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

Day: 2 1/27/21
Room name: Logistics & Operations

Questions asked:

County jail – has planning grant – how is eligibility determined?

> Now – through drug court, so referral / eligibility is already determined. As we think about expanding, not sure how we will handle eligibility determinations. We do use bridge MH screen and medical intake now, but will need to review medical intake form.

Do you offer all forms of MAT?

I have questions about facilities that have specific units for MAT. Is that in jails or also state DOC facilities?

> Both

Staffing ratios (security, medical) & physical plant/structure challenges

> Manpower analysis – requires research infrastructure built into system, but partnerships with local universities / graduate students can be extremely beneficial

How are people removed from the program? Bc of diversion - detox protocol, medical clearance, then go back to pod; lots of ethical and medical questions

How do you handle the assessment process on the front end after the individual has been screened by intake?

Do people have P&Ps they're willing to share?

Discussion themes that arose:

- Resistance (nuanced and overt);
- Staffing (ratios/#s/manpower; buy-in/personal philosophies);
- Identifying, mitigating diversion (coercive diversion and concentrated diversion);
- Physical structures are not conducive to therapeutic environments;
- General receptivity to the pharmaceutical nature of this approach
- Nuances of policies and practices "on the ground"

- Connections to community for soft/warm handoff
- Logistics of working with community based OTP programs; for larger jail/state doc networks building in-house OTP program
- Eligibility for treatment
- Development of withdrawal/detox protocols, particularly when folks go to SHU/RHU
- P&P/Use of recovery coaches/certified peer specialist (CPS) who can assist with therapy recovery efforts

Creativity – monitoring individuals, sitting "eye-to-eye" and give crackers and water – to manage diversion and ensure the suboxone strip is dissolved. Practical security reasons to do this (not taking officers outside the building for appts for inmates)

Identifying benefits that are attractive to leadership (i.e., mitigating security issues / chances of escape) initially and then continue to educate to create more buy-in

Lots of staff and stakeholders do not understand why MOUD / MAT is necessary – education and buy-in is key; resistance is significant – and it can be silent or explicit

Nuanced details of protocols, policies, and practices

Openness – come to the table AND be ready to listen and have a conversation
Buy-in is key – judges, sheriffs, superintendents talking in peer-to-peer networks helps too

Discrete separate MAT units – requires housing units of appropriate sizes and need to staff responsibly (trauma informed training, understanding MOUD, etc.

OTP certification for facility

Fear, hard-no's, personal/individual reactions to MAT, nuance of emotions that staff are experiencing. Silent resistance translates to lack of education and engagement

Peer Recovery Coaches / Peer Mentors

- Michigan DOC – uses peer recovery coaches (offenders who have completed SA program and are trained by DOC) – Indiana DOC does too, and they have grants for them to complete credentialling exams
- In Michigan our offenders who are incarcerated work with other incarcerated individuals.
- Medication Assisted Recovery Anonymous – similar to NA/AA but allow MAT
- There's also a national program: Certified Peer Specialist (CPS) for those with lived experience and it's a national credentialing process

Covid

- We have outside peers that come in, but during Covid they are unable to do so.
- Behavioral tx counselor / psychologist – meeting only individually w MAT participants bc of covid, no groups
- Integrated services with MAT – check in with people re: how they're feeling, is the dosage right (under or over medicated; modality) – clinical and medical monitoring of the individual's response to the medicine

CHAT

I too loved the practical and simple way they handle diversion when administering MAT. I liked how she went step by step, this is what we do. I love hearing from people who do this day to day. Very helpful.

I love that she talked about opening conversations and gaining knowledge. The stigma is so real around MOUD, substance use, and incarceration. The stigma is killing our neighbors regularly in all communities and I think it's so important to look at data, research and real-life scenarios.

Some facilities are able to isolate the MAT population in a discreet unit. this eliminated "the market" for diverted meds as everyone was getting the med, and there was not contact with people who would want to buy/coerce it.