

Medication-Assisted Treatment in the Criminal Justice System

MIKE GAUDET LICSW

DIRECTOR OF QUALITY ASSURANCE, COMPLIANCE AND PRIVACY OFFICER

ARBOUR COUNSELING SERVICES



New England (HHS Region 1)

ATTC

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Disclosures

The development of these training materials were supported by grant H79 TI080209 (PI: S. Becker) from the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. The views and opinions contained within this document do not necessarily reflect those of the US Department of Health and Human Services, and should not be construed as such.



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Goals of Today's Training

After this training, you will be more familiar with:

✓ **Addiction**

- ✓ and how it affects the brain
- ✓ dopamine and the reward pathway

✓ **Medications**

- ✓ for addiction treatment
- ✓ how they work & what they do

✓ **Benefits**

- ✓ of addiction treatment to the CJ System

✓ **Planning**

- ✓ By PPI leadership, staff, Board & Parole
- ✓ To think about whether/how to expand MAT use

An Open Conversation about MAT

Using medication to treat addiction is a good idea because...

- **Using medication in addiction treatment is a not-so-good idea because...**

An Open Conversation About MAT

Concerns about MAT?

- The medications?
 - Methadone, Buprenorphine, Vivitrol
 - Diversion, safety concerns
- The clinics?
 - “Bad” methadone clinics
 - Attracting dealers and crime
 - Therapeutic communities don’t allow MAT

MAT Myth Busters: Myth #1

“Medication is not a part of treatment.”

- Medication can be an effective part of treatment.
- Medication is used in the treatment of many diseases, including addiction.
- Medical decisions must be made by trained and certified medical providers.
- Decisions about using medications are based on an objective assessment of the individual client’s needs.

MAT Myth Busters: Myth #2

“Medicines are drugs, too.”

Errors in Language:

Physical Dependence vs Addiction

**Drugs are used to *get high*, but
medications are used to *get better*.**

Medicine (n.) an innovation of the human species which has given us a competitive advantage for thousands of years; innovations in science & medicine have historically been helpful and progressive.

MAT Myth Busters: Myth #3

“Alcoholics Anonymous (AA) & Narcotics Anonymous (NA) do not support the use of medications.”

While some specific NA chapters are not tolerant of methadone, AA/NA literature and founding members did not speak or write against using medications.

MAT Myth Busters: Myth #4

“MAT is not effective.”

MAT medications had to demonstrate the same level of effectiveness as all other types of medications for other diseases to get FDA approval.

We tend to have a biased perception:

- Patients who improve, leave and are forgotten
- Patients who do *not* improve return frequently and are remembered
 - Leads us to think that most patients do not improve

...contrary to scientific data.

The Clinician's Illusion After *Cohen & Cohen Arch Gen Psych 1984*

MAT Myth Busters: Myth #5

“Clients who are not using drugs at present do not need MAT.”

**More than half of inmates
will relapse
within one month of release.**

Reasons include:

- peer pressure
 - familial pressure
 - tensions of daily life
 - few job opportunities
 - lack of safe housing
- isolation
 - disillusionment & apathy
 - the stress of complying with correctional supervision

Some sobering statistics...

Nearly 1 in 10 persons will die within 2 years after an initial overdose

There is a 50% reduction in number of deaths for those on MAT

Only about 5% of persons with OUD are getting MAT

Opioid death rates are 120x's greater in MA for those with a history of incarceration.
In RI?

Majority of life-threatening incidents occurs within 4 weeks of release.

Overdose deaths are 30 times higher for homeless population

Higher rates of overdose for those with co-occurring disorders

What does this all mean for the Criminal Justice System?

More Sobering Statistics

Service/Training Need	Supporting Data/Statistics
1. Promoting access to treatment	<ul style="list-style-type: none"> • Across the 6 New England (NE) states, only 14-20% of those who meet criteria for a substance use disorder receive any specialty treatment
2. Increasing capacity to address opioid epidemic	<ul style="list-style-type: none"> • Five of the 6 New England states are in the top 10 states nationwide for opioid-related overdose deaths • Opioid-deaths reflect soaring rates of both heroin and fentanyl: 5 NE states were in the top 12 for heroin deaths and all 6 NE states were in the top 9 states nationwide for deaths due to synthetic opioids
3. Improving integration	<ul style="list-style-type: none"> • Many individuals with or at risk of SUDs interact with other service systems (e.g., primary care, criminal justice, schools) often representing a missed opportunity for linkage to care
4. Enhancing the quality of care for youth	<ul style="list-style-type: none"> • All 6 NE states are at or above the national average for rates of adolescent binge drinking, marijuana use, and use of other illicit drugs • Major shortage of regional providers/facilities with specialized training in adolescents (e.g., RI has no long-term residential services for youth) • Young adults in NE have rates of opioid use above the national average, suggesting teens may represent an opportunity for intervention
5. Advancing cultural and linguistic competence	<ul style="list-style-type: none"> • Regional workforce is over 80% Caucasian • Only 3 NE states provided data to the National Office of Minority Health on adherence to CLAS Standards: only 2 reported conducting a baseline assessment
6. Improving access to recovery supports	<ul style="list-style-type: none"> • Several NE states are investing in peer recovery models, but data in support of these models and how to best evaluate, implement, and regulate them are often lacking

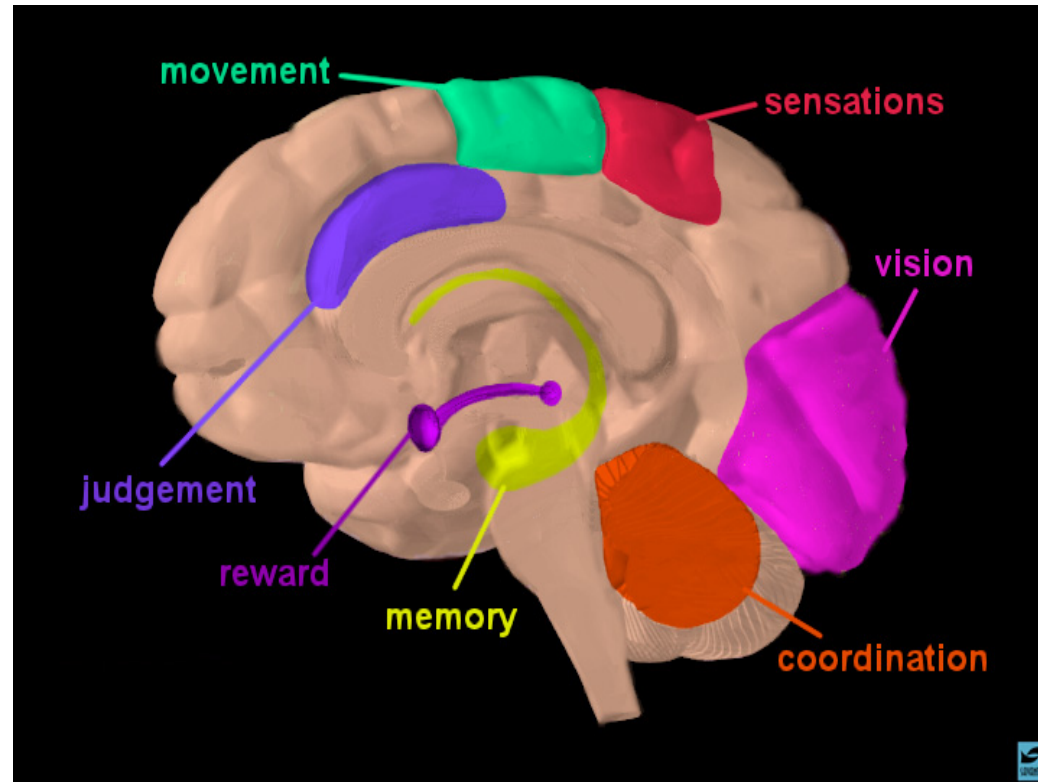
Addiction is...



A CHRONIC DISEASE

Can the brain get hijacked?

Research shows...

