Bringing Medication for Opioid Use Disorder to Individuals Involved in the Criminal Legal System in North Carolina

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BACKGROUND

• Individuals with recent criminal legal system (CLS) involvement are at especially high-risk of overdose death during community re-entry and are 40 times more likely than the general population to die of overdose (Ranapurwala, Shanahan et al, 2018).
• The COVID-19 pandemic has compounded the overdose crisis further, with spikes in overdose deaths in the general population and concern for the safety of individuals released in accordance with COVID-19 recommendations. (CDC, 2020).
• Because medication for opioid use disorder (MOUD) is the most effective evidence-based approach to address opioid use disorder (OUD) (Connery, 2015), implementing MOUD programs in CLS settings is a vitally important tool for preventing overdoses and opioid-related deaths.
• In 2019, stakeholders in Durham County, North Carolina began work to implement an MOUD program at the Durham County Detention Center (DCDC) in two phases:
  - Phase one: Screening all individuals for OUD, allowing individuals who come into the facility for short-term stays to continue their MOUD regimen (Suboxone, Naltrexone, Methadone).
  - Phase two: Screening all individuals for SUD, initiating individuals on MOUD who come into the facility for short-term stays and screen positive for opioid use disorder (if they are interested in starting medication).
• Phase one of the program began September, 2019 with plans to roll out phase two delayed by the COVID-19 pandemic’s significant impact on correction settings.

METHODS

Collaboration between stakeholders: Engaging with diverse stakeholders and formalizing relationships through community task force meetings has been an essential but challenging endeavor among necessary partners. The Durham Joins Together Task Force has three sub-committees that focus on prevention and education, mental health treatment, and data and policies.
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, to rolloff phase two delayed by the COVID-19 pandemic’s significant impact on correction settings.

Stigma and resistance to MOUD: Stigma and objections to MOUD are still prominent barriers to engaging in this work, and getting stakeholders on board often requires education on MOUD and harm reduction principles.

As far as stigma... in a detention center, there are certainly individuals that were trained in an abstinence-based philosophy, and so, [to them] providing MOUD was simply replacing a drug for a drug... and there’s [some] that don’t understand MOUD; that simply think that it’s something that is ultimately going to harm the person... You have to learn a new vocabulary.

MOUD continuation: MOUD is an essential medicine for individuals with OUD, and for individuals already receiving medication, forced disconnection is demobilizing and potentially dangerous. Providing MOUD in a CLS setting will help reduce harm for individuals with OUD.

I think continuation is just sound medical practice. You know, [AUD] is the only health concern that folks are coming into correctional spaces and there is a discussion. Or there has to be a program to address it. Nobody ever does that with blood pressure medication. Anti-epileptic medication, that just doesn’t happen. It doesn’t have to be a program. It doesn’t have to be stakeholders. It doesn’t have to be a big study around it. We just know that is the medically sound thing to do.

PRELIMINARY FINDINGS

PRELIMINARY FINDINGS CONTINUED

Data management: Formalizing the data collection process to better measure impact of the program is an important part of developing an MOUD program and should include thinking through who will be responsible for data collection and what platforms are available for management of the data.

Methadone provision: Developing protocols for providing methadone in a CLS setting requires extra considerations given federal restrictions on distribution; however, including methadone as a MOUD option is essential for providing quality care. The DCDC is considering becoming an Accredited and Certified Opioid Treatment Program (OTP) so they can administer and dispense FDA-approved MOUD medications on site. While this may come with more bureaucratic challenges, it could streamline the process for providing individuals with access to MOUD, especially methadone.

Linkage to care: Continuation of MOUD post-release requires formal partnerships with community MOUD providers and effective coordination. Involving peers with lived experience in this transition is a useful way to support individuals through the re-entry process and in navigating the health system.

With transition to phase 2, the protocol for linking individuals to care will require that individuals initiated on MOUD in the detention center establish a key success in using an MOUD provider in the community.

COVID impact: CLS settings have been heavily impacted by COVID-19, which required resources and energy to be shifted to responding to the crisis. The DCDC has been able to continue phase 1 during the pandemic, but initiation of phase 2 has been delayed.

Funding challenges: While grant funding allowed the DCDC to develop and implement the MOUD program, finding long-term funding sources that allow for greater flexibility in spending is key for sustainability.

I think, partly financially, we’re just piecing this thing together with a series of grants. And I think my feedback to the state would be, we need some kind of a longer-term commitment, so not just starting up on its feet and starts, and doing a three-month grant here, and then you have to find more money to go for another nine months... It’s not the way I would pay my mortgage, you know?... I need something a little more long-term before I’m going to sign those papers.

Leading by example: The DCDC’s experiences developing the MOUD program can serve as an example for how to get leadership buy-in, convene stakeholders, mobilize resources, and design protocols for an MOUD program and provide guidance for other CLS settings.

I think the impact that the Durham Detention Center has had is statewide because [it] has shown that this can be done, the importance of it being done. I think [it] has put pressure on the other detention centers around the state to be able to offer this as well, but it was a part of the larger conversation with all of the sheriffs around North Carolina.

CONCLUSIONS

• Engaging diverse stakeholders is key for developing and implementing an MOUD program in a CLS setting.
• Providing ongoing education on MOUD and harm reduction principles to stakeholders is a useful way to start addressing stigma related to substance use.
• Providing MOUD contributes to safety and reduces harm in a CLS setting.
• MOUD program protocols should include procedures for data collection and take into account the extra federal restrictions involved with providing methadone.
• Collaborating closely with community MOUD providers is necessary to formalize linkages to care for individuals leaving the CLS setting.
• Involving peer support can be a helpful facilitator for linkages to care.
• Identifying long-term funding sources is necessary for sustainability of an MOUD program.

ACKNOWLEDGMENTS

We would like to thank the community partners who greatly contributed to this work, including Eljah Bazmore and the Durham County Detention Center.
This project is supported by the Duke School of Medicine’s Opioid Collaborative, administered through the Department of Population Health Sciences. The Collaboratory’s mission is to save lives and reduce the harmful impact of opioids in North Carolina through the development, implementation, and/or evaluation of system-level interventions.
This research project was funded by the Duke Endowment.

REFERENCES