ASAM American Society *of* Addiction Medicine

THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: 2020 FOCUSED UPDATE WEBINAR

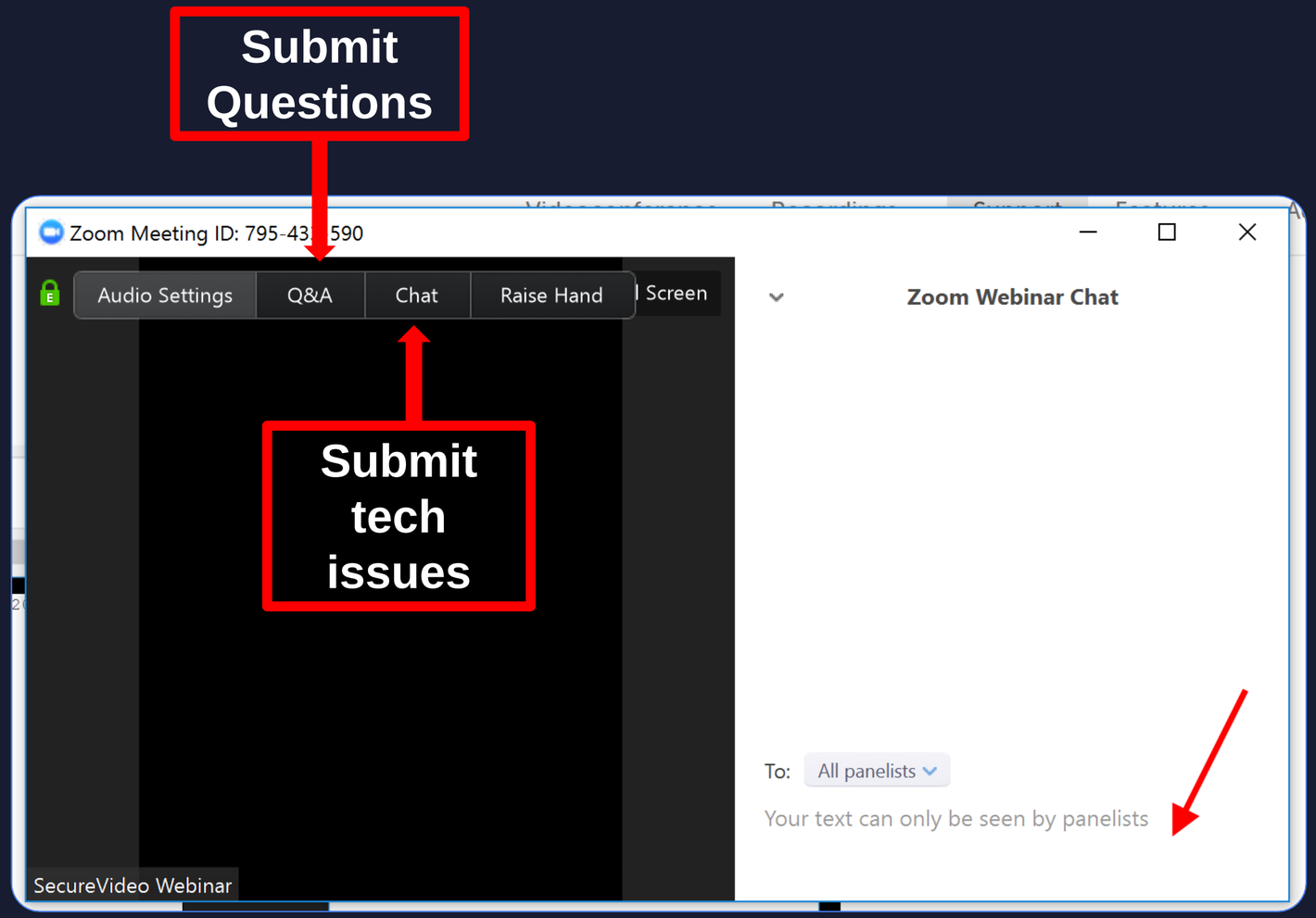
INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM

SCHEDULE

12:00 – 12:05 pm	Announcements ASAM STAFF
12:05 – 12:45 pm	Presentation DR. SANDRA A. SPRINGER
12:45 – 1:00 pm	Questions & Answers DR. SANDRA A. SPRINGER
1:00 pm	Concluding Remarks ASAM STAFF

ANNOUNCEMENTS

1. Information on obtaining your CME will be provided at the end of the webinar.
2. Attendee Audio: Mics are automatically set to mute.
3. Questions? Type questions into the Q&A box.
4. Technical Issues? Use the chat box feature to submit questions to your hosts.



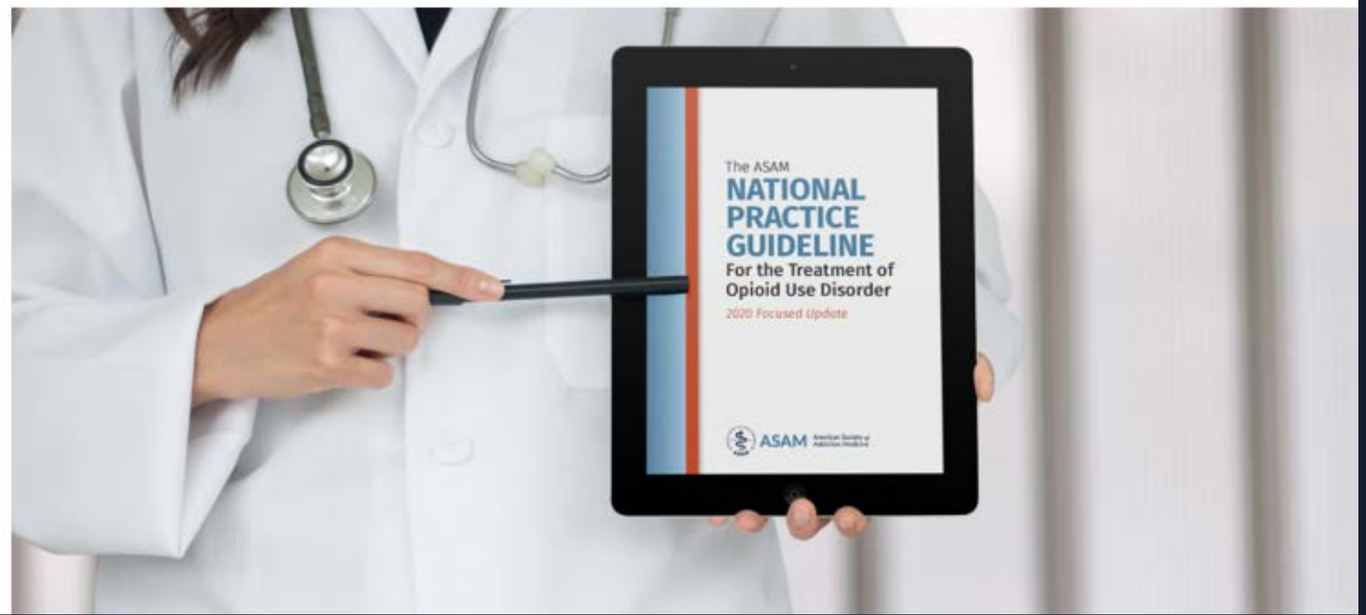
The ASAM National Practice Guideline 2020 Focused Update Webinar – Individuals in the Criminal Justice System

MANAGE PRODUCT

★★★★★ 5 (1 vote)

Includes a Live Event on 09/10/2020 at 12:00 PM (EDT)

Overview | Speakers | Handouts | Credits & Disclosures | Contents (3)



HOW TO OBTAIN CME

1. Go to:

   https://elearning.asam.org/p/NPG2020_Webinar4
2. Go to *Contents* tab.
3. Complete:
   - ❑ CME Quiz
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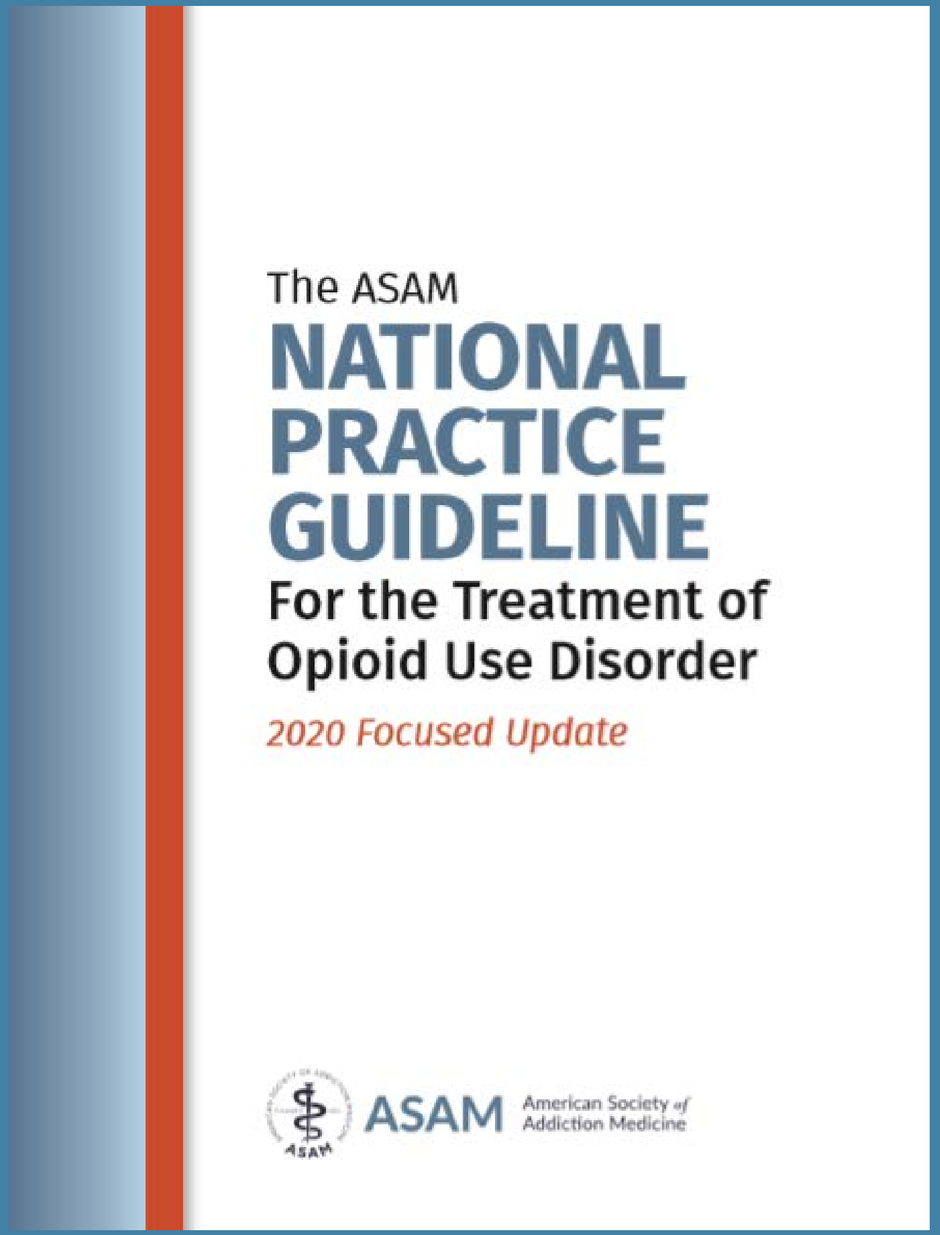
   - ❑ Credit and Certificate



THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM

PRESENTER

Sandra A. Springer, MD

- Sandra Springer, MD is an Associate Professor of Medicine in the Department of Internal Medicine, Section of Infectious Diseases at the Yale School of Medicine. Dr. Springer is Board-Certified in Internal Medicine, Infectious Diseases and Addiction Medicine. In addition, she is the Director of the Infectious Disease Clinic at the Newington site of the VA Connecticut Healthcare System where she oversees the care of Veterans living with HIV (VLH).

