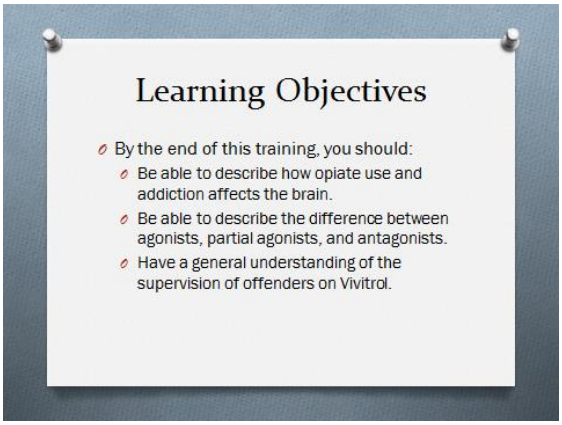
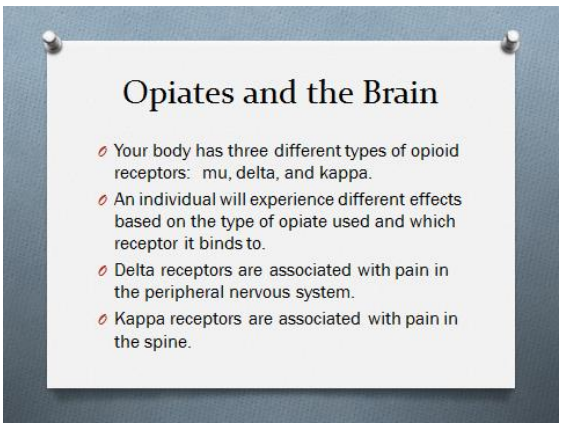
DEPARTMENT OF CORRECTIONS
Division of Management Services
DOC-544A (Rev. 4/01)

LESSON PLAN

Lesson Title Vivitrol - SST

Presentation Guide	Notes to Trainer
Introduction: Today's topic is opiates, their effect on the brain, and how we can supervise offenders with the use of Medically Assisted Treatment and Vivitrol. Ask class who has someone on their caseload with an opiate addiction. If not everyone has their hands raised, have everyone raise their hands and explain chances are better than not everyone supervises someone with an opiate addiction. **Learning Objectives:** 1) Be able to describe how opiate use and addiction affects the brain. 2) Describe the difference between agonists, partial agonists, and antagonists. 3) Have a general understanding of the supervision of offenders on Vivitrol.	 
PRESENTATION: **Opiates and the brain:** Your body has three different types of opioid receptors: • Delta – Peripheral Nervous System • Kappa – Spine • Mu – Central Nervous System **Mu receptors activate the "Reward Center" of the brain, these are the receptors opiates bind to.** When opiates bind to these receptors, they reduce the amount of GABA, a neurotransmitter which controls the release of dopamine in the body.	

When GABA is suppressed, a flood of dopamine is released in the brain, creating a euphoric feeling ("high").

Addiction vs. Dependence

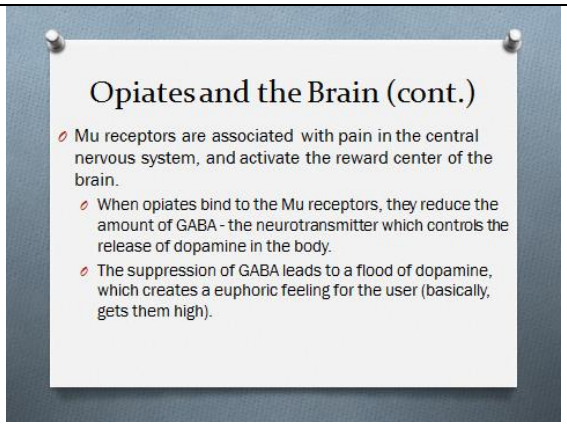
When the opiates bind to the mu receptors and suppress the GABA neurotransmitter, the user gets high. The brain then creates memories which associate that high with the act of using – this creates an addiction.

