this is okay!
  - Decision should be individualized; medication type should too, in collaboration with medical provider

Schuckit (2016); Pierce et al. (2015); Mattick et al. (2009); WHO (2009); Gibson et al. (2008)

Medication to treat SUD should only be used for a short or limited amount of time.

FALSE!

- **Fewer than 90 days** is ***not*** associated with positive outcomes
- Long enough to produce **stable behavioral change**
- Services should be **tailored** to the individuals
- Individuals on maintenance treatment **longer** are **less likely** to relapse

SAMHSA (2012); Gibson et al. (2008); Amato et al. (2005)

Medications like methadone and buprenorphine (Suboxone) are commonly diverted.

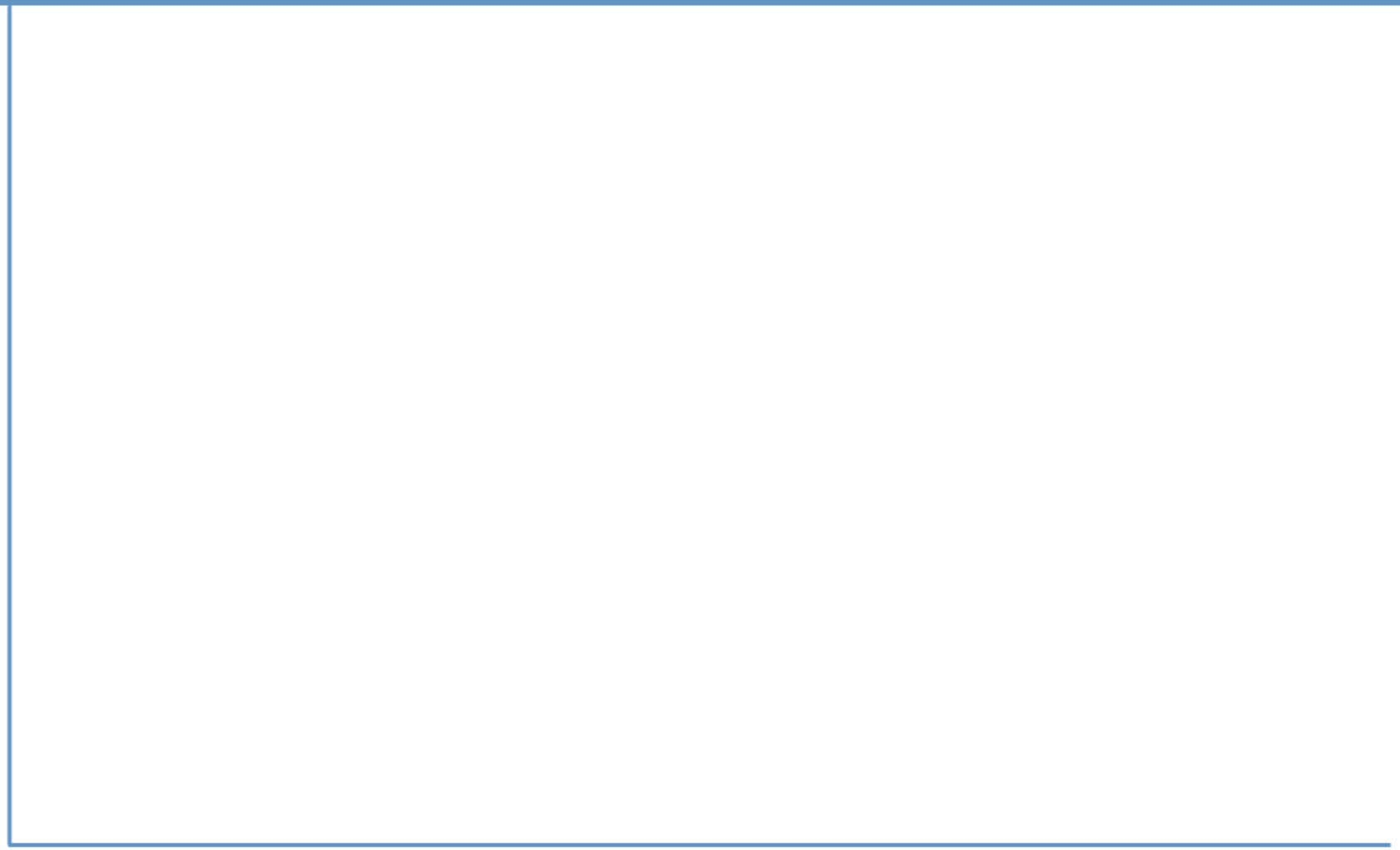
FALSE!

- Diversion more common among prescription pain relievers
- Buprenorphine
  - **Less than 2%** of all reported drug-related incidents in 2016 in U.S. (DEA-NFLIS)
- Methadone
  - **Less than 1%** of all reported drug-related incidents in 2016 in the U.S.
- Diversion may signal need for MAT; self-treating
  - Withdrawal sickness
  - Weaning off opioids
  - Dependence, pain, depression
- For jails/prisons—largely driven by supplies smuggled in by friends, family, or correctional staff

