



NC Department of Health and Human
Services

NC Opioid and Prescription Drug
Abuse Advisory Committee
(OPDAAC)

December 13, 2019

Welcome and Introductions of Attendees

Kody Kinsley, Deputy Secretary for Behavioral Health & Intellectual and Developmental Disabilities

Alan Dellapenna, Head, Injury and Violence Prevention Branch, Chronic Disease and Injury Section, Division of Public Health

Margaret Bordeaux, Justice-Involved Overdose Prevention Specialist, Injury and Violence Prevention Branch, Chronic Disease and Injury Section, Division of Public Health

- *Take breaks as needed*

What's New in the Jail World? Harm Reduction and Jails - A Public Health Approach to Working with Individuals in Correctional Settings Who Use Drugs

Joe Prater

Realities

Governments Hate 2 Things

1. Change
2. The way things currently are

The 4 “S’s” you deal with

1. Safety and Security
2. Structure
3. Staffing
4. Society

A Fifth “S” about you

- ✓ Service

“Correction”

- ...is defined as “a change made to something in order to correct or improve it, or the action of making such a change.”

“Harm Reduction”

- ...is defined as “a set of practical strategies and ideas at reducing negative consequences associated with drug use.”

“Control” to “Correction”

- Rehabilitation
- Recovery
- Harm Reduction
- Education/Training

What Kinds of Harm?

- Public health risks
 - HIV/Hep C
 - Other chronic and persistent medical and mental health issues/comorbidity/co-occurring disorders
 - Drug/Alcohol addiction/Overdose/Overdose deaths
- Public safety risks
 - More crimes
 - Recidivism/return to jails
 - More victims
 - Families
 - Children
 - You and me
- Costs to communities
- “Public safety is public health; public health is public safety.”

“Justice-involved population” ...through the CJ system

- Arrest
 - Jail
 - Court
 - Jail/Prison/Community Corrections
(Probation/Parole/Post-Release Supervision)
 - Reentry/Transition back to communities
- All are harm reduction “points of intercept.”

Examples of Harm Reduction

- Syringe exchange
- Laws and legislation
 - Good Samaritan law/Second Chance legislation and laws, etc.
- Pre-arrest diversion
- Pre-trial release
- Jail/prison/community corrections
 - Education
 - Treatment
 - Medication-Assisted Treatment (MAT)
 - Reentry/transition support
 - Linkage to care and case management

Why is there a need for harm reduction in a correctional setting?

- ✓ Societal changes
 - ✓ De-institutionalizing of mental health
 - ✓ Criminal Justice Reform in NC
 - ✓ Justice Reinvestment Act of 2011 (JRA)
 - ✓ S.L. 2014-100
- ✓ ...Resulting in larger jail population with...
 - ✓ More medically and mentally ill
 - ✓ More addicted to drugs and alcohol
- ...requiring treatment and...
- ...requiring different approaches than in the past
- ✓ Bottom line = Enhancing the quality of life for JI individuals = enhancement of public safety and public health through recidivism reduction and healthier/more productive lifestyles = community enhancement

A “New Day” for jail operations

- “Jails have become a revolving door for individuals struggling with mental health and substance use disorders. More than 10 million individuals pass through jails around the country annually, with at least half of those individuals having substance use disorders, half of whom are opioid abusers.”
- Historically, it has not been the responsibility of the sheriffs and jail administrators to be primary care providers of substance use disorder treatments. But with thousands of Americans dying every week from drug overdoses and those recently released from jail among the most defenseless, the situation has changed – sheriffs have taken on the challenge.”

- Jonathan F. Thompson
Executive Director and CEO
National Sheriffs’ Association

Some Other Realities

Why Jail-Based Populations?

➤ Two-thirds

- How many people incarcerated who meet the criteria for drug dependency or abuse.

➤ 11

- How many times more likely post-incarceration people are to die of an opioid overdose in the first year after release from incarceration, compared to a typical NC resident.

➤ 40

- How many times more likely post-incarceration people are to die of an opioid overdose in the first 2 weeks after release from incarceration, compared to a typical NC resident.

➤ 74

- How many times more likely post-incarceration people are to die of a heroin overdose in the first 2 weeks after release from incarceration, compared to a typical NC resident.

How can jails support individuals in reducing drug-related & health-related needs?

“ALES”

“Jails represent perhaps the most unique place to get individuals off drugs and on the path to long-term recovery. But jails can only help individuals begin that journey – communities must shepherd those in need through that journey.”

- Jonathan F. Thompson

Access (housing referrals, referrals for safer use and safer sex supplies)

Linkages (HIV/Hep C treatment, drug and alcohol treatment, mental health care, primary care home)

Education (HIV/STI/Hep C testing and prevention, overdose response and survival education)

Support (active listening, CASE MANAGEMENT, motivational interviewing techniques)

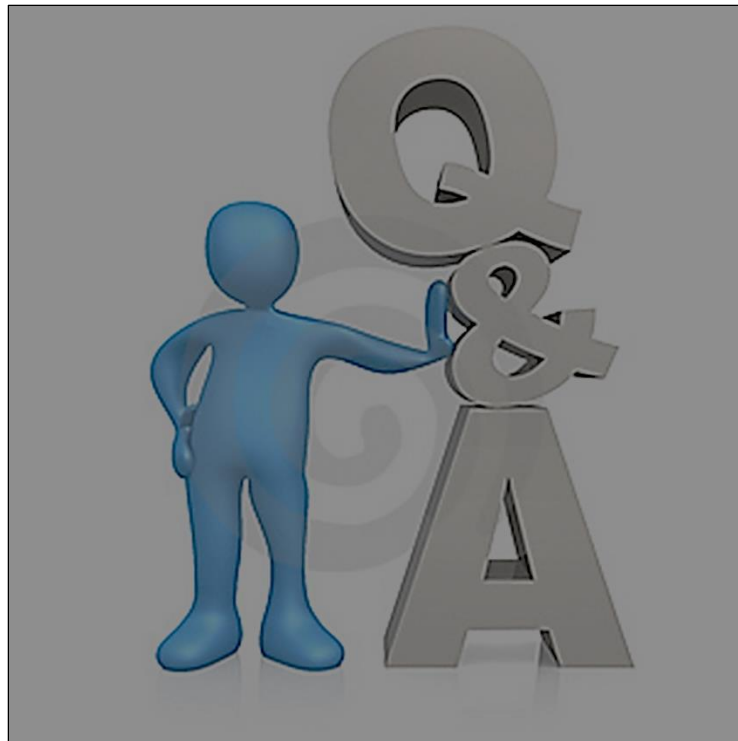
NC DHHS Menu of Local Actions to Prevent Opioid Overdose in NC

- Connect justice-involved persons to harm reduction, treatment, and recovery supports.
 - i. Establish pre-release harm reduction health education programs in county jails/prisons
 - ii. Help individuals establish a medical care relationship for continued primary and mental health care after release

You can pay me now....



