Implementing Buprenorphine within the Juvenile Justice Setting

Challenges & Benefits

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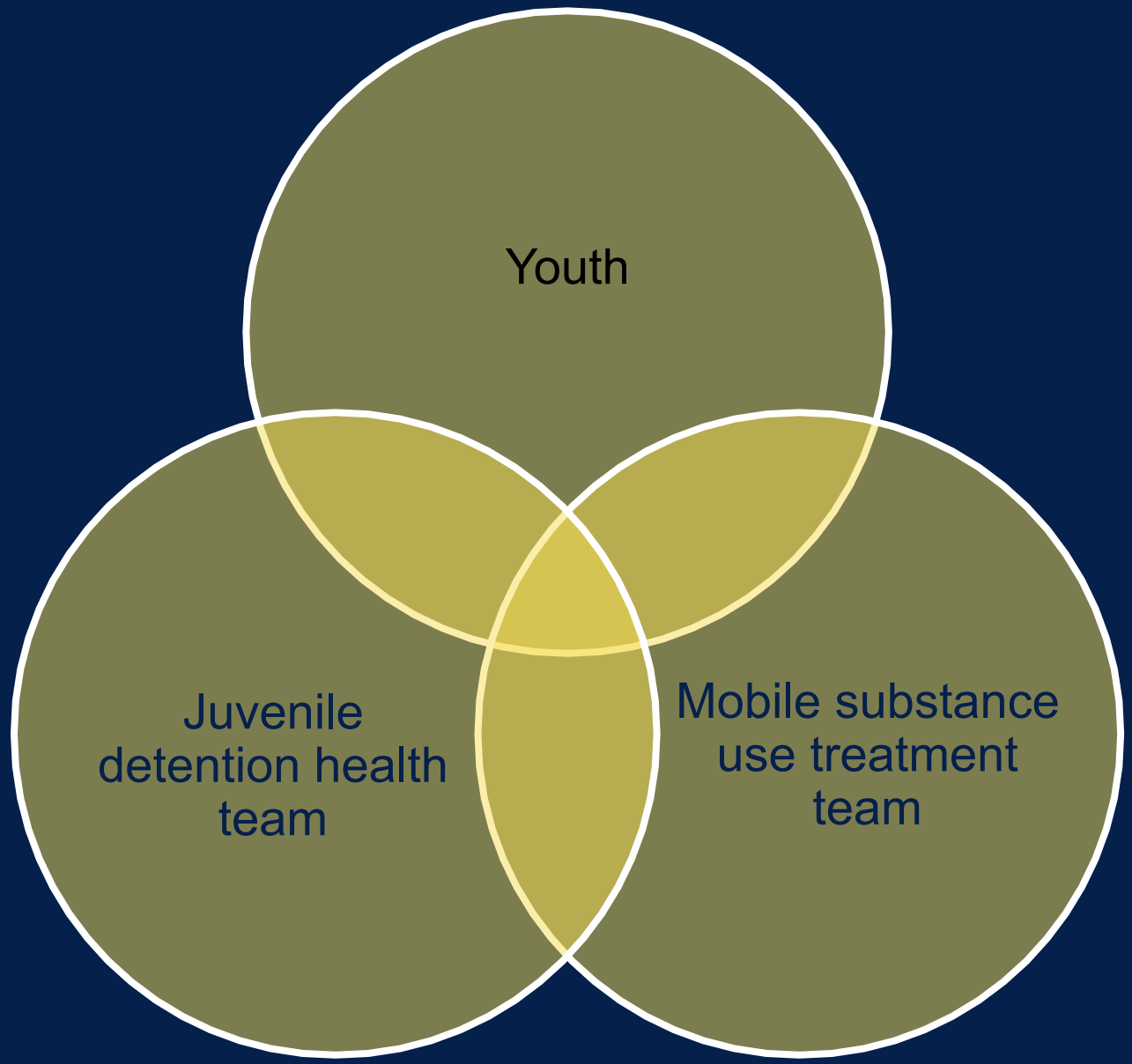
Disclosure Information

