CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Medication-assisted Treatment for Substance-use Disorders

Final Legislative Report

March 2019

California Department of Corrections and Rehabilitation
California Correctional Health Care Services

Executive Summary

The California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) implemented a Medication Assisted Treatment (MAT) Pilot Program as required by Senate Bill 843. The Program has received significant interest and support from both patients and staff, resulting in almost 600 program referrals. Of the nearly 250 patients started on MAT, 79% of them remained on medication. In addition, of the patients released to the community on MAT, 76% attended their first post-release appointment. Although the Pilot Program is scheduled to end on June 30, 2019, CDCR/CCHCS intend to continue, expand, and enhance substance-use disorder treatment (SUDT) by increasing the number of patients treated, the number of medication options available, and the fidelity of behavioral interventions, and by strengthening care coordination and care management with our community partners.

Background

On June 27, 2016, Governor Brown approved Senate Bill 843, requiring CDCR, under the direction of the Undersecretary of Health Care Services, to develop and implement a three-year MAT Pilot Program at one or more of CDCR's adult institutions. This legislative mandate was in response to the large proportion of urine drug tests (UDT) that were positive for opioids[1], and significant increases in the number of fatal drug overdoses in CDCR, related mostly to opioids.[2]

MAT, which is the use of medications in combination with counseling and behavioral interventions, is an effective treatment for patients with opioid-use disorders (OUD).[3] Numerous studies support the efficacy of MAT, with data showing that it is associated with significant reductions in overdose deaths, illicit drug use, and the spread of infectious diseases; it is also associated with increased treatment adherence and retention.[4] [5] [6] Preliminary data from Rhode Island shows that targeting people with opioid addiction releasing from the state's jails and prisons reduced the death rate among this group by 61%, which contributed to an overall 12% reduction in overdose deaths in the state.[7] [8] In addition, treatment of OUD results in lower

[1] Raphael, S.; Loftstrom, M.; and Martin, B. (2017) The Effects of California's Enhanced Drug and Contraband Interdiction Program on Drug Abuse and Inmate Misconduct in California's Prisons. The UC Berkley Goldman School of Public Policy, 1-73. https://escholarship.org/uc/item/0n71z0wk

[2] Analysis of CCHCS Medical Claims Data and 2016 CCHCS Death Reviews by Dr. Kent Imai, MD. https://cchcs.ca.gov/wp-content/uploads/sites/60/2017/11/2016-Inmate-Death-Reviews.pdf

[3] NIDA (2018) Effective Treatment for Opioid Addiction. https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction

[4] SAMSHA Tip 63 https://store.samhsa.gov/system/files/sma18-5063fulldoc.pdf

[5] CHCF https://www.chcf.org/wp-content/uploads/2017/12/PDF-Why-Health-Plans-Should-Go-to-the-MAT.pdf

[6] Schwartz et al., (2014) "Opioid Agonist Treatments"; Judith I. Tsui et al., "Association of Opioid Agonist Therapy With Lower Incidence of Hepatitis C Virus Infection in Young Adult Injection Drug Users," *JAMA Internal Medicine* 174, no. 12: 1974–81, http://archinte.jamanetwork.com/article.aspx?articleid=1918926; and David S.

[7] JAMA Psychiatry Media Advisory https://media.jamanetwork.com/news-item/examination-postincarceration-fatal-overdoses-addiction-treatment-medications-correctional-system/

