Alcoholism & Drug Abuse WEEKLY

News for policy and program decision-makers

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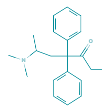

OPIOID TREATMENT PROGRAMS

Going from theory to practice: Succeeding with OTPs in corrections

With her compassion and knowledge, Linda Hurley, CEO of CODAC Behavioral Healthcare in Rhode Island, is able to convince corrections staff of the benefits of methadone and buprenorphine. But it isn't easy.

Bottom Line...

Methadone for jail and prison inmates is a must for those who need it — this has been accepted for some time — but implementing it is difficult. A treatment official who has done it successfully explains how she did it in an AATOD-sponsored webinar.

In a webinar on using medications to treat opioid use disorder (OUD) in correctional settings this month, Hurley provided clear advice with examples from real programs, including her own. Hosted by the American Association for the Treatment of Opioid Dependence (AATOD), the webinar focused on the importance of providing treatment in justice settings. As AATOD CEO Mark Parrino said in introducing her, there is now a great need for compassionate care, adding that this is also the time "to go from theory to practice."

Getting rid of stigma

While stigma is a problem for opioid treatment programs (OITPs)

See Corrections page 2

Kentucky treatment backers mobilize to oppose access-limiting proposals

By many measures, policy leaders in Kentucky have taken important steps to combat opioid overdose deaths and related challenges. State leaders embraced Medicaid expansion, in a region of the country where several holdout states remain. Regulations that would have severely limited access to care during the COVID-19 pandemic were lifted. A record number of syringe services programs statewide have made a difference in curbing infectious disease transmission.

Bottom Line...

Some recent policy proposals in Kentucky, especially suggested revisions to buprenorphine prescribing regulations, appear to be in conflict with progress that has been made in combating opioid overdoses in the state.

These successes have made it all the more difficult for treatment advocates to accept some recent policy proposals in the state, including proposed changes to buprenorphine prescribing regulations that they have said contradict the national move to expand access to medication treatment for opioid use disorder (OUD); (see "Kentucky physicians call rewrite of buprenorphine rules onerous," *ADAW*, Aug. 26, 2024; https://doi.org/10.1002/adaw.34228).

Groups that include the Kentucky Society of Addiction Medicine

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in the community, it's a particular problem in correctional settings, where staff is often one of the holdout groups in viewing methadone, and even buprenorphine, as "substitute" addictions. "I've been at this for 37 years, and there have been heartening changes," Hurley said. But more work needs to be done. The key is focusing on the best ways to implement medication-assisted treatment (MAT) in justice settings, as medical settings already know the science.

It is certainly not necessary to go to prison or jail in order to receive treatment for OUD, and in many cases, those people belong in treatment, not in carceral settings, which are costly and not helpful. But if they are incarcerated and have OUD, there are four basic models to get this care to them, Hurley explained.

Model #1: Mobile Medication Unit

Benefits

- Low threshold access
- Reduces logistical barriers for partnered community-based OTP and the facility

Challenges

- Determine appropriate physical model of the unit
- Funding for unit and services

Outcomes

- 1613 total served
- 1419 released from jail on medication

- Potential decreased in recidivism

Source: CODAC

Four models

- A mobile medication unit, which goes to jails to deliver medication. This model uses a van that has been modified to deliver methadone and buprenorphine to individuals who are in prison or jail. There is much interest in this model, but only limited data. The program is staffed by a doctor and nurse, in the example given by Hurley: Project Kick Start in the Atlantic County Justice Facility in New Jersey, which partners with the John Brooks Recovery Center. This program serves 450 patients a year.
- The external vendor model, which involves the transportation of methadone and buprenorphine from a community OTP to the respective Department of Corrections for daily administration. This would be "couriered" medication. In Vermont, under its "hub and spoke" system, this was implemented in 2018. The facility administers buprenorphine and naltrexone to "spoke" patients, while community-based OTPs provide methadone to "hub" patients. The Vermont Department of Corrections model services 650 patients a day. After Vermont's implementation of the program in 2018, MAT during incarceration increased by 0.8% to 33.9%, MAT post-release increased, and overdoses, both non-fatal and fatal, decreased.
- The internal OTP model, in which the respective Department of Corrections licenses its own OTP, dispensing and administering medication daily. In this model, the prison or jail becomes a licensed OTP, obtaining approval from the federal Drug Enforcement Administration. The Franklin County Jail in Greenfield, Massachusetts, was approved as an OTP in August of 2019. The emphasis is on holistic care during incarceration as well as upon release. The program serves about 40 people a day at a cost of $27 a day per person. There were specific lessons learned: obtaining OTP

ALCOHOLISM & DRUG ABUSE WEEKLY
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licensure is time-consuming and complex. There is great importance on a team-based approach with the cooperation of security personnel and medical staff. So far, no outcomes have been published since the facility obtained OTP licensure.