- Presenters do not have financial interests or relationships to disclose

Learning Objectives

- Understand barriers to care for opioid use treatment for detention- involved youth
- Review minor consent & confidentiality guidelines across the country
- Illustrate our progress of transitioning from policy into practice
- Discuss the importance of partnering with a low barrier, community substance use team to enhance long-term engagement

Team Introduction



Choose *your* answer with Mentimeter

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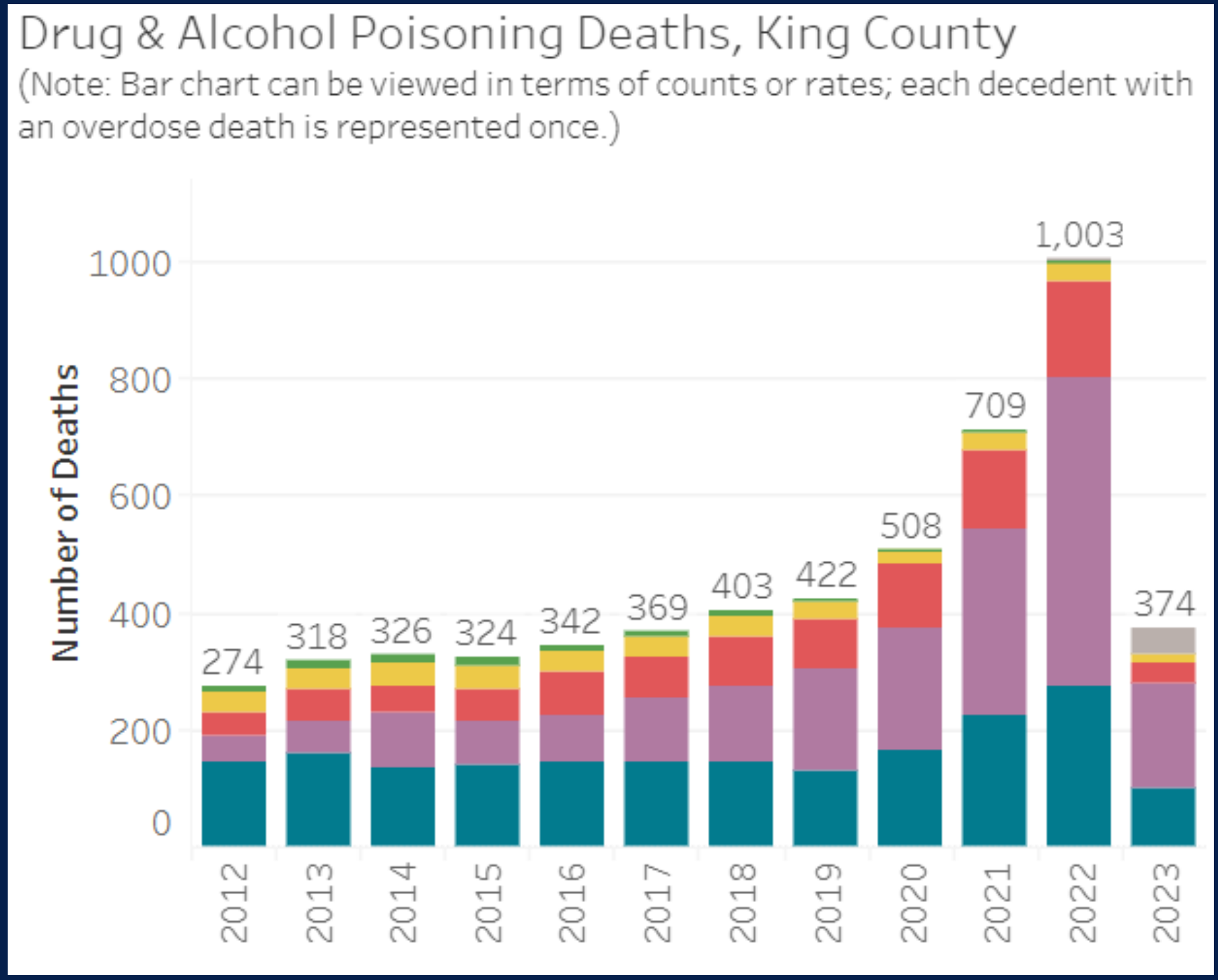
4. Withdrawal support medications and buprenorphine for stabilization with option ongoing maintenance therapy.

