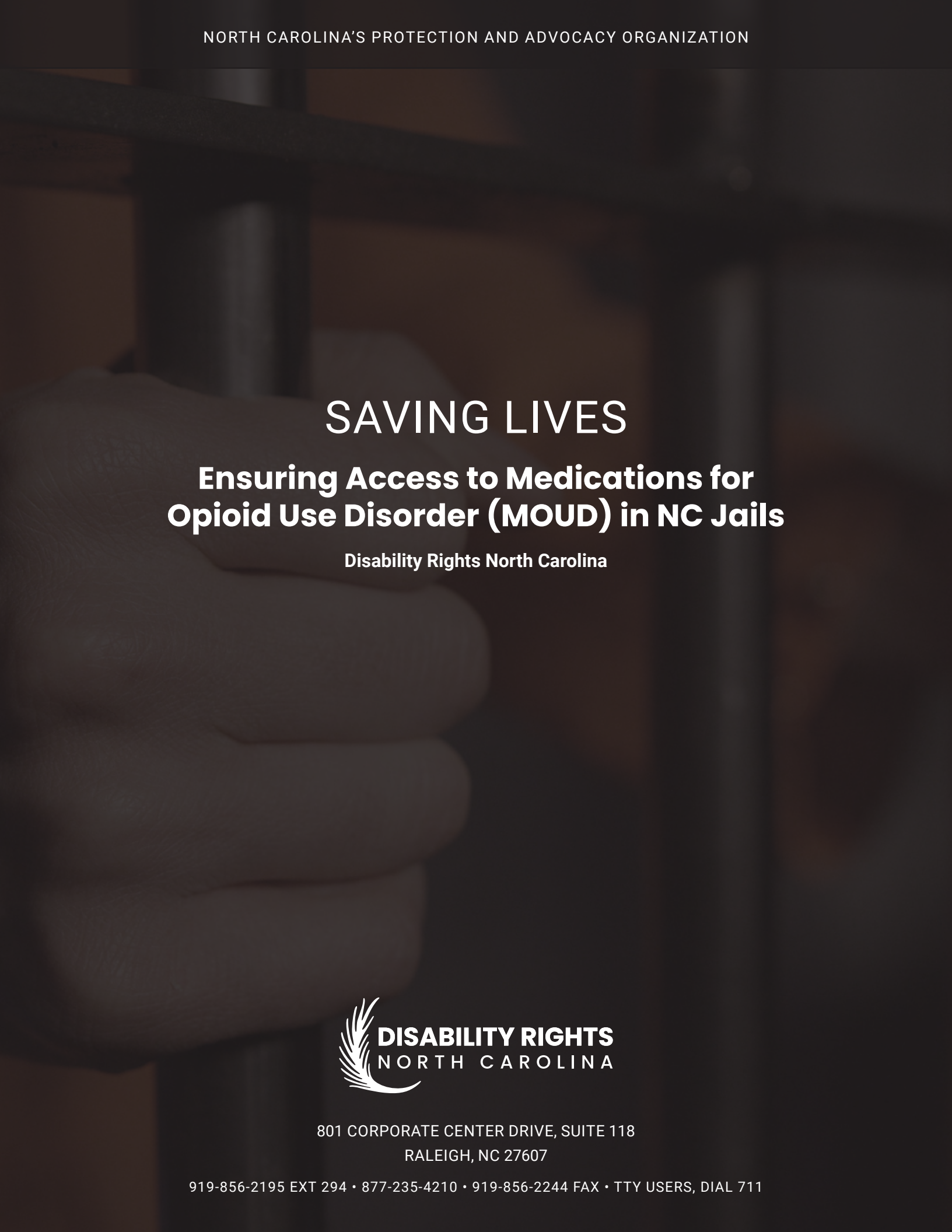

SAVING LIVES

Ensuring Access to Medications for Opioid Use Disorder (MOUD) in NC Jails

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Introduction

North Carolina is facing an overdose crisis where our loved ones, friends, and neighbors are being tragically taken away from us. These are also individuals we interact with daily in our communities, from our places of worship to our schools and workplaces. Despite having effective tools like Medications for Opioid Use Disorder (MOUD) within our reach, we're failing to provide access to them.

This extends to NC's jails. In large part due to the inadequacy of community services, people with disabilities, including those with Opioid Use Disorder (OUD), are overrepresented in NC jails and prisons. In 2023, Disability Rights North Carolina (DRNC), the state's Protection and Advocacy organization charged with safeguarding the legal rights and lives of nearly 3 million North Carolinians with disabilities, began an in-depth look at the availability of MOUD in NC jails.

OUD is not merely a personal struggle; it's a medical condition and a disability. There are legal bases to require that MOUD be provided to people with OUD in our jails (and prisons): the US Constitution and the Americans with Disabilities Act (ADA). Under the ADA, people with disabilities are safeguarded from discrimination. Denying access to medications for treating OUD is a form of discrimination.

DRNC, a leading advocate for people with disabilities, has federally granted access authority to obtain information affecting disabled people who are jailed in all North Carolina's 100 counties. As DRNC gathered information, we also provided education and information to people with disabilities who experienced discrimination and to the sheriffs, their staff, other county employees, and community providers.

There are three FDA-approved medications designed to address OUD, with methadone and buprenorphine emerging as the most effective. Methadone and buprenorphine not only treat the disorder – they also significantly reduce the risk of fatal overdoses and the return to illicit drug use and increase the likelihood of remaining in treatment. By providing access to these medications, we offer individuals struggling with OUD the chance to heal and rebuild their lives. Denying them this opportunity is to rob them of a future that's within their grasp.

Jails have a unique opportunity to provide access to critically needed MOUD and have a major impact on NC's overdose death crisis. While some jails are providing this lifesaving treatment in their facilities, others are not. Providing these medications is a best practice for our communities and puts NC on the right track to stop the overdose death crisis.

Our report **Saving Lives: Ensuring Access to Medications for Opioid Use Disorder (MOUD) in NC Jails** provides a detailed look into the issues of opioids and MOUD, DRNC's findings, barriers and problems within NC jails, helpful resources, and actionable recommendations for change. We hope you will read this report and join DRNC in working towards progress that we believe will save lives and make our communities stronger.

Executive Summary

The US and North Carolina are experiencing an overdose death crisis. Over 100,000 people in the US lost their lives to overdose in 2022[I] and North Carolina lost 3,875 family members, friends and neighbors[II]. Opioids, primarily illicit fentanyl, are the main driver of the overdose death crisis.[III]

National Statistics

- Nationally, opioids were involved in 80,411 overdose deaths in 2021 (75.4% of all drug overdose deaths). [IV]
- Opioids are a factor in 7 out of every 10 overdose deaths. [V]
- Opioids kill more than 136 Americans every day.[VI]

NC Statistics

- In NC, more than 36,000 people have lost their lives to overdose from 2000-2022.[VII]
- Opioids are a factor in 78.9% of all overdose deaths.[VIII]
- More people die in North Carolina of an accidental drug overdose–usually an opioid–*than from any other cause of accidental death.*[IX]

I Provisional Drug Overdose Death Counts, Ctrs. for Disease Control and Prevention (CDC), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (Jan. 7, 2024). For all overdose deaths nationally—not limited to only opioids—over 100,000 people lost their lives to overdose in 2022. Id.

II Opioid Substance Use Action Plan Data Dashboard, N.C. Dep't. Health Hum. Servs. (NCDHHS), https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard (last visited Feb. 15, 2024). Provisional 2022 data indicate that over 11 North Carolinians died each day from a drug overdose, not limited to opioids; and the rate is 38.5 deaths per 100,000 people. Id. (data pulled from the "Welcome" tab and the "Metrics" tab along the top of the dashboard).

III Nat'l. Ctr. for Injury Prevention, Understanding Drug Overdoses and Deaths, CDC (May 8, 2023), https://www.cdc.gov/drugoverdose/epidemic/index.html.

IV Nat'l. Ctr. for Injury Prevention, Drug Overdose Deaths, CDC (Aug. 22, 2023), https://www.cdc.gov/drugoverdose/deaths/index.html.

V Opioid Epidemic: Addiction Statistics, Nat'l. Ctr. for Drug Abuse Stats. (NCDAS), https://drugabusestatistics.org/opioid-epidemic/ (last visited Feb. 15, 2024).

VI Id.

VII Overdose Epidemic: Combating North Carolina's Opioid Crisis, NCDHHS, https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic (last visited Feb. 15, 2024).

VIII Opioid Epidemic: Addiction Statistics, NCDAS, https://drugabusestatistics.org/opioid-epidemic/ (last visited Feb. 15, 2024) (N.C. state data).

IX Attorney General Josh Stein, Opioid Crisis, N.C. Dep't. Just. (NCDOJ), https://ncdoj.gov/responding-to-crime/opioid-epidemic/ (last visited Feb. 15, 2024).

- On average, at least five people die from opioid overdoses every day.[X]
- Those leaving incarceration in North Carolina have a 50 times greater chance of dying from an overdose than the general population in the first two weeks following release.[XI]

Nationally, in 2020, the opioid crisis cost the US close to 1.5 trillion dollars.[XII] More important than the economic cost of the crisis is the human cost. Loved ones, friends and neighbors are being lost unnecessarily to a treatable medical condition. This devastating trend does not need to continue. Opioid use disorder (OUD) is a **treatable** medical condition that responds well to the proven and effective medications available for opioid use disorder.[XIII]

According to the National Academy of Sciences, Engineering and Medicine, "The verdict is clear: effective agonist medication used for an indefinite period of time is the safest option for treating OUD."[XIV] Agonists reduce opioid use and help people remain in treatment.[XV] Agonist medications such as methadone and buprenorphine have proven to be the most effective in treating OUD and are the standard of care. [XVI]

Recent studies found that agonist medications are key to treatment of OUD and preventing overdose deaths. One study compared 6 different treatment pathways found that only agonist medications, methadone and buprenorphine, had a 76% reduction of overdose at 3 months and a 59% decrease at 12 months; similar benefits were not found with other treatments or treatment with antagonist

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X Id.

XI Shabbar I. Ranapurwala, et al., Opioid Overdose Deaths Among Formerly Incarcerated Persons and the General Population: North Carolina, 2000–2018, 112 Am. J. Pub. Health 300, 301–302 (2022). Other studies outside of NC have also consistently found higher rates of mortality immediately after release from incarceration. See Commonwealth of Mass. Dep't. Pub. Health, An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011-2015) 49–52 (2017), https://www.mass.gov/doc/legislative-report-chapter-55-opioid-overdose-study-august-2017/download; Md. Dep't. Health and Mental Hygiene, Risk of Overdose Death Following Release from Prison or Jail (2014), https://health.maryland.gov/vsa/Documents/Overdose/Briefs/corrections%20brief_V3.pdf ; Lia N. Pizzicato, et al., Beyond the Walls: Risk Factors for Overdose Mortality Following Release from Philadelphia Prisons, 189 Drug Alcohol Depend. 108, 108–115 (2018); Ingrid A. Binswanger, et al., Release from Prison—A High Risk of Death for Former Inmates, 356 New Eng. J. Med. 157, 159–160 (2007).

XII Ahmed Aboulenein, Opioid Crisis Cost U.S. Nearly $1.5 Trillion in 2020—Congressional Report, Reuters (Sept. 28, 2022, 1:08 PM), https://www.reuters.com/world/us/opioid-crisis-cost-us-nearly-15-trillion-2020-congressional-report-2022-09-28/.

XIII Nat'l. Acad. Sci. Engineering Med. (NASEM), Medications to Treat Opioid Addiction Are Effective and Save Lives, But Barriers Prevent Broad Access and Use Says New Report, (Mar. 20, 2019), https://www.nationalacademies.org/news/2019/03/medications-to-treat-opioid-addiction-are-effective-and-save-lives-but-barriers-prevent-broad-access-and-use-says-new-report; NASEM, Medications for Opioid Use Disorder Save Lives 38 (2019), https://nap.nationalacademies.org/catalog/25310/medications-for-opioid-use-disorder-save-lives [hereinafter NASEM, Medications for Opioid Use Disorder Save Lives].

XIV NASEM, Medications for Opioid Use Disorder Save Lives 38 (2019).

XV Id.

XVI William C. Goedel et al., Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States, 3 JAMA Network Open 1, 7 (2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764663 ; see also Substance Use Prevention and Treatment Project, Opioid Use Disorder Treatment in Jails and Prisons, PEW (2020), https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/opioid-use-disorder-treatment-in-jails-and-prisons.

medications (naltrexone/Vivitrol).[XVII] Another study concluded that non-MOUD treatments provided **no protection** against opioid overdose death, but the risk was reduced following exposure to MOUD[XVIII] - in order to stop these deaths, efforts need to expand access to agonist MOUD treatment.