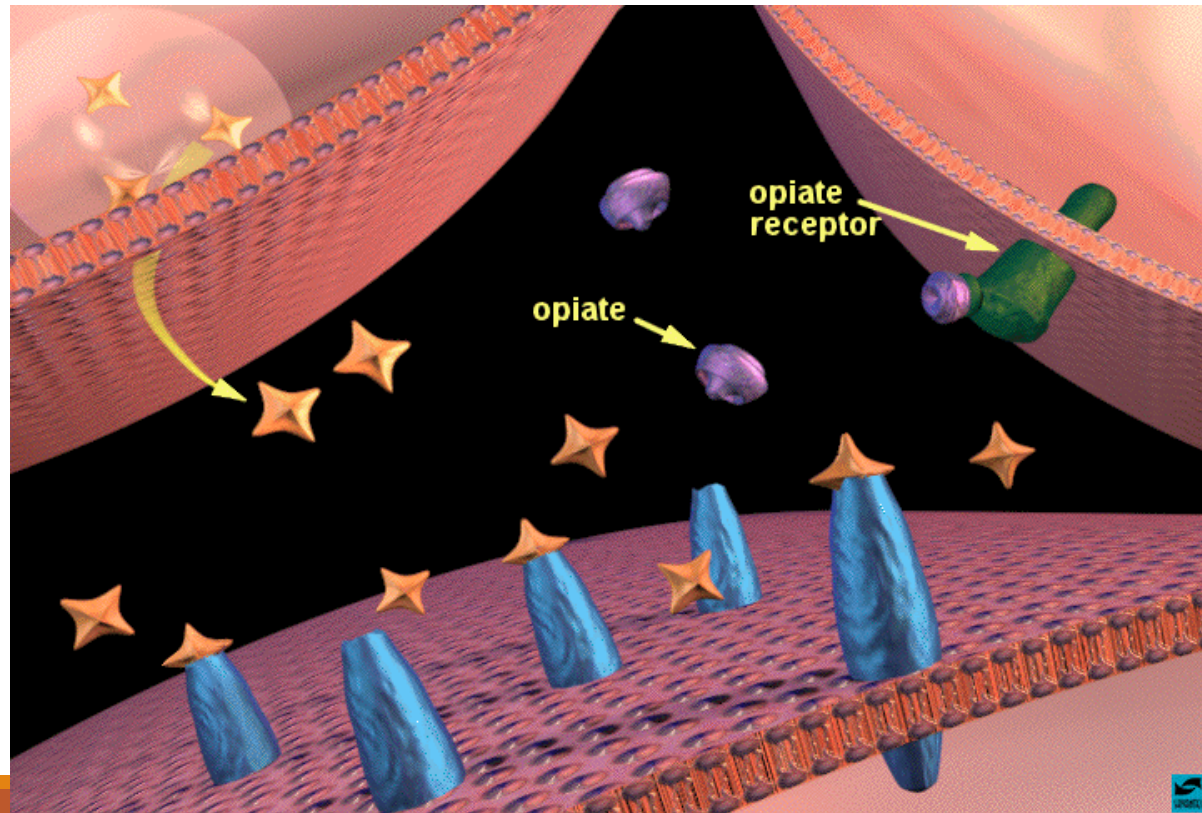


that prolonged drug use can **change brain chemistry.**

First, let's take a look at Opioid Addiction

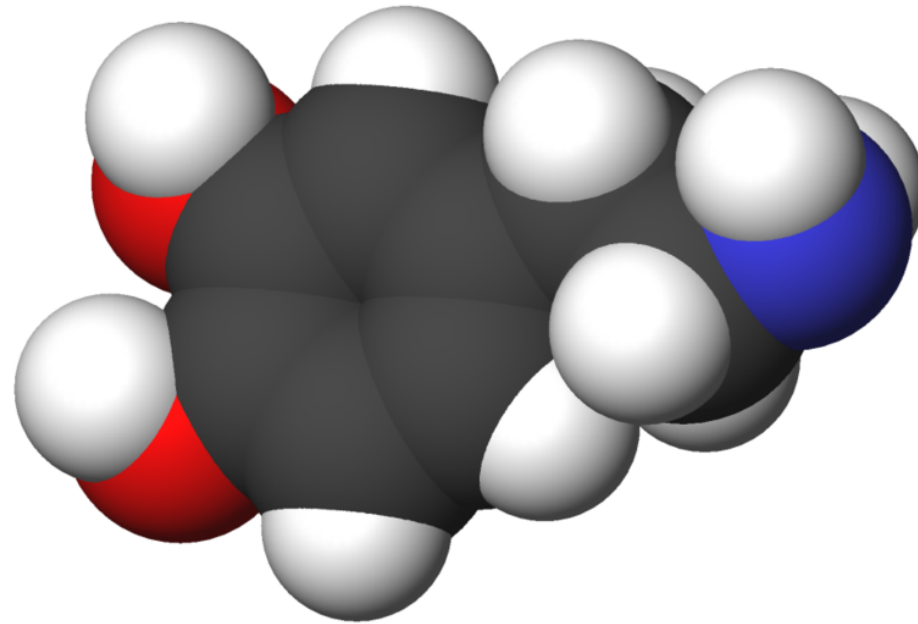
Some Examples:

- Morphine
- Heroin
- Codeine



How can the brain get hijacked by opioids?

Opioid use...



disrupts normal Dopamine functioning.

How do medications for opioid addiction work?

There are three types of medications that can block the “high”:

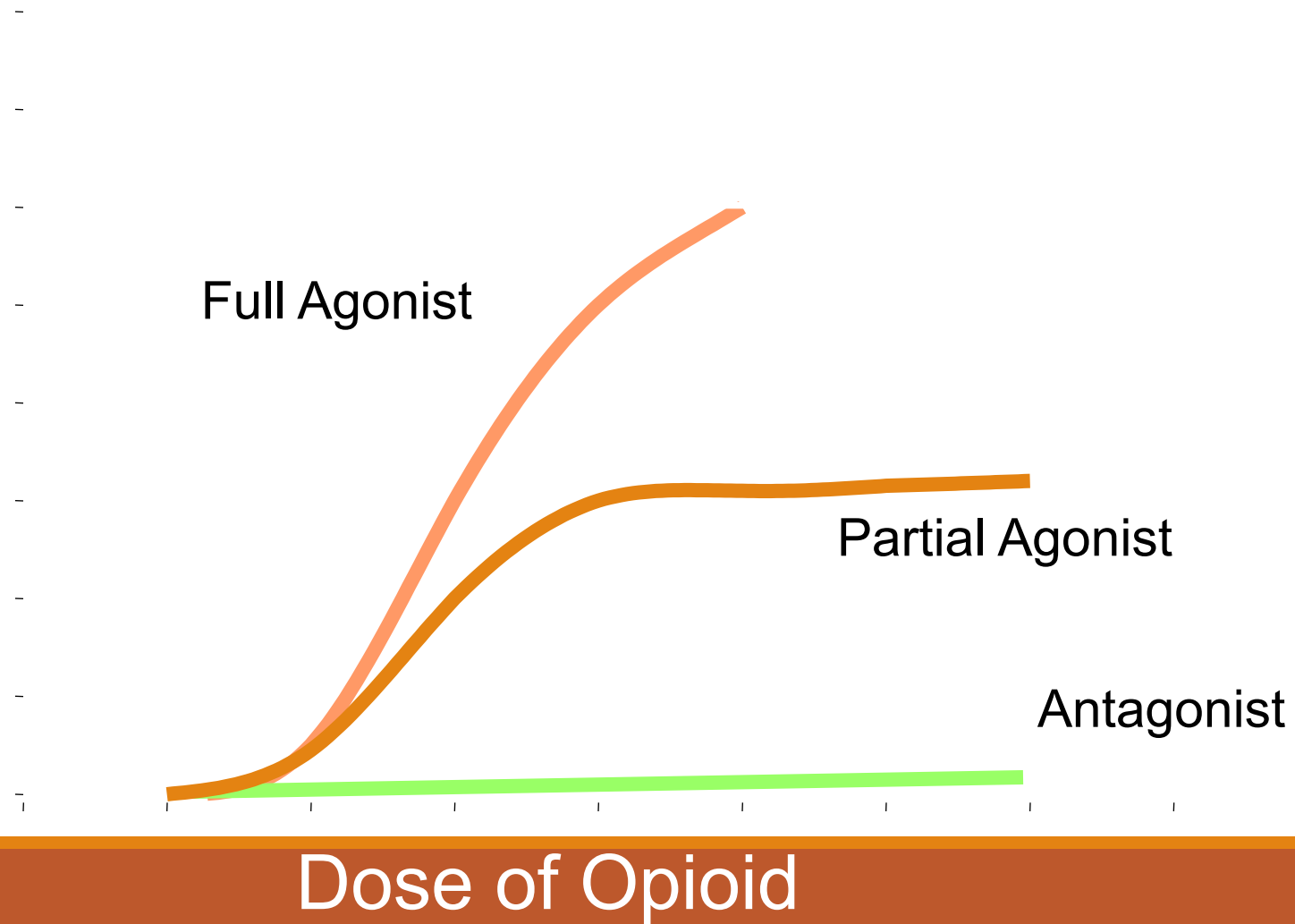
- **Agonists**
 - produce opioid effects
- **Partial Agonists**
 - produce moderate opioid effects
- **Antagonists**
 - block opioid effects

How Does Buprenorphine Work?