Background



Opioid= Fentanyl, Heroin, and/or Rx Opioids
Stimulant=Meth. and/or cocaine
*May also include sedating drugs and/or alcohol.

Background

Number of individuals with confirmed opioid overdose related death in King County, WA by age group and year

Age group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<20	4	4	5	4	3	1	2	3	4	3	3	10	21	21
20-29	25	17	28	29	36	37	41	34	41	52	47	50	82	76
30-39	34	38	24	38	32	48	49	50	46	55	60	90	86	97
40-49	57	60	55	42	43	44	50	39	46	57	50	46	67	88
50-59	63	52	53	48	55	53	63	58	48	54	61	54	62	101
60+	15	21	19	18	21	32	24	32	40	32	54	46	55	62

Fentanyl crisis

Background

Prevalence of all substance misuse higher in the juvenile justice system than general adolescent and young adult population

Prevalence of opioid misuse at local Juvenile Detention Center (JDC) in King County, WA from Sept 2020-April 2021 was 16.9% compared to 3.6% in general adolescent population (SAMHSA, 2020)

Acute withdrawal from opioids and other substances is a significant health issue within correctional facilities

Rate of opioid overdose deaths within 2 weeks after release from incarceration range from 40-129x higher than general population.

Background

The American Academy of Pediatrics (AAP), the Society of Adolescent Health and Medicine (SAHM), American Society of Addiction Medicine (ASAM) support Medications for Opioid Use Disorder (MOUD) for the adolescent and young adult (AYA) population

The Substance Abuse and Mental Health Services Administration (SAMHSA) strongly encourages all eligible practitioners to screen each patient for opioid use disorder and offer access to treatment

Adolescents ages 13-16 are the least likely cohort to receive medications for opioid use disorder (MOUD)

In 2017, only 2.4% of adolescents up to 18 yoa compared to 26.3% of adults received MOUD

Case 1

15 year old youth with history of opioid misuse presents to juvenile detention with agitation, chills, and complaints of aches and insomnia. .

