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Linkage facilitation for opioid use disorder in criminal legal system contexts: a primer for researchers, clinicians, and legal practitioners

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Abstract

At the intersection of drug policy, the opioid crisis, and fragmented care systems, persons with opioid use disorder (OUD) in the United States are significantly vulnerable to contact with the criminal legal system (CLS). In CLS settings, provision of evidence-based treatment for OUD is variable and often secondary to punitive approaches. Linkage facilitation at every touch point along the CLS Sequential Intercept Model has potential to redirect persons with OUD into recovery-oriented systems of care, increase evidence-based OUD treatment connections, and therefore reduce CLS re-exposure risk. Research in this area is still nascent. Thus, this narrative review explores the state of the science on linkage facilitation across the varied CLS contexts, including general barriers, facilitators, and opportunities for using linkage facilitation for OUD treatment and related services. Following the CLS Sequential Intercept Model, the specific CLS contexts examined include community services, police encounters, the courts (pre- and post-disposition), incarceration (pre-trial detention, jail, and prison), reentry (from jails, prisons, and unified systems), and community supervision (probation and parole). Examples of innovative linkage facilitation interventions are drawn from the Justice Community Opioid Innovation Network (JCOIN). Areas for future research and policy change are highlighted to advance the science of linkage facilitation for OUD services in the CLS.

Keywords Criminal justice, Criminal legal system, Linkage facilitation, Linkage to care, Opioid use disorder, Recovery, Sequential intercept model

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Part 1: Introduction to linkage facilitation to Opioid Use Disorder services in criminal legal settings

The opioid epidemic persists as a leading public health crisis in the United States. Since 2019, the nation has had yearly record overdose rates, with the highest proportion of deaths attributable to opioids (Ahmad et al., 2023). Historically, the United States has relied upon criminalization policies to deter substance use. An estimated 65% of incarcerated persons have an active substance use disorder (SUD; National Institutes on Drug Abuse [NIDA], 2020) and, in 2019, an estimated 15% of the 1.8 million persons incarcerated had opioid use disorder (OUD; National Academies of Sciences, Engineering, & Medicine [NASEM], 2019). As such, persons with OUD (PWOUD) have greater chances of criminal legal system (CLS) involvement than those who do not use opioids (Winkelman et al., 2018). The CLS is a de-facto substance use treatment setting that has demonstrated itself to be ineffective (Pew Charitable Trusts, 2018; Tomaz et al., 2023); without medical treatment, PWOUD are significantly more likely to return to opioid use within 90 days of release (Kinlock et al., 2008). Overdose is a leading cause of death post-incarceration (e.g., Binswanger et al., 2007; O'Connor et al., 2022; Ranapurwala et al., 2022).

Evidence-based medications for OUD (MOUD) include two opioid replacement therapies (i.e., opioid agonists, buprenorphine and methadone) and a non-opioid therapy (i.e., opioid antagonist, naltrexone). MOUD effectively reduces opioid-related health disparities (e.g., recurrent substance use, overdose, infectious disease, care discontinuity, reincarceration) and improves quality of life among PWOUD with incarceration histories (Evans et al., 2022; Green et al., 2018; Springer et al., 2018). In recent years, legislative and institutional policies have encouraged the expansion of OUD treatment access within the CLS and strengthening of OUD care transitions to community sites (Pivovarova et al., 2023). Yet, few PWOUD under CLS supervision can access evidence-based treatment (Stahler et al., 2022) and only 5% of incarcerated PWOUD receive MOUD (NASEM, 2019). Even in CLS drug treatment courts that are specifically intended to address substance use, less than 50% of individuals who use opioids received MOUD (Fendrich & LeBel, 2019) and less than 5% of persons referred to treatment by CLS sources (e.g., probation, court) received MOUD (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). When MOUD is offered within CLS contexts, many CLS leaders and staff are biased against opioid agonists due to their associated costs (i.e., medication, storage, dose supervision), diversion risk, and stigma-driven concerns about "substituting one addiction for another" (Booty et al., 2023), preferring opioid antagonist naltrexone or the lowest cost approach: non-medicated forced abstinence. Given the adverse outcomes associated with OUD and the CLS's disproportionate contact with persons at risk for OUD (Brinkley-Rubenstein et al., 2018), it is critical to eliminate policies that obstruct access to MOUD and develop acceptable and effective ways to identify CLS-impacted PWOUD who need treatment and both link and maintain them in care. While MOUD is effective alone, clinical behavioral support services have been found to improve MOUD effectiveness and retention (Cooperman et al., 2024). Research supports the use of such psychosocial approaches in combination with MOUD (e.g., Dugosh et al., 2016), particularly for patients with behavioral comorbidities and other high-risk clinical features (Samples et al., 2022), as is prevalent among patients impacted by the CLS (Baranyi et al., 2022).