It's a Partial Agonist.

- Agonist effect helps the patient to feel normal, without craving or withdrawal
- Binds strongly to opiate receptor
- Blocks opiate effects
- Ceiling effect at higher doses
- Safer than methadone or other full agonists...not necessarily better...

How do medications for
opioid addiction work?



Some Advantages of Buprenorphine

Available through a physician office or non-methadone clinic

Easier to keep job, participate in other activities

Lower level of physical dependence

Limited potential for overdose

Minimal subjective effects (e.g., sedation)

Some Disadvantages of Buprenorphine

1. Greater medication cost
2. Lower level of physical dependence
-i.e., patients can discontinue treatment
3. Not detectable in most urine toxicology screenings:
have to specifically request it.

What does the research say?

Over 25 years of research and over 5,000 patients exposed during clinical trials, show that

Buprenorphine is a safe and effective treatment for opioid addiction.

What does the research say?

- Buprenorphine is about as effective as 60 mg daily of methadone.
- In one study, after a year of bupe plus counseling, **75%** of patients were retained, compared to **0%** in a placebo plus counseling condition.

Naltrexone

*Used to treat **opiate and alcohol** addiction.

■ Trade Names/Formulations

- Depade® oral tablets
- ReVia® oral tablets
- Vivitrol® Extended-release naltrexone

Naltrexone

Addictive Properties: Not addictive and no withdrawal symptoms.

Oral formulations:

Cost: \$110.68 per month, which is around \$3.69 a day.⁶⁹

Third-Party Payer Acceptance: Covered by most major insurance carriers, Medicare, Medicaid, and the VA.⁶⁸

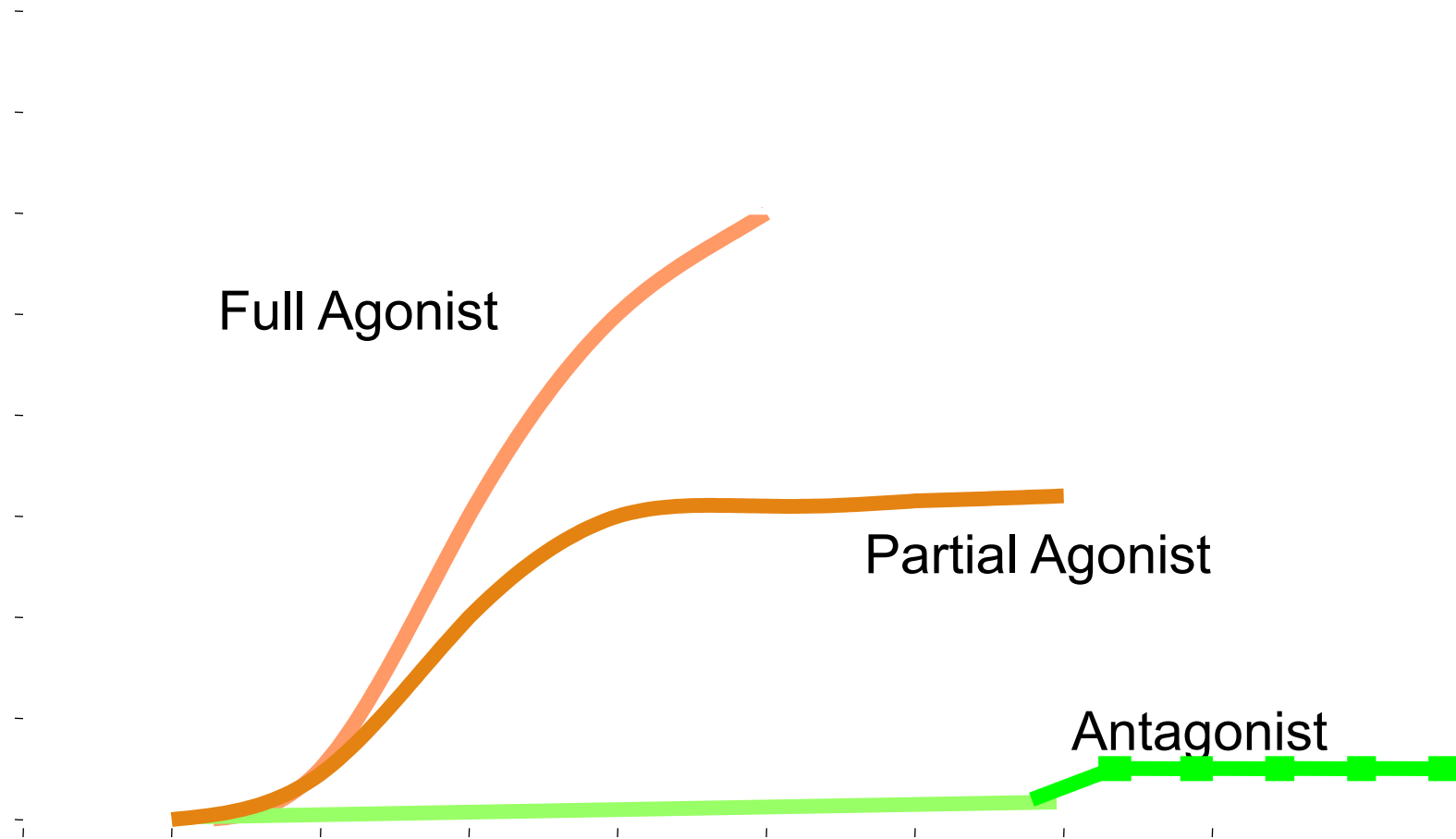
Long-acting injectable formulation:

Cost: \$866.46 per month, which is around \$28.88 per day (injectors fee not included).

Third-Party Payer Acceptance: Approximately 90% of patients thus far have received insurance coverage with no restrictions.

How Does Naltrexone Work?