He is placed in a room and sleeps for most of 3 days

He is offered electrolyte drinks and vitals are monitored prn

Juvenile Detention: Workforce

Health Clinic Staff

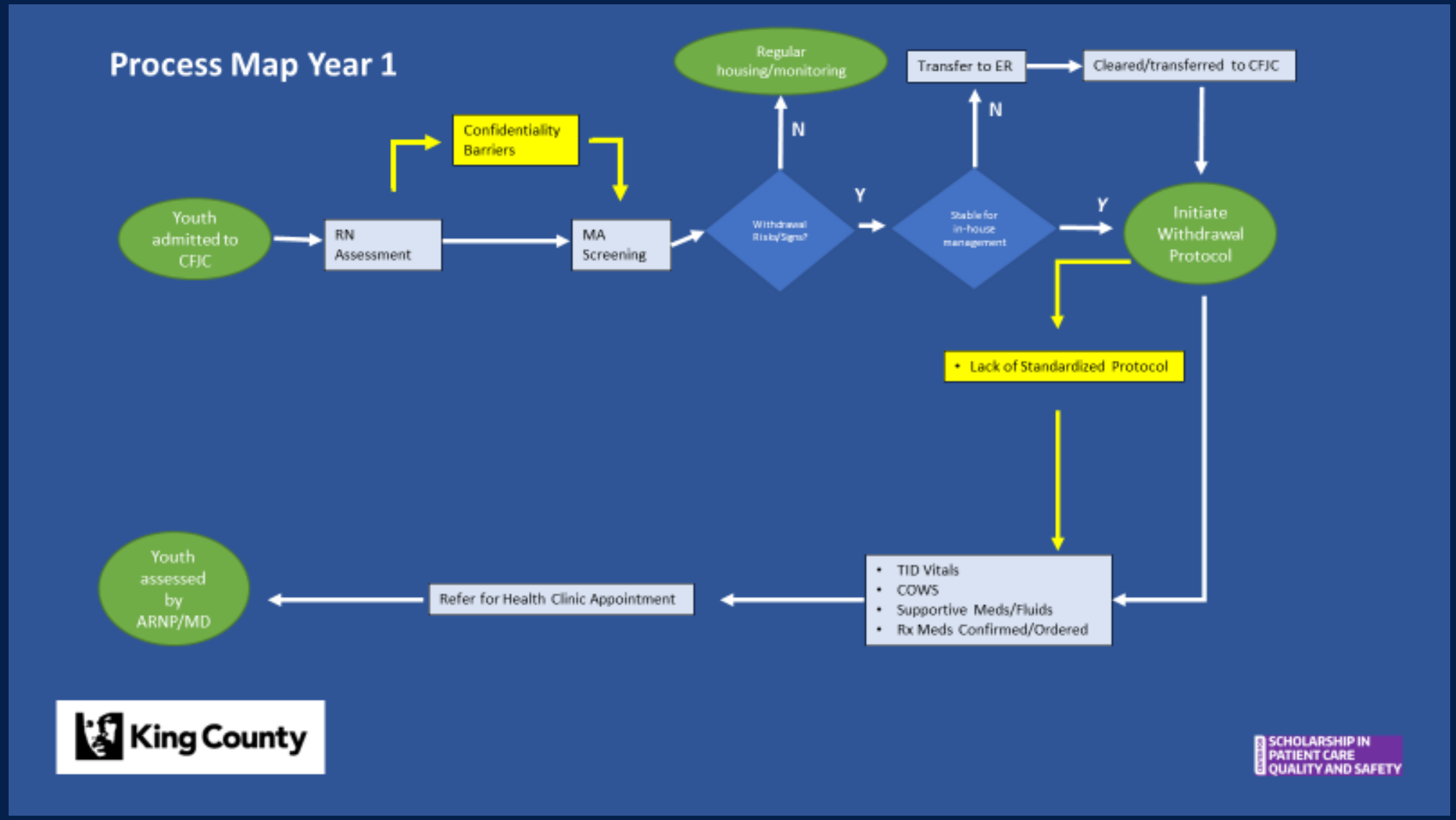
Medical providers from University of Washington

- MD, NP from Adolescent Medicine division
- Child and Adolescent Psychiatrist
- Mental health counselors
- 5 days/week