Linkage facilitation (LF; i.e., linkage to care) is one psychosocial approach encouraged by SAMHSA (2017) to help persons with SUD become engaged and remain in recovery. LF for OUD refers to a range of services intended to help access appropriate OUD treatment and harm reduction interventions, maintain adherence to medications and other treatment, utilize recovery support services, and obtain behavioral and social capital resources that abet immediate and long-term recovery goals (Centers for Disease Control and Prevention [CDCP], 2022; Hogue et al., 2024). LF may be especially valuable for persons receiving MOUD given the considerable treatment access, initiation, and retention barriers (Crotty et al., 2020). LF models drive MOUD service engagement in many settings including primary care, behavioral care, emergency departments, perinatal care, criminal legal settings, and harm reduction settings such as syringe services (CDCP, 2022). Research in various settings shows LF's promise for boosting service access, fostering MOUD uptake and adherence, and promoting behavioral and social service engagement, including in the CLS (Chan et al., 2021; Enich et al., 2023; Grella et al., 2022). While interest in LF is growing across disciplines, the field is nascent; many questions remain regarding both the effectiveness and implementation of various forms for varied indications in various settings, including for OUD in CLS settings.

The Sequential Intercept Model (SIM) is a theoretical framework for communities to reduce CLS exposure among persons with mental illness (Fig. 1; Munetz & Griffin, 2006). It has since been adapted to describe opportunities to direct PWOUD to screening, treatment, diversion, and overdose prevention, with the Intercepts organized and discussed by each CLS context (Brinkley-Rubenstein et al., 2018), including: community services: prevention and early intervention (Intercept 0), police encounters (Intercept 1), the courts: pre- and post-disposition (Intercepts 2–3), incarceration: pre-trial detention,

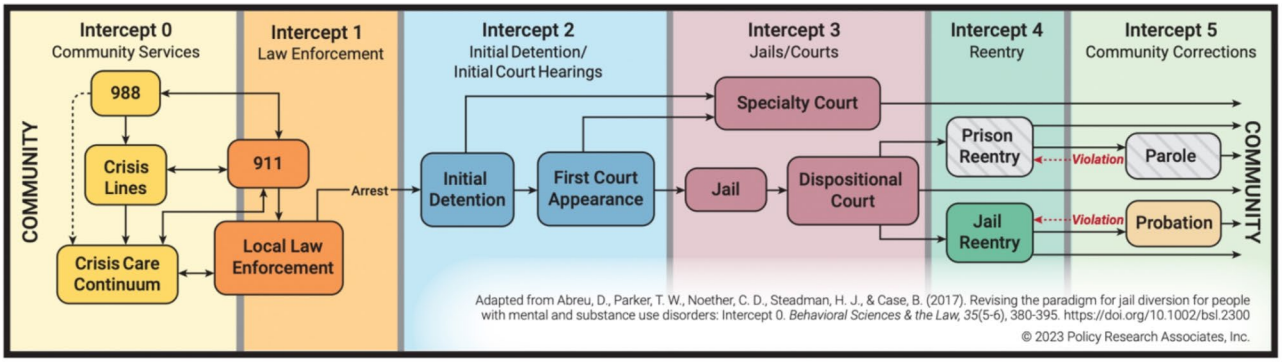

Fig. 1 Sequential intercept model. (reprinted with authors' permission)