- She graduated from Harvard University, then later received her Medical Degree from University of Massachusetts Medical School. She did her Internal Medicine Residency and Infectious Disease Fellowship at Yale School of Medicine.

- Dr. Springer has significant clinical and research experience with persons living with HIV disease (PLH) and those with comorbid substance use disorders (SUD). Her research has focused on evaluation of integration of SUD and HIV treatments. In particular, she has focused on medication treatment for opioid use disorder (OUD) (MOUD) and medication treatment for alcohol use disorders (AUD) to improve substance use relapse outcomes and HIV treatment outcomes, especially among those released from prison and jail.

FINANCIAL DISCLOSURES

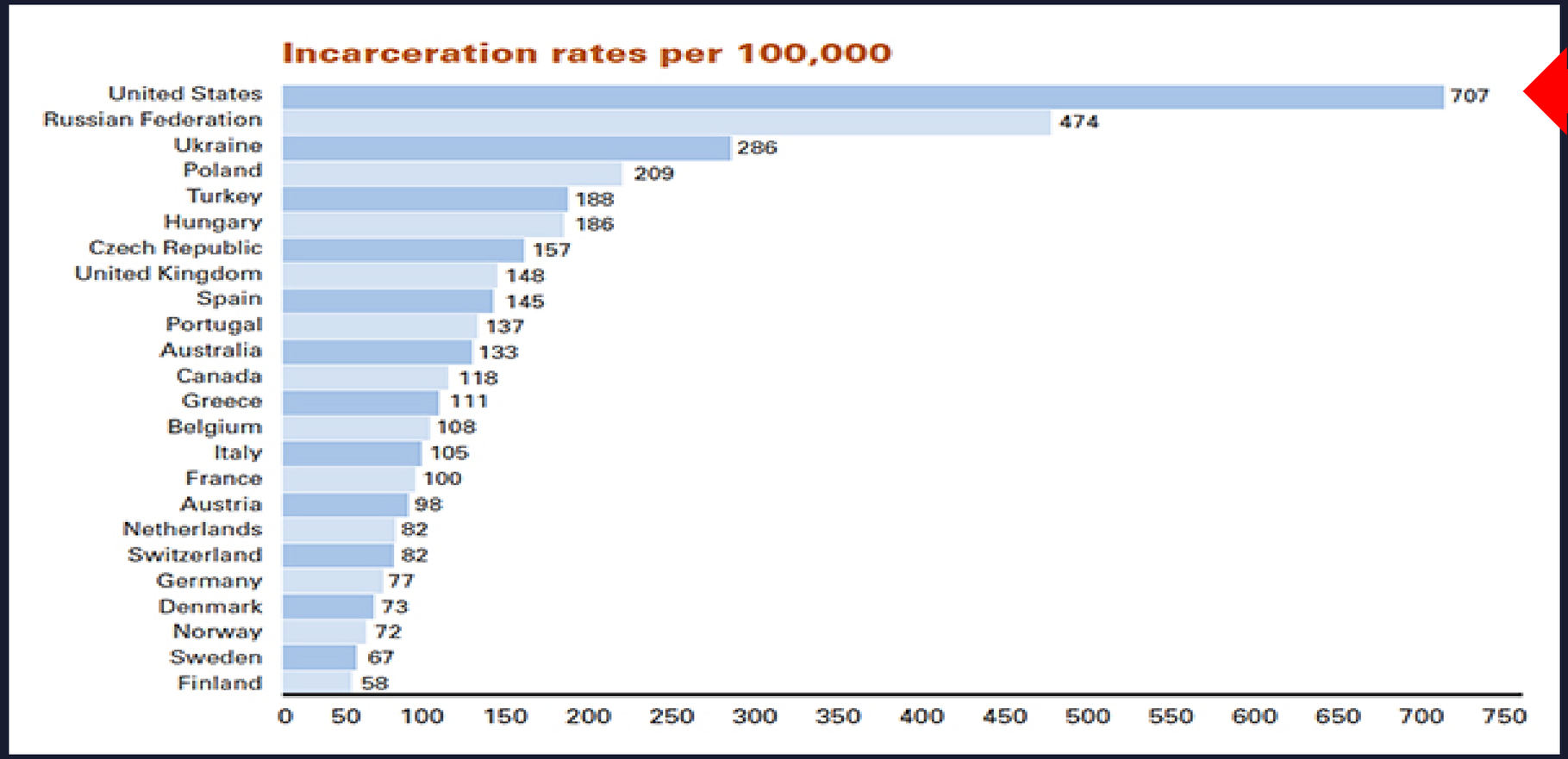
Alkermes Inc.

Clinical Care Options, Inc.

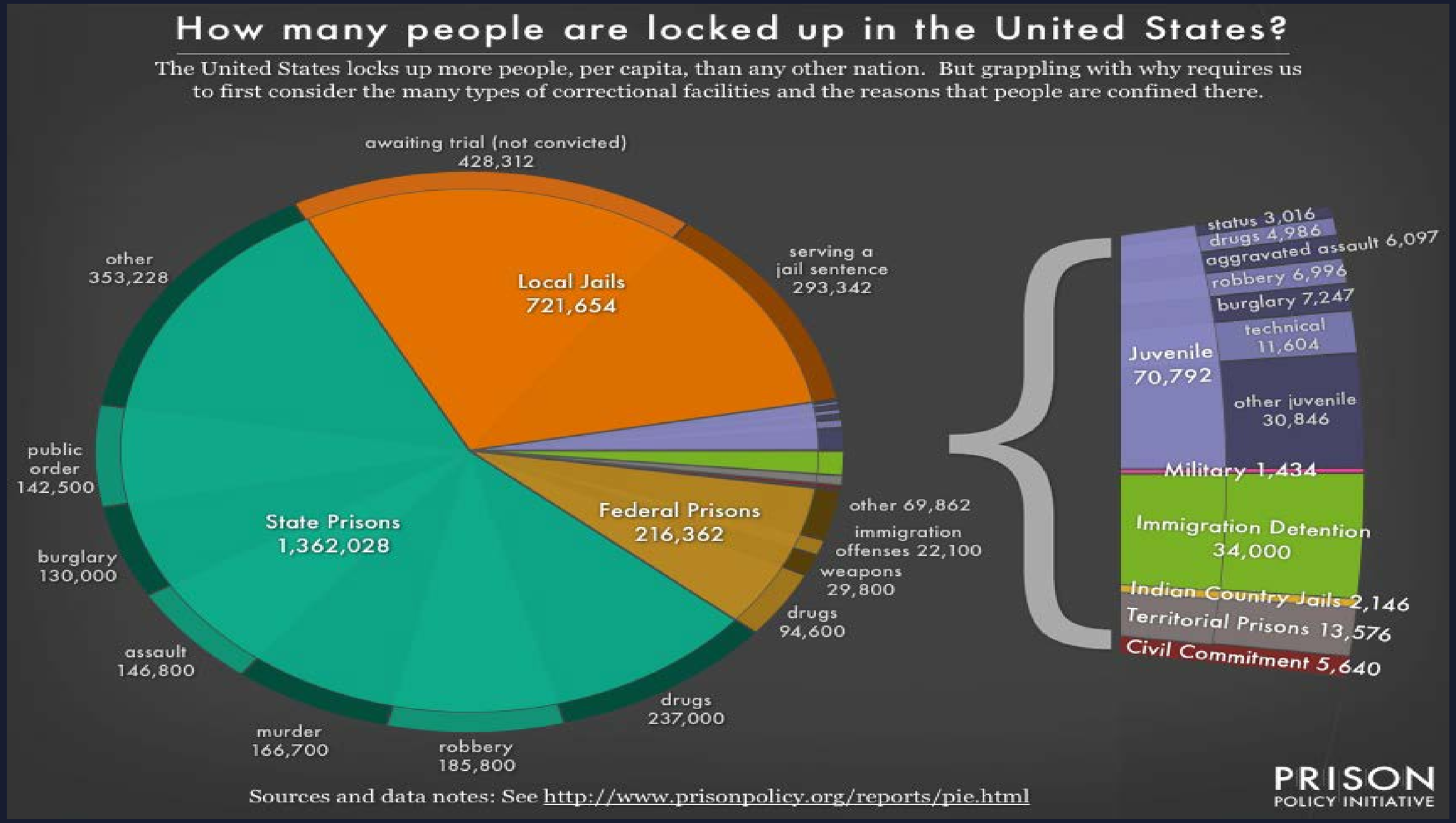
OBJECTIVES OF THE WEBINAR

- Summarize the guideline's **treatment recommendations** for individuals in the criminal justice system and how they should be used in practice.
- Identify the fundamental components of an OUD patient assessment and diagnosis for individuals in the criminal justice system.
- Recognize the **unique needs and treatment recommendations** for individuals in the criminal justice system.