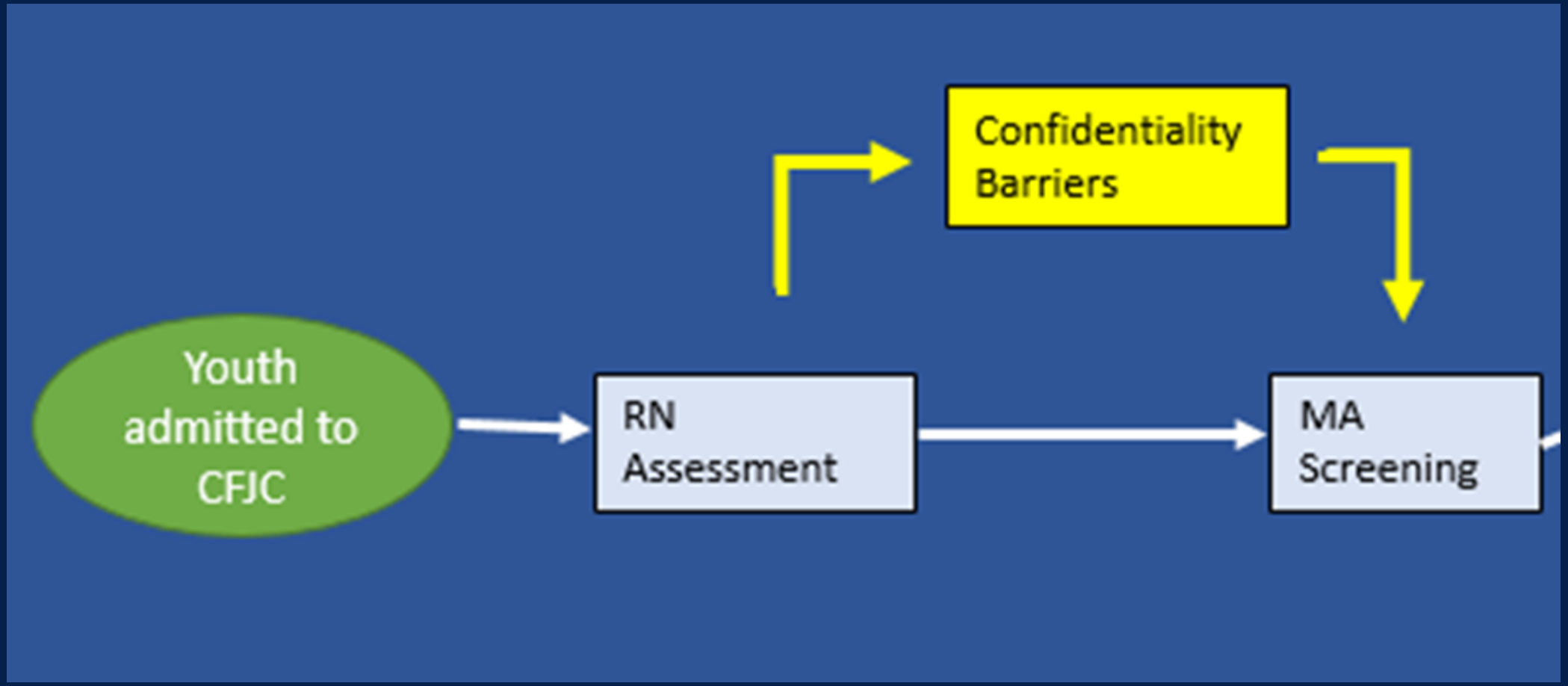
RN/MA employed by County

Juvenile detention officers

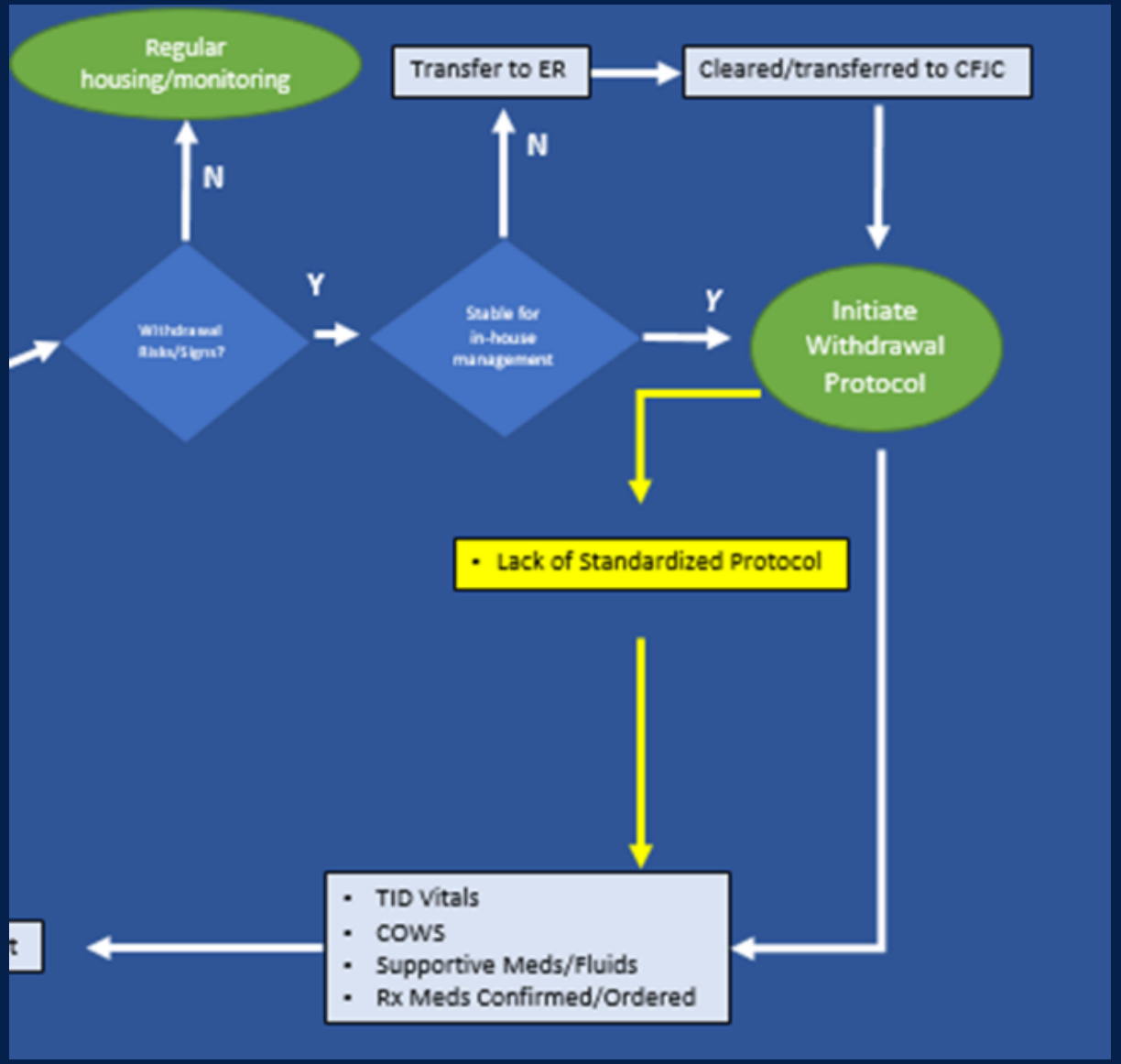
Youth Intake at JDC



Youth Intake at JDC



Youth Intake at JDC



Previous Practice

All youth screened through MAYSI (Massachusetts Youth Screening Instrument)

Youth in withdrawal offered oral hydration with electrolyte drink

Vital signs done 1-3 times per day - not standardized

Most youth stayed in their rooms on the unit instead of being placed in the infirmary

Youth with opioid use disorder experienced withdrawal with limited support

Some youth received substance use assessment for treatment/placement

Previous Practice Limitations

Screening youth upon admission often resulted in limited engagement and trust

Distance between units and detention health clinic hindered timely and frequent assessments

Providers in facility lacked expertise in substance use treatment

Lack of standardization for management and referral

Addressing Practice Limitations

RN/MA and Officer education on confidentiality in adolescent care

