ASAM COVID-19 TASK FORCE RECOMMENDATIONS

CARING FOR PATIENTS DURING THE COVID-19 PANDEMIC

Managing Justice Involved People with Addiction During COVID-19 Pandemic

AMERICAN SOCIETY OF ADDICTION MEDICINE
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MANAGING JUSTICE INVOLVED PEOPLE WITH ADDICTION DURING COVID-19 PANDEMIC

A guide for addiction treatment clinicians and programs working to treat patients with substance use disorders safely and effectively during the COVID-19 pandemic[1].

For additional recommendations for the Ongoing Management of the Continuum of Addiction Care during COVID-19, please click here.

CONTENT DISCLAIMER

This Clinical Guidance ("Guidance") is provided for informational and educational purposes only. It is intended to provide practical clinical guidance to addiction medicine physicians and others caring for individuals with substance use disorders during the COVID-19 pandemic as it unfolds. Adherence to any recommendations included in this Guidance will not ensure successful treatment in every situation. Furthermore, the recommendations contained in this Guidance should not be interpreted as setting a standard of care or be deemed inclusive of all proper methods of care nor exclusive of other methods of care reasonably directed to obtaining the same results.

The ultimate judgment regarding the propriety of any specific therapy must be made by the physician and the patient in light of all the circumstances presented by the individual patient, and the known variability and biological behavior of the medical condition.

This Guidance and its conclusions and recommendations reflect the best available information at the time the Guidance was prepared. The results of future studies may require revisions to the recommendations in this Guidance to reflect new data.

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MANAGING JUSTICE INVOLVED PERSONS WITH ADDICTION DURING THE COVID-19 PANDEMIC

Purpose of the document

The COVID-19 pandemic is presenting unprecedented challenges for correctional and community supervision systems across the world. During this crisis, individuals with addiction should continue to receive addiction treatment in these settings. This guidance is intended to provide guidance on issues related to adaptations

[1]This resource was developed by a Task Force appointed by ASAM's Executive Council. To enable more rapid development and dissem-ination it was not developed through ASAM's normal process for clinical guidance development that is overseen by the ASAM Quality Improvement Council.

correctional settings, community supervision programs, and addiction treatment clinicians and programs may need to make to support individuals with addiction and criminal legal involvement during the COVID-19 crisis.

TOPICS:

1. Treating Addiction in Jails and Prisons During the COVID-19 Crisis

While jails and prisons across the country are struggling to address the COVID-19 crisis, we continue to face an addiction crisis. Individuals with addiction should continue to receive treatment with effective medications during incarceration. Despite the realities of the pandemic, jails and prisons should not halt delivery of addiction treatment (See ASAM's Public Policy Statement on Treatment of Opioid Use Disorder in Correctional Settings). However, there may be additional considerations regarding choice of medication and medication formulation.

2. Considerations for Reentry of Individuals with Addiction During the COVID-19 Crisis

Reentry is an incredibly vulnerable time for individuals with a history of addiction. In one study in Washington state, during the first 2 weeks after release from prison, the risk of death from drug overdose was 129 times higher than the general populations.[2] Other research clearly demonstrates that medications for opioid use disorder, and particularly opioid agonist medications, reduce this risk.[3] Therefore, correctional and community supervision programs must consider the risks associated with COVID-19 as well as the risks associated with addiction when planning for reentry.

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/

[3] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2671411

The coronavirus presents unique challenges for correctional settings, where physical distancing may not be possible. Many jurisdictions are working to rapidly release incarcerated individuals who are at high risk for severe COVID-19 illness and pose a low risk to public safety. However, many individuals with addiction are being released from correctional settings with insufficient planning for ongoing addiction treatment post-release.

While reentry planning may need to be simplified and expedited as prisons and jails work to more rapidly release individuals into the community, for individuals with addiction, whether active or in remission, overdose prevention, medication continuity, community treatment, and safe housing must be addressed.

Overdose prevention

Individuals with active, or a history of, opioid addiction should be provided with naloxone upon release.

Consistent with ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder, all individuals with addiction involving opioids as well as stimulants (because stimulant drugs may be adulterated with fentanyl or other opioids) should be given a naloxone rescue kit prior to release and instructions on how to use them. If distribution of kits prior to/at time of release is not possible, the jail/prison should work with local naloxone distribution programs, local or state health departments, or a local pharmacy to ensure that individuals in need can access naloxone upon release.

Medication Initiation and Continuity

Individuals with addiction who are reentering the community should be provided a clear plan for uninterrupted supply of medications, including medications to treat addiction.