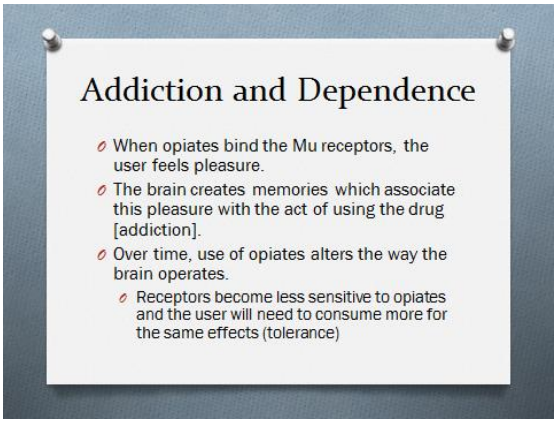
Over time, continued use will make these receptors less receptive to opiates, requiring a higher amount of the drug to create the same feeling – this creates a tolerance.

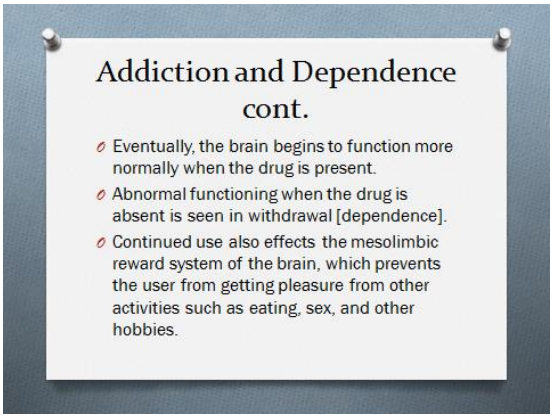
Eventually, the brain begins to function more "normally" when the drug is present. If the brain functions abnormally without the drug, this is called withdrawal and is a sign of physical dependence.

Continued use of opiates will affect the mesolimbic reward system of the brain, preventing the user from getting pleasure from other activities such as eating, sex, and other enjoyable things.

"Caveman Brain" – the craving for the drug will overrule all other basic desires. This is what addiction to opiates does to the brain.







Today we are talking about medically assisted treatment, there are three different types of medications generally used to treat opiate addiction:

AGONISTS:

Opioid agonists fully activate the opioid receptors in the brain giving the user the "full opioid effect," or a high.

Examples include:

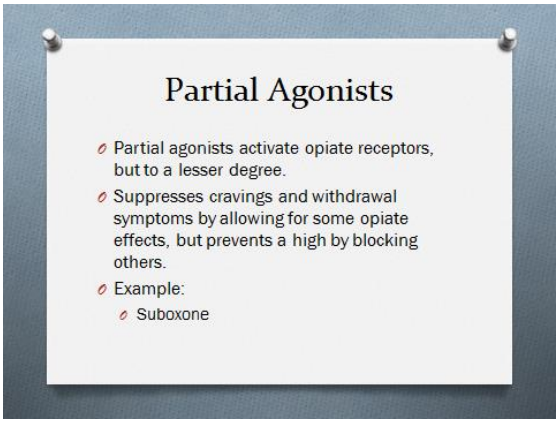
- Heroin
- Oxycodone
- Methadone

- Hydrocodone
- Morphine

PARTIAL AGONISTS:

Partial agonists activate the opioid receptors, but to a lesser degree. They suppress cravings and withdrawal symptoms by allowing some opiate affects.

The most common example of a partial agonist is Suboxone.

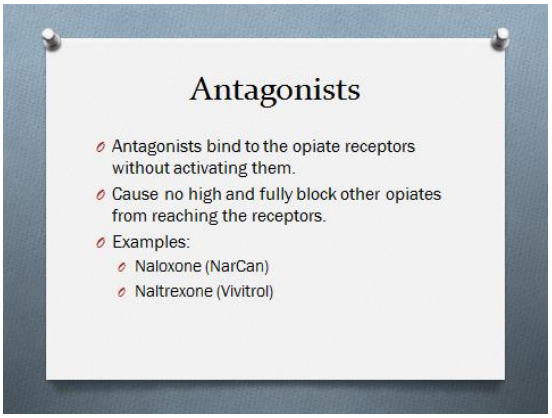


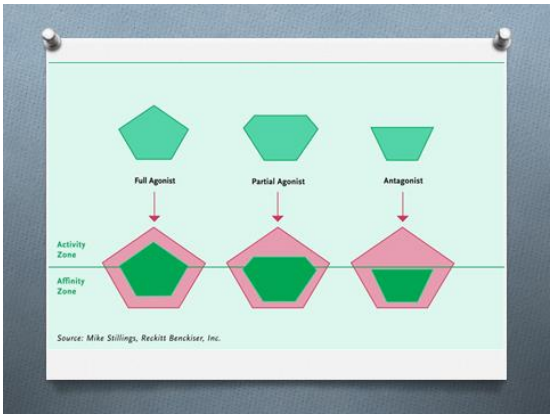
ANTAGONISTS:

Antagonists bind to the opiate receptors without activating them. They produce no high and fully block other opiates from reaching these receptors:

Examples:
-Nalaxone (NarCan)
-Naltrexone (Vivitrol)

Show and explain visual representation.