Clarify process and order of screening by officer and assessment by RN/MA

Designation of private space in intake area

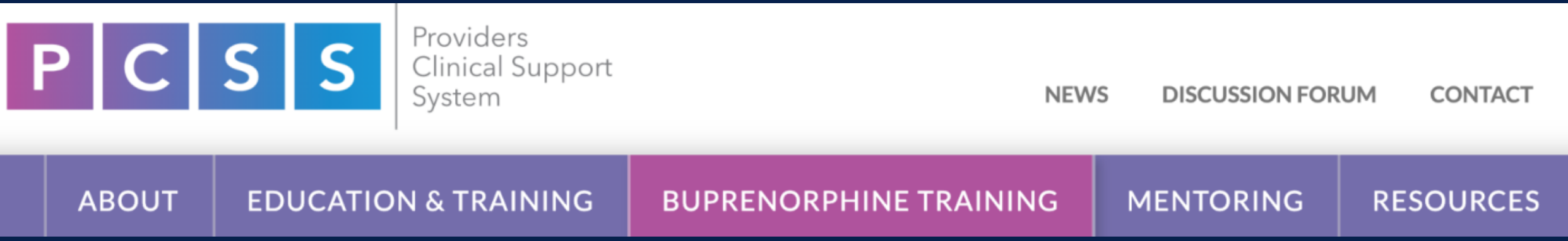
Sample script for RN/MA to explain objective and limitations of confidential care to officer and youth

Youth monitored in infirmary (located in JDC health clinic) while under the influence or exhibiting withdrawal signs

Addressing Practice Limitations

Provider Education:

- Physician and NP completed buprenorphine training in 2020
- Request for SAMHSA expedited waiver



https://pcssnow.org/medications-for-opioid-use-disorder/waiver-training-for-physicians/

Legislation

On December 29th, 2022 the DATA-Waiver program (X-waiver program) was eliminated as well as limitations or caps on the number of patients one could treat

- This helps to reduce a major barrier of providing treatment to those in need
- The education requirement will be 8 hours of focused training vs the 24 hours required for non-physician providers
- Will this legislation increase access for AYAs to receive MOUD?