These medications must be made available and easily accessible to people who need them, including those who are incarcerated.

OUD is also a disability which is protected under the Americans with Disabilities Act (ADA).[XIX] In April 2022, the US Department of Justice (DOJ) provided guidance that OUD is a disability covered by the ADA, that people in jails and prisons are covered under the ADA, and that blanket policies that prohibit the use of MOUD in these facilities violates the ADA.[XX]

Recent settlement agreements in 2023 between the DOJ and jails have gone further in outlining how jails must "offer the option to all individuals with OUD booked into [the jail] to receive treatment with any FDA-approved OUD medication….including those who were not being treated with OUD medication prior to their incarceration at [the jail]."[XXI] Despite all of this, many who would benefit from these medications don't receive them. This is due in large part to stigma and moral judgments surrounding this medical condition and the medications used to treat it.[XXII] This is especially true for those in our jails and prisons.[XXIII]

XVII Sarah E. Wakeman, Marc R. Larochelle, & Omid Ameli, Comparative Effectiveness of Different Treatment Pathways for Opioid use Disorder, 3 JAMA Network Open 1, 8 (2020) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032 .

XVIII Robert Heimer et al., Receipt of Opioid Use Disorder Treatments Prior to Fatal Overdoses and Comparison to No Treatment in Connecticut, 2016-17, 254 Drug Alcohol Depend. 1, 5 (2024) ("It is also clear that risk of death associated with exposure to non-MOUD forms of treatment was no less than that for no treatment; indeed, non-MOUD treatment might have produced worse outcomes than no treatment.").

XIX The Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131–12134 (1990) (citing Title II, protecting individuals from discrimination in government programs); 42 U.S.C. §§ 12112, 12132, 12182 (prohibiting discrimination on the basis of disability); 42 U.S.C. §12102(1)-(2) (defining disability). For facilities that accept federal funding, there is also a potential claim under Section 504 of the Rehabilitation Act of 1973. See e.g., Taylor v. Wexford Health Sources, Inc., No 2:23-CV-00475, 2024 U.S. Dist. LEXIS 1187, (S.D. W.Va. Jan. 3, 2024) (citing 29 U.S.C. §§ 701, 794; Wicomico Nursing Home v. Padilla, 910 F.3d 739, 750 (4th Cir. 2018); Halpern v. Wake Forest Univ. Health Scis., 669 F. 3d 454, 461 (4th Cir. 2012)) (comparing claims under the ADA and the Rehabilitation Act and holding that claims are plausible under both laws).

XX U.S. Dep't. of Just. C.R. Div., The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery (Apr. 5, 2022), https://archive.ada.gov/opioid_guidance.pdf.

XXI U.S. Atty's. Off. E.D. Ky., U.S. Attorney's Office Announces Agreement to Ensure Access to Medications for Opioid Use Disorder at Big Sandy Regional Detention (Dec. 4, 2023), https://www.justice.gov/usao-edky/pr/us-attorneys-office-announces-agreement-ensure-access-medications-opioid-use-disorder; see also U.S. Dep't. of Just. Off. Pub. Affs., Justice Department Secures Agreement from Pennsylvania Jail to Provide Medications for Opioid Use Disorder (Nov. 30, 2023), https://www.justice.gov/opa/pr/justice-department-secures-agreement-pennsylvania-jail-provide-medications-opioid-use; U.S. Atty's. Off. D. Mass., U.S. Attorney Rollins Announces Correctional Facilities Statewide to Maintain All Medications for Opioid Use Disorder (Apr. 1, 2022), https://www.justice.gov/usao-ma/pr/us-attorney-rollins-announces-correctional-facilities-statewide-maintain-all-medications

XXII NASEM, Medications for Opioid Use Disorder Save Lives 12 (2019).

XXIII Id.

People with opioid use disorder are overrepresented in our criminal justice system, jails and prisons. It is estimated that 15% of 1.8 million people in the U.S. who are incarcerated have an opioid use disorder.[XXIV] This problem is compounded for BIPOC communities, who are more likely to face criminal justice involvement for their drug use[XXV] and are less likely to have access to evidence-based treatment.[XXVI]

Since jails are the de facto medical providers due to lack of sufficient resources in the community, these facilities have a unique opportunity to offer medical treatment that can help their communities and turn the tide on the overdose crisis. Agonist medications for OUD are associated with an estimated 50% reduction in death among people with OUD.[XXVII] This medical treatment provides stability, better retention in treatment, and better outcomes for people with OUD.[XXVIII] Jails can help those in custody and their communities and comply with anti-discrimination laws by introducing MOUD to those not already in treatment and continuing MOUD for those who were already in treatment in the community.

XXIV Ashish P. Thakrar, G. Caleb Alexander, & Brendan Saloner, Trends in Buprenorphine Use in US Jails and Prisons From 2016 to 2021, 4 JAMA Network Open 1, 1 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8672225/.

XXV Johns Hopkins Bloomberg Sch. of Pub. Health, Principle #4: Focus on Racial Equity, https://opioidprinciples.jhsph.edu/focus-on-racial-equity/ (last visited Feb. 15, 2024) ("Black individuals represent just 5% of people who use drugs, but 29% of those arrested for drug offenses and 33% of those in state prison for drug offenses. Additionally, American Indian and Alaska Native (AI/AN) people are overrepresented amongst incarcerated populations. However, inconsistency in data collection for this population does not provide an accurate estimate on the percentage of AI/AN incarcerated for drug offenses. Communities of color are also more likely to face barriers in accessing high-quality treatment and recovery support services.").

XXVI Harv. T.H. Chan Sch. of Pub. Health, Substantial Racial Inequities Despite Frequent Health Care Contact Found in Treatment for Opioid Use Disorder (May 10, 2023), https://www.hsph.harvard.edu/news/press-releases/substantial-racial-inequalities-despite-frequent-health-care-contact-found-in-treatment-for-opioid-use-disorder/ (citing Michael Barnett et al., Racial Inequality in Receipt of Medications for Opioid Use Disorder, 388 New. Eng. J. Med. 1779 (2023)); Mara A.G. Hollander et al., Racial Inequity in Medication Treatment for Opioid Use Disorder: Exploring Potential Facilitators and Barriers to Use, 227 Drug Alcohol Depend. 1, 8–14 (2021); Oluwole Jegede, Chryell Bellamy, & Ayana Jordan, Systemic Racism as a Determinant of Health Inequities for People with Substance Use Disorder, JAMA Psychiatry Online (Jan. 17, 2024), https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2814162.

XXVII NASEM, Medications for Opioid Use Disorder Save Lives 39 (2019) (citing Louisa Degenhardt et al., The Impact of Opioid Substitution Therapy on Mortality Post-Release From Prison: Retrospective Data Linkage Study, 109 Addiction 1306 (2014); Marc R. Larochelle et al., Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study, 169 Annals of Internal Med. 137 (2017); Jun Ma et al., Effects of Medication-Assisted Treatment on Mortality Among Opioids Users: A Systematic Review and Meta-Analysis, 24 Molecular Psychiatry 1868 (2018); Matthias Pierce et al., Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England, 111 Addiction 298 (2016); Luis Sordo et al., Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies, 357 BMJ j1550 (2017)).

XXVIII NASEM, Medications for Opioid Use Disorder Save Lives 38 (2019)

Findings

Disability Rights North Carolina (DRNC) studied the availability of medications for opioid use disorder (MOUD) in NC Jails by contacting all 100 counties.* It is gratifying to report there has been some progress since the initiation of this project. However, North Carolina must persist in implementing changes in its jails, justice, and correctional systems and focus on improving access to treatment, not simply on punishment.

MOUD treatment	Reported
Continuation	23
Continuation and induction	11
Medication for pregnant women only	3
Vivitrol only	1
Developing a plan	7
No response	15
No program	26
Insufficient or contradictory information	6

*There are 5 counties with either no jail or less than 10 cell capacity. Bertie and Martin Counties share a regional jail as do Camden, Pasquotank and Perquimans Counties. There are 92 County jails represented in the total count.

The displayed data is generated from the many jails that responded to DRNC's outreach efforts to learn more about the status of MOUD treatment and resources. Attempts were made to obtain other reliable information to determine what each NC jail offered people in their custody. However, some jails showed a lack of transparency in their policies and practices when we reached out for clarification of information received. Other counties failed to respond to any of our staff's outreach efforts, including public records requests. Based on these findings, DRNC developed recommendations to improve access to MOUD in NC jails.

Recommendations

- The State, public health directors, and other community leaders need to expand public education to reduce stigma around OUD and its medications.
- Community medical professionals who specialize in OUD and the use of MOUD should provide ongoing education to law enforcement, jail staff, and detention facility third party medical providers. This education should focus on OUD as a disability, the effectiveness of MOUD, and proper access to MOUD. This education should be continuing, not a one-time offering.
- Barriers to access of MOUD in jails and prisons should be removed. MOUD should be available and easily accessible for people with OUD. Stop the use of drug screens on intake to deny MOUD and other rigid rules around access (e.g., do not force someone to engage in therapy to receive medication), do not discontinue access to medication as a punishment, and remove arbitrary limits to medication types and dosages - this needs to be assessed individually.
- The State must require that MOUD, including agonist medications, be made available to those with OUD in all NC jails and prisons. If the facility does not have the ability to provide MOUD, anyone who needs MOUD should immediately be transferred to another facility.
- Community leaders and policymakers need to support the use of MOUD in carceral settings and efforts to help those released re-integrate into their community by publicly supporting and improving funding for these programs, and providing guaranteed continued access to MOUD to people who are uninsured when they leave the facility. This must include assistance from the Local Management Entity/Managed Care Organization (LME/MCO) to make sure that all people with OUD who are leaving the facility are connected with services.

Opioids and the overdose crisis

The U.S. and North Carolina are experiencing an overdose death crisis. In 2021 in the U.S. there were 80,411 overdose deaths and 75.4% of all overdoses nationally involved an opioid.I We lost more than 36,000 North Carolinians from opioid overdose deaths from 2000-2022II and opioids were involved in 78.9% of all NC overdose deaths.[III] At least five people in NC die every day from opioid overdoses.IV The risk of overdose death is much higher for people leaving incarceration. People leaving carceral settings in NC have a 50 times greater chance than the general population of dying from an overdose within the first two weeks of release.[V]

In addition to the staggering cost of human life, there are considerable economic costs to our communities from opioid use disorder (OUD): $35 billion in health care costs, $14.8 billion in criminal justice system costs, and $92 billion in lost productivity.VI However, each dollar spent on OUD treatment produces a return of $4-7 dollars by reducing drug related crimes and related criminal justice costs.[VII]

The opioid crisis impacts people from all walks of life and all racial and ethnic groups. However, it has disproportionately impacted black, indigenous and people of color (BIPOC) communities. In 2020, data from the CDC showed overdose death increased from the previous year by 44% for Black/African Americans, 40% Hispanic/Latinos, and 39% for Native Americans, while Whites saw a 22% increase

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I Nat'l. Ctr. for Injury Prevention, Drug Overdose Deaths, CDC (Aug. 22, 2023), https://www.cdc.gov/drugoverdose/deaths/index.html.

II Overdose Epidemic: Combating North Carolina's Opioid Crisis, NCDHHS, https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic (last visited Feb. 16, 2024).

III Attorney General Josh Stein, Opioid Crisis, NCDOJ, https://ncdoj.gov/responding-to-crime/opioid-epidemic (last visited Feb. 16, 2024).

IV Id.

V Shabbar I. Ranapurwala, et al., Opioid Overdose Deaths Among Formerly Incarcerated Persons and the General Population: North Carolina, 2000–2018, 112 Am. J. Pub. Health 300, 301–302 (2022). Other studies outside of NC have also consistently found higher rates of overdose mortality immediately after release from incarceration. See Commonwealth of Mass. Dep't of Pub. Health, An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011-2015) 49–52 (2017), https://www.mass.gov/doc/legislative-report-chapter-55-opioid-overdose-study-august-2017/download; Md. Dep't. Health and Mental Hygiene, Risk of Overdose Death Following Release from Prison or Jail (2014), https://health.maryland.gov/vsa/Documents/Overdose/Briefs/corrections%20brief_V3.pdf ; Lia N. Pizzicato et al., Beyond the Walls: Risk Factors for Overdose Mortality Following Release from Philadelphia Prisons, 189 Drug Alcohol Depend. 108, 108–115 (2018); Ingrid A. Binswanger, et al., Release from Prison—A High Risk of Death for Former Inmates, 356 New Eng. J. Med. 157, 159–160 (2007).

VI Substance Use Prevention and Treatment Project, The High Price of the Opioid Crisis, 2021, PEW (Aug. 27, 2021), https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2021/the-high-price-of-the-opioid-crisis-2021.