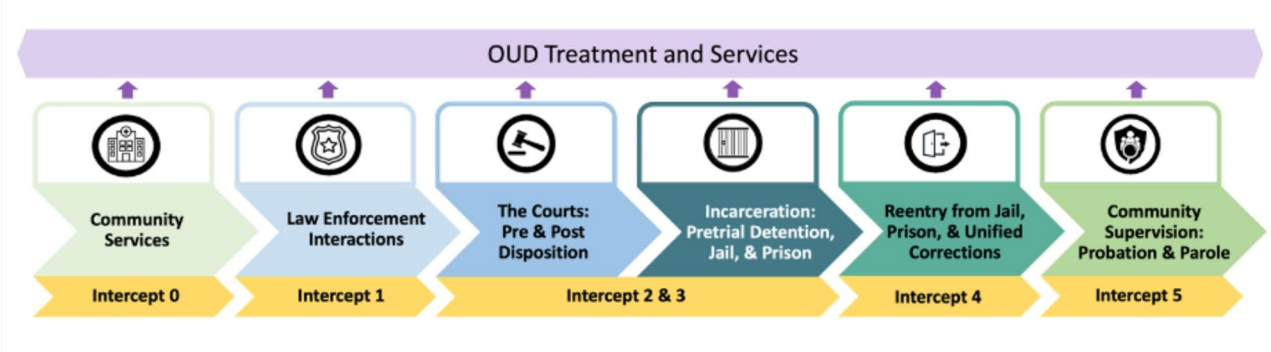

Fig. 2 Sequential intercept model for opioid use disorder, organized by criminal legal system context. *(adapted from* Brinkley-Rubenstein et al., 2018)

jail, and prison (Intercepts 2–3), reentry (Intercept 4), and community supervision: probation and parole (Intercept 5). Using this context-specific organization of the SIM (see Fig. 2), the present paper presents a narrative review that is primer on the state of the science on LF for OUD services (i.e., MOUD and behavioral support services) in the United States' CLS, identifying knowledge gaps and needs for rigorous research on its effectiveness and implementation in each CLS context along the SIM.

Methods

Given the emergent nature of research on LF for OUD services, particularly within the CLS, this primer presents a focused narrative review of peer-reviewed literature. A narrative review was selected over other review types to leverage the expertise of researchers and practitioners experienced in this young field to broadly explore the state of LF to OUD services in CLS contexts, identify gaps where research efforts should be deployed, and recommend future directions for research and practice (Sukhera, 2022). Narrative reviews take a wide variety of forms, and there are no prescribed methods for conducting them (Grant & Booth, 2009). This review was conducted over a one-year period (September 2022–2023) by a team of researchers, clinicians, persons with lived experience in the CLS and with SUD, and persons who have been employed within the CLS. Because this area of research is nascent, investigators from two NIDA-funded initiatives collaborated to provide their CLS and MOUD treatment and recovery services expertise to the review: (1) Consortium on Addiction Recovery (CoARS), which seeks to increase understanding of recovery support services, particularly for PWOUD, and supports the Justice-involved and Emerging Adult Populations (JEAP) Initiative to advance research on the efficacy and effectiveness of recovery support services for emerging adults and justice-involved adults with SUD; (2) The Justice Community Opioid Innovation Network (JCOIN), which is engaged in multisite, community-partnered research to improve access to evidence-based OUD treatment in the CLS and includes innovative LF studies within the CLS. Articles were identified through a combination of online searches in research literature databases and authors' expertise and knowledge related to specific content areas within the review's scope. Articles were included in the review by team consensus among a subgroup of the authors (MFS, SB, ACL, KJW, MRM, TKD, AFB, NZ, AMS, AH, AJS, LAR). This group used a matrix to organize literature findings for each Intercept and compared findings across contexts to distinguish common and distinct barriers and facilitators to delivering LF. The group determined whether a review of LF practices,

barriers, and facilitators could be generalized across all CLS contexts versus context-specific reviews of LF practices, barriers, facilitators, and research opportunities. A few Intercept-generalizable factors could be summarized, but context-specific (i.e., by CLS setting) reviews were determined to be necessary. This group met monthly to discuss content and utilized a consensus approach to develop each section of the paper. Additional authors were included to address identified expertise gaps (NV, BdP, DPW, PFH, RS). Additional literature for inclusion was contributed by *Health & Justice* peer-reviewers.