The United States Incarcerates More People than any other Country

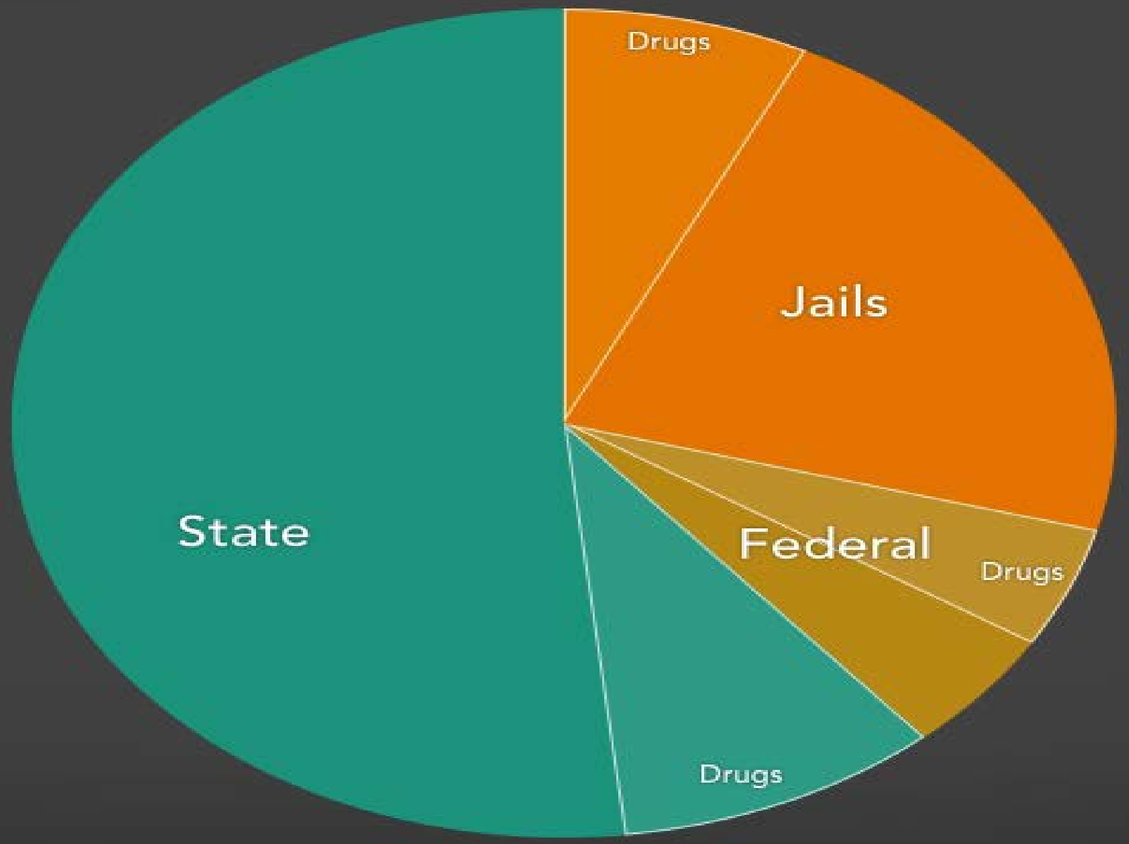


Source: “The Growth of Incarceration in the United States: Exploring Causes and Consequences,” The National Research Council, 2014.


How many people are locked up in the United States?
The United States locks up more people, per capita, than any other nation. But grappling with why requires us to first consider the many types of correctional facilities and the reasons that people are confined there.
awaiting trial (not convicted) 428,312
Local Jails 721,654
serving a jail sentence 293,342
other 353,228
public order 142,500
burglary 130,000
assault 146,800
murder 166,700
robbery 185,800
drugs 237,000
State Prisons 1,362,028
Federal Prisons 216,362
other 69,862
immigration offenses 22,100
weapons 29,800
drugs 94,600
Juvenile 70,792
status 3,016
drugs 4,986
aggravated assault 6,097
robbery 6,996
burglary 7,247
technical 11,604
other juvenile 30,846
Military 1,434
Immigration Detention 34,000
Indian Country Jails 2,146
Territorial Prisons 13,576
Civil Commitment 5,640
Sources and data notes: See http://www.prisonpolicy.org/reports/pie.html
PRISON POLICY INITIATIVE

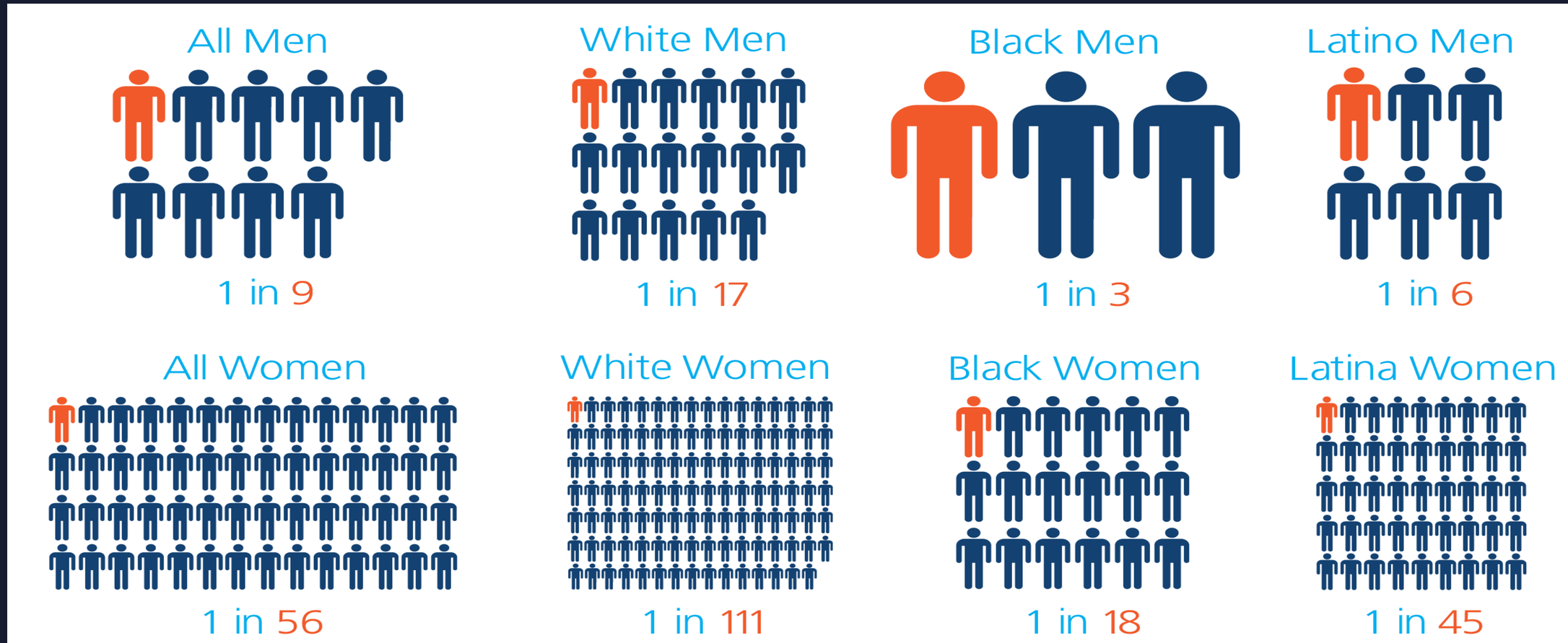
1 in 5 incarcerated people are locked up for a drug offense

Nonviolent drug offenses are a defining characteristic of the federal prison system, but play only a supporting role at the state and local levels



PRISON POLICY INITIATIVE

Likelihood of Imprisonment for U.S. Residents Born in 2001

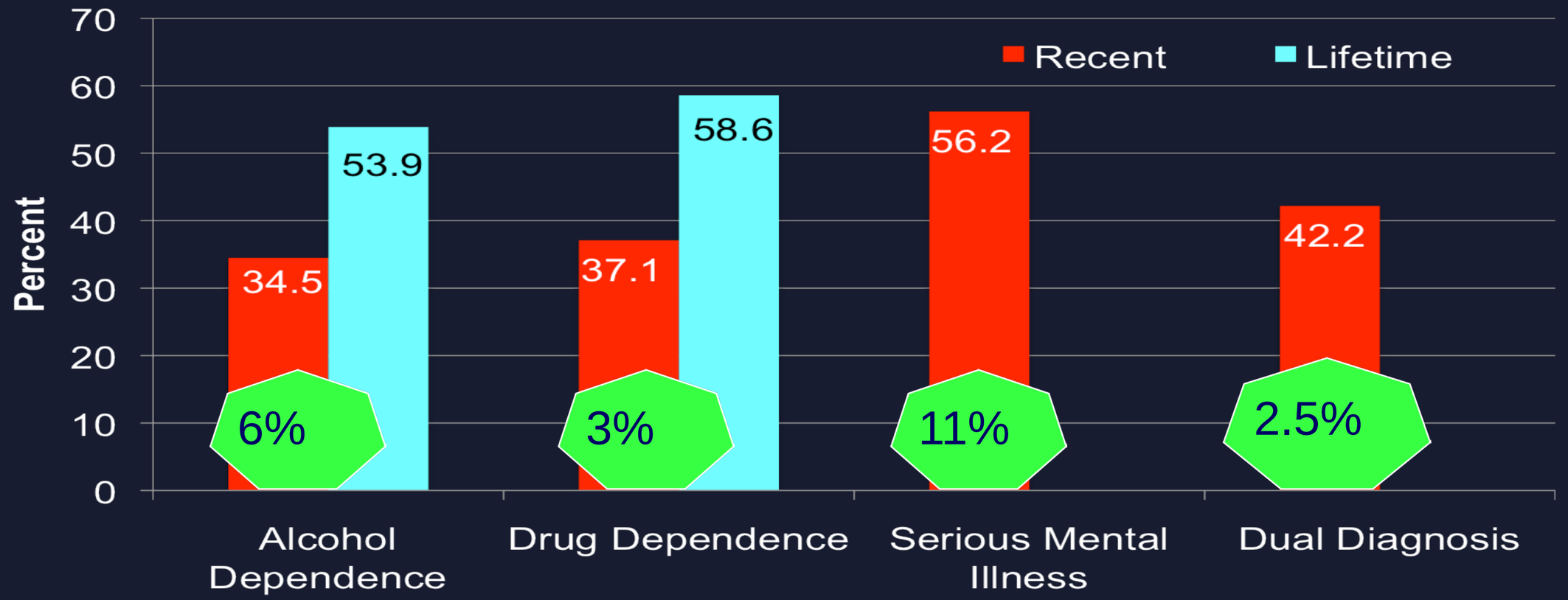


Source: Bonczar, T. (2003). *Prevalence of Imprisonment in the U.S. Population, 1974–2001.* Washington, D.C.: Bureau of Justice Statistics

THE SENTENCING PROJECT

AMERICAN SOCIETY OF ADDICTION MEDICINE FOUNDED 1954 ASAM

Prevalence of DSM-IV Diagnoses Among U.S. Prisoners



Peters, 1998

Peters, 1998

James, 2006

Baillargeon, 2009

James, 2006

The Revolving Door

- 97% of prisoners will eventually be released into the community (10 million/year)
- Most reenter society after <2 years of incarceration
- 60% reincarcerated

1. The Report of the Re-Entry Policy Council.www.re-entrypolicy.org
2. Beck et al. BJS, US Dept of Justice; 1989, 1999.
3. Bonczar T. BJS, US Dept of Justice; 2003.