VII Id.

in overdose deaths. [VIII] Racial and ethnic disparities also exist in the receipt of medications for opioid use disorder (MOUD), with BIPOC populations receiving MOUD less frequently than whites.[IX]

In the criminal legal system, racial disparities also increase the risk for time in jail. BIPOC populations, especially Black/African Americans, with similar charges/histories to whites, are disproportionately overrepresented in jail admissions (instead of probation), have higher bail set, and receive longer sentences.[X] The rise in overdose deaths for black/African Americans and Hispanic/Latino communities started in 2015.[XI]

According to the CDC there have been 3 waves impacting the rise of opioid overdose deaths:[XII]

- The first wave began in the 1990s – increased prescribing of opioids led to an increase in overdose death from prescription opioids.
- The second wave began in 2010 – when heroin caused a rapid increase in overdose deaths.
- The third wave of overdose deaths began in 2013 and continues to the present - caused by synthetic opioids, mainly fentanyl.

Not only people who use opioids and/or have an opioid use disorder are at risk of overdose death. People who use other drugs can unknowingly risk exposure to fentanyl and overdose as the drug supply has been contaminated with fentanyl. [XIII] Another consideration is polysubstance use, which is also common.[XIV]

VIII Mbabazi Kariisa et al., Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics –25 States and the District of Columbia, 2019-2020, 71 Morbidity Mortality Wkly. Rep. 940, 941–42 (2022).

IX Timothy Dean, New Study Finds Substantial Racial Inequities in Treatment for Opioid Use Disorder, Dartmouth Sch. Med. (May 12, 2023), https://geiselmed.dartmouth.edu/news/2023/new-study-finds-substantial-racial-inequities-in-treatment-for-opioid-use-disorder/. See also Tami L. Mark et al., Improving Research on Racial Disparities in Access to Medications to Treat Opioid Use Disorders, 17 J. Addiction Med. 249 (2023).

X Public Safety Performance Project, Racial Disparities Persist in Many U.S. Jails, PEW (May 16, 2023), https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/05/racial-disparities-persist-in-many-us-jails.

XI Joseph R. Friedman & Helena Hansen, Evaluation of Increases in Drug Overdose Mortality Rates in the US by Race and Ethnicity Before and During the COVID-19 Pandemic, 79 JAMA Psychiatry 379, 379–81 (2022).

XII Nat'l. Ctr. for Injury Prevention, Understanding the Opioid Overdose Epidemic, CDC, https://www.cdc.gov/opioids/basics/epidemic.html (last visited Feb. 8, 2024).

XIII Jeffrey Brent & Stephanie T. Weiss, The Opioid Crisis—Not Just Opioids Anymore, 5 JAMA Network Open 1 (2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2792965.

XIV Nat'l. Ctr. for Injury Prevention, Other Drugs, CDC (Aug. 22, 2023), https://www.cdc.gov/drugoverdose/deaths/other-drugs.html; see also Daniel Ciccarone, The Rise of Illicit Fentanyls, Stimulants and the Fourth Wave of the Opioid Overdose Crisis, 34 Current Op. Psychiatry 344, 348 (2021).

Opioids are not in and of themselves a problem. Opioids are necessary medical tools for treatment after surgery or injury, cancer, end of life care, etc.[XV] It is important to understand that not everyone who uses opioids will go on to develop opioid use disorder[XVI], even if they have a physical dependence and increased tolerance or experience withdrawal.[XVII] Opioid use disorder is a medical condition diagnosed by medical providers.[XVIII]

Opioid Use Disorder

OUD is a serious medical condition, not a moral failing. It is a chronic, but treatable, brain disorder that responds to medications that normalize brain structure and function.[XIX] OUD affects people from all walks of life, education/socio-economic levels and racial/ethnic groups.[XX] According to 2022 data released by SAMHSA, among people aged 12 or older in 2022, 2.2 percent (or **6.1 million people**) had an opioid use disorder in the past year.[XXI]

OUD can be mild, moderate or severe and is characterized by 2 or more from the following groups of symptoms in a 12-month period: physical dependence (developing tolerance, experiencing withdrawal), loss of control over their use of opioids (taking greater quantities, inability to quit, etc.) and continued use despite negative consequences (such as problems at home or work, loss of job, legal system involvement, impaired relationships, etc.).[XXII] As with other medical conditions, effective medical treatments are available.

XV Nat'l. Ctr. for Injury Prevention, Prescription Opioids, CDC, https://www.cdc.gov/opioids/basics/prescribed.html (last visited Feb. 20, 2024); see also Am. Psychiatric Ass'n., What is an Opioid? (2022), https://www.psychiatry.org/patients-families/opioid-use-disorder.

XVI Cleveland Clinic, Opioid Use Disorder (Oct. 4, 2022), https://my.clevelandclinic.org/health/diseases/24257-opioid-use-disorder-oud.

XVII Jeremy Ledger, Opioid Use Disorder, Yale Med. (2020), https://www.yalemedicine.org/conditions/opioid-use-disorder; see also https://www.cdc.gov/opioids/healthcare-professionals/prescribing/opioid-use-disorder.html

XVIII American Psychiatric Association, The Diagnostic and Statistical Manual of Mental Illness, DSM 5-TR (5th ed., 2022); see also Nat'l. Ctr. for Injury Prevention, Opioid Use Disorder: Preventing and Treating, CDC, https://www.cdc.gov/opioids/healthcare-professionals/prescribing/opioid-use-disorder.html (last visited Feb. 20, 2024).

XIX NASEM, Medications for Opioid Use Disorder Save Lives 3–4 (2019).

XX Cong. Budget. Off., The Opioid Crisis and Recent Federal Policy Responses 2 (2022), https://www.cbo.gov/publication/58532 http://www.cbo.gov/publication/58221 ("Although people from all income levels, regions of the country, and backgrounds use and misuse opioids, the opioid crisis has affected demographic groups in different ways."); see also Nat'l. Ctr. for Injury Prevention, Opioid Overdose Prevention Saves Lives, CDC, https://www.cdc.gov/drugoverdose/featured-topics/abuse-prevention-awareness.html (last visited Feb. 8, 2024) ("OUD is a medical condition that can affect anyone – regardless of race, gender, income level, or social class.").

XXI SAMHSA, Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health 36 (2022), https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report.

XXII Jeremy Ledger, Opioid Use Disorder, Yale Med. (2020), https://www.yalemedicine.org/conditions/opioid-use-disorder.

Treatment of OUD-MOUD

The standard of treatment for OUD is the use of medications for opioid use disorder (MOUD).[XXIII] MOUD is the preferred term, as the older term ”medication assisted treatment (MAT)“ supports the belief that medication is simply an adjunct to other treatments.[XXIV] Medications for opioid use disorder can successfully be the sole treatment and does not require that someone engages in other therapies in order to be effective.[XXV] Engaging in other therapies should not be a requirement in order to receive or continue on MOUD.[XXVI]

There are three FDA approved medications for opioid use disorder: methadone, buprenorphine and naltrexone. Methadone and buprenorphine are agonist medications. Naltrexone (e.g., Vivitrol) is an antagonist medication. These medications work in different ways.

Methadone and buprenorphine, the agonist medications, are much more effective than other forms of treatment as they address withdrawal and cravings by acting on the opioid receptors in the brain.[XXVII] Agonist medications work by binding to the receptors in the brain that opioids would bind to, and they produce a similar response to the intended chemical and receptor.[XXVIII] However, they are longer acting and safer than illicit opioids and to a person with OUD, these medications do not provide the euphoria or other effects that opioids produce[XXIX], so these agonist medications are not simply trading one drug for another[XXX]. Methadone and buprenorphine relieve withdrawal symptoms and minimize cravings

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XXIII Shelley R. Weizman et al., To Save Lives, Prioritize Treatment for Opioid Use Disorder in Correctional Facilities, Health Affairs (Jun. 22, 2022), https://www.healthaffairs.org/content/forefront/save-lives-prioritize-treatment-opioid-use-disorder-correctional-facilities.

XXIV Opioid Sols. Ctr., Medication-Assisted Treatment (“MAT”) for Opioid Use Disorder, Nat’l. Ass’n. of Cntys. (NACo), https://www.naco.org/sites/default/files/documents/OSC_Strategy_MOUD_References.pdf (last visited Feb. 8, 2024).

XXV Id. See also NASEM, Medications for Opioid Use Disorder Save Lives (2019) (chronicling how medications for OUD are the most comprehensive and sustainable treatment strategy).

XXVI SAMHSA, Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings 25–29 (2019), https://store.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS. SAMHSA, Advisory: Low Barrier Models of Care for Substance Use Disorders 5 (2023), https://www.med.unc.edu/fammed/justicetateam/wp-content/uploads/sites/1256/2023/12/SAMHSA-Low-barrier-models-SUD_dec-2023.pdf.

XXVII NIDA, How do Medications to Treat Opioid Use Disorder Work?, NIH (2021), https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-do-medications-to-treat-opioid-addiction-work.

XXVIII Boukje A.G. Dijkstra et al., Does Naltrexone Affect Craving in Abstinent Opioid-Dependent Patients?, 12 Addiction Biology 176, 176–82 (2007); Nat’l. Inst. on Drug Abuse (NIDA), How do Medications to Treat Opioid Use Disorder Work?, NIH (2021), https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-do-medications-to-treat-opioid-addiction-work.

XXIX NIDA, How do Medications to Treat Opioid Use Disorder Work?, NIH (2021), https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-do-medications-to-treat-opioid-addiction-work.

XXX NIDA, What are Misconceptions About Maintenance Treatment?, NIH (2021), https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/what-are-misconceptions-about-maintenance-treatment.

and substantially reduce the risk of opioid overdose and death[XXXI] Research shows that agonist medications at the right dose for an extended period are the most successful to treat OUD.[XXXII]

> **A 2020 study comparing 6 different treatment pathways found that only agonist medications, methadone and buprenorphine, had a 76% reduction of overdose at 3 months and a 59% decrease at 12 months; similar benefits were not found with other treatments or treatment with antagonist medications.[XXXIII]**
>
> **A 2024 Connecticut study concluded, "Exposure to non-MOUD treatments provided no protection against fatal opioid poisoning whereas the relative risk was reduced following exposures to MOUD treatment, even if treatment was not continued. Population level efforts to reduce opioid overdose deaths need to focus on expanding access to agonist based MOUD treatments and are unlikely to succeed if access to non-MOUD treatments is made more available."[XXXIV]**

People who receive agonist medications are more likely to remain in treatment[XXXV] and reduce illicit drug use.[XXXVI] As one person described it after they took suboxone (an agonist medication):

> **"I was a different person than I am now. I had lost everything. I was tired, I was sick, it was more than a full-time job - the urge to use was always there. The drive-always doing everything and anything to get it [opioids]." After starting suboxone: "it [opioids] wasn't the number one focus-it takes it off the table-it [the urge to use] is so far back there, not in my face. I'd rather be on the medication having a normal life, being a productive member of society - a parent, working. … That's the difference between life and death-I don't think I would still be here [without the medication]. I'm trying to help other people now."**

Antagonist medications such as naltrexone and Vivitrol work by entirely blocking the opioid receptor which stops the receptor from producing a response to opioids, they require detoxification before use, do not relieve withdrawal symptoms or cravings, and have poor tolerance and treatment adherence/

XXXI Shoshana V. Aronowitz et al., Lowering the Barrier to Medication Treatment for People with Opioid Use Disorder, Leonard Davis Inst. of Health Econ. (Jan. 18, 2022), https://ldi.upenn.edu/our-work/research-updates/lowering-the-barriers-to-medication-treatment-for-people-with-opioid-use-disorder/; see also Bertha K. Madras, Improving Access to Evidence-Based Medical Treatment for Opioid Use Disorder: Strategies to Address Key Barriers Within the Treatment System, NAM Persp. Online (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8916813/.

XXXII NASEM, Medications for Opioid Use Disorder Save Lives 11–14 (2019).

XXXIII Sarah E. Wakeman, Marc R. Larochelle, & Omid Ameli, Comparative Effectiveness of Different Treatment Pathways for Opioid use Disorder, 3 JAMA Network Open 1, 8 (2020) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032 .

XXXIV Robert Heimer et al., Receipt of Opioid Use Disorder Treatments Prior to Fatal Overdoses and Comparison to No Treatment in Connecticut, 2016-17, 254 Drug Alcohol Depend. 1, 5 (2024) ("It is also clear that risk of death associated with exposure to non-MOUD forms of treatment was no less than that for no treatment; indeed, non-MOUD treatment might have produced worse outcomes than no treatment.").

XXXV NASEM, Medications for Opioid Use Disorder Save Lives 38 (2019).