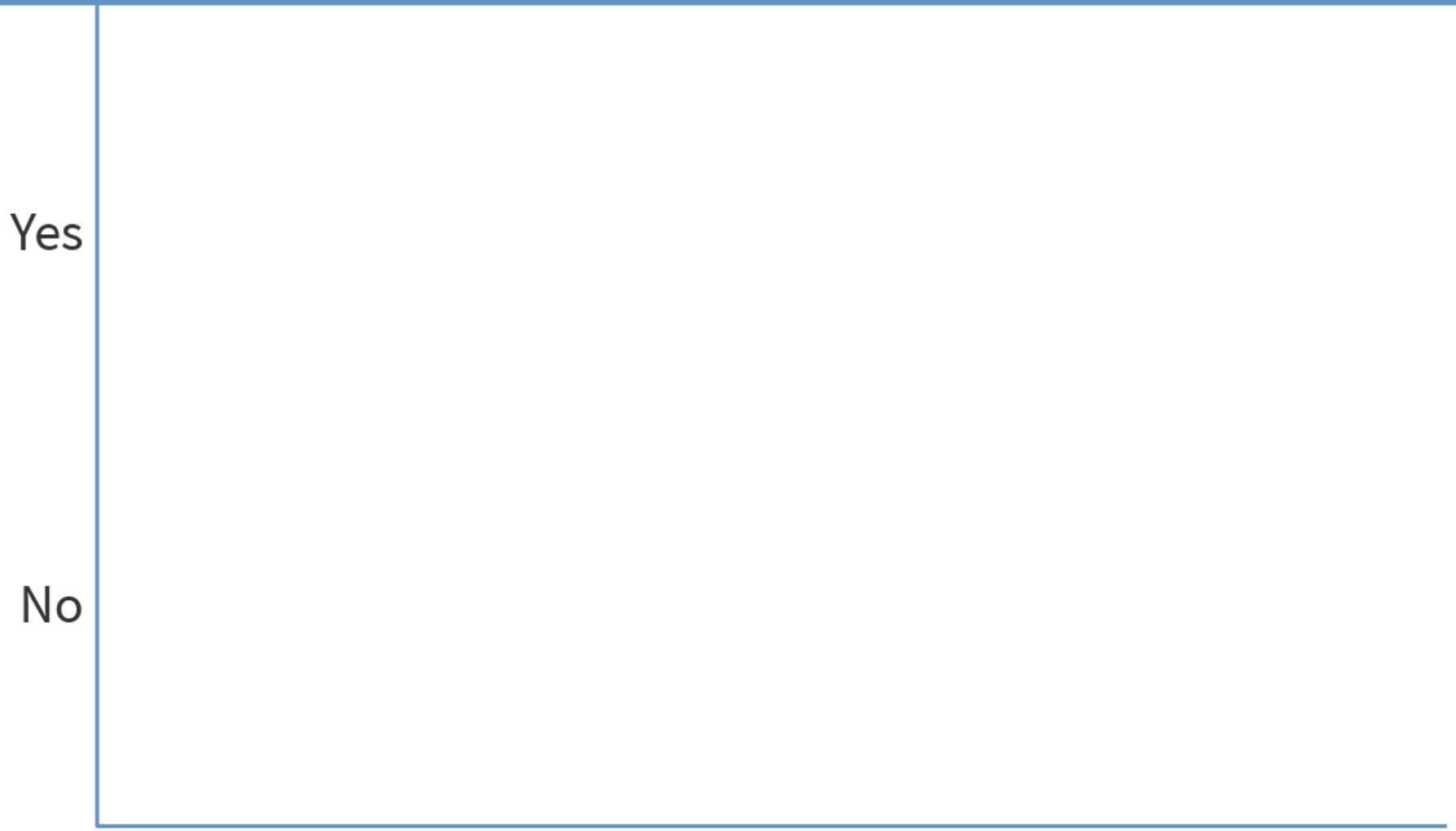
DEA-NFLIS 2016 (2017); Tompkins et al. (2009)

Medication-Assisted Treatment

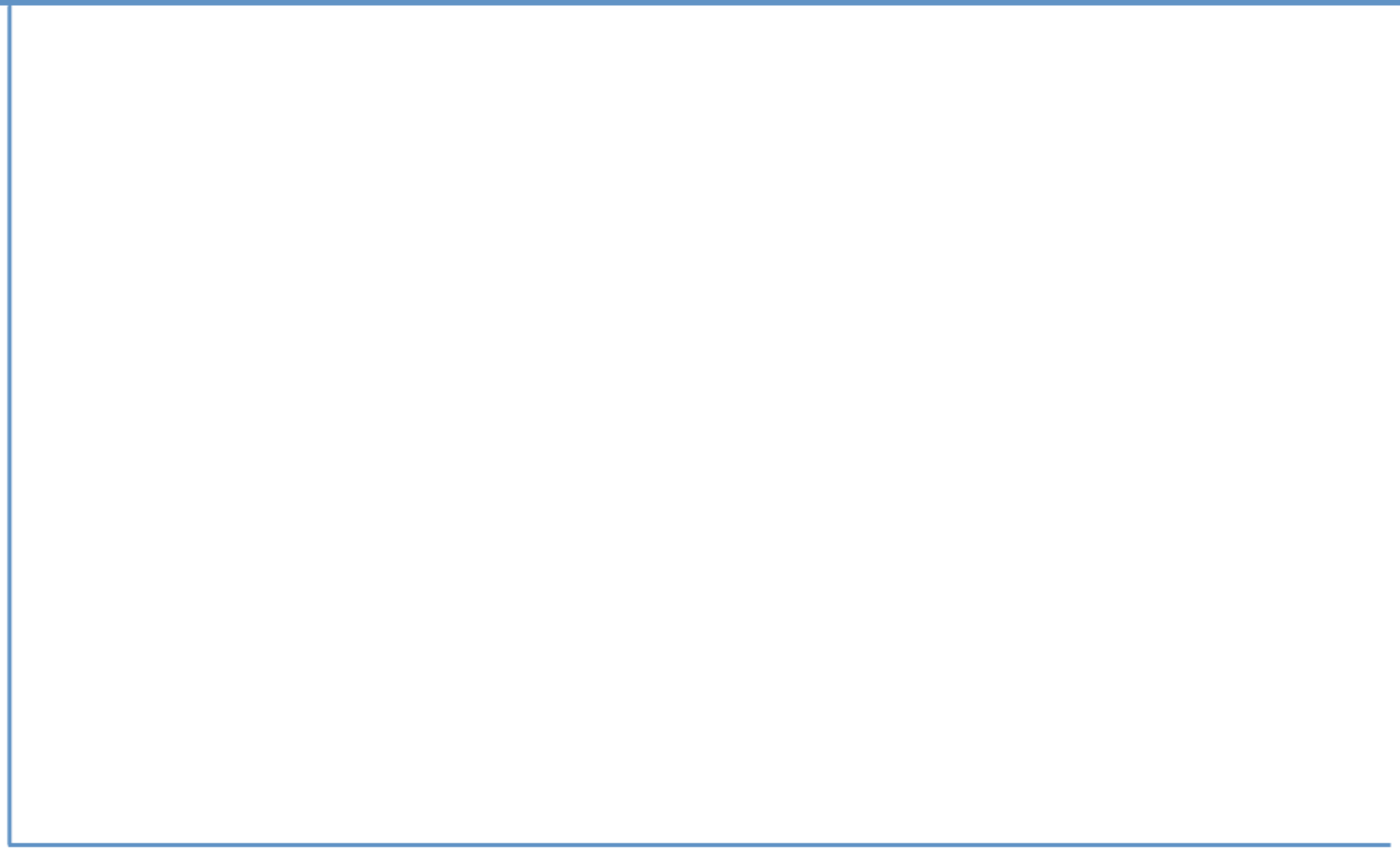
Have you worked with clients who follow an abstinence-based treatment program?