QUESTIONS?



Evidence-Based Treatment for Opioid Use Disorder

Dr. Shuchin Shukla

Goals

- ❑ Review the origins of opioid use disorder and the national overdose epidemic
- ❑ Describe the three FDA-approved medications that treat opioid use disorder:
 - ❑ How they work
 - ❑ How they are effective at preventing overdose death
 - ❑ How they are effective at reducing recidivism
- ❑ Discuss issues that connect opioid use disorder and the criminal justice system

What Can We Do to Stop the Overdose and Incarceration Cycle?

- Medication Assisted Treatment (MAT)
- Naloxone distribution
- Case management and peer support services to connect to substance use treatment upon release from jail/prison
- Drug court, diversion programs, housing, vocational training

What Can We Do to Stop the Overdose and Incarceration Cycle?

- All forms of MAT are found to be more effective for ceasing illicit use than unassisted abstinence or detoxification alone
- The use of the opioid agonists methadone and buprenorphine reduces:
 - Overdoses and overdose deaths
 - Transmission of and interactions between infectious diseases such as Hep C, HIV, etc.
 - Illicit substance use
 - Arrests, criminal activity, probation revocation, and reincarceration
- Every \$1 invested in addiction treatment returns a yield of \$4 to \$7 in reducing drug related crimes, criminal justice and theft
- MAT with buprenorphine or methadone in prison resulted in 85% reduction in overdose death in 1st 4 weeks of community re-entry

Opioid Use Disorder Treatment Approaches & Rates of Adherence

- Buprenorphine:
 - ≈ **46-54%** (Weiss et al., 2017; Mintzer et al., 2007; Potter et al., 2013)
- Methadone
 - ≈ **43 -53%** (Strain et al., 1993; Potter et al., 2013)
- Naltrexone
 - ≈ **35%** (Lee et al., 2018)
- Detox then abstinence:
 - ≈ **7-13%** (Weiss et al., 2017; Tuten et al., 2012)

Major Features of Methadone

Full Agonist at mu receptor

Long acting

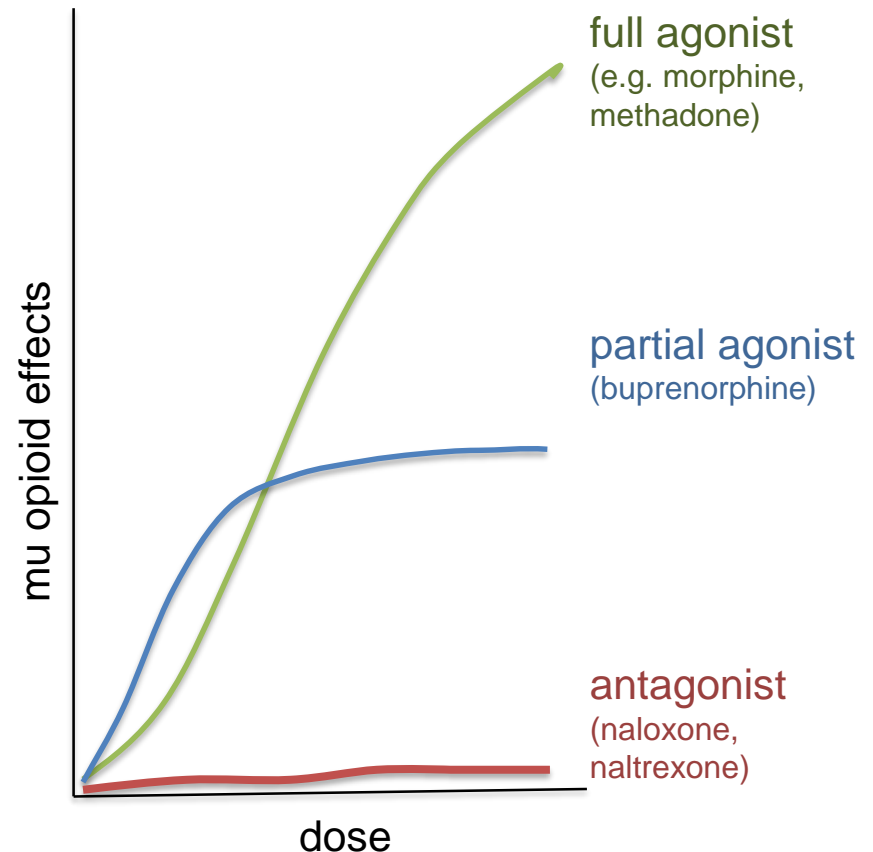
- Half-life ~ 15-60 Hours

Weak affinity for mu receptor

- *Can be displaced by partial agonists (e.g. buprenorphine) and antagonists (e.g. naloxone, naltrexone), which can both precipitate withdrawal*

Monitoring

- Significant respiratory suppression and potential respiratory arrest in overdose
- QT prolongation



