CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

California Department of Corrections and Rehabilitation

Road To Recovery

Integrated Substance Use Disorder Treatment Program

Board of Parole Hearings Training

Renee Kanan, MD, MPH
Chief Quality Officer & Deputy Director, Medical Services

Donna Kalauokalani, MD, MPH
Deputy Medical Executive, Medical Services
California Correctional Health Care Services

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Presentation Overview

- Section 1: ISUDT Program Context & Impact
- Sections 2: ISUDT Program Components
- Section 3: Case Studies & Discussion

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SECTION I

The ISUDT Program

Overdose Treatment Impact

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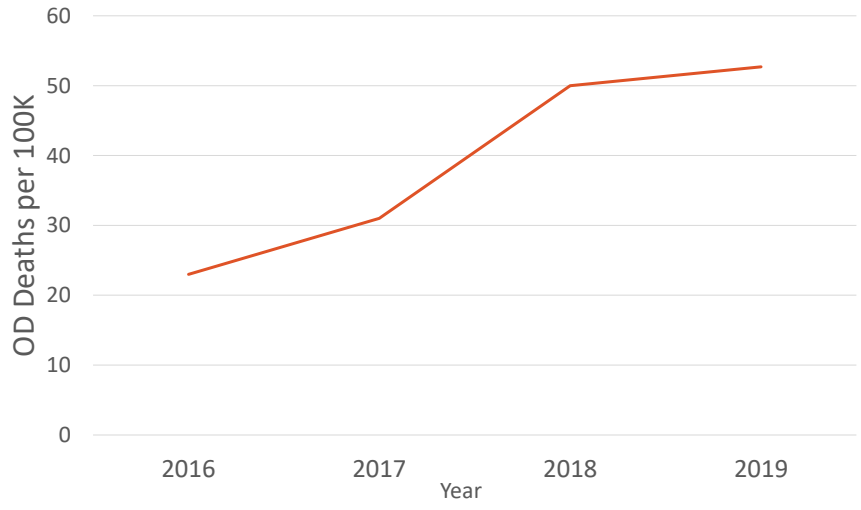
CDCR Overdose Deaths (Per 100k) 2016 – 2019 (Before ISUDT Program)



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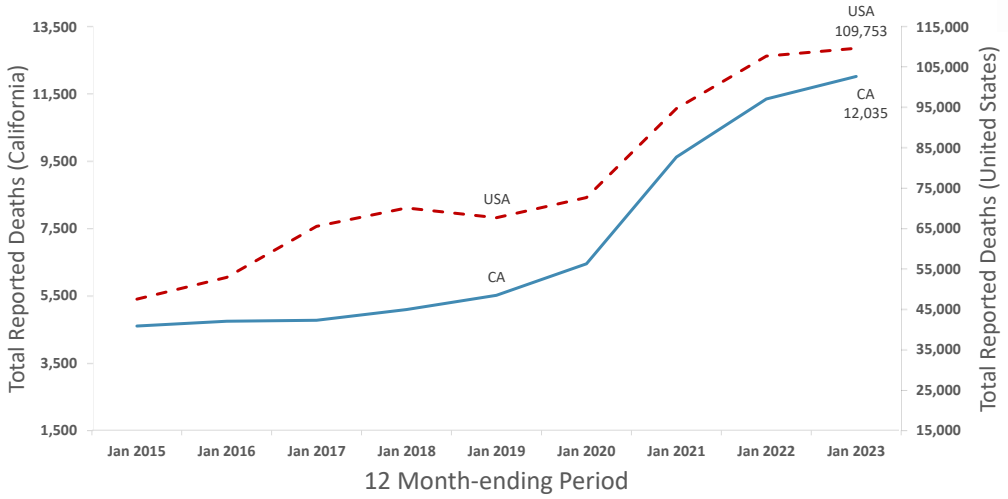
Drug-Related Overdose Deaths in the U.S. and California



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ISUDT Impacts

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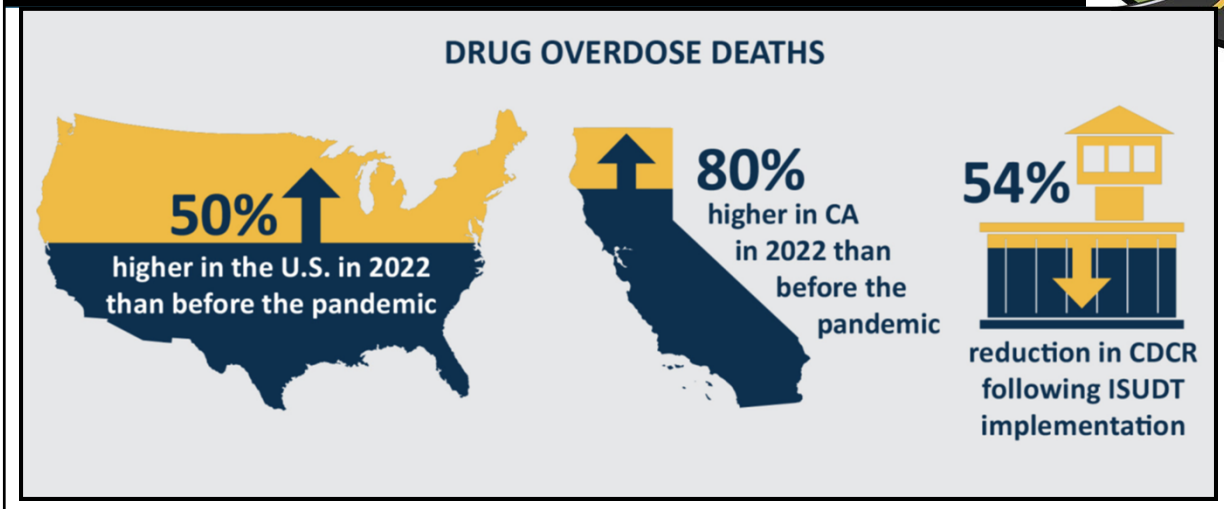
ISUDT Saves Lives
Overdoses Decreased Following Program Implementation



