Medication for Opioid Use Disorder in a Criminal Legal Setting: Recommendations from a North Carolina case study

SETTING: Jail-based program in an urban county

MEDICATIONS USED: buprenorphine, naltrexone, methadone

PROGRAM MODEL: In 2019, collaborators in North Carolina began work to implement a medication for opioid use disorder (MOUD) program at the Durham County Detention Center (DCDC) in two phases:

PHASE 1	Continue providing MOUD to incarcerated individuals who were already on the medication upon entry
PHASE 2	Initiate MOUD treatment for individuals who screen positive for opioid use disorder upon entry

Upon release, individuals can be linked to care through the local federally qualified health center.

Researchers at Duke University and the University of North Carolina at Chapel Hill conducted interviews with stakeholders involved in design, implementation, and provision of the program at the detention center. The following recommendations are based on lessons learned from these interviews.

KEY TAKEAWAYS

- Providing MOUD can help promote safety and reduce harm in a criminal legal setting
- Engaging diverse stakeholders and getting buy in from leadership is key for developing and implementing an MOUD program in a criminal legal setting
- Collaborating closely with community MOUD providers is necessary to formalize linkages to care for individuals leaving the criminal legal setting, and involving peer support can be a helpful facilitator
- Providing ongoing education on MOUD and harm reduction principles is a useful way to start addressing stigma related to substance use for both the jail staff and individuals involved in planning and implementation
- MOUD program protocols should include procedures for data collection and take into account the extra federal restrictions involved with providing methadone
- Identifying long-term funding sources is necessary for sustainability of an MOUD program

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This project was part of the Duke Opioid Collaboratory, funded by The Duke Endowment and administered through the Duke School of Medicine Department of Population Health Sciences. The Collaboratory convenes diverse partners to save lives, reduce stigma, and mitigate the harmful impact of drugs through the development, implementation, and evaluation of system-level interventions.

RECOMMENDATIONS

Assessing the context—Existing resources

Before starting an MOUD program in a criminal legal setting (CLS), it is important to assess what local resources are available, especially for individuals post-release. Even in settings with fewer options for MOUD, behavioral health, or support for other drivers of health, programming can be scaled to fit a community's current stage of readiness. For example, in a community that does not have an established relationship with a local accredited and certified Opioid Treatment Program (OTP) qualified to dispense methadone, implementing a program that provides forms of MOUD that can be administered directly at the corrections facility has tremendous safety and quality of life benefits for incarcerated individuals being treated for opioid use disorder (OUD). In addition, in areas with fewer MOUD providers, programs that utilize telemedicine and group visits for MOUD care can help increase local capacity to care for individuals with OUD being linked to care post-release.

In states where Medicaid has not been expanded (like North Carolina), linking individuals to care post-release is a challenge. Building partnerships with local federally qualified health centers and hiring peer navigators or community health workers to support uninsured individuals in accessing affordable care and available financial support is critical. The University of North Carolina at Chapel Hill's Formerly Incarcerated Transition (FIT) program is an example of a program that addresses this challenge by leveraging partnerships with local programs, hiring community health workers with a personal history of incarceration to connect individuals to appropriate health care services post-release, and providing vouchers to help cover any costs associated with care.

> *Peers could be internal and external, so they would be able to connect with individuals while they're in the [corrections facility] and then when they are discharged, be able to follow them into the community, help work through any of social determinants, and make sure [the individual is] securely connected to services.*

Investing in local programs that distribute naloxone in the community and to individuals who are incarcerated can help prevent overdose and enhance safety especially for individuals leaving CLS.

Identifying and engaging project champions

It is important to identify champions that can advocate for the importance of MOUD in CLS and help design and implement a program that incorporates lessons learned from other CLS that provide MOUD, yet is tailored to a community's specific resources. Some helpful champions may include leadership within the CLS, local MOUD providers, and individuals with prior experience implementing MOUD in CLS or with other local programs that provide supportive services to individuals during and post incarceration.