MEDICALLY ASSISTED TREATMENT:

According to the Substance Abuse and Mental Health Services Administration:

READ LONG DEFINITION

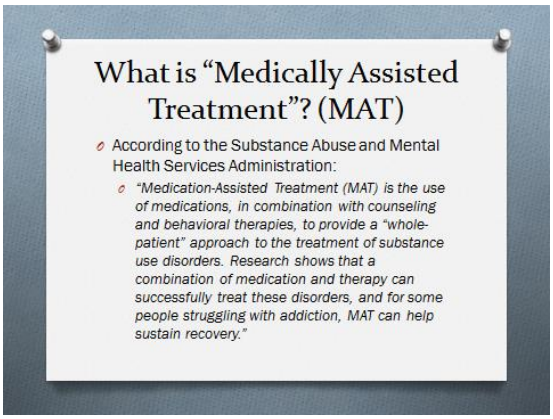
So what does that actually mean?

Basically, it's the pairing of treatment with medication to hopefully address substance abuse issues with a higher success rate.

Why do we use it?

Research has shown use of MAT improves patient survival rates, increases retention in treatment, decreases illicit substance use, and reduces the risk of contracting Hep C or HIV (needle use)

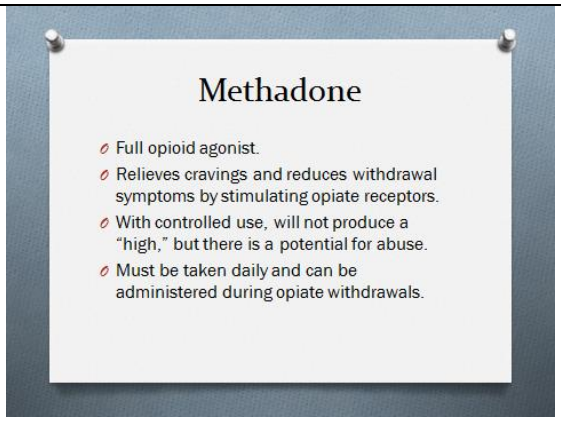
Ask the class how well they are able to focus when they are starving, or exhausted. Compare this to an offender who is dealing with an opiate craving. How well are they going to retain information in treatment? Probably not very well.

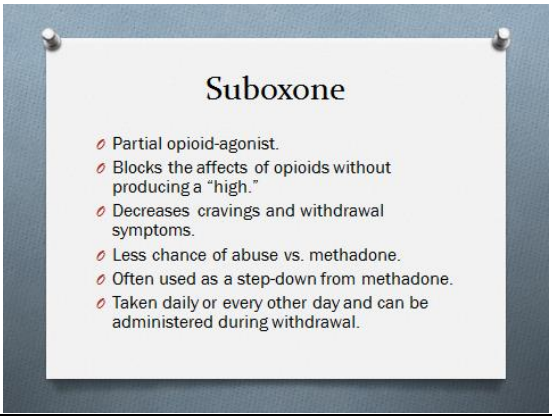


We previously talked about three different types of medications used in MAT, now we will go a little more in depth.

Methadone:
-Full opioid agonist
-Relieves cravings and reduces withdrawal symptoms.
-With controlled use, will not produce a high – but there is a higher risk of abuse
-Must be taken daily
-Can be administered during active withdrawal.

Suboxone:
-Partial opioid agonist
-Blocks opiate affects
-Decreases cravings and withdrawal symptoms
-Often used as a step down from methadone.
-Taken daily or every other day
-Can be administered during withdrawal

