Medications for Opioid Use Disorders
Correctional Health in the U.S.
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Medical Director, Franklin County House of Corrections
Director of Substance Use Disorders, Behavioral Health Network
Medical Director, Pioneer Valley Regional School District
Medical Director, Opioid Taskforce Franklin County and North Quabbin
Working with communities to address the opioid crisis.

- SAMHSA’s State Targeted Response Technical Assistance (STR-TA) grant created the Opioid Response Network to assist STR grantees, individuals and other organizations by providing the resources and technical assistance they need locally to address the opioid crisis.

- Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

Funding for this initiative was made possible (in part) by grant no. 6H79TI080816 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Working with communities to address the opioid crisis.

- The Opioid Response Network (ORN) provides local, experienced consultants in prevention, treatment and recovery to communities and organizations to help address this opioid crisis.
- The ORN accepts requests for education and training.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.
Contact the Opioid Response Network

✧ To ask questions or submit a request for technical assistance:

- Visit www.OpioidResponseNetwork.org
- Email orn@aaap.org
- Call 401-270-5900
Incarceration Rate
Number of prisoners per 100,000 population

- more than 500
- 400-500
- 300-400
- 200-300
- 100-200
- less than 100
- No data
Amendment VIII

EXCESSIVE FINES, CRUEL AND UNUSUAL PUNISHMENT

Passed by Congress September 25, 1789. Ratified December 15, 1791. The first 10 amendments form the Bill of Rights

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.
**What is a serious medical need?**
The Eighth Amendment prohibits the "unnecessary and wanton infliction of pain."\(^9\)
Some factors courts have considered in determining whether a "serious medical need" is at issue are "(1) whether a reasonable doctor or patient would perceive the medical need in question as important and worthy of comment or treatment; (2) whether the medical condition significantly affects daily activities; and (3) the existence of chronic and substantial pain."\(^10\) Additionally, courts will be likely to find a "serious medical need" if a condition "has been diagnosed by a physician as mandating treatment or … is so obvious that even a lay person would easily recognize the necessity of a doctor’s attention."\(^11\)

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9 Estelle v. Gamble, 429 U.S. at 104.
10 Brock v. Wright, 315 F.3d 158, 162 (2nd Cir. 2003) (internal quotation marks omitted).
11 Hill v. DeKalb Reg’l Youth Detention Ctr., 40 F.3d 1176, 1187 (11th Cir. 1994) (internal quotation marks, citation omitted).
Evidence-Based Medical Care Treatment and Prevention
Prevalence of Top Chronic Conditions, 2014

- Hypertension: 27.0%
- Lipid disorders (e.g., high cholesterol): 21.6%
- Mood disorders (e.g., depression, bipolar disorder): 11.9%
- Diabetes mellitus: 10.4%
- Anxiety disorders (e.g., anxiety, panic disorders, stress): 9.7%
- Other upper respiratory disorders (e.g., chronic laryngitis, chronic sinusitis): 7.4%
- Inflammatory joint disorders (other than arthritis): 7.4%
- Osteoarthritis: 6.5%
- Asthma: 6.3%
- Coronary atherosclerosis and other heart disease: 4.8%

Heavy on heart disease:
One in four U.S. adults has hypertension, and about one in five has high cholesterol.

SOURCE: Multiple Chronic Conditions in the United States, Christine Buttorff et al., RAND Corporation, TL221-PFCD, 2017 (available at www.rand.org/t/TL221).
Substance Use & Incarceration

- 48% of federal prisoners incarcerated for drug offenses
- 85% substance-involved
  - 1.5 million meet DSM criteria for substance use disorder
  - 458,000 history of SUD, under the influence, or crime committed to obtain money to buy drugs
- In 2006, alcohol and other drugs were involved in:
  - 78% of violent crimes
  - 83% of property crimes
  - 77% of public order, immigration or weapons offenses and probation/parole violations
PEOPLE COMING OUT OF PRISON ARE 12 TIMES MORE LIKELY TO DIE IN THE FIRST 2 WEEKS AFTER THEIR RELEASE

Release from Prison —
A High Risk of Death for Former Inmates

Ingrid A. Binswanger, M.D., Marc F. Stern, M.D., Richard A. Deyo, M.D.,
Patrick J. Heagerty, Ph.D., Allen Cheadle, Ph.D., Joann G. Elmore, M.D.,
and Thomas D. Koepsell, M.D.

ABSTRACT

BACKGROUND
The U.S. population of former prison inmates is large and growing. The period
immediately after release may be challenging for former inmates and may involve
substantial health risks. We studied the risk of death among former inmates soon
after their release from Washington State prisons.