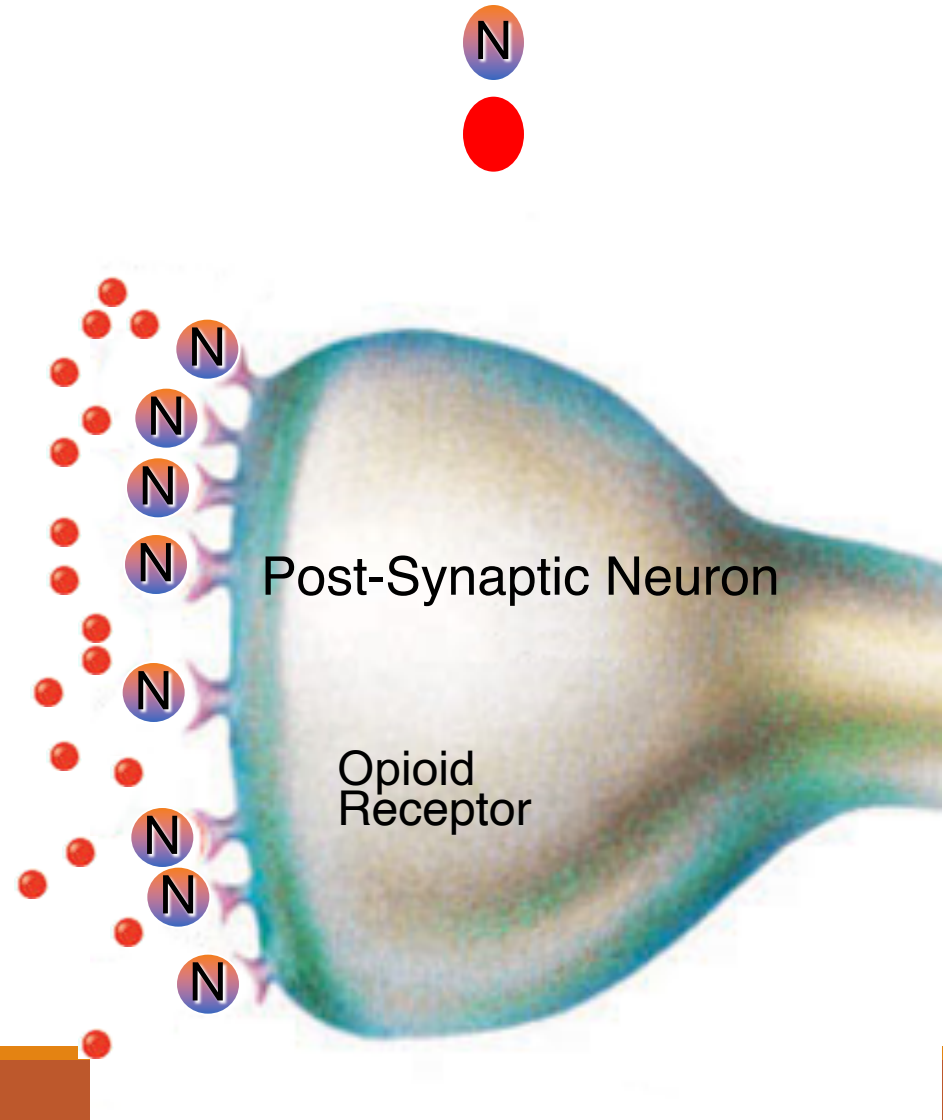
Antagonist



How *Does* Naltrexone Work?

It's an antagonist.

- 1) It blocks opioid receptors,
- 2) the reinforcing "reward" effects from dopamine are reduced,
- 3) drug consumption is thus reduced.



What does the research say?

Naltrexone is effective for opiate and alcohol addiction.

Reduces risk of re-imprisonment

Lowers risk of opiate use, with or without psychological support

Extended-release naltrexone addresses the issue of patient compliance

What does the research say?

Naltrexone for opiates was well tolerated and associated with a significant abstinence rate.

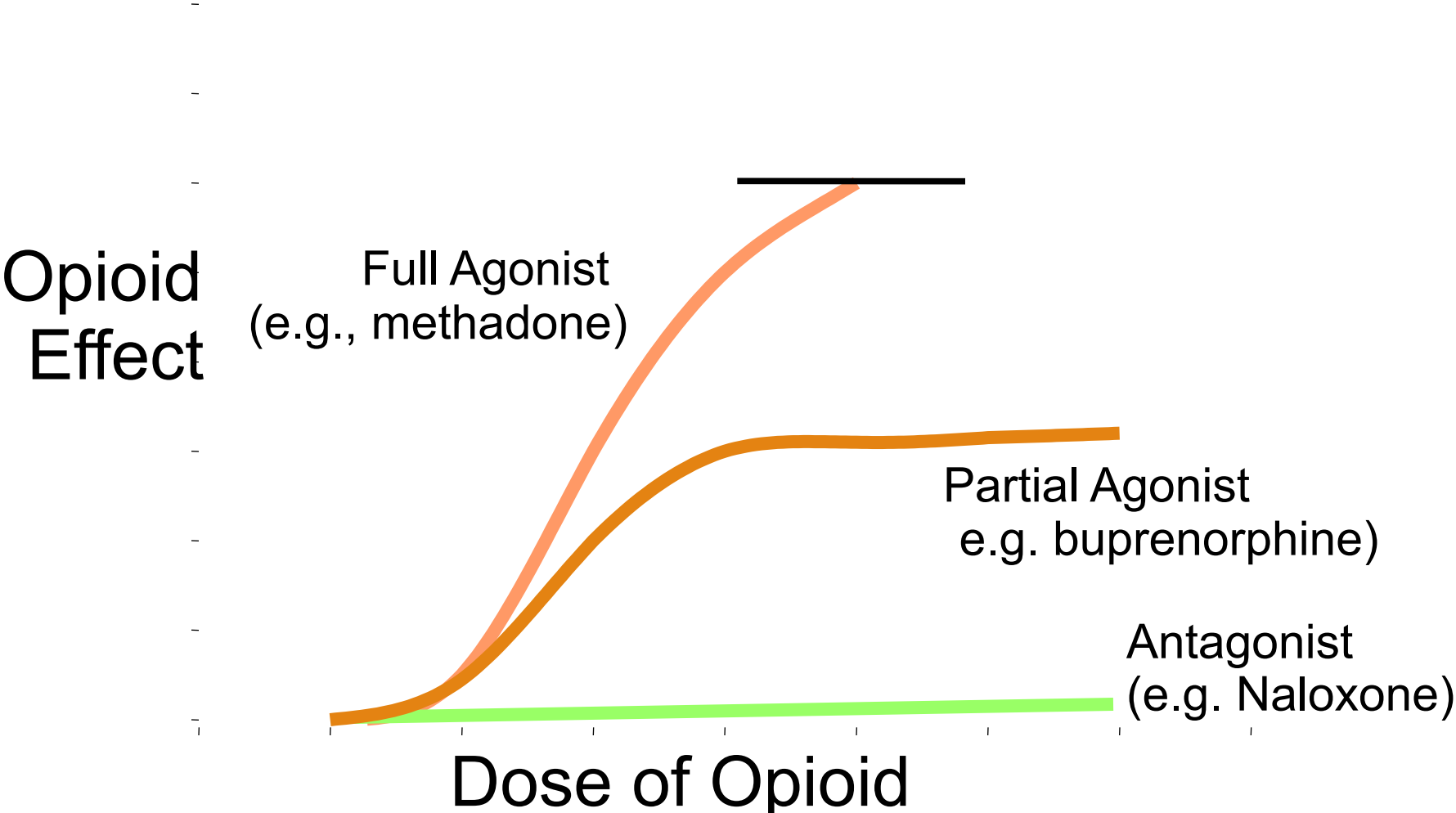
In a five-year follow up study, naltrexone with behavioral therapy for opiates saw improvements in drug use, days of depressant use, legal status, and psychiatric factor.

Methadone

- Alleviates withdrawal & blocks euphoria.
- Is used for detoxification or maintenance.
- Also known as:
 - Methadose®
 - Dolophine®
- Approved: 1964
- Third-Party Payer Acceptance: Covered by most major insurance carriers, Medicare, Medicaid and the VA.

How does Methadone Work?

Full Agonist



What does the research say?

Methadone is the most studied medication for opioid addiction.

- 8-10 fold reduction in death rate
- Reduces opioid use
- Reduces crime
- Improves family and social functioning
- Increases likelihood of employment
- Improves physical and mental health
- Reduces spread of HIV
- Low drop-out rate compared to other treatments

Methadone; an agonist medication



Agonist Therapy: Methadone

By the mid- and late 1960's, heroin related mortality was the leading cause of death for young adults between ages 15-35 in New York City.