Major Features of Naltrexone

Full Antagonist at mu receptor

- Competitive binding at mu receptor

Long acting

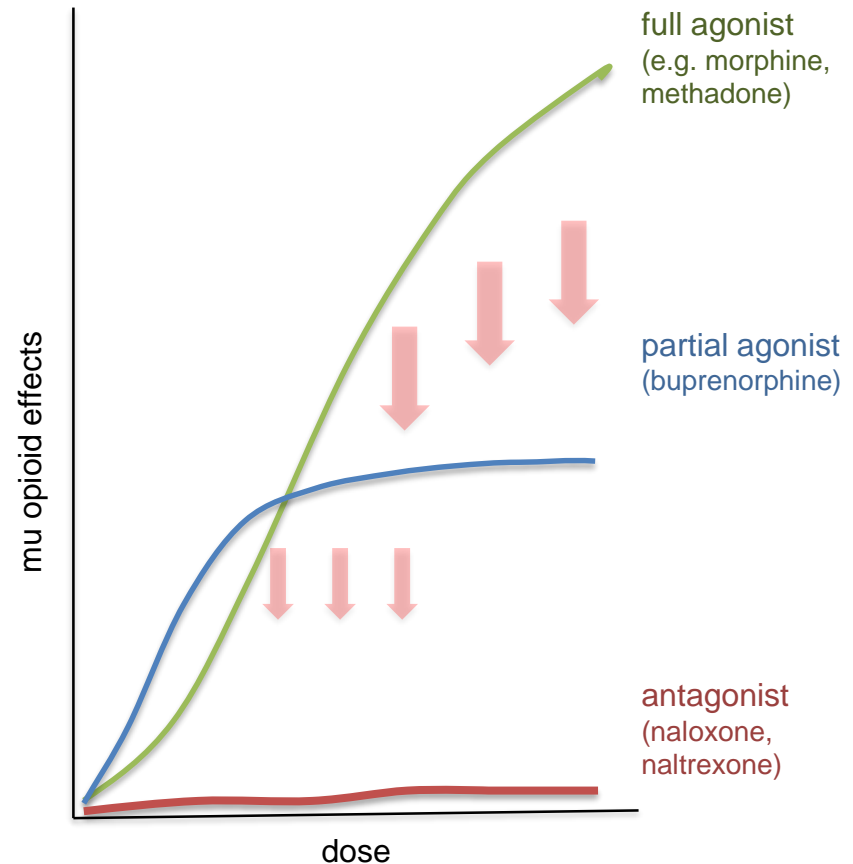
- Half-life:
 - Oral ~ 4 Hours
 - IM ~ 5-10 days

High affinity for mu receptor

- *Blocks* other opioids
- *Displaces* other opioids
 - Can precipitate withdrawal

Formulations

- *Tablets: Revia®: FDA approved in 1984*
- *Extended-Release intramuscular injection: Vivitrol®: FDA approved in 2010*



Major Features of Buprenorphine

Partial agonist at mu receptor

- Comparatively minimal respiratory suppression and no respiratory arrest when used as prescribed

Long acting

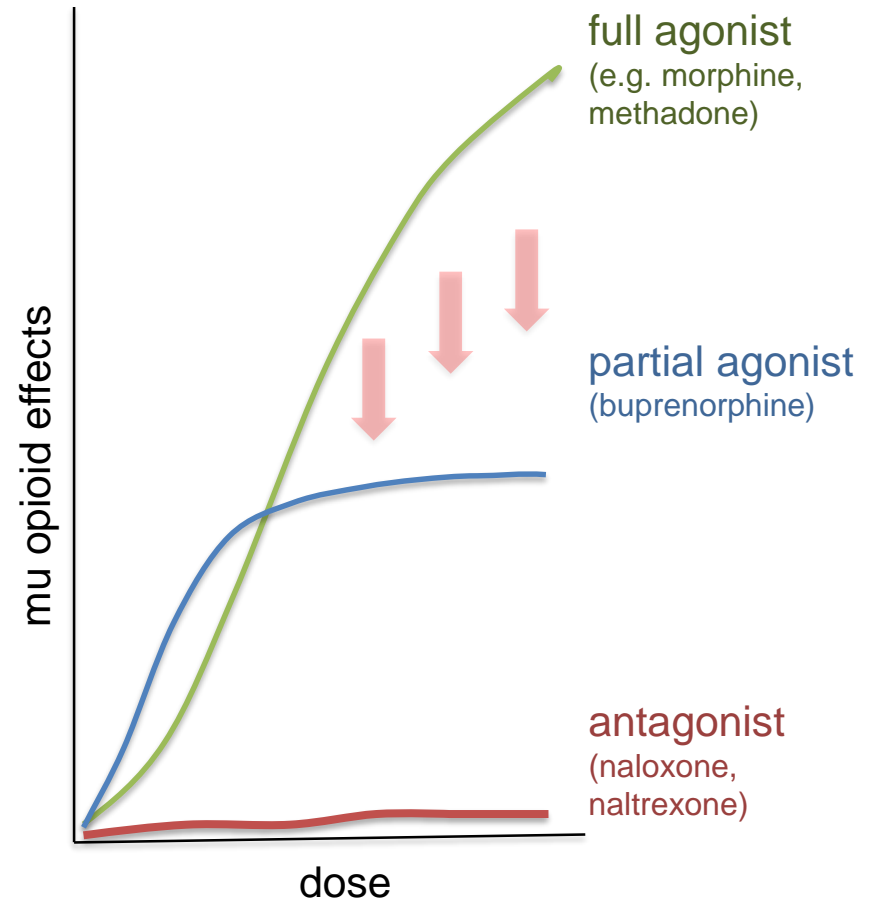
- Half-life ~ 24-36 Hours

High affinity for mu receptor

- *Blocks* other opioids
- *Displaces* other opioids
 - Can precipitate withdrawal

Slow dissociation from mu receptor

- *Stays on receptor for a long time*



How Does Suboxone™ (buprenorphine-naloxone) Work?