> *Having people who can bring in expertise from having been at other places [implementing MOUD] has been wonderful. It's these champions who have an external perspective that provide that vision of what can be done and what should be done.*

Developing an implementation team

Funding and time should be specifically devoted to bringing together diverse stakeholders to build relationships and engage in the planning and implementation of MOUD in a CLS. Scheduling formal, facilitated meetings to discuss challenges and solutions, identify next steps and action items, and follow up on progress is an important way to keep stakeholders engaged and accountable and maintain momentum.
Some important stakeholders to consider engaging in this work include:

- Individuals with lived experienced related to incarceration and substance use
- Corrections facility staff and leadership including the county sheriff
- The health care provider for the corrections facility
- Community Corrections or other local organizations charged with supervising individuals on probation, parole, or post-release supervision

- Local physicians and community MOUD providers, and federally qualified health centers
- Local and state public health and social services agencies, including individuals working in injury and violence prevention, epidemiology, and surveillance
- Local organizations that provide support for drivers of health such as food and housing
- Local harm reduction and direct service organizations, including syringe services programs
- State Opioid Treatment Authority
- Local university researchers, especially with grant writing or evaluation experience

> *There's always the level of being uncomfortable when you're doing something that feels new. You have to learn new vocabulary. You have to meet new people. You have to develop different relationships and contacts that maybe you aren't as familiar with, or as used to having to trust.*

Building a strong, diverse team is critical for maintaining momentum when implementing MOUD in the CLS. Because some important stakeholders may be elected to their position and job turnover can happen in all sectors, it is important that efforts are not reliant on only a few key champions in the long term. This also means that education and efforts to maintain buy in must be ongoing.

> *Ideally, we would have a system that was robust and not vulnerable to any lapses when people leave. If the sheriff were to be not re-elected, or if [our champion in the corrections facility] retired, would the project continue to go? How do you maintain projects, especially really important ones like this, in those circumstances?*

Obtaining buy in

Obtaining buy in from stakeholders is an important step that requires education and training aimed at reducing stigma against people who use drugs or are engaged in MOUD and promoting harm reduction principles that emphasize respect for individuals who use drugs. Providing ongoing training for jail staff and convening facilitated stakeholder meetings that provide space for discussions that address hesitance to support MOUD can be key opportunities for building connections and understanding.

> *I think, when are the times that I've changed my language or changed my mind? They haven't been when I was confronted as much as when I was exposed to other information.*

Messaging and advocacy for MOUD in CLS should emphasize that MOUD is an essential medicine for individuals with OUD, and for individuals already receiving medication, forced discontinuation is destabilizing, dangerous, and potentially life threatening. The following points may be helpful to include in messaging.

MOUD is an evidence-based treatment for OUD. Providing MOUD in a CLS setting will help reduce harm for individuals with OUD and can be protective against overdose.

> *For those individuals that come in [on MOUD], being able to continue on their medications helps with reducing the overdose risk, helps them not have to go through those severe withdrawals, and [without it] means they have to restart once they are released. Research has shown that those individuals who enter the detention center and go through detox, and then are released, have a higher rate of death because of an overdose.*

> *If we know that an individual is wanting treatment and is at higher risk of overdose, this is an opportune time to offer [MOUD] as an intervention, to start them on treatment, and transition them to care afterwards. Hopefully, that enables them to get on the path to recovery and perhaps even address some of the reasons they came into the detention center.*

SUD should be addressed with evidence-based treatment like any chronic illness.

> *If you want to change the dynamic of people with opiate use disorder being treated fairly and equally as a medical problem, then in a corrections facility, you should be getting your medication (MOUD). You're going to get your cardiac medication, your blood pressure*

medication. There's no reason that the most evidence-based, recommended practice (MOUD) is not continued medically.

Evidence suggests that implementing MOUD in CLS does not increase diversion of controlled substances.