In 1962, Dr. Vincent Dole received grant to study feasibility of opiate maintenance in NY/Rockefeller University

Dr. Nyswander and Dr. Mary Jeanne Kreek joined Dr. Dole's staff in 1964

Agonist Therapy: Methadone

No euphoric/analgesic effects

Doses between 80-120mg held at level to block their euphoric and tranquilizing effects

No change in tolerance level over time

Could be taken once a day

Relieved craving attributed to relapse

Medically safe and nontoxic

Agonist Therapy: Methadone

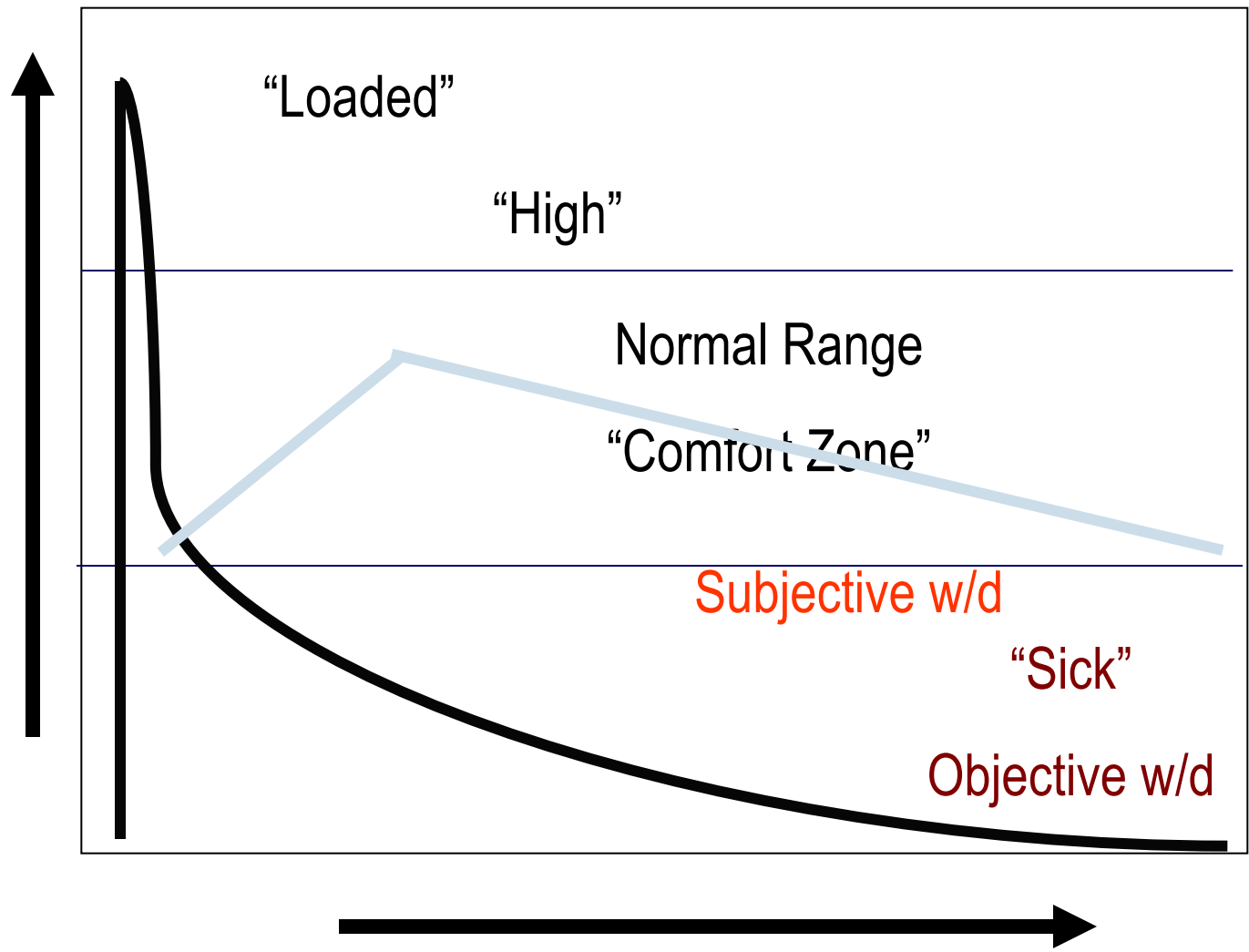
Proper dose lasts between 24 - 36 hours

Does not create euphoria, sedation or analgesia

Duration of treatment individualized

Most significant long term effects on health is marked improvement

Side effects usually subside within a month



"Loaded"

"High"

Normal Range

"Comfort Zone"

Subjective w/d

"Sick"

