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Anticipated Barriers to Sustained Engagement in Treatment With Medications for Opioid Use Disorder After Release From Incarceration

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Abstract

Background: Although the burden of opioid use disorder is disproportionately high among persons who are incarcerated, medications for opioid use disorder are often unavailable in correctional settings. The Rhode Island Department of Corrections provides all 3 classes of medications for opioid use disorder to clinically eligible persons who are incarcerated. Despite a decrease in fatal overdoses among persons with recent criminal legal system involvement since the program's implementation, barriers to continued engagement in treatment after release from incarceration still exist.

Methods: We conducted 40 semistructured, qualitative interviews with people who were incarcerated and enrolled in the comprehensive medications for opioid use disorder program at the Rhode Island Department of Corrections. Analysis applied a general, inductive approach using NVivo 12.

Results: Participants discussed barriers to treatment engagement before incarceration, as well as anticipated barriers to medications to treat opioid use disorder continuation after release from incarceration. Structural factors including housing, health insurance, transportation, and the treatment program structure, as well as social factors such as social support networks were perceived to influence retention in medications to treat opioid use disorder post-release.

Conclusion: Our findings suggest that people with opioid use disorder who are incarcerated encounter unique challenges upon community reentry. Addressing structural factors that pose barriers to post-release engagement is essential to sustaining retention. We recommend utilization of peer recovery specialists to alleviate some of the stress of navigating the structural barriers identified by participants.

Keywords

medication for opioid use disorder; treatment retention; incarceration; reentry barriers

For over 2 decades, US fatal overdoses have risen exponentially.[1] People who are involved in the criminal legal system are disproportionately affected by the opioid overdose epidemic.[2,3] With limited access to opioids, persons who are incarcerated rapidly lose tolerance and are at increased risk of overdose post-release.[2,4] During the 2 weeks post-release, people are 129 times more likely to experience a fatal overdose than the general population.[5]

The Food and Drug Administration has approved 3 classes of medications to treat opioid use disorder (MOUD): methadone, buprenorphine, and naltrexone.[2] Corrections-based MOUD are associated with dramatic decreases in overdose-related deaths during the critical period immediately post-release.[6,7] In 2016, The Rhode Island Department of Correction (RIDOC) became the first statewide correctional system to screen, initiate, and provide all classes of medications to clinically eligible persons in all prison or jail settings.[8] Before the program, only pregnant individuals and a few with unique medical complications were maintained on methadone, none on buprenorphine. Preliminary research demonstrated that overdose deaths among persons recently released from RIDOC declined dramatically after the program's implementation.[9]

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The RIDOC contracts with CODAC Behavioral Healthcare, a statewide, community based, nonprofit opioid treatment program, to provide medication, counseling, and discharge planning, including scheduling post-release MOUD appointments for individuals in the MOUD program. Although those who receive this linkage to care are more likely to continue treatment upon release,[10,11] previous research has demonstrated that significant barriers in the community may still prevent these individuals from receiving MOUD in the community, including disenrollment from federal health coverage upon incarceration,[2,12] limited community provider availability and/or willingness to prescribe MOUD,[13–15] and long waiting lists and limited geographic MOUD coverage.[16,17]

Additional research has begun exploring the barriers that justice-involved people face when seeking treatment in the community including stigma, limited social support, inadequate access to health care, and unstable housing.[18–21] The purpose of this study was to deepen our understanding of the factors that impact post-release treatment engagement among people who are incarcerated with access to all 3 MOUD options and discharge planning. To identify barriers, we conducted an analysis of semistructured qualitative interviews with patients in the RIDOC MOUD program and examined their prior experiences with MOUD in the community, previous discharge planning experiences, and anticipated barriers to treatment engagement in the community post-release.

METHODS

Setting and Participants

Study methods have been described in detail previously.[22,23] Briefly, between June and August 2018, 40 semistructured, qualitative interviews were conducted with persons who were incarcerated and enrolled in the RIDOC MOUD program. Patients were recruited during group sessions, where study participants were able to confidentially sign up and later had an hour-long interview.

