Public Safety Track

Rx and Illicit Drug Summit

Bridging the Gap Between Theory and Practice: Building Support for Medications for Opioid Use Disorder in Jails and Prisons

Regina LaBelle, JD (Moderator)

Director, Addiction and Public Policy Initiative, The O'Neill Institute at Georgetown Law
Director, Professor, MS in Addiction Policy and Practice Program, Georgetown Graduate School of Arts & Sciences

Suzula Bidon, JD, MS

Founder, Bidon Law PLLC
Certified Peer Recovery Specialist
Yoga Alliance Certified Teacher

Peter J. Koutoujian, JD, MPA

Sheriff
Middlesex Sheriff's Office
Middlesex County, Massachusetts

Andrew Kolodny, MD

Medical Director, Opioid Policy Research Collaborative
Schneider Institute for Behavioral Health, Heller School
Brandeis University

Faculty Disclosures

- Regina LaBelle, JD, has no financial relationships to disclose relating to the subject matter of this presentation.
- Suzula Bidon, JD, MS, ADPP, has no financial relationships to disclose relating to the subject matter of this presentation.
- Peter Koutoujian, JD, MPA, has no financial relationships to disclose relating to the subject matter of this presentation.
- Andrew Kolodny, MD, has no financial relationships to disclose relating to the subject matter of this presentation.

Disclosures

- The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational use(s) of drugs, products, and/or devices (any use not approved by the US Food and Drug Administration).
- Applicable CME staff have no relationships to disclose relating to the subject matter of this activity.
- This activity has been independently reviewed for balance.

Learning Objectives

- Analyze critically MOUD programs in a correctional setting and advocate for establishing and/or improving existing programs in their own jurisdictions
- Assess the reasons behind the lack of access to MOUD in criminal justice settings, including the ramifications from both a public health and public safety standpoint.
- Assess the impact of attitudinal forces that strive to prevent MOUD in a correctional setting and how to work through and change those roadblocks.
- Discuss the potential available collaborations between correctional professionals and research institutions in an effort to expand the availability of MOUD in a correctional setting
- Review the policy implications related to the pharmacologic differences of methadone, buprenorphine, and naltrexone

An Overview & Policy Perspective

Regina LaBelle, JD

Director, Addiction and Public Policy Initiative, The O'Neill Institute at Georgetown Law

Director, Professor, MS in Addiction Policy and Practice Program, Georgetown Graduate School of Arts & Sciences

1. The Bureau of Justice Statistics estimates that 63% of people in jail and 58% in prison have a substance use disorder.

2. 40% of deaths in jails occur within the first 7 days of entry.

3. Risk of recidivism is shown to decrease if OUD is treated with buprenorphine while incarcerated.

Bronson J, et al. Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009, Bureau of Justice Statistics (June 2017). https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf. Carson EA. Mortality in local jails, 2000–2019 – statistical tables. U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics. (2021, December). Accessed March 26, 2024. https://bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf. Evans EA, et al. (2022). Recidivism and mortality after in-jail buprenorphine treatment for opioid use disorder. *Drug and Alcohol Dependence*. 2022;231:109254. https://doi.org/10.1016/j.drugalcdep.2021.109254

Dying Inside: Litigation Patterns for Deaths in Jail Custody

Taleed El-Sabawi, JD, PhD,[1,2] Shelly R. Weizman, JD,[1] Somer M. Brown, JD,[1,*] and Regina M. LaBelle, JD[1]

Abstract

Millions of dollars are spent annually in private litigation against jails. This article analyzes a novel dataset developed from dockets and reports of cases filed against jails by the estates of individuals who died in jail custody. The total amount of plaintiffs' awards represented in the sample was over $292,234,224. Cases attributing the cause of death to officer use of force had the highest average award ($2,243,079). Our findings suggest that suicide is still the most common cause of death for people in jail custody. Yet complications from a physical illness were not far behind, and nearly 20% of all cases in the sample were drug or alcohol related. In the first 24 hours of custody, people in jail were most at risk of drug-related deaths and suicide.

El-Sabawi T, et al. Dying Inside: Litigation Patterns for Deaths in Jail Custody. *Journal of Correctional Health Care*. Aug 2023:275-281.http://doi.org/10.1089/jchc.22.04.0026

DYING INSIDE: TO END DEATHS OF DESPAIR, ADDRESS THE CRISIS IN LOCAL JAILS

Shelly Weizman et al., *Dying Inside: To End Deaths of Despair, Address the Crisis in Local Jails*, O'Neill Institute of National and Global Health Law (Dec. 2022), https://oneill.law.georgetown.edu/wp-content/uploads/2022/12/ONL_Big_Ideas_Dying_Inside_P5.pdf.

STATISTICS ON DEATHS IN JAIL CUSTODY

- From 2000 to 2019, at least **20,413 people died while incarcerated** in local jails.
- Deaths in jail custody from all causes have been increasing in recent years.
- **Deaths in jails due to drug or alcohol intoxication increased by almost 19%** from 2017 to 2018 and more than quadrupled between 2000 and 2018.
- **Suicide is the leading cause of death in jails.** The mortality rate from suicide is twice that of individuals in the community.
- About 40% of deaths **occurred within the first 7 days of admission to jail**.
- Almost 77% of persons who died in local jails in 2019 **were not convicted of a crime at the time of their death**.
- 42% of persons held in jail custody pretrial who died between 2000 and 2019 **died of either suicide or drug or alcohol intoxication**.