XXXVI Id.

retention.[XXXVII] Withdrawal/detoxification with abstinence puts people at increased risk for return to use and overdose.[XXXVIII]

Even though agonist medications are the standard of treatment, only 1 in 5 U.S adults with OUD receive this medication.[XXXIX] According to the National Institute of Drug Abuse, failing to use these proven and lifesaving medications perpetuates opioid use disorder, is prolonging the opioid overdose crisis and makes existing health disparities, including racial/ethnic disparities, worse in our communities.[XL] Stigma is the most common barrier to the provision of MOUD, with logistical issues the second most common barrier (time, cost, insurance, regulatory issues).[XLI] Stigma is also a barrier to MOUD treatment in the criminal legal system, including jails.[XLII] People in NC jails have experienced this stigma.

XXXVII NIDA, How do Medications to Treat Opioid Use Disorder Work?, NIH (2021), https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-do-medications-to-treat-opioid-addiction-work . See also Shoshana V. Aronowitz et al., Lowering the Barrier to Medication Treatment for People with Opioid Use Disorder, Leonard Davis Inst. of Health Econ. (Jan. 18, 2022), https://ldi.upenn.edu/our-work/research-updates/lowering-the-barriers-to-medication-treatment-for-people-with-opioid-use-disorder/.

XXXVIII NIDA, How do Medications to Treat Opioid Use Disorder Work?, NIH (2021), https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-do-medications-to-treat-opioid-addiction-work . See also Sarah E. Wakeman, Marc R. Larochelle, & Omid Ameli, Comparative Effectiveness of Different Treatment Pathways for Opioid use Disorder, 3 JAMA Network Open 1, 8 (2020) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032.

XXXIX NIDA, Only 1 in 5 U.S. Adults with Opioid Use Disorder Received Medications to Treat it in 2021, NIH (Aug. 7, 2023), https://nida.nih.gov/news-events/news-releases/2023/08/only-1-in-5-us-adults-with-opioid-use-disorder-received-medications-to-treat-it-in-2021. (citing Christopher M. Jones, Beth Han & Grant T. Baldwin, Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021, 6 JAMA Network Open (2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807964?resultClick=1).

XL Id.

XLI Shoshana V. Aronowitz et al., Lowering the Barrier to Medication Treatment for People with Opioid Use Disorder, Leonard Davis Inst. of Health Econ. (Jan. 18, 2022), https://ldi.upenn.edu/our-work/research-updates/lowering-the-barriers-to-medication-treatment-for-people-with-opioid-use-disorder/; see also Whitney Bremer et al., Barriers to Opioid Use Disorder Treatment: A Comparison of Self-Reported Information from Social Media with Barriers Found in Literature, 11 Frontiers of Pub. Health 1, 2 (2023).

XLII Kelly E. Moore, Negative Attitudes About Medications for Opioid Use Disorder Among Criminal Legal Staff, 3 Drug Alcohol Depend. Rep. Online (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9948914/#:~:text=Background,on%20what%20drives%20these%20attitudes.

At a facility not offering MOUD:

> **"I was the sickest I had ever been- I couldn't rest, eat, sleep, do anything. I was puking, feeling like i was going to die…and given motrin- when I asked for it….at med pass. I even mentioned it was against the law or my rights as a human to be denied my prescribed medication. I was told I had no rights…I know that to be false, but I was treated so badly, it was horrible. Degraded, … laughed at, called a junkie, all the things [officers] would say about anyone addicted to drugs … just a junkie, not worth the narcan used…it was terrible. I wanted to die everyday."**

Even at facilities that offer MOUD, a person with OUD taking MOUD can have vastly different experiences. One person reported at the first jail they were continued on MOUD:

> **"[I was] treated like an individual taking a medication, I was not treated like a Junkie." After transfer to a different facility in another county where they were not allowed to continue MOUD: "I was treated like I was on street drugs, like I am an addict…Being treated like a drug addict, when I am in recovery."**

Unfortunately, not enough people in our jails nationwide or in North Carolina have access to these lifesaving medications, especially methadone and buprenorphine.

Section 2 MOUD Availability in Jails Nationwide and in NC

Availability of MOUD in Jails Nationwide

Each year over 9 million people pass through jails in the US.[I] An estimated 15% of those individuals have an OUD.[II] Despite the scope of the OUD problem and the availability of proven medications, only approximately 1 in 5 adults in the community received any MOUD.[III] There is even less access to this proven treatment for those who are incarcerated. The Bureau of Justice Statistics released a report in April 2023 reviewing opioid use disorder screening and treatment in local jails in the US for 2019.[IV] The report findings revealed that while approximately 63% of local jails conducted screening for OUD on intake, only 24% of these facilities continued people on MOUD after entering the facility.[V] Continuation was for any MOUD, including less effective antagonist medications.

Another study, using a cross-sectional survey, studied the availability of MOUD in US jails from September 2019 - March 2020.[VI] The researchers found MOUD, either continuation or initiation, is not widely available in US jails.[VII] Most jails did not adhere to the standard of care by providing MOUD to those with OUD.[VIII] The researchers initially sent out 2986 surveys and received 836 surveys with analyzable responses.[IX] Of those 836 responses, 32% of jails reported making MOUD available in some capacity: 13% initiated and continued people on at least one medication, 11% of facilities only continued people on MOUD, and 17% provided more than one medication.[X] When only one medication was offered, the most common was naltrexone and the least common was methadone.[XI]

I Off. of the Assistant Sec'y for Plan. and Eval. (ASPE), Incarceration & Reentry, NIH https://aspe.hhs.gov/topics/human-services/incarceration-reentry-0#:~:text=Each%20year%2C%20more%20than%20600%2C000,release%20and%20half%20are%20reincarcerated (last visited Feb. 8 2024).

II Ashish P. Thakrar, G. Caleb Alexander, & Brendan Saloner, Trends in Buprenorphine Use in US Jails and Prisons From 2016 to 2021, 4 JAMA Network Open 1, 1 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8672225/(citing NASEM, Medications for Opioid Use Disorder Save Lives 98 (2019)).

III Christopher M. Jones, Beth Han, & Grant T. Baldwin, Use of Medication for Opioid Use Disorder Among Adults with Past Year Opioid Use Disorder in the US, 2021, 6 JAMA Network Open (2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807964?resultClick=1.

IV Laura M. Maruschak et al., Opioid Use Disorder Screening and Treatment in Local Jails, 2019. Bureau of Just. Stats. (BJS) (2023), https://bjs.ojp.gov/library/publications/opioid-use-disorder-screening-and-treatment-local-jails-2019#0-0 (accessed using full report link on webpage).

V Id. at 1.

VI Carolyn Sufrin et al., Availability of Medications for Opioid Use Disorder in U.S. Jails, 38 J. Gen. Int. Med. 1573, 1573–75 (2023).

VII Id.

VIII Id.

IX Id.

X Id.

XI Id.

Availability of MOUD in NC Jails

People with disabilities, including those with OUD, are overrepresented in our jails and prisons.[XII] People of color who have OUD are especially overrepresented.[XIII] The ADA protects people with OUD from discrimination. The right to treatment for medical conditions like OUD is protected. Denying medical treatment because someone has OUD is a form of discrimination.

Opioid use disorder is a medical condition and a disability that is protected under the Americans with Disabilities Act (ADA).[XIV] The US Department of Justice (DOJ) published guidance in April of 2022 outlining protections for people with opioid use disorder (OUD) as a disability covered under the ADA.[XV] The ADA protects people who have OUD[XVI], including those in jails and prisons[XVII], and these facilities may not develop blanket policies that prohibit the use of MOUD to treat this medical condition.[XVIII] In 2023 the DOJ entered into settlement agreements with several jails that further outline how facilities must offer FDA-approved MOUD as an option to all individuals entering the facility, continue those already on the medications, and offer MOUD to those with OUD who were not receiving treatment when they entered the facility.[XIX]

XII Marcella Alsan, et al., Health Care in U.S. Correctional Facilities —A Limited and Threatened Constitutional Right, 388 New Eng. J. Med. 847, 847 (2023) ("more than half have a mental health problem, a substance use disorder, or both.").

XIII NCCHC, Opioid Use Disorder Treatment in Correctional Settings (2021), (Mar. 11, 2021) https://www.ncchc.org/position-statements/opioid-use-disorder-treatment-in-correctional-settings-2021 ("While the prevalence of OUD is similar by race and ethnicity, black and brown people are more often incarcerated and more often have their treatment interrupted by incarceration.") (citation omitted). Additionally, black/African Americans are approximately 5.1 times more likely than whites to be incarcerated, American Indian (Native American)/Alaska Natives are 4.1 times more likely and Hispanic are 2.5 times more likely to be incarcerated than whites. Id. See also Public Safety Performance Project, Racial Disparities Persist in Many U.S. Jails, PEW (May 16, 2023), https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/05/racial-disparities-persist-in-many-us-jails (finding Black/African American people overrepresented in jail populations).

XIV See The Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131–12134 (1990) (citing Title II, protecting individuals from discrimination in government programs); 42 U.S.C. §§ 12112, 12132, 12182 (prohibiting discrimination on the basis of disability); 42 U.S.C. §12102(1)-(2) (defining disability).

XV U.S. Dep't. of Just. C.R. Div., The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery (Apr. 5, 2022), https://archive.ada.gov/opioid_guidance.pdf.

XVI Id. (citing 28 C.F.R. §§ 35.108(b)(2), 36.105(b)(2)). Regulations implementing Title I of the ADA define the term "physical or mental impairment" as including "any physiological disorder or condition." See 29 C.F.R. § 1630.2(h).

XVII U.S. Dep't. of Just. C.R. Div., The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery (Apr. 5, 2022), https://archive.ada.gov/opioid_guidance.pdf (citing 42 U.S.C. §§ 12131-12134).

XVIII Id. (citing 42 U.S.C. §§ 12112, 12132, 12182 and § 12102(1)-(2)).

XIX See e.g., U.S. Atty's. Off. E.D Ky., U.S. Attorney's Office Announces Agreement to Ensure Access to Medications for Opioid Use Disorder at Big Sandy Regional Detention (Dec. 4, 2023), https://www.justice.gov/usao-edky/pr/us-attorneys-office-announces-agreement-ensure-access-medications-opioid-use-disorder; U.S. Dep't. of Just. Off. Pub. Affs., Justice Department Secures Agreement from Pennsylvania Jail to Provide Medications for Opioid Use Disorder (Nov. 30, 2023), https://www.justice.gov/opa/pr/justice-department-secures-agreement-pennsylvania-jail-provide-medications-opioid-use; U.S. Dept. of Just., Agreement to Resolve the Department of Justice's Investigation of the Cumberland County Jail (May 17, 2023), https://www.justice.gov/opa/press-release/file/1584086/.

Further legal support for the availability of MOUD to those with OUD exists through case law. The US Supreme Court held in 1976 that the 8th and 14th Amendments to the Constitution require jails and prisons to provide adequate medical care and not show deliberate indifference to an incarcerated persons' serious medical needs.[XX] In addition, the US DOJ along with legal advocates across the country have filed lawsuits to protect the rights of those with OUD in carceral settings to have access to all three types of medications, especially agonist medications. There are a growing number of settlement agreements[XXI] and court cases[XXII] that reinforce the right of people with OUD to be provided MOUD in carceral settings.

XX Estelle v. Gamble, 429 U.S. 97, 103 (1976). Jail officers, doctors, and employees are deliberately indifferent when they know of a serious medical need yet fail to provide treatment, delay treatment or deny treatment for a non-medical reason. Id. at 104–105.

XXI E.g., Kortlever v. Whatcom County, ACLU Washington, https://www.aclu-wa.org/cases/kortlever-et-al-v-whatcom-county (last visited Feb. 12, 2024) (Class action settled with agreement to provide MOUD on class wide basis, including maintenance and induction primarily of buprenorphine); Finnigan v. Mendrick, No. 21-CV-341, 2021 WL 736228 (N.D. Ill. Feb. 24, 2021) (settlement provides Plaintiff access to her medication and made plans to implement a policy to provide MAT); Sclafani v. Mici, ACLU Massachusetts, https://www.aclum.org/en/cases/sclafani-v-mici (last visited Feb. 16, 2024) (settlement provides plaintiffs access medications throughout entire stay at facility); Smith v. Fitzpatrick, ACLU Maine (Sept. 28, 2018), https://www.aclumaine.org/en/cases/smith-v-fitzpatrick-et-al (MOUD medications will be provided while plaintiff remains in custody). See also U.S. Atty's. Off. E.D Ky., U.S. Attorney's Office Announces Agreement to Ensure Access to Medications for Opioid Use Disorder at Big Sandy Regional Detention (Dec. 4, 2023), https://www.justice.gov/usao-edky/pr/us-attorneys-office-announces-agreement-ensure-access-medications-opioid-use-disorder; U.S. Dep't. of Just. Off. Pub. Affs., Justice Department Secures Agreement from Pennsylvania Jail to Provide Medications for Opioid Use Disorder (Nov. 30, 2023), https://www.justice.gov/opa/pr/justice-department-secures-agreement-pennsylvania-jail-provide-medications-opioid-use; U.S. Dept. of Just., Agreement to Resolve the Department of Justice's Investigation of the Cumberland County Jail (May 17, 2023), https://www.justice.gov/opa/press-release/file/1584086/.