- In the model CODAC uses in the Rhode Island Department of Corrections (RIDOC) system, the OTP vendor is co-located within the prison or jail. The licensed OTP operates within the walls and dispenses the medication daily. The RIDOC system is unified — there are six facilities, combining what is usually thought of as prison (more than a one-year sentence) and jail (shorter sentences or awaiting conviction, sentencing or release). The average daily census of MAT patients is 2,298, with 6,413 individuals receiving care. The average sentence length is 16.2 months. More than 50% of the individuals awaiting trial are released within six days of commitment.

Best place for treatment

The criminal legal system represents one of the highest impact avenues to provide treatment, said Hurley, noting that at least 1 in 45 people die in re-entry, when they go back to using drugs and, as they are no longer tolerant, overdose. "This is a highly vulnerable population," she said of people leaving incarceration who have not used drugs for days. "The risk of relapse two weeks following re-entry is extremely high — more than 29 times higher than the general population,' she said.

In addition, not offering treatment is cruel and unusual punishment, a violation of the 8th Amendment of the U.S. Constitution, she stressed.

There are also many randomized controlled trials showing that MAT with methadone or buprenorphine is effective in corrections populations.

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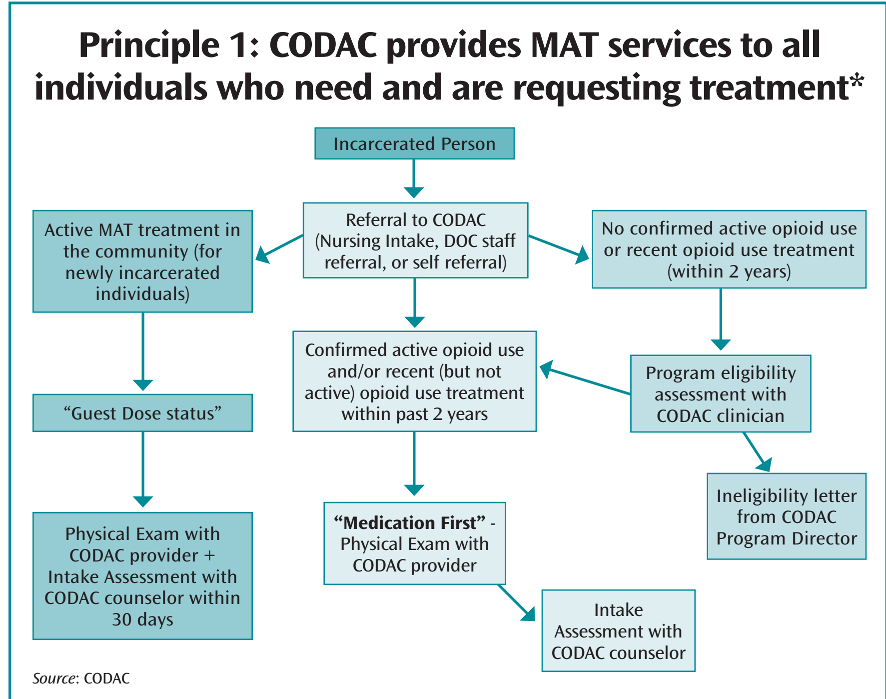
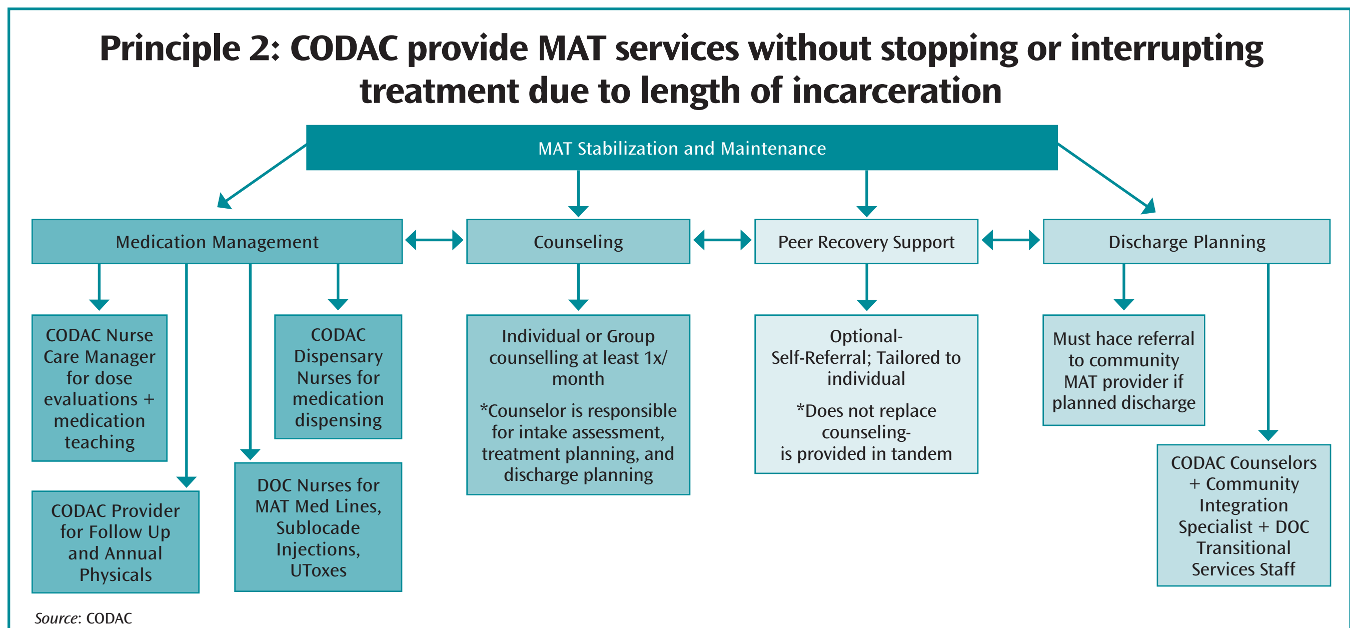