- Sublingual
- Partial Agonist
 - Ceiling Effect
 - Most patients on 8 to 16mg/day (dosing different for perinatal)
- What is the maximum mg/day?
 - 24mg/day
- How does the naloxone component in the dual product work?
 - Blocks potential opioid analgesic effects of buprenorphine alone
 - Thought to discourage non-therapeutic/illicit use
 - Thought to reduce diversion of product away from patient to illicit market

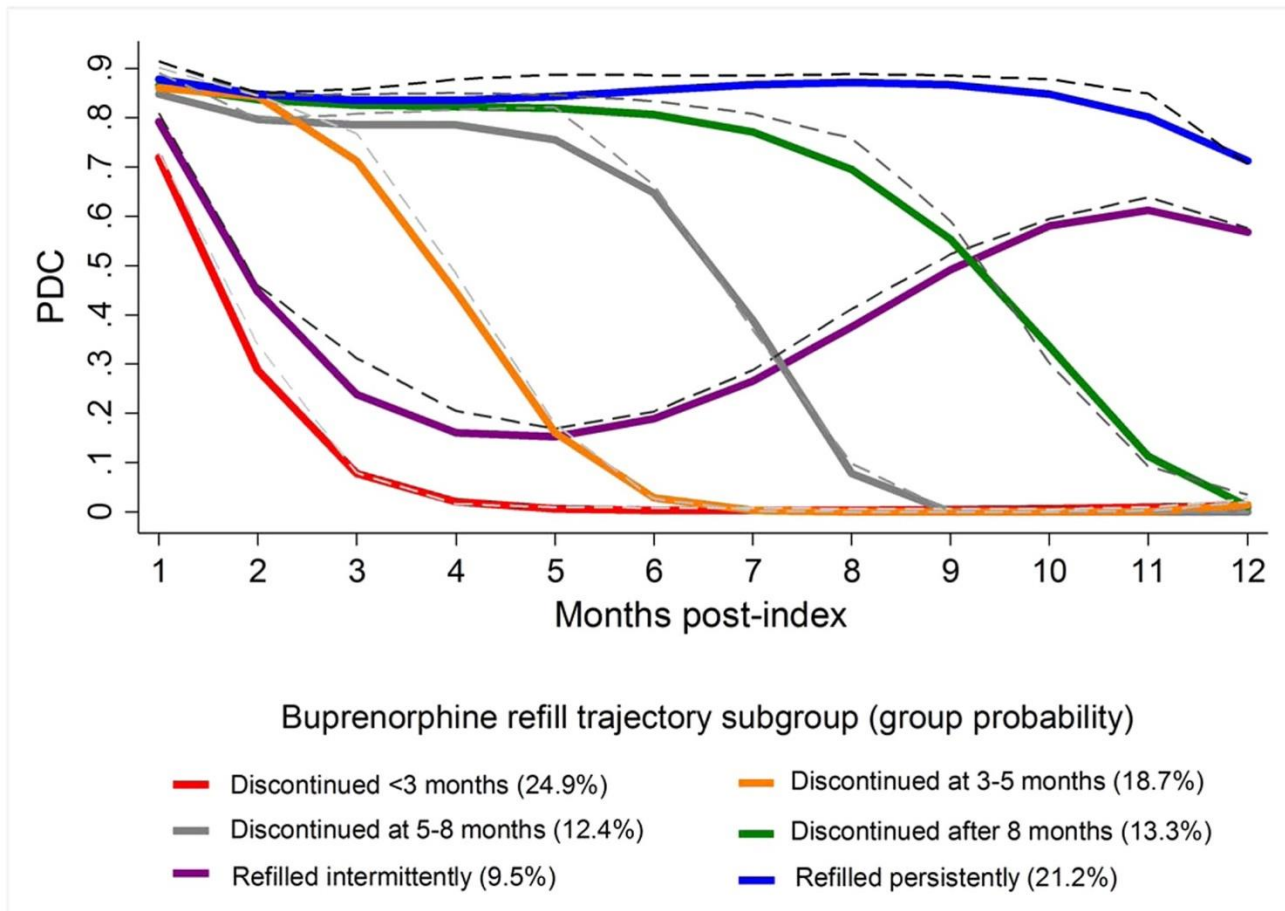
Buprenorphine-Naloxone

- 1) If used correctly, takes care of withdrawal and cravings, but patient does not get high
- 2) Few Drug-Drug interactions
- 3) Hard stop at 24mg/day
- 4) It is safe – if you take too much you do not die
- 5) Combo product has an abuse deterrent
- 6) Some studies show an antidepressant effect
- 7) Patients do not build up a tolerance

Common Concerns Associated with MAT

- *“You are just substituting one addiction for another”*
- *“Addicts are hiding in MAT programs”*
- *“Is my loved one going to be on this medication forever”*
- *“Patients are abusing methadone/suboxone”*

Association between Trajectories of Buprenorphine Treatment and Emergency Department and In-patient Utilization



Community Treatment Settings

- Opioid Treatment Centers (OTPs)
 - Aka “methadone clinics”: only community healthcare source for methadone for opioid use disorder
 - Daily dosing
 - Some can prescribe buprenorphine or naltrexone
 - Federal regulations
 - Usually NO primary care or psychiatry care
 - Waiting lists, transportation issues
 - More structure, more stigma
- Office Based Opioid Treatment (OBOT)
 - Buprenorphine and naltrexone prescriptions in community clinics- no methadone, no daily dosing
 - Colocated medical, psychiatric, HIV/HCV services
 - Less stigma, more geographic access, less structure
 - Often via Community Health Centers (CHCs) for uninsured or Medicaid:
 - Federally Qualified Health Centers (FQHCs)
 - Rural Health Centers (RHCs)
 - Health Departments (HDs)

According to the CDC...

- MAT works best in criminal justice settings if:
 - Continued for those receiving MAT prior to incarceration
 - Can be initiated in jail/prison
 - All three MAT options are available
 - Pre-release planning for warm handoff upon community re-entry

QUESTIONS?



