MOUD in Corrections: Moving to Implementation Notetaking Template – Breakout Rooms

Day 1 1/26/2020
Room name: 1A: Unsure or interested, but haven't started yet

Questions asked:

1. Do we need the permission of the individual to provide MOUD? (Sugrim Singh, FL) – Shannon discussed the right of autonomy and that MOUD cannot be forced upon a person and the importance of having a meaningful assessment and education process so individuals can understand why MOUD is being recommended.

Discussion themes that arose:

Things that worked or are in progress for those who started implementation:

- Finding a strong advocate for the program
- Education for individuals that are in the justice system and their concerned others
- Phased rollout/pilot programs across related systems

Barriers to implementation:

- Lack of motivation for change until force by legislation
- General lack of knowledge of the purpose and process of MOUD across various sectors and stakeholders
- Diversion

Summary (a brief description summarizing key points that came out of interactive breakout session):

General Group Knowledge

The majority of the participants in the group were attending the conference to increase their general understanding of MOUD. They appreciated the opportunity to learn during the conference.

Community Networking and Resources:

There was much discussion around the need to connect with community providers and plan for re-entry and continue MOUD in the community. Accessibility of prescribers in the community was of particular focus (accessibility in turns of availability and geographic location).

Important relevant stakeholders were discussed including but not limited to legislature, referral resources, mentors that have already implemented MOUD, probation and parole officers, Medicaid experts, and peers in recovery. There was discussion on the importance of widespread education for these groups, dispelling myths, and fighting stigma.

Understanding the Need:

There was discussion about how to understand the needs of the individual and the community in terms of the provision of MOUD. This included how individuals are identified as a candidate for MOUD (self-reporting vs. clinical assessment). How do OUD rates vary from other SUDs? How do OUD rates in prisons vary from the community?

The history of the individual and their MOUD preferences are also important to take into consideration. Has the individual received MOUD in the past? Do they have a medication preference? If yes, can that preference be met?

MOUD In Corrections: Moving to Implementation Notes for Breakout Rooms

Day: Tuesday, January 26th,2021

Challenge/Barrier of Focus: Breakout room 1A: Unsure or interested, but haven't started anything yet

Questions Asked:

- How do we prevent risk of overdose for inmates who were previously on MOUD and violated probation/parole, and were sent back to jail (since most jails only detox inmates and don't provide MOUD)? How do we communicate with jails that inmates were previously on MOUD?
- How do we assess client history, how is that incorporated into our work, and and how do we refer to providers in the community?
- What are the barriers to implementing MOUD in your state/county systems?
- Who will cover the costs of transferring clients out for MOUD and who will distribute the meds if you do not provide in your system?
- What stakeholders are needed at the table when planning for your MOUD program?
- What are your policies around U/A testing?
- In thinking of re-entry for your clients, do you know the providers in your area, what meds they provide, what is their service population, and eligibility requirements?
- Can MOUD be used where you are and if no, why?
- In thinking of phased roll outs, how do you look at the cultural and structural differences in your institution and modify if you are replicating other systems? What are the barriers to replicating the program when looking at different regions in your state or county?
- How do you coordinate MOUD between prison/jails, and probation/parole?
- How much mapping of the MOUD process have you done?
- One attendee asked, do inmates need to volunteer for MOUD and how do you educate the inmates and their families regarding MOUD treatment?

Discussion Themes That Arose:

- Some prisons in their system were concerned about diversion in the beginning of the MOUD implementation discussion.
- How stakeholders/champions are important in starting a MOUD program.
- Where to find funding for the program.
- Not all systems provide all three types of MOUD and how does this impact the inmate when referred to an outside provider upon release, if their medication is changed.
- Education regarding MOUD and how it works. Needed for inmates and their families as well, since some family members discourage its use. Needed for corrections staff as there may be stigma around MOUD as just substituting one opiate for another, worry about diversion, and not understanding OUD as a chronic, relapsing, disease. There also needs to be education in the CJ systems as to who the MAT providers are in their areas and how to make referrals.

- Phased roll outs in certain regions. If there are cultural or logistical differences from region to region, you can discuss these, look at the barriers, and come up with a specific plan for each region to implement MOUD.
- How to identify clients who can best be served with MOUD treatment.
- Are systems capturing data points and if so, what are they looking at. Some attendees stated they are being captured but not tracked.

Summary (a brief description summarizing key points that came out of interactive breakout session):

- CJ systems need to look at client assessment (who does the assessment, what tools do they use, eligibility and what that means for continuation of services upon release, what are the client's options for transitioning).
- Each system must address their barriers to implementing MOUD (ex. Fear of diversion, lack of education regarding MOUD and how it works for inmates, their family, and corrections staff, lack of buy-in from corrections staff and inmates, lack of funding and how to obtain)
- Need better communication between systems (prisons, jails, probation, parole, medical providers, community providers, police, EMS, ER docs, medical examiners).
- Address who should be at the table for your implementation planning and to bridge systems (state legislators, corrections line staff, medical providers, probation/parole staff, court staff, community providers).
- For phased roll outs in regions, look at other regions plans and barriers to your region. Discuss modifications to make the program work in your region.
- Important to assess how to measure and track key data points to see if your program is beneficial to all clients and see where the gaps are. Helps to understand the scale and scope of OUD in your system and the community. Helps to justify need for funding for MOUD program.
- Build a repository of MOUD providers in your community and include what meds they provide, what are client eligibility requirements, what other services do they provide (ex. Counseling, CBT). Share this with other areas in your system (ex, probation, parole, court) so they have access to these referral resources as well and explain the referral process.
- Important to think about providing MOUD choices to clients based on what the community providers can offer.
- Need a good communication plan between all services/facilities (Jail, prisons, probation, parole, court, community providers) to prevent risk of overdose upon release.
- Need to look at how each system uses UA testing and the policies and procedures. Advocate against testing and if it is used, be aware of the implications. What does a positive test mean for probation/parole and if they are revoked and person goes back to prison/jail, how do you communicate as to what MOUD they were on? If they are detoxed, how do you prevent risk for overdose? If test comes back negative, how do we ensure in the assessment process that the person may be using infrequently, and if the drug is out of their system be aware that they may test negative, but they still may want access to treatment.
- Look at the challenges (organizational buy-in, cultural challenges, client engagement challenges, operational challenges, continuity of care challenges).