RELAPSE TO DRUGS AND ALCOHOL OCCURS AFTER RELEASE REGARDLESS OF TIME OF INCARCERATION

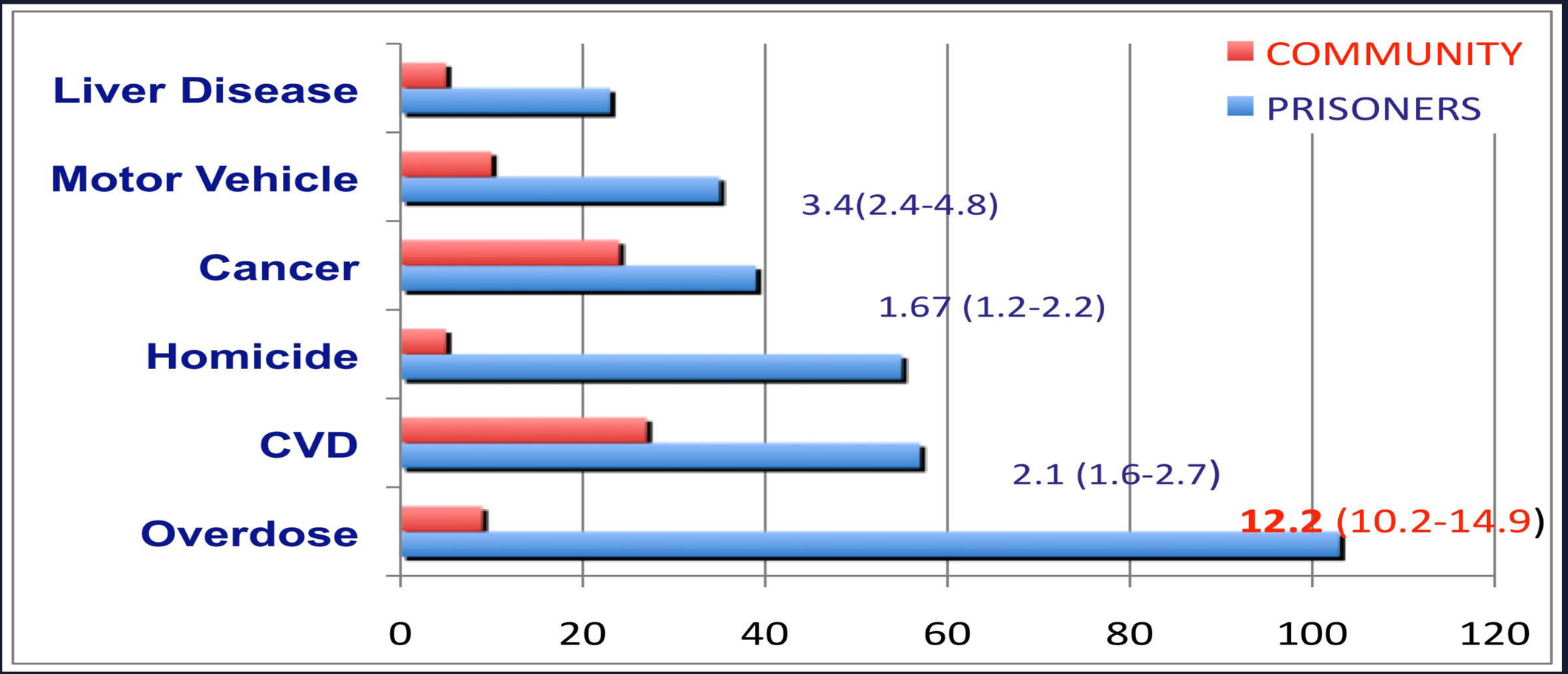
Relapse to Opioid Use

- >90% of inmates with opioid dependency relapse to drug use within 1 year of release to the community[1]

- Relapse to opioid use is associated with
  - ↑ mortality[4]
  - ↓ adherence to medical care [2]
  - ↑ acquisition of HIV (and HCV)[2] (↑transmission of HIV to public)
  - ↑ increased recidivism (cost to the public)[3]

1 Kinlock J Subst Abuse Tx 2002
[2]CID.2002:35.307.
[3]Levasseur . Ann Med Interne. 2002.
[4] Binswanger IA et al. NEJM2007.

Overdose is the Leading Cause of Death After Release from Prison



Binswanger IA et al. N Engl J Med 2007;356:157-165

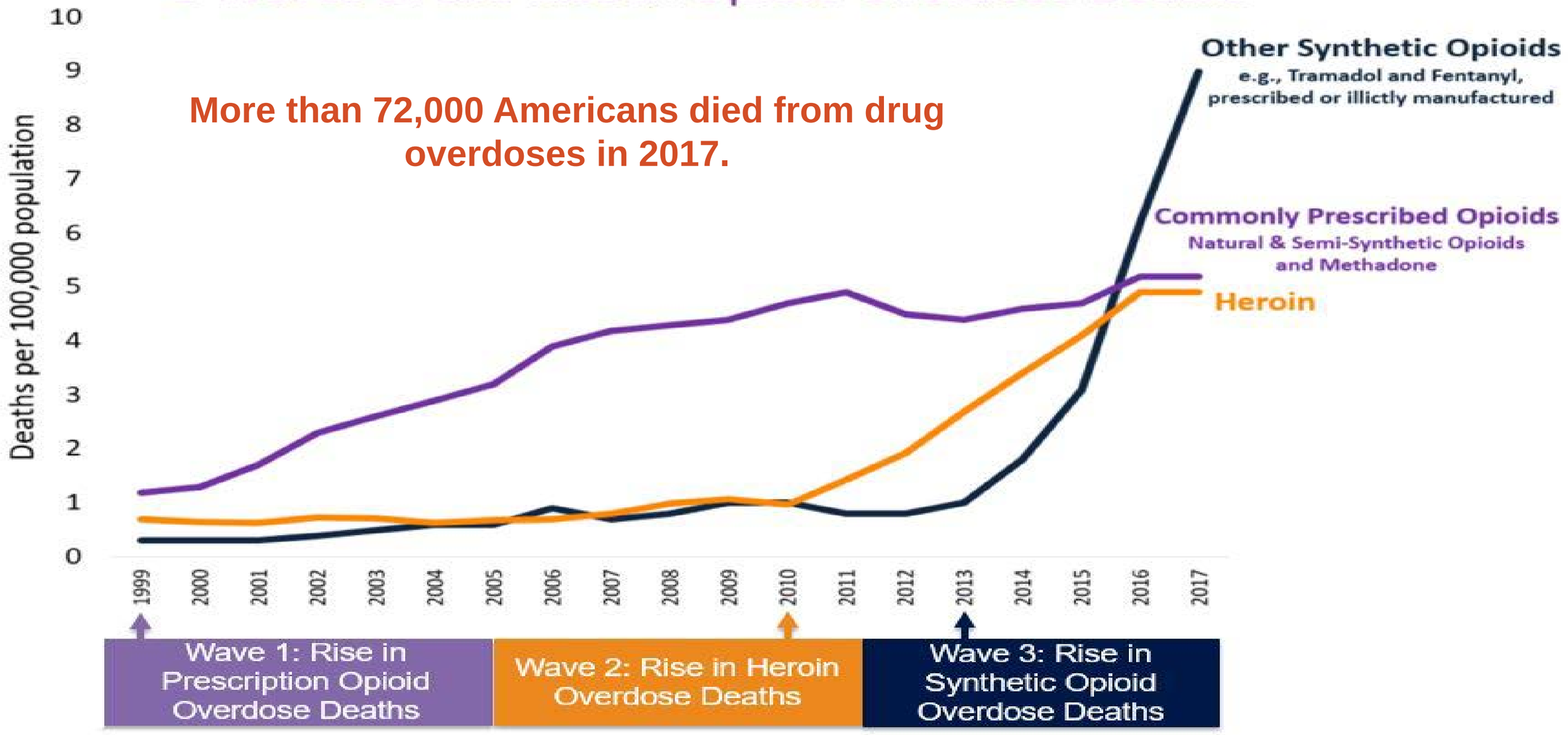
The Opioid Epidemic in the U.S.

- In 2017, 72,000 deaths from drug overdoses (190/ day)
- 48,000 deaths from Opioids alone (130/day)
- The total number of people who died from opioid overdose since 1999 is now more than 800,000
  - About 4 times than Americans died in Vietnam war
  - More than the deaths due to AIDS at the height of the AIDS epidemic
- Opioid Overdose is now the leading cause of accidental death in U.S.
- 2.1 million people with opioid use disorder
- Illicitly manufactured Fentanyl is now the number one opioid abused in U.S.
- CDC estimates cost of this at $78.5 billion