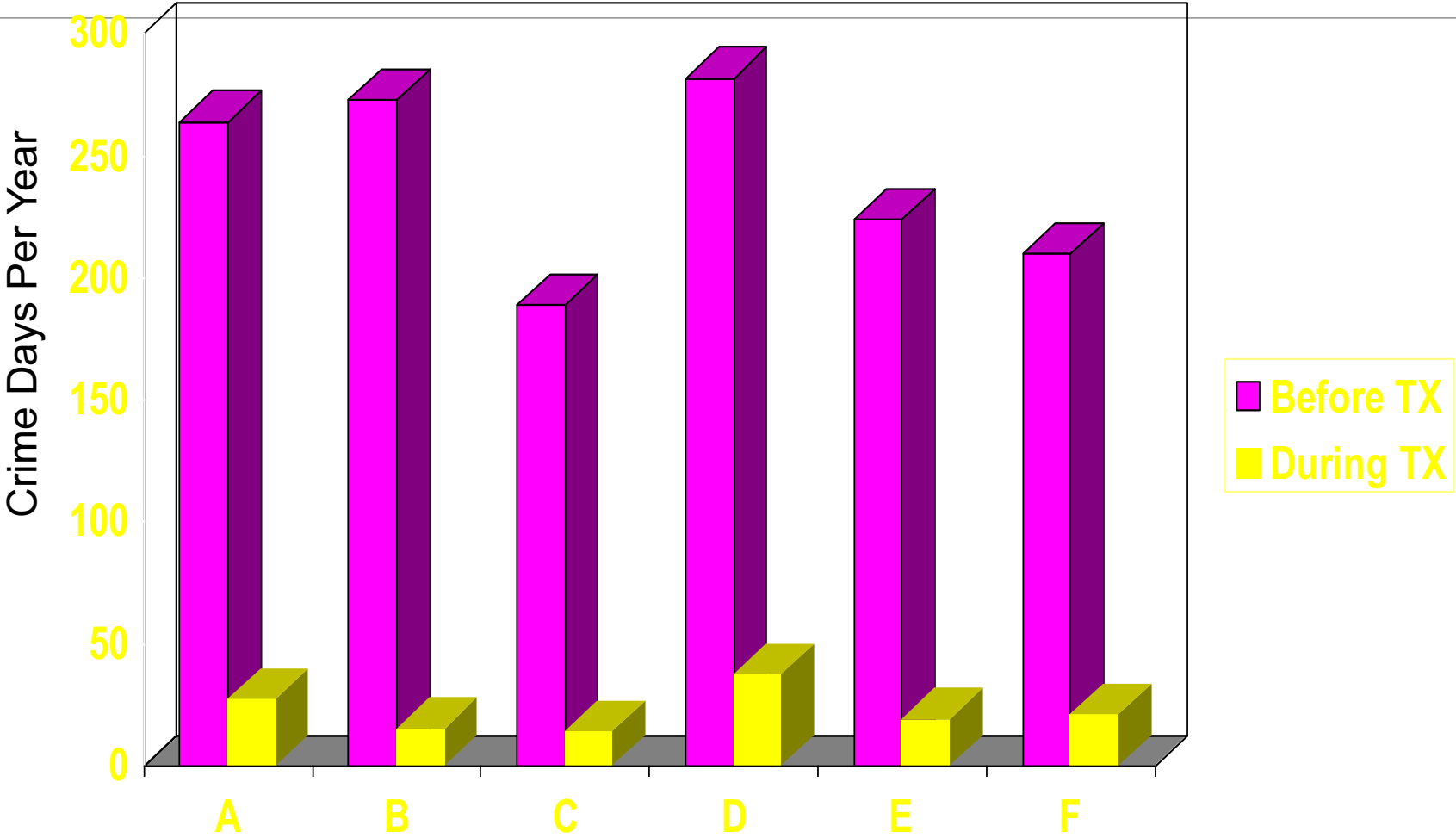
Objective w/d

Agonist Therapy: Methadone

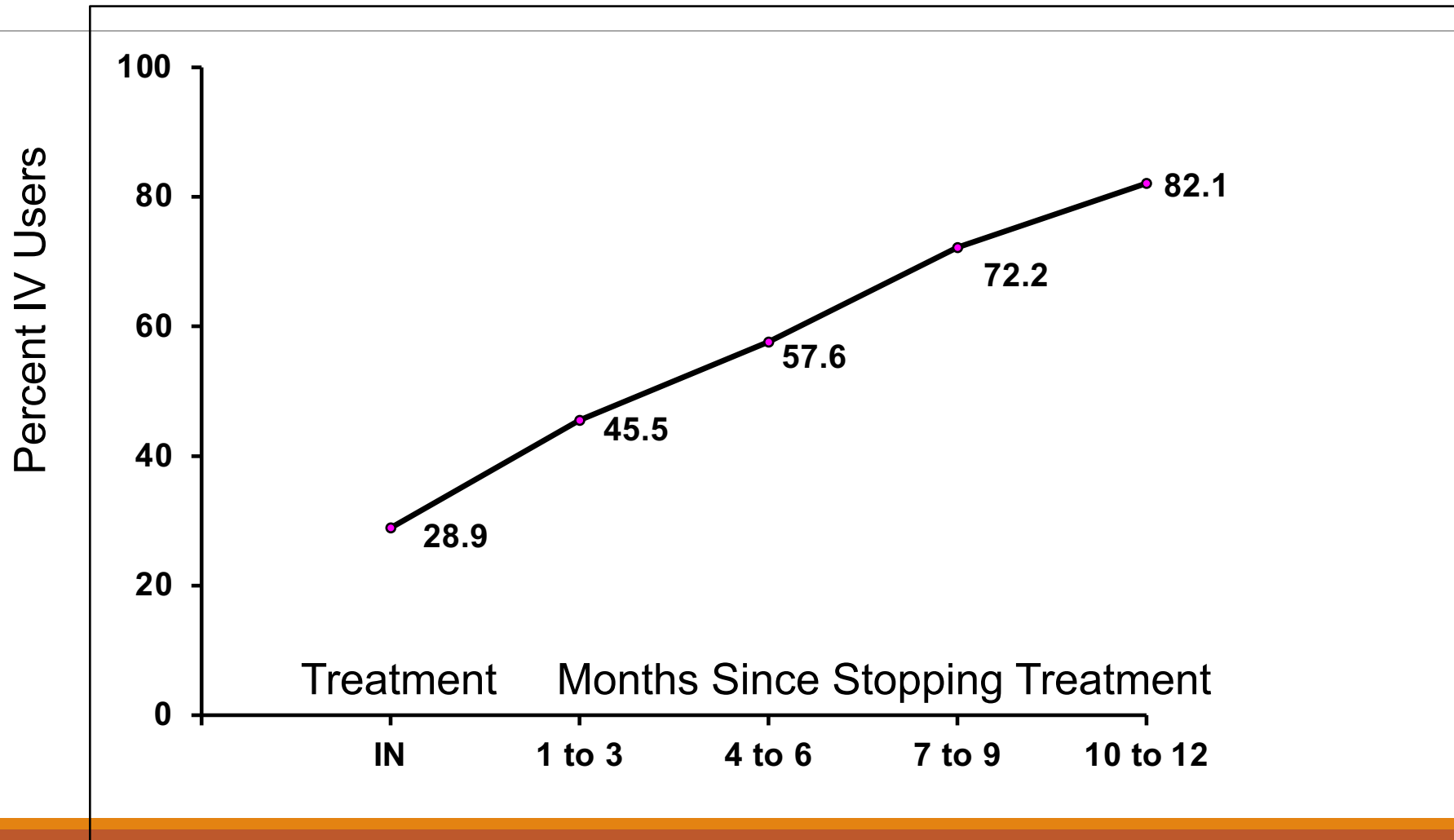
Indicated for use with pregnant and nursing mothers