XXII See Taylor v. Wexford Health Sources, Inc., No.2:23-cv-00475, 2024 U.S. Dist. LEXIS 1187*11 (2024) (denying defendant's motion to dismiss claims for discrimination under both ADA and Rehabilitation Act for denial of continuation of MOUD); Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018) (holding that it likely violates ADA and 8th Amendment to deny MOUD without individual assessment and contrary to treating provider's recommendation); Smith v. Aroostook Cty., 376 F. Supp. 3d 146 (D. Me.), aff'd, 922 F.3d 41 (1st Cir. 2019) (granting a preliminary injunction and holding that it likely violates ADA to deny incarcerated person access to MOUD without an individualized assessment of the need for medication); Rokita v. Pa. Dep't of Corr., 273 A.3d 1260 (Pa. Commw. Ct. 2022) (denying Commonwealth's preliminary objection and holding that refusal to provide plaintiff with access to a physician who could prescribe MAT, allowed plaintiff to make out a claim that the DOC acted with deliberate indifference under the 8th Amendment and also violated ADA by having policy prohibiting MAT for the general population); P.G. v. Jefferson County, No. 5:21-CV-388-DNH-ML (N.D.N.Y. Sept. 7, 2021) (holding that it likely violates Title II of ADA and 14th Amendment of the Constitution to deny pre-trial detainees access to medically necessary methadone treatment); M.C. v. Jefferson Cty., No. 6:22-CV-190, 2022 U.S. Dist. LEXIS 87339 (N.D.N.Y. May 16, 2022) (granting class certification and preliminary injunction and holding that the facility's policy to only provide MOUD to pregnant detainees and forcing others to go off of their MOUD without individualized assessments by a medical professional likely violates Title II of the ADA as well as the 8th and 14th Amendments).

Examples of Nationwide Cases and Settlements:

- DOJ Settlements:
  - Agreement with Big Sandy Regional Jail Authority in Eastern Kentucky (Dec. 4, 2023) https://www.justice.gov/media/1327496/dl
  - Agreement with Allegheny County Jail in Pennsylvania (Nov. 30, 2023) https://www.justice.gov/opa/media/1326786/dl?inline
  - Massachusetts Correctional Facilities Statewide to maintain MOUD https://www.justice.gov/usao-ma/pr/us-attorney-rollins-announces-correctional-facilities-statewide-maintain-all-medications
- Other cases and settlements:
  - *Pesce v. Coppinger* (Mass. 2018): holding that it likely violates ADA and 8th Amendment to deny MOUD without individual assessment and contrary to treating provider's recommendation.
  - *Kortlever v. Whatcom County* (Wash. 2024): class action settled with agreement to provide MOUD on class wide basis, including maintenance and induction primarily of buprenorphine.
  - *Taylor v. Wexford Health Sources, Inc.* (W. Va. 2024): denying defendant's motion to dismiss claims for discrimination under both ADA and Section 504 of the Rehabilitation Act for denial of continuation of MOUD.
  - *P.G. v. Jefferson County* (N.Y. 2021): holding that it likely violates Title II of ADA and 14th Amendment of the Constitution to deny pre-trial detainees access to medically necessary methadone treatment.
  - *Rokita v. Pa. Dep't of Corr.* (Pa. 2022): holding that refusal to provide plaintiff with access to a physician who could prescribe MAT properly underpins a claim that the DOC acted with deliberate indifference under the 8th Amendment and also violated ADA.
  - *Smith v. Aroostook Cty.* (Me. 2019): holding that it likely violates ADA to deny incarcerated persons access to MOUD without an individualized assessment of the need for medication. First circuit affirmed in 2019.
  - ***Full citations for these cases available in endnotes 21-22***

DRNC's Study of MOUD Offered in NC Jails

Given the legal requirements to provide FDA-approved treatments to those in jails with OUD, as it is a disability, DRNC reached out to all the counties in the state to ascertain the accessibility of these life-saving medications for individuals in custody. Beginning in March of 2023, DRNC examined the current availability of MOUD in North Carolina jails for those with OUD. As our staff gathered information, we also provided education and information to people with disabilities who experienced discrimination, outreach and information to the sheriffs, their staff, and other county employees, and engaged in other outreach to community providers.

Methods

DRNC used a variety of approaches to gather the most complete and up-to-date information. Although multiple approaches were used, our staff encountered some barriers to determining what each jail offered.

Initially, in April 2023, DRNC reached out to public health directors in all 100 counties across North Carolina and requested a copy of the jail medical plan. Public health directors are required to annually review and approve jail medical plans.[XXIII] Our staff did not receive many medical plans through this request as many public health directors reported they did not retain a copy or simply referred our staff to the jail to make the request. Staff re-requested the jail medical plans for all counties in a public records request to ensure obtaining the most up to date copy of the plan.

DRNC called the jail facilities in all 100 counties to complete a phone survey (copy available in Appendix A) to learn more about the prevalence of opioid use disorder among those entering NC jails and the provision of MOUD. 30 surveys were completed; however, the rest of the counties did not participate in the survey.

DRNC followed these outreach efforts with a public records request (copy available in Appendix B) sent out in late July 2023. Our team used this request to try to gather information about any existing MOUD plan, decision making around developing an MOUD plan, the number of intakes and the number of intakes with OUD (both by demographics gender, race, ethnicity), policies and medical plans to learn more about MOUD practices, etc… Beginning in September 2023 staff began providing follow-up reminders to those counties that did not provide public records in response to our request. Staff then began follow up to counties that did respond but did not produce the records. Some form of response was received from 49 counties.

Beginning in December 2023, DRNC followed up our efforts with an emailed letter to most of the sheriffs in NC. Letters were not sent to sheriffs with facilities that were already providing both continuation and induction of MOUD. Sheriffs were informed that our report would classify facilities based on the responses (or lack thereof) received. As a result of those letters, DRNC continued to receive more information. A general copy of the letter was also posted on our website.[XXIV]

When information was not available from the jail, other reliable sources of information (e.g., the CORE-NC Data Dashboard – Local Spending Plans[XXV]) were used to determine what care the jail was providing. Some information was also gained during jail monitoring visits performed as part of DRNC's responsibilities as the federally mandated protection and advocacy agency (P&A) for the state. We used these multiple sources of information to try to determine the overall landscape of MOUD in NC Jails. While this information was collected to the best of our staff's ability, some missing and contradictory information was received. Information continues to be gained as time goes on, so the findings below are a snapshot at the time of the report.

XXIII 10A N.C. Admin. Code 14J .1001(e).

XXIV Open Letter to Sheriffs: ADA Requires MOUD in Jails, DRNC (Jan. 15, 2024), https://disabilityrightsnc.org/news/drnc-newsfeed/open-letter-to-sheriffs-ada-requires-moud-in-jails/

XXV North Carolina Opioid Settlements, Data Dashboard—Local Spending Plans, CORE-NC, https://ncopioidsettlement.org/data-dashboards/spending-plans/ (last visited Feb. 13, 2024).

Findings

The numbers below are comprised of 92 counties (there are two regional jails and 5 counties had limited facilities)

Facility size: Large facilities 650+ person capacity; Medium facilities 649-201 person capacity; Small facilities under 200 person capacity

23 counties offered continuation (plans for pregnant women only or Vivitrol only are not included in this count)

- The majority of these programs offer at least buprenorphine, many offer both buprenorphine and methadone
  - 2 require that the person bring their buprenorphine with them
- 7 counties are also working toward offering induction
- 1 county required that the provider be local
- 3 are large facilities, 6 are medium facilities, 14 are small facilities

11 counties offered continuation and induction

- most offer buprenorphine and methadone for continuation;
- four offer only buprenorphine for induction;
- one offers continuation and induction for Vivitrol or buprenorphine
- 3 are large facilities, 6 are medium facilities, 2 are small facilities

3 counties offered MOUD to pregnant women only – all were small facilities

1 county offered a Vivitrol only plan – medium facility

7 counties were developing a plan

- 2 of these counties were developing a Vivitrol only program
- 1 is a large facility, 2 are medium facilities, 4 are small facilities

6 counties provided insufficient or contradictory information -3 are medium facilities and 3 are small facilities

26 counties had no MOUD program in the jail-1 is a medium facility, 25 are small facilities

15 counties had no response or responded but did not provide requested information[XXVI] - 1 is a large facility, 2 are medium facilities, 12 are small facilities

5 counties had no jails or had facilities with under 10 cells and are not included in the 92 counties

Discussion

This project was initiated to study the availability of MOUD in NC jails in March of 2023. Ten months later, at the time of this report, several things of note have been identified. Encouragingly, more MOUD plans were developed or are being developed than when at the onset of the project. More jails also intend to move from continuation to include induction. One of the project goals was to encourage people to talk about and think about treating OUD and to provide resources to advocate for action. DRNC believes that this trend of developing formal plans will continue. Some jails have or are expanding their MOUD programs to offer additional supports, such as access to mental health services, case management and peer supports, and help with reintegration after release. However, only about one-third of jails fell into the categories of continuation or continuation and induction of MOUD, so efforts need to continue to improve access to MOUD.

Many jails that responded to our public records request provided monthly intake data of all intakes into the jail. However, very few kept aggregate data of people at intake with an OUD. It was common for the medical providers to be the ones most often screening for OUD, and of those who responded to the question about a screening tool used, most reported using the Clinical Opiate Withdrawal Scale (COWS)[XXVII] protocol to screen intakes. Medical providers in general did not keep this information in aggregate data, but rather in individual case files.

Keeping aggregate data on the number of people entering the facility with disabilities is important for several reasons. It can provide concrete information to the administrators and sheriffs about the scope of the problem in the community. This information can then be used to request additional grants and other sources of funding to support an MOUD program in the facility. This information can also be used to evaluate the effectiveness of an existing program to determine if the program needs to be modified.

DRNC requested and received copies of jail medical plans (or portions of plans). Medical services at detention facilities are most often provided by contracted third party medical providers such as Wellpath, Southern Health Partners, IMS, Advanced Correctional Healthcare, NaphCare, etc. On review of the plans, or portions of plans, received, most medical plans did not contain information on the availability of MOUD but did often refer to detoxification and withdrawal protocols.

XXVI Lack of transparency was an issue for the jails in some of the counties. This lack of transparency can be problematic for determining whether or not people with disabilities are being provided with the healthcare services that they are entitled to receive. A total of 17 counties provided no information in response our requests, although some indicated that they would, but had not provided the information as of the time of this report. For 15 of these counties, we were not able to gather information from other reliable sources about the practices in those facilities. Those counties/facilities include Bertie-Martin Regional Jail, Alamance, Beaufort, Craven, Granville, Halifax, Henderson, Hertford, Mecklenburg, Moore, Pamlico, Rowan, Rutherford, Scotland, and Swain. 2 counties, Robeson and New Hanover County, also did not provide the requested information by the time of the report, but we were able to gather information from other reliable sources.

XXVII Donald R. Wesson & Walter Ling, The Clinical Opiate Withdrawal Scale (COWS), 35 J. Psychoactive Drugs 253, 253–59 (2003).

The medical plan itself was often not in sync with the actual MOUD policies/practices at the facilities. Sometimes the facility's medical provider did have an MAT (using the provider's terminology) or MOUD protocol available, but the facility did not adopt the plan. Some facilities use community providers for all or a portion of the medications and services for their MOUD program. Others use services through public health departments. For consistency, easier access, and better understanding of any MOUD policy, all jail medical plans should contain the current MOUD plan.

Some counties reported having a recovery court or similar program in their county that diverted people from jail in the first place. These programs may be helpful, but all should offer or allow MOUD to help retention in treatment and reduce risk of overdose death.[XXVIII]

Although many positive changes were identified, barriers to MOUD and issues with existing plans were also discovered. These barriers will be addressed in the following section.

XXVIII See generally Taylor Sisk, Once-Resistant Rural Court Officials Begin to Embrace Medications to Treat Addiction, NC Health News (Jul. 29, 2023), https://www.northcarolinahealthnews.org/2023/07/29/drug-courts-embrace-medication-assisted-treamen/ (discussing the expansion of MOUD treatments into rural North Carolina); Julia Dickinson-Gomez et al., Barriers to Drug Treatment in Police Diversion Programs and Drug Courts: A Qualitative Analysis, 92 Am. J. Orthopsychiatry 692, 692–701 (2022) (studying the success of drug diversion programs in three states); Douglas B. Marlowe et al., Drug Court Utilization of Medications for Opioid Use Disorder in High Opioid Mortality Communities, 141 J. Substance Abuse Treatment 108850 (2022) (providing recommendations on how diversion programs using MOUD can be expanded).