Source: CODAC



Source: CODAC

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Given all of these arguments in favor of treatment, why is it so hard to put into place in carceral settings? "These are simply medicines," Hurley pointed out.

The answer is that the medicines — methadone and buprenorphine — aren't well understood by corrections staff, said Hurley. The other reason is that the disease of addiction isn't well understood by corrections staff.

Communicating to corrections staff

Sometimes the best way to convince people to embrace MAT in their facilities, said Hurley, a soft-spoken master educator whose almost motherly demeanor belies her toughness and authoritativeness, is to tell them that they will be happy with the results. "Just say, 'I urge you to use this because it works,'" she said.

Explaining the disease sometimes means taking the staffers through what is well known as the typical pathway to addiction, using the metaphor of footprints in the sand on the shore as the tide comes in and out. "People use once on a Saturday night, the footprints are there, the tide comes in, and the footprints go away," she said. "But then you're using six Saturday nights in a row, and you wake up Sunday morning, and you say I really liked that, I want it again tonight. Now there's a permanent footpath. And then, you wake up on Monday, and you don't feel well, because you need it [because you're in withdrawal]." There is now what Hurley calls a deep foundation, and different spots in the brain know about this new little rural road that it must follow. "And then, there's a seven-lane highway, and the second you have a spoon, or see anything that reminds you of a substance, you are compelled to use."

When patients get to the seven-lane highway stage, methadone — not buprenorphine or naltrexone — is the most effective medication, said Hurley.

Fast facts about RIDOC

- As of 2021, RI has the 2nd highest rate of community corrections supervision and the 3rd highest rate of probation supervision in the nation
- As of 2018, RI has the 3rd longest average probation term in the nation (44 months)
- CY19 Release Cohort: Within 3 years of release, 45% of individuals returned to RIDOC as sentenced offenders
- Lowest reported rate since tracking began in 2004
- Community MAT services and Harm Reduction
- Healthcare (Medical, Behavioral Health, Insurance)
- Basic Needs (Housing, Transportation)
- Multidisciplinary approach to discharge planning
- CODAC staff (Counselors, Community Integration Specialist)
- RI Public Defender and other legal agencies

