

A Regional Learning Health System Approach to SUD Care for Individuals involved in Criminal-Legal Systems

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Presenter Disclosure Information

- ◆ Jordan Boulger, MA
 - ◆ No Disclosures
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 - ◆ No Disclosures
- ◆ Thomas Lyons, PhD
 - ◆ No Disclosures
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 - ◆ No Disclosures

Learning Objectives

Upon completion, attendees will be able to:

- ◆ Define a Learning Health System (LHS).
- ◆ Describe the application of the LHS framework to substance use disorder (SUD) care for individuals involved in the criminal legal system.
- ◆ Describe barriers and facilitators to applying a regional LHS framework for a specific population.

What is a Learning Health System (LHS)?



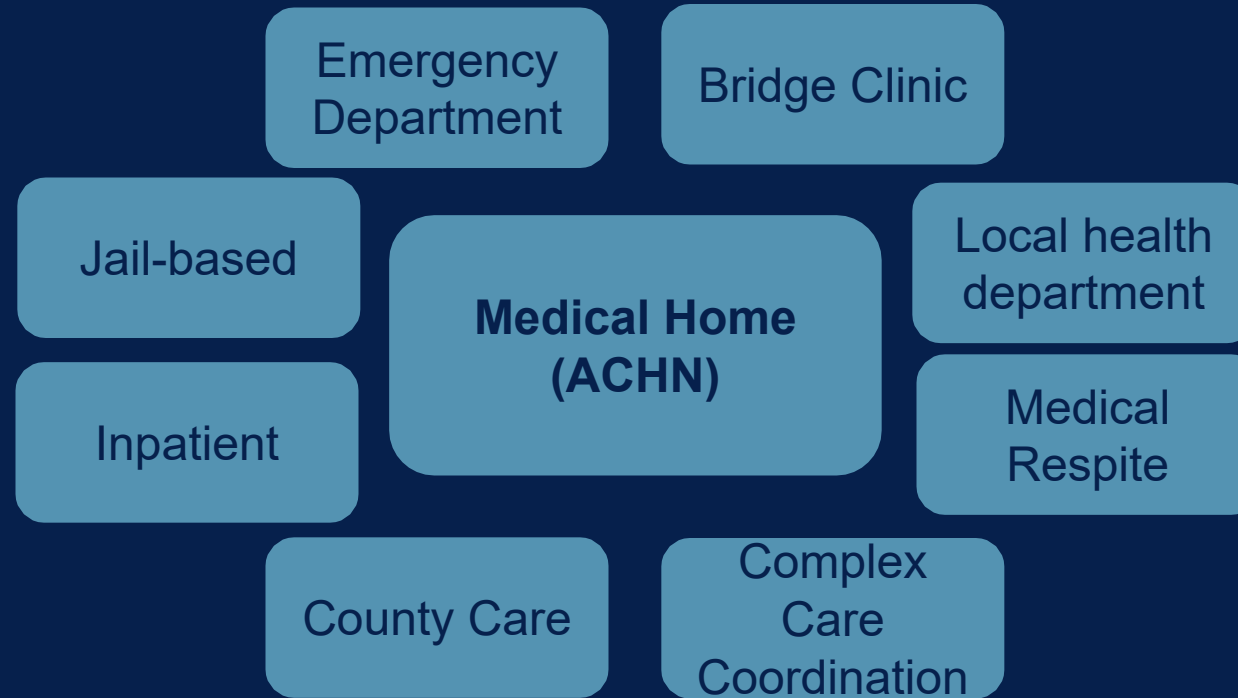
- ◆ “...a health system in which internal data and experience are systematically integrated with external evidence, and that knowledge is put into practice. As a result, patients get higher quality, safer, more efficient care, and health care delivery organizations become better places to work.”

Cook County Health (CCH) Substance Use Disorder Program

System-Level: No Wrong Door

Program Principles

- Multidisciplinary
- Patient-centered
- Physical, Mental, Social Health
- Harm reduction / overdose prevention



Medical home:

500+ active patients each month
35+ engaged medical providers
Embedded recovery coaches

Why an LHS approach?

- ◆ U.S.: over 5.7 million under correctional control, >50% on probation (2022).¹
- ◆ Nearly 2/3 of incarcerated individuals have a history of substance use disorder.²
- ◆ Approx. 1/3 SUD treatment referrals come from the criminal legal system.³
- ◆ Inequities: Black men 5x more likely arrested for drug-related charges than white men (similar rates of SUD).⁴



1. <https://www.prisonpolicy.org/reports/pie2022.html>

2. https://www.asam.org/docs/default-source/advocacy/mat-in-crmj-settings-final.pdf?sfvrsn=10a559c2_2

3. Smith, K. and Strashny, A.

4. Mitchell O, Caudy C.

Why an LHS approach?



ASAM American Society of
Addiction Medicine

**Public Policy Statement on Access to Medications for Addiction Treatment for Persons Under
Community Correctional Control**

The American Society of Addiction Medicine recommends:

1. All persons under community correctional control should have equitable access to evidence-based treatment for substance use disorder (SUD), including all FDA-approved medications available in the community or via telehealth. Treatment decisions should be made collaboratively between the patient and their healthcare provider(s). Judges and probation/parole officers should not make specific treatment recommendations or mandate or prohibit any particular type of treatment or peer support, but instead should know how to help patients identify and connect with local SUD treatment providers. Treatment is most likely to be successful when patients have a choice and provide informed consent regarding the type of behavioral and medication treatment(s) they engage in. Patients should be able to accept or decline any particular treatment, and they should be able to stop treatment if they wish.

- ◆ Probation officers survey: MOUD as least likely referral option among treatment options used by probation officers²

1. <https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2021/08/09/access-to-medications-for-addiction-treatment-for-persons-under-community-correctional-control>

2. Reichert, J., & Gleicher, L.



Why an LHS approach

IL Dept.
Human
Services
(SUPR)

Cook
County
Health

SUD
licensed
treatment

Adult
Probation

Learning Health Systems



Systematically gather and
create evidence.

Apply the most promising evidence
to improve care.