Section 3: NC Jails Discussion: barriers to MOUD treatment and problems with existing programs

Barriers to plan development

As DRNC collected information about the availability of MOUD for OUD in NC's jails, several barriers to developing MOUD plans and issues that impact the provision of MOUD in facilities with existing MOUD plans were identified.

- One major barrier to developing an MOUD plan is a firmly held belief that abstinence is the right way to address OUD. This belief appeared to be held by various people in the facility, sheriffs and jail staff, third party medical providers, and abstinence only based community providers who serve these facilities. People in custody also confirmed that this is a barrier.
- A lack of support from third party provider medical staff at the facility for the use of MOUD was especially problematic as they are viewed as experts and deference was given to their opinion. At some facilities our staff heard directly from medical providers, both doctors and nurses, that they did not support the use of MOUD, because they believe that withdrawal and abstinence are the best way to address OUD. Many of these medical providers shared their belief with us that the use of MOUD was simply trading one drug for another (a belief also shared by some sheriffs and jail administrators). Another issue was abstinence only community service providers that worked in the facility who advocated for this viewpoint with jail staff. These providers are also viewed as experts in OUD and their opinion was given weight in the decision not to provide MOUD. This deference is misplaced as it is contrary to the standard of care of experts in the community as well as legal obligations.I While abstinence may work for some, this model has not proven to be effective in the overdose epidemic.II Too many facilities are relying on outdated detox/withdrawal protocols which are contrary to the standard of care and legal requirements.III This is also an example of a blanket policy that is

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I See Nat'l. Comm'n. on Corr. Health Care (NCCHC), Opioid Use Disorder Treatment in Correctional Settings (2021), (Mar. 11, 2021), https://www.ncchc.org/position-statements/opioid-use-disorder-treatment-in-correctional-settings-2021/; Jennifer J. Carroll, Effective Treatment for Opioid Use Disorder for Incarcerated Populations, NACo (Jan. 23, 2023), https://www.naco.org/resources/opioid-solutions/approved-strategies/incarcerated-pops.

II See e.g., Mallory Locklear, Treating Opioid Disorder Without Meds More Harmful Than No Treatment at All, YaleNews (Dec. 19, 2023), https://news.yale.edu/2023/12/19/treating-opioid-disorder-without-meds-more-harmful-no-treatment-all (citing Robert Heimer et al., Receipt of Opioid Use Disorder Treatments Prior to Fatal Overdoses and Comparison to No Treatment in Connecticut, 2016-17, 254 Drug Alcohol Depend. 111040 (2024)); Sarah E. Wakeman, Marc R. Larochelle, & Omid Ameli, Comparative Effectiveness of Different Treatment Pathways for Opioid use Disorder, 3 JAMA Network Open 1, 8 (2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032.

III See Nat'l. Comm'n. on Corr. Health Care (NCCHC), Opioid Use Disorder Treatment in Correctional Settings (2021), (Mar. 11, 2021), https://www.ncchc.org/position-statements/opioid-use-disorder-treatment-in-correctional-settings-2021/; Jennifer J. Carroll, Effective Treatment for Opioid Use Disorder for Incarcerated Populations, NACo (Jan. 23, 2023), https://www.naco.org/resources/opioid-solutions/approved-strategies/incarcerated-pops.

prohibited under the ADA.[IV]

- Some sheriffs and jail administrators expressed that they would not allow opioids in their facilities. However, this blanket denial ignores the fact that MOUD is safe, effective and FDA approved. Many other jails across the U.S. and in North Carolina are providing MOUD successfully. In fact, providing MOUD can make the facility safer for both those in custody and jail staff.[V]
- Another barrier encountered is that some facilities have developed or are developing Vivitrol-only programs. While developing an MOUD program is a positive step, developing an injectable naltrexone only program is problematic for several reasons. Naltrexone is the least effective of the three types of FDA approved medications for OUD.VI Providing only naltrexone likely violates the ADA, especially for those coming into the facility who are taking a different medication, as the decision of what medication to provide should be based on an individualized assessment and not based on a blanket policy.VII Recent settlement agreements reached with the U.S. DOJ reject offering Vivitrol only because it is an inadequate MOUD program.[VIII]
- Limited medical provider hours, facilities that only have medical staff available a few hours a day or a few days per week in the jail, were also cited as a barrier to developing a plan and providing MOUD. However, a number of small facilities with limited medical staff hours have been able to work around this limitation. As seen in the current NC jail data in this report, facilities of all sizes are able to offer both continuation programs and continuation/induction programs. Facilities should work with their Public Health Director in their county to find solutions to this barrier. If and until there is a resolution, the facility should arrange transfer to another facility that can provide MOUD. A related concern is that in some places there are no MOUD providers in the county. Transfer to another facility that can provide the treatment is an option already in operation by other

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IV U.S. Dep't. of Just. C.R. Div., The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery at *2 (Apr. 5, 2022), https://archive.ada.gov/opioid_guidance.pdf.

V Nat'l. Sheriffs' Ass'n. & Nat'l. Comm. on Correctional Health Care, Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field 5 (2018), https://www.sheriffs.org/jail-based-mat or https://www.ncchc.org/jail-based-mat/ ; See also NCCHC Foundation, From the General Public to America's Jails: MAT Saves Lives 11 (2021), https://www.ncchc.org/wp-content/uploads/From_the_General_Public_to_Americas_Jails_-_MAT_Saves_Lives-_Indivior.pdf (providing MOUD agonist medications methadone and buprenorphine reduce the overall use of illicit drugs in jails and reduces disciplinary problems).

VI Sarah E. Wakeman, Marc R. Larochelle & Omid Ameli, Comparative Effectiveness of Different Treatment Pathways for Opioid use Disorder, 3 JAMA Network Open 1, 8 (2020) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032; see also Taylor Knopf, Strings Attached to New State Funds for Addiction Treatment in Jails, N.C. Health News (May 10, 2022), https://www.northcarolinahealthnews.org/2022/05/10/strings-attached-to-new-state-funds-for-addiction-treatment-in-jails/ (expressing concern with the use of Vivitrol as an MOUD plan due to problems with effectiveness and prohibitive cost.).

VII See Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018) (holding that it likely violates ADA and 8th Amendment to deny MOUD without individual assessment and contrary to treating provider's recommendation); U.S. Dep't. of Just. C.R. Div., The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery at *2 (Apr. 5, 2022), https://archive.ada.gov/opioid_guidance.pdf.

VIII See e.g., U.S. Atty's. Off. E.D. Ky., U.S. Attorney's Office Announces Agreement to Ensure Access to Medications for Opioid Use Disorder at Big Sandy Regional Detention (Dec. 4, 2023), https://www.justice.gov/usao-edky/pr/us-attorneys-office-announces-agreement-ensure-access-medications-opioid-use-disorder.

NC counties facing this issue.

- Waiting for an external event to occur is another barrier to MOUD program development. Some counties indicated that they are waiting for a new facility to be built before they will initiate a program. There are other jails who are also waiting on new facilities; however, these counties have already started an MOUD program. An MOUD program does not require a new facility. MOUD is a medication, like other medications. Other counties told us they recognized that they will need to develop an MOUD program, but they are waiting on the state to mandate the provision of this service. Unfortunately, both reasons ignore the legal requirements that currently exist to provide appropriate treatment-the constitution and the ADA.[IX]

Problems with existing programs

Problems were identified when our staff examined existing MOUD programs that are important to highlight as they interfere with the provision of appropriate OUD care. Most of this information was reported by the facilities themselves, but our staff also gathered information from other sources such as community partners and from the experiences of people with OUD who were incarcerated in jails.

- A major issue was the use of drug screens on intake into jails. These drug screens, used to screen for evidence of illicit substance use, are used to block people from participating in MOUD programs. This refusal to provide MOUD happens even when the community provider of MOUD is aware of a positive test result and said the MOUD should continue. Issues like false positive drug screens, refusing to retest, or look at alternative explanations for positive results were reported by people who experienced this during incarceration. In addition, this practice of using intake drug screens to discontinue access to MOUD violates the ADA. Although people using illicit substances are generally not protected by the ADA,[X] there is a health care exemption to that exception in the ADA[XI] explained in the DOJ guidance.[XII] Jail medical providers are part of that health care exemption. Medical providers are not allowed to deny services to people with an OUD on the basis of current illegal use of drugs, who are otherwise eligible to receive that service.[XIII]

IX U.S. Dep't. of Just. C.R. Div., The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery at *2 (Apr. 5, 2022), https://archive.ada.gov/opioid_guidance.pdf.

X 42 U.S.C. § 12210(a); 28 C.F.R. §§ 35.131(a)(1), 36.209(a)(1); U.S. Dep't. of Just. C.R. Div., The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery at *3 (Apr. 5, 2022), https://archive.ada.gov/opioid_guidance.pdf.

XI 42 U.S.C. § 12210(c); 28 C.F.R. §§ 35.131(b)(1), 36.209(b)(1).

XII 42 U.S.C. § 12210(c); 28 C.F.R. §§ 35.131(b)(1), 36.209(b)(1); U.S. Dep't. of Just. C.R. Div., The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery at *4 (Apr. 5, 2022), https://archive.ada.gov/opioid_guidance.pdf.

XIII See U.S. Dep't. of Just. C.R. Div., The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery at *3–4 (Apr. 5, 2022), https://archive.ada.gov/opioid_guidance.pdf. Since jails are the medical health care providers to the people in their custody and care, the illicit drug use exception from ADA protections does not apply due to the medical provider exemption, so jails and jail medical providers may not deny medications if the person with an OUD tests positive on an intake drug screen, if they are otherwise entitled to medical care/services. Id.

- DRNC received several complaints about this practice of denying MOUD because of positive drug screen on intake in the jail. One person that they had been stable on MOUD in the community for years yet when they entered the jail, the nurse at the facility told them they tested positive and took them off their medications. Another person reported that when they complained about not being allowed to continue MOUD.

> **"[T]he nurse said, 'what is crazy, what is BS, is people being on this medication for 8-9 years'… but I had been on the medication less than 6 months…. I started to have drug dreams again."**

- People entering jail who are already prescribed MOUD can experience long delays while waiting for drug screen results and on the facility's follow up confirmation of current treatment from community providers. This can lead to unnecessary withdrawal and someone having to take a much lower dose than they might have been prescribed in the community - requiring people to slowly titrate back to the dose that works for them. Staff received numerous reports from people who have experienced this. One individual described jail medical staff waiting 3-4 days before contacting the methadone provider, and not only did they have to go through withdrawal, but they also had to start on a lower dose than they were taking in the community.
- Use of only one type of medication or only allowing one set dosage for everyone was another problem frequently reported. This included changing the amount/type of medication that a person received from what they received in the community. One person reported a different set dosage for women and men, based only on gender, not the needs of the individual. One community provider reported that people were all put on the same dose and schedule regardless of what they were taking in the community. Another individual had to go through withdrawal for 7-8 days then was put on a different medication, with a very low dose so withdrawal symptoms continued.
- Unnecessary punitive measures, such as putting someone in segregation to avoid the risk of diversion of medication to other inmates, were also reported. There are many ways of addressing concerns of diversion that medical providers can put into place. Putting someone in segregation because they take MOUD out of fear of diversion should not be one of those methods.
- One client reported a delay in getting their methadone, so they went through withdrawal; once they began to receive methadone again, they were then put in segregation due to fear of diversion of methadone. Going through withdrawal followed by being placed in isolation to receive medication had a terrible impact on their mental health.
- One county did not provide MOUD if a person was housed in segregation. People in segregation should receive their medications as prescribed. This relates back to the stigma that exists toward this medical condition and the medications used to treat it.[XIV] MOUD is a medication, not a reward or punishment. This would be an unacceptable practice for medications such as insulin and hypertension medications, etc.
- Some facilities have no formal plans but provide some form of MOUD. While it is encouraging to learn that at least some people are provided with MOUD, with a formal

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XIV Julia Dickinson-Gomez et al., "You're Not Supposed to be on it Forever": Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People Who Use Opioids, 16 Substance Abuse 1, 2 (2022).

plan in place there is less chance for inequitable practices that can creep in when there are no formal procedures in place.

- Lack of transparency of a jail's policies/practices is a major problem, especially for those with disabilities in the jail's custody. People with disabilities are overrepresented in jails.[XV] People in jail must rely on the jail to provide for their medical care. Inspections of jails are infrequent.[XVI] Not sharing information on the practices/policies for health-related matters does not allow any community or expert input if there are problems with the medical treatment that people in custody receive. There should be transparency in the care that people with disabilities receive in a detention facility.
- Lack of data is problematic for similar reasons. If the facility does not gather and keep aggregate data on the people entering their facility who have OUD, they will not have a clear understanding of the problem in their community. If data is not kept, they are also unable to evaluate any MOUD program and determine if changes to the program need to be made. Data is also important when asking for grants and increased money for medications/programming, etc.