Looking at the way MOUD would be administered, there is very little opportunity for diversion. Findings from [another criminal legal setting that implemented MOUD] even showed that contraband significantly decreased [when MOUD was provided]. Because when you're offering MOUD, there's less motivation for it to be illegally diverted or passed through the facility.

Initiating people on MOUD in CLS is not likely to overburden the local health system when individuals are linked to care post-release.

I think leadership at federally qualified health centers can definitely be wary of signing on to be a part of any new project. But ultimately, all they were going to have to do [to support the linkages to care post-release] was just provide the patient care that they were already providing.

When there is a consistent standard of care for providing MOUD in CLS, interruptions in care becomes less of a challenge when individuals are transferred between facilities.

That is the other challenge, what is the likelihood of this individual being transferred to another county jail and would they be able to continue this medication there? If that wasn't a barrier, then I think that there would be perhaps less hesitancy.

Ultimately, withholding treatment or medication can be a legal or liability issue.

There's a treatment that's effective and it's an illness that should be given treatment. Why would you be denied [MOUD] treatment, in any setting? It would seem to be a violation of the Eighth Amendment and the Americans with Disabilities Act, the same as providing treatment for diabetes.

Delivery of treatment

Intake and assessment are two key points of contact with individuals entering a corrections facility that will require clear protocols and staff training when implementing MOUD. Workflows will need to incorporate screening all individuals for OUD or current MOUD prescription, and for individuals who screen positive, assessment of withdrawal and severity of OUD, timely linkage to a medical provider within the facility and, for individuals currently on MOUD, coordination with their provider they visit in the community. Current MOUD prescriptions may be able to be confirmed by checking Prescription Drug Monitoring Programs (PDMPs) such as the NC Controlled Substance Reporting System (CSRS), a state-run database of all controlled substances prescriptions dispensed in outpatient pharmacies across North Carolina.

Developing protocols for providing methadone in a CLS setting requires extra considerations given the federal restrictions, however, including methadone as a MOUD option is essential for providing quality care. CLS interested in providing MOUD should involve stakeholders from local OTPs from the beginning so that provision of methadone is incorporated in all planning activities. It is also possible for corrections facilities to become an OTP so they can administer and dispense FDA-approved MOUD medications on site. While this may come with more bureaucratic hoops, it can streamline the process for providing individuals with access to MOUD, especially methadone.

Care coordination and linkages to services post-release

Linkages to care post-release require formal partnerships with community MOUD providers and effective coordination. Involving community providers in planning of the program can help ensure that the plan for linkages to care is realistic and tailored to your specific context.

Be prepared to provide care for the "whole person." Individuals who are incarcerated and being treated for OUD may also need support for other chronic illness and/or pain, behavioral and mental health, polysubstance use (if the individual identifies this as a personal concern), and drivers of health like housing, transportation,

and employment post-release. When establishing relationships with community providers and developing an implementation team, it is important to remember that individuals may need to be linked to affordable care and supportive services beyond MOUD.

Funding for staff to support linkages to care like peer support specialists and bridge counselors is an important budget item to consider in planning for a MOUD program. Peers with lived experience can support individuals through the re-entry process and navigating the health system, and bridge counselors can follow up with individuals post-release to check whether they have been able to connect to needed care and provide support for barriers they are experiencing to accessing care.

> *It seems like the peer support could potentially play a huge role in terms of helping bridge that communication gap between the patient and [community provider] or between the jail and [community provider]. If the patient does have to leave the jail suddenly or doesn't have an appointment in place, but [the peer] is able to check-in with the patient and [the community provider] to set up an appointment or figure out what the patient's needs are, I think that that would make a huge difference.*

Data monitoring and evaluation

Developing a data monitoring and evaluation plan should be a component of program planning so that reach and impact can be measured and used to advocate for further support of MOUD in the CLS. Some important measures to capture include number and demographics of individuals continued and initiated on MOUD, and if possible, outcomes post-release such as linkages to care, overdoses and emergency department admissions, and rates of rearrest among individuals who received MOUD while incarcerated.