Problem
solving
courts

FQHCs

Additional
partners

Community-
based orgs

Recovery
homes +
housing
providers

Persons
with lived
experience

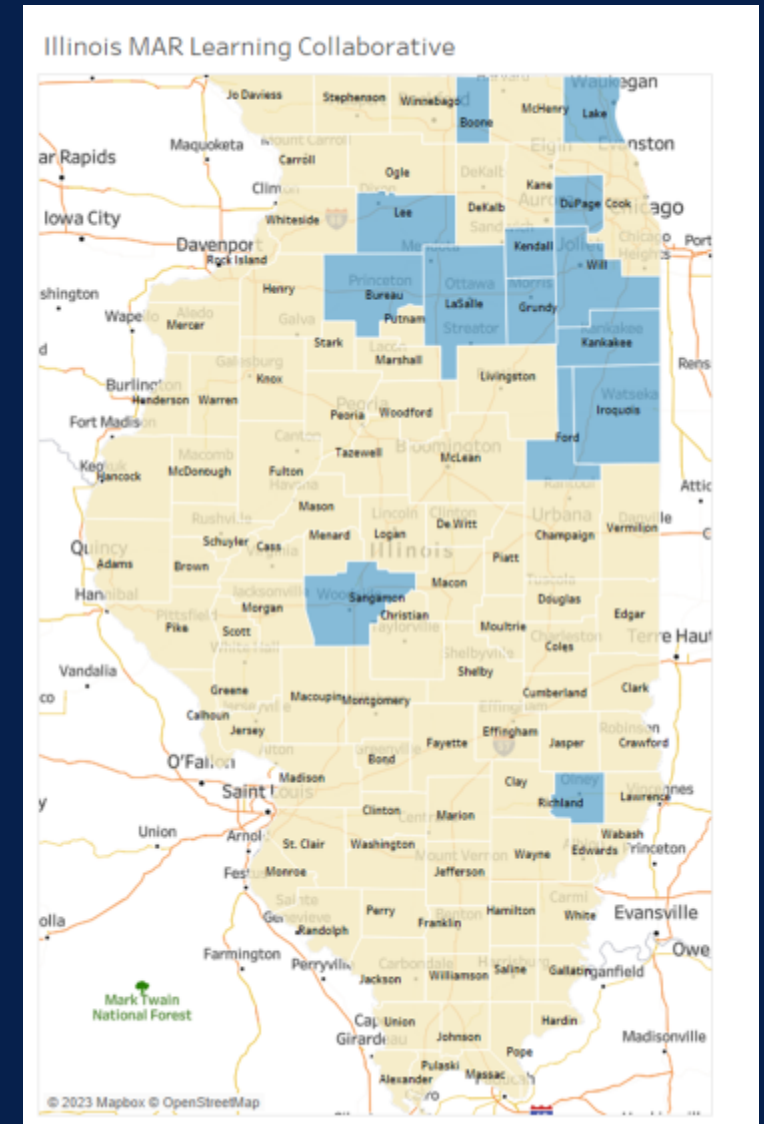
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electronic
monitoring

LHS Case Studies



Case 1: IL Medication assisted Recovery (MAR) Learning Collaborative for County Jails: Overview

- ◆ **Problem:** People with OUD have much higher risk of OD death at release from incarceration
- ◆ **Solution:** Evidence shows that receiving medication assisted recovery (MAR) in jail can reduce OD deaths
- ◆ **Problem:** Few jails offer this treatment
- ◆ **Solution:** A Learning Collaborative program can facilitate implementation of MAR in county jails



Case 1: Illinois MAR Learning Collaborative for County Jails

◆ Priority Population

- ◆ Illinois State Overdose Action Plan identifies justice-involved individuals as high priority for receiving services to treat and prevent overdose
- ◆ Treatment for incarcerated people is one of the eight core strategies for overdose settlement funds in IL

◆ Learning Collaborative

- ◆ IL SUPR contracted with Health Management Associates (HMA) to provide robust expert technical assistance (TA) for county teams interested in standing up or expanding medication assisted recovery (MAR) programs in their jail and to support continued recovery support in the community post-release.
- ◆ Modeled after highly successful California jail MAT implementation learning collaborative
- ◆ Initiated with SOR II funding, continuing with SOR III funding
- ◆ 14 counties currently participating with “open enrollment” to other interested counties to join the learning collaborative: Receive individualized county team coaching, participation stipends, and multiple modes of learning and TA

Case 1: Illinois MAR Learning Collaborative for County Jails

- ◆ Why focus on MAR in jails?
 - Nationally, most jails and prisons:
 - Withdrawal management with only symptom response ("comfort meds") is common
 - Erratic and non-evidence-based practice is common and especially risky for pregnant women
 - Forced withdrawal from MAR when incarcerated is common
 - In jails/prisons, custody trends *toward*:
 - Transition to accepting OUD as identical to other chronic diseases
 - Growing recognition that appropriate treatment reduces custody challenges

Growing body of case law finding counties liable for not providing access to MAR in jails



Over-Jailed and Un- Treated

https://www.aclu.org/sites/default/files/field_document/20210625-mat-prison_1.pdf