- A clear chain of responsibility for ensuring that the individual maintains access to medications upon re-entry should be created. For example, the probation or parole officer could be assigned the responsibility of ensuring the individual is able to access their community treatment providers to assure uninterrupted treatment.
- Individuals taking methadone for treatment of OUD should be proactively connected to a community opioid treatment program (OTP) with sufficient take-home doses until their scheduled visit with the community OTP. Ideally, this gap would stretch no longer than 48-72 hours post-release, as evidence shows the longer the wait, the less likely someone is to engage in ongoing care. In addition, the tran- sition should be carefully coordinated between the OTP that has been providing care to the patient during incarceration and the OTP that will provide care after community reentry.
- Individuals taking buprenorphine for treatment of OUD should have a prescription waiting for them at a nearby pharmacy for pickup at time of release. This prescription ideally provides 30 days of buprenorphine because individuals may have delays in effectively accessing buprenorphine in the community, particularly during the COVID pandemic. At a minimum, these individuals should be provided enough medication to cover the time until they can reasonably be expected to obtain follow up in the community.

Ideally, coordination with a community buprenorphine prescriber prior to release would allow for a phone-based initial evaluation and establishment of concrete steps for follow-up post- release.

- Consider including refills with a "do not fill before" date if the likelihood of finding an available prescriber within 30 days post-release is small.
- The individual should also be provided guidance related to how to get refills if they are not able to access follow up care in a timely manner. For example:
  - Provide instructions regarding who they can reach out to for assistance if they are unable to access care and need more medication (e.g. their probation or parole officer, or the re-entry coordinator).
  - Provide guidance on options for low barrier access that might be in the community.
- Individuals receiving buprenorphine should be educated about and alerted to the need for safe, secure storage and the dangers of sharing medication with others. While diversion of buprenorphine may occur, current research suggests that most diverted buprenorphine is used for therapeutic purposes (i.e., to reduce withdrawal symptoms, reduce heroin use, etc.).[4]

- Patients taking non-controlled medications for treatment of OUD, alcohol use disorder or tobacco use disorder, should be given a 30-day supply of medication and proactively connected with ongoing care.
  - The individual should be provided guidance related to how to get refills if they are not able to access follow up care in a timely manner. For example:
    - Provide instructions regarding who they can reach out to for assistance if they are unable to access care and need more medication (e.g. their probation or parole officer, the re-entry coordinator, a state warm line, local low barrier addiction treatment clinicians, programs, or community health centers).

Reentry planning from prison typically takes months of coordination. However, the urgencies of the COVID-19 crisis will necessitate more rapid planning for individuals with addiction. Many federal and state policies can create barriers to this process, particularly around obtaining insurance coverage. Correctional and community supervision programs should work with their state and community leaders to try to reduce these barriers. These steps might include, for example, working with their state Medicaid Director to explore opportunities for supporting more rapid access to Medicaid, such as instituting a rapid application and initiation process for emergency access to Medicaid and working to automatically activate this upon re-entry. Another example could include working with the state addiction agency to identify state-funded treatment programs that can prioritize intake for people leaving incarceration, support Medicaid enrollment, and ensure free care while waiting for Medicaid activation.

[4] https://www.drugabuse.gov/publications/medications-to-treat-opioid-addiction/what-treatment-need-versus- diversion-risk-opioid-use-disorder-treatment

Community Treatment Connection:

There should be a proactive plan for connection to community treatment.

- Even prior to the COVID-19 crisis, some communities did not have sufficient treatment capacity. During the COVID-19 crisis, access to addiction treatment has been reduced further in many communities because of reductions in accepting new patients, limitations on how many individuals can be physically present in the facility, and/or because many individuals do not have the resources to participate in virtual treatment. Treatment capacity in the community may be insufficient. Consideration should be given to how patients leaving incarceration can access treatment. For example:
    - Are local OTPs or buprenorphine clinicians or programs taking new patients?
        - OTPs presently have no caps on the number of patients they can treat with buprenorphine. Current federal guidance provides flexibility for addiction treatment providers during this public health emergency (see ASAM's Telehealth Guidance and Guidance for OTPs). These waivers on regulations allow OTPs to initiate and main- tain patients on buprenorphine through telehealth, including telephone-based visits.
    - Is there a local federally qualified health center (FQHC) that can provide buprenorphine treatment? (https://findahealthcenter.hrsa.gov/)
        - Buprenorphine can be initiated and maintained through telehealth, including telephone-based visits.
    - Are there providers, within or outside of the community that can provide the necessary services through telehealth for the patient?
- Consideration should also be given to the individual's access to healthcare coverage.
    - Can the patient afford their medications and clinical care? If not, are there community programs available to subsidize the individual's medication or treatment costs, e.g. FQHCs, 340b, pharmaceutical discounts, state or county programs?
    - Is the patient eligible for Medicaid or other health care coverage? What needs to be done to re-enroll the individual or reactivate their coverage?
- Consideration should be given to how the individual will participate in telehealth-based appoint- ments.
    - Does the individual have reliable access to a phone?
    - Could a phone be provided to them for this purpose? For example, through referral to the federal lifeline program that helps provide phones and limited minutes. https://www.fcc.gov/sites/default/files/lifeline_support_for_affordable_communicatio ns.pdf
    - Consider assigning a staff person to assist individuals with installing any required apps on their phones that will be needed to access the telehealth services they will be expected to use.
- Consider establishing telehealth services for addiction treatment or contracting with addiction treatment programs or clinicians who can provide telehealth services. These services can be used to provide reliable access to care (including treatment with opioid use disorder medications) to individuals with addiction immediately post-release.