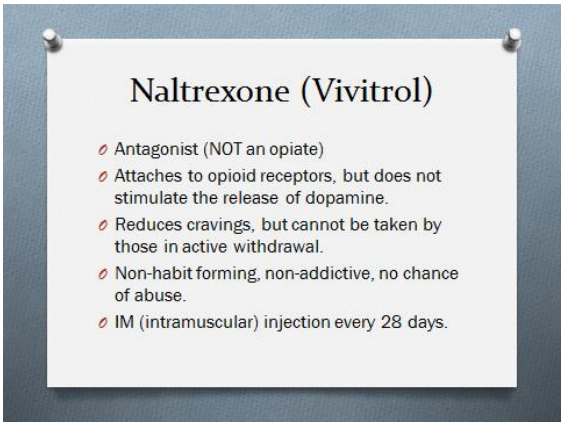


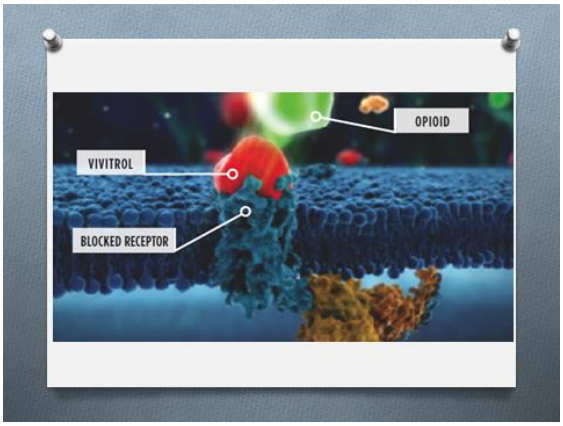


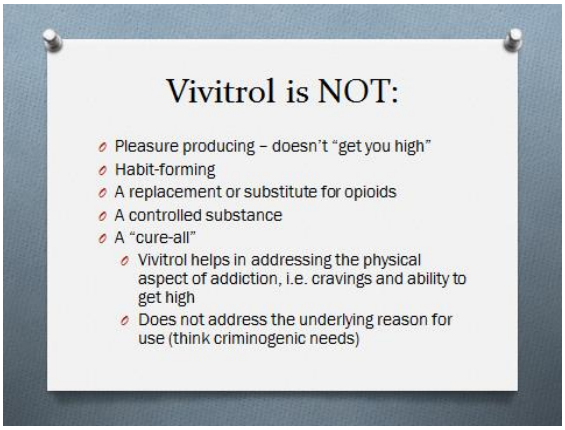
Naltrexone (Vivitrol)
-Antagonist
-NOT an opiate
-Attaches to the opiate receptors, but does not produce a high
-Non-habit forming/non-addictive/no chance of abuse
-Reduces cravings, but CANNOT be administered during withdrawal.
-IM (intramuscular) injection every 28 days.

Show and explain visual.

VIVITROL IS NOT:
-Pleasure producing (no "high")
-Habit-forming or addictive
-A replacement/substitute for opiates
-A "cure-all"
-Vivitrol helps in addressing the physical aspect of addiction
-Does not address the underlying reasons for use (criminogenic needs)

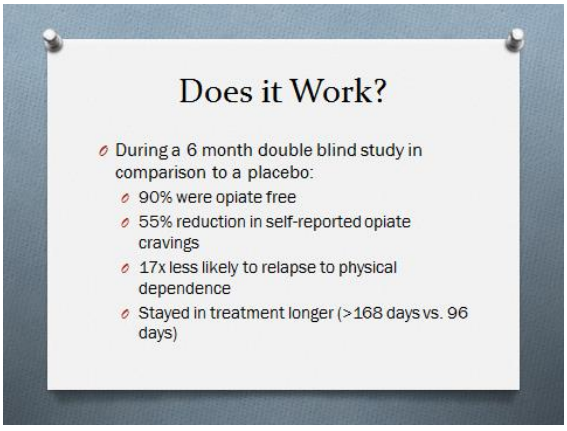






Does it work?

Read and explain study shown on slide.

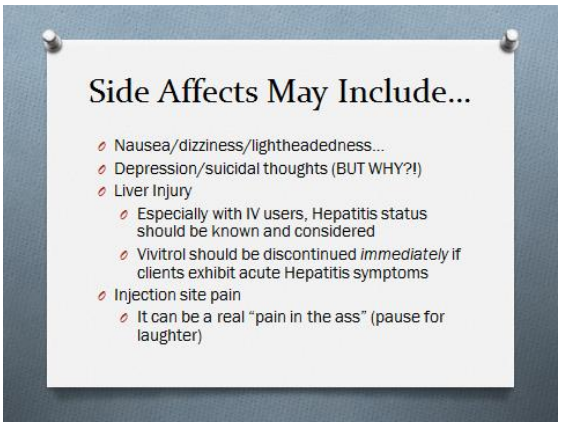


Side affects:

-Nausea/dizziness/lightheadedness
-Depression/suicidal thoughts

Inform class the Vivitrol does not cause depression. Ask why offenders may experience depression after receiving Vivitrol. Answer: They are no longer able to use drugs as a coping skill for their emotions, they now have to experience their emotions and find alternate coping skills (anti-social personality

-Liver injury – newer data indicates there is a much lower risk of liver injury than previously thought, but if an offender is exhibiting signs of jaundice or other severe liver issues, they should consult a doctor to determine if they should discontinue Vivitrol.
-Injection site pain – it is a large shot and can be painful. Offenders should ask their doctor if they experience severe or long-lasting pain, or if there is excessive swelling at the injection site.