CDC.gov, SAMHSA.gov/disorders/substance-use

3 Waves of the Rise in Opioid Overdose Deaths

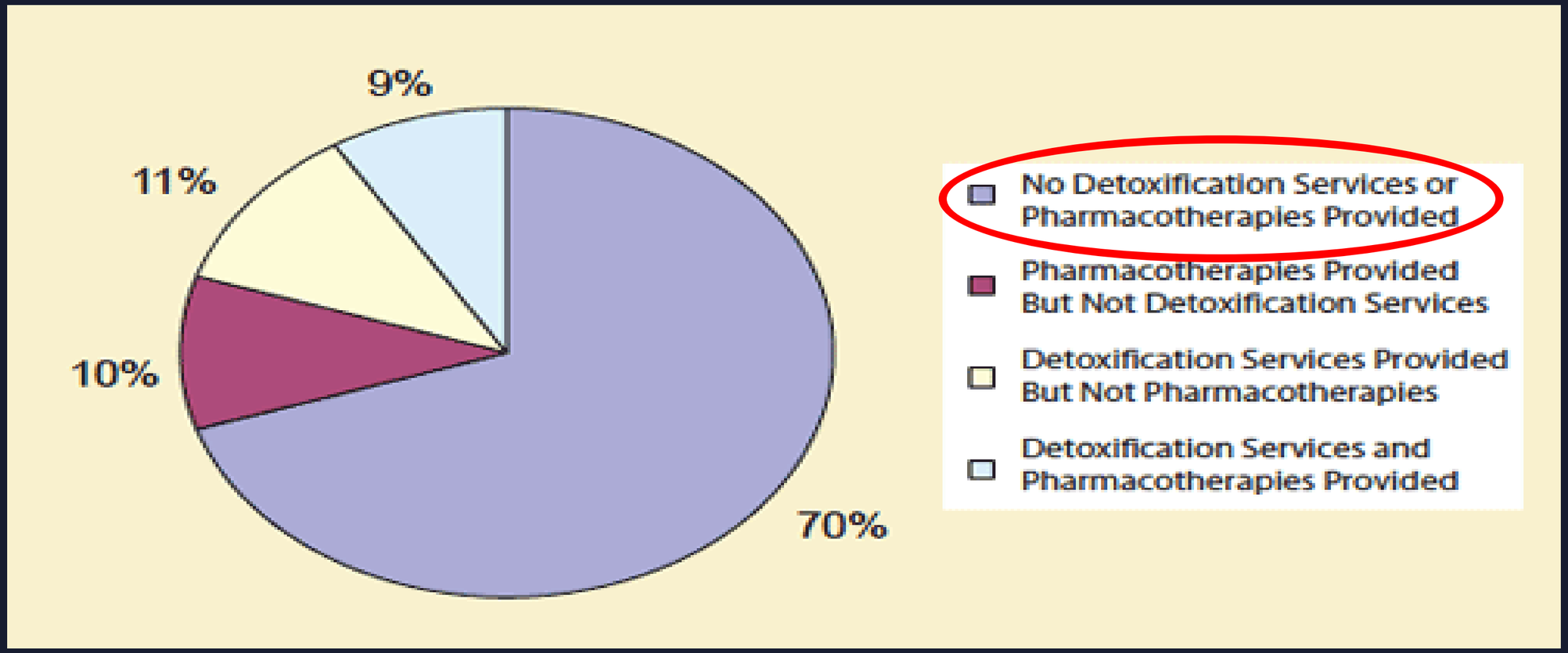
More than 72,000 Americans died from drug overdoses in 2017.



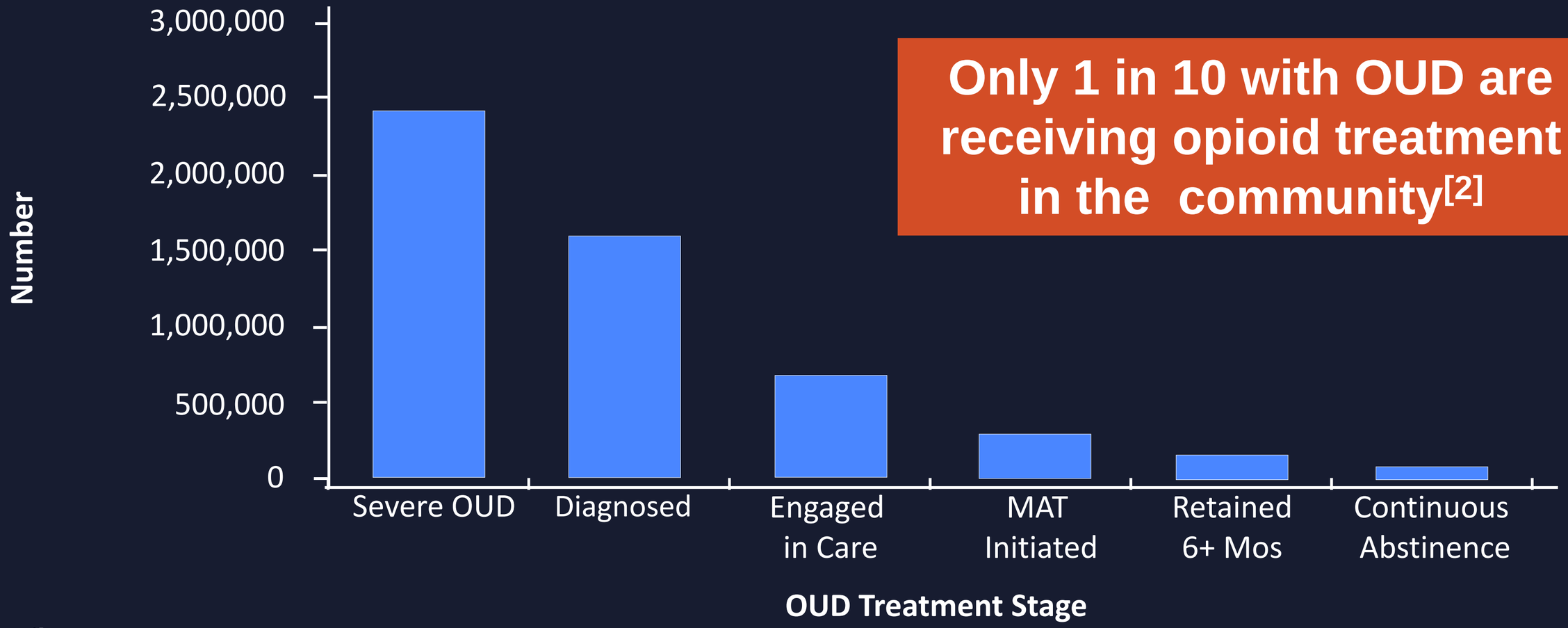
SOURCE: National Vital Statistics System Mortality File.

Organizational-Level Correlates of the Provision of Detoxification Services and Medication-Based Treatments for Substance Abuse in Correctional Institutions

Carrie B. Oser[1], Hannah K. Knudsen[2], Michele Staton-Tindall[3], Faye Taxman[4], and Carl Leukefeld[5]



OUD Cascade of Care in United States: 2014 National Estimates[1]



Only 1 in 10 with OUD are receiving opioid treatment in the community[2]

1. Williams. https://academiccommons.columbia.edu/doi/10.7916/D8RX9QF3.
2. O'Donnell. Mo Med. 2017;114:181

Screening and Diagnosis

- All persons involved in the Criminal Justice System should be **screened for OUD**, and if screened positive, then evaluated with an appropriate DSM-5 diagnostic tool for moderate to severe OUD.

- Diagnosis leads to **ability to offer effective FDA-approved forms of MOUD**.

Defining OUD: DSM-5 Diagnostic Criteria

- **Diagnosis:** ≥ 2 symptom criteria within a 12-mos period
- **Severity:** Mild 2-3 symptoms; Moderate 4-5 symptoms; Severe 6 or more symptoms

Category	Criteria
Loss of control	▪ Opioids are often taken in larger amounts or over a longer period than was intended ▪ There is a persistent desire or unsuccessful efforts to cut down or control opioid use ▪ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects ▪ Craving, or a strong desire or urge to use opioids
Social problems	▪ Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home ▪ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids ▪ Important social, occupational, or recreational activities are given up or reduced because of opioid use
Risky use	▪ Recurrent opioid use in situations in which it is physically hazardous ▪ Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
Pharmacologic problems	▪ Exhibits tolerance: need for a larger amount to achieve desired effect or diminished effect with same amount ▪ Exhibits withdrawal: occurrence of a characteristic opioid withdrawal syndrome or continued use of opioids or closely related substances to avoid withdrawal symptoms

American Psychiatric Association. (2013). Opioid Use Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

Standardized Screening Instruments for OUD

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	Up to 6 dozen items, depending on “skip outs”
Drug Abuse Screening Test (DAST)	10 items, no information about drug of concern
Substance Use Brief Screen (SUBS)	4 items, preliminary testing in primary care
Rapid Opioid Dependence Screen (RODS)	8 items, good sensitivity/specificity, validated in CJS settings to initiate MOUD

NIDA-Modified ASSIST (NM ASSIST)

Table 1. Screening Tools for Opioid Use Disorder

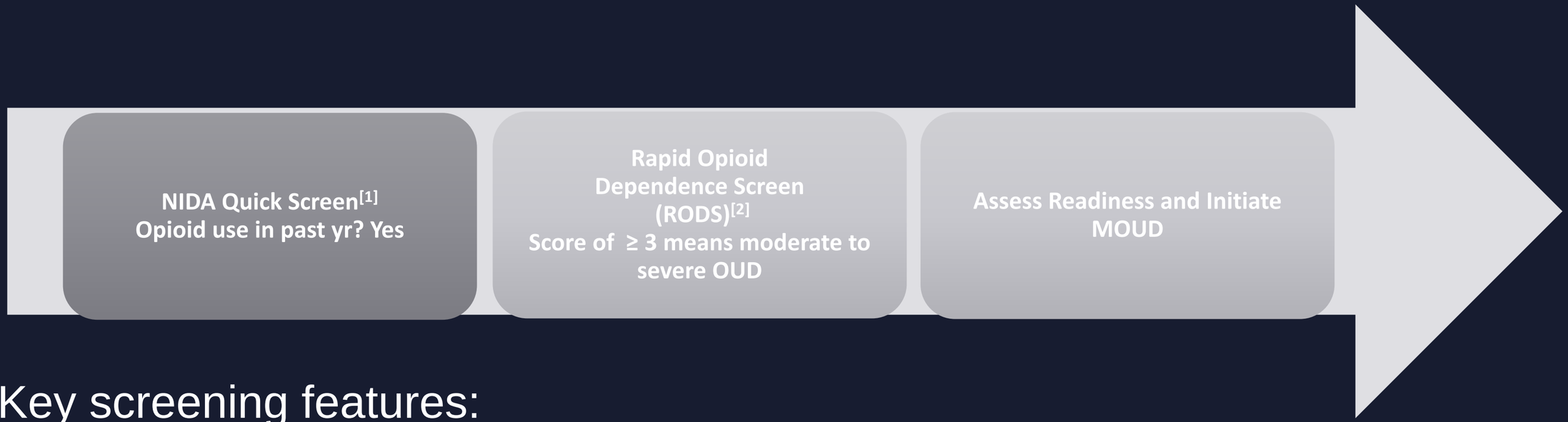
NIDA Quick Screen (OUD)
In the past year, how often have you used the following?
Prescription drugs for non-medical reasons:
☐ Once or twice ☐ monthly ☐ weekly ☐ daily or almost daily
Illegal drugs:
☐ Once or twice ☐ monthly ☐ weekly ☐ daily or almost daily
Reflex positive to NM ASSIST

Adapted from The National Institute on Drug Abuse. NIDA Drug Screening Tool. NIDA-Modified ASSIST (NM ASSIST). Available at: https://www.drugabuse.gov/nmassist/. Accessed 18 November 2019.

Go to this link - Online Clinician's screening tool for drug use in General Medial settings.

Table 1 From Seval et al. Open Forum Infectious Disease. 2020.