Safe Housing in the Community: Individuals should have a pro-active plan for shelter/ housing post-release

The COVID-19 pandemic is likely to make it more challenging for individuals re-entering the community to find housing. Jails and prisons are high-risk environments for virus transmission. Relatives or friends, particularly those that are at risk for severe COVID-19 illness, may be unwilling to provide temporary housing. In addition, many residential addiction treatment programs and recovery residences are limiting acceptance of new patients/residents. Similarly, homeless shelters are also limiting access to be able to enforce and maintain physical distancing recommendations. Jails and prisons should coordinate with local and state partners to identify options for emergency or transitional housing.

3. Considerations for Clinicians and Programs Caring for Recently Incarcerated Patients with Addiction

Jails and prisons are high risk environments for the transmission of the novel coronavirus. Treating clinicians/ programs should assume that the patient may have been exposed to the virus and take precautions for infection control and mitigation as appropriate (See ASAM's Guidance on Infection Mitigation in Outpatient Settings and Residential Settings).

4. Role of FQHCs in Addiction Treatment During COVID-19

In addition to other healthcare settings such as OTPs, federally qualified health centers (FQHCs) can play an important role in the ongoing care of recently incarcerated individuals with addiction because they are used to working with populations without insurance or with Medicaid. They have sliding fee scales and programming that allows patients to get medications at substantially reduced cost. Many FQHCs have existing office-based opioid treatment services, and many have behavioral health staffing qualified to provide addiction treatment. Most aim to treat all patients including people who were formerly incarcerated with dignity and respect. Correctional and community supervision programs should consider working with local FQHCs to support effective coordination of care upon reentry. Memoranda of understanding can facilitate processes for ensuring coordination of care and communication.

https://www.fqhc.org/covid19-coronavirus-health-center-resources

5. Considerations for Probation and Parole in the Supervision of People with Addiction

Probation and parole services can play an important role in supporting continuity of care as individuals with addiction are released from incarceration. Individuals treated with medication for opioid use disorder are at significant risk of relapse and overdose if their medication is disrupted. Probation and parole officers can follow up to assist the individual to access needed medications and safe housing.

Probation and parole officers should also consider how to minimize person to person contact during the COVID-19 crisis.

- Transition to virtual meetings with individuals assigned to them whenever possible.
- Reinforce/encourage individuals under community supervision to follow quarantine and isolation recom- mendations, use of universal face coverings, and frequent hand washing.
- Consider suspending or reducing drug testing requirements to minimize person-to-person COVID-19 transmission (see ASAM's COVID Guidance on Drug Testing).
- Facilitate virtual recovery support group meeting.
- Follow the recommendations of CDC and state/local governments to reduce transmission.

Probation/parole requirements should be modified to reflect what is reasonable in the current crisis for those individuals with addiction who are under their supervision. Probation and parole officers should connect with treatment programs to understand how they are currently operating and how the patient is expected to engage in treatment. Probation and parole officers should also be cognizant of the impact increased stress and anxiety caused by the COVID-19 crisis can have on people with addiction. It will be important to understand each individual's circumstances related to the pandemic and whether it warrants additional flexibility. For example:

- Is the individual at high risk for severe COVID -19 illness due to age or health conditions?
- Is the individual experiencing symptoms concerning for COVID, has the infection been confirmed, or are they awaiting a COVID test result?
- Are they living with someone who is at high risk for severe COVID-19 illness?
- Are they caring for someone who has tested positive for COVID-19, or is ill with COVID-type symptoms or confirmed infection?
- Do they have children who need daily supervision and/or support with schoolwork?

Probation and parole officers should also consider the standards they apply to revocation of probation or parole during the COVID-19 crisis. Relapse is common in patients with addiction, particularly during times of significant stress. Relapse or other symptoms of addiction should be addressed through changes in the person's treatment plan; they should not be used as the basis for reincarceration. The National Association of Drug Court Professionals (NADCP) recommends against issuing a warrant just for relapse:

"Issuing a warrant is not recommended just because the participant has relapsed, especially when treatment court team members have maintained contact. In areas with shelter-in-place orders, the participant may stay in touch through phone calls, Skype, or some other electronic means.

Remember, there are collateral consequences associated with arrest and custody. Courts are operating at reduced capacity. As a result, the participant may be in custody for a period of time before he or she sees the judge. As always, judges should balance the need to apprehend the participant against the cost of incarceration, such as loss of Medicaid, leaving children without a caregiver, loss of housing, and perhaps most importantly, loss of hope."[5]

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[5] https://www.nadcp.org/covid-19-resources/hot-topics/