- preferable to street drugs
- prevents fetal withdrawal
- does not harm infant

Crime before and during Methadone Treatment at 6 programs

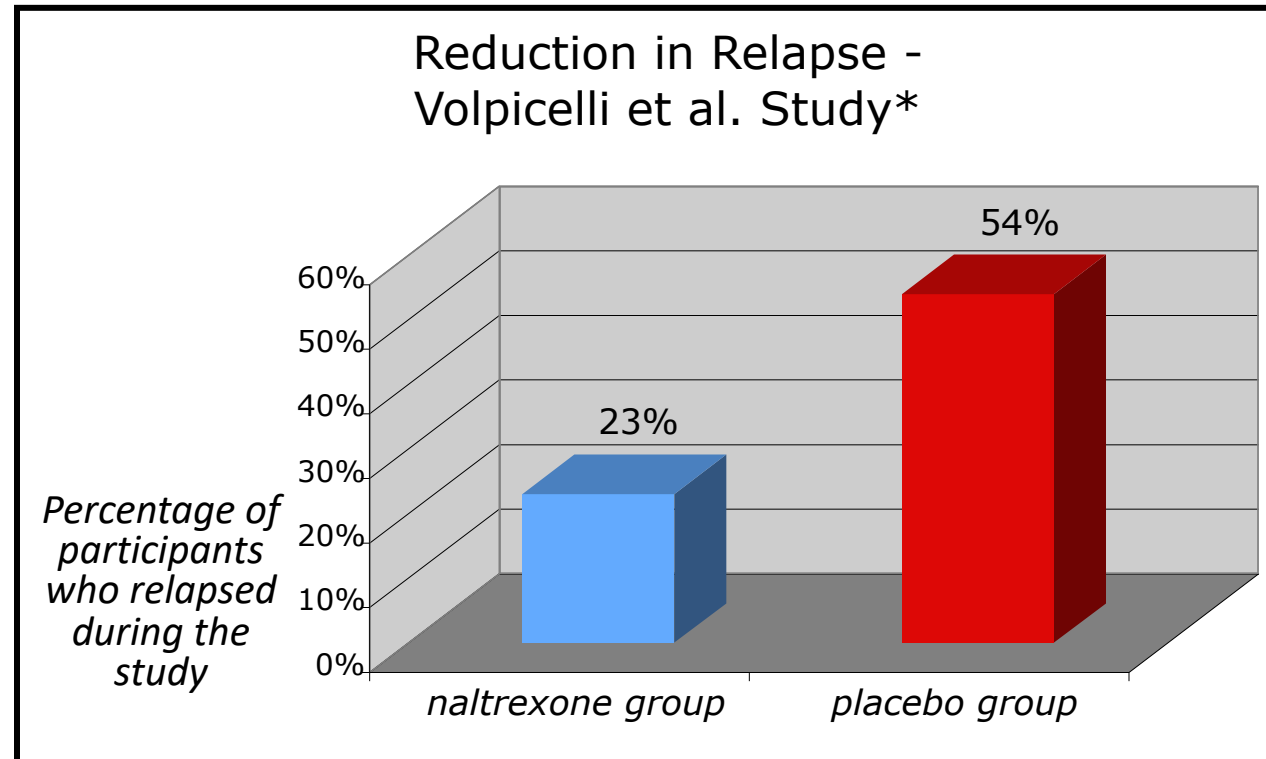


High Rate of Relapse to IV drug use after drop-out from Methadone Treatment



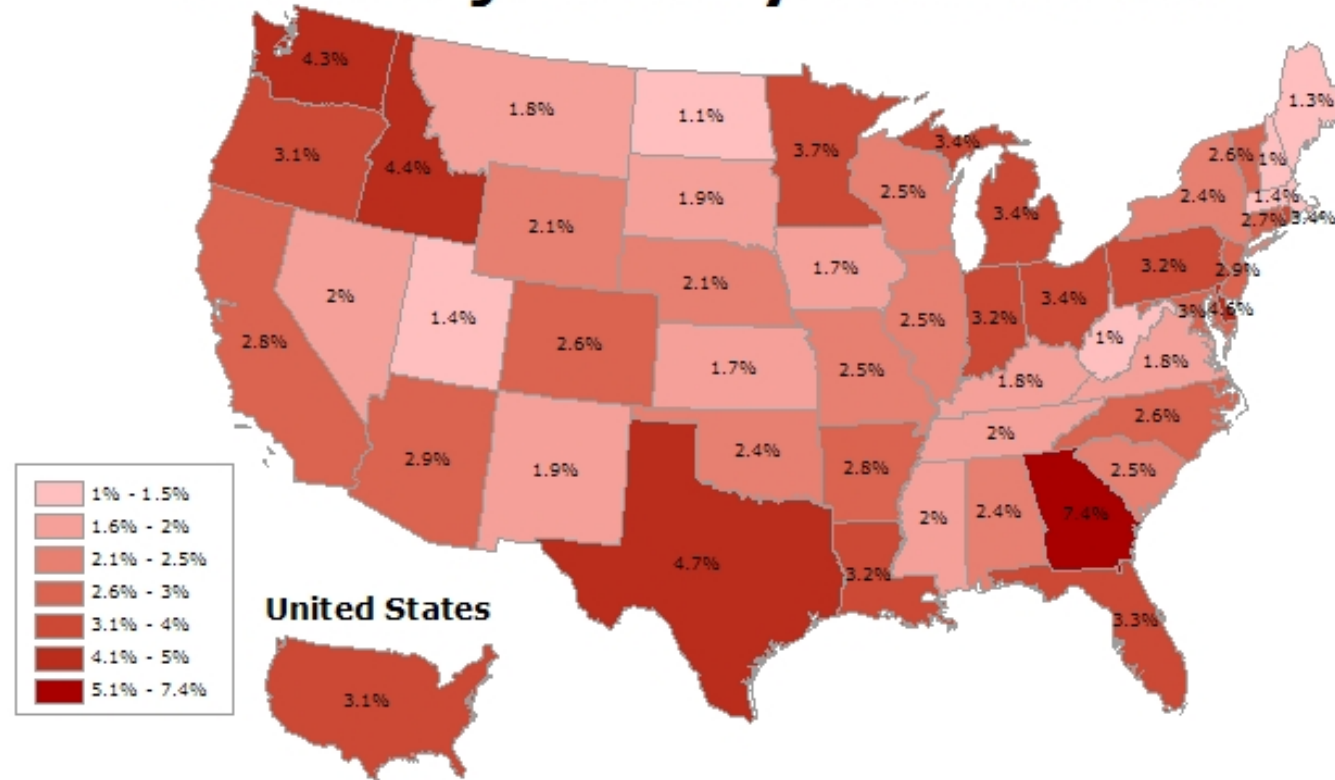
What does *the research* say?

In two studies, participants treated with naltrexone had a greater reduction in relapse during the entire study than those treated with placebo.



What does MAT offer to the Criminal Justice System?

Adults under criminal justice system control

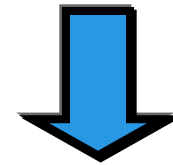


Source: Bureau of Justice Statistics, Probation and Parole in the United States, 2002.
(Criminal justice system control includes prisoners, jail inmates, probation and parole.) *Prison Policy Initiative*

Benefits to the CJ System Include:



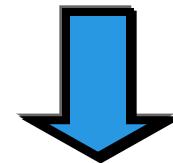
public safety



rate of opiate overdose



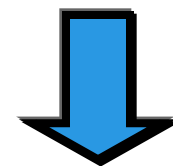
public health



recidivism



**effectiveness
of Probation &
Parole**



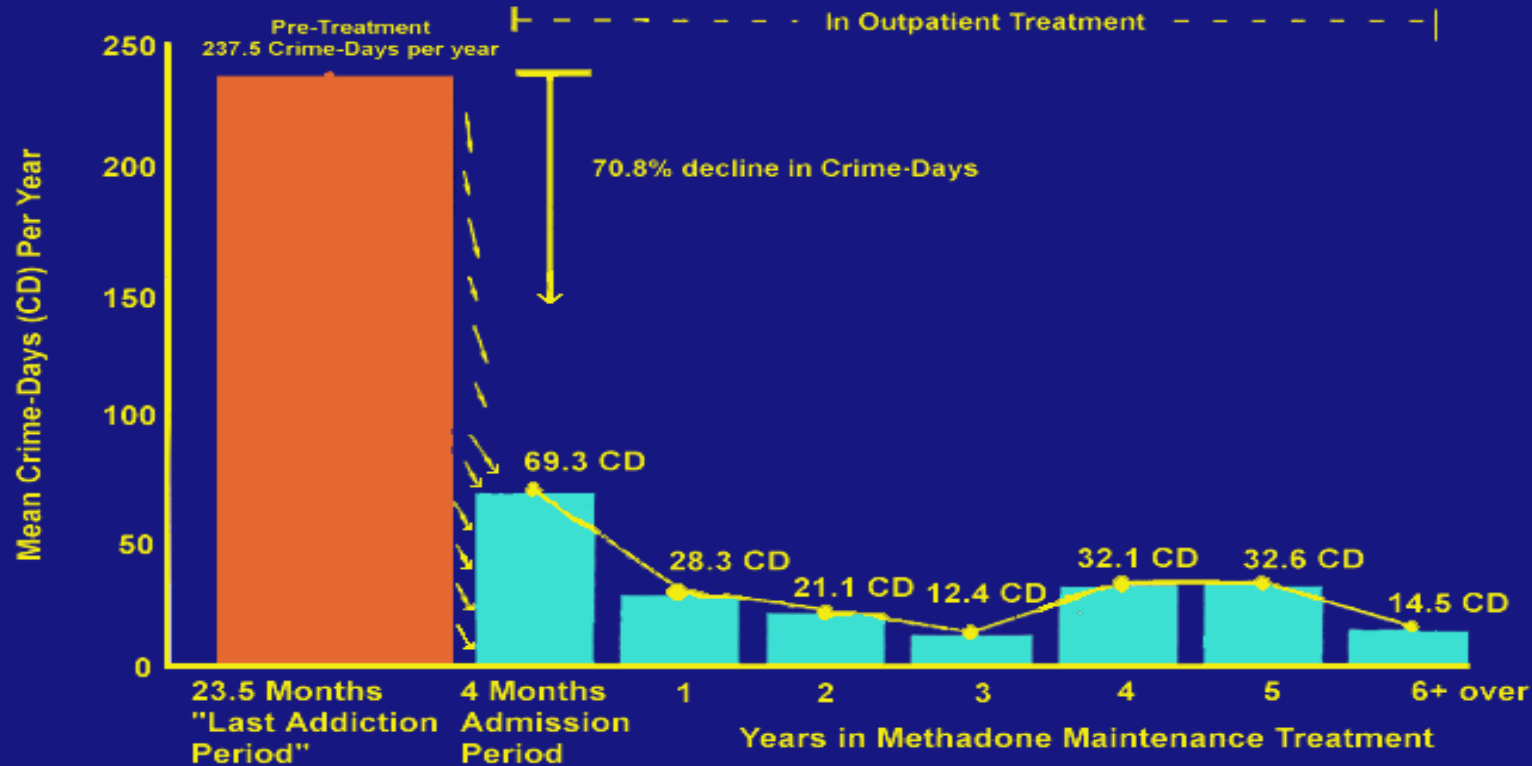
**public and DOC
Costs**

Increased Public Safety

Longer Time in MAT Decreases Crime-Days

Mean Crime-Days per

yr.



Reduction in crime by years in methadone maintenance treatment.

From the Effectiveness of Methadone Maintenance Treatment (p. 182), by J. C. Ball and A. Ross, 1991, New York: Springer-Verlag. Copyright 1991 by Springer-Verlag New York, Inc. Reprinted with permission.