Screening for OUD and Readiness for Treatment



- Key screening features:
  - RODS was developed by Dr. Springer[2]
  - Quick (< 5 min)
  - Can be self-administered via iPad/paper
  - Evaluated in multiple settings (jails, prisons, post-release, hospitals)[3-6]

1. NIDA. https://www.drugabuse.gov/nmassist/. 2. Wickersham. J Correct Health Care. 2015;21:12.
3. Springer. J Urban Health. 2010;87:592. 4. Springer. PLoS One. 2012;7:e38335.
5. Springer. J Acquir Immune Defic Syndr. 2018;78:43 6. DiPaola. Contemp Clin Trials. 2014;39:256.

Rapid Opioid Dependence Screen (RODS)

Rapid Opioid Dependence Screen (RODS)

Instructions: [Interviewer reads] The following questions are about your prior use of drugs. For each question, please indicate "yes" or "no" as it applies to your drug use during the last 12 months.

1. Have you ever taken any of the following drugs?

a. Heroin	○ Yes	○ No
b. Methadone	○ Yes	○ No
c. Buprenorphine	○ Yes	○ No
d. Morphine	○ Yes	○ No
e. MS Contin	○ Yes	○ No
f. Oxycontin	○ Yes	○ No
g. Oxycodone	○ Yes	○ No
e. Other opioid analgesics (e.g., Vicodin, Darvocet, etc.)	○ Yes	○ No

If any drug in question 1 is coded "yes", proceed to questions 2 to 8.

If all drugs in question 1 are "no", skip to end and code "no" for opioid dependent.

2. Did you ever need to use more opioids to get the same high as when you first started using opioids? ○ Yes ○ No
3. Did the idea of missing a fix (or dose) ever make you anxious or worried? ○ Yes ○ No
4. In the morning, did you ever use opioids to keep from feeling "dope sick" or did you ever feel "dope sick"? ○ Yes ○ No
5. Did you worry about your use of opioids? ○ Yes ○ No
6. Did you find it difficult to stop or not use opioids? ○ Yes ○ No
7. Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high? ○ Yes ○ No
8. Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of opioids? ○ Yes ○ No

Scoring Instructions: Add number of "yes" responses for questions 2 to 8. If total is > 3, code "yes" for opioid dependent. If total is < 2, code "no" for opioid dependent.

Opioid Dependent: ○ Yes ○ No

- 8 questions created by Dr. Springer and used to assess opioid dependence, validated with the MINI[1]
- Used to safely initiate buprenorphine at time of release from prison or jail[1-3]
- Used to identify patients eligible to start extended-release naltrexone in prison or jail **before** release[4,5]

1. Wickersham. J Correct Health Care. 2015;21:12. 2. Springer. J Urban Health. 2010;87:592. 3. Springer. PLoS One. 2012;7:e38335. 4. Springer. J Acquir Immune Defic Syndr. 2018;78:43 5. DiPaola. Contemp Clin Trials. 2014;39:256.

NEW RECOMMENDATION

All FDA approved medications for the treatment of opioid use disorder **should be available to individuals receiving healthcare within the criminal justice system**. The treatment plan, including choice of medication, should be based on the patient's individual clinical needs.

Rationale:

- Federal law requires that incarcerated individuals be treated for health problems since they have no other way to access medical care.
- Addiction treatment has historically been excluded from the range of services provided in U.S. correctional facilities.

MAJOR REVISION

Initiation or maintenance of pharmacotherapy for the treatment of opioid use disorder is recommended for individuals within the criminal justice system (including both jails and prisons). Criminal justice staff should coordinate care and access to pharmacotherapy to avoid interruption in treatment. Patients should not be forced to transition from agonist (methadone or buprenorphine) to antagonist (naltrexone) treatment.

Rationale:

Evidence has found that pharmacotherapy can effectively treat opioid use disorder among incarcerated individuals.

NEW RECOMMENDATION

Individuals entering the criminal justice system should **not be subject to forced opioid withdrawal**.

- Patients being treated for opioid use disorder at the time of entrance into the criminal justice system should continue their treatment.
- Patients with opioid use disorder who are not in treatment should be assessed and offered individualized pharmacotherapy and psychosocial treatment as appropriate.

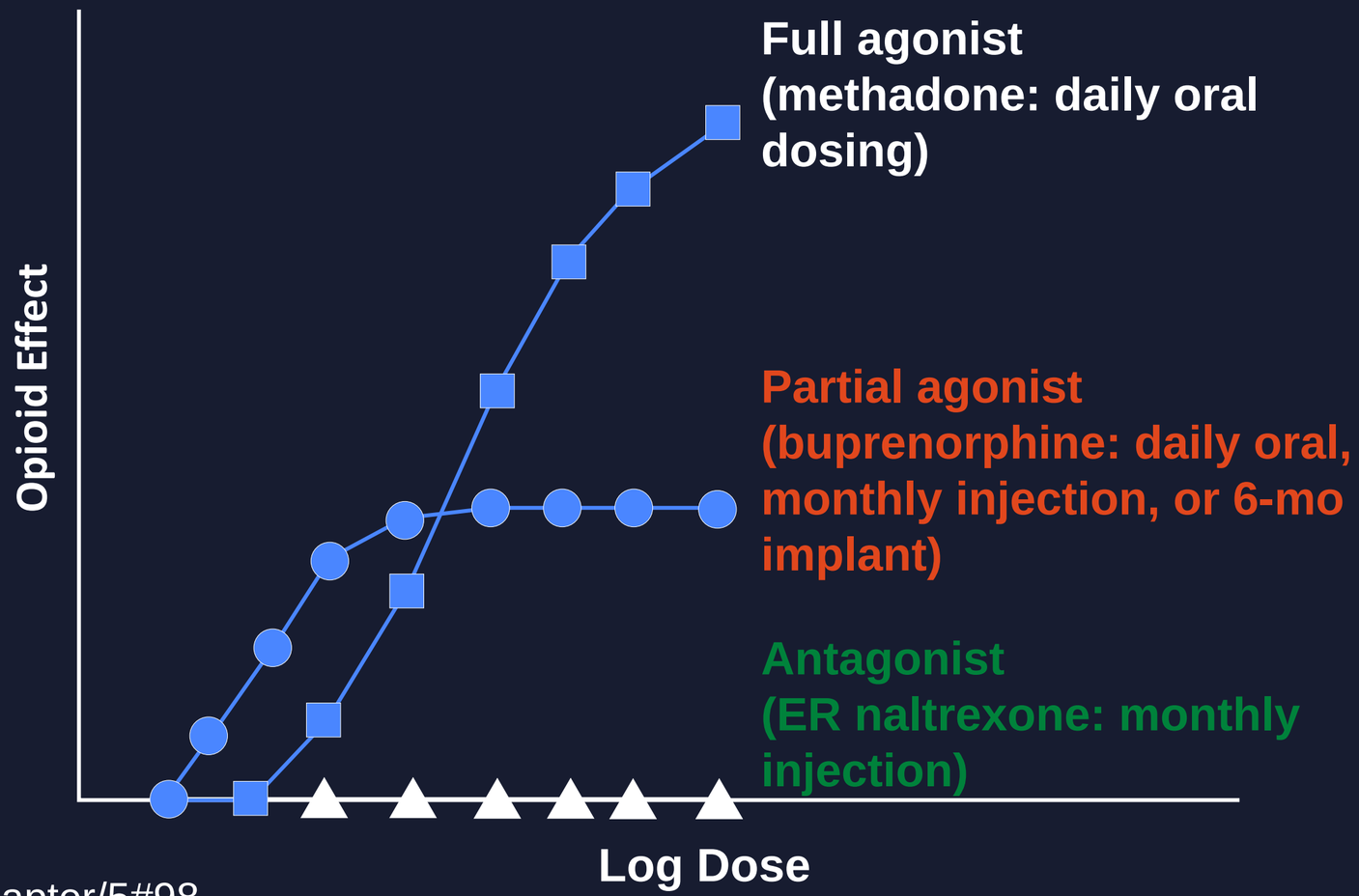
Rationale:

- Federal law requires that incarcerated individuals be treated for health problems since they have no other way to access medical care.
- Addiction treatment has historically been excluded from the range of services provided in U.S. correctional facilities.

All FDA-Approved Forms of MOUD Should Be Available in Criminal Justice Settings

Medications for Treatment of OUD:

- **Methadone:** full agonist that activates mu-receptor
- **Buprenorphine:** partial agonist that activates mu-receptor at lower levels
- **Naltrexone:** antagonist that occupies mu-receptor without activating it



https://www.nap.edu/read/25153/chapter/5#98

FDA-Approved Medications for Treatment of Opioid Use Disorder (MOUD)

Characteristic	Methadone	Buprenorphine	Extended-release Naltrexone
Mechanism of Action	Full μ agonist	Partial μ agonist Partial κ antagonist	Full μ antagonist
Delivery	Oral	Sublingual film, implant, injection	Injection
Frequency	Daily	Daily oral Monthly injection Implant 6 mos	Monthly
Setting	Licensed drug treatment program	Primary/CJS/Specialty care setting (MD with 8 hr training; PA/NP with 24 hr training)	Primary/CJS/Specialty setting (no special licensing)

Schuckit. NEJM. 2016;375:357.

Buprenorphine Formulations

Generic Name	Route of Administration (Dosing)	Brand Names	For the Treatment of	Formulation Considerations
Buprenorphine (monoproduct)	Sublingual Tablets (daily)	Generic versions available similar to Subutex*	Opioid withdrawal and opioid use disorder	Some risk for diversion or misuse; requires daily compliance
Buprenorphine and naloxone	Sublingual tablets or film (daily)	Generic versions available in addition to Suboxone (SL film, and tablet), Cassipa (SL film)^, Zubsolv (SL tablet), Bunavail (buccal film)	Opioid withdrawal and opioid use disorder	Lower potential for misuse and diversion (compared to monoproduct); requires daily compliance
Buprenorphine extended-release	Extended-release Injection (monthly)	Sublocade^	Moderate to severe opioid use disorder in patients who have initiated treatment with transmucosal buprenorphine followed by dose adjustment for a minimum of 7 days	No risk for patient diversion or misuse; requires patients to be on a stable dose of transmucosal buprenorphine for at least 7 days; monthly instead of daily medication compliance; less fluctuation in buprenorphine levels (compared to daily doses)

*SL, sublingual; *Subutex discontinued. ^ Approved September 2018, FDA Website currently says it has been discontinued*
Some patients may experience withdrawal/cravings when switched to a different formulation.
Table content was derived from FDA labels. Labels and label updates can be accessed at https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm.