LF is a multidimensional construct consisting of a diversity of practitioners, (i.e., "linkage facilitators;" e.g., peer recovery support specialists, patient navigators, case managers), goals, and activities. To promote consistent communication about LF standards and practices, this paper draws upon a taxonomy developed by Hogue et al. (2024). The taxonomy describes LF services for OUD along eight dimensions: facilitator identity; facilitator lived experience; linkage client; facilitator-client relationship; linkage activity; linkage method; linkage connectivity; and linkage target (see Fig. 3). Where relevant,

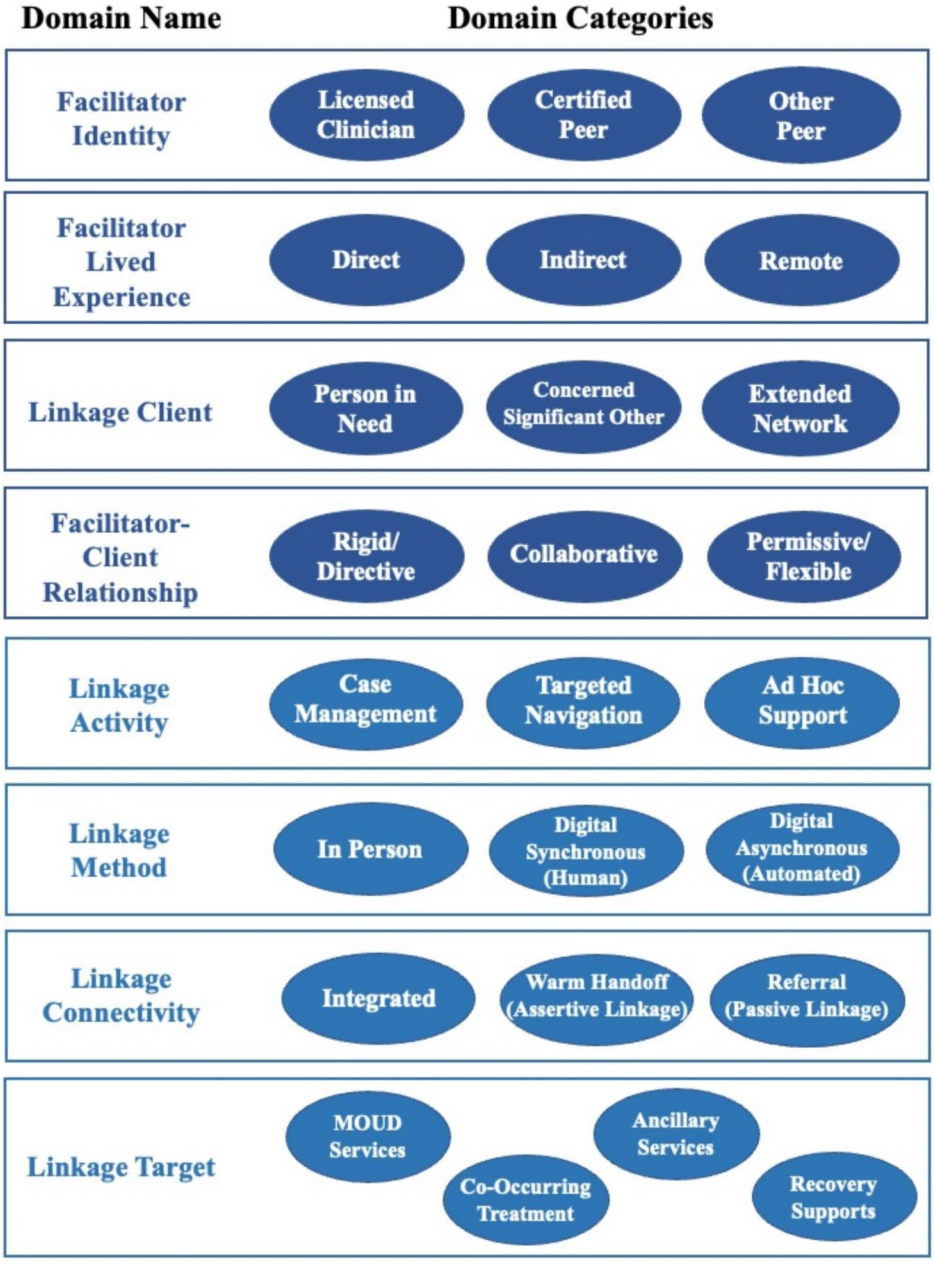

Fig. 3 Taxonomy of linkage facilitation services for OUD *(reprinted with authors' permission)*