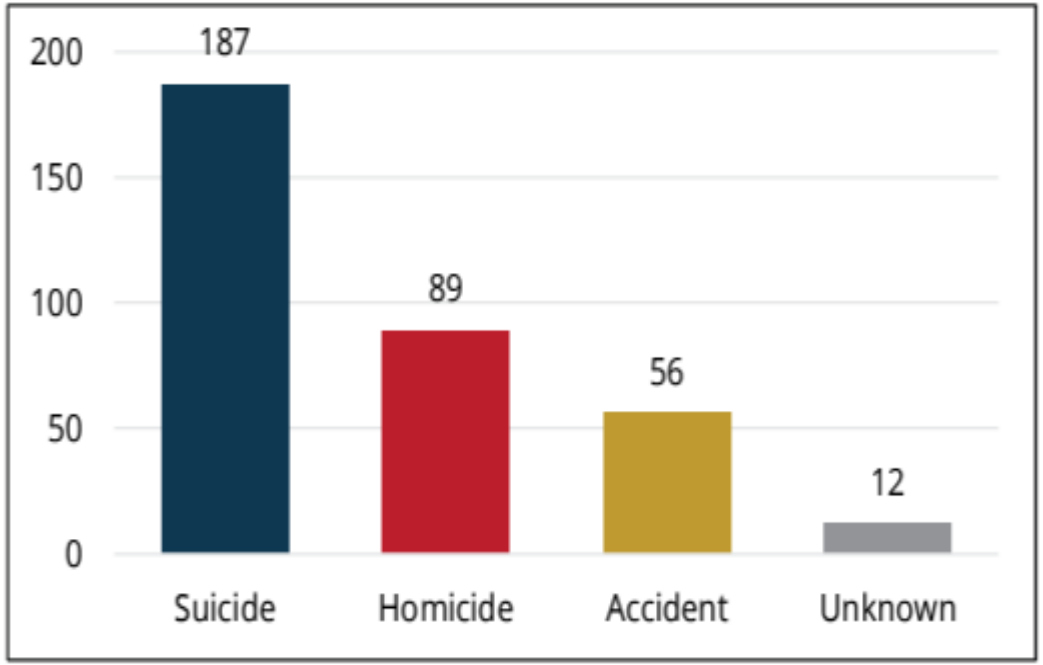
Source: Carson, E. A. Mortality in local jails, 2000–2019 – statistical tables. U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics. (2021, December), from https://bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf[2]

Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions

★ ★ ★

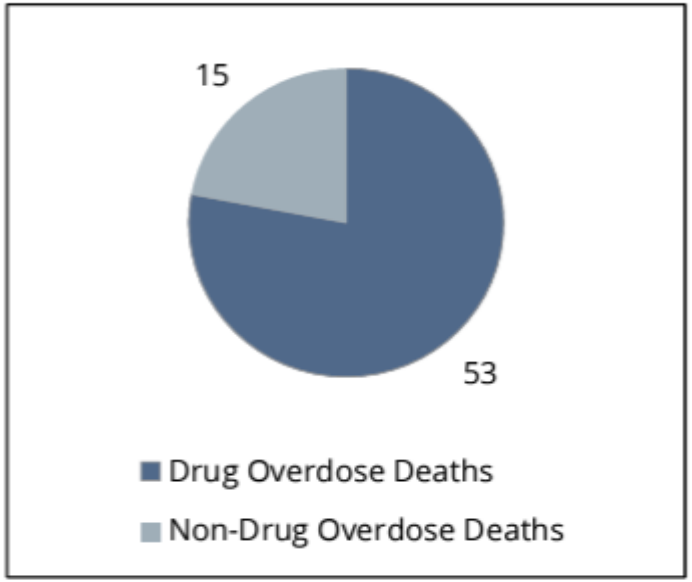
***Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions*, Department of Justice, Evaluation and Inspections Division (Feb. 2024), https://oig.justice.gov/sites/default/files/reports/24-041.pdf.**

Inmate Deaths by Type, FYs 2014–2021



Source: OIG analysis of BOP data

Drug Overdose Deaths Categorized as Accidental and Unknown, FYs 2014–2021



Source: OIG analysis of BOP data

***Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions*, Department of Justice, Evaluation and Inspections Division (Feb. 2024), https://oig.justice.gov/sites/default/files/reports/24-041.pdf.**

April 2023, NCJ 305179

Opioid Use Disorder Screening and Treatment in Local Jails, 2019

Laura M. Maruschak, Todd D. Minton, and Zhen Zeng, PhD, *BJS Statisticians*

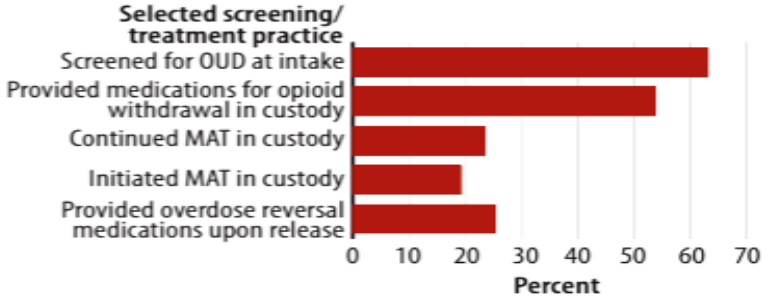
Bulletin

At midyear 2019, fewer than two-thirds (63%) of local jail jurisdictions conducted opioid use disorder (OUD) screenings at intake and more than half (54%) of jail jurisdictions provided inmates medications to treat opioid withdrawal (figure 1). Nearly a quarter (24%) of jail jurisdictions continued medication-assisted treatment (MAT) for OUD for persons admitted with a current prescription or for those who were getting services from a methadone clinic prior to admission. Nearly a fifth (19%) of jail jurisdictions initiated MAT. A quarter (25%) of jail jurisdictions provided overdose reversal medications upon release to persons with OUD.