Case 1: Illinois MAR Learning Collaborative for County Jails

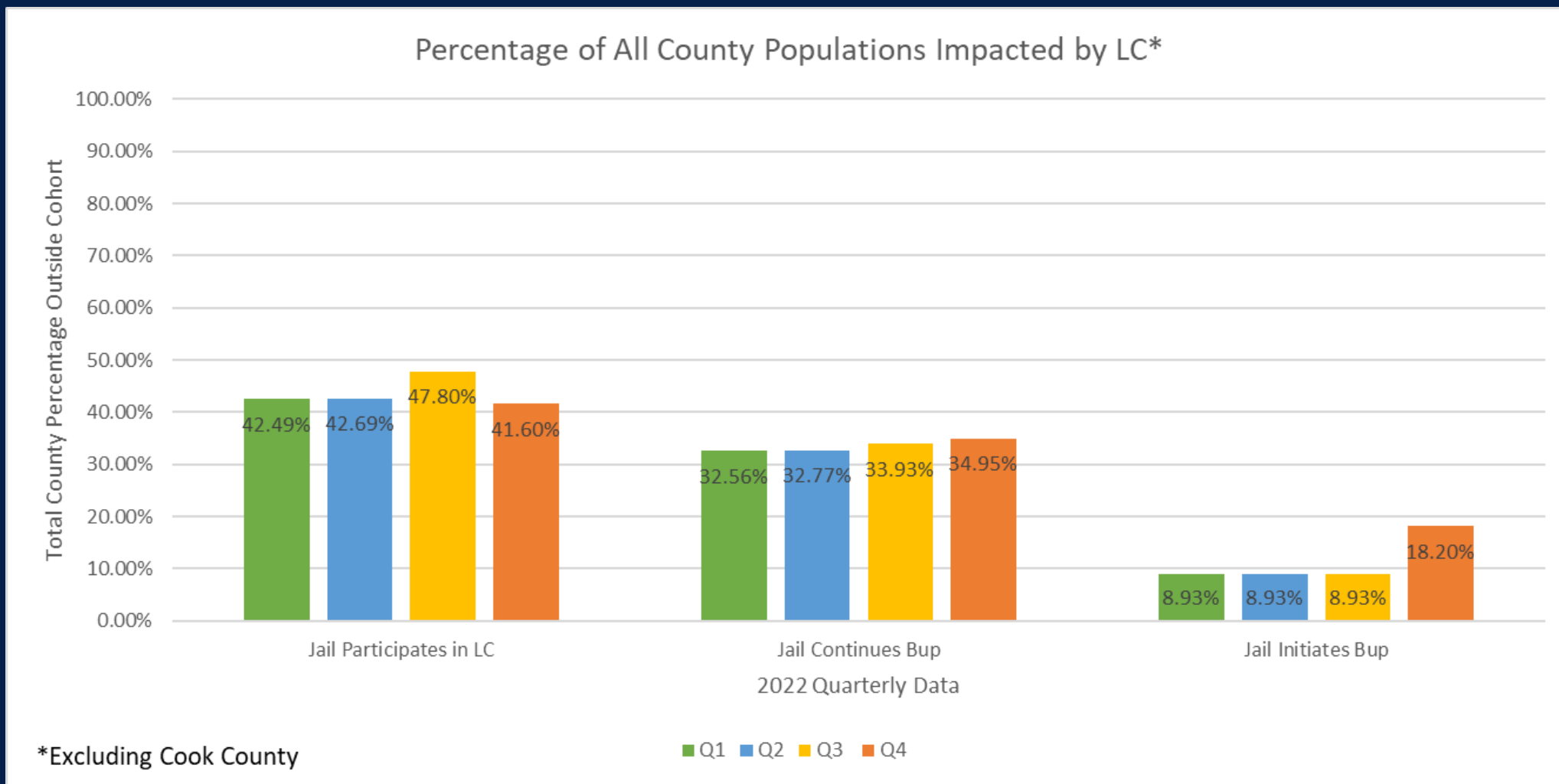
◆ Why develop a Learning Collaborative model?

- **The jail is a health care site in the community's health care safety net**
- Important to engage all stakeholders. The county has a single standard of care such that persons with OUD have access to all FDA-approved forms of MAR available to them, via an individualized treatment plan, as well as effective treatment for stimulant use disorder

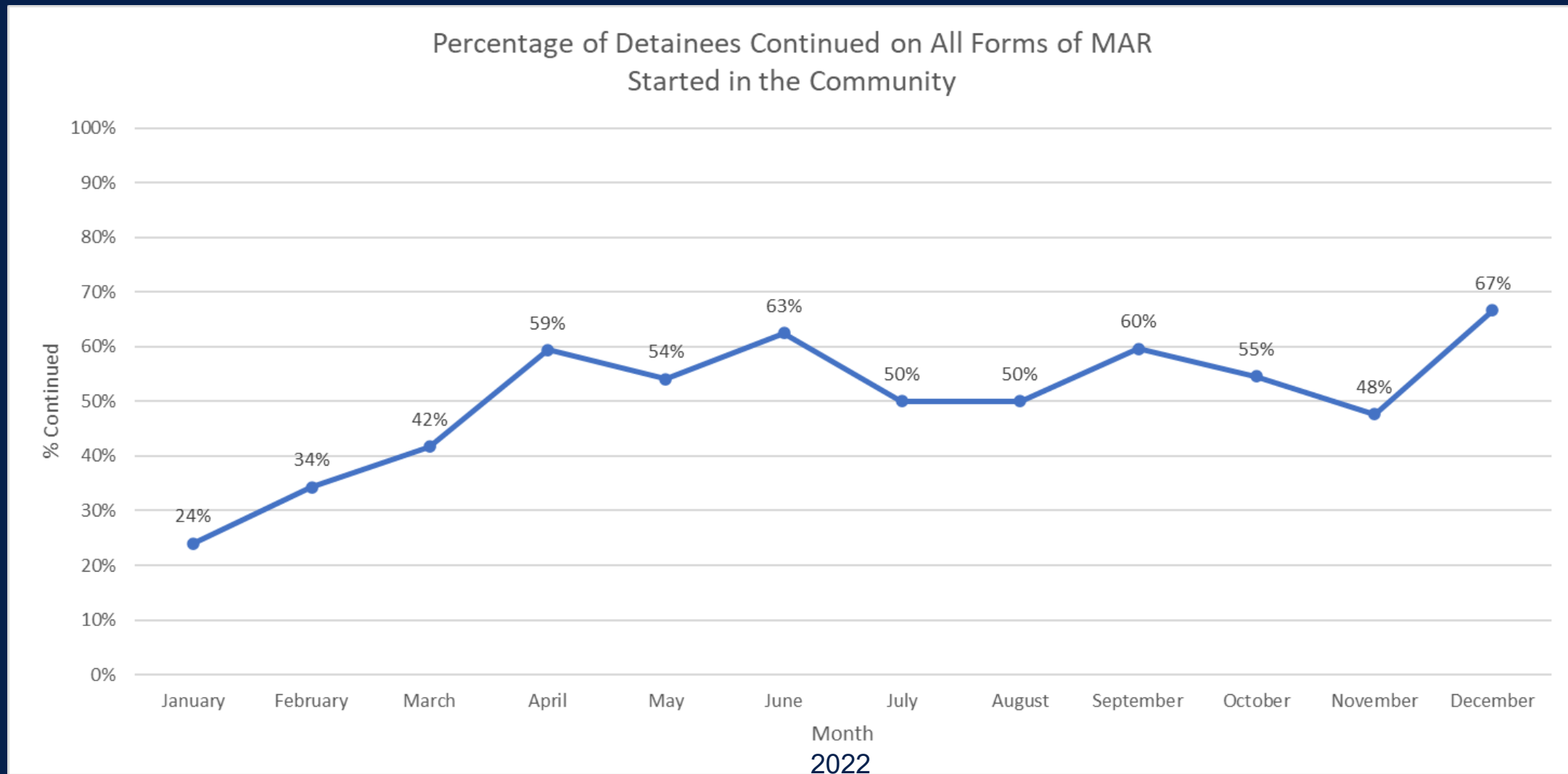
- **Different perspectives on person with SUD:**