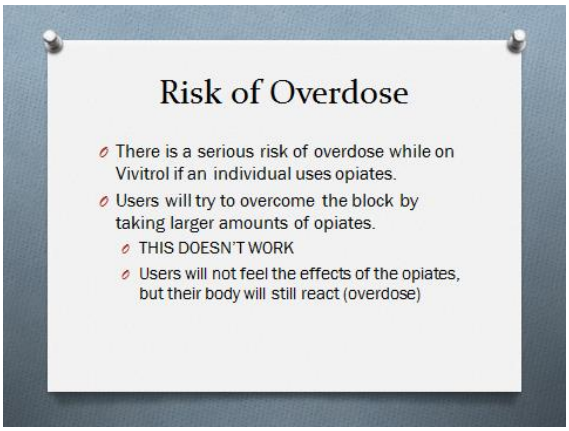


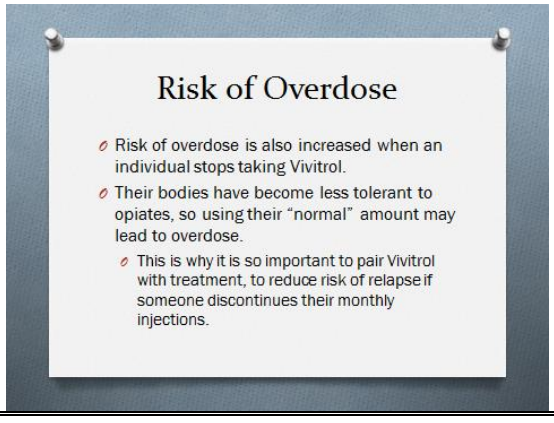
RISK OF OVERDOSE:

Risk of overdose increases greatly for offenders who use after being on Vivitrol. This happens as a result of two things: they have been sober for a long enough time that their tolerance has decreased and their previous "normal" dose may now be too much. Or, because they do not feel the effects of the drug, they make take a higher dose to try to overcome the block.

Risk of overdose is also higher when an individual stops taking Vivitrol due to the lowered tolerance.

This is why it is so important to pair the medication with treatment. Hopefully when they decided to discontinue injections, they will have had sufficient treatment and will have other coping skills to help reduce their risk of relapse and overdose.





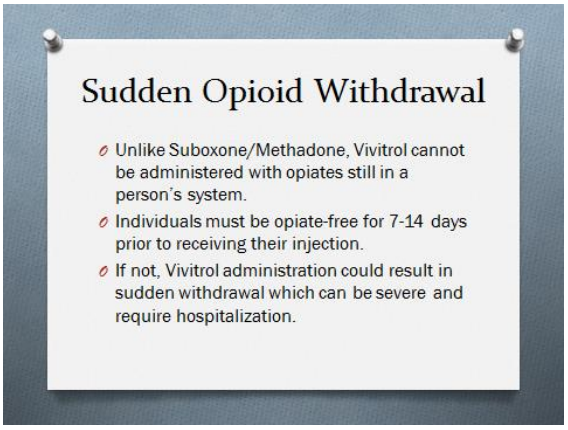
Sudden Opioid Withdrawal:

Unlike Suboxone and Methadone, Vivitrol CANNOT be administered during active withdrawal.

Initially, it was mandated offenders be clean from opiates for a minimum of 7-14 days. However, because many opiate users are unable to abstain in the community for this amount of time, injections are now able to be administered with small amounts of Methadone/Suboxone in an offender's system. This is to help reduce the amount of offenders put into custody to detox in jail.