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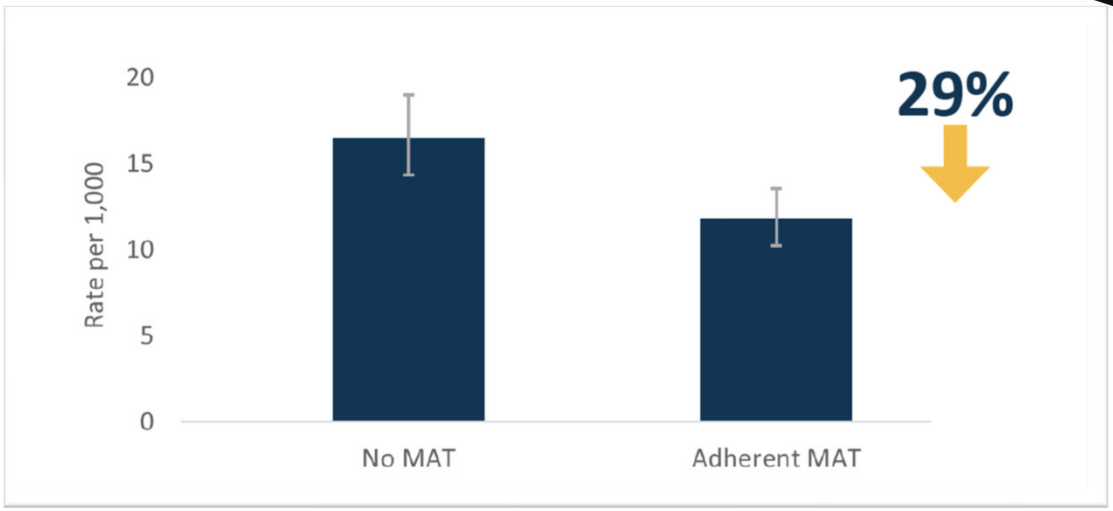
Drug Overdose Rates among CDCR's Population with OUD by MAT Status

January 2020 – June 2022



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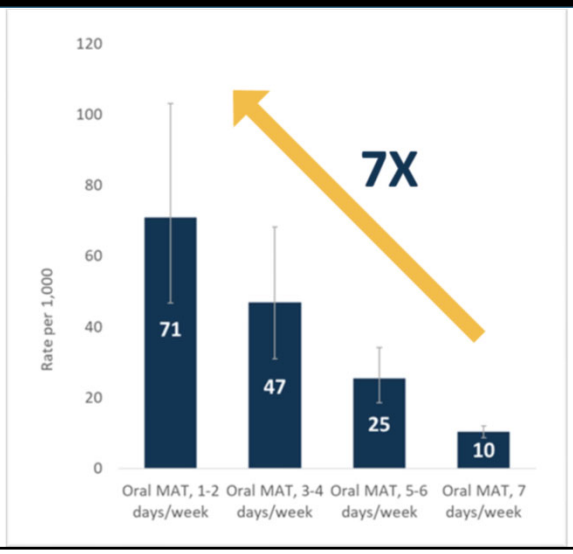
Drug Overdose Rates among CDCR's Population with OUD on Oral MAT by Adherence

January 2020 – June 2022



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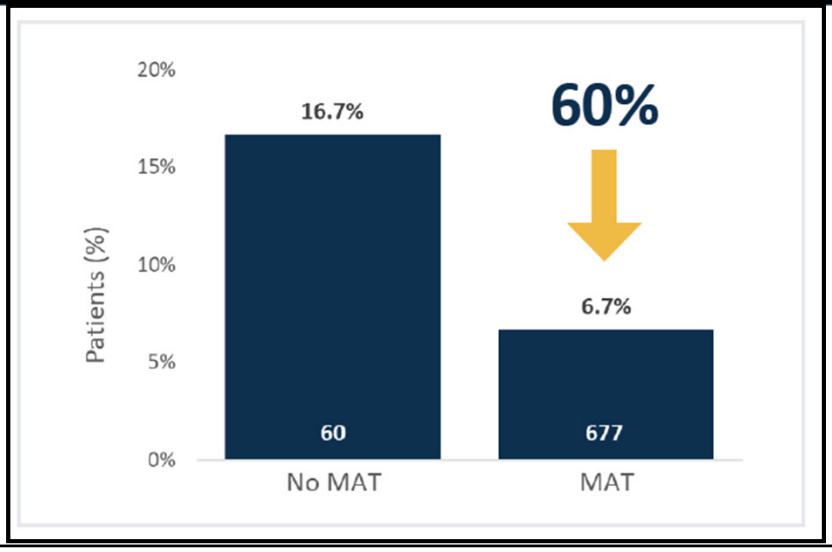
HCV Reinfection Rates MAT vs. Non-MAT