The sample was stratified to proportionately represent participants' medication type, facility where they were incarcerated (eg, pretrial, minimum and medium security), and whether MOUD induction occurred before incarceration or at RIDOC. Participants' length of incarceration and previous experience with MOUD also varied significantly.

Two team members, trained in qualitative research, conducted the interviews in a private room. Interviews were audio-recorded and later transcribed verbatim. Participants were compensated $25, deposited in their commissary. The interviewer used a semistructured interview protocol, which consisted of open-ended questions that covered a broad range of topics around MOUD, including predetermined questions on previous experience with MOUD and anticipated barriers to treatment continuation (see Appendix A, http://links.lww.com/JAM/A364). The study was approved by The Miriam Hospital's Institutional Review Board, the RIDOC Medical Research Advisory Group, and the Federal Office for Human Research Protections.

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Data Analysis

A general inductive analysis was used.[24] Five team members trained in qualitative research analysis developed an initial codebook that mapped onto the study objectives. Four interviews were then cross coded by all 5 team members to further refine the codebook and ensure coder agreement and uniform use. All codes were then compiled into a final codebook, and 3 team members coded the remaining transcripts in NVivo 12. This article examines results from "MOUD knowledge," "MOUD attitudes," and "postincarceration plans."

RESULTS

The mean age of the 40 participants was 37 (range, 22–66), the majority (83%) were non-Hispanic White, and 70% were male. See Table 1 for sociodemographics and medication history.

Specific circumstances that were perceived to impact engagement in MOUD post-release varied across interviews, but recurrent themes emerged. Structural and social factors included health insurance, housing status, transportation, treatment program structure, social support, and stigma. Specific to the carceral setting, participants frequently related anticipated barriers with their previous experience with discharge planning, or rather lack thereof.

Structural Factors

Transportation—Approximately half of participants (n = 17)—9 of whom were on methadone, 7 of whom were on buprenorphine, and 1 of whom was on naltrexone—reported that transportation was a barrier to engaging in MOUD post-release. The frequency at which participants are required to attend appointments in the community varies by medication type. A 31-year-old female participant described, "I was on methadone, and then I stopped methadone because I couldn't get to the clinic. My car broke down. It was just a hassle." Transportation was critically important to those on methadone, given daily clinic dosing. However, regardless of medication type, participants anticipated that access to transportation would be essential to continuing MOUD in the community. One 48-year-old participant on buprenorphine explained:

> "Because again, getting to my doctors, getting to appointments with my doctors, getting to other doctors concerns me. It's related to the Suboxone [buprenorphine] as well, because it's all part of my health now."

Several participants discussed transportation services that could aid their treatment in the community, including a subsidized bus pass. One 37-year-old participant anticipated that continuing MOUD post-release would be made more challenging without transportation access but noted that the contracted MOUD provider at RIDOC provides bus passes to aid with the transition:

> "Challenges would be like transportation […] they will give you a bus pass when you leave. So that's good for a week, so you can get your dose and where you need to be wherever you are in Rhode Island there is bus services. They help you with

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> for the first week, so at least you can, you know, get there. And then hopefully within a week's time you can figure something out."

Notably, housing and transportation barriers were often conflated in participants' responses. Nearly half of people who cited issues with transportation also reported unstable housing situations (41%; n = 7). A 28-year-old male participant demonstrates how not having a stable place to live exacerbated transportation-related barriers:

> "Transportation might be a big thing. I'm not sure how— I lived in Providence before, but [now] I'm not sure where I'm going to be going; how—if the bus routes go together to get to the place."

Housing—Nine participants described housing instability as a factor that may impact sustained engagement in MOUD post-release. Six of those feared that experiencing homelessness post-release would cause them to relapse and concurrently discontinue treatment.

Participants expressed a desire for safe, stable housing and perceived it as an immediate concern that may be prioritized over treatment. For example, one 41-year-old participant stated:

> "First thing is I need to know I'm going somewhere, you know what I mean? That's going to be a huge weight lifted off my chest […] then I worry about the doctor stuff."

