Expanding Medication for Opioid Use Disorder in County Jails

Medications for Opioid Use Disorder (MOUD)
How they work
For Whom
Implications in Jails

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DISCLOSURES

Faculty	Nature of Commercial Interest
Jean Glossa, MD, MBA, FACP	Dr. Glossa discloses she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
Shannon Robinson, MD	Dr. Robinson discloses she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
R. Corey Waller, MD, MS, FACEP, DFASAM	Dr. Waller discloses he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
Jeanene Smith, MD, MPH (Curriculum Advisor)	Dr. Smith discloses she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.

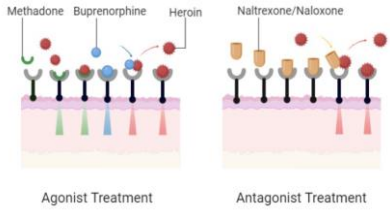
LEARNING OBJECTIVES

- Describe the medications approved for treatment of opioid use disorder
- Discuss the implications of using these medications in carceral settings

FDA APPROVED AGENTS for OPIOID USE DISORDER (OUD)

- Agonists
  - Methadone
    - Approved for cough in 1940s
    - Approved for OUD in 1972
  - Buprenorphine
    - Approved for pain in 1981
    - Approved for OUD in 2002 (oral formulation), patch, implants & injection later
- Antagonists
  - Naltrexone
    - Oral approved 1984
    - Injectable approved 2006 alcohol use disorder (AUD)
    - Injectable approved 2010 approved for OUD
  - Naloxone- approved 1961, autoinjector 2014, nasal spray 2015

MU OPIOID RECEPTOR BINDING



HMA Proprietary Slide

METHADONE OVERVIEW

How it works

- Mu opioid agonist without a ceiling effect
- Must start low & it takes longer to reach therapeutic dose
- Can only be given by Opioid Treatment Program(OTP)/ Narcotic Treatment Program (NTP) for OUD beyond 3 days
- < 60mg/ day is NOT evidence-based
- Typical dose 60-120mg/day for nonpregnant persons
- Higher and more frequent doses in pregnancy

Who is appropriate?

- >1 year of OUD
- More severe OUD
- Unable to initiate or unsuccessful with buprenorphine
- Can manage or benefit from daily visit to the clinic

Implications for Jails

- Relationship with NTP
- Become certified as NTP
- Liquid formulation decreases diversion risk

Sources: Code of Federal Regulation (CFR) 41 and 42
Federal Guidelines for OTPs 2015 SAMHSA. https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP
ASAM National Practice Guidelines for the Treatment of OUD 2020. https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline?gclid=CjwKCAjwy7CKBhBMEiwA0Eb7aslZ1RSWUK9U-DAbHkUF52amCa-SbwuO3CRhmepZc5UdOavipnXaIxoCkdkQAvD_BwE

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BUPRENORPHINE: How it works

- Partial mu opioid agonist with a ceiling effect
- Greater affinity than full agonists; displaces full agonists
  - Must be in withdrawal before starting this;
  - Otherwise, precipitated withdrawal occurs
- Tight binding and slow dissociation
- The addition of opioids is generally ineffective
- Sublingual or buccal & long acting injectable
- Dosing <8 mg is NOT evidence-based
- Typical dose 16 mg/ day nonpregnant persons
- Doses above 24-32 mg are no more effective
- Doses above ~32 mg do not cause more euphoria
- Higher and more frequent doses in pregnancy

Who is appropriate?

- Opioid withdrawal and/ or OUD

Implications for Jails

- X waiver for prescribers
- Sublingual tabs vs films
- Injectable formulation decreases diversion risk

Source: ASAM National Practice Guidelines for the Treatment of OUD 2020.

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NALTREXONE OVERVIEW

How it works for OUD

- Mu opioid antagonist
- Does not treat withdrawal
- Does not treat low dopamine
- High affinity & competitive binding
- Must be opioid free x 7 days before starting
- Injectable- every 28 days IM; AUD & OUD
- Oral 50-100mg/ day approved for AUD

Implications for Jails

- Does not require X-waiver or NTP certification
- Does not treat withdrawal
- Does not treat dopamine depleted state
- No diversion risk
- Not as effective

Who is appropriate?

- Patients with OUD who have:
  - Positive reinforcement from normal stimuli
  - Haven't used while incarcerated, but have cravings or worries about relapse
  - Occasionally uses (funerals)….
  - Had poor outcomes with agonists
  - Have a history of Alcohol Use Disorder (AUD)
    - Decreases cravings and use
- Can be very useful after discontinuation of agonists

Source: ASAM National Practice Guidelines for the Treatment of OUD 2020

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NALOXONE: How it works and who it is appropriate for?