(OUD assessed NIDA MA 16+, followed for at least 14 months post-SVR)



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SECTION II

ISUDT Program Components

Assessment Treatment Transition Support

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ISUDT Program Components

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ISUDT Program Dashboard
12/12/23

- 94% of MAT on Suboxone
- 3% on Injectable Buprenorphine

STATEWIDE

Screening & Assessment

93,876	Screened for Substance Use Disorder (SUD)
38,145	Assessed for SUD Treatment Needs
25,919	Evaluated for Medication Assisted Treatment (MAT)

Treatment

16,539	MAT Provided
10,238	Cognitive Behavior Interventions (CBI) Provided
23,610	SUD Treatment Provided

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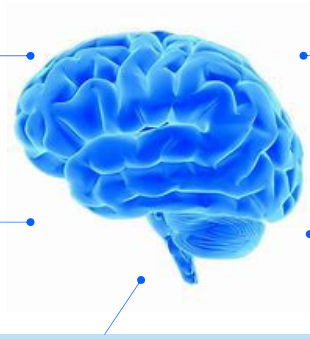
How MAT Works

MAT



- Normalizes Brain Chemistry
- Relieves physiologic cravings
- Blocks euphoric effects of drugs
- Normalizes Body Functions without withdrawal
- Long-term facilitates successful sobriety

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Myths about MAT

Myth #1: You are simply substituting one drug for another

Reality: No. Drugs do not define addiction – behaviors do

- MAT helps to minimize cravings & severe urges to seek drugs
- By stabilizing brain chemistry (esp dopamine), MAT allows people to engage in healthy positive behaviors
- Not focused on next fix; rather on recovery and rehabilitation

MAT Myths

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Myths about MAT

Myth #2: MAT should only be used to support detox

Reality: No. Detox is not an evidence-based practice or standard of care for OUD.

- Medication-free (abstinence) treatment for OUD has a high failure rate: ~85%
- Detox actually increases risk of overdose death compared to long term MAT

MAT Myths

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Myths about MAT

Myth #3: One can get high and overdose on Suboxone

Reality: No. Suboxone is unlike other opiates.

- Suboxone does not typically render a "high" euphoric effect.
- Suboxone is actually *protective* against the action of other opiates, preventing overdose.

MAT Myths

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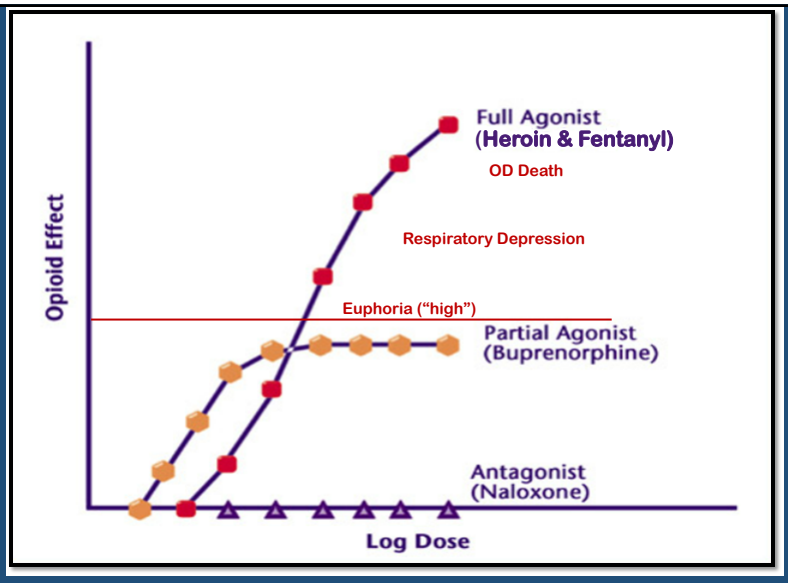
MAT

Risk of opioid overdose

DECREASES

with increased

Suboxone



- The Opioid Effect for Buprenorphine plateaus at ~24 mgs/day
- This plateau generally occurs *before* respiratory suppression

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Myths about MAT

Myth #4: MAT is highly diverted in prison causing safety concerns

Reality:

- Most diverted buprenorphine is not from the medication line, it comes from outside and mostly used to avoid withdrawal and relieve cravings
- Safety concerns are related to illicit drugs such as fentanyl, heroin which cause the majority of overdose deaths.
- Best way to reduce diversion is to increase access to MAT

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Diversion Prevention Methods

- Nurse Administered Dosing
- Directly Observed Therapy
- Hold for 30 sec after placing under tongue
- Remove Cup/Receptacle After Dosing
- Custody Over Watch
- Suboxone SL Preparation has Naloxone Combination (Blocks misuse by injection)