METHODS
We conducted a retrospective cohort study of all inmates released from the Washington
State Department of Corrections from July 1999 through December 2003. Prison
records were linked to the National Death Index. Data for comparison with Washington
State residents were obtained from the Wide-ranging OnLine Data for Epidemiologic
Research system of the Centers for Disease Control and Prevention. Mortality
rates among former inmates were compared with those among other state residents
with the use of indirect standardization and adjustment for age, sex, and race.

RESULTS
Of 30,237 released inmates, 443 died during a mean follow-up period of 1.9 years.
The overall mortality rate was 777 deaths per 100,000 person-years. The adjusted
risk of death among former inmates was 3.5 times that among other state residents
(95% confidence interval [CI], 3.2 to 3.8). During the first 2 weeks after release, the
risk of death among former inmates was 12.7 (95% CI, 9.2 to 17.4) times that among
other state residents, with a markedly elevated relative risk of death from drug over-
dose (129; 95% CI, 89 to 186). The leading causes of death among former inmates
were drug overdose, cardiovascular disease, homicide, and suicide.

CONCLUSIONS
Former prison inmates were at high risk for death after release from prison, particularly
during the first 2 weeks. Interventions are necessary to reduce the risk of death
after release from prison.
Risk of Overdose Death After Release

Relative Risk* of Dying of an Unintentional Opioid Overdose by Time Since Release from Prison or Jail, Maryland, 2007-2013.

*Compared to deaths occurring 91-365 days following release.
PRISONERS ARE AMONG THE sickest members of society

- Higher rates of chronic disease: hypertension, asthma, arthritis, cervical cancer
- Higher rates of communicable diseases, such as HIV, and Hepatitis C
- 65-80% have a history of substance use and abuse, compared with about 10% in the general population
- Up to 50% have symptoms of mental illness
650,000 Returning Prisoners + HIGH RATES of Chronic & Communicable Disease + SIGNIFICANT BARRIERS to Healthcare

= PUBLIC HEALTH CRISIS
Figure 2.C

Percent of Inmates Who Are Alcohol Involved by Type of Crime

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Inmate Population</td>
<td>56.6</td>
</tr>
<tr>
<td>Violent Crime</td>
<td>57.7</td>
</tr>
<tr>
<td>Property Crime</td>
<td>55.9</td>
</tr>
<tr>
<td>Drug Law Violators</td>
<td>51.6</td>
</tr>
<tr>
<td>Other Crimes</td>
<td>52.0</td>
</tr>
</tbody>
</table>

Note: An additional 1.3% of inmates committed crimes that were not specified; 33.8% were alcohol involved.

The World Health Organization (WHO)\(^1\)
National Institutes of Health (NIH)\(^2\)
National Institute of Drug Abuse (NIDA)\(^3\)
…and countless other health institutions\(^4\)

Have endorsed the **effectiveness** of MAT and have urged correctional systems to provide **inmates** with the same **evidence-based treatment** that is available in the community.

**Citations:**
2018 - 2019 Court Decisions

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

GEOFFREY PESCE,
Plaintiff,
v.
KEVIN F. COPPINGER, in his official capacity as Essex County Sheriff,
AARON EASTMAN, in his official capacity as Superintendent of the Essex County House of Corrections – Middleton,
Defendants.

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

BRENDA SMITH,
Plaintiff,
v.
AROOSTOOK COUNTY and SHAWN D. GILLEN in his official capacity as Sheriff of Aroostook County,
Defendants.

Violation of the Americans with Disability Act
### What are the benefits of MAT in corrections?

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduces <strong>illicit opioid use</strong> post-incarceration</td>
<td>Mattick, Breen, Kimber, &amp; Davoli, 2009</td>
</tr>
<tr>
<td>Reduces <strong>criminal behavior</strong> post-incarceration</td>
<td>Deck el al., 2009</td>
</tr>
<tr>
<td>Reduces mortality and <strong>overdose risk</strong> post-incarceration</td>
<td>Degenhardt et al., 2011; Kerr et al., 2007</td>
</tr>
<tr>
<td>Reduces <strong>HIV risk behaviors</strong> (i.e., injection drug use) post-incarceration</td>
<td>MacArthur et al., 2012</td>
</tr>
</tbody>
</table>

Additional **social, medical, and economic** benefits of providing MAT to inmates who are opioid-dependent are well-documented
(Rich et al., 2015; Zaller et al., 2013; McKenzie et al., 2012; Heimer et al., 2006; Dolan et al., 2003)
Why is MOUD so hard to put in place?