the present paper uses language from this taxonomy to describe LF in CLS contexts. Examples of innovative LF interventions that help elucidate concepts are drawn from JCOIN, where possible.

Part 2: State of linkage facilitation practices in criminal legal system contexts

General barriers to linkage facilitation services across criminal legal system contexts

Each CLS context has unique LF considerations that are shaped by distinct functions, operations, settings, and players therein; the external social, economic, and political environment; and interactions between the setting and its environment (Rapport et al., 2022). However, this section considers the common general barriers faced across all CLS contexts.

Traditional CLS policies and practices do not align with the expected clinical presentation of OUD, and SUD more generally, and the treatment models it requires. The CLS's purpose is to enforce the law, examine accusations of law-breaking, and enact consequences for breaking the law (Apel & Diller, 2016). Across CLS settings, setbacks (e.g., recurrent substance use) are punished (e.g., arrest, court sanctions, carceral disciplinary tickets, parole violations, permanent records) (Møllman & Mehta, 2017), which disregards OUD's chronic neurobiological susceptibility to relapse (Strang et al., 2020). Setbacks can even trigger withholding of MOUD in some CLS facilities (American Civil Liberties Union, 2021). Conversely, healthcare aims to maximize health, do no harm, respect individual autonomy, and protect privacy (Varkey, 2021). LF for OUD aligns with clinical ethics and guidelines, which expect setbacks and assert that recurrent substance use indicates the need for increased support and linkage to evidence-based treatment, not punishment (Crotty et al., 2020). This goal misalignment between CLS and healthcare systems presents both logistical and ethical challenges to LF for OUD (Adams & Lincoln, 2021), which may involve coordination across sectors with conflicting frameworks, such as legislators, CLS administration and medical teams, public health departments, community-based healthcare, and community-based social services (Grella et al., 2020). Federal privacy policies like the Health Information Portability and Accountability Act of 1996 (i.e., HIPAA, 45 CFR Parts 160, 162, and 164) and the Confidentiality of Substance Use Disorder Patient Records regulation (i.e., 42 CFR part 2 privacy rules specific to patients with SUD) require written patient consent or court order to share health information with a specified entity. Community-based entities may hesitate to partner with the CLS in LF due to concerns about the risk for coercive dynamics and unintended consequences, such as inadvertently facilitating CLS surveillance or arrests from shared health information (Hibbard & Sheidow, 2022).

Programmatic barriers include insufficient training, treatment protocols, and support for CLS staff to engage in evidence-based treatment planning and work effectively with linkage facilitators (Grella et al., 2020; Moradi et al., 2015; Nunn et al., 2010; Scannell, 2021). While some CLS settings provide MOUD linkage activities, many such activities have not been formally evaluated (Grella et al., 2020). CLS institutions employing linkage facilitators may lack evidence-based training and supervision, risking inconsistent LF practices, insufficient support to navigate challenges, and variable linkage success. The lack of evidence-based guidelines for developing and implementing LF for OUD services in CLS contexts hinders broader adoption.