Addressing Practice Limitations

Patient Label Here

Orders for Opioid Withdrawal Syndrome

Purpose: To provide supportive care for youth exhibiting signs and symptoms of opioid withdrawal syndrome. Mild symptoms may not require treatment. Moderate to severe symptoms can be managed to decrease risk of the following (refer to COWS):

- Self-harm behaviors
- Complications related to other serious illnesses
- Severe dehydration
- Electrolyte imbalance
- Vital sign instability

Screens/Vitals:

- COWS (Clinical Opiate Withdrawal Scale) daily x 5 days pending MD/ARNP assessment
- Vitals TID x 5 days pending MD/ARNP assessment

Follow up: Please refer the youth to the next available Sick Call or contact MD on call if urgent concerns.

Medications for Opioid Withdrawal Syndrome by Symptoms: if COWS >10 or clinical concerns

RNs are authorized to dispense the below medications as indicated for opioid withdrawal syndrome. Medication administered should be documented in the youth's MAR.

- For aches/pain:
  - ibuprofen 400 mg PO Q6 hours PRN x 5 days (caution if history of renal disease or GI ulcers)
  - acetaminophen 650mg PO Q6 hours PRN x 5 days (not to be used with ETOH use)
- For anxiety/insomnia:
  - diphenhydramine (Benadryl) 50 mg Q6 hours PRN x 5 days

Please call MD for verbal orders for the following Rx if indicated

- For GI cramps:
  - dicyclomine (Bentyl) 10 mg Q6 hours PRN x 5 days
- For nausea:
  - ondansetron (Zofran) 4 mg ODT PO Q8 hours PRN x 3 days (caution when already on Benadryl)

To continue youth on medication for opioid use disorder (i.e. Suboxone), please verify dose by home prescription or direct communication with youth's PCP/substance use disorder provider. Call waivered providers (Do-Quyen Pham MD or Rachel Ghosh ARNP) for verbal orders.

Barriers to Implementing Improvements

Differing perspectives regarding appropriate level of care for incarcerated youth with OUD among different management teams.

DAJD directors have to approve policy & protocol changes

Stigma among staff regarding medication for opioid use disorder in detained youth

Barriers to Implementing Improvements

Concerns about medication safety and their effect on brain development have been implicated in not prescribing MOUD for AYAs (Welsch et. al 2022)

Overall adolescent substance use disorder is believed to be less severe than adult substance use disorder (Johnson-Kwochka et. al 2021)

- This can lead to caregivers seeking less care or treatment for these AYAs
- “Trying” substances is often normalized by adults & guardians for adolescents and young adults

Case 2

Youth presents to detention with prescription of buprenorphine/naloxone

Youth was very anxious about missing doses of MOUD

This was a catalyst to initiation of using MOUD in the facility

Patient Label Here

Order for Continuation of MOUD (Medication for Opioid Use Disorder)

If able to verify use of medications for opioid use disorder through dispensed prescription, medication bottle, or communication with substance use disorder provider, please call waivered provider on call (Do-Quyen Pham MD, Rachel Ghosh ARNP) for verbal order of one of the following medications.

Buprenorphine/naloxone (Suboxone) film **sublingual**

- ☐ 12 mg/3 mg sublingual once daily
- ☐ 8 mg/2 mg sublingual once daily
- ☐ 4 mg/1 mg sublingual once daily
- ☐ 2 mg/0.5 mg sublingual once daily
- ☐ Other _____

Buprenorphine/naloxone (Suboxone) film **buccal**

- ☐ 6.3 mg/1 mg buccal once daily
- ☐ 4.2 mg/0.7 mg buccal once daily
- ☐ 2.1 mg/0.3 mg buccal once daily
- ☐ Other _____

Buprenorphine/naloxone (Suboxone) **tablet** sublingual

- ☐ 8 mg/2 mg sublingual once daily
- ☐ 2 mg/0.5 mg sublingual once daily
- ☐ Other

****Please confirm medication is dissolved after administration. Sublingual tablet can take up to 10-15 minutes to dissolve. ****