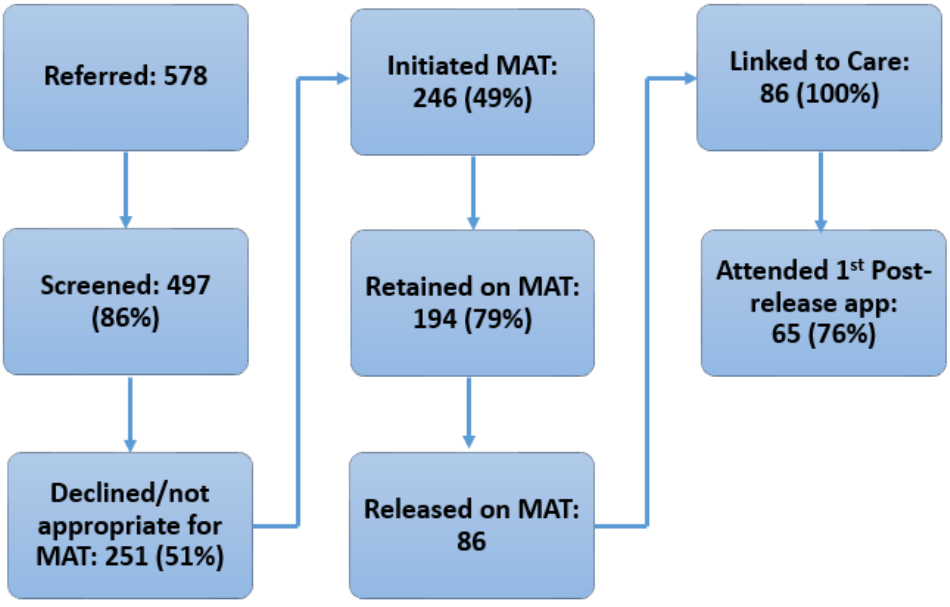
[8] https://www.ri.gov/press/view/32505

criminal justice and health care costs, with estimates showing that every dollar invested in treatment yields a return on investment between $4 and $7. These costs include reductions in drug-related crime, criminal justice costs, and theft. When savings related to health care are included in these calculations, total savings can exceed costs by a ratio of 12 to 1.[9] CDCR/CCHCS' MAT Program utilizes oral long-acting injectable naltrexone and acamprosate to treat alcohol-use disorder (AUD), and oral and long-acting injectable naltrexone for OUD. All medications used as part of the MAT Program are FDA-approved to treat either AUD or OUD.

This is the third and final MAT Report to the California Legislature related to the Pilot Program, and is intended to document the status of the program at the California Institution for Men (CIM), which was implemented on January 4, 2017, and the program at the California Institution for Women (CIW), which was implemented on September 5, 2017. This report also provides an overview of a new proposal to establish a comprehensive evidence-based Integrated SUDT Program, contingent upon approval of resources.

Pilot Status

At present, there are 108 patients participating in the MAT Program: 72 at CIW, and 36 at CIM. Data as of February 12, 2019, show that the MAT program has provided psychosocial treatment to 168 patients in group settings, and MAT to 246 patients, as well as individualized psychosocial treatment to each MAT patient. In addition, 194 MAT patients also received services through the Division of Rehabilitative Programs' SUDT Program. The figure below shows the breakdown of MAT Program referrals compared to those treated, released on MAT, and linked to care upon release.



[9] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost

Of the 194 patients retained on MAT, a majority reported opioids (52%) as their drug of choice. The remainder reported either alcohol (29%) or both alcohol and opioids (19%). The percentage of positive UDTs among patients retained on treatment was comparable to findings from community trial data (31% compared to 25%, respectively).[10] UDTs were performed for clinical management purposes, with positive results indicating that the urine contained a substance that was not prescribed for the patient.

Notably, while the number of patients released on MAT is still relatively small, the percentage that is linked to care is 100%, and 76% actually utilize care as measured by the percentage of patients who attended their first post-release appointment. This is nearly twice as high as other CDCR release cohorts. For example, the percentage of offenders released from CDCR with a substance-use need who received at least one Medi-Cal service in 2016 was 41%[11], whereas only 30% of offenders released from CDCR identified with an HIV infection between calendar years 2016 and 2017 were linked to care within 30 days of release[12]. Since individuals with SUD are at greatest risk of death due to overdose immediately following release from prison, the MAT team has prioritized increasing linkages to community MAT providers, which is demonstrated by this preliminary but meaningful finding.[13] [14]

Community outreach, on a county-by-county level, has enabled the MAT team to significantly increase communication and working relationships with county partners, which directly supports continuity and linkages to care. At present, the MAT team is in communication with all 58 counties and is able to link patients to post-release care.