Attitudinal barriers refer to negative or stigmatizing attitudes or beliefs on the part of any actor with consequential influence on LF (e.g., CLS staff, community providers, linkage facilitators, or clients themselves). While CLS MOUD adoption is improving through the dissemination of evidence-based research and legislative efforts to promote implementation, stigma and criminalization of substance use continue to hinder access to all forms of MOUD across CLS contexts (Andraka-Christou, 2017; Andraka-Christou et al., 2019) and reduce client engagement in linkage services during and beyond their CLS involvement (Awgu et al., 2010). Both individuals who are CLS-impacted and CLS staff may favor abstinence-focused treatment models because they perceive MOUD as "creating another addiction," addiction as a lack of willpower, and abstinence without MOUD as morally superior to MOUD treatment (Azbel et al., 2017; Staton et al., 2021; Booty et al., 2023). Despite healthcare's goal to "do no harm," some community treatment providers, social service agents, and even linkage facilitators themselves have similar biases (Cioe et al., 2020; Pasman et al., 2024; Suzuki et al., 2023) and may act upon them in the absence of regulatory limits (e.g., clinic discharge for positive urine drug tests; Williams & Bonner, 2020); bias and punitive practices by healthcare actors further impede connection to or maintenance of MOUD (Stone et al., 2021) and can increase the risk of fatal overdose and adverse outcomes for PWOUD (Woody et al., 2007). Negative beliefs about MOUD add to confidentiality risks for linkage facilitators communicating with CLS staff, enacted stigma against clients, and legal repercussions related to client drug use. Beyond the CLS, societal stigma may oppose the development of LF services for PWOUD, co-occurring disorders, or CLS involvement (De Benedictis-Kessner & Hankinson, 2019), particularly in rural areas with limited privacy (Tsai et al., 2019; Bunting et al., 2018).

Federal, state, and local policies also shape the institutional policies of the CLS, including the extent to which adherence to clinical guidance will be enforced (Pivovarova et al., 2023), though policies themselves tend to be driven by many elements, in addition to data, that have more to do with cultural, political, and logistical pressures (DeLeo & Duarte, 2022). Certain institutional policies may prevent linkage facilitators from accessing CLS settings or clients (e.g., Adams & Lincoln, 2021); for example, persons under CLS custody (i.e., incarcerated, parole, probation) are prohibited from interacting with someone with a felony record, limiting connection to linkage facilitators with lived experience (Administrative Office of the U.S. Courts, 2016). Federal and state policies govern OUD treatment provision in CLS and community settings, MOUD prescribing practices, public insurance coverage of LF services and MOUD, information exchange, and public health budgets (Saunders & Panchal, 2023), with implications for care linkage and treatment continuity both within and outside of the CLS. For example, the federal prohibition of public health insurance coverage during incarceration (i.e., Medicaid Inmate Exclusion Policy) limits the extent to which community-based linkage facilitators can "reach in" to the CLS to serve PWOUD (Fiscella et al., 2017). Outside of incarceration, insurance may refuse to cover the level of care mandated by CLS actors, especially when their level of care determination differs from a community-based provider's assessment (e.g., American Society of Addiction Medicine [ASAM] criteria) or exceeds their coverage limits (Møllman & Mehta, 2017). As healthcare actors, linkage facilitators can educate CLS actors on the insurance coverage limitations associated with proposed legal conditions, reframe 'non-compliance' as a product of structural barriers rather than willful disobedience, and agitate for the use of non-punitive harm reduction approaches for PWOUD in CLS contexts.

Community services: prevention and early intervention (intercept 0)

Orientation to community services

SIM approaches to *Community Services* (Intercept 0) are deployed in community settings to connect persons with behavioral health crises (e.g., active intoxication, withdrawal, and overdose) to medical and behavioral supports instead of punitive approaches centered on law enforcement. Persons experiencing such crises are at increased risk of arrest and incarceration (Ray, 2022; Pew Charitable Trusts, 2023). This risk deters PWOUD from seeking medical and behavioral support during emergencies, leading to preventable adverse outcomes (e.g., overdose) (Latimore & Bergstein, 2017). Even witnesses of such crises may hesitate to seek assistance due to potential legal consequences (e.g., arrest for active warrants, probation/parole violations, child custody risks) (Latimore & Bergstein, 2017; Koester et al., 2017). Good Samaritan laws limit liability to bystanders who respond to medical emergencies before prehospital medical responders arrive. While 48 states and the District of Columbia have Good Samaritan laws that protect overdose witnesses from criminal liability, protections vary widely and are confounded by drug-induced homicide laws (Legislative Analysis and Public Policy Association, 2023). Such circumstances suggest that timely, community-based LF to non-punitive, low-barrier, harm reduction services during crises may prevent CLS entry and increase access to OUD services.