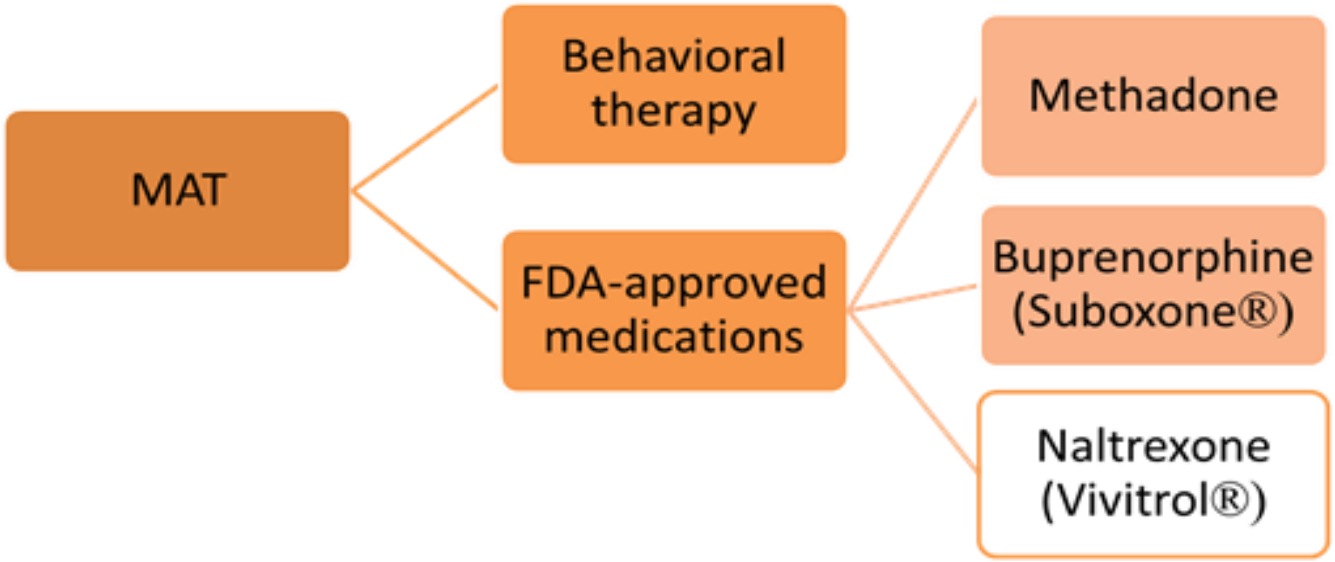
Have you worked with clients who use methadone or buprenorphine (Suboxone) as part of treatment?



Have you worked with clients who use naltrexone (Vivitrol) for their treatment program?



Medication-Assisted Treatment



MAT ≠ Medically managed withdrawal or detoxification

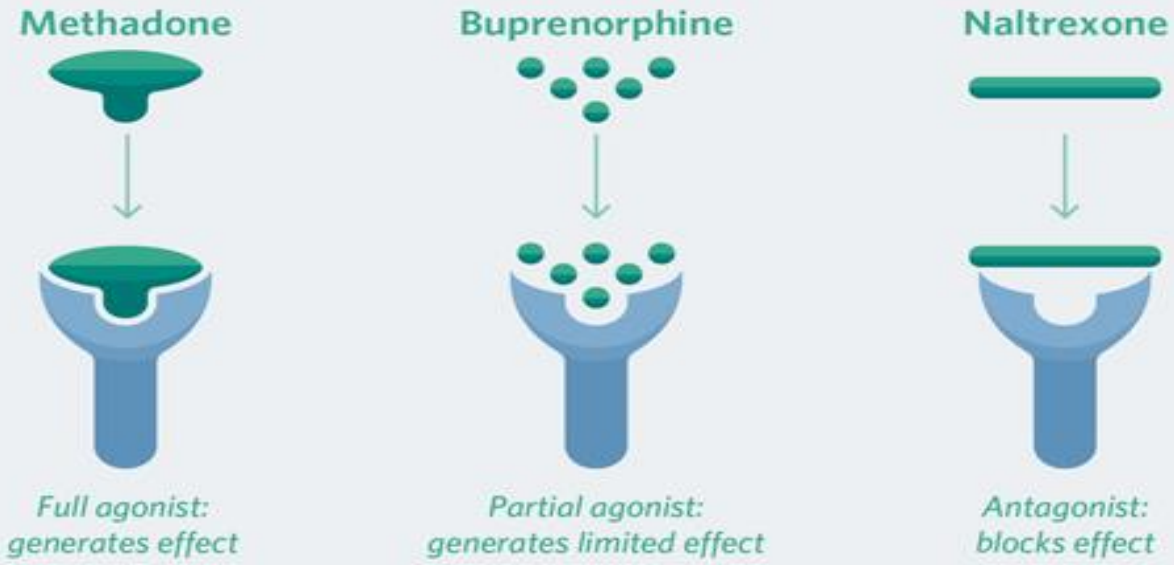
Source: ICJIA

Medication Types

Medication	Mechanism	Formulations	Regulations/Availability
Methadone	Agonist	Oral -wafer, pill, liquid	Designated, federally regulated Opioid Treatment Programs (OTPs)
Buprenorphine	Partial agonist	-Sublingual tablets or film -Buccal film -Subdermal implant -1-month injection	Requires waiver; Office-based treatment
Naltrexone	Antagonist	Intramuscular -1-month injection	Office-based treatment, no regulations