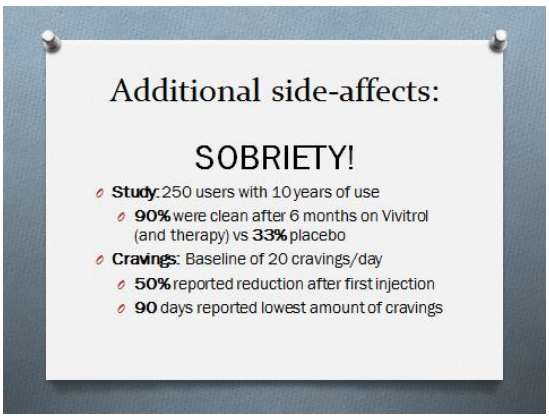
If an offender has a large amounts of opiates in their system and they receive the injection, they could experience sudden opioid withdrawal. This looks like "dope sick" but is immediate and severe – can be life-threatening.

Offenders who get the injection with the allowed small amounts of Suboxone/Methadone may experience symptoms of this, but they will not be as severe.



SOBRIETY

Read/explain study on slide.

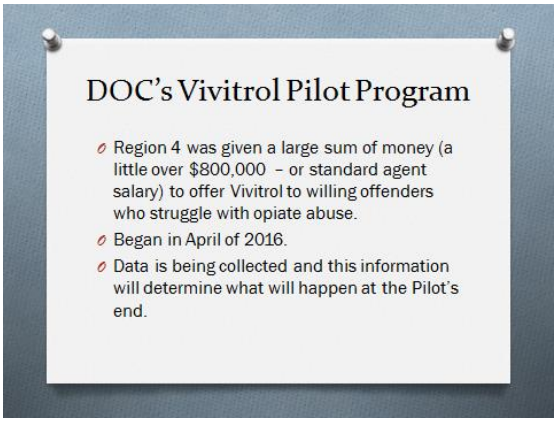


DOC Vivitrol Pilot Program:

The pilot program began in April of 2016 in Region 4. The state granted $800,000 to the region to offer Vivitrol to willing offenders who struggle with opiate abuse.

Initially, the pilot was targeted at offenders releasing from ERP, but it was modified to include those on community supervision and those releasing from medium security institution

The pilot officially ended in June of 2017, and the hope is



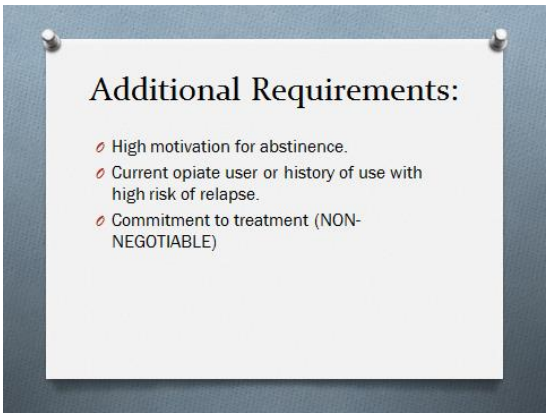
the program will be moving statewide. Wisconsin is one of the first states to use this model, and the data collected is being shared on a nationwide level.

Who can participate?

People on active supervision or releasing to supervision may volunteer to be a part of the program. DOC cannot mandate individuals being on medication, so this cannot be used as a formal ATR and cannot be made a rule of supervision.

Must have an identified opiate addiction, or history of addiction with a high risk of relapse. While Vivitrol can be used for alcohol, the DOC program is targeted specifically for those with opiate addictions.

Individuals must have a high motivation for sobriety. Those who do not will be identified quickly, as they will likely continue to use other drugs while on the shot. They must be committed to treatment, this is non-negotiable. If offenders fail to comply with treatment and do not take the conditions seriously, they will be terminated from the program.



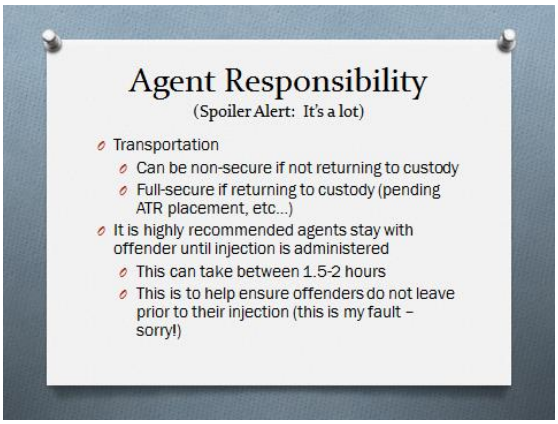
Agent Responsibility:

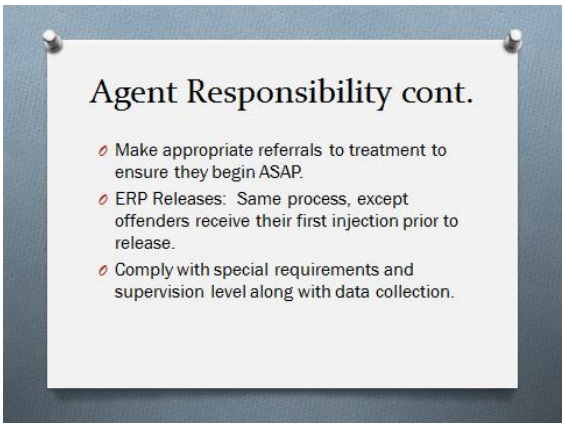
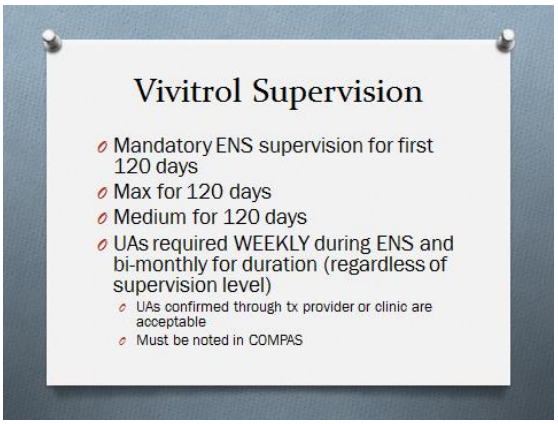
Agents are responsible for transportation of offenders to their first injection.

Discuss scenarios: In custody releasing to community, in custody and returning to custody, or out of custody

It's recommended agents stay with offenders until they receive their injection. This is to ensure offenders actually stay and receive their injections.
*Remind class this can be a scary experience for individuals, especially if they are releasing for custody and their first instinct might be to run.

Also, Vivitrol is a refrigerated injection. In order for it to be administered, it has to be removed from refrigeration and shaken to be brought to room temperature. If an offender absconds prior to receiving their injection, the drug has a very short shelf life and if it passes that, the DOC is billed



$1200 for an injection which was never received. This can also be a good time to establish professional alliance with your offender, especially if they are new to supervision and to your caseload. It is also good to meet and get to know the treatment providers in your community.	
Additional Responsibilities: Agent should be making appropriate referrals as soon as possible. Because the offender is on Vivitrol, they should be treated as a priority and there should be no waitlist for them to get into treatment. ERP/INST releases should follow the same procedures, but will receive their injections prior to release. Agent should work with the social worker and the offender to ensure this is completed and that their second and subsequent injections are arranged prior to their release to avoid any hold-ups in the community. Agents will also be expected to comply with the supervision requirements and contact standards required for offenders on Vivitrol and accurately collect and report data.	
Supervision Requirements: Make sure this is explained to your offenders. Vivitrol supervision is intensive and they should be prepared for a new level of supervision. ENS for the first 120 days MAX for 120 days MEDIUM for 120 days UA's need to be completed weekly during ENS and, at a minimum, bi-weekly throughout the remainder of their supervision. UAs confirmed through treatment providers are acceptable, but should be documented in COMPAS.	
Response to Violations: Violations should always be responded to in an evidence based manner. Staff with your supervisor to determine an appropriate response.	

Common violations include "test-runs," or offenders trying opiates one last time to see if the injection work. There has also been an increased use in methamphetamines. It is important to respond to these violations. Vivitrol should not be used as an excuse to use other drugs.

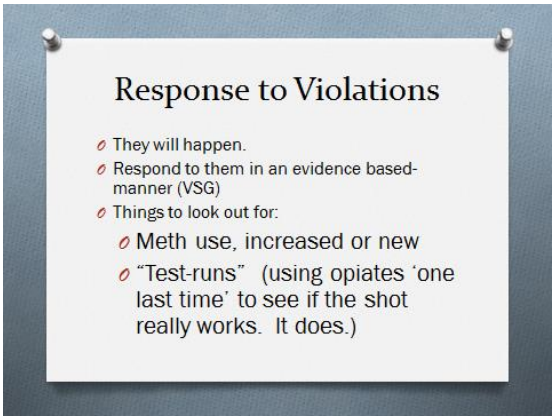
Example: An offender cannot continue to smoke weed while on Vivitrol, because "at least I quit doing heroin." This person would not be acceptable for the program because they do not have a genuine desire to be sober.