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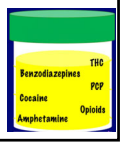
Monitoring - Urine Drug Screens

MAT

UDS results are like a vital sign:

- Frequent random testing to monitor for adherence
- Interpreting results requires knowledge about how drugs are metabolized
- Used to guide therapy, not as a "gotcha"



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CBI/CBT and Relapse Prevention

CBI/CBT

- CBI curriculum includes:
  - Social Networks and Recovery
  - Support Groups
  - Challenges for the Future

skills specific to transition & relapse prevention

- CBT Seeking Safety Curriculum includes:
  - Coping with triggers
  - Evaluating healthy and unhealthy relationships in one's life
  - Creating an action plan

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CBI/CBT and Relapse Prevention

CBI/CBT

Relapse is a process that involves both cognitive and behavioral factors, such as high-risk situations, coping skills, outcome expectancies, and self-efficacy

CBI helps to:

- **Identify** specific triggers and patterns of relapse for each person, and helps to develop personalized strategies to cope with them
- **Teach** cognitive and behavioral skills, such as problem-solving, decision-making, assertiveness, relaxation, and mindfulness, to enhance self-control and resilience
- **Reframe** one's perception of relapse as a learning opportunity rather than a failure, and helps to recover from lapses and prevent further relapse

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ISUDT Program Components

Enhanced Pre-Release Planning

- Enroll & Activate Medi-CAL
- Apply for DMV identification
- Provide Medications and Naloxone
- Schedule Health Care Appointments

Transition Services

- Engage Family & Peer Support
- Transitional Guidance for
  - Employment
  - Education

Care Management & Care Coordination for Successful Reintegration Back to Community

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ASAM RISE

Enhanced Pre-Release Planning

- The American Society of Addiction Medicine (ASAM) CONTINUUM assesses six dimensions that impact recovery
- The Re-entry Interview Script Enhancement (RISE) is a version that evaluates the patient's needs and environment upon release

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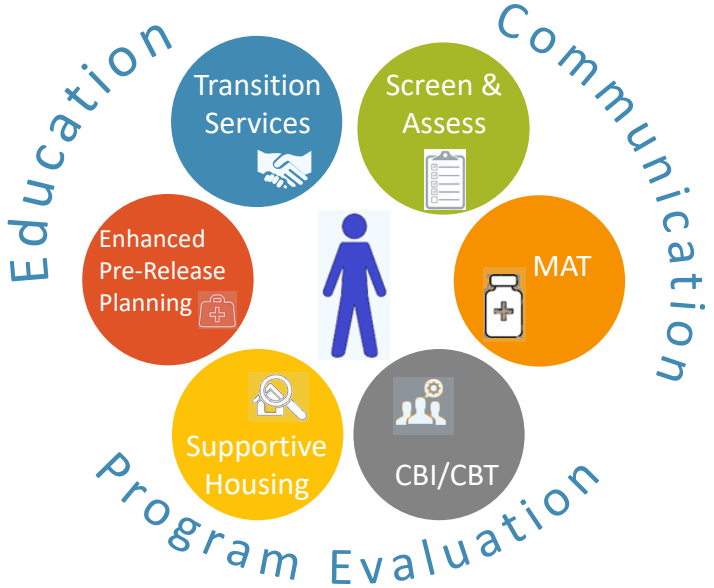
ISUDT Program Components



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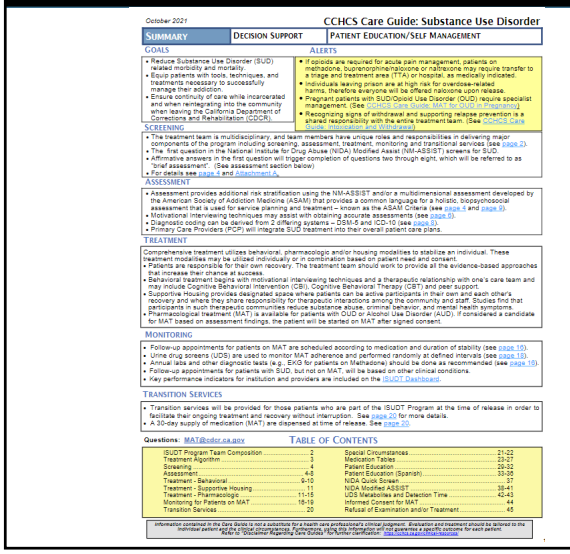
CCHCS Care Guide: SUD



October 2021

CCHCS Care Guide: Substance Use Disorder

SUMMARY | DECISION SUPPORT | PATIENT EDUCATION/SELF MANAGEMENT

GOALS

- Reduce Substance Use Disorder (SUD) related morbidity and mortality.
- Equip patients with tools, techniques, and treatments necessary to successfully manage their addiction.
- Ensure continuity of care while incarcerated and when reintegrating into the community when leaving the California Department of Corrections and Rehabilitation (CDCR).