Answering tough questions

Some tough questions have been fielded by Hurley over the years, and corrections officials want answers. Hurley cuts to the chase. One question from a member of the webinar audience was: "There doesn't appear to be any end stage for treatment – is this going from one form of dependence to another?" Hurley's response: "It is going from one form of dependence to another" (echoing Vincent Dole, M.D., who invented methadone treatment, and told skeptics cheerfully that "it is a crutch" -- what you would have someone with a broken leg do to get around?) "The reason that methadone works so well, and why people are happy to use it for the rest of their lives, is that it gave them their lives back," she says. And like many clinicians, when asked by patients on any long-term medication, including methadone, "it's a medication." Patients don't want to rock the boat now that they are doing well.

What about Vivitrol and the criminal justice system? Unlike methadone and buprenorphine, Vivitrol (naltrexone) is an antagonist, an injection given once a month that blocks the effects of opioids. It won't stop a patient from using opioids, but it will stop the opioids from having any effect. Because it's not a controlled substance, sheriffs in local jails may prefer it. "I think it's great," says Hurley of Vivitrol. "I stress that having three medications [naltrexone, methadone, and buprenorphine, the only FDA-approved medications for OUD] available is always good." One of the problems with Vivitrol is that it cannot be given to anyone with opioids in their system, or it will precipitate acute withdrawal (severe sickness including vomiting and diarrhea). This means that patients must have already gone through withdrawal, with no opioids in their system for a week. Nevertheless, Hurley supports it as long as it is what the individual wants. Hurley noted that in Massachusetts, much work has been done in the western part of the state with Vivitrol alone. "You're going to meet the least resistance across the board" in corrections if promoting Vivitrol, she said. "You'll also buy people some time."

One of the messages Hurley conveys repeatedly to treatment providers and corrections officials alike: "you can't have good programming without good security."

Another question is more about what some of the problems all methadone and buprenorphine advocates encounter behind the scenes in corrections: notably, opposition from the powerful unions representing custodial (prison guard) workers. The unions opposed the provision of methadone to inmates in

Continues on page 6

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REPORT FROM CCSAD

Experimental, but effective: Noninvasive brain stimulation for addiction

In a presentation by Antonello Bonci, M.D., at the Cape Cod Symposium on Addictive Disorders meeting in Massachusetts this month, work by Italian researchers on the use of noninvasive brain stimulation to treat addiction was a popular feature. "We studied it in rats first," he said. The lab animals learned that if they self-administered cocaine, they would get a foot shock, and 70% of the rats stopped pressing the lever for cocaine. But 30% kept running around waiting for the lever to come out, and kept pressing it, getting the shock. These were the addicted rats."

In the prefrontal cortex, where most decisions are made, there was "no brain activity left" in the addicted rats who kept using cocaine. Half of the brain activity was gone in the rats who stopped taking cocaine. But in the rats who never used cocaine, all of the brain activity remained.

So what researchers did was inject a virus into brain cells and they found that the brain activity returned. "We published a beautiful paper — *Nature*, NPR, everything — so everyone asked, what are you going to do about people?"

Deep brain stimulation can be very precise, but it requires surgery. So Bonci and his colleagues developed a method using transcranial magnetic stimulation (TMS). First, with a pilot on heavily addicted cocaine patients, the procedure had excellent results. The next step was to treat patients with other types of substance use disorders, including alcohol.

The benefit was that patients would say "I don't think about cocaine anymore; I'm not triggered, I don't dream about it anymore." If the craving did return, they would come back for another session, he said.

There were many questions from the audience about patients with autism. Parents do want to know if TMS will help, because there is no medication for autism. "I love this, when people ask, I pretend I am in Italy. What are the symptoms that are bothering you?" said Bonci, whose practice is in Florida. "If it comes down to severe anxiety, ADHD, depression, we can say yes, there are protocols. We can change their awareness of their emotions. Only tiny changes. But we never promise anything besides what we know."

The point is, the protocols were first used with cocaine addiction.

It's not clear whether it will work with opioids. So far, TMS may reduce cravings, but fewer than 50 patients have been treated for opioid use disorder with the protocol.

Bonci shared that he has a cross-gender son "who went through hell in high school." He was severely depressed, and on Wellbutrin and Zoloft. He is in Italy now, treated with TMS. "In five weeks, he went from high dose to zero," Bonci said. "Because it is his privilege, he does TMS once a month. In theory, when you prime the brain with plasticity, lower doses should work."