Related Issues

Lack of continuity of care

Interruptions in MOUD occur when individuals go to one facility for a time then are transferred to another jail or prison that does not offer MOUD. Some facilities will not continue or initiate people on MOUD if they are going to be transferred to another facility without MOUD. Others may continue, then taper the dose to lessen withdrawal. Some keep the MOUD dose the same without tapering, which forces the person to go through withdrawal at the next location.

Ignoring court orders for continued treatment. Facilities did not often report receiving court orders to continue treatment/medications. However, even with a court order, sometimes people are still not receiving their medications.

> **"[I] was not only misled, but was promised--through vocal and formal statement--by the judge of my case that I'd be able to receive treatment which was untrue, I was made to feel as if my OUD and symptoms were meaningless."**

XV Nat'l. Jud. Task Force to Examine State Cts. Response to Mental Illness, State Courts Leading Change: Report and Recommendations 9 (2023), https://www.ncsc.org/__data/assets/pdf_file/0031/84469/MHTF_State_Courts_Leading_Change.pdf ("[M]ore than 70% of people in American jails and prisons have at least on diagnosed mental illness or substance use disorder, or both.").

XVI N.C. Gen. Stat. § 153A-222, Inspections of local confinement facilities ("(a) Department personnel shall visit and inspect each local confinement facility at least semiannually. The purpose of the inspections is to investigate the conditions of confinement, the treatment of prisoners, the maintenance of entry level employment standards for jailers and supervisory and administrative personnel of local confinement facilities as provided for in G.S. 153A-216(4), and to determine whether the facilities meet the minimum standards published pursuant to G.S. 153A-221. facilities as provided for in G.S. 153A-216(4), and to determine whether the facilities meet the minimum standards published pursuant to G.S. 153A-221."); see also 10A N.C. Admin. Code 14J .1301 ("All jails shall be visited and inspected at least twice each year, but a jail shall be inspected more frequently if the Department considers it necessary or if it is required by an agreement of correction pursuant to 10A NCAC 14 .1304.).

When a facility does not provide MOUD many people will suffer withdrawal. Withdrawal protocols, often of the third-party medical providers, that only provide minimal care for those going through withdrawal were identified. The symptoms of withdrawal are terrible: vomiting, diarrhea, nausea, pain and muscle cramps, etc. Withdrawal is especially problematic if there are underlying health issues, both known and unknown. DRNC staff received information from many who reported they did not receive any care while being forced to go through withdrawal.

> **One person reported that they informed the nurse that they were taking buprenorphine from a community provider, which the facility would not allow, so they would be going through withdrawal. The nurse said they would give them medications to try to help with the discomfort, then failed to leave a note instructing that the person be provided these medications, so the person never received any medications to help them. When the nurse returned days later, it was reported that the nurse said 'oh, well you are already through the worst of it, kind of pointless to put you on anything.'**

Withdrawal symptoms can also happen at facilities that do provide MOUD but take too long to get the person back on their medications.

> **"I was forced to go through withdrawal for 7-8 days, I was not given anything to help with withdrawal-not even Gatorade" another said, "I was miserable, couldn't sleep or eat for days, my blood pressure was so high I was seeing Nat's [sic] and about passing out every time I stood up my breathing was ragged and I felt as if I was having trouble breathing. I was easily agitated and highly irritable. After about 2 weeks I was feeling some better but still never got to feeling normal again until I got out. It was a horrible and scary situation; they just don't care about your medical health in there…."**

People who are not provided with MOUD while incarcerated experience ongoing problems after release

In addition to the unacceptable increased risk of overdose death following release, people who do not receive MOUD in jail are less likely to return to their treatment[XVII] and are more likely to return to use.[XVIII] Destabilizing people by discontinuing medications, or not taking the effort to stabilize people by starting medications while they have the opportunity to provide treatment in jail, is harmful to our citizens and communities. Unless changes are made, the overdose epidemic will continue. DRNC identifies recommendations and resources to help in the next section.

XVII See e.g., Lara Cates & Aaron R. Brown, Medications for Opioid Use Disorder During Incarceration and Post-Release Outcomes, 11 Health Just. 1,2 (2023) (finding that most studies have shown that MOUD provided during incarceration increased community based treatment engagement post-release); PEW, Opioid Use Disorder Treatment in Jails and Prisons 5 (2020), https://www.pewtrusts.org/-/media/assets/2020/04/caseformedicationassistedtreatmentjailsprisons.pdf ("The preponderance of evidence suggests that people who are incarcerated and started on medication and counseling in jail or prison are more likely to engage in treatment post-release than people who do not receive medication while incarcerated."); Rural Health Information Hub, Considerations for People Who Are Incarcerated When Implementing MOUD Programs (2019), https://www.ruralhealthinfo.org/toolkits/moud/4/population-considerations/incarcerated (people who are incarcerated and receive MOUD prior to release are more likely to engage in treatment after release, engage in treatment sooner, and stay in treatment longer).

XVIII Lara Cates & Aaron R. Brown, Medications for Opioid Use Disorder During Incarceration and Post-Release Outcomes, 11 Health Just. 1,2 (2023).

Section 4: Recommendations and Resources

Recommendations

The State, public health directors, and other community leaders need to expand public education to reduce stigma around OUD and its medications.

Stigma remains a major barrier to MOUD, undermining current efforts to increase the understanding that OUD is a medical condition and a disability, MOUD is a medication, and that MOUD is effective to save lives. Examples may include the use of print, online, radio, and TV educational advertisements, social media campaigns, and billboards.

Stigma surrounding OUD and the medications used to treat it is a major barrier to MOUD access[I] because it stops people with OUD from seeking out MOUD, interferes with MOUD being offered as a treatment, and interferes with program development and implementation in NC jails. North Carolina needs to continue to focus on OUD as a disability and MOUD as a necessary medication, rejecting the outdated notion that MOUD is simply trading one drug for another. Public education efforts on a widespread scale are needed to address this stigma. Every part of the community, not just those involved in this work, needs to be included in this educational outreach.

> **Community medical professionals who specialize in OUD and the use of MOUD should provide ongoing education to law enforcement, jail staff, and detention facility third party medical providers. This education should focus on OUD as a disability, the effectiveness of MOUD, and proper access to MOUD. This education should be continuing, not a one-time offering.**

Leaders in jail administration must promote MOUD and its effectiveness, modeling their support of the program and enforcing that the program is implemented and accessible to all those with OUD.

> **Barriers to access of MOUD in jails and prisons should be removed. MOUD should be available and easily accessible for people with OUD. Stop the use of drug screens on intake to deny MOUD and other rigid rules around access (e.g., do not force someone to engage in therapy to receive medication), do not discontinue access to medication as a punishment, and remove arbitrary limits to medication types and dosages - this needs to be assessed individually.**

Lower barrier access to MOUD, which limits demands placed on clients to make treatment readily available and easily accessible and without judgment, should be the focus for treatment as recommended by SAMHSA.[II] Care should be person-centered and individualized, with consideration

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I See Julia Dickinson-Gomez et al., "You're Not Supposed to be on it Forever": Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People Who Use Opioids, 16 Substance Abuse 1, 2 (2022); Shoshana V. Aronowitz et al., Lowering the Barrier to Medication Treatment for People with Opioid Use Disorder, Leonard Davis Inst. of Health Econ. (Jan. 18, 2022), https://ldi.upenn.edu/our-work/research-updates/lowering-the-barriers-to-medication-treatment-for-people-with-opioid-use-disorder/.

II SAMHSA, Advisory: Low Barrier Models of Care for Substance Use Disorders 1 (2023), https://www.med.unc.edu/fammed/justicetateam/wp-content/uploads/sites/1256/2023/12/SAMHSA-Low-barrier-models-SUD_dec-2023.pdf.

for the person's unique needs and experiences.[III] Flexibility and availability are key to successful treatment if a person comes into jail with OUD and needs treatment.[IV] MOUD should be started immediately and without unnecessary barriers, such as positive drug screens stopping a person from continuing or initiating treatment, unless there is a specific medical issue.[V] Medication type, dosage and the duration of treatment must be individualized.[VI] Additional therapy should be offered, but not required, to receive the medications.[VII]

> **The State must require that MOUD, including agonist medications, be made available to those with OUD in all NC jails and prisons. If the facility does not have the ability to provide MOUD, anyone who needs MOUD should immediately be transferred to another facility.**

The lack of access to MOUD in jails and prisons (including the lack of continuity of care if one facility provides MOUD and the next does not) is not helping to stem the overdose crisis that plagues North Carolina. Jails have a unique opportunity to be a major contributor to the wellbeing of their community and its members by providing treatment to those with OUD and helping them to stabilize.

Some jails reported that a lack of resources, such as low staffing, lack of funding, lack of providers, or diversion concerns have prevented them from developing and implementing an MOUD program. However, these reasons do not excuse jails from compliance with the duty to provide adequate medical care, including MOUD. Other jails facing the same constraints have MOUD programs in place. There is no need to reinvent the wheel; there are sheriffs, jail administrators, and contracted medical providers available to share how they overcame these obstacles to develop a plan. Community experts are also able to help.

> **Community leaders and policymakers need to support the use of MOUD in carceral settings and efforts to help those released re-integrate into their community by publicly supporting and improving funding for these programs, and providing guaranteed continued access to MOUD to people who are uninsured when they leave the facility. This must include assistance from the Local Management Entity/Managed Care Organization (LME/MCO) to make sure that all people with OUD who are leaving the facility are connected with services.**

Community leaders such as county managers, county commissioners, and public health officials must present a united front and show their support of MOUD. County Commissioners can choose

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III Id. at 1–4.

IV Id. at 3–4.

V Id. at 4–5.

VI Id. at 1,4.

VII Id. at 4–5.

to use Opioid Settlement funds for jail populations to receive treatment in the facility and supportive services on release.[VIII] Public health directors can provide more education to their communities and support the use of MOUD in jails by requiring the jail medical plan to include MOUD.[IX]

Policymakers and community leaders must support programs for those with OUD who have experienced incarceration by ensuring access to treatment and re-entry programs in the community, regardless of the ability to pay. These supports must include access to housing, food, continued access to medications - and if desired, to counseling and other supportive services like case management and peer supports, re-entry programs such as Formerly Incarcerated Treatment (FIT), and access to job training/Vocational Rehabilitation.

Many people leaving jail have no access to insurance. For those entering jails who are on Medicaid, NC Medicaid should be suspended not discontinued and should be in place on release from jail.[X] Those not on Medicaid should be assisted to apply before release.

The Local Management Entity/Managed Care Organizations (LME/MCO a.k.a. Tailored Plans) that serve the county where the detention center is located should dedicate positions for staff who are knowledgeable about the needs of those leaving incarceration, coordinate with the jails, and provide services to people with OUD leaving incarceration.[XI] Prior to release from incarceration, provide warm handoffs to supports, services and treatment in the community.

Resources for Jails

Resources are available to help jails develop MOUD programs that comply with legal requirements.

- Major Bazemore worked in the Durham Sheriff's Office for over 30 years and successfully implemented a MOUD program in the detention facility. He is now a consultant with Vital Strategies and his focus is to help NC Sheriffs implement MOUD in their facilities.
  ebazemore.consultant@vitalstrategies.org

VIII North Carolina Opioid Settlements, Data Dashboard—Local Spending Plans, CORE-NC, https://ncopioidsettlement.org/data-dashboards/spending-plans/ (last visited Feb. 13, 2024).

IX 10A N.C. Admin. Code 14J .1001(e).

X The Governor has also made this a priority, see N.C., Exec. Order No. 303: Sec. 4 Part B i–ii, Establishing a Unified Approach to Improving Education, Rehabilitation, and Reentry Services for Incarcerated and Formerly Incarcerated People in North Carolina (Jan. 29, 2024), https://governor.nc.gov/executive-order-no-303/open. The Governor's order reads in part, "[t]he North Carolina Department of Health and Human Services ("DHHS") shall: i. Work with the Centers for Medicare & Medicaid Services with the goal of securing approval for the NC Section 1115 Demonstration Waiver to allow certain eligible people to receive certain Medicaid services prior to release. ii. Create mechanisms to allow people to be pre-screened before leaving prison for federal and state benefits (e.g., TANF, SNAP, Medicaid, and LIHEAP) including ensuring processes exist for people preparing for release who are otherwise eligible for Medicaid to receive Medicaid services immediately upon release." Id.