The number of counties able to provide post-release care for CCHCS patients has significantly increased from the first legislative report when 12 of 58 counties (21%) had MAT programs, to all 58 counties now having access to MAT for their residents. Although not all counties have their own MAT program, counties without programs contract with nearby counties for services.

In addition to the services provided at the pilot sites, MAT was expanded to the California Substance Abuse Treatment Facility in Corcoran, CA in FY 2018-19. With this expansion, Nursing Services is leading the development of patient educational groups on a wide-range of SUD-related topics.

During the reporting period, the MAT team continued to connect to a number of internal and external communication forums, including participating in institutional and headquarter-level policy-making committees, quality improvement workgroups, and leadership conferences across CDCR and CCHCS disciplines. Also, during the reporting period, MAT Program administration participated in an external stakeholder summit with representatives from the courts and the

[10] Kakko J, Svanborg KD, Kreek MJ, Heilig M. (2003). 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. Lancet Lond Engl. 2003;361(9358):662-668. doi:10.1016/S0140-6736(03)12600-1. https://ebm.bmj.com/content/ebmed/8/5/150.full.pdf

[11] https://sites.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/4/2018/12/Offender-Medi-Cal-Utilization-Study-Research-Report-CCJBH-FINAL.pdf

[12] CCHCS Internal Evaluation of HIV Continuum of Care

[13] Binswanger. (2007). Release from prison – a high risk of death of former inmates. *N. Eng J Med,* 356(2):157-165. https://www.nejm.org/doi/full/10.1056/NEJMsa064115

[14] Centers for Disease Control and Prevention https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm?67

legislature, as well as state and county agencies involved with healthcare delivery, and criminal justice organizations to identify opportunities to improve care coordination and care management for CCHCS patients.

Next Steps

Despite the availability of behavioral-based SUDT at all 35 adult institutions, CDCR has had significant increases in the number of fatal and non-fatal drug overdoses over the past several years. Between 2014 and 2017, CDCR experienced a 54% increase in emergency department encounters and hospitalizations related to drug overdoses, and a 160% increase in overdose deaths, with opioids as the primary driver behind these deaths. Access to MAT is currently limited to only the pilot institutions, and the continued rise in overdoses, as well as patients reporting opioids as their drug of choice, demonstrates the need for increased accessibility to MAT for patients with OUD.

As a result, CDCR and CCHCS have sought guidance from national experts on the development of a proposal to fund and implement a comprehensive evidence-based Integrated SUDT Program. Lessons learned from the current Pilot Program, which include the need for dedicated program staff, and the need to offer all FDA-approved medications (naltrexone, buprenorphine, and methadone) for the treatment of OUD, have been considered in the program development process.

If funded, this program will increase access to both behavioral and medication therapies for patients with SUD while they are incarcerated at CDCR, and includes strategies to effectively link patients to post-release community resources. Immediate program goals include identifying patients at highest risk for SUD-related harms, and providing treatment that reduces risk of overdose and other complications associated with SUD. The longer-term goals for this system-wide effort are to build a program that is prepared to recognize and treat SUD as a chronic illness, and provide all levels of clinical care required to optimize patient outcomes during and after the incarceration period.

The proposed program will focus on screening and risk stratification of patients, offering SUDT (including MAT, as appropriate) at selected institutions for those patients at highest-risk for morbidity and mortality related to SUD. This will include offering all medications required to effectively treat OUD, standardizing core SUD rehabilitative programming statewide, enhancing program fidelity, and strengthening care coordination and care management in order to support successful transition back to the community. Implementation of a cross-divisional Integrated SUDT Program is expected to result in reductions in SUD-related morbidity and mortality and recidivism, successful reintegration of individuals into their community at time of release, and enhanced public safety and healthier families and communities over the long term.