ALERTS

- If opioids are required for acute pain management, patients on methadone, buprenorphine/naloxone or naltrexone may require transfer to a triage and treatment area (TTA) or hospital, as medically indicated.
- Individuals leaving prison are at high risk for overdose-related harms, therefore everyone will be offered naloxone upon release.
- Pregnant patients with SUD/Opioid Use Disorder (OUD) require specialist management. (See Identify Care Guide: MAT for OUD in Pregnancy)
- Recognizing signs of withdrawal and supporting release prevention is a shared responsibility with the entire treatment team. (See CCHCS Care Guide: Intoxication and Withdrawal)

SCREENING

- The treatment team is multidisciplinary, and team members have unique roles and responsibilities in delivering major components of the program including screening, assessment, treatment, monitoring and transitional services (see page 2).
- The first question in the National Institute for Drug Abuse (NIDA) Modified Assist (NM-ASSIST) screens for SUD.
- Affirmative answers in the first question will trigger completion of questions two through eight, which will be referred to as "brief assessment". (See assessment section below)
- For details see page 4 and Attachment A.

ASSESSMENT

- Assessment provides additional risk stratification using the NM-ASSIST and/or a multidimensional assessment developed by the American Society of Addiction Medicine (ASAM) that provides a common language for a holistic, biopsychosocial assessment that is used for service planning and treatment – known as the ASAM Criteria (see page 4 and page 9).
- Motivational interviewing techniques may assist with obtaining accurate assessments (see page 5).
- Diagnostic coding can be derived from 2 differing systems – DSM-5 and ICD-10 (see page 6).
- Primary Care Providers (PCP) will integrate SUD treatment into their overall patient care plans.

TREATMENT

Comprehensive treatment utilizes behavioral, pharmacologic and/or housing modalities to stabilize an individual. These treatment modalities may be utilized individually or in combination based on patient need and consent.

- Patients are responsible for their own recovery. The treatment team should work to provide all the evidence-based approaches that increase their chance at success.
- Behavioral treatment begins with motivational interviewing techniques and a therapeutic relationship with one's care team and may include Cognitive Behavioral Intervention (CBI), Cognitive Behavioral Therapy (CBT) and peer support.
- Supportive Housing provides designated space where patients can be active participants in their own and each other's recovery and where they share responsibility for therapeutic interactions among the community and staff. Studies find that participants in such therapeutic communities reduce substance abuse, criminal behavior, and mental health symptoms.
- Pharmacological treatment (MAT) is available for patients with OUD or Alcohol Use Disorder (AUD). If considered a candidate for MAT based on assessment findings, the patient will be started on MAT after signed consent.

MONITORING

- Follow-up appointments for patients on MAT are scheduled according to medication and duration of stability (see page 16).
- Urine drug screens (UDS) are used to monitor MAT adherence and performed randomly at defined intervals (see page 16).
- Annual labs and other diagnostic tests (e.g., EKG for patients on Methadone) should be done as recommended (see page 16).
- Follow-up appointments for patients with SUD, but not on MAT, will be based on other clinical conditions.
- Key performance indicators for institution and providers are included on the ISUDT Dashboard.

TRANSITION SERVICES

- Transition services will be provided for those patients who are part of the ISUDT Program at the time of release in order to facilitate their ongoing treatment and recovery without interruption. See page 20 for more details.
- A 30-day supply of medication (MAT) are dispensed at time of release. See page 20.

Questions: MAT@cdcr.ca.gov

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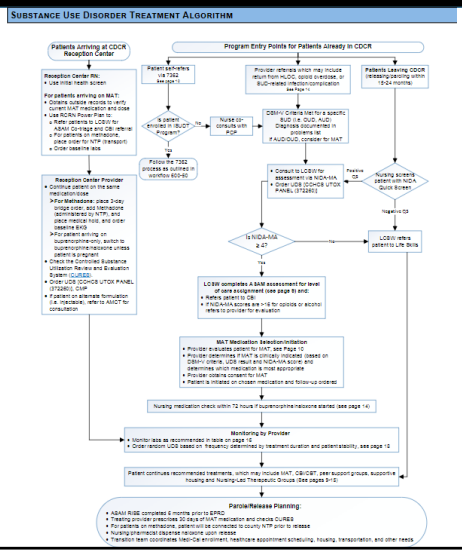

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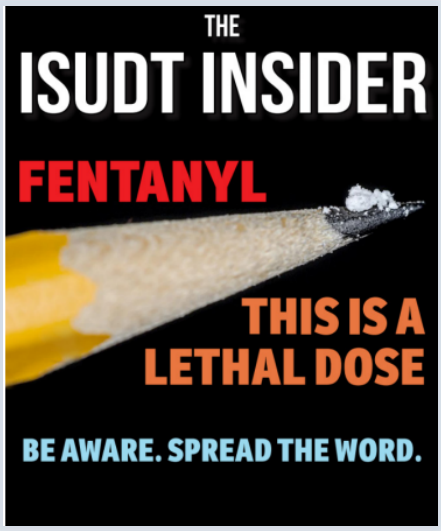
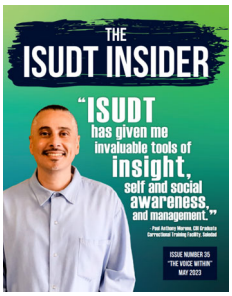
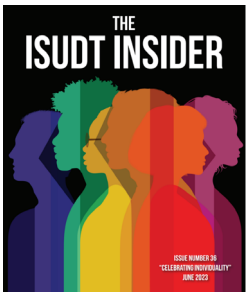
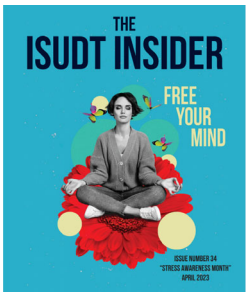
ISUDT Insider Newsletter for CDCR Residents