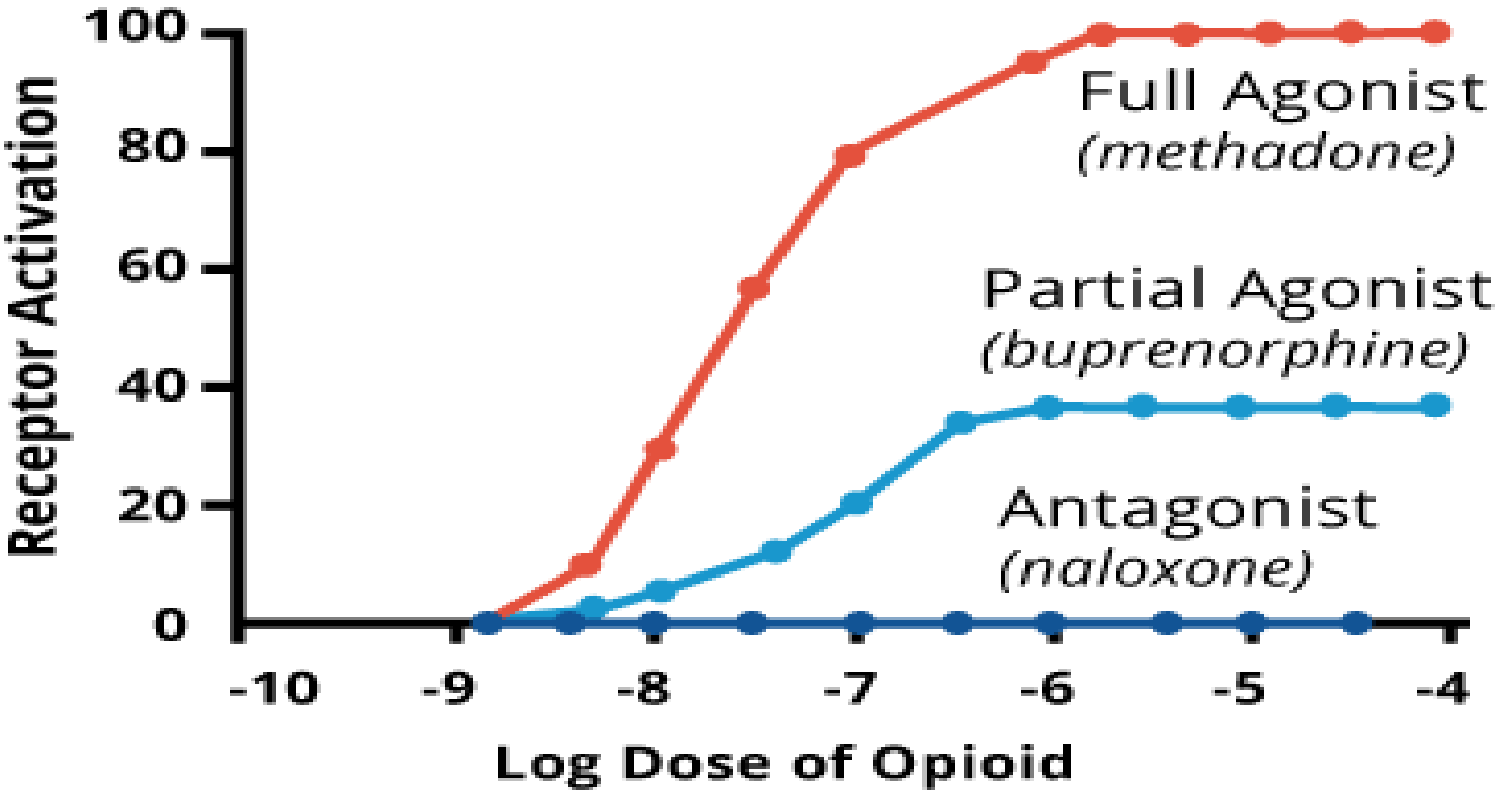
Figure 1

How OUD Medications Work in the Brain



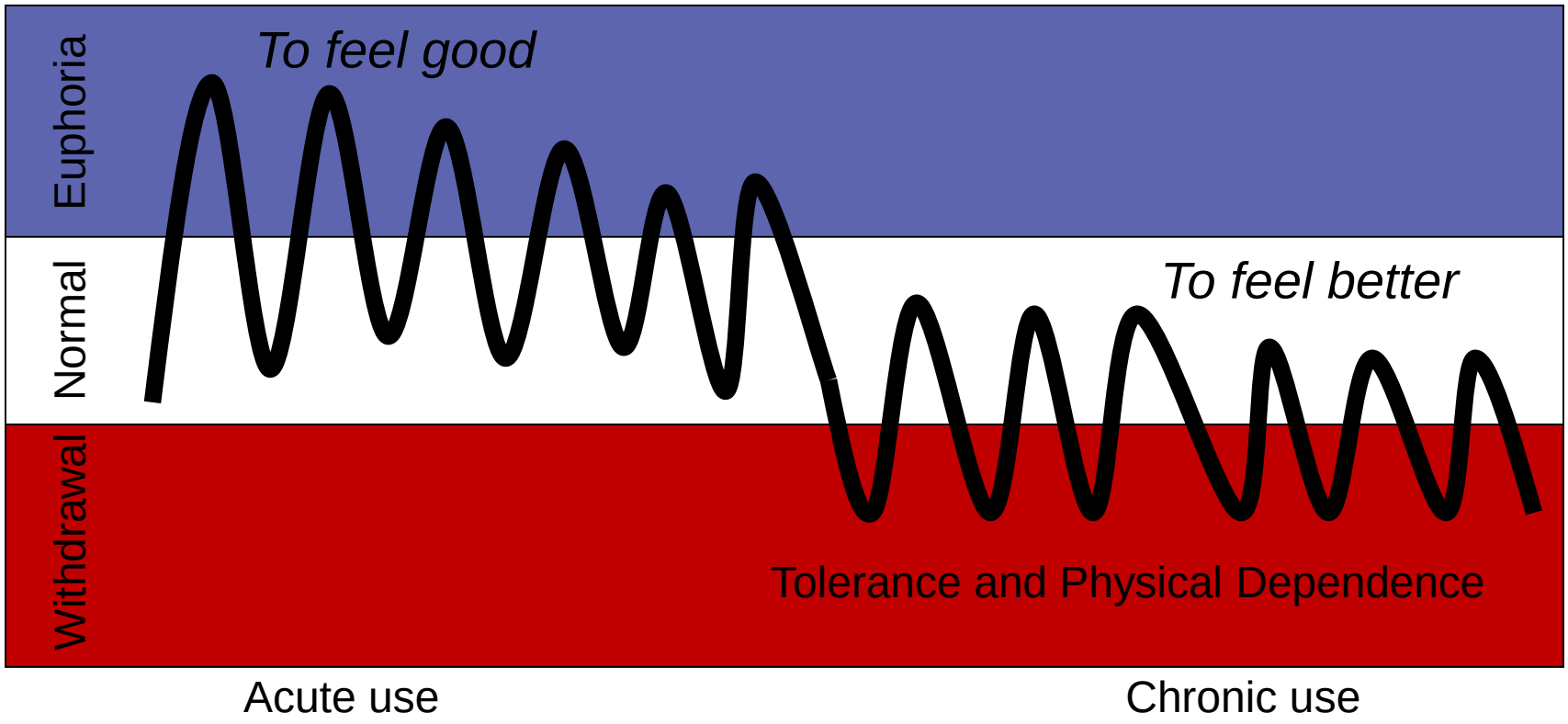
Source: PEW, 2016

Receptor Activation
Full Agonist, Partial Agonist, Antagonist



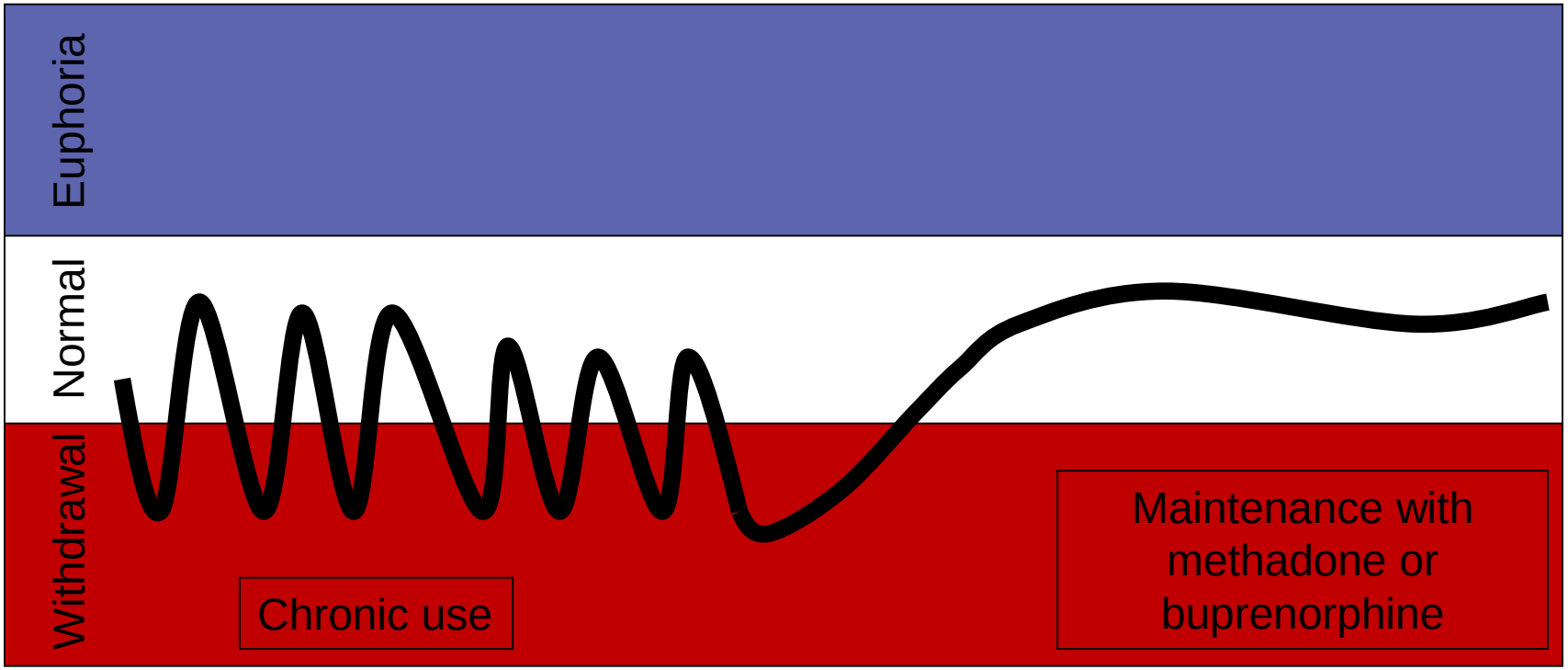
Source: SAMHSA, 2001

Chronic Opioid Use



Source: SAMHSA

Maintenance Therapy



Source: SAMHSA

IS IT EFFECTIVE?

Benefits of Methadone & Buprenorphine

- ↑ Client survival/decrease mortality related to opioid use
- ↑ Treatment retention/compliance
- ↑ Client's ability to obtain/maintain employment
- ↑ Birth outcomes for pregnant women
- ↑ Social functioning
- ↑ Improved outcomes for babies
- ↑ Rates of employment
- ↑ Length of life
- ↑ Supervision compliance

- ↓ Potential for relapse and overdose
- ↓ Opioid use and related criminal activity
- ↓ Risk to contract HIV or Hep B or C
- ↓ Mortality rate upon release from prison/jail
- ↓ Total healthcare costs (greater health benefits)
- ↓ Abuse potential (Suboxone)
- ↓ Violent crime rates (methadone)

Tzschentke (2002); Johnson et al. (2003); WHO (2009); Desmarias et al. (2016); SAMHSA (2016); Degenhardt et al. (2014);Connock et al. (2007); Mattick et al. (2009); Fiellin et al. (2006); Clark et al. (2014)