Findings in this report are based on the 2019 Census of Jails (COJ). The Bureau of Justice Statistics (BJS) periodically conducts the COJ, a complete enumeration of local jail jurisdictions and facilities and of the Federal Bureau of

FIGURE 1

Percent of local jail jurisdictions that screened or treated inmates for opioid use disorder, midyear 2019



Note: OUD denotes opioid use disorder. MAT denotes medication-assisted treatment. See *Terms and definitions* for details on screening and treatment practices. Excludes the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Includes 15 locally operated jails in Alaska. See appendix table 1 for item response rates. See tables 2, 5, and 8 for percentages.

Source: Bureau of Justice Statistics, Census of Jails, 2019.

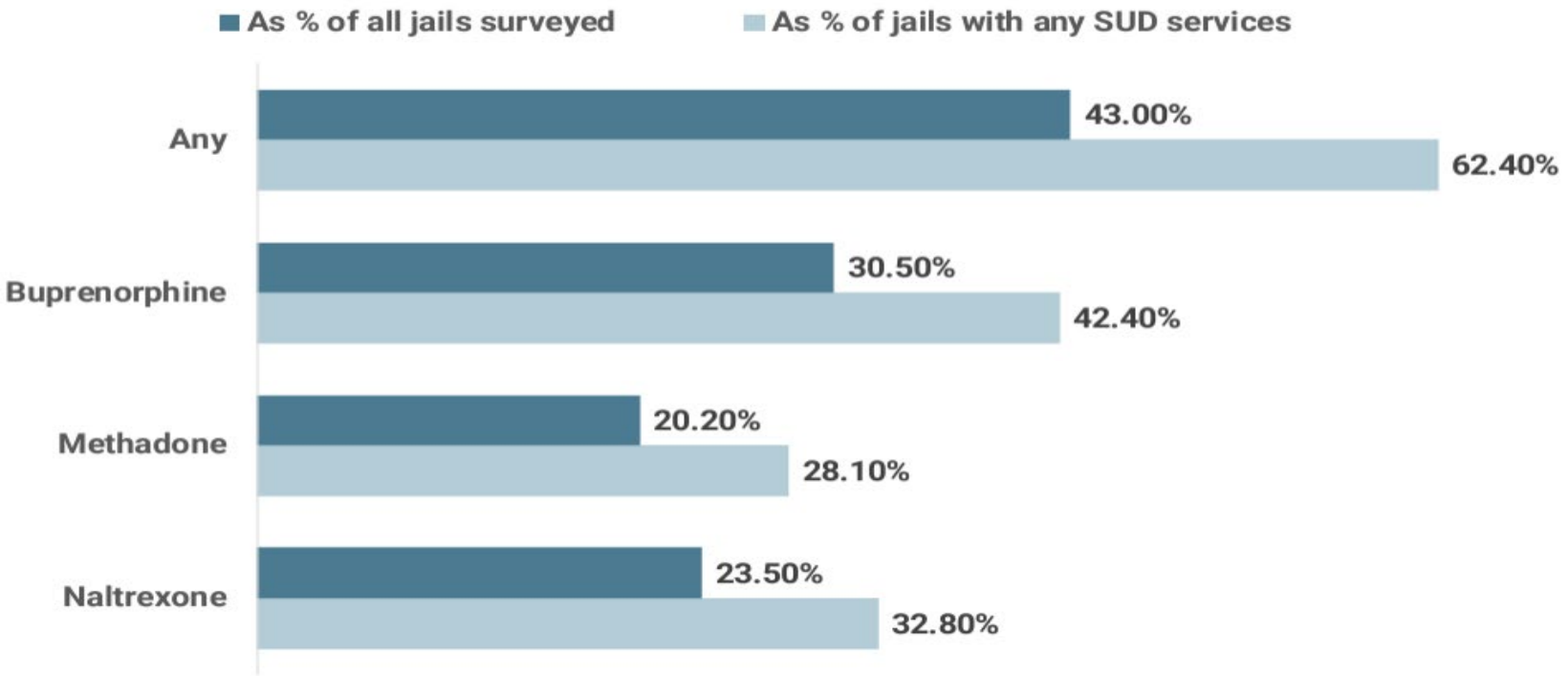
Maruschak LM, et al., *Opioid Use Disorder Screening and Treatment in Local Jails, 2019.* Bureau of Justice Statistics (Apr. 2023). https://bjs.ojp.gov/document/oudstlj19.pdf.

JCOIN's National Survey of Substance Use Services in Jails

Describing U.S. Jails and Their Screening, Treatment, Recovery, and Re-entry Practices

Suggested citation:
NORC at the University of Chicago, 2023. JCOIN's National Survey of Substance Use Services in Jails: Describing U.S. Jails and Their Screening, Treatment, Recovery, and Re-entry Practices.
Accessed at https://jcoinctc.org/MAT-results-from-JCOIN-national-jail-survey/ on [date].

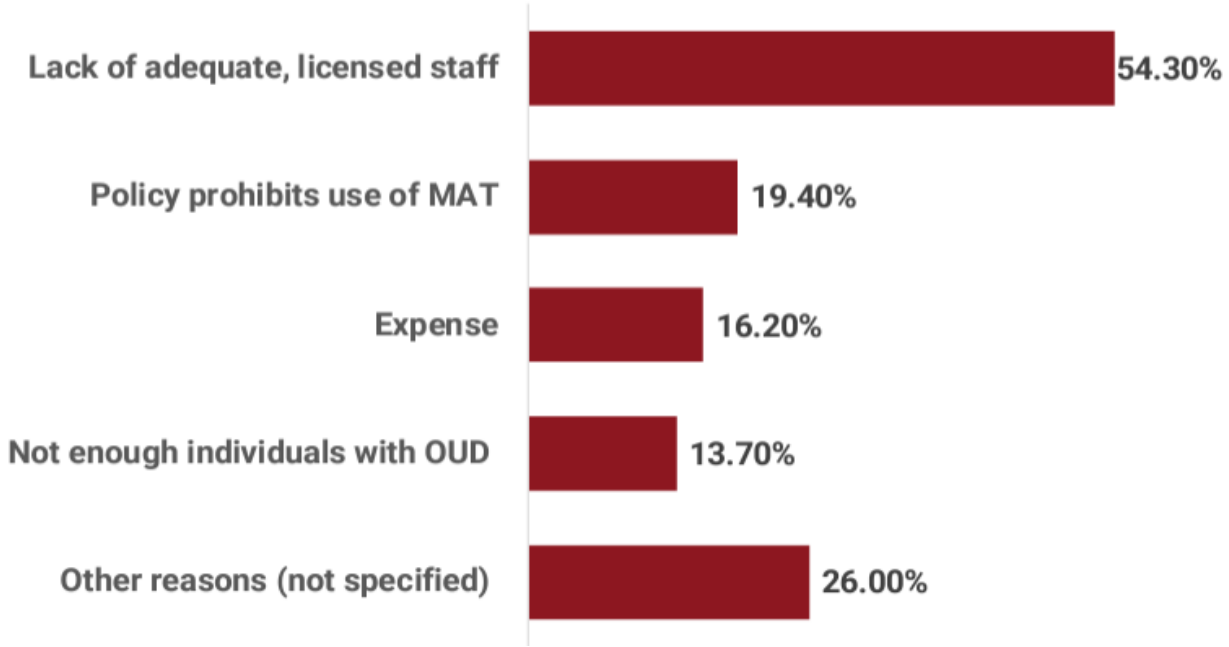
Availability of MAT as Part of SUD Treatment Services*



*** Each Question on MAT was asked separately.**

NORC at the University of Chicago, 2023. *JCOIN's National Survey of Substance Use Services in Jails: Describing U.S. Jails and Their Screening, Treatment, Recovery, and Re-entry Practices*. Accessed at https://jcoinctc.org/MAT-results-from-JCOIN-national-jail-survey/ on February 25, 2024.

Among Jails that Offer SUD Services, but Do Not Offer MAT, Reasons Included:



NORC at the University of Chicago, 2023. *JCOIN's National Survey of Substance Use Services in Jails: Describing U.S. Jails and Their Screening, Treatment, Recovery, and Re-entry Practices*. Accessed February 25, 2024. https://jcoinctc.org/MAT-results-from-JCOIN-national-jail-survey/ .

A Legal and Personal Perspective

Suzula Bidon, JD, MS

Founder, Bidon Law PLLC
Certified Peer Recovery Specialist
Yoga Alliance Certified Teacher

An Operational Perspective

Peter J. Koutoujian, JD, MPA
Sheriff
Middlesex Sheriff's Office
Middlesex County, Massachusetts

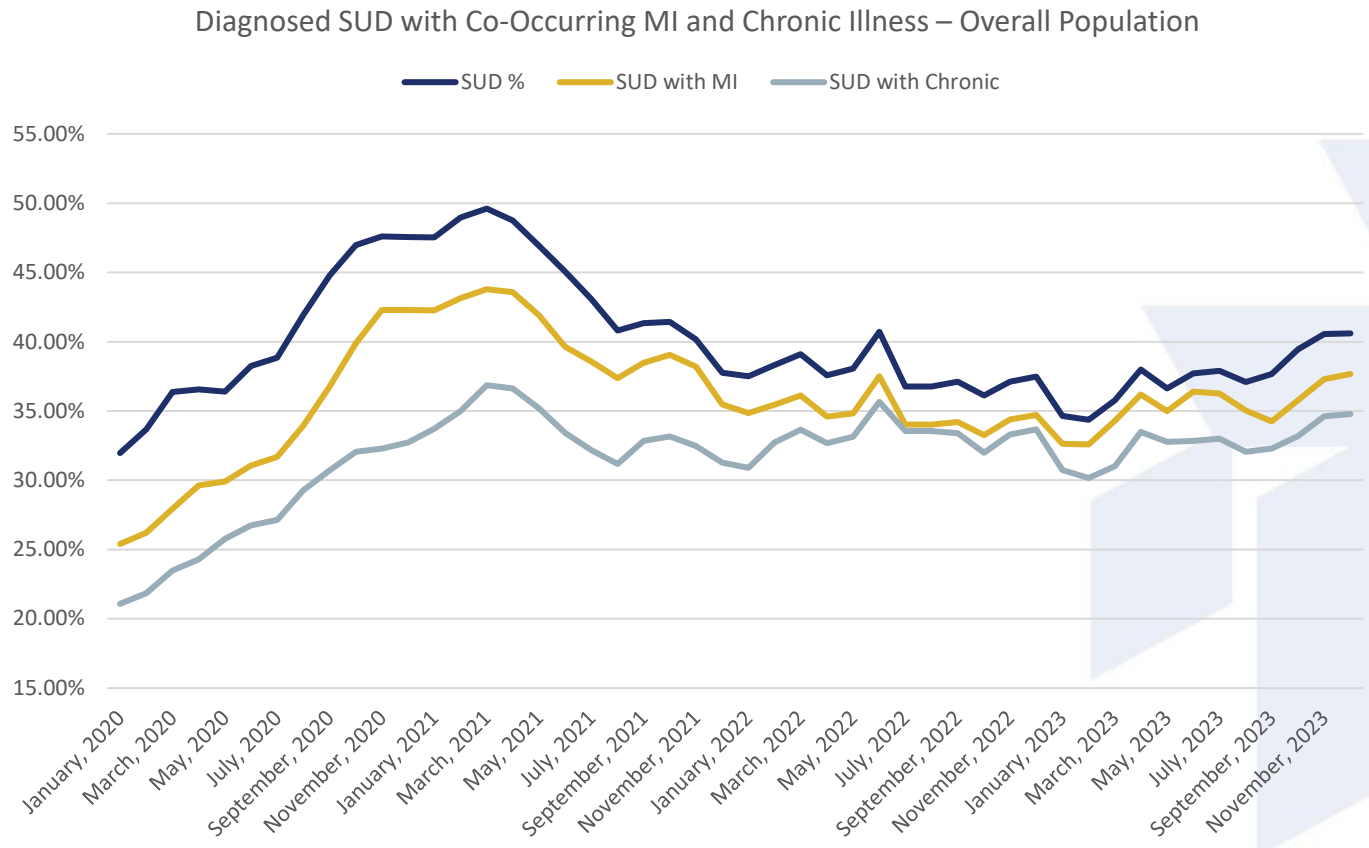
About the MSO

- ★ Founded in 1692
- ★ Serve 1.8 million residents
- ★ Operate Middlesex Jail & House of Correction
- ★ Epicenter of opioid epidemic
- ★ Mix of urban, suburban, rural communities

About the Sheriff

- ★ Prosecutor & defense attorney
- ★ Legislator, Chair of Joint Committee on Public Health
- ★ Professor of criminal justice
- ★ Past President, MSA & MCSA
- ★ VP, CSG Justice Center

The Growing Need for MOUD in Jails & Prisons



- **Since 2020, 40%** of our average daily population had a **diagnosed SUD**
- On average, **90%** of those with an SUD have a **Co-occurring MI**
- On average, **80%** of those with an SUD have a **Co-occurring Chronic Illness**

History of MSO MOUD

MATADOR 1.0
2013 - 2014

- First Attempt: Failure to launch
- Offered 1 form of MOUD (XR-NTX)
- No community linkage or post-release navigation
- Limited staff buy-in and resources

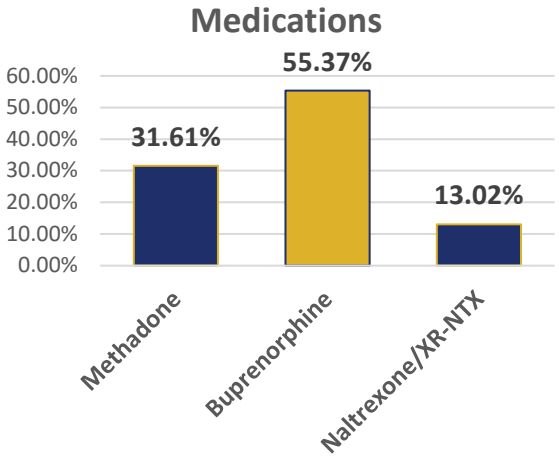
MATADOR 2.0
2015 - 2019

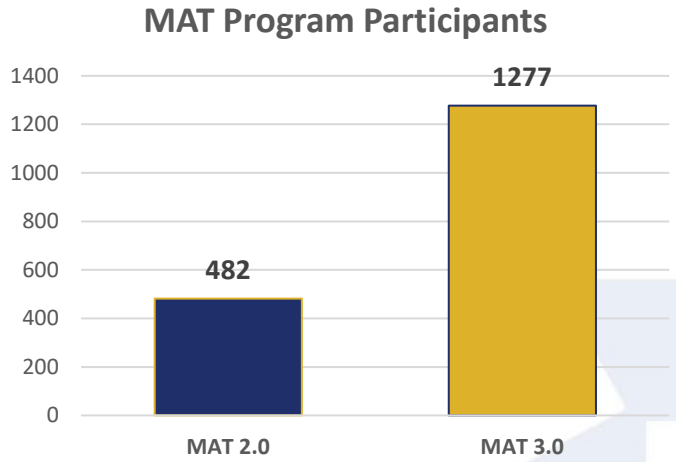
- Vivitrol prior to release
- Dedicated Recovery Navigator & rapport building pre-release
- Data-driven process (outcome measures and analytics)
- Significant investment in the right staff
- Active advocacy for expanded community care
- Recognized as evidence-based best practice by ONDCP, SAMHSA, NCCHC, and NGA

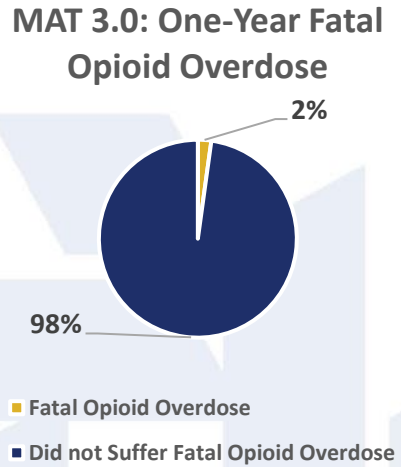
MATADOR 3.0
2019 - present

- This pilot builds on the successes of 2.0
- All 3 forms of FDA approved MOUD available to incarcerated persons
- Includes robust data collection for policy analysis and planning
- External evaluation with NIDA funded state-wide grant

MAT 3.0: Overview





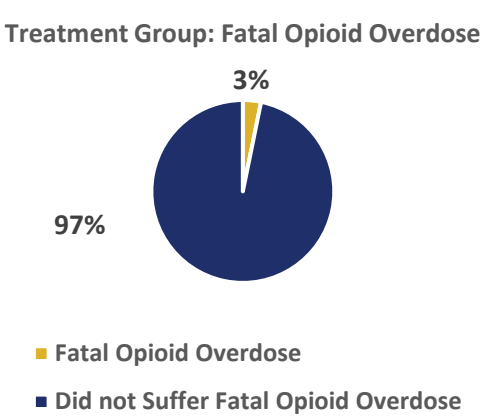


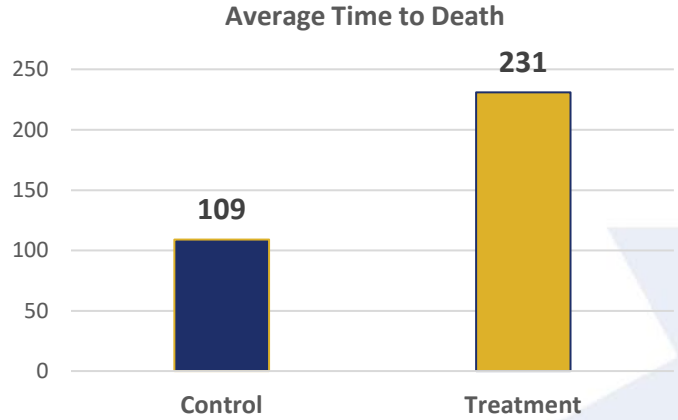
- MAT 3.0 now includes all 3 forms of MOUD
- The most popular form is Buprenorphine, with over half of patients receiving this treatment modality

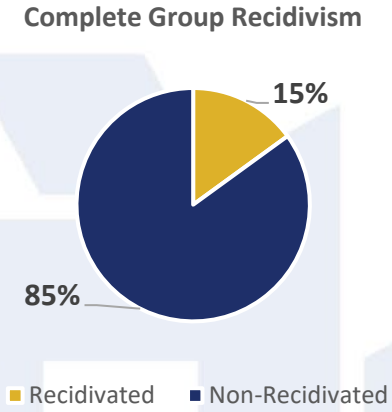
- MAT 3.0 has nearly triple the number of patients as MAT 2.0
- A 164.94% increase from MAT 2.0 to MAT 3.0 patients

- 98% of MAT 3.0 participants **have not** suffered a fatal opioid overdose within 1-year post-release
- We are working on a separate MAT 3.0 survival analysis

MAT 2.0 Results: Mortality and Recidivism







- 97% of MAT program participants **did not** suffer a fatal opioid overdose within 1-year post-release

- Of those who **did suffer** a fatal overdose, those who completed MAT 2.0 survived on average for 122 more days than those who did not participate
- Enhanced window of opportunity for intervention

- Of **all sentenced** individuals who completed the MAT 2.0 program, only 15% recidivated within one year of release
- Compared to a propensity matched control group with a 23% recidivism rate

MAT 2.0 Survival Analysis

- Unable to complete an RCT
- Created propensity matched control groups which had the following characteristics:
  - ❖ Served time in the MJHOC between January 2015 and September 2019
  - ❖ Received a medical detox for narcotics or polysubstance on intake
  - ❖ Excluded individuals who suffered a fatality unrelated to overdose
  - ❖ Excluded individuals with no MA residency
  - ❖ Excluded individuals who served less than 30 days at MJHOC
- Measured mortality in two separate propensity matched groups
  - ❖ Intention to treat (n=374)
  - ❖ Treatment completers (n=191)

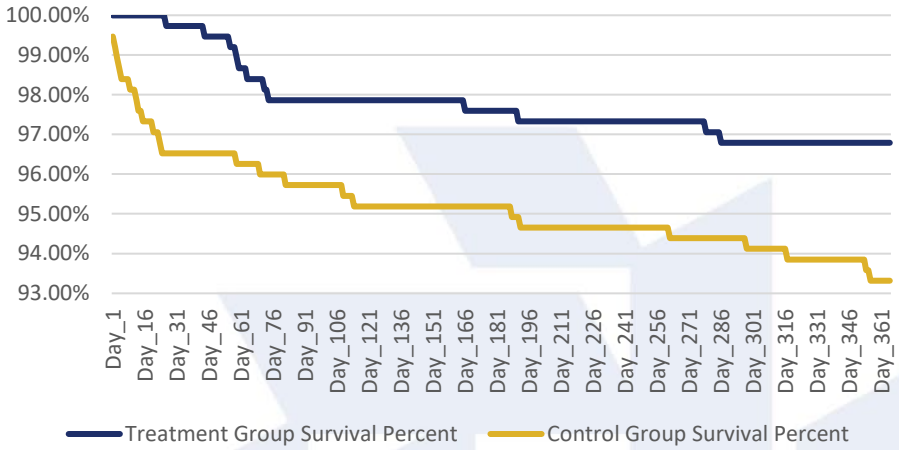
Propensity-Score Matched Intention-to-Treat & Treatment Completers

Covariates	Control Group (n=570)	Intention to Treat (n=374)	ITG Matched Control (n=374)	Completed Group (n=191)	Completed Group Matched Control (n=191)
BIPOC	30.35%	22.19%	22.73%	25.13%	26.70%
Overdose History	20.35%	5.08%	6.42%	3.66%	1.57%
Q5 Status	33.68%	29.68%	30.21%	28.80%	24.08%
Average Age at Release	37.80	36.40	35.84	37.15	37.03
Time Served	113.14	167.84	126.83	186.19	159.30
Sentenced	34.21%	76.74%	52.14%	74.35%	71.20%
Average Number of Prior Convictions	12.19	20.10	16.14	20.37	18.52

MAT 2.0 Survival Analysis

Covariates	Intention to Treat HR (95% CI)	Treatment Completers HR (95% CI)	One Shot Only HR (95% CI)	History of OD HR (95% CI)
Treatment	0.38** (0.18 - 0.79)	0.10** (0.02 - 0.51)	1.10 (0.19 - 6.39)	0.21 (0.02 - 2.30)
BIPOC	1.75 (0.81 - 3.79)	2.15 (0.61 - 7.59)	4.03 (0.39 - 41.60)	6.83* (1.03 - 45.19)
Overdose History	0.95 (0.19 - 4.82)	NA	0.27 (0.02 - 3.50)	0.56 (0.05 - 6.44)
Q5 Status	0.78 (0.8 - 1.61)	0.24* (0.06 - 0.90)	1.36 (0.18 - 10.37)	2.50 (0.70 - 8.95)
Age at Release	1.04* (1.00 - 1.08)	1.11** (1.03 - 1.19)	1.15** (1.04 - 1.26)	0.99 (0.93 - 1.04)
Time Served	0.99* (0.99 - 1.00)	0.99 (0.99 - 1.00)	0.98** (0.97 - 0.99)	0.99 (0.99 - 1.00)
Sentenced	1.45 (0.65 - 3.22)	0.25 (0.05 - 1.22)	0.18 (0.24 - 1.31)	1.99 (0.45 - 8.64)
Number of Prior Convictions	0.99 (0.96 - 1.01)	0.99 (0.96 - 1.03)	1.03 (0.93 - 1.10)	0.97 (0.92 - 1.02)

	Intention to Treat	Intention to Treat Control	Treatment Completers	Treatment Completers Control
Fatal OD Within One Year	12 (3.31%)	26 (6.95%)	4 (2.09%)	16 (8.38%)
Survived One Year	362 (96.69%)	348 (93.05%)	187 (97.91%)	175 (91.62%)
Total	374	374	191	191



- **The above table reflects the results of a Cox Regression of the propensity matched groups**
- **The Intention to Treat group was 62% less likely to suffer a fatal opioid OD**
- **The Treatment Completers group was 90% less likely to suffer a fatal opioid OD**
- **No iatrogenic effect among individuals who received only one injection**
- **Still conducting analysis on competing risk factors against these outcomes**

Collaborating with Local, State, and Federal Partners

- Office of National Drug Control Policy
- National Institute on Drug Abuse - JCOIN
- National Institute of Corrections
- Bureau of Justice Assistance (DOJ)
  - COSSAP Grant
- BioBot Analytics, Inc.
- Massachusetts Legislature
  - MOUD Funding
  - Suspension vs. Termination
- Legislative Analysis and Public Policy Association
- Drug Enforcement Administration
- Brandeis University

A Clinical Scientist's Perspective

Dr. Andrew Kolodny

Medical Director, Opioid Policy Research Collaborative
Schneider Institute for Behavioral Health, Heller School
Brandeis University

Positioning Treatment

How to Select the Right Medication for the Right Patient?

- Methadone- oral only, mainly administered from OTPs; Diverted methadone is very dangerous.
- Buprenorphine- sublingual & long-acting injection; Diverted buprenorphine is less dangerous.
- Naltrexone- oral & long-acting injection; Exposure can increase risk of overdose.

Naltrexone Use Increases Morphine Sensitivity

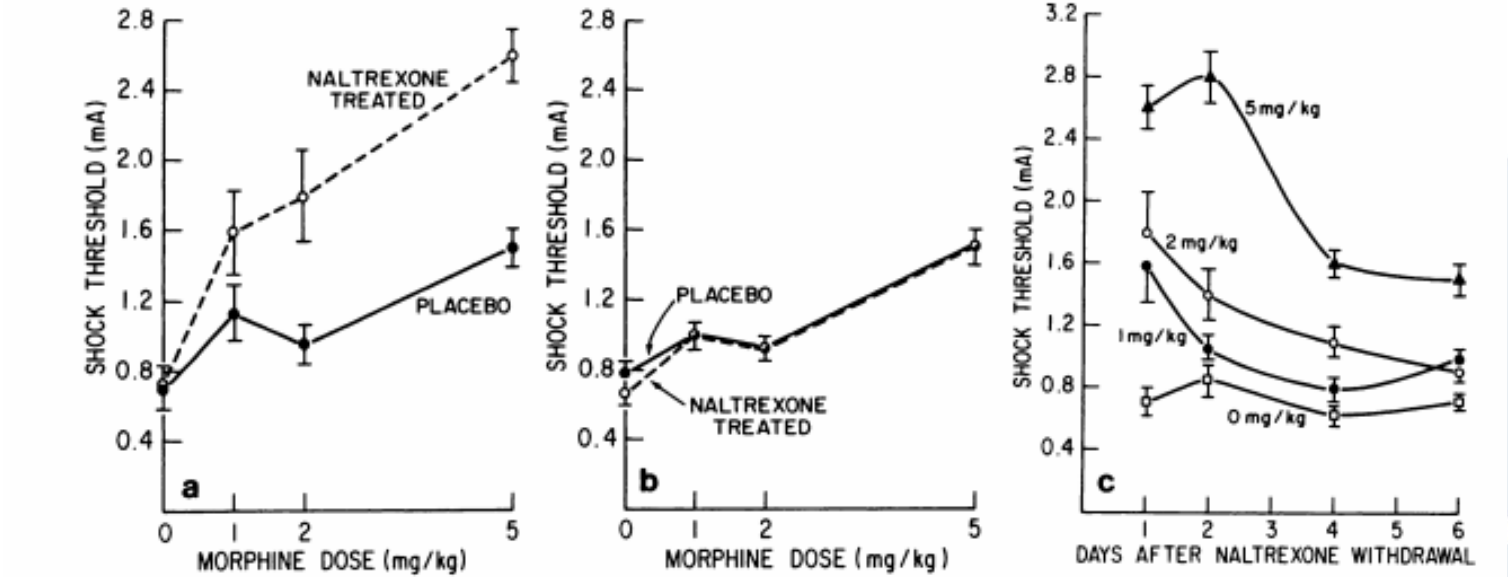


Fig. 4. Morphine-induced analgesia in animals treated chronically with naltrexone or saline (8 days) as a function of morphine dose. Thresholds were determined (a) 24 hr or (b) 6 days after removal of the naltrexone. c, time course of the dose-dependent decrease in morphine supersensitivity on various days after withdrawal from chronic naltrexone treatment. Animals were tested for pain thresholds after injections of either 1) 0 mg/kg, 2) 1 mg/kg, 3) 2 mg/kg or 4) 5 mg/kg of morphine sulfate. A separate group of animals was used for each dose of morphine (N = 10 rats per group). Data were analyzed by analysis of variance for repeated measures and posthoc Scheffé tests of interactions (Kirk, 1968).

Tempel A, et al. Neurochemical and functional correlates of naltrexone-induced opiate receptor up-regulation. *J Pharmacol Exp Ther.* 1985 Feb;232(2):439-44.

High Drop-out Rate in Vivitrol® (naltrexone extended-release injectable) Registry Trial

	n (%)
Enrolled	403
Provided ≥ 1 post-baseline assessment	288 (71.5)
Discontinued after 3 months	134 (33.3)
Discontinued after 6 months	97 (24.2)
Discontinued after 12 months	70 (17.4)

Alkermes. Presented at American Society of Addiction Medicine (ASAM) Scientific Meeting; April 10-13, 2014; Orlando, FL.

More than 90% of Naltrexone Extended-Release Injectable Registry Patients Failed Treatment

Reasons for Discontinuation	n (%)
Lost to follow up	199 (49.4)
Withdrawal by Patient	60 (14.9)
Study Terminated by Sponsor	30 (7.4)
Patient feels treatment goal met	**22 (5.5)**
Other	21 (5.2)
Physician intended planned course of treatment met	**12 (3)**
Insurance loss or loss of coverage for Vivitrol	11 (2.7)
Lack of efficacy by Patient	10 (2.5)
Noncompliance	10 (2.5)
Incarcerated	9 (2.2)
Relocated	9 (2.2)
Death	**5 (1.2)***
Time constraints	3 (0.7)
Withdrawal symptoms or re-entered detox	2 (0.5)

Alkermes. Presented at American Society of Addiction Medicine (ASAM) Scientific Meeting; April 10-13, 2014; Orlando, FL.

Extended-release naltrexone for opioid use disorder started during or following incarceration

Thomas Lincoln [a,b,*], Benjamin D. Johnson [a], Patrick McCarthy [b], Ellen Alexander [c]

[a] Baystate Medical Center, Baystate Brightwood Health Center, 380 Plainfield St., Springfield, MA 01107, United States
[b] Hampden County Sheriff's Department, 627 Randall Rd., Ludlow, MA 01056-1079, United States
[c] Clean Slate Addiction Treatment Centers, Administrative Office, P.O. Box 32, Northampton, MA 01061, United States

Table 2
Treatment participation.

	XR-NTX begun prior to release $n = 47$			XR-NTX planned after release $n = 20$		
	Yes	No/Unknown	BUP/MTHDN	Yes	No/Unknown	BUP/MTHDN
Received 1st XR-NTX	47 (100%)	0	0	7 (35%)	12 (60%)	1 (5%)
Received 2nd XR-NTX	24 (51%)	21 (45%)	2 (4%)	4 (20%)	15 (75%)	1 (5%)
Received 3rd XR-NTX	13 (28%)	30 (64%)	4 (9%)	3 (15%)	15 (75%)	2 (10%)
Received 6th XR-NTX	6 (13%)	37 (79%)	4 (9%)	1 (5%)	17 (85%)	2 (10%)
Switched to BUP	8 (17%)			3 (15%)		

XR-NTX = extended release naltrexone, BUP = buprenorphine, MTHDN = methadone.

Table 3
Comparing XR-NTX started in jail versus the community.

	NTX begun prior to release $n = 47$	NTX planned after release $n = 20$	Fisher's p value
Received 1st XR-NTX or BUP	47 (100%)	8 (40%)	
Received 2nd XR-NTX or BUP or MTHDN	26 (55%)	5 (25%)	0.032
Received 3rd XR-NTX or BUP or MTHDN	17 (36%)	5 (25%)	0.41
Received 6th XR-NTX or BUP or MTHDN	10 (21%)	3 (15%)	0.74
Kept 1st Community MAT Appointment	41 (87%)	11 (55%)	<0.01
Recidivism: new arraignment <6 months	12 (26%)	7 (35%)	0.55
Overdose death <1 year post release	3 (6%)	0	0.55

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders

Table 2. Opioid Relapse and Related Outcomes during the 24-Week Treatment Phase.*

Outcome	Extended-Release Naltrexone (N=153)	Usual Treatment (N=155)	P Value	Hazard Ratio, Odds Ratio, or Incidence-Density Ratio (95% CI)
Primary outcome: median time to relapse — wk†	10.5	5.0	<0.001	0.49 (0.36–0.68)‡
Opioid-relapse event — no. (%)	66 (43.1)	99 (63.9)	<0.001	0.43 (0.28–0.65)§
Percentage of 2-wk intervals with confirmed abstinence	71.1	49.5	<0.001	2.50 (1.66–3.76)¶
Percentage of opioid-negative urine samples	74.1	55.7	<0.001	2.30 (1.48–3.54)¶
Percentage of days with self-reported opioid use	4.6	12.7	0.02	0.35 (0.21–0.59)‖

Lee JD, et al. *N Engl J Med*. 2016;374(13):1232-42. DOI: 10.1056/NEJMoa1505409

Fatal ODs in MATADOR 2.0 vs Controls

	Intention to Treat	Intention to Treat Control	Treatment Completers	Treatment Completers Control
Fatal OD Within One Year	12 (3.31%)	26 (6.95%)	4 (2.09%)	16 (8.38%)
Survived One Year	362 (96.69%)	348 (93.05%)	187 (97.91%)	175 (91.62%)
Total	374	374	191	191

Rx and Illicit Drug Summit

Q&A