Current state of linkage facilitation research in community services

Research on the effectiveness and implementation of community-based LF for OUD services as a preventive measure against CLS entry is limited. Existing program evaluations heavily focus on critical time interventions, which provide time-limited targeted navigation and linkage services for persons experiencing critical events or transitions. For example, first responder assertive linkage programs train firefighters, emergency medical services, and/or police to facilitate OUD linkages during medical crises, sometimes in collaboration with a peer recovery support specialist and/or behavioral health specialist (Worthington et al., 2022). A scoping review of first responder post-overdose response programs reported 23–81% of linkage clients began OUD treatment (Bailey et al., 2023). Crisis stabilization units and mobile interventions leverage multidisciplinary teams (e.g., behavioral health, peer recovery support specialist, clinician) to address acute behavioral health crises (e.g., post-overdose) and link patients to both medication and behavioral treatments via assertive linkages and referrals (SAMHSA, 2014; Saxon, 2018). Some crisis stabilization units offer case management for ongoing LF and support. Innovative strategies to link PWOUD to treatment in the community include telehealth-based LF to MOUD and ad hoc LF embedded into accessible spaces frequented by community members, such as supervised injection facilities, syringe services, and recovery community centers (Potier et al., 2014; Kelly et al., 2020; Watson et al., 2021).

General barriers and facilitators to linkage facilitation in community services

The United States heavily relies on ineffective punitive approaches to manage behavioral health (Friedman, 2011). While OUD care and services increasingly embrace collaborative, strengths-based harm reduction, a lack of education persists among clinicians (NASEM, 2019). This can result in hesitance to offer MOUD (Madras et al., 2020), enacted stigma in prescribing

practices (Allen et al., 2020), and reluctance to expand treatment access (McGinty et al., 2020). Providers' reluctance to treat patients with SUD is also driven by logistical barriers (e.g., time, staffing), mistrust of people with addiction (i.e., concerns for safety risks, practice disruptions), and disinterest in treating "difficult patients" (i.e., stigma) (DeFlavio et al., 2015; van Boekel et al., 2013). As discussed in greater detail in the *Police Encounters* (Intercept 1) section, many police officers also lack harm reduction and evidence-based treatment knowledge (Ekelund & Charlier, 2019). Thus, implementing linkages to community-based OUD treatment in lieu of police involvement may require significant culture change and buy-in from both institutions of care and policing, in addition to training and policy. In some communities, concerns about unintended consequences for clients (e.g., eviction, involuntary commitment, arrest) may deter LF implementation (Worthington et al., 2022). Depending on the linkage facilitator's relation to the linkage target (e.g., embedded versus external), OUD linkages may also be limited by data-sharing restrictions between systems (Worthington et al., 2022). While privacy policies (e.g., HIPAA and 42 CFR part 2) protect PWOUD's privacy and reduce opportunities for stigma, in practice these can also limit the speed of care coordination across organizations. For patients lacking the structural resources (i.e., income, phone/internet access) to maintain regular contact with linkage facilitators, privacy policies may delay just-in-time linkages to newly identified services. First-responder OUD linkages are facilitated by cross-agency partnerships, leadership buy-in from all agencies, mutual understanding of limits and norms, involvement of impacted persons, information sharing agreements, and use of "boundary spanners," meaning persons experienced in multiple fields (Bailey et al., 2023; Worthington et al., 2022).

Suggested research directions for linkage facilitation in community services

Effective implementation of LF for OUD services in *Community Services* has immense potential to provide primary prevention of CLS exposure. Research in this context should inform: multisystem strategies and policies to support OUD linkages in community settings, linkage facilitator functions and supervision needs across distinct systems, efficient ethical data sharing, and strategies to prevent unintended consequences. LF interventions at this Intercept should evaluate their impact on preventing CLS contact. Research should also explicitly examine the LF needs and experiences of racially/ethnically minoritized communities, who are disproportionately impacted by both policing and limited access to MOUD (SAMHSA, 2020; Volkow, 2021; Barnett et al., 2023).