Benefits of Naltrexone

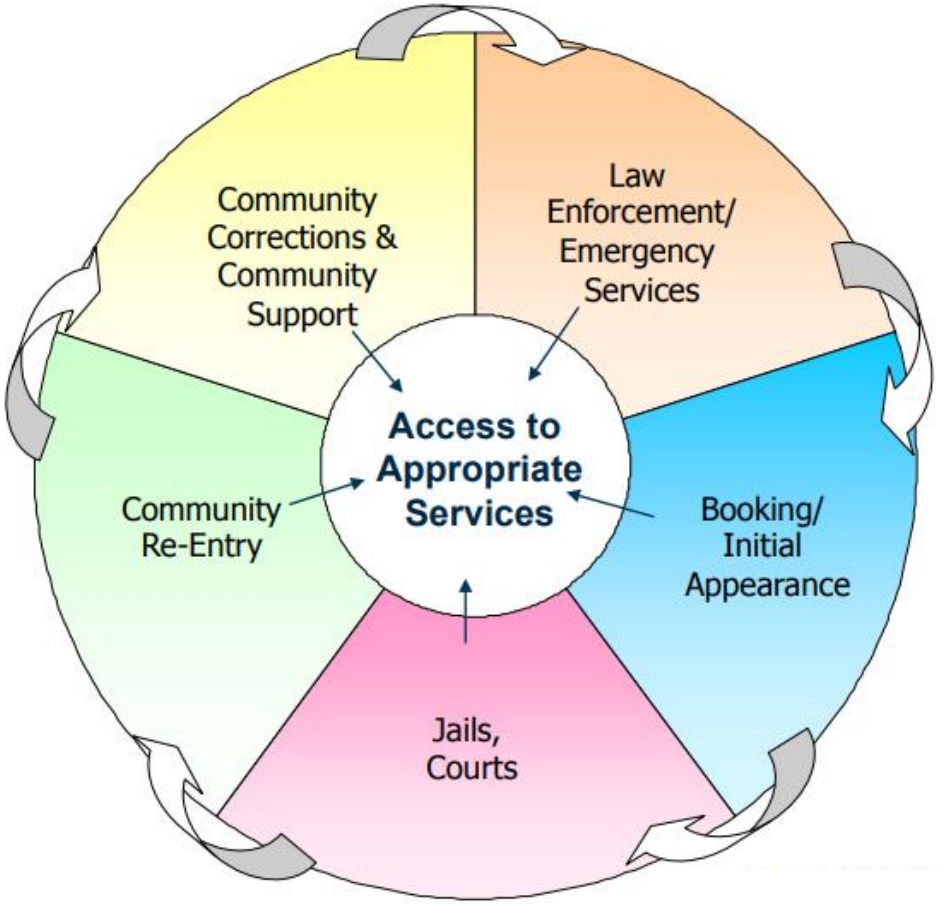
- ↑ Days abstinent
- ↑ Treatment retention

- ↓ Rate of relapse over 24-weeks
- ↓ Cravings*
- ↓ Reactivity to drug-conditioned cues

Fewer studies, particularly long-term, related to naltrexone (Vivitrol)

SAMHSA (2016); Lee et al. (2017)

Sequential Intercept Model



Source: Munetz & Griffin (2006)

Who would you need to collaborate with in your jurisdiction to connect individuals to medication-assisted treatment programs?

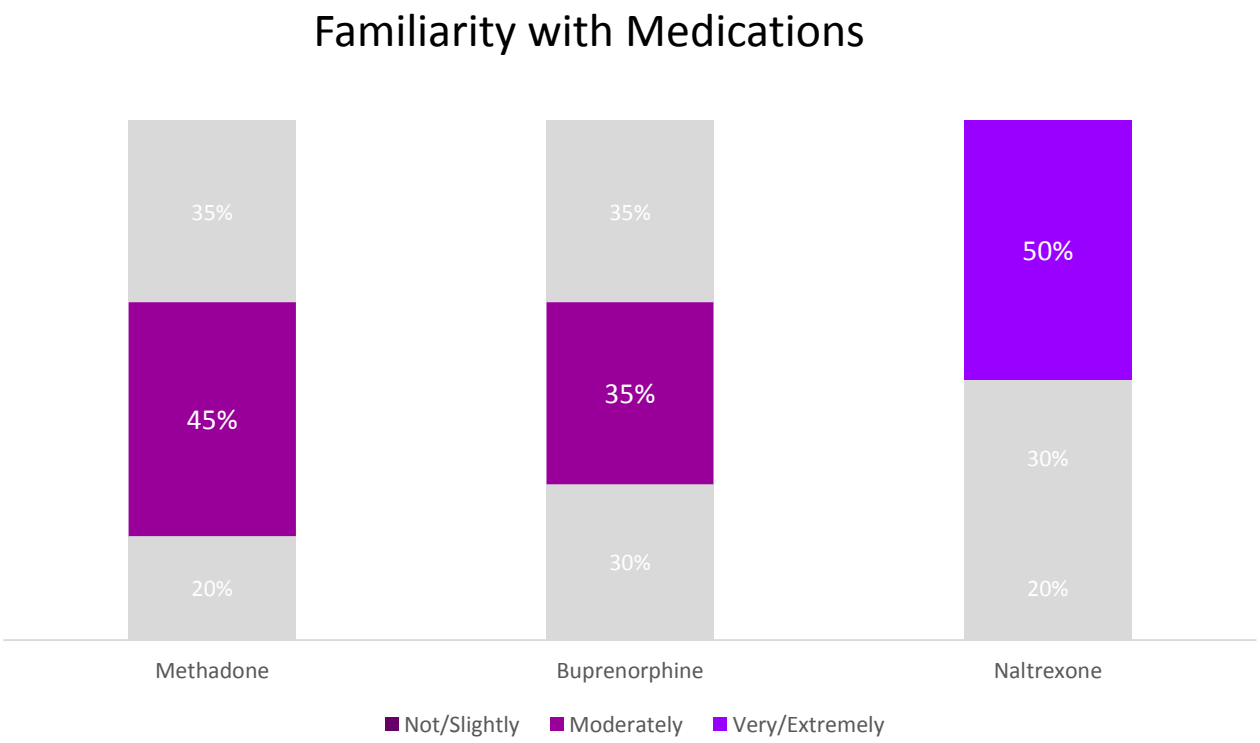
CHALLENGES AND CONCERNS

CJ-DATS Survey of Community Corrections on MAT

- Factors other than affordability and availability impact connection to MAT
  - **Individual**
    - Beliefs, experiences, knowledge, perceived roles, attitudes towards EBPs, medication, and etiology of OUDs/SUDs
  - **System**
    - Judge mandates, agency guidelines, interagency agreements for services, conflicting goals
- General limited understanding of SUDs and MAT

Mitchell et al. (2016); Clark et al., (2014); Gordon et al. (2015); Gryczynski et al. (2012)

Preliminary ICJIA Study on MAT: Probation (N=20)