Programs should conduct ongoing evaluation of the MOUD program to support continual improvements and adjustments. Formal evaluations of the program can also be useful for identifying lessons learned that can be shared with other CLS interested in implementing MOUD. Monitoring demographics of individuals involved in MOUD in a CLS can help identify disparities in which individuals are being offered MOUD continuation and initiation. If disparities are identified, this can be an opportunity for more implicit bias training of staff involved in intake and assessment and for review of intake and assessment procedures or tools.

> *Look at the numbers and the data on racial demographics and access [to MOUD in the jail]. If there is a disparity in that, what are the factors that are causing that disparity? What implicit biases are we bringing to the screening and assessments?*

Funding and sustainability

Grant funding is a useful way to start planning and implementation work for MOUD in a CLS, however finding long-term funding sources that allow for greater flexibility in spending is key for sustainability.

Implementation teams should have a designated member whose formal job responsibilities include identifying and applying for grant funding. Partnering with local institutions with experience in grant writing, such as local universities, can also be helpful for navigating the application process.

In the long term, program data that highlights the impact of MOUD programming can be a useful tool to advocate for inclusion of MOUD programming costs in county or state budgets or to secure more sustainable funding sources.

Impact of COVID-19

With the burden COVID-19 has put on CLS, implementing MOUD may become lower priority. However, with significant increases in rates of overdose during the pandemic, providing access to MOUD for individuals who are incarcerated is more urgent than ever.

Strategies to Address Common Challenges

Working with stakeholders that have been involved in the design and implementation of MOUD programming in other CLS is a useful way to learn about potential challenges and solutions, so an appropriate model of MOUD can be adapted for your specific setting.

CHALLENGE	POTENTIAL SOLUTION
Getting key stakeholders and leadership engaged and supportive of MOUD	• Invite diverse stakeholders to the table and ensure time and funding is devoted to relationship building • Facilitate formal stakeholder meetings regularly that generate action items and follow up on progress • Consult with stakeholders with experience implementing MOUD in other CLS
Stigma and misinformation about substance use and MOUD	• Train stakeholders and corrections staff on MOUD and SUD focusing on harm reduction principles on an ongoing basis • Organize facilitated meetings to make space for ongoing conversations to address hesitance around MOUD • Engage local harm reduction stakeholders and people with lived experience in planning and implementation
Difficulty individuals may experience navigating process to access services post-release	• Fund peer support specialist positions to support individuals leaving the corrections facility in the linkage to care process • Fund bridge counselors to follow up with individuals post release and if necessary, help them reengage in care
Lack of health insurance and cost of health services for individuals post-release	• Partner with local federally qualified health centers that work with uninsured patients • Do your research – are there programs in your area that provide financial support for MOUD or other health care? • Hire peer support specialists to help individuals navigate linkages to care and identify affordable care options
Availability of MOUD providers in the community	• Partner with local providers and explore options for telemedicine or group visits to maximize capacity • Tailor your program to the MOUD resources available in your community
Sustainable funding for MOUD programming (especially staffing)	• Partner with local universities or other organizations with grant writing and evaluation experience • Involve local and state level stakeholders from public health and social service agencies in program planning • Collect program outcome data to help advocate for the program budget to be included in county or state budgets
Regulations around providing methadone as an option for MOUD	• Partner with local opioid treatment programs (OTPs) that can provide methadone to individuals in the corrections facility • Tailor your program to the OTP resources available in your community • Work with stakeholders from your State Opioid Treatment Authority to understand whether your facility could become an OTP
Transferring of incarcerated individuals to other facilities that may not provide MOUD	• Advocate for standardized requirements for providing MOUD in CLS throughout your state and the country • Share successes and lessons learned from your program to support other CLS implementing MOUD
Shifting priorities during COVID	• Share data on local overdose rates and program outcomes to advocate for the importance of providing MOUD in the CLS