Police encounters (intercept 1)

Orientation to police encounters

SIM approaches to *Police Encounters* (Intercept 1) describe strategies police can use to divert persons with behavioral health needs to treatment instead of arrests and jail bookings. In 2022, police arrested 766,595 people for drug-related offenses (Federal Bureau of Investigation, 2023) and about one-fifth of all persons detained in prisons or jails were held for a drug-related offense (Sawyer & Wagner, 2024). Turning police encounters with PWOUD from funnels toward incarceration to opportunities for LF to treatment may effectively prevent exposure to the high risk of fatal overdose that occurs upon release from jail or prison (O'Connor et al., 2022).

Current state of linkage facilitation research in police encounters

There have been significant efforts in recent years to engage police around the public health principles of harm reduction, which some argue can be readily applied to policing practices (Kammersgaard et al., 2019). For example, one basic harm reduction approach is to emphasize the use of citations in lieu of arrest. Arresting a person and sending them to judicial arraignment can take from several hours to up to a few days, sending a person with OUD into dangerous withdrawal in the process, interrupting access to care and harm reduction in some cases, and creating other vulnerabilities and disruptions that increase exposure to overdose. Citations, on the other hand, allow people who are charged with less serious crimes to leave police custody after a much shorter period with summons to appear in court at a later date, lessening the potential for these harmful outcomes. Some programs go further by converting minor charges traditionally met with arrest and arraignment to not only a citation, but a civil adjudication process that precludes a conviction and criminal penalties (Kopak, 2019). Despite these advantages, use of citations varies significantly by state and can stand to be expanded in many jurisdictions (Trautman & Haggerty, 2019).

Another police approach that targets Intercept 0 (*Community Services*) is employed by the Police Assisted Addiction and Recovery Initiative (PAARI). Originated in Massachusetts, PAARI encourages PWOUD to proactively utilize police facilities as places where they can obtain linkages to treatment and harm reduction, with accompanying amnesty for minor drug possession (Knopf, 2023). Doing so leverages a police department's high-profile presence throughout a municipality by providing access points for care prior to confrontational police encounters that can lead to arrest; PAARI also encourages police to distribute harm reduction resources such as naloxone and fentanyl test strips in the field (Larson et al., 2022).

Perhaps one of the most prominent examples of existing police facilitated LF interventions is the Law Enforcement Assisted Diversion (LEAD) program, which is a pre-arrest or pre-booking diversion program that connects PWOUD and other SUDs to case management and treatment services. Preliminary data suggest police can effectively conduct LF to treatment and reduce subsequent police interaction (Collins et al., 2017; Clifasefi et al., 2017). LEAD's initial successes have facilitated program adoption by more than 50 sites nationally, with dozens more either exploring or developing programs (LEAD, 2023).

However, limited empirical data exist regarding the effectiveness of LF by police; a recent scoping review identified only 6 studies involving police-facilitated interventions among PWOUD (Yatsco et al., 2020). Another review identified 27 studies and concluded diversion holds promise for reducing CLS involvement for people with SUD, but more research is needed to understand how programs affect substance use and recovery trajectories (Blais et al., 2022).

Finally, many police agencies conduct post-overdose outreach for LF, recognizing the heightened risk of subsequent fatal overdose and window of treatment readiness that people can experience after a nonfatal overdose. Such emerging programs leverage police access to overdose data without the need for a HIPAA waiver and have been associated with reductions in overdose deaths in some settings (Xuan et al., 2023). However, people who have overdosed often cite fear of the police as a deterrent to engaging with these police-led LF services (Carroll et al., 2023). For instance, police execution of arrest and bench warrants during a post-overdose LF visit use police-led LF engagements as enforcement opportunities rather than lifesaving interventions, eroding their legitimacy and effectiveness (Tori et al., 2022).

General barriers and facilitators to linkage facilitation during police encounters

The success of any police-led alternatives to enforcement for PWOUD (e.g., PAARI) is contingent on trust in the police on the part of people who use drugs, which is not always forthcoming. In some cases, police have been shown to arrest people at the scene of an overdose up to 10% of the time (Ray et al., 2022), and people calling 9-1-1 to seek help for Black overdose