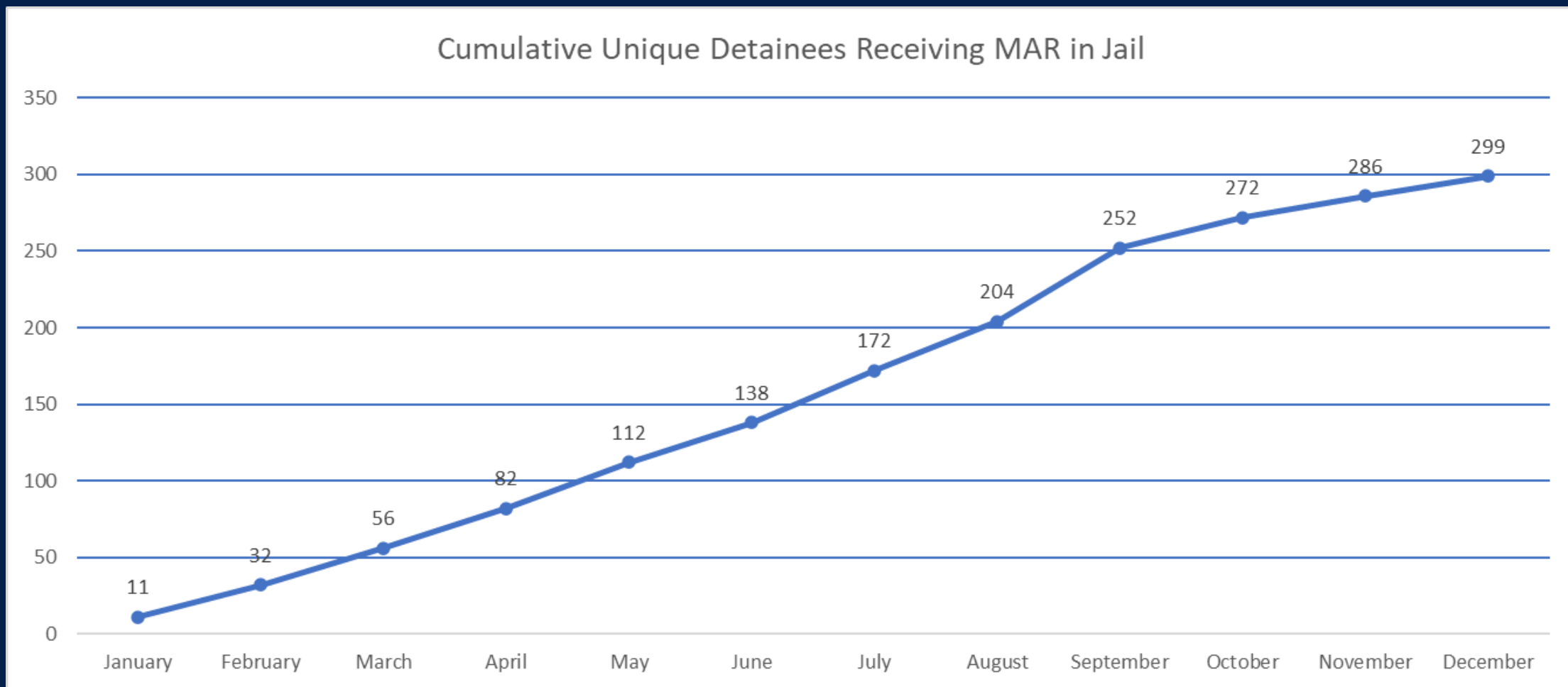
Case 1: Illinois MAR Learning Collaborative for County Jails



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Case 1: Illinois MAR Learning Collaborative for County Jails



Case 1: Illinois MAR Learning Collaborative for County Jails

Barriers

- ◆ Stigma, stigma, stigma.
 - ◆ Jail healthcare providers profess that they “don’t believe in MAR”
 - ◆ Custody staff recognize MAR drugs as trafficked drugs; just “clean up your act” attitude
- ◆ Fear of diversion in jail; Quote from sheriff, *“I don’t want to be known as the sheriff that brought that crap into the jail.”*
- ◆ Fear of change; Quote from jail administrator, *“There are two things that custody professionals don’t like--the way things are and change.”*
- ◆ Correctional HC vendors not equipped
- ◆ Lack of funding for sustainability
- ◆ Custody staffing a significant issue (i.e. not a WFH workplace)
- ◆ No MAR at IL Dept of Corrections
- ◆ COVID impact on jails

Facilitators

- ◆ IL SUPR commitment and support
- ◆ Jail leadership; all jails are hierarchy
- ◆ Growing risk of liability (one actual threatened suit in Illinois county); DOJ statement on ADA violation for failure to continue MAR
- ◆ LC model with stipend, jail-peer sharing, and TA to make change easier
- ◆ Pressure from community leaders such as LHDs and providers
- ◆ Collaboration with providers including MAR NOW



Case 1: Illinois MAR Learning Collaborative for County Jails

◆ Next Steps:

- ◆ Continue to move jails along continuum of MAR provision and SUD care
 - ◆ E.g. some jails only providing continuation of community-prescribed MAR; one jail refuses to provide naloxone at release
- ◆ Work on community integration, SUD treatment, and re-entry coordination for all jails
- ◆ Recruit additional jails to participate; aiming for additional 8 jails in 2023

Case 2: Cook County Adult Probation

- ◆ Overview of the need for opioid response for probation populations
 - ◆ High levels of opioid use within probation population
 - ◆ Unknown levels of overdose-related mortality
 - ◆ Gaps in probation officer knowledge on evidence-based referrals
- ◆ Department's goals
 1. Understand the scope of the problem and the demand/need for services
 2. Develop partnerships with public health agency (Cook County Health) and community-based providers to fill gaps

Case 2: Opioid-related mortality (ORM)

Key Findings

- ◆ ORM rate of 361 per 100,000 for probation clients is 15 times higher than the general Cook County population (23 per 100,000)
- ◆ Fentanyl was detected in 86.8% of deaths
- ◆ Older clients (45+), white clients, and those with a history of opioid use (positive urinalysis or treatment placement) were at a higher risk
- ◆ Black clients experience ORM in higher numbers, but white clients had higher relative risk



Case 2: Responses to the problem

- ◆ Project START – Standardized & Technology Assisted Referrals to Treatment
- ◆ CAT-MH and social worker referrals
- ◆ Research partnership to understand housing needs of clients in recovery
- ◆ Formalized data sharing between probation and CCH for Medicaid eligibility or redetermination
- ◆ Exploring partnership between probation and CCH for overdose response plan

Case 2: Project START & CAT-MH

Project START

- ◆ Staff interviews on treatment referral process
- ◆ Identified gaps in knowledge of availability and effectiveness
- ◆ Staff training on IL Helpline tool