Health Services in Jails: What's Required by Law

Anna Stein

Legal Obligation to Provide Health Services in NC Jails

Federal Law

Courts

- 8th Amendment prohibition against cruel and unusual punishment is violated by “deliberate indifference” to an inmate’s “serious medical needs”
(*Estelle v. Gamble*, US Supreme Court, 1976)

Legal Obligation to Provide Health Services in NC Jails

State law

Courts

- Duty to provide “adequate” medical care to inmates
(*Medley v. NC Dept. of Corrections*, NC Supreme Court, 1992)

Legislation

NCGS §153A-225(a)

- Each governmental unit that operates a jail must develop a plan for providing medical care for inmates
- Medical plan must be approved by local or district health director

DHHS Regulations

NC Jail Health Standards

10A NC Administrative Code 14J .1001

- Jails must develop a written medical plan to include policies and procedures addressing:
 - Health screening of inmates upon admission
 - Handling of routine medical care
 - Handling of inmates with chronic illnesses or known communicable diseases
 - Administration of medications
 - Handling of emergency medical problems

Recent Decisions Requiring MAT to be Provided in Jail

Pesce v. Coppinger, US District Court, Massachusetts, November 26, 2018

Geoffrey Pesce sought a preliminary injunction to force county to allow him access to methadone while in jail

- 32 years old, had been in “active recovery for two years with the help of a methadone treatment program prescribed by his doctor”

Pesce v. Coppinger

Court granted the preliminary injunction based on violation of the Americans with Disabilities Act (ADA) and the 8th Amendment of the US Constitution

- Pesce, who suffers from opioid use disorder, is a “qualified individual with disabilities” under the ADA
- Medical care provided in jail qualifies as a “service” that must be provided indiscriminately under the ADA

Pesce v. Coppinger

“Defendants, in lieu of conducting an individualized assessment of Pesce’s medical needs or his physician’s recommendation, would require Pesce to participate in a treatment program that bares a strong resemblance to the methods that failed Pesce for five years, including detoxification, and administration of Vivitrol. Not only would Defendants’ treatment program contradict Pesce’s physician’s recommendations and place Pesce at a higher risk of relapse upon his release from Middleton, but it would also make him physically ill for several days while he undergoes forced withdrawal.”

Pesce v. Coppinger

“Defendants here have not given any consideration to Pesce’s specific medical needs nor indicated any likelihood to do so when he is incarcerated given their present policy against methadone treatment. Medical decisions that rest on stereotypes about the disabled rather than ‘an individualized inquiry into the patient’s condition’ may be considered discriminatory.”

Recent Decisions Requiring MAT to be Provided in Jail

Smith v. Aroostook County, US District Court, Maine (March 2019); affirmed by the 1st US Circuit Court of Appeals (April 2019)

- Brenda Smith had been taking buprenorphine for the previous five years and sought a preliminary injunction to be able to continue the medication while in jail
- Court held that withholding buprenorphine violated Smith's rights under the ADA
- Judge: "I find that forcing Ms. Smith to withdraw from her buprenorphine would cause her to suffer painful physical consequences and would increase her risk of relapse, overdose, and death."

Recent Decisions Requiring MAT to be Provided in Jail

Kortlever v. Whatcom County, US District Court, Western District of Washington, filed 2018

- Class-action suit; proposed settlement reached in April 2019 to allow use of Subutex, Suboxone and Vivitrol in Whatcom county jail

The ADA and Substance Use Disorders

- To benefit from the ADA, a person must be a “qualified individual with a disability”
- In the context of substance use disorders, this includes:
 - A person who has been successfully rehabilitated and is no longer engaged in the illegal use of drugs;
 - A person who is currently participating in a rehabilitation program and is no longer engaging in the illegal use of drugs
- To be a “qualified individual with a disability,” a person may not currently be engaging in the illegal use of drugs

Addressing the Justice System: Opioid Action Plan Update and Priorities

Elyse Powell



NORTH CAROLINA'S OPIOID ACTION PLAN

Updates and Opportunities

Since the launch of the Plan:



Opioid dispensing has **decreased by 24%**

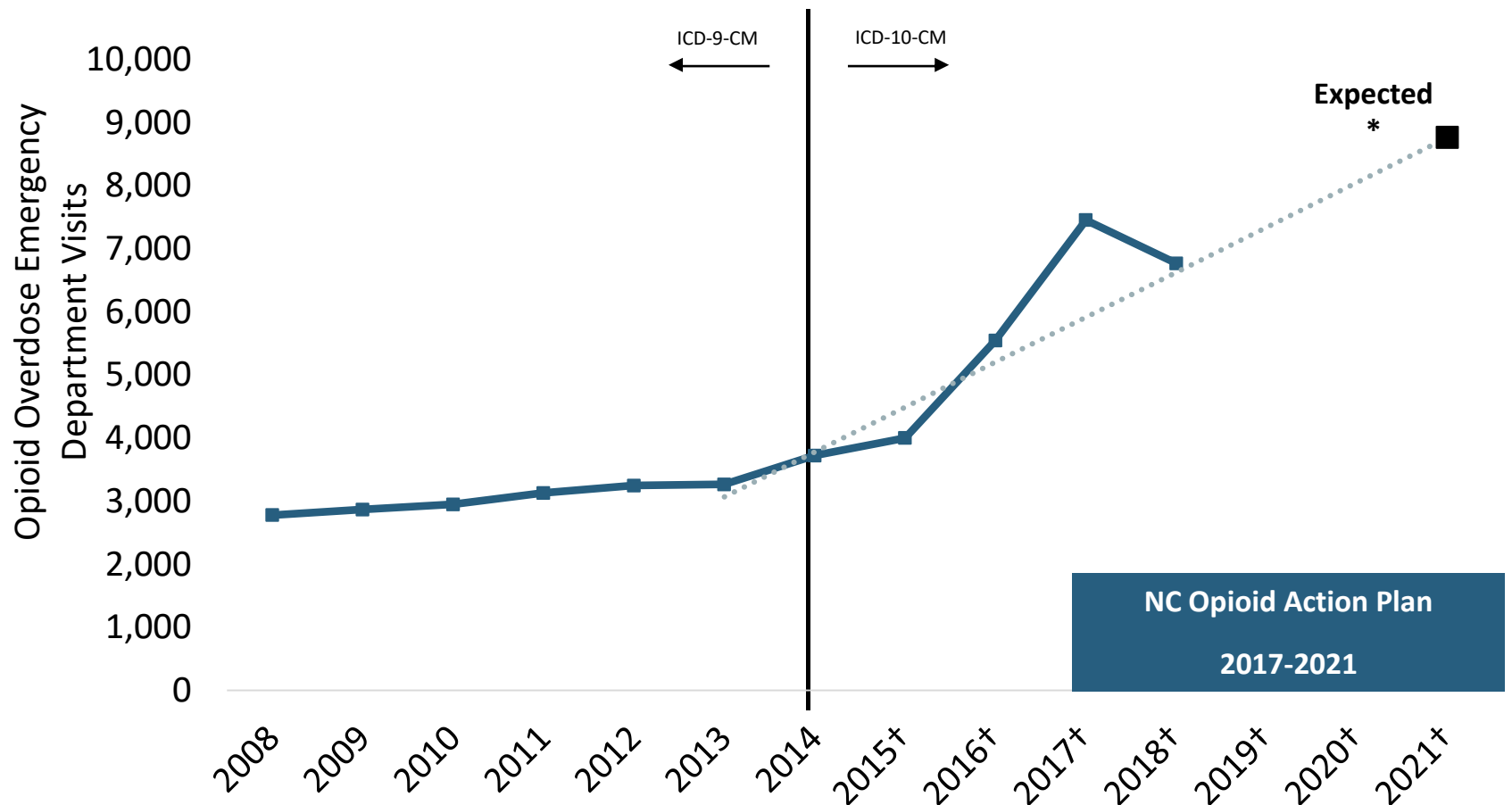


Buprenorphine dispensing has **increased 15%**



Uninsured and Medicaid beneficiaries who have received opioid use disorder treatment has **increased by 20%**

Opioid overdose emergency department visits have declined for the first time in over a decade.



*Data are preliminary and subject to change

Source: NC Division of Public Health, Epidemiology Section, NC DETECT, 2009-2018 Q3

Detailed technical notes on all metrics available from NC DHHS; Updated October 2018

BUT THERE IS STILL
MUCH MORE WORK
TO DO ...