- “Drug Free” Treatment is the model (Nunn 2009, Freidmann 2012)
- Bias against Methadone and Buprenorphine
- Deep concern for diversion within the facility
- Costs of hiring and training staff
- Costs of acquiring the medicines
- Costs of meeting the federal and DPH standards to be a MMT
- Suffering with withdrawal is seen as part of your punishment
“Drug Free” Treatment
Medications Currently Available

For Nicotine Use Disorder
- Nicotine Replacement Therapies (NRT)
- Bupropion
- Varenicline

For Alcohol Use Disorder
- Disulfiram
- Naltrexone
- Acamprosate
- Naltrexone Depot
- Topiramate

For Opioid Use Disorder
- Methadone
- Naltrexone (Vivitrol)
- Buprenorphine
- Buprenorphine/Naloxone

10% - 30% Effective

<20% Effective

40% - 60% Effective

Principles of Drug Addiction Treatment, National Institutes of Health – National Institute on Drug Abuse
Practitioners Certified to Administer, Prescribe and Dispense Buprenorphine

Source: ONDCP
Worry about Diversion/Contraband
One of the surprises in Rhode Island, Clarke says, is that the treatment program has itself improved security. As doctors enroll an increasing number of people, Clarke says she hears from patients that the black market for drugs behind the walls is waning. One such patient, whom the authorities asked The Marshall Project not to identify by name, has been in and out of the Rhode Island system for a decade before getting on methadone during his current stay. With money in your commissary, this patient says, it’s easy to get drugs like fentanyl in jail. But during his current stay, “it’s almost been absent. Almost every opiate addict I know, no one talks about it. It’s weird. Everybody’s so grateful they’re on the Suboxone and methadone, I don’t hear much about heroin or pills right now.
Subordination of medical judgement for security concerns

- Vaccine needles
- Scalpels
- Benzos for alcohol withdrawal

Emma R. Brezel, Tia Powell & Aaron D. Fox (2019): An ethical analysis of medication treatment for opioid use disorder (MOUD) for persons who are incarcerated, Substance Abuse, DOI: 10.1080/08897077.2019.1695706
Why is MOUD so hard to put in place?

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Franklin County Jail Is The First Jail In The State That's Also A Licensed Methadone Treatment Provider

November 12, 2019  By Deborah Becker

Nurse Jennifer Maillet prepares addiction medications at the Franklin County Jail in Greenfield. (Deborah Becker/WBUR)
## Drug Prices

<table>
<thead>
<tr>
<th>Drug</th>
<th>Cost</th>
<th>Duration/Usage</th>
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<tbody>
<tr>
<td>Methadone</td>
<td>24.00 for 30 days (80 mg a day)</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>130.00 for 30 days (at 16 mg a day)</td>
<td></td>
</tr>
<tr>
<td>Naloxone</td>
<td>1300.00 – 1600.00 for shot (lasts 28 days)</td>
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### Options and Steps to Implement MAT in Pilot Houses of Correction

**All 3 Medications:** Methadone, Buprenorphine, Naltrexone

<table>
<thead>
<tr>
<th>OPTION 1</th>
<th>OPTION 2</th>
<th>OPTION 3</th>
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<tbody>
<tr>
<td>HOC/DOC Acquires OTP Certification</td>
<td>HOC partners with an existing OTP who provides onsite Meds</td>
<td>HOC partners with an existing OTP who provides offsite or transports meds daily</td>
</tr>
</tbody>
</table>

#### Provision of Methadone
- Obtain SAMHSA Certification (which include counseling, MAT and other required SUD services)
- Requires approvals from:
  - DEA
  - DPH DCP
  - DPH BSAS

#### Provision of Buprenorphine
- Once OTP Certified, can begin prescribing under OTP

#### Provision of Naltrexone
- Prescribed by onsite healthcare professional with MCSR

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<td>OTP must hold SAMHSA Certification (which include counseling, MAT and other required SUD services)</td>
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</tr>
</tbody>
</table>
| | OTP obtains additional approvals to operate at corrections location: 
  - SAMHSA 
  - DEA 
  - DPH DCP 
  - DPH BSAS | Methadone may not be stored at the DOC or a HOC. |
| | QSOA Qualified Service Organization Agreement (QSOA) executed by OTP and HOC | Qualified Service Organization Agreement (QSOA) executed by OTP and HOC |
Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomised, open-label trial

Josiah D Rich, Michelle McKenzie, Sarah Larney, John B Wong, Liem Tran, Jennifer Clarke, Amanda Noska, Manasa Reddy, Nickolas Zaller

Summary
Background Methadone is an effective treatment for opioid dependence. When people who are receiving methadone maintenance treatment for opioid dependence are incarcerated in prison or jail, most US correctional facilities discontinue their methadone treatment, either gradually, or more often, abruptly. This discontinuation can cause uncomfortable symptoms of withdrawal and renders prisoners susceptible to relapse and overdose on release. We aimed to study the effect of forced withdrawal from methadone upon incarceration on individuals’ risk behaviours and engagement with post-release treatment programmes.