CAT-MH

- ◆ Adaptive screening for certain MH concerns and opioid use
- ◆ Automated text message link sent to new probation clients
- ◆ Flagged results sent to social workers and partner treatment provider for follow up

Case 2: Barriers

- ◆ Unknown scope
 - ◆ How big is this issue in Cook County?
 - ◆ What is driving it?
 - ◆ What are the risk factors?
- ◆ Knowledge gap for staff
 - ◆ Understanding of best practices
 - ◆ Understanding of available providers
- ◆ Skepticism and resistance
 - ◆ Staff and judicial hesitation around medications
 - ◆ Agency hesitation around distribution of naloxone

Case 2: Facilitators

- ◆ Receptive administration & leadership
- ◆ Availability of detailed, case-level data
- ◆ Strong local partners
 - ◆ Public health system – Cook County Health
 - ◆ Research support – University of Chicago, Illinois Criminal Justice Information Authority
 - ◆ Treatment providers and supports – Family Guidance Center, IL Helpline

Case 2: Next steps

- ◆ Expanding training on resource referrals and use of Helpline
- ◆ Continuing to send the CAT-MH to new clients
- ◆ Continuing with research on housing needs for clients in recovery
- ◆ Building an ongoing, formalized data sharing structure with CCH (executed data use agreement- Feb 2023)
- ◆ Developing and implementing a departmental overdose response plan

Case 3: Data Collecting and Monitoring in Problem-Solving Courts

Why: An estimated 70% of individuals involved in the criminal justice system have a behavioral health disorder, making state courts a significant referral source to community behavioral health treatment, and often making jails the largest behavioral health facilities in the jurisdiction.

Priority Population: High-Risk/High Need individuals

Strategy: Problem-Solving Courts

https://www.ncsc.org/__data/assets/pdf_file/0031/84469/MHTF_State_Courts_Leading_Change.pdf



Case 3: Data Collecting and Monitoring in Problem-Solving Courts

- ◆ Problem-solving courts, such as mental health courts, drug courts, and veterans courts are comprised of teams of specially trained judges, attorneys, probation officers, coordinators, and clinical specialists who provide wrap-around services and intensive monitoring of defendants who are in the criminal justice system as a result of substance abuse, mental health, or co-occurring disorders.



Marlow, D. B. (2010). Research update on adult drug courts. Washington, DC: National Association of Drug Court Professionals.

Case 3: Data Collecting and Monitoring in Problem-Solving Courts



Illinois Problem-Solving Court Standard 4.6: STATISTICAL DATA MONITORING AND REPORTING

- ◆ (a) Each PSC shall establish a formal plan for data collection and program evaluation
- ◆ (b) Achievement of PSC program goals and objectives shall be monitored and evaluated by the PSC team.
- ◆ (c) Program operational reviews of the PSC shall be conducted on a consistent basis.

Case 3: Data Collecting and Monitoring in Problem-Solving Courts

Administrative Office of the Illinois Courts
Award # 2019-MU-BX-0018



BJA FY 19 Adult Drug
Court Discretionary Grant
Program Solicitation

- ◆ Determine PSC data elements
- ◆ Create definition data set
- ◆ Develop a data collection process
- ◆ Reporting in 2023

Case 3: Data Collecting and Monitoring in Problem-Solving Courts

Continue to Evaluate Problem-Solving Courts

Without randomized control trials or studies using matched samples, it is difficult to truly understand whether courts produce the desired outcomes. This becomes even more important as programs expand to different locations and populations. Extensive evaluation can help build consistency and effectiveness. According to state standards developed by the Administrative Office of the Illinois Courts, all PSCs must establish a formal plan for data collection.



<https://icjia.illinois.gov/researchhub/articles/an-overview-of-problem-solving-courts-and-implications-for-practice>

Case 4: Peer Support in Drug Court Project

- ◆ Offer peer recovery support services to participants in Cook County problem solving court
- ◆ Cook County Office of the Chief Judge/Problem Solving Courts + Cook County Health's SUD Program partnership
- ◆ Funded in part by Department of Justice Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP)

Case 4: Peer Support in Drug Court Project

2022 timeline:

- ◆ Jan: Chicago Sun Times Op-Ed re: Drug Courts
 - ◆ Reflect the CCH patient experience? Participant who does not graduate?
- ◆ Feb: Initial exploratory meeting
- ◆ Planning meetings, additional team members
- ◆ June: Court observation, introduce peer
- ◆ Aug: Intro to national models
- ◆ Sept: Intervention orientation with court
- ◆ Oct: Launch of Peer Engagement to Enhance Recovery (PEER)

Case 4: Peer Support in Drug Court Project

Working on Recovery Goals? Erik is here to help!



Cook County Health Recovery Coach

How can Erik help me reach my goals?

Erik has been in recovery for 31 years. He can use both his personal experiences and 29 years of professional training to help identify recovery goals and problem solve any barriers.

Who is Erik able to support?

Erik is able to support all participants of Drug Court.

What information will Erik share with the Drug Court team?

None! Erik is not a part of the Drug Court Treatment team. Conversations between you and Erik will remain confidential. Erik can help support you to communicate your successes and challenges to the treatment team. He is here to advocate and support you. He is here to support goal setting and problem solving.

How do I reach Erik?

Erik can be reached Monday – Friday from 8am to 4pm at (773) 919-5528 (call or text is okay!)

The Peer Engagement to Enhance Recovery ("PEER") Program (Sept 2022)

What:

- PEER is a partnership between the Office of the Chief Judge and Cook County Health.
- Goal: offer peer recovery coach support to participants engaged in the Problem-Solving Courts.

Why:

- Growing evidence for effectiveness of peer support
- drug courts have embedded peer recovery support
- amended in June 2022 to include a peer recovery coach
- Create optional and confidential supports for participants
- services offered by the ACT team
- Pilot the intervention in Judge Walsh's ACT court
- effectiveness. If favorable, plan to disseminate information

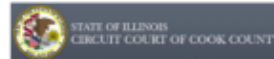
Pilot Details:

- Erik Bady is a certified alcohol and drug counselor
- Health. He has 29 years of experience directly providing
- and helping individuals with SUD navigate care services
- comfortable sharing his journey with participants
- Mr. Bady is not a member of the ACT team. Info shared with the ACT team. Mr. Bady may encounter
- with the ACT team.
- Mr. Bady will be introduced by Erin Deegan to participants
- explaining the program
- Mr. Bady and Ms. Deegan will meet regularly to discuss
- outcomes and to address challenges.