The main barrier to treatment with TMS is cost, said Bonci. Other barriers are the steps that are required. "You have to show up many times. It's a major commitment. It only takes a few minutes a day. But you have to come back to the clinic for several days."

In other words, it's not like taking a pill every morning. It is more like surgery.

This is true for training as well. "It's not like turning on a machine and training a technician for 12 hours," said Bonci. "We train our technicians for weeks. Sure, you can buy a fancy piano, but you're not going to be a [classical pianist Daniel] Barenboim."

European approval was very important, but Bonci is now hoping that the National Institute on Drug Abuse will fund trials. •

People at CCSAD

Below are some of the presenters at CCSAD held in Massachsetts this month.

Among the many presentations at CCSAD in Massachusetts earlier this month....

Dr. Kimberly Emery, clinician at Fault Line Counseling and Core Faculty at Divine Mercy University, presents a session on "Animal Assisted Therapy: An Evidence Based Approach to Substance Abuse Treatment" at the 2024 Cape Cod Symposium on Addictive Disorders.

Thomas Donovan, Clinical Supervisor at Recovery Centers of America, presents a session on "A Novel Inpatient Treatment Unit Dedicated to First Responders and Frontline Workers: Substance Use Recovery and Life Skills In and Out of Uniform," at the 2024 Cape Cod Symposium on Addictive Disorders.

Dr. Adam McLean, Director of Clinical Outreach at The Guest House Ocala, presents a Vision Session on "Betrayal: Unraveling the Complexities of Betrayal, Resilience and PTSD" at the 2024 Cape Cod Symposium on Addictive Disorders.

Dr. John O'Neill, Chief Clinical Officer at Luna Recovery Services, presents a session on "The Importance of Examining Sexual Health in Treatment," during the 2024 Cape Cod Symposium on Addictive Disorders.

Source: HMP (Not a paid advertisement)

Continued from page 4

Rhode Island, at first. Why, and what did Hurley do about it? "It went by steps," said Hurley. First, the unions said it was "too much work," and cited "understaffing of security." She sympathized with the security issue. Unlike many medical and harm reduction advocates, Hurley has taken the time to learn the carceral culture so she can communicate better with it. "Anytime someone moves in a carceral facility, there have to be two individuals" (jail or prison staff) to accompany that person. So having two medication lines – a special one for methadone – means more work. The unions were opposed to this because there was no plan to compensate them for the extra work.

The prison unions in Rhode Island are "strong," she said. "They put up bill boards on I95." So how did the methadone project end up working? "We won them over because the director of the department said 'you're doing this,'" said Hurley.

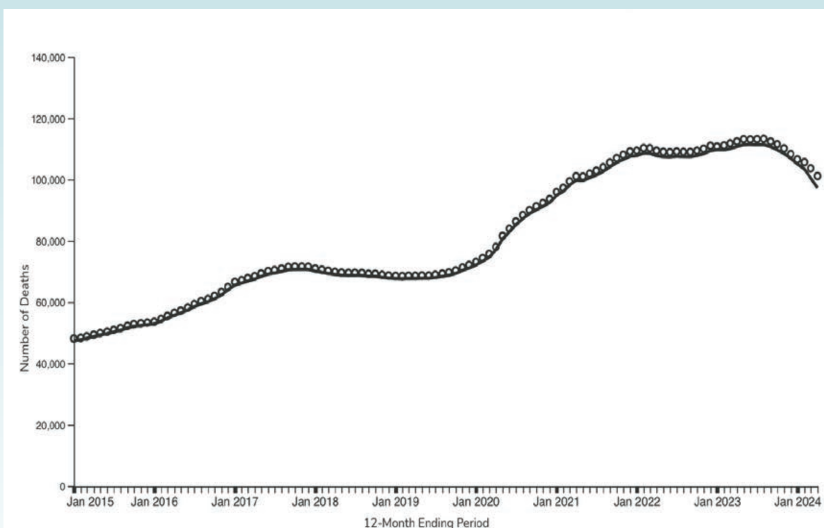
But then, when CODAC explained that they would bring their own nurses in, the unions complained because they wanted the extra jobs and work and money. The prison unions in Rhode Island are "strong," she said. "They put up bill boards on I95." So how did the methadone project end up working? "We won them over because the director of the department said 'you're doing this,'" said Hurley. •

Next week: More on methadone in carceral settings from Hurley's presentation.