- 33 editions, 486,472 copies
- Engaging, recovery-focused
- Journaling, art, testimonials







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Case: Mr. R

- 36 yo Man incarcerated since 2006
- History of obesity, hepatitis C, anxiety, heroin use
- Multiple hospitalizations for soft tissue infections
- Known gang involvement; no stable assignment
- NIDA MA, SI score 35 for street opioids
- Addiction Medicine consultation (2020), diagnosed with OUD with *8/11 + DSM5 criteria*
- Started on Suboxone

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SUD DSM – 5 Criteria

Impaired control

- ☐ Substance is often taken in larger amounts or over a longer period than was intended
- ☑ There is a persistent desire or unsuccessful efforts to cut down or control substance use
- ☑ A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- ☑ Craving, or a strong desire or urge to use the substance.

Social impairment

- ☑ Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home.
- ☑ Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- ☑ Important social, occupational, or recreational activities are given up or reduced because of substance use.

Risky use of substance

- ☐ Recurrent substance use in situations in which it is physically hazardous.
- ☑ Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

Pharmacological criteria

- ☐ Tolerance, as defined by either: a need for markedly increased amounts of the substance to achieve intoxication or desired effect OR markedly diminished effect with continued use of the same amount of the substance.
- ☑ Withdrawal, as manifested by either: the characteristic withdrawal syndrome for the substance OR the substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

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Case: Mr. R – 3 years into treatment

- Now on Suboxone 12/3 mg SL daily and stable
- Completed CBI programming
- Works in the kitchen
- Frequent communication with his family
- No RVR's last 3 years
- DSM-5 now 1/11 (occasional craving)
- Adherent with appointments and UDS

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SUD DSM – 5 Criteria

Impaired control

- Substance is often taken in larger amounts or over a longer period than was intended
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- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
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Urine Toxicology	1	2	3
Creatinine	138.1	182.8	127.3
Specific Gravity	1.005	DNR	DNR
pH	6.3	5.8	6.8
Oxidant	NEGATIVE	NEGATIVE	NEGATIVE
Abnormal Specimen Validity Test:	DNR	DNR	DNR
6 Acetylmorphine	NEGATIVE	NEGATIVE	NEGATIVE
6 Acetylmorphine			
Amphetamines	NEGATIVE	NEGATIVE	NEGATIVE
Amphetamine	DNR	DNR	DNR
Methamphetamine	DNR	DNR	DNR
Opiates	NEGATIVE	NEGATIVE	NEGATIVE
Codeine			
Hydrocodone			
Norhydrocodone			
Hydromorphone			
Morphine			
Fentanyl			
Fentanyl	NEGATIVE	NEGATIVE	NEGATIVE
Norfentanyl			
Buprenorphine	POSITIVE	POSITIVE	POSITIVE
Buprenorphine	66 (H)	87 (H)	154 (H)
Norbuprenorphine	247 (H)	174 (H)	567 (H)

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Case: Mr. R – 3 years into treatment

Clinical Notes:

- He is anxious about BPH date in near future
- Wants to consider discontinuing MAT because he heard being on MAT might make the granting of parole unlikely

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Mr. R's Case: Discussion Points

Does being on MAT make it more or less likely that Mr. R would …

- relapse?

What other factors would you consider to determine "current unreasonable risk?"

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Board of Parole Hearings

The California Parole Process Handbook

Board's Review and Consideration of Substance Use Treatment Records

The Board is obligated to review all relevant, reliable information when deciding a person's parole suitability.[114] This includes the person's medical treatment records, such as participation in the Integrated Substance Use Treatment (ISUDT) program and use of Medication Assisted Treatment (MAT).[115] If substance use issues contributed to the circumstances that led to the person's commitment offense or other criminal behavior, the hearing panel will want to know what caused the person to use substances, how the person has addressed the issue, and what tools they have to manage the issue in the community.

Participating in treatment shows that the person is willing to get help and learn ways to deal with their substance use issues, which helps them become more suitable for parole. Hearing panels view a person's participation in ISUDT and use of MAT as a positive thing.

Some common questions hearing panels may ask those in ISUDT or using MAT are:

- What is your substance use history?
- When did you last use?
- How did your substance use impact your actions and your beliefs in the past?
- How did your substance use affect others?
- What are some of the circumstances that led to your substance use in the past?
- Do you understand why you turned to substances? What were the underlying issues or trauma that caused you to turn to substances?
- Have you addressed the underlying issues or trauma so that you have a positive way of responding to similar situations in the future without turning to substances or violence?
- Are you able to openly seek help from others when needed?
- Do you have a relapse prevention plan you use today that works for you? How will this plan need to be modified when you are in the community?
- What will you do in the community when you want to use substances again?
- If you are receiving MAT, what has been your experience with MAT? Have you been compliant with taking the medication? Do you plan on continuing to use it – why or why not?
- If you relapsed, what circumstances led to your relapse? Have you learned different ways of addressing those circumstances in the future?