Outcome measures:

- Number of participants linked for potential engagement
- Number of participants who successfully connect
- Length of time and number of engagement sessions
- Inventory of services provided (directly or via link)
- Inventory of barriers to recovery addressed by participants
- Qualitative feedback from team members and participants

Questions? For more information, contact Ms. Erin Deegan



¹ https://3.amazonaws.com/peer-content/peer-embedded/files/9eb8d379dc8b_C1EAgovintheEvidenceRSE22.pdf

² <https://www.iga.gov/legislation/lcs/lcs3.asp?ActID=2014>

CCH Peer Recovery Support Agreement

A Recovery Coach (Peer Advocate) is someone who will support your recovery goals by helping to identify barriers and partner in problem solving.

Working with a Peer Recovery Coach in the Drug Court Program is completely voluntary. How often and what activities you and your Recovery Coach work on are completely up to you.

Your Recovery Coach can support you in the following ways:

Direct Support:

- Your Recovery Coach may help you to identify your goals of recovery and understands that there are multiple paths that meet them. Your Recovery Coach will support you to find a path that is meaningful for you.
- Your Recovery Coach can share knowledge as you request for recovery resources including referrals for groups in the community, sober social events, substance use treatment, if you wish, or employment, transportation, healthcare, housing, etc.
- Your Recovery Coach is not a sponsor or therapist, but can help you find one if you'd like.
- Your Recovery Coach can share their own personal experience in Recovery, if appropriate, to share what worked or did not work for them, while also understanding that you will have your own unique path to recovery.

Confidentiality:

- Your Recovery Coach is NOT a part of the Drug Court Treatment team. Conversations and information you share with your Recovery Coach will NOT be reported to the Drug Court Treatment team. Your Recovery Coach may support you to communicate your successes and challenges directly with the team.
- If you wish to have your Recovery Coach share information with the team, a consent must be signed.
- In some emergency cases or concerns of safety, your Recovery Coach may have a legal responsibility to disclose information to individuals who can help. For instance, if your coach suspects you might harm yourself or others, or if there is any suspicion of child abuse or neglect, your coach may break confidentiality to keep people safe.

Contact Information

	Recovery Coach	Participant
Name		
Phone number (text okay?) (Okay to leave messages?)		
Availability (Days, times) Other info?		
I agree and understand (Signature)		

Case 4: Peer Support in Drug Court Project

- ◆ Quality improvement cycles
 - ◆ Proactive outreach with consent
 - ◆ Aggregate and qualitative data loop
 - ◆ Evolving frequency of court visits
 - ◆ Revise data collection tools via RedCap
- ◆ Pilot outcomes: 15 engaged participants (Oct 2022-Feb 2023)

Case 4: Peer Support in Drug Court Project

- ◆ Barriers:
 - ◆ Hiring challenges (ie- coach covering Emergency Dpt.), team bandwidth
- ◆ Facilitators:
 - ◆ Acknowledgement of perspectives and alignment: health intervention
 - ◆ Trust and communication
 - ◆ Funding for peer
 - ◆ Intervention champions within Problem-solving court
 - ◆ Qualitative and quantitative data driving implementation
- ◆ Next steps:
 - ◆ Sustained funding through 2025
 - ◆ Planned expansion to Maywood courtroom- March 2023
 - ◆ Explore policy collaboration- urine drug screening

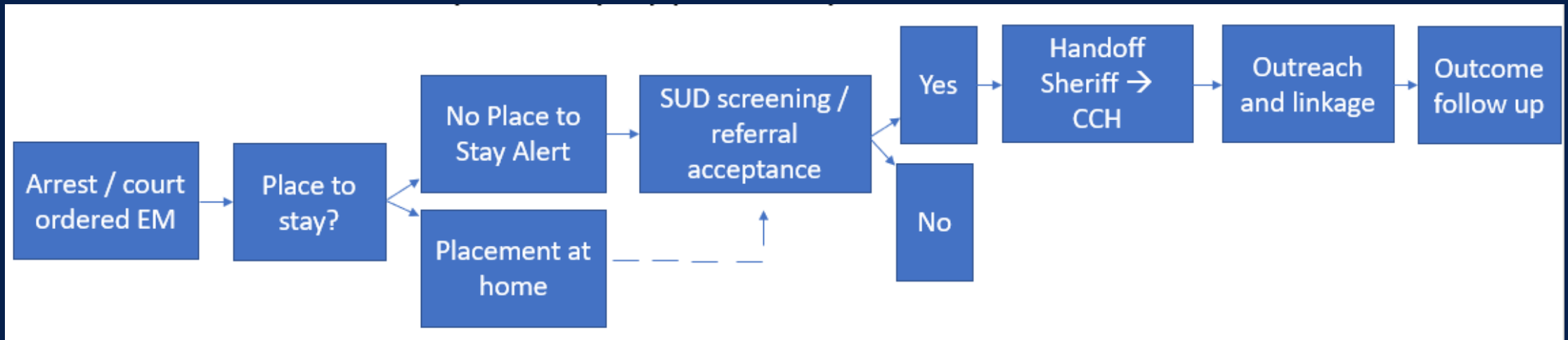
Case 5: “No Place to Stay” Project

- ◆ Linkage to evidence-based SUD care + recovery support services for individuals on electronic monitoring
- ◆ Cook County Sheriff’s Programming Department + Cook County Health’s SUD Program
- ◆ Funded in part by Department of Justice/Arnold Ventures Planning Initiative to Build Bridges Between Jail and Community-Based Treatment for Opioid Use Disorder (OUD)

Case 5: “No Place to Stay” Project

- ◆ Pre-intervention 6 mo. Baseline data:
 - ◆ 19 referrals for psychosocial SUD tx
 - ◆ 14 referrals for MOUD
- ◆ Plan-Do-Study-Act (PDSA) Quality Improvement Cycles:
 - ◆ Virtual and existing resources
 - ◆ Flyer distribution
 - ◆ Sign-up sheets at discharge
 - ◆ “No Place to Stay” Alert as an opportunity