A 30-year-old female participant who had been previously incarcerated shared how her previous experience of homelessness post-release related to her treatment retention:

> "I did like 9 months, and I was eager to get clean and everything and then the closer I got to leaving, you know, I started thinking about [using]. And then I didn't have anywhere to go, you know, and it just made it worse."

Similarly, A 42-year-old participant noted:

> "And if I'm staying on the streets, well, then I'll probably hustle […] I'm probably hustling in ways of drugs and stuff like that. I'm looking for quick turnovers of cash […] I have drugs in my hand. So, if I have drugs, I tend to want to use them. It's hard."

Multiple participants, who faced unstable housing conditions upon release, sought out transitional housing to facilitate MOUD access. A 48-year-old male participant detailed how discharge planners from the contracted MOUD provider helped him apply to recovery-based shelter housing. He stated:

> "They offered me the [recovery-based shelter]… I'm still waiting. I signed the contract and some paperwork. I haven't heard anything back yet.… With this application, I can go there. It's a dry house. It could probably help me be more responsible with medications other than just my Suboxone."

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A few participants who wished to enter sober houses or residential treatment programs upon release expressed frustration with their long waiting lists and lack of adequate discharge planning support.

Health Insurance—A few participants (n = 7) anticipated lack of health insurance as a challenge to MOUD engagement in the community and specifically expressed concern regarding reenrollment upon release. When asked about factors that may make it difficult to continue MOUD in the community, one 37-year-old male participant stated: "Hopefully my medical is still active because when you get locked up, they shut your medical down. So I've got to work on that."

Other participants described previous experiences when they were unable to obtain MOUD in the community without health insurance. For example, one 36-year-old male participant recounted how losing his insurance disrupted his treatment:

> "When I lost my [health insurance], I was forced to buy them [buprenorphine] off of people [with] prescriptions, just so I didn't go back to dope. I know it's wrong to not have it prescribed, but I was prescribed, and I knew that it was working for me. So I continued to do it. That was the better alternative to doing fentanyl or heroin too."

Many participants, anticipating the lack of health insurance upon release as barrier to care, sought to ensure their insurance was active before discharge. A 36-year-old participant shared:

> "My insurance—I've got to make sure that I have insurance before I leave here, and it's definitely one of the main things; because it is expensive to fill the subscriptions. It's three—almost $400 to do a monthly prescription. So I have to make sure I have my insurance in order and an appointment with a provider so that there's no lapse in time."

Treatment Program Structure—Opinions on how community-based MOUD programs' policies impact treatment engagement varied among participants regardless of medication type. Some (n = 7) felt that MOUD program rules—such as regular urine toxicology screens and daily dosing at clinics—deterred people from engaging, whereas others (n = 7) found these rules helpful. When asked what may make it difficult for someone to attend their buprenorphine appointments, a 48-year-old participant responded:

> "Having to worry about taking a urine. Some individuals probably use opiates. Again, beyond Suboxone [buprenorphine] they would use any other substitute besides Suboxone to get high. They'd be paranoid they're going to have a dirty urine and lose their chance of having Suboxone."

The above participant explained that fear of being discharged from a program due to illicit substance use may serve as a barrier to treatment engagement. On the other hand, a 55-year-old participant on buprenorphine felt that urine screens kept them accountable:

> "Yeah, because the doctor's office, they take your urine, and if you come out dirty, you could be sanctioned. And then the second or third time, they take you off […]

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> So that keeps you on your toes […] If I slack off or something like that next time, you're going to be taken off of it. Then it's going to cost money to get it, and I don't want that. I want to do the right thing."

Participants on methadone presented a variety of reasons of why they disliked daily dosing at clinics. Some participants felt that daily dosing would conflict with their work schedules. For others, the methadone clinic was a triggering environment. As one 42-year-old participant explained:

> "I don't like having to go to clinics every day, because it screws up your confidentiality; you run into people. When you're an active addict, you know a lot of people that are active, and a lot of the people are still active, smoking crack. It's harder on methadone clinics, to be around that many addicts, for me, to stay clean."