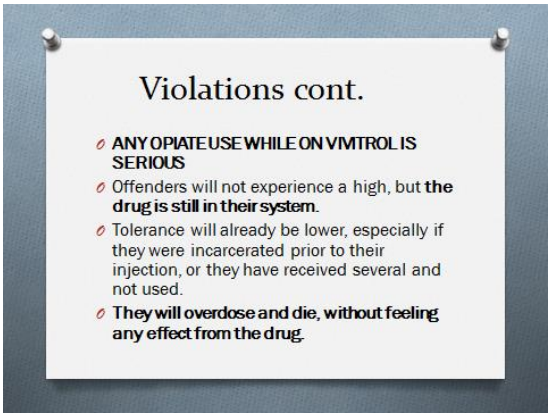
Violations involving opiates:

Due to the high risk of overdose, any opiate use while on Vivitrol is serious, and can be a serious safety issue. We already talked about why this is such a risky behavior, so what do we do?

*Ask class how they think they should respond in this situation. If the answer is to take them into custody, emphasize the following:

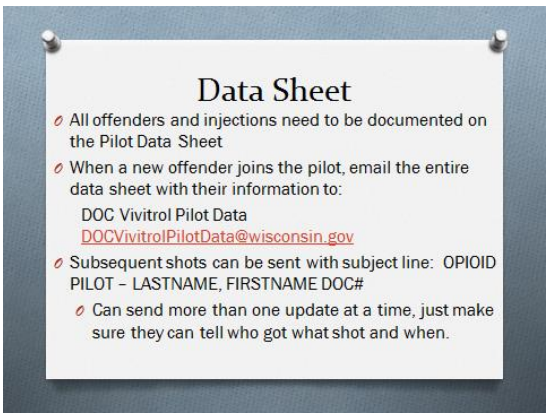
While a custody may temporarily reduce their risk of relapse, this will be pointless if they are released into the same environment after a day or two. We already know through evidence based practices this type of sanction is not effective in the long run. If an offender is placed into custody, make sure there is a good release plan to ensure they release into a situation which is less-risky than it was during their relapse (halfway house, residential treatment…).

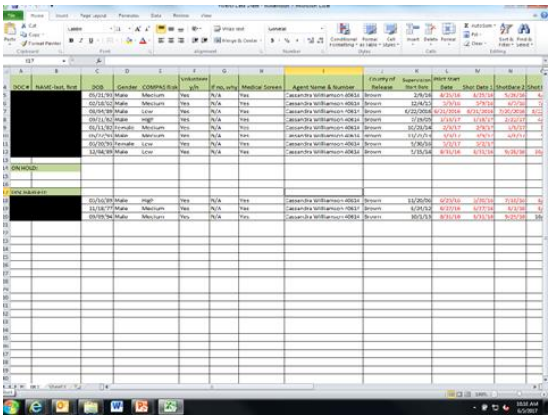
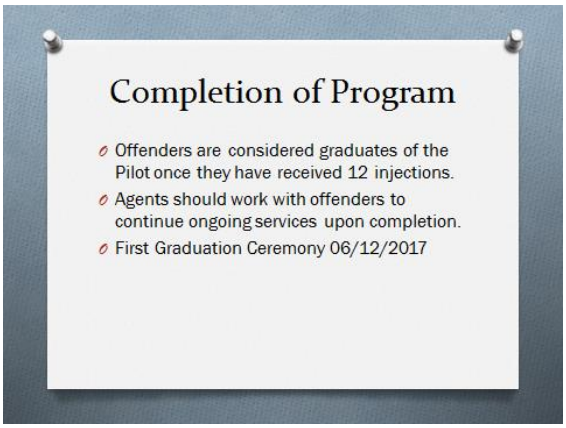




DATA SHEET:

Data is being collected and is essential to this program's future. The overall goal of Vivitrol in DCC is to ultimately reduce the number of deaths due to overdose over time. Hopefully, the data collected will indicate that use of Vivitrol over time is ultimately beneficial. This will allow the program to continue (hopefully statewide), and act as a model for the rest of the nation who are hoping to start something similar.



Show data sheet, explain it needs to be sent a an attachment every time someone new is enrolled, graduated, or terminated. Shot updates can be emailed in the format seen on the slide.	
Completion of Program: The first graduation was held on 06/12/2017. As of 03/14/2018, there have been three graduation ceremonies. Graduates are individuals who have completed the 12 months of injections. They are recognized by their agents, regional chiefs, and members of the Secretary's office.	
If there is time left, review slides with statistics on the program. Data is current as of 3/14/2018.	