Effect of MAT on Parole & Probation

An additional tool for repeat offenders

Increased retention and effectiveness of community addiction treatment

Decreased recurrent drug use

Decreased behavioral problems and crime

Decreased violations and arrests

Decreased P&P workload & hassles

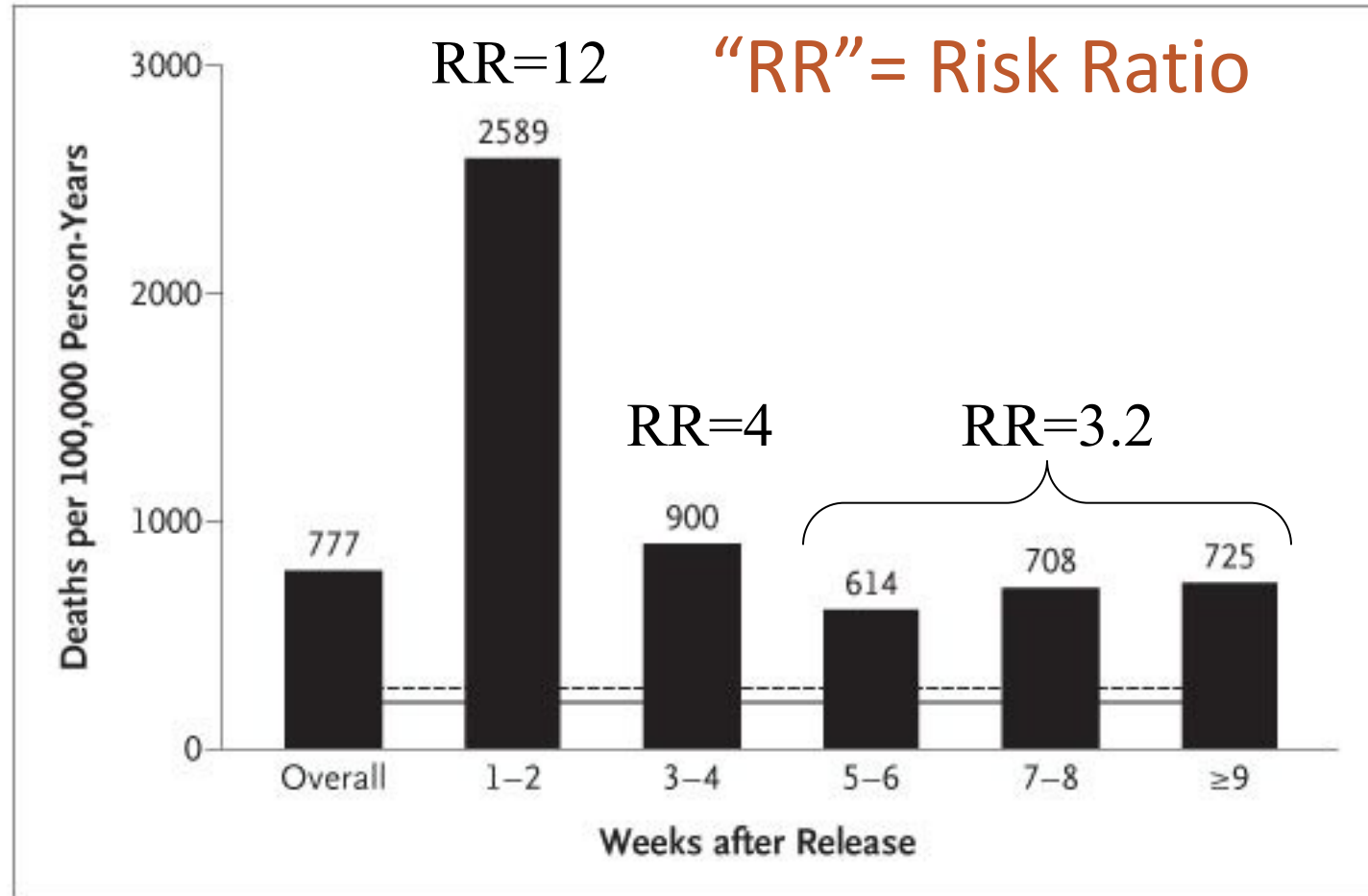
Increased Public Health

*Drug abuse treatment is
HIV and HCV prevention!*

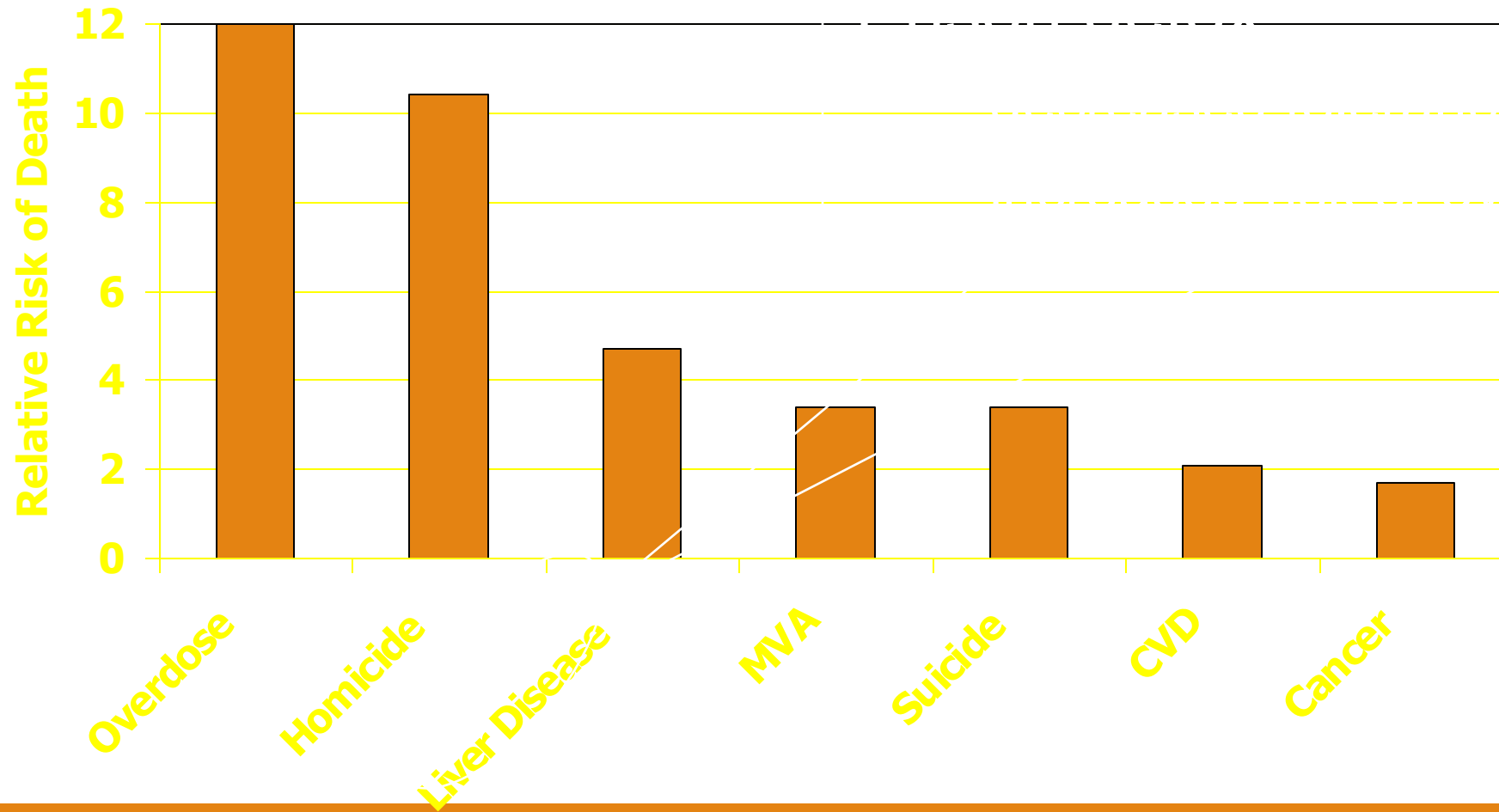
- Drug injectors who do not enter treatment are up to 6x more likely to become infected with HIV than injectors who enter and remain in treatment
 - Treatment reduces associated risk behaviors such as sharing injection equipment and unprotected sex
-
- Treatment provides opportunities for screening, counseling, and referral to additional services, including early HIV treatment

Lower rates of opiate Overdose

“Sentenced to death...*after release!*”



Causes of Death among Releasees Adjusted for Age, Sex, and Race



Effect of MAT on DOC Budget

Reduces number of persons going through repeated arrest-incarceration-release cycles

Increases retention and effectiveness of community addiction treatment

Decreases recurrent drug use

Decreases drug-related crime

Decreases addicted persons violated or arrested

Increases community time between relapses

Decreases incarceration costs

You might be wondering...

-WHO is a good candidate to refer?2885

Consider:

History of substance abuse

Willingness to consider MAT

-WHERE is MAT typically offered?

- Which local agencies?
- What happens after you make a referral?

So, what does MAT offer to the Criminal Justice System?

MAT strengthens the efficacy of the Criminal Justice System.

How?

By enriching the CJ System with an evidence-based practice that addresses one of its root problems....

....Addiction.