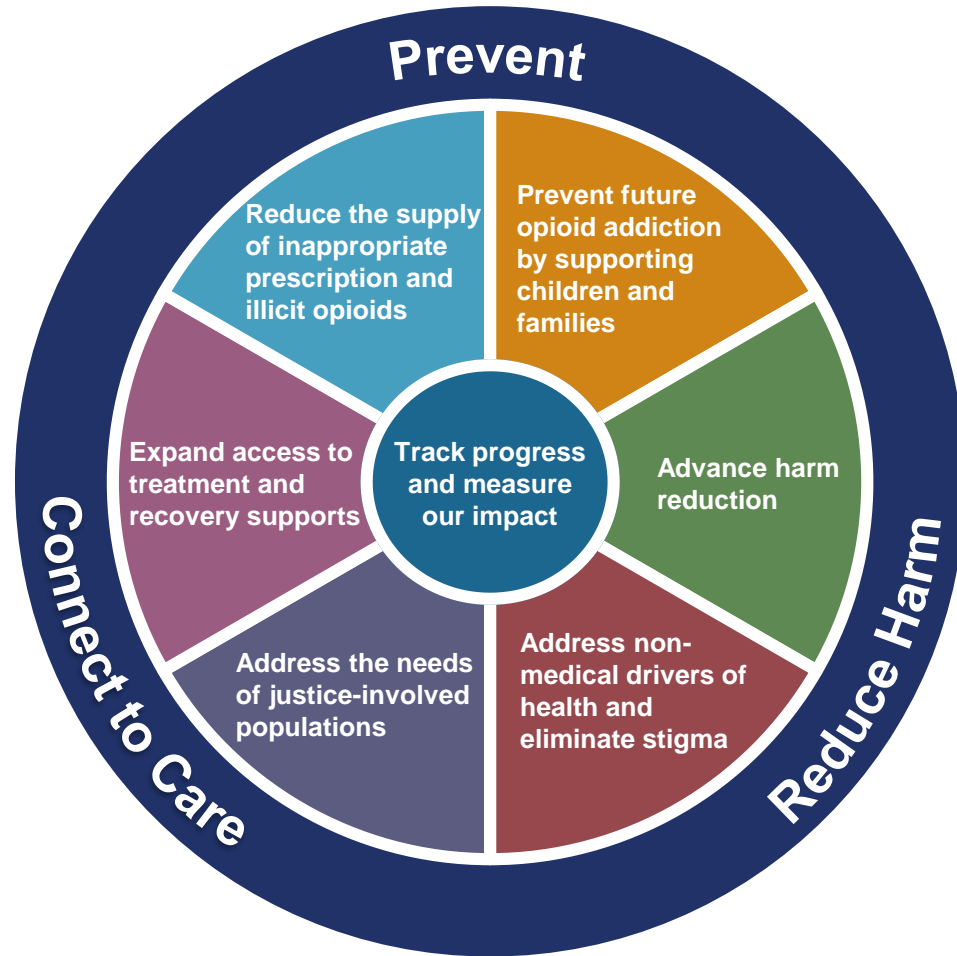
NORTH CAROLINA'S OPIOID ACTION PLAN

Updates and Opportunities
2.0

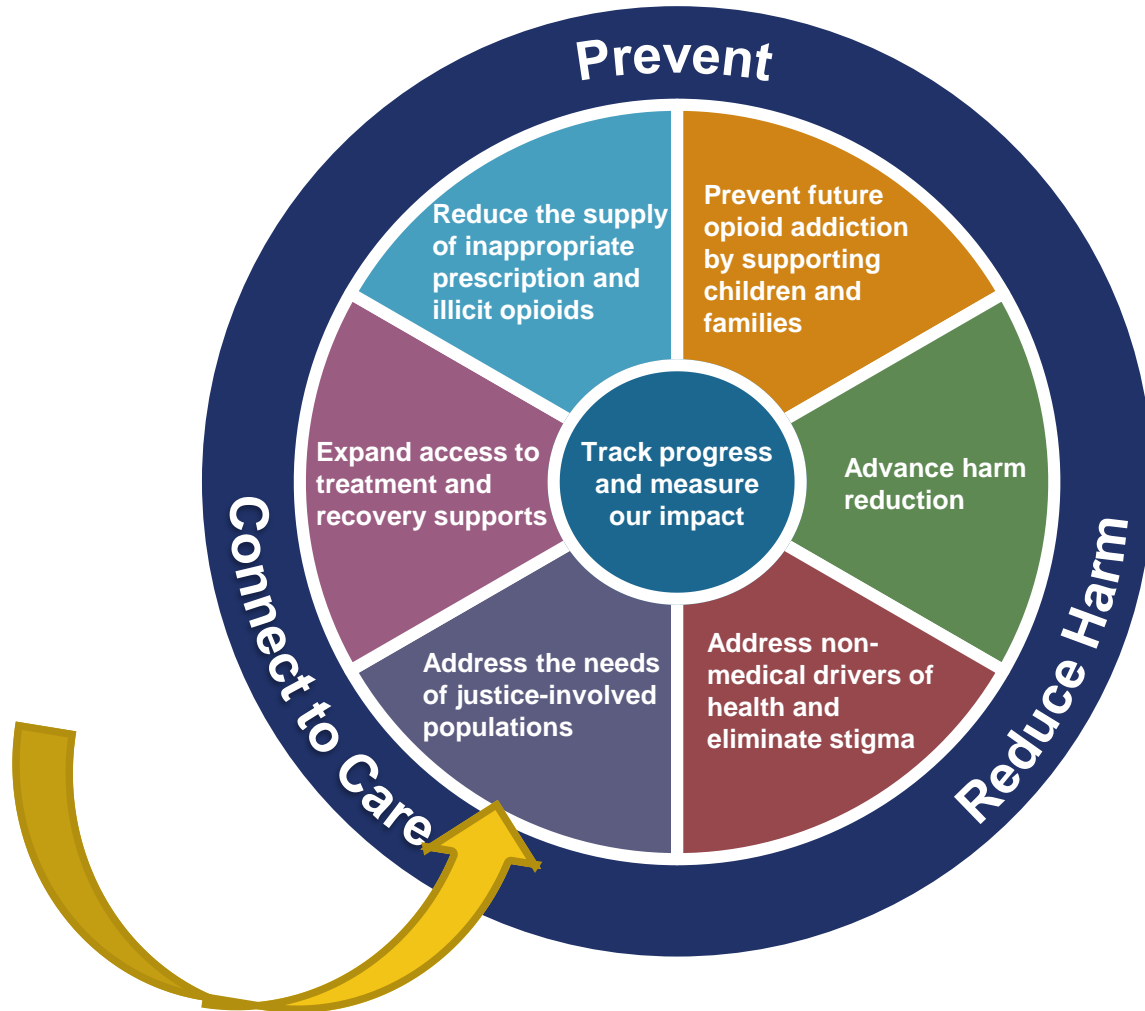
Version

The Opioid Action Plan 2.0 aims to identify impactful, feasible strategies to **reduce opioid overdoses** in North Carolina and **prevent the next wave** of the epidemic.

Opioid Action Plan Version 2.0



Opioid Action Plan Version 2.0



Connect to Care



**AN ESTIMATED 89% OF PEOPLE
DON'T RECEIVE THE SUBSTANCE
USE DISORDER TREATMENT
THEY NEED.**



**PEOPLE ARE 40 TIMES MORE
LIKELY TO DIE OF AN OVERDOSE
IN THE TWO WEEKS POST
INCARCERATION THAN THE
GENERAL POPULATION.**

Connect to Care: Address the needs of justice-involved populations

Increase pre-arrest diversion of low-level offenders

- Support counties in adopting pre-arrest diversion programs to divert low-level offenders to community-based programs and services.
- Maintain and enhance therapeutic (mental health, recovery and veteran) courts.

Provide overdose prevention education and medication-assisted treatment (MAT) during incarceration and upon release.

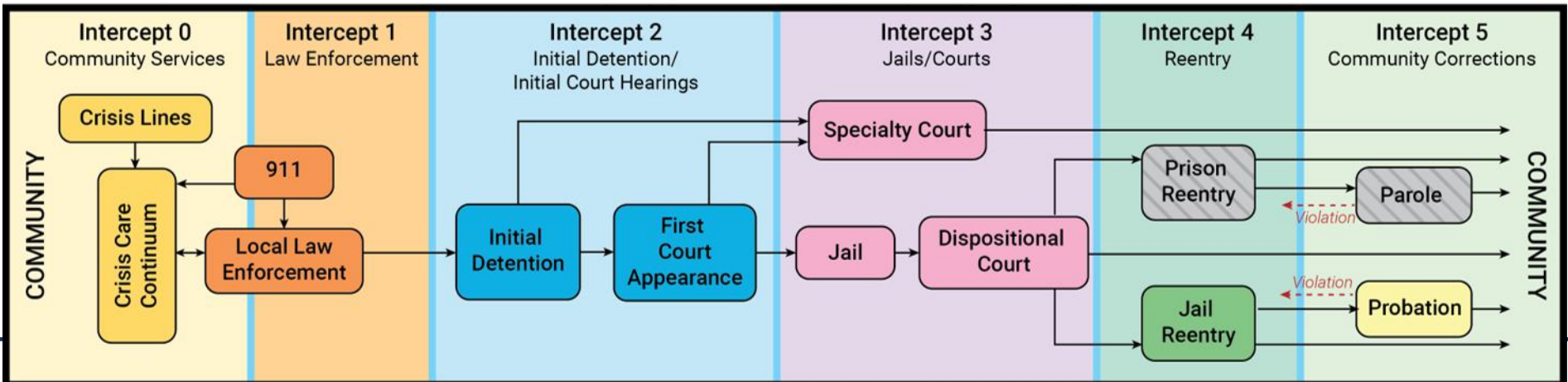
- Identify model policies to screen for substance use disorders and connect to overdose prevention education and treatment during incarceration or upon release
- Work with at least six jails to screen for substance use disorders, use FDA-approved medications for treatment, and provide overdose prevention education and connections to care upon release.