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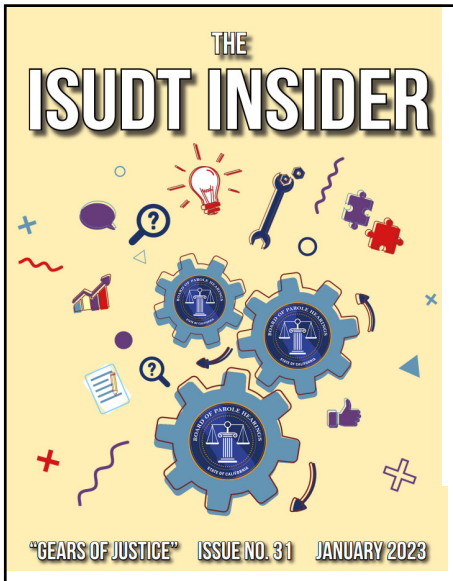

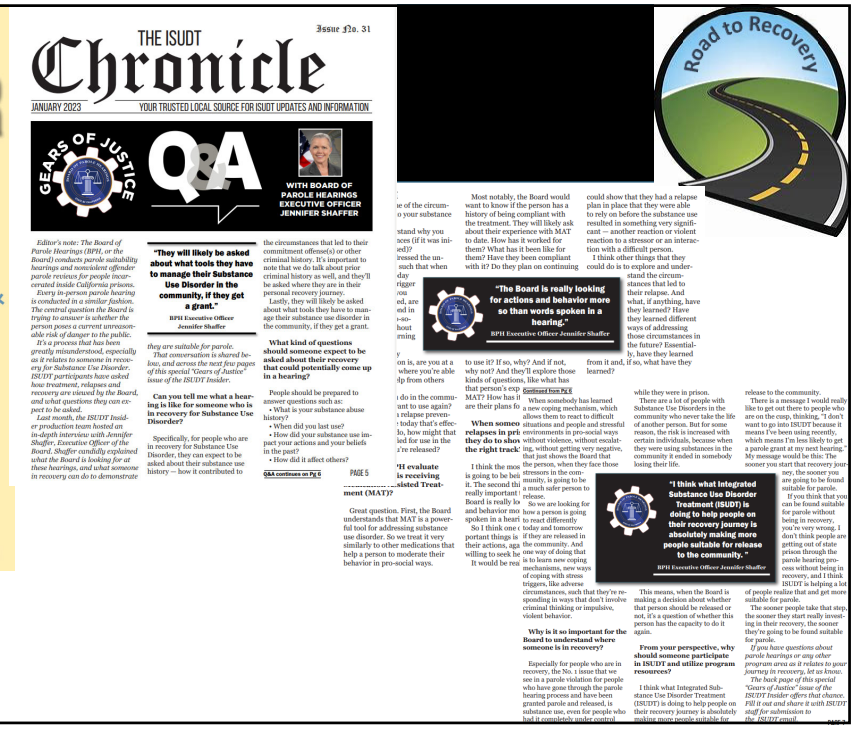

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Case: Mr. T

- 43 yo Man incarcerated since 2004
- History of previous treated hepatitis C, Moderate depression on SSRI, heroin use
- Addiction Medicine consultation (2020), diagnosed with OUD with 7/11 + DSM5 criteria
- Started on Buprenorphine/ Naloxone (Suboxone) 8/2 mg SL Daily
- Completed CBI programming
- Works in laundry
- Patient admitted to heroin use after bad news from home ~ 1 year ago

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Urine Toxicology	1	2	3	4
Creatinine	127.3	138.1	113.8	182.8
Specific Gravity	DNR	1.005	1.005	DNR
pH	6.8	6.3	7.3	5.8
Oxidant	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
Abnormal Specimen Validity Test:	DNR	DNR	DNR	DNR
6 Acetylmorphine	NEGATIVE	NEGATIVE	POSITIVE	NEGATIVE
6 Acetylmorphine				
Amphetamines	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
Amphetamine	DNR	DNR	DNR	DNR
Methamphetamine	DNR	DNR	DNR	DNR
Opiates	NEGATIVE	NEGATIVE	POSITIVE	NEGATIVE
Codeine			NEGATIVE	
Hydrocodone			NEGATIVE	
Norhydrocodone			NEGATIVE	
Hydromorphone			NEGATIVE	
Morphine			1857 (H)	
Fentanyl			41.1 (H)	
Fentanyl	NEGATIVE	NEGATIVE	POSITIVE	NEGATIVE
Norfentanyl			>500.0 (H)	
Buprenorphine	POSITIVE	POSITIVE	POSITIVE	POSITIVE
Buprenorphine	154 (H)	69 (H)	66 (H)	87 (H)
Norbuprenorphine	567 (H)	248 (H)	247 (H)	174 (H)

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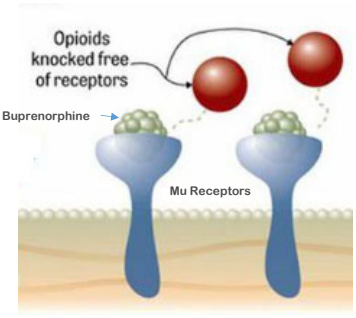
Buprenorphine