XI Id. at B.iii. ("Ensure released people who are diagnosed with Serious Mental Illnesses (SMIs), Substance Use Disorders, Intellectual or Developmental Disabilities (I/DD) or Traumatic Brain Injuries (TBIs) are engaged in the appropriate behavioral health services upon release from state prisons and county jails.").

- North Carolina Substance Treatment and Recovery (NC STAR Network) is a free resource for jails that is funded through the state. They will provide free outreach and training to both detention center staff and jail medical providers (free CME credits are available) throughout the state. Reach out to Brenda Pearson for assistance: Pearson, Brenda brenda_pearson@med.unc.edu

  From its website https://ncstarnetwork.org/:

  The NC STAR Network is a statewide initiative with an overarching goal of expanding access to addiction treatment for all citizens of North Carolina through utilization of a Hub and Spoke model. The Hubs are academic centers with a strong focus on providing addiction treatment and education. Currently, the NC STAR Network hubs are located at UNC, Mountain Area Health Education Center (MAHEC), and East Carolina University (ECU). The Hubs are strategically located in the West (MAHEC), central (UNC) and East (ECU) portions of NC which allows each to provide service to a wide range of citizens.

- North Carolina Technical Assistance Center
  nctac@unc.edu
  https://www.med.unc.edu/fammed/justicetateam

  From the website:

  Funded by NC DHHS Division of Mental Health, The North Carolina Technical Assistance Center (NC-TAC) is a statewide initiative to provide technical assistance to programs that support individuals at risk of incarceration and overdose. We provide tailored, evidence-based, technical assistance with a harm reduction approach. Our goal is to improve access to resources for people who use drugs and are impacted by the legal system, in North Carolina. Our services are available to any North Carolina non-profit, private, or government entity that provides services to people impacted by the legal system.

  We have specific expertise in the following areas:
  - Harm reduction (Drug user health, engaging key populations)
  - Supporting release from incarceration (Reentry)
  - Diversion/Deflection, including Law Enforcement Assisted Diversion (LEAD)
  - Jail-based Medication for Opioid Use Disorder (MOUD)
  - Naloxone access and distribution
  - Program evaluation
  - Data management

- **DRNC has created a statewide resource list for people with opioid use disorder (OUD) and substance use disorder (SUD) that is searchable by county:**
  https://disabilityrightsnc.org/nc-statewide-opioid-use-disorder-and-substance-use-disorder-resources/

- **Toolkits/Webinars:**
  - https://www.med.unc.edu/fammed/justicetateam/resources/jail-based-mat/
  - https://www.vitalstrategies.org/resources/medication-assisted-treatment-for-opioid-use-disorder-in-jails-and-prisons-a-planning-and-implementation-toolkit/
  - https://www.naco.org/resources/opioid-solutions/approved-strategies/incarcerated-pops
  - https://prisonopioidproject.org/best-practices-and-protocols/
  - https://ncopioidsettlement.org/resources/addiction-treatment-for-incarcerated-persons/
  - https://www.cossup.org/Topics/CourtsCorrections/JailResources/Guidelines
  - https://www.thenationalcouncil.org/resources/medication-assisted-treatment-mat-for-opioid-use-disorder-in-jails-and-prisons-a-planning-and-implementation-toolkit/
  - https://app.smartsheet.com/b/publish?EQBCT=d4801dd761084fd29e50e8494f80f009

Information on grants/funding and grant writing:

  - https://bja.ojp.gov/funding
  - https://www.ojp.gov/funding
  - SL 2023-134 Competitive Grants to Sheriff's Offices for Addiction Treatment [XII]

DOJ Guidance, recent actions, and related information on positive drug screens:

  - https://www.ada.gov/resources/opioid-use-disorder/
  - https://www.justice.gov/usao-edky/pr/us-attorneys-office-announces-agreement-ensure-access-medications-opioid-use-disorder
  - https://www.justice.gov/opa/pr/justice-department-secures-agreement-pennsylvania-jail-provide-medications-opioid-use
  - https://disabilityrightsnc.org/resources/illegal-drug-use-and-medications-for-opioid-use-disorder-ada-protections-for-people-entering-jail-prisons/

XII S.B. 105, Gen. Assem. Sess. 2021, S.L. 2021-180 (N.C. 2021), Competitive Grants to Sheriff's Offices for Addiction Treatment in Jails. (Sec. 19A.10(f) reads, "[t]he working group created under subsection (e) of this section shall establish the operational criteria and application process for the grant program created by this section and shall communicate information regarding the grant program to all sheriffs' offices in the State. The working group shall evaluate applications for each of the categories under subsection (b) of this section and may award lower amounts than requested to individual sheriffs' offices in order to assure broader access to funds. The working group may establish protocols for the allotment of funds to assure that funds can be expended efficiently."). See also H.B. 259, Gen. Assem. Sess. 2023, S.L. 2023-134 (N.C. 2022) (specifically Sec. 19F.3(a) which rewrites the 2021 senate bill to add, "[t]he working group shall ensure all Federal Drug Administration (FDA)-approved drugs for the treatment of opioid dependence through Medication-Assisted Treatment (MAT) in jails be considered as options for treatment, including, but not limited to, long-acting, injectable medication regimes.").

Appendix A

DISABILITY RIGHTS
NORTH CAROLINA

Statewide survey of jails in NC for the availability of medications for opioid use disorder

Disability Rights North Carolina is working with Vital Strategies to gather information on the availability of medications for opioid use disorder (MOUD) in jails across the state. This survey should be completed by the person who would be most familiar with your facility's policies or procedures on MOUD.

Date:
Name of Facility:
Name/Title of Facility Representative:
Contact Information email/phone:

1. Does your facility screen for Opioid Use Disorder (OUD)?

    a. Who conducts the screening?

    b. How long after admission does the screening have to be done?

    c. Can the screening be postponed or skipped for any reason?

    d. Do you use a standardized screening tool? What do you use to screen?

        i. If you use a commercial standardized screening tool, please specify the name.

2. On average, how many people per month do you identify in this screening as having an OUD?

    a. What is the percentage of those identified with OUD out of the total number of people screened per month?

    b. Do you collect data on the number of people who are identified as having an opioid use disorder during the screenings?

    c. If you collect data, do you collect that data using demographic information such as race and ethnicity or gender?

3. What services, if any, do you provide to people with an opioid use disorder (e.g., medications, counseling, peer support, etc.)?

a. If services are provided, when are those services initiated?

    b. Does your facility have a withdrawal protocol?

4. Does your facility have a written policy(ies) for OUD treatment?

    a. If YES, what do the policies cover?

    b. If NO, is there a policy being developed or considered?

5. Does your facility provide any Medications for Opioid Use Disorder (MOUD) treatment?

    (If NO, answer a. and a. i-ii, if YES, skip to b.)

    a. **If no**, what are the barriers preventing MOUD services from being offered in your facility?

        i. Does your facility plan to develop an MOUD treatment program if they are currently not offering one?

        ii. If you plan to develop an MOUD treatment program, do you have a timeframe to develop the plan?

        [FOR FACILITIES WITH NO MOUD PROGRAM SKIP TO QUESTION 10]

    b. **If yes,** your facility does offer MOUD,

        i. Does your MOUD program work with any outside agencies? If so, which agencies.

        ii. Who administers the medications-what staff take part in this process? [E.g., jail staff? COs? internal medical? External medical?]

        iii. Where does the administration of the MOUD take place? Is it in the medical unit, in cells, in an outside clinic, etc. Please describe the process.

        [FACILITIES WITH AN MOUD PROGRAM CONTINUE TO NEXT QUESTIONS]

6. For those with an MOUD program:

    a. When are the MOUD services initially offered?

    b. What medications are offered?

    c. Do you collect demographic data such as race/ethnicity for the MOUD program?

7. Is this MOUD treatment offered to all people in custody?

    a. If only offered to some populations, which population(s) is it offered to (e.g., pregnant women, those who enter the jail with existing MOUD prescriptions, anyone who requests and is approved by medical)?

b. If your facility provides MOUD, what standards, if any, must patients meet in order to be provided with MOUD?

8. Are any other treatments/resources provided for those receiving MOUD services? (e.g., counseling, therapy, group therapy, 12 step groups, peer support, etc.)

a. If provided, are these treatments/resources offered as voluntary treatment or are they mandatory in order to receive MOUD?

9. Have the people under your care experienced any interruption in their dosage schedule, e.g., people are not able to get the doses each day or as often as prescribed?

a. If so, what is the cause of that interruption (some reasons may be staff availability, provider availability, discipline, diversion, etc.)

i. If there are interruptions for diversion (e.g., medication not going to the person intended) of MOUD, do you collect data on this and do you know the reasons for any diversion? Please describe:

10. Are those who have an opioid use disorder provided with aftercare and/or follow-up community resources/referrals upon release?

a. Are you experiencing any barriers to getting people aftercare in the community and please describe what the barriers are that you have encountered?

11. Does your facility have an ADA Coordinator (Americans with Disabilities Act)?

a. If yes, may we have the name and contact information for that person?

12. Does your facility contract with a third-party provider to provide medical services in the facility?

a. If yes, what is the name of that third party provider?

Thank you for your participation. **Please return the completed survey to** lisa.gessler@disabilityrightsnc.org or dane.mullis@disabilityrightsnc.org

Appendix B

DISABILITY RIGHTS
NORTH CAROLINA

July 20, 2023

To: Sheriff's Department/County Detention Center(s)

Re: Public Records Request

I am writing to make a public records request. As necessary to fulfill this request, please redact personally identifying information protected by HIPAA. If there is more than one detention facility in the county, please provide the information for all facilities in the county. You may do this separately, if needed, if the information differs based on the facility.

We are requesting the following records for the dates of January 1, 2022 to present (unless otherwise specifically noted):

1. The name, title and contact information (email and phone number) of the person in charge of the jail's medications for opioid use disorder (MOUD)/medication assisted treatment (MAT) program. MOUD/MAT includes methadone and buprenorphine/suboxone and similar medications.
    a. If no MOUD/MAT program is in place, the name, title and contact information of the person in charge of making decisions about the use of MOUD/MAT in the jail.

2. The name, title and contact information (email and phone number) of the ADA Coordinator for the jail/Sheriff's Office.

3. All documents pertaining to opioid use disorder in the County jail/detention center(s), including, but not limited to, the use of MOUD or MAT, the current jail medical plan, records, policies and procedures, memorandum, MOUs (memorandum of understanding), withdrawal protocols, contracts with third party medical providers, and

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screening tools used (or please provide the name of the screening document used if it is a proprietary tool by ASAM (American Society of Addiction Medicine) or other entity).

4. Written communications including, but not limited to, emails, letters, and memos written by or to jail staff, county officials, or other county employees, or contracted medical staff related to the determination to provide/not provide MOUD/MAT and/or the decision to use to other treatment or monitoring protocols.

5. Records evidencing the demographic data of the total number of individuals in jail, month by month, including race and gender.

6. Records evidencing the demographic data of the number of unique individuals, month by month, who present with opioid use disorder (OUD) during intake, broken down by race and gender.

7. Records evidencing the number of unique individuals receiving MOUD/MAT, month by month, broken down by race, gender, pregnant/not pregnant, and type of medication.

8. Records evidencing the number of individuals who received MOUD/MAT in the community prior to incarceration broken down by race and medication, but whose MOUD/MAT was terminated while at the jail. Indicate if this was discontinued due to lack of MOUD program in the facility,

9. Records evidencing the number of unique individuals who received MOUD/MAT at the jail, but whose MOUD/MAT was later terminated, month by month broken down by race and medication and the reason that the medication was terminated or discontinued.

10. Records evidencing the number of unique individuals who received MOUD/MAT based on a court order.

11. Records evidencing the amount budgeted for MOUD/MAT. Specify what is used for medications alone and what is used for costs to administer the program such as staffing, etc., and the amount spent by year.

12. A copy of any disciplinary policies, including but not limited to any policies around medication diversion (medication given to a person other than the intended recipient), that would impact initiation or continued provision of MOUD/MAT.

13. Any grievances related to MOUD/MAT medications (including, but not limited to, Buprenorphine, Suboxone, Sublocade, Methadone, Naltrexone, and Vivitrol), and/or opioid withdrawal. Include the written or other response to those grievances as well as any internal documents, emails, etc. touching on or regarding the grievance.

14. The number of appeals to those grievance decisions and copies of any appeal documents and responses.

*** If such data is not collected, please indicate that data does not exist.**

**** If such policies and procedures do not exist, please respond with "does not exist."**

***** If data is not collected broken down by race, etc., please provide what data you do have.**

Thank you for your assistance. If there is more than a nominal fee associated with filling this request, please contact us first. Please contact Lisa Gessler, DRNC Staff Attorney, with any questions you may have about this request. I can be reached at 919-856-2195 x207 or lisa.gessler@disabilityrightsnc.org .