In contrast, a few participants preferred daily dosing because of the structure it provided. One 30-year-old participant explained why he preferred methadone over buprenorphine:

> "When I went to get on the [buprenorphine] before the methadone, they basically handed me pills and this and that. And I wasn't really ready for anyone to hand me a large prescription and everything so I just sold it […] And then, you know, a few days goes by and now you're really short on what you're going to need for the month. And with methadone, there is no short on what you're going to need for the month because you've got to go to the clinic no matter what."

Social Factors

Support networks composed of family members, significant others, reentry advocates, and peer recovery specialists (n = 29) were also reported to aid engagement in MOUD and recovery. Participants described receiving reminders about appointments, assistance with scheduling appointments, traveling to appointments, and finding employment. Emotional support was helpful in maintaining recovery. For example, a 22-year-old participant described how his peer advocate assisted his recovery:

> "[The peer advocate's] job is to just like make sure that, you know, I'm doing all right and I'm having an easy transition back into the community. And part of that is [if] I have an appointment at [methadone clinic] and I can't make it because my car breaks down or something, I can call on him and he'll come pick me up and bring me to my appointment […] So it's really good to have somebody like that around."

Similarly, when asked about continuing MOUD post-release, a 35-year-old participant replied that his mother was committed to helping him receive MOUD in the community by driving him to and from appointments. He went on to explain:

> "Right now, the only place I'm going to be able to get dosed at is in Cranston, it becomes an inconvenience. My mother and I have already agreed that it doesn't matter that it's an inconvenience. It's going to happen either way. You know what I mean? I'm not going to let that stand in my way, and she's not going to let it stand in my way."

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Some participants suggested that recovery support groups, social events, and recreational spaces created specifically for individuals on MOUD may help them build a community and aid their recovery. Although most of the participants felt that Alcohol Anonymous (AA) and Narcotics Anonymous (NA) meetings were helpful recovery strategies, a few described feeling uncomfortable at these meetings because MOUD did not fit within the abstinence-only model promoted by AA and NA. For example, 35-year-old participant explained:

> "Because you're going to a meeting that you're not on the same page as everybody else. I mean, you're on the same page as everybody else about not doing drugs, but in their eyes, you still are because you're on [MOUD]. So if there was meetings on the street just like there are meetings, AA and NA. If you called it an [MOUD] meeting or whatever you want to call it, I forget what the name of it is. But I feel like if there was more meetings like that where people that were on [buprenorphine] and methadone could go and talk and discuss what they're going through on a daily basis, it would help."

In addition, a few participants shared their plans to avoid individuals with whom they previously used illicit substances and environments they frequented while using. For instance, when asked what may make it challenging to continue MOUD in the community, a 22-year-old participant replied:

> "People, places, and things. You know, the same areas, the same stuff. You know, I live in a neighborhood where all the people that live on my street are people that I've known for years and people that I used to hang out with, and I used to use and abuse with."

The above participant felt that engaging with individuals and environments that he associated with illicit substance use may make MOUD engagement in the community more difficult.

DISCUSSON

By talking with impacted individuals, we identified structural and social factors that impacted MOUD treatment engagement after release from incarceration. These include unstable housing, lapses in health insurance, unreliable transportation, and MOUD program structures that may impede their treatment continuation. Although a few participants were optimistic that the discharge planning services would assist them in navigating these anticipated barriers upon reentry, many reported previous lack of support. Many participants described social support as an integral part of treatment engagement. They described experiences receiving support from friends and family, plans to avoid potentially triggering relationships, and a desire to seek spaces specifically tailored for people on MOUD.