- Partial Mu opioid receptor agonist
- High affinity for the Mu receptor
- Activates the receptor with a ceiling effect
- Less reinforcing/rewarding
- Less risk of overdose from other opioids
- Long half life

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Case: Mr. T (cont'd)

- Clinical note after UDS #3:
  - Discussion about apparent tainted supply of heroin (fentanyl)
  - Encouraged to engage fully with his treatment program
  - Urged to work on strengthening his coping skills
  - Offered 1:1 visit with LCSW and he accepted; now in CBT group
- Since relapse, adherent with all appointments and UDS
- Talks with a chaplain and attends NA meetings regularly

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- How does the relapse episode affect current assessment of risk?
- What other factors would you consider to determine current risk?

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Case: Mr. S

- 42 yo male with OUD
- Started on suboxone in 2021, currently on 16 /4 mg daily
- Nursing notes he pulls the strip out of mouth, puts in pocket
- Adherent with his appointments and UDS

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Urine Toxicology	1	2	3	4	5
Creatinine	139.1	185.8	127.3	201.6	292.1
Specific Gravity	DNR	DNR	DNR	DNR	DNR
pH	6.3	5.8	6.8	5.3	5.4
Oxidant	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
Abnormal Specimen Validity Test:	DNR	DNR	DNR	DNR	DNR
6 Acetylmorphine	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
6 Acetylmorphine					
Amphetamines	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
Amphetamine	DNR	DNR	DNR	DNR	DNR
Methamphetamine	DNR	DNR	DNR	DNR	DNR
Opiates	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
Codeine					
Hydrocodone					
Norhydrocodone					
Hydromorphone					
Morphine					
Fentanyl					
Fentanyl	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
Norfentanyl					
Buprenorphine	POSITIVE	POSITIVE	POSITIVE	POSITIVE	POSITIVE
Buprenorphine	76 (H)	89 (H)	154 (H)	52 (H)	37 (H)
Norbuprenorphine	267 (H)	184 (H)	567 (H)	243 (H)	172 (H)

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Case: Mr. S

Clinical notes:

- Questioned about nursing reports of behaviors at med line
- Mr. S admits he tries to save his dose for later (cravings at night)
- Consider change dosing from AM to PM
- Consider need for Suboxone dose increase

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Reasons for Non-Adherence (in prison)

- Avoid withdrawal
- Avoid untoward side effects
- Undertreatment
- Yard/political yard pressures
- Save for later in the day
- To help a buddy
- Fear of being discontinued
- Self manage
  - Pain
  - Anxiety
  - Depression

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Mr. S's Case: Discussion Points

- Does this case illustrate "diversion?"
- What is the difference between diversion and misuse?
- How does this behavior affect determination of risk?

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Case: Mr. H

- 32 yo man with OUD, HCV, HIV, using heroin since age 12
- NIDA-MA score 38 for street and prescribed opioids
- Several overdoses; last OD 6 weeks ago
- Frequently misses/refuses appointments and UDS

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Urine Toxicology	1		2		3
Creatinine	138.1	158.8	182.8	172.9	127.3
Specific Gravity	1.005	DNR	DNR	DNR	DNR
pH	6.3	5.3	5.8	7.6	6.8
Oxidant	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
Abnormal Specimen Validity Test:	DNR	DNR	DNR	DNR	DNR
6 Acetylmorphine	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE
6 Acetylmorphine					
Amphetamines	NEGATIVE	POSITIVE	NEGATIVE	POSITIVE	NEGATIVE
Amphetamine	DNR	1651 (H)	DNR	557 (H)	DNR
Methamphetamine	DNR	5977 (H)	DNR	1799 (H)	DNR
Opiates	NEGATIVE	NEGATIVE	NEGATIVE	POSITIVE	NEGATIVE
Codeine					
Hydrocodone					
Norhydrocodone					
Hydromorphone					
Morphine				171 (H)	
Fentanyl				3.0 (H)	
Fentanyl	NEGATIVE	NEGATIVE	NEGATIVE	POSITIVE	NEGATIVE
Norfentanyl				124.4 (H)	
Buprenorphine	POSITIVE	POSITIVE	POSITIVE	POSITIVE	POSITIVE
Buprenorphine	192 (H)	59 (H)	166 (H)	179 (H)	306 (H)
Norbuprenorphine	856 (H)	281 (H)	965 (H)	1271 (H)	939 (H)

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Case: Mr. H (Cont'd)

- Sees his PCP and requests to get off MAT
- Gang pressure to avoid MAT
- PCP recognizes this is a HIGH RISK situation
- Offered injectable buprenorphine (Sublocade)

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Mr. H's Case: Discussion Points

- How does his behavior affect determination of risk?
- What can we offer to support his recovery?

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Summary

- Overdose deaths
  - Increasing in U.S. & California since 2019
  - Decreasing in CDCR since ISUDT Program implemented
- SUD is a treatable, chronic relapsing disease
- SUD treatment reduces morbidity & mortality risk
- SUD treatment adherence reduces relapse risk
- Recovery is a journey not a destination

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