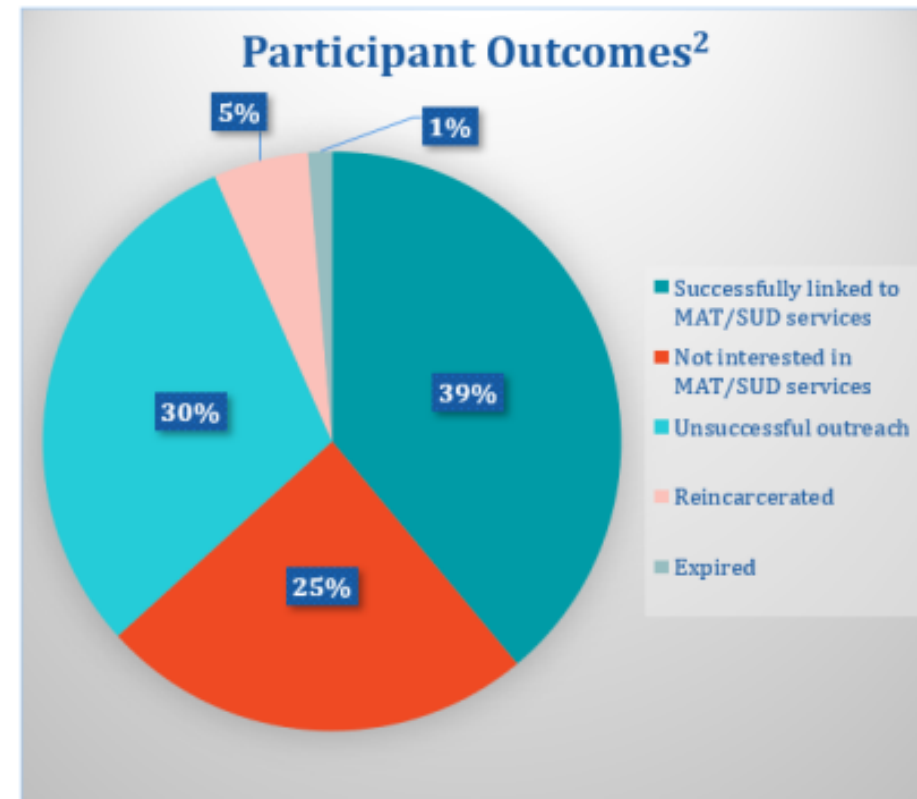
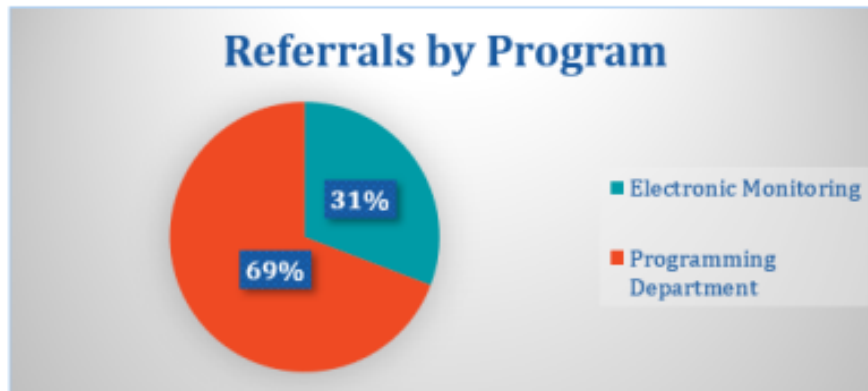
Case 5: “No Place to Stay” Project



Case 5: "No Place to Stay" Project

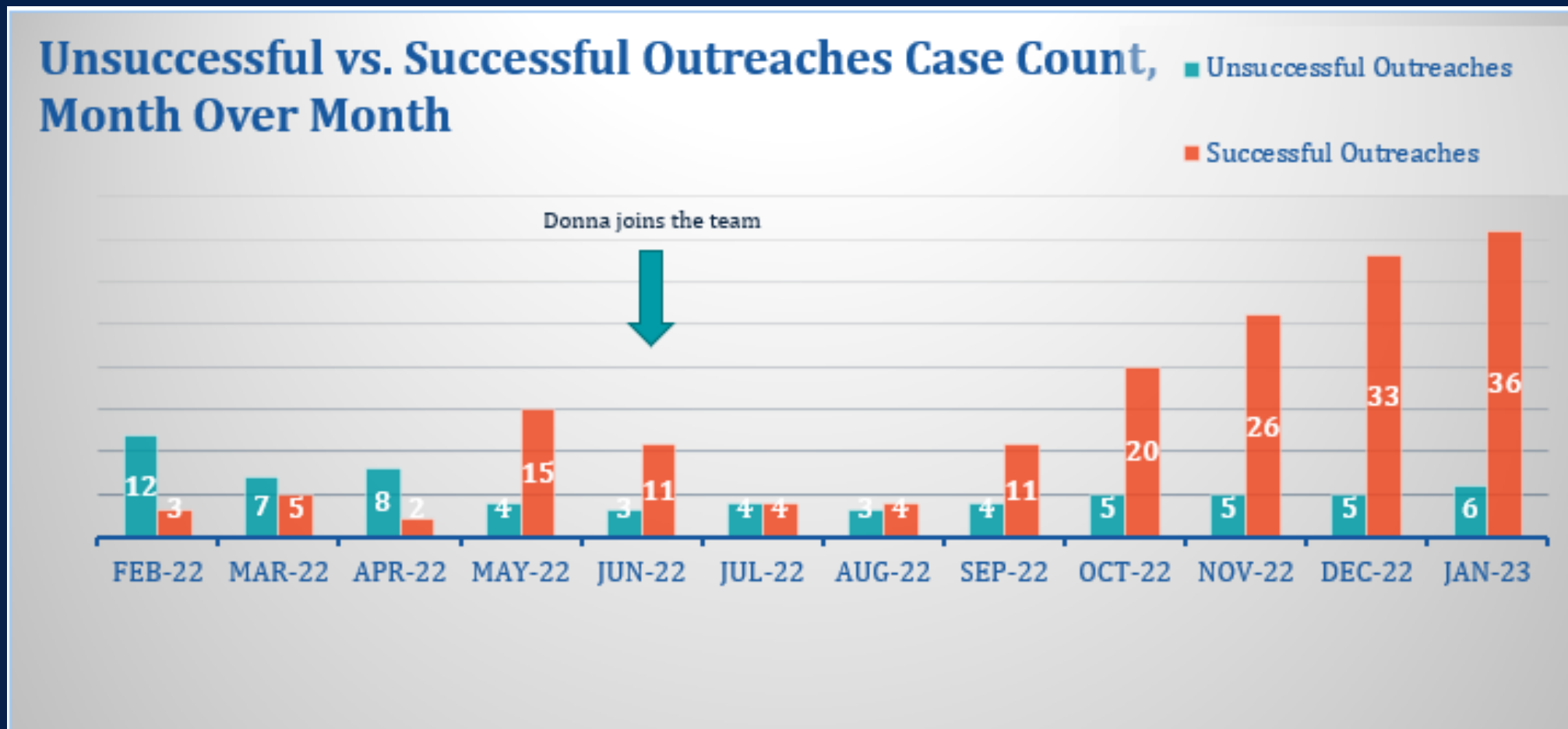
Results: October 2020-July 2021

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Case 5: “No Place to Stay” Project