Our findings are broadly consistent with existing literature on the barriers to MOUD engagement in the community.[18–20,25,26] Two qualitative studies conducted with individuals who were recently released from incarceration described structural-level barriers, including housing insecurity and access to transportation, that exacerbate challenges to accessing and sustaining treatment with MOUD.[19,20] In addition, social factors have previously been noted to influence people's ability to stay in treatment.[18–20] For some, incarceration fractures

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social networks, disrupts social support, and contributes to social isolation upon reentry—all of which have been found to augment people's sense of hopelessness and increase their risk of returning to substance use.[20,27] Echoing findings from previous studies, our participants also described the challenge of interacting with people and places associated with previous opioid use.[18–20,25]

This study expands upon the literature by providing insight into treatment attrition post-release from a correctional system with a comprehensive MOUD program. Although the RIDOC has contracted with an opioid treatment program to operate the MOUD program and promote seamless transition to care in the community, our participants described treatment barriers similar to those noted in community-based studies. These findings suggest that expanded MOUD access can be further augmented with additional resources to address the overlapping systemic barriers people reentering the community, as well as people on MOUD in the community, face.

As a growing number of prisons and jails implement MOUD programs,[28,29] it becomes increasingly necessary to understand these barriers to develop more impactful solutions. Previous research has demonstrated that employment of peer recovery support specialists and patient decision aid services result in favorable outcomes in helping individuals overcome barriers such as lack of transportation, unstable housing, and lack of health insurance during reentry.[11,30–33] Creating a network where people with OUD who are reentering the community have available peer support and reentry navigation services may alleviate some of the stress of navigating the structural barriers identified by participants and increase individuals' capacity to focus on their continued recovery. In addition, our study participants' responses demonstrate a variety of preferences surrounding MOUD program structure. For example, opinions on the ideal level of monitoring in treatment programs varied among participants. Their preferred amount of clinical supervision, in turn, informed their medication choice, as previously reported.[23] Thus, using peer recovery support specialists many ensure patients are connected to their ideal program.

Although Rhode Island is a Medicaid expansion state, and Medicaid is routinely reactivated during discharge, health insurance still emerged as a major obstacle to treatment uptake and adherence. A study participant described using illicit buprenorphine when he was unable to activate his health insurance post-release. This is corroborated in the current literature, which suggests that people frequently use diverted buprenorphine to manage their withdrawal symptoms and treat their OUD when unable to access MOUD legally. As of August 2020, 17 states have not yet implemented Medicaid expansion, which allows more people to qualify for Medicaid and successfully use services.[34] We postulate that health insurance is an even more pronounced barrier in states that have not implemented the Affordable Care Act's Medicaid expansion, and thus would expect this finding to be even more robust in those states with more limited access to health care.

The present study should be interpreted considering several limitations. Overall, 83% of our sample was White. Although Rhode Island's incarcerated population is predominantly White, our findings may not be generalizable to other correctional settings that have more diverse populations. In addition, our analysis of barriers to sustained MOUD engagement

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relied on self-report data, which may be subject to recall and social desirability bias. Furthermore, our findings reflect anticipated or perceived barriers to sustained treatment engagement in the community—although past experiences inform participant perception, this study does not include data post-release.

CONCLUSION

People with OUD who are incarcerated encounter extensive barriers to continue treatment upon community reentry. Despite the RIDOC MOUD's explicit focus on promoting a seamless transition to the community, study participants still anticipated extensive barriers including lack of sufficient discharge planning services, housing insecurity, unreliable transportation, lapses in health insurance, and difficult MOUD program structures in the community. To promote sustained retention in MOUD during community reentry, it is essential to consider and address the factors that pose barriers to post-release engagement and retention in treatment.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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TABLE 1.

Sociodemographic Characteristics and Medication Type

	Total Sample (N = 40)	
	n	**%**
Age, median (IQR), y	36	(33, 41)
Sex		
Male	28	70%
Female	12	30%
Race		
White, non-Hispanic	33	83%
Other	7	18%
Sexual orientation		
Heterosexual	35	88%
Gay or lesbian	2	5%
Bisexual	3	8%
Education		
Did not complete high school	8	20%
Completed high school	16	40%
Completed beyond high school	16	40%
Medication type		
Methadone	20	50%
Buprenorphine	19	48%
Naltrexone	1	3%

IQR, interquartile range.