Buprenorphine Formulations

Generic Name	Route of Administration (Dosing)	Brand Names	For the Treatment of	Formulation Considerations
Buprenorphine extended-release	Extended-release Injection (weekly or monthly)	Brixadi^	Moderate to severe opioid use disorder in patients who have initiated treatment with a single dose of transmucosal buprenorphine or who are already being treated with buprenorphine	Tentative approval from FDA (not eligible for marketing in the U.S. until November 30, 2020). No risk for patient diversion or misuse; only a single prior dose of transmucosal buprenorphine required prior to initiation; weekly or monthly instead of daily medication compliance; Less fluctuation in buprenorphine levels (compared to daily doses)
Buprenorphine hydrochloride	Subcutaneous Implant (every 6 months)	Probuphine Implant^	Treatment of opioid use disorder in patients who have achieved and sustained prolonged clinical stability on low-to-moderate doses of a transmucosal buprenorphine (i.e., no more than 8 mg per day)	Requires prolonged stability on 8 mg per day or less transmucosal buprenorphine; no risk for patient diversion or misuse; healthcare provider training required for implant insertion and removal; insertion site should be examined one week after insertion; implant must be removed after 6 months; risks associated with improper insertion and removal; currently only FDA approved for a total treatment duration of one year (one insertion per arm); less fluctuation in buprenorphine levels (compared to daily doses)

*SL, sublingual; *Subutex discontinued. ^ Approved September 2018, FDA Website currently says it has been discontinued*
Some patients may experience withdrawal/cravings when switched to a different formulation.
Table content was derived from FDA labels. Labels and label updates can be accessed at https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm.

Appropriate Way to Initiate MOUD

- Education about OUD.
- Treatment of withdrawal with continuation of maintenance MOUD to prevent relapse.
- No person should be subject to forced withdrawal or forced to transition from one form of treatment to another, i.e. forced to go from an agonist or partial agonist to an antagonist.
- All persons in the CJS as in the community should receive a form of MOUD that is based on individual clinical needs (not based on one form of treatment).

MAJOR REVISION

Individuals in the criminal justice system who have opioid use disorder or who are **experiencing opioid withdrawal should be offered a combination of pharmacotherapy and psychosocial treatment**.

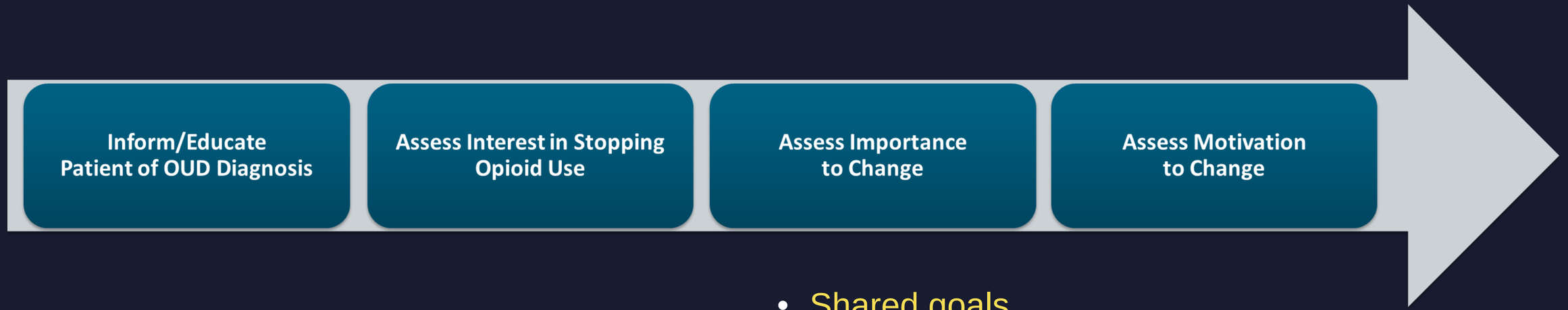
A patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment **should not preclude or delay** pharmacological treatment of opioid use disorder.

Motivational interviewing or enhancement can be used to **encourage patients to engage** in psychosocial treatment services appropriate for addressing their individual needs.

Rationale:

A requirement for psychosocial treatment can present barriers to access to treatment for some patients and is not consistent with the evidence base.

Brief Intervention: Assessing Readiness for Medication Treatment for OUD and Building a Therapeutic Alliance



- Attitude
  - Nonjudgmental, curious, empathetic
- Respectful
  - Recognize adversity
  - Recognize strengths
  - Use the non-stigmatizing language
- Honesty

- Shared goals
  - Why is patient seeking treatment?
  - Provider/treatment team concerns
- Reassurance
  - Assure patient your objective is concern for his or her health
  - Confidentiality (with qualifiers); safety of self, well-being of others (especially children)

Miller. Motivational Interviewing. 2013:22.

Review of Initial Evaluation

Goals	Details
Therapeutic alliance	▪ Nonjudgmental, understanding, respectful; use language of recovery; shared goal-setting
Collateral information	▪ Prescription monitoring programs ▪ Other treatment providers
Comprehensive assessment	▪ Medical, psychiatric, review/perform lab tests, physical exam
Signs of withdrawal	▪ Clinical Opioid Withdrawal Scale (COWS)
Diagnostic clarification of substance use disorder	▪ DSM-Criteria with: ○ Descriptor: use disorder; intoxication; withdrawal ○ Specifiers: In early remission; in sustained remission; in a controlled environment ○ Severity: mild, moderate, severe
Risk assessment	▪ Active suicidal ideation; homicidal ideation; overdose
Assessment of appropriateness	▪ Buprenorphine treatment (any contraindications); is office-based opioid treatment appropriate for patient at this time?
Plan	▪ Medication for OUD treatment; therapy; referrals; safety measures

www.samhsa.gov. www.asam.org

Treatment Initiation: FDA-Approved Medications for OUD Treatment

Buprenorphine	Extended Release-Naltrexone	Methadone
Feasible in primary/CJS settings with BUPE-X-waived provider	Feasible in primary/ CJS settings (no special licensing/waiver)	Only available in federally licensed methadone clinics and CJS can have as well*
Patients with acute/chronic pain can be safely inducted on buprenorphine	No identified acute pain condition Patient must be free from opioids for at least 7 days	Patients with acute / chronic pain condition can be safely inducted on methadone

1. Liebschutz. JAMA Intern Med. 2014;174:1369. 2. Englander. J Hosp Med. 2017;12:339. 3. Trowbridge. J Subst Abuse Treat. 2017;79:1. 4. Springer. J Urban Health. 2010;87:592. 5. Springer. PLOS ONE. 2012;7:e38335. 6. Springer. J Acquir Immune Defic Syndr. 2018;78:43

NEW RECOMMENDATION

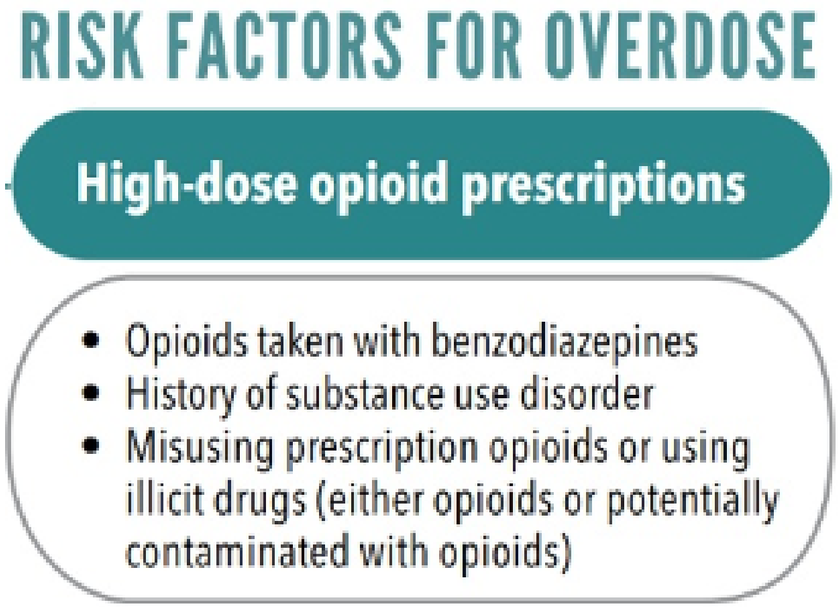
Naloxone kits should be available within correctional facilities. Individuals with opioid use disorder should receive a naloxone kit prior to release, and individuals and families should be educated in how to administer naloxone.

Rationale:

Recent State legislation and new formulations (including a naloxone nasal spray approved in 2015) has made the use of naloxone for the treatment of opioid overdose accessible to first responders, including correctional officers.

Naloxone (*Narcan*)

- **Naloxone prescription recommended for anyone at high risk for opioid overdose.**
  - From 2017 to 2018: naloxone prescriptions increased 2-fold.
  - Only 1 naloxone prescription dispensed for every 70 high-dose opioid prescriptions.
  - Rural counties nearly 3 times more likely to be low-dispensing vs metropolitan counties.
- **Many states have laws allowing pharmacists to dispense naloxone without prescription (standing orders).**



CDC. Aug. 6, 2019. https://www.cdc.gov/media/releases/2019/p0806-naloxone.html.

Naloxone Facts: Administer to Any Person Who Shows Opioid Overdose Signs or Overdose is Suspected

- Administered by IM or IV injection or by nasal spray; can be given every 2-3 minutes
- Titrate to smallest effective dose that maintains spontaneous normal respiratory drive
- Goal is to restore adequate spontaneous breathing, not necessarily complete arousal
- IM vs IV route may be more suitable if history of opioid dependence because of slower onset of action and prolonged duration of effect, which may minimize rapid onset of withdrawal symptoms
- Duration of effect is 30-90 mins; observe after this time frame for return of overdose symptoms
- Safety profile is high, especially when used in low doses and titrated to effect

- Withdrawal triggered by naloxone can feel unpleasant but is not life-threatening
- Some persons become agitated or combative when withdrawal is triggered and need help to remain calm
- If given to individuals not opioid-intoxicated or opioid-dependent, naloxone produces no clinical effects, even at high doses
- Safe for opioid overdose reversal in pregnant women; use lowest dose to maintain spontaneous respiratory drive and to avoid triggering acute opioid withdrawal, which may cause fetal distress
- Has been used for decades by emergency medical personnel

SAMHSA. https://www.integration.samhsa.gov/opioid_toolkit_firstresponders.pdf.

MAJOR REVISION

Patients being treated for opioid use disorder while in prison or jail should **be stabilized on pharmacotherapy** (methadone, buprenorphine or naltrexone) **and continue in treatment after their release**.

Patient care on reentry to the community should be **individualized and coordinated** with treatment providers in the community.

Rationale:
Risk for relapse and overdose is particularly high in the weeks immediately following release from prison and jails.