Barriers to Implementing Improvements

Differences in youth/guardian consent to care

Staffing concerns regarding change in workflow and increase in workload

Concerns for potential diversion of medications

Limited access to inpatient facilities and outpatient providers willing to accept youth on buprenorphine/naloxone

Minor Consent & Confidentiality

Varies state-by-state within the United States

Substance Misuse is considered a Sensitive Health Issue

- Mental health treatment is a separate sensitive health category from substance misuse
- “Most states allow minors to consent for substance abuse treatment; however, 2 states leave this unclear, and 15 have minimum age requirements.” (Sharko et. al 2021)

Minor Consent Law by State for Substance Abuse Treatment

State	Minor Consent Law
WA	Yes, if 13 or older
MA	Yes, if 12 or older
VA	Yes, for outpatient

State-by-State Variability in Adolescent Privacy Laws | Pediatrics | American Academy of Pediatrics (aap.org)

Overcoming Barriers

Monthly touchpoints with staff to elicit feedback and address their concerns

Administration of buprenorphine reserved to health clinic space

- Coordinated with juvenile detention officers
- Set clear expectations with youth

Overcoming Barriers

Building community partnerships

- Developed outpatient referral list

Advocating for continuation of MOUD at inpatient treatment facilities

Warm handoff with outpatient treatment facilities through telehealth

Case 3

14 year old adopted, Native American youth with OUD and Alcohol Use Disorder who is hesitant to use MOUD despite recent overdose and frequent inpatient treatment stays.

Connected them with the mobile SUD team via telehealth while they were detained, multiple times.

Discussed holistic treatment, including MOUD, together.

Upon discharge, the youth connected with the mobile SUD team and remained engaged.

Community partnership: key roles

Work with providers inside detention to develop an outpatient support team as soon as youth is identified to as opioid user and at risk of overdose

Can integrate telehealth to establish connection between the youth and the community prescriber while youth is still detained

Community partnership: key roles

Flexible, mobile community based team that is well versed in engaging criminal justice involved youth with opioid use disorder and removing barriers for MOUD

Multi-disciplinary team with case managers, chemical dependency counselors and MOUD provider to engage youth on multiple levels

Mobile based SUD team

Support for adolescent: build on relationship started in JD

- Take them to breakfast or take them to sublocade shot

Setting up points of contact upon release

- Does youth have a phone? A ride? A place to sleep? Discharge medication?

Responding to concerned adults involved in care

- Parents, JD health clinic, probation counselors

Mobile based SUD team

Goal setting for treatment of their OUD with the adolescent

Relentless follow through

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14 year old adopted, Native American youth with OUD and Alcohol Use Disorder who is hesitant to use MOUD despite recent overdose and frequent inpatient treatment stays.

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“We meet you where

you’re at but don’t leave

you where you’re at”

Benefits of buprenorphine treatment within juvenile justice settings

Crucial period for intervention when youth is in withdrawal

Health clinic provides confidential space separate from legal/criminal justice system

Maximize benefit of taking MOUD in a structured setting that is hard to replicate in the community

Opportunity to provide education to youth who did not have access in the community

Benefits of buprenorphine treatment within juvenile justice settings

Can continue to address substance use over multiple interactions and often multiple stays in detention

Positive experience with MOUD in detention can lay path for seeking outpatient treatment in future even if have relapse after discharge

Trust can be leveraged for a warm introduction to outpatient team

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Your Local Juvenile Justice Facilities

What do your local facilities do?

Do they offer Narcan to the youth?

Do they offer MOUD?

Do they connect them with community providers?

How does discontinuation of Medicaid during incarceration affect care of youth?

Final Takeaways

Barriers to MOUD for AYAs are prevalent but possible to overcome with education and advocacy

The adolescent and young adult cohort are the least likely to receive MOUD despite their high risk factors for dependency and overdose

Initiation of MOUD should start prior to discharge in an effort to prevent the high chance of overdose after leaving a correctional facility

As a medical provider, you have decision making capabilities; you can be a leader for change in both patient care AND policy

Collaborating with community partners improves long term healthcare outcomes

Our Contact Information

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Do-Quyen Pham: doquyen.pham@fairfaxcounty.gov

Taryn Hansen: taryn.m.hansen@kp.org

Johnny Ohta: johnny.ohta@gmail.com

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