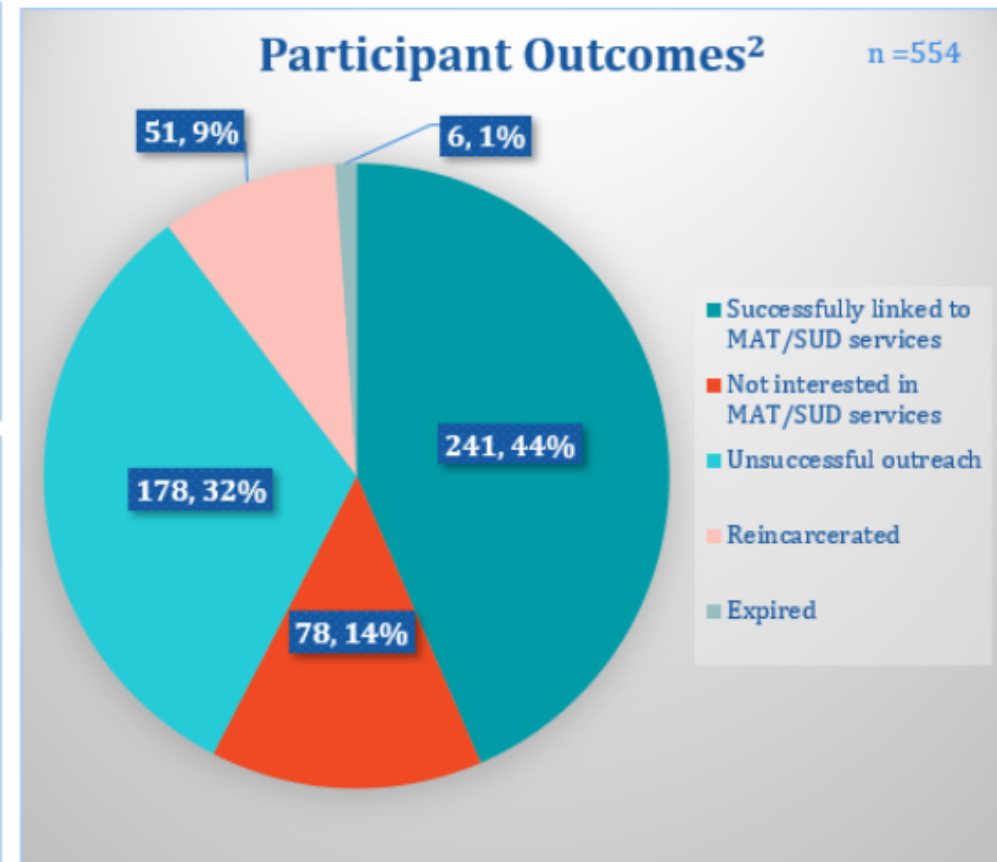
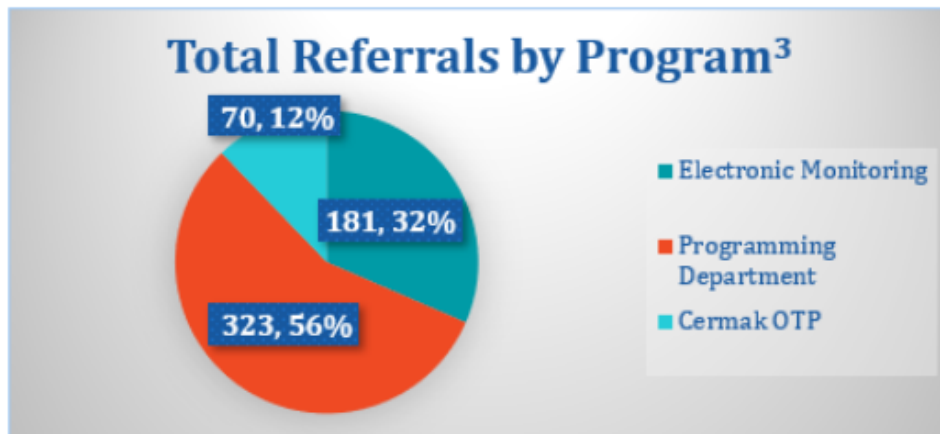
PDSA continued: Dedicated staff, new referral pathways



Case 5: “No Place to Stay” Project

EM Referrals Overview Dashboard – February 2022 to January 2023

2



1: Total referrals refers to all referrals received. This total may include duplicates.
2: Outcomes based on patients with “closed case status”. Patients we are actively working with aren’t counted towards outcomes.
3: Cermak OTP referrals were implemented on 9/26/2022

Case 5: “No Place to Stay” Project

Barriers

- ◆ Many factors at play:
 - ◆ Criminal legal involvement
 - ◆ MOUD not allowed/supported at some community sites
 - ◆ Systems are complex
 - ◆ Competing priorities
- ◆ Staffed/resourced for success
 - ◆ Hiring challenges, COVID
- ◆ Fluctuating resource capacity (especially in COVID)
 - ◆ SUD residential treatment, housing resources...

Case 5: “No Place to Stay” Project

Facilitators:

- ◆ Trust and respect
- ◆ Regular communication
- ◆ Outcomes measurement as key driver for QI

Next steps:

- ◆ Sustainability: transition of funding, additional partners

Panel Discussion / Q&A

- ◆ If you could start the project over again, what would you do differently, if anything?
- ◆ What is a benefit of taking an LHS approach? What is a challenge to the approach?

Takeaways: Learning Health System



Collaboration

Data-driven

Patient-centered

Systems thinking

Takeaways: Learning Health System

◆ Common Barriers:

- ◆ Stigma
- ◆ Behavior change is difficult. System behavior change even harder.
- ◆ Health and criminal legal approaches are different

◆ Common Facilitators:

- ◆ Leadership and on the ground buy-in
- ◆ Data: measuring outcomes and disseminating
- ◆ Flexibility for quality improvement and process change
- ◆ Policy changes and community pressure
- ◆ External funding for pilot of interventions

◆ Resource: Expert Recommendations for Implementing Change (ERIC):

- ◆ <https://implementationscience.biomedcentral.com/articles/10.1186/s13012-015-0209-1/tables/3>

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Thank you!