May equal >100% due to rounding

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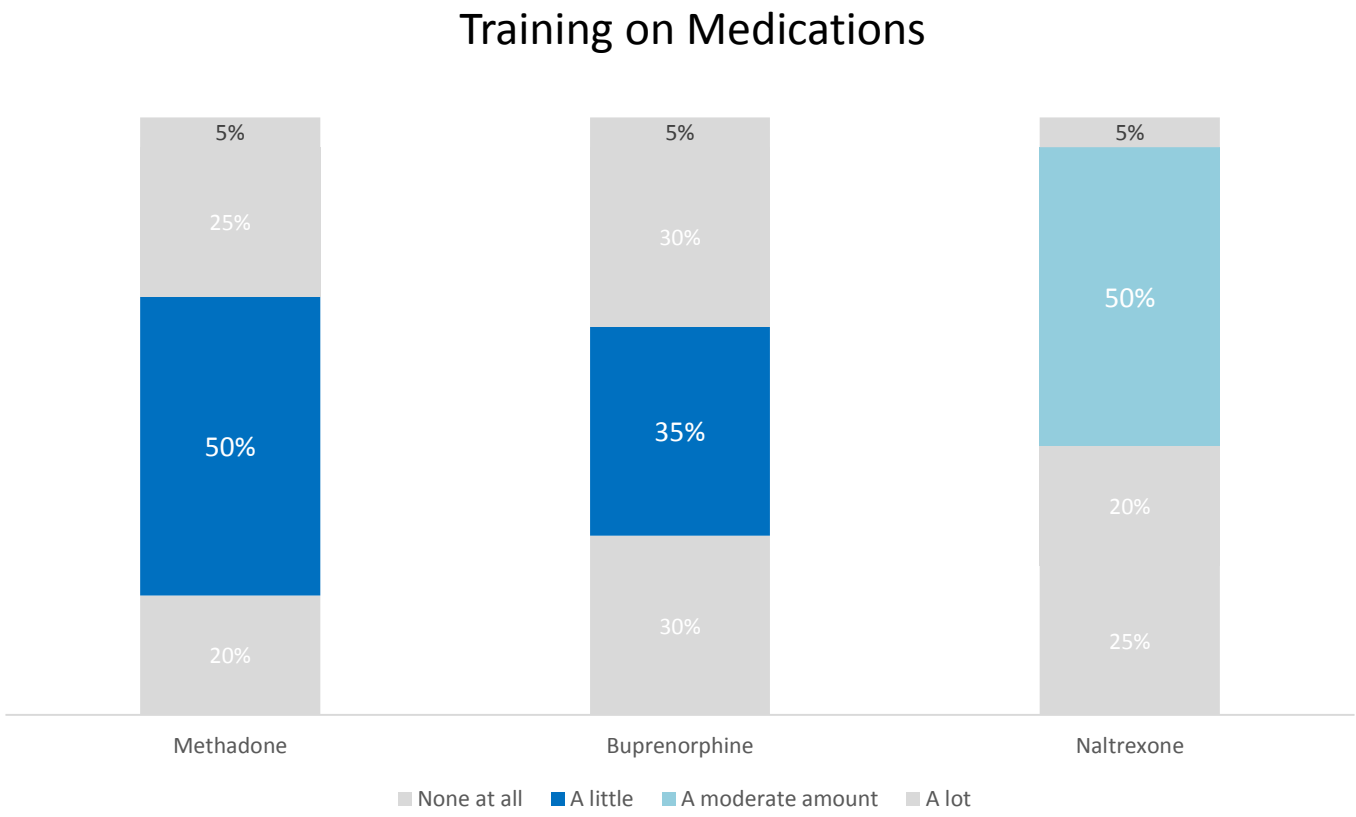

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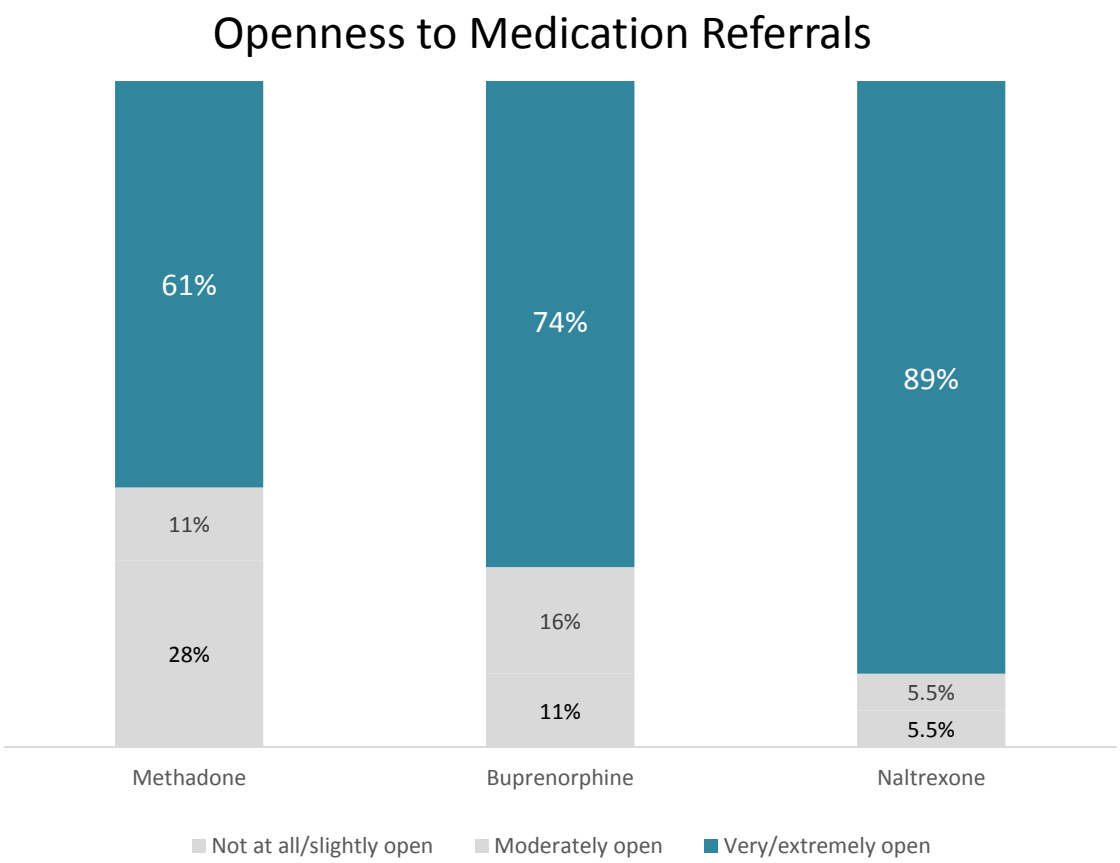

May equal >100% due to rounding

What are some challenges, concerns, questions you have about MAT within your jurisdiction?