- Mu opioid antagonist
- Shorter half life & more rapid onset of action than naltrexone
- High affinity & competitive binding
  - Opioid overdose reversal agent
  - May require more than one dose, especially with fentanyl overdoses
  - Opioids have longer half life than naloxone
- Intranasal or intramuscular by a by-stander

Implications for Jails: How do you make naloxone available to your inmates upon release?

- Medical write prescription and the written prescription is given to inmate at release
- Medical prescribes it- patient given naloxone with release meds
- Custody provides naloxone to all inmates upon release, as no RX is required
- Naloxone vending machine in LA County jail release area

Source: ASAM National Practice Guidelines for the Treatment of OUD 2020

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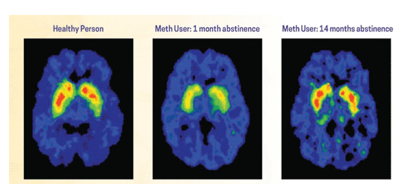
To taper or not to taper?

Evidence is clear that long-term or indefinite treatment with medications for OUDs is often required for effective and sustained outcomes[1]	In practice, successful tapers from methadone or buprenorphine typically occur in only about 15 percent of cases[2,3]	According to the U.S. Surgeon General, successful tapers typically occur, if at all, when individuals have been treated with Medicated Assisted Treatment (MAT) for at least 3 years[4]

1. National Academies of Sciences, Engineering, and Medicine. (2019). *Medications for opioid use disorder save lives*. Washington, DC: The National Academies Press.
2. Nosyk, B., Sun, H., Evans, E., Marsh, D. C., Anglin, M. D., Hser, Y. I. et al. (2012). Defining dosing pattern characteristics of successful tapers following methadone maintenance treatment: Results from a population-based retrospective cohort study. *Addiction*, 107, 1621-1629.
3. Substance Abuse and Mental Health Services Administration. (2018). *Medications for opioid use disorder: Treatment improvement protocol (TIP 63) for healthcare and addiction professionals, policy makers, patients and families*. (Rep. No. HHS Publication No. SMA 18-5063). Bethesda, MD: Author.
4. Substance Abuse and Mental Health Services Administration and Office of the Surgeon General. (2018). *Facing addiction in America: The Surgeon General's spotlight on opioids.* Washington, DC: US Department of Health and Human Services.

It takes time for your brain to recover

- Prolonged drug use changes the brain in long lasting ways
- Changes are both functional and structural
- Return to normal takes > 1 year
- If we stop medication before the brain recovers you may lose the desired outcomes
- Studies of all FDA approved meds for Opioid Use Disorder indicate a risk of relapse upon discontinue of meds



Source: Volkow (2001)

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To taper or not to taper?

Many factors need to be evaluated when considering a taper

- Choice of the patient
- Adequate duration of treatment
- Overall level of functioning
  - Able to handle interpersonal conflicts without relapsing
- Presence of co-occurring illness
- Severity/ duration/ amount of use prior to starting treatment
- Side effects of medication
- Available supports during taper
  - Family, friends, mutual support groups (12 Step, SMART…), church
  - Not living with people who are using/ selling
- Ability to monitor functioning with early return to treatment
  - Times of transition are not ideal times to taper
- Engagement with behavioral health therapy
- Most successful tapers are very gradual, and may have plateaus

Source: Volkow (2001)

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RESOURCES

- SAMHSA Federal Guidelines for OTPs https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP
- ASAM National Practice Guidelines for the Treatment of OUD 2020 Focused Update https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline?gclid=CjwKCAjwy7CKBhBMEiwA0Eb7asIZ1RSWUK9U-DAbHkUFS2amCa-SbwuO3CRhmepZc5UdOavipnXaIxoCkdkQAvD_BwE
- National Academies of Sciences, Engineering, and Medicine. (2019). *Medications for opioid use disorder save lives.* Washington, DC: The National Academies Press.
- Substance Abuse and Mental Health Services Administration. (2018). *Medications for opioid use disorder: Treatment improvement protocol (TIP 63) for healthcare and addiction professionals, policy makers, patients and families.* (Rep. No. HHS Publication No. SMA 18-5063). Bethesda, MD: Author. https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002
- Substance Abuse and Mental Health Services Administration and Office of the Surgeon General. (2018). *Facing addiction in America: The Surgeon General's spotlight on opioids.* Washington, DC: US Department of Health and Human Services. https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf

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QUESTIONS/COMMENTS?

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