Coordination of Care at time of Re-entry to the Community is Essential to Reduce Overdose and Death after Release from CJ Setting

- **Coordinated Referral System** that links persons involved with CJS to the community and provides appointments prior to release with OUD treatment provider/ Harm reduction and prevention services (SSPs, PrEP, Naloxone etc.) are essential.

- **Peer/Patient navigators** meet with patients prior to discharge from CJS and then takes patient upon discharge to first appointment in community to continue to receive MOUD (evidence-based programs).

CASE DISCUSSION & CLINICAL QUESTIONS

Case 1: Emphasize Recognition of Opioid Withdrawal, Screening and Diagnosis

A 25-year-old young man is arrested for possession of illicit substance. He is found to be agitated and concern for opioid withdrawal is assessed.

Case Question 1:

Which of the following steps could law enforcement take?

(a) Ignore him, opioid withdrawal is not life-threatening.

(b) Wait for the substance use disorder clinician to arrive and let them figure it out

(c) Do a quick screen for opioid use disorder and get a MOUD prescriber to help treat his withdrawal immediately.

Case 1 Cont’d: Emphasize OUD Education and Individualizing of the Form of MOUD

- The patient feels better within 20 minutes after a nurse initiates sublingual buprenorphine/ naloxone 4 mg and then another 4 mg for a total of 8mg that first day.
- His withdrawal symptoms are relieved, and his opioid craving has diminished somewhat.
- He goes to court later that day and is sentenced to jail time for 10 days.

Case Question 2:

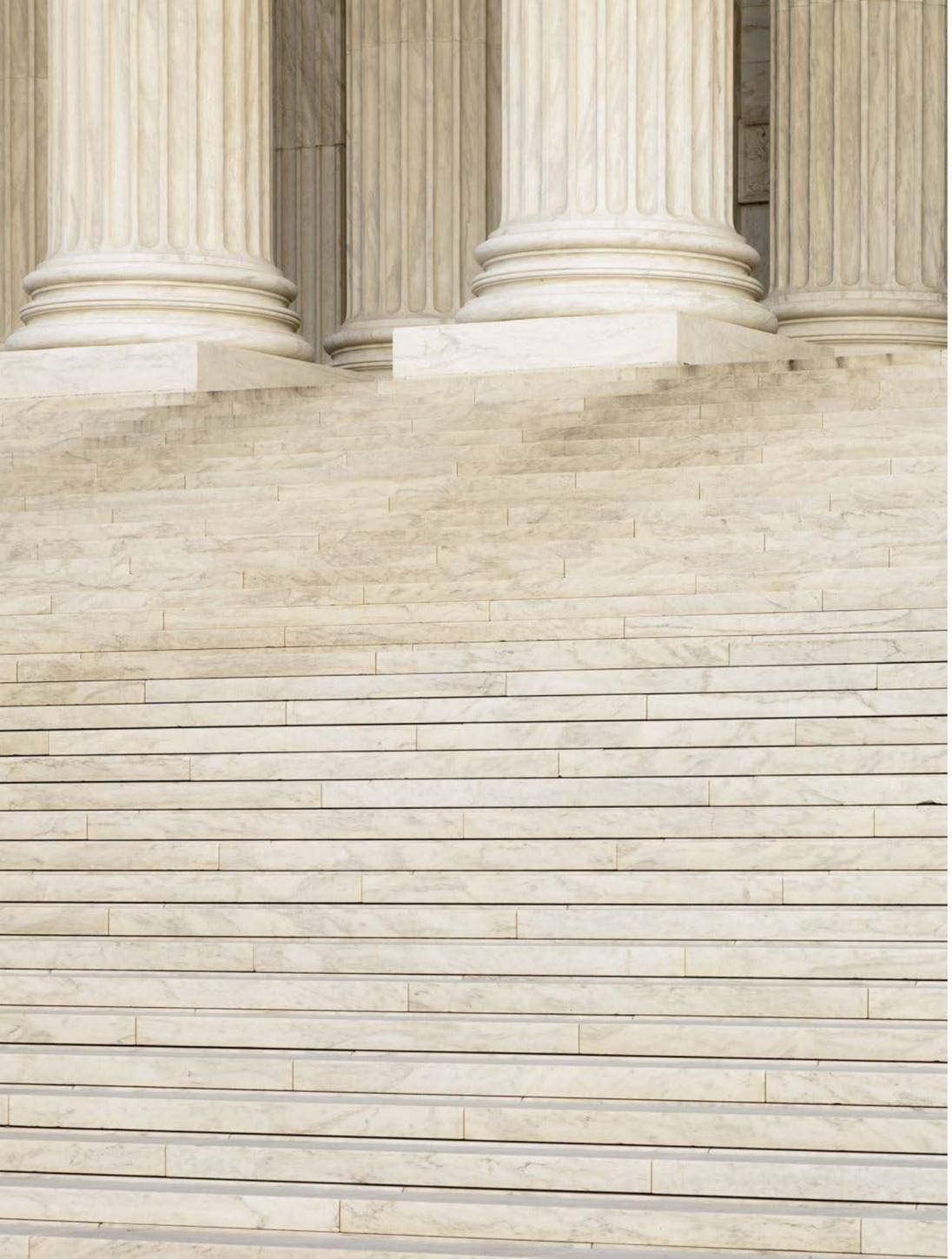
At this time, what should the clinician in the criminal justice setting do?

(a) He does not need any more treatment now that he is in jail.

(b) He should obtain XR-NTX at time of release.

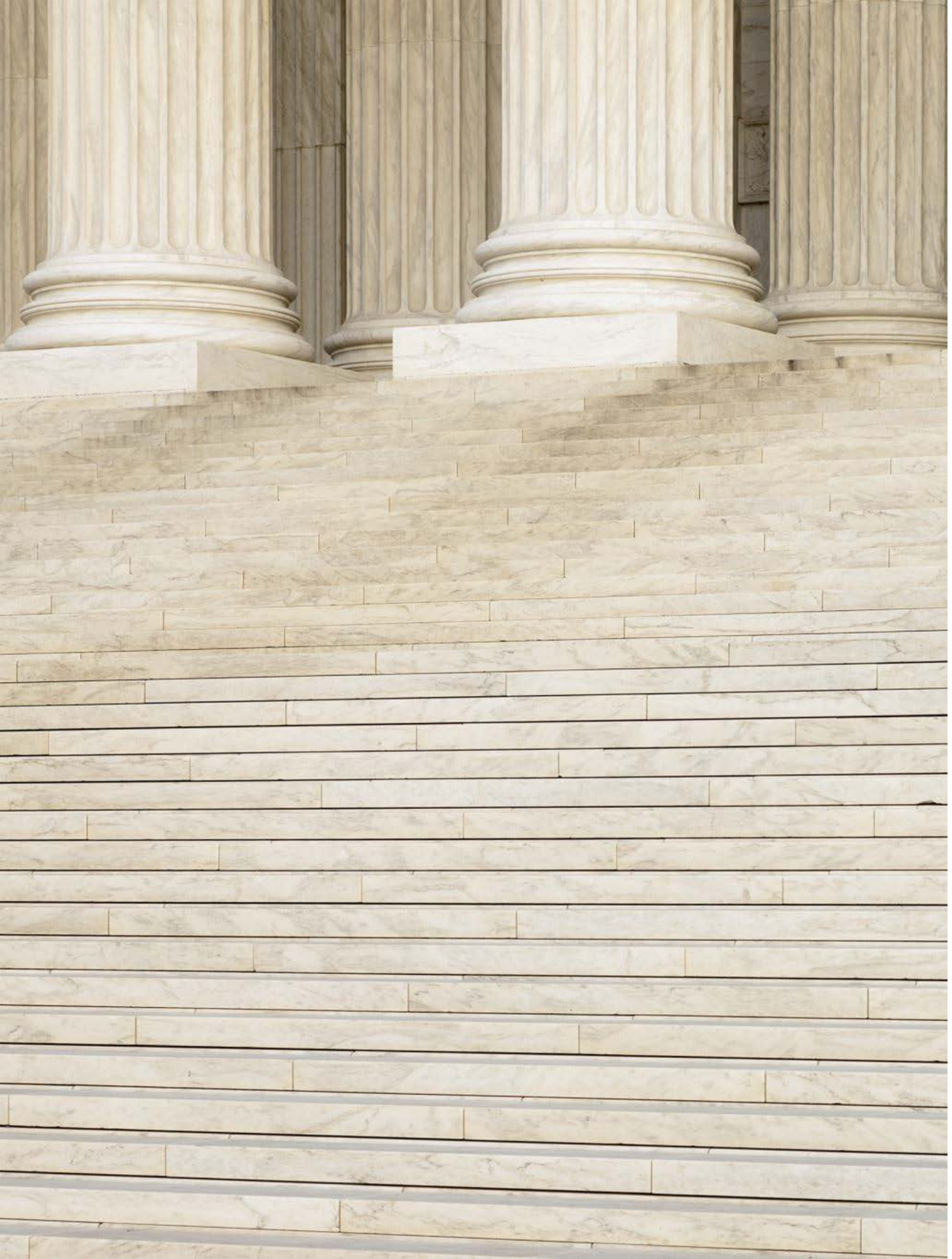
(c) He should continue his buprenorphine then stop it before he gets released.

(d) A clinician who can prescribe MOUD should talk to the patient and determine his interest in continuing to take medication and decide what the best form of MOUD is for him to continue.



Case 1 Cont’d: Emphasize Coordination of Care Prior to Re-entry to the Community and Offer Linkage Services to OUD Treatment.

The patient is now due to be released in 24-28 hours to the community after being incarcerated for 10 days. He was kept on sublingual buprenorphine/ naloxone at a dose of 16 mg per day while in jail and did not have any opioid cravings.



Case Question 3:

What should be done ahead of time to improve his re-entry period?

(a) No need to do anything. He can find a prescriber in the community if he wants to.

(b) Give him a shot of extended-release naltrexone on his day of release.

(c) Have a Case manager / nurse care coordination work to arrange a follow-up in the community at the time of release or within the time frame of medication treatment allowance.

(d) Provide a link to a Patient/ Peer Navigator service that can help bring him to the next community MOUD appointment.

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AUDIENCE Q & A

UPCOMING EVENTS

❑ The ASAM National Practice Guideline 2020 Focused Update Webinar: Adolescents and Young Adults	Marc Fishman, MD, DFASAM	Tuesday, Sept. 24 @ 1:00 p.n. EST

THE ASAM NATIONAL PRACTICE GUIDELINE SERIES

For past on-demand recordings from the ASAM National Practice Guideline 2020 Focused Update series on Fundamentals and Pregnancy, visit:

https://elearning.asam.org/p/NPG2020_WebinarSeries

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THANK YOU.