Challenges & Concerns

- Funding
- Resources
  - Qualified providers, OTPs
- Buy-in
- Stigma
- Medication diversion
- Rejection* by 12-step
- Insurance coverage (or lack)
- Conflicting goals
- Individual factors
- Agency policies
- Stigma
- Diversion/misuse

Treatment Gap

- **23%** of publicly funded treatment programs indicated offering *any* FDA-approved medications to treat SUDs, including OUDs
  - **Less than half** of private sector treatment reported physician prescribing
- ACA mandates OUD coverage; does not specify which benefits covered
  - Medicaid coverage for buprenorphine predictor of adoption by community-based treatment

Knudsen et al. (2011); PEW (2016); Ducharme & Abraham (2008)

Diversion

- Predominant reasons for buprenorphine and methadone diversion:
  - Self-medicate **withdrawal sickness**
  - **Self-weaning** off opioids
  - **Self-treating** opioid dependence, pain, depression
- **Lack of access** to buprenorphine provider; inattentive providers (methadone, buprenorphine)
- **Decrease** in illicit use with **increase** in legal access (70%)
  - Also why dosing is important—possible under dosing
- Sharing norms among the opioid-using community

Cicero et al. (2014); Schuman-Olivier et al. (2009); Feroni et al. (2005)

Stigma

- **Reduces help-seeking behaviors**
- Results in non-evidence-based policies and practices
- Associated with drug use and SUDs
- Associated with discrimination and social disapproval
- Can create ambivalence toward treatment and sanctions against continued use
- Negative attitudes of health professionals can impact care

Richter et al. (2018) Rx summit presentation; Shatterproof.org

Solutions to Consider

- Telehealth models
- Reconsidering agency, state policies to align with EBPs of OUDs
- Educational training for staff
- Connection/discussion with local health department(s)
- Enhance prevention efforts—education, awareness
- Modification of legal/regulatory restrictions
- MAT provider training and support
- Work with local ERs, urgent care; med schools
- Work with local jails to incorporate MAT
- More wraparound services/collaboration between service providers
- Accountability for quality

MAT is **not** a panacea!

It is **what works best** for most people.

There will, unfortunately, be individuals who **misuse** medications or who are **non-compliant.**

But the number of those that **benefit outweigh this cost.**

I would highly recommend accessing this resource from SAMHSA for more information and research on MAT: https://store.samhsa.gov/shin/content//SMA18-5063FULLDOC/SMA18-5063FULLDOC.pdf

Questions

Can you identify any resources where you may be able to refer clients for MAT?

- What about resources that you may be able to collaborate with to acquire those resources?

- What questions do **you** have about OUD and MAT?

ILLINOIS CRIMINAL JUSTICE INFORMATION AUTHORITY

OPIOIDS IN ILLINOIS

EFFORTS TO INFORM & ASSIST THE CRIMINAL JUSTICE SYSTEM

RESEARCH & EVALUATION

- Overview of opioid crisis in Illinois
- Pre-arrest diversion and deflection programs
- Evidence-based practices for substance use disorders
- Medication-assisted treatment for criminal justice populations
- Post-overdose responses for first responders
- Self-reported prescription drug use among Illinois prisoners
- Illinois Drug Threat Assessment
- Drug trends and distribution in Illinois

COLLABORATION

- State of Illinois Opioid Plan
- State Opioid Use Disorders in Corrections Working Group
- Summit: Pre-diversion strategies
- Conference: Criminal Justice Response to Opioid Crisis

FUNDING

- Police deflection/diversion programs
- Multi-jurisdictional drug task forces
- Prescription drug disposal
- Prison-based treatment

Illinois Criminal Justice Information Authority

RESEARCH AND ANALYSIS UNIT

Dr. Megan Alderden, Associate Director

The ICJIA Research and Analysis Unit serves as Illinois' Statistical Analysis Center (SAC). State SACs provide objective analysis of criminal justice data to inform statewide policy and practice. The Illinois SAC features four research centers and acts as a liaison between state agencies and the U.S. Department of Justice.

CENTER FOR JUSTICE RESEARCH AND EVALUATION

- Applied research
- Program evaluation
- Technical reports and articles
- Policy analysis
- Technical assistance for local and state agencies
- Collaboration with criminal justice practitioners and academics
- Criminal justice forums and events
- National and state presentations

Jessica Reichert, Manager
Jessica.Reichert@Illinois.gov

CENTER FOR CRIMINAL JUSTICE DATA AND ANALYTICS

- Data collection and analysis
- Distribution of crime and risk factor information
- Data management and visualization
- Dissemination of state criminal history record information (CHRI) data for research purposes
- Technical assistance in statistical methods, database design, data analysis, and data presentation

Christine Devitt Westley, Manager
Christine.Devitt@Illinois.gov

CENTER FOR SPONSORED RESEARCH AND PROGRAM DEVELOPMENT

- Support for selected experts in the field who conduct research and evaluate programs
- Selection of programs viable for evaluation and further research
- Technical assistance to programs supported with ICJIA-administered grant funds

Tracy Hahn, Manager
Tracy.Hahn@Illinois.gov

CENTER FOR VICTIM STUDIES

- Research examining the nature and scope of victimization in Illinois
- Evaluation of programs that address victim needs
- Technical assistance to victim service programs
- Management of InfoNet System, a web-based data collection and reporting service for standardized victim service data

Jaclyn Houston-Kolnik, Manager
Jaclyn.Kolnik@Illinois.gov

Contact Information

ILLINOIS
CRIMINAL JUSTICE
INFORMATION AUTHORITY

300 West Adams, Suite 200
Chicago, Illinois 60606 | 312.793.8550
TDD: 312.793.4170 | Fax: 312.793.8422
Lily.Gleicher@illinois.gov
icjia.org

Lily Gleicher, M.S.
Research Analyst
Center for Justice Research and Evaluation

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