Expand supports for people after release

- Train community corrections and Treatment Accountability for Safer Communities (TASC) offices on substance use disorders and connecting to naloxone, harm reduction resources and treatment.
- Increase education opportunities for those with criminal history by working with institutions of higher education to not screen people out based on criminal records alone.
- Reduce barriers to employment for those with a criminal history, and provide information on education options, career paths and licensures that are available to people with different classes of convictions.

Criminal Justice-Involved Work - Diversion

- **Promoting and providing training for Crisis Intervention Teams (CIT).** CIT aims to train police to intervene effectively to de-escalate people in crisis, and take them to treatment rather than to jail.
- **Working with our jails and courts to establish / promote jail diversion programs.** These programs aim to identify people in jail with mental health needs, and work to divert them to treatment in the community.
 - Includes mental health and drug court programs.
- **Leading the state's Stepping Up Initiative** with the goal of helping counties reduce the numbers of people with behavioral health disorder in jail.
 - They examine each stage of the criminal justice system, as people with MI flow through it. The end result is an actionable plan that is developed locally.



Criminal Justice-Involved Work- Treatment

- **Medication Assisted Treatment Pilots in Jails**

- Funded by the State Opioid Response grant awarded in 2018 to DHHS by the Substance Abuse and Mental Health Services Administration.

- Pilot sites continue or induct individuals, and connect them to care upon release

- National Sheriffs Association: Jail-Based MAT programs can reduce recidivism, connect people to care, and reduce jail system costs.

- **MAT Pilot in Prison Re-entry Facilities**

- DHHS and DPS creating a new medication-assisted treatment (MAT) program to reduce the overdose-related deaths of people with an opioid disorder who are re-entering their communities upon leaving prison

- **Pilot Locations**

- NC Correctional Institution for Women in Raleigh
- Wake Correctional Center in Raleigh
- Orange Correctional Center in Hillsborough.



JAIL-BASED MEDICATION-ASSISTED TREATMENT
PROMISING PRACTICES, GUIDELINES,
AND RESOURCES FOR THE FIELD

Additional Resources

- Year 2 of **funding to Local Health Departments**: Community Linkages to Care for Overdose Prevention and Response (CLC) Request for Applications was recently awarded
 - *Support core strategies from the Menu of Local Options:*
 - Syringe Exchange Programs
 - Justice Involved Persons
 - Post-Overdose Response teams
 - Small amount for innovative pilot projects
 - *Contact beinjuryfreenc@dhhs.nc.gov for additional information*

Bureau of Justice Administration Comprehensive Opioid Abuse Program (BJA COAP) Grant

- DHHS was recently awarded a \$6.5 million, three year federal grant to implement strategies from OAP 2.0 to address the needs of justice involved individuals
- Funds will be **competitively subawarded to a minimum of 9 applicants** to implement one, two or three of the following:
 - *Pre-arrest diversion programs*
 - *Comprehensive Jail-based medication assisted treatment*
 - *Overdose prevention education and naloxone upon release*
- **‘Menu’ approach allows counties and communities flexibility** to apply for the projects that best fit the unique needs and resources in their own county, while ensuring the funding goes to support high-impact initiatives to achieve the best outcomes for North Carolinians.

BJA COAP Grant

- The RFA is still under development and has not yet been released. The RFA will be released **January 2020**, and [posted](#) to the NCDHHS website.
- **The RFA will provide complete details** on application due date, eligibility criteria for applying, allowable use of funds, and length of award.
- **To receive email notifications** about when this and other funding opportunities related to opioid epidemic response are available, please [sign up](#) for the Opioid And Prescription Drug Abuse Advisory Committee email list.
- **For additional questions**, please contact Beth Nelson, Justice System Innovations Section Chief, at elizabeth.nelson@dhhs.nc.gov.

Panel: How to Start a MAT Program in a Jail Setting

Margaret Bordeaux, Moderator

“MAT programs require a multidisciplinary team of staff from inside and outside the jail or prison in order to safely deliver medications and prevent their diversion. While these teams may look different across programs, the relationships fostered through a multidisciplinary approach can create the necessary program environment and trust to reduce mistakes, increase transparency, and minimize the opportunities for medication diversion.”

Source: <https://store.samhsa.gov/product/MAT-Inside-Correctional-Facilities-Addressing-Medication-Diversion-co-branded-with-BJA-since-is-in-their-lane/PEP19-MAT-CORRECTIONS>

Durham County Detention Center

- Carlyle Johnson – *Director of Provider Network Strategic Initiatives, Alliance Health*
- Shonicia Jones – *Health Services Administrator, WellPath*

Rutherford County Detention Center

- Suzanne Mizsur-Porter – *Executive Director*, United Way of Rutherford County

Buncombe County Detention Center

- Sarah Gayton – *Community Integration and MAT Services Director*, Buncombe County Sheriff's Office/Detention Division
- Amy Upham – *Opioid Response Coordinator*, Buncombe County Health and Human Services
- Jasmine Beach-Ferrara – *Commissioner*, District 1, Buncombe County Commission

Orange County Detention Center

- Sheriff Charles Blackwood – *Sheriff of Orange County, NC*
- Alison Zirkel, LCAS, LCSW - *Criminal Case Assessment Specialist, Orange County Criminal Justice Resource Department*

Questions?

Margaret Denise Bordeaux

Justice-Involved Specialist

(Mobile) 910-354-0035

Margaret.Bordeaux@dhhs.nc.gov

Injury and Violence Prevention Branch
North Carolina Division of Public Health

Thank you!

Wrap up and THANK YOU!

Alan Dellapenna, Branch Head, Injury and Violence Prevention Branch, Division of Public Health

Skill Building Breakouts:

Room 8A: Justice-involved Work at the Local Level

Room 8B: Jail-based Education Overview

Room 9: Stepping Up Initiative

THANK YOU!

(Please travel safely!)

Next OPDAAC Meeting: Friday, March 6, 2019

Theme: Medical Prescribing and Chronic Pain