CDC data show some relief in overdose deaths

The most recent data from the federal Centers for Disease Control and Prevention indicate that the death rate from overdoses took a dip, for the first time in years. It's still bad news. But possibly, if the trend continues, good news.

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States



Source: CDC

For the full report, go to https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Kentucky from page 1

(KYSAM) have asked the state Board of Medical Licensure to reopen the process that led to the proposed amendments to the buprenorphine regulations. Now KYSAM's immediate past president has signaled that the treatment community should take its concerns about these changes all the way to the office of the state's governor, Andy Beshear.

"Please help me get the message to our governor that Kentucky's outdated buprenorphine regulation needs to be gone," James Patrick Murphy, M.D., wrote in a blog communication on Sept. 17, the day after Gov. Beshear, other government leaders and numerous treatment and recovery groups gathered in Frankfort for a Recovery Month commemoration event. "The science, the data, and the lived experience of thousands in recovery confirm that buprenorphine treatment for opioid addiction promotes recovery, prevents overdoses and saves lives."

Those who have seen firsthand the benefits of making medication treatment for OUD more accessible have questioned many components of the proposed regulatory changes

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that first came to light in June. Some of the amendments call for more stringent drug testing requirements for buprenorphine patients, expanded counseling and referral provisions for pregnant women who use the medication, and a limit of once-daily dosing of buprenorphine.

"A lot of our state policies are quite excellent. The buprenorphine regulations seem to be a bit of an outlier," Michelle Lofwall, M.D., a board-certified addiction medicine specialist and a professor in the Departments of Behavioral Science and Psychiatry at the University of Kentucky, told *ADAW*.

The buprenorphine regulations are not the only item of concern on treatment professionals' radar. The mayor of the city of Somerset, Alan Keck, has formally asked state leaders to consider reinstating preauthorization requirements for publicly funded substance use treatment; these requirements were lifted during the COVID-19 public health emergency. According to local news reports, Keck has said he believes preauthorization would help to reduce provider abuses in the Medicaid system.

"It doesn't make sense to me that we would try to roll back the lack of prior authorization," Lofwall said. She recalled that the office manager at an outpatient addiction treatment clinic where she worked as a prescribing physician would often have to go to the office on weekends to catch up on dozens of pages of preauthorization paperwork.

Earlier this year, Keck was among the Kentucky political leaders who were pushing for legislation that would block out-of-state individuals from establishing residency in Kentucky in order to receive Medicaid-funded substance use treatment (see "Some out-of-staters not welcome for care under Kentucky proposal," *ADAW*, Feb. 12. 2024; https://doi.org/10.1002/adaw.34029).

A spokesperson for the mayor's office has not replied to *ADAW*'s requests for comment from the mayor.

> **"Now is not the time to start to limit access. It's time to take advantage of the federal government getting rid of its regulations."**
>
> Michelle Lofwall, M.D.

Don't impede progress

Some initiatives in Kentucky and nationally have combined to contribute to a recent decline in the state's overdose rates, but under-resourced communities in the state still are facing harsh impacts from the opioid crisis, Lofwall said.

"Now is not the time to start to limit access," she said. "It's time to take advantage of the federal government getting rid of its regulations."

Lofwall added, "Buprenorphine is the most acceptable of the medications to patients and the most accessible. Most counties don't have a methadone clinic."

She cited numerous concerns about the proposed revisions to the buprenorphine prescribing regulations, which the Board of Medical Licensure has said were developed through efforts of a workgroup that included some current and former KYSAM leaders. The addition of gabapentin and common, locally used illicit drugs (presumably a reference to xylazine) to the list of substances to be screened for in buprenorphine patients' required drug tests has no basis in science, Lofwall suggested.

Because there are no point-of-care tests for gabapentin or xylazine, Lofwall said, this requirement would result in physicians having to order expensive confirmatory tests that she said she believes would be wasteful.

Another problematic provision from Lofwall's standpoint would require that a patient's level of care be based on the results of urine drug screens and prescription drug monitoring findings, which she said flies in the face of science-based level-of-care standards from the American Society of Addiction Medicine (ASAM).

In total, "The regulations don't allow for any flexibility," Lofwall said. "They don't acknowledge that we now have injectable formulations of buprenorphine," which even can be initiated in unstable patients. "We're definitely in the minority of states when it comes to buprenorphine," Lofwall said.

The licensure board's executive director, Michael Rodman, has not replied to multiple requests for comment from *ADAW*.

Reason for optimism

Murphy agrees that the state has made significant progress on several fronts in combating the opioid crisis, and he told *ADAW* that he considers expanding access to buprenorphine to be the one missing piece toward ultimate success. "If we can get to the governor, he will listen," he said.

In his blog post, Murphy cited comments at the Sept. 16 Recovery Month event from Eric Friedlander, secretary of the state Cabinet for Health and Family Services, who said he was thankful to work for a governor who "believes in science." Murphy wrote that the state's Medicaid commissioner, Lisa Lee, pointed out that she won't be satisfied with the state's progress "until all barriers to treatment are gone."

Murphy told us that he doesn't believe the recent suggestion to restore prior authorization requirements has gained traction in the state Capitol, though KYSAM will continue to monitor and speak out on the issue. "We're trying to be proactive with education," he said. •

Names in the News

Obituary: Kenneth R. Warren, Ph.D.

Last month, Kenneth R. Warren, Ph.D., died. The deputy director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) since 2008, Warren was also acting director from 2008 to 2014. He retired in 2015.

"Ken Warren was an esteemed scientist who made significant contributions to studies exploring the impact of prenatal alcohol exposure," said NIAAA Director George F. Koob, Ph.D. "More than that, Ken is fondly remembered for his kind collegiality and tireless dedication to NIAAA's mission. He was a generous mentor and a dear friend to many of us in the alcohol research community. We, at NIAAA, will miss Ken very much and offer sincere condolences to his family and friends." •

Coming up...

The **Addiction Health Services Research Conference** will be held **October 16-18** in San Francisco. For more information, go to **https://www.ahsrconference.org/2024/**

The **NAADAC Annual Conference and Hill Day** will be held **October 18-23** in Washington, DC. For more information, go to **https://www.naadac.org/annualconference**

The annual **AMERSA Conference** (Association for Multidisciplinary Education and Research in Substance use and Addiction) will be held **November 14-16** in Chicago. For more information, go to **https://amersa.org/**

The annual meeting scientic symposium of the **American Academy of Addiction Psychiatry** (AAAP) will be held **November 14-17** in Naples, Florida. For more information, go to **https://www.aaap.org/training-events/annual-meeting/2024-annual-meeting-and-scientific-symposium/**

Briefly Noted

Watch those OD numbers!

In a comment entitled "the new math," Rob Kent, former general counsel for the federal Office of National Drug Control Policy, and before that general counsel for the New York Office of Addiction Services and Supports (OASAS), sent us this:

"NYS leadership issues a press release stating that, 'Estimated overdose deaths in areas of New York State outside New York City declined 9 percent in the 12-month period ending March 2024 compared to the prior 12-month period, according to new provisional data released by the Centers for Disease Control and Prevention (CDC). Estimated overdose deaths in New York City declined 3.1 percent in the same period.' However, on the NYS Overdose Death Dashboard, NYS leadership just recently posted that total projected overdose deaths for 2023 is 6,330 compared to 6,358 for 2022. 79% increase since 2019! When does 28 equal 9%!! https://oasas.ny.gov/overdose-death-dashboard

By any math, NYS is losing more than 6,000 individuals to overdose every year! The Governor should declare an emergency to allow the settlement funds to be distributed more swiftly ("made available" does not mean in the hands of front line providers), to waive SUD treatment co-pays, to make all forms of naloxone available, to adjust the OASAS staffing rules, to allow all providers to bid on the settlement funds.

"No urgency, new math = 6,000 deaths every year."

Kent is president of Kent Strategic Advisors, LLC •

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In case you haven't heard...

Exhibit halls at conferences are interesting things. At the Cape Cod Symposium on Addictive Disorders, for example, the booth from Indivior was promoting only Sublocade, a long-term version of buprenorphine. Nothing about OPVEE, the overdose reversal medication. In the next hallway over, the Hikma Pharmaceuticals booth was promoting only Kloxxado, the overdose reversal medication, but nothing about methadone. Indivior produced the first major buprenorphine product in the United States — Suboxone — and Hikma is one of the few major producers of methadone for opioid treatment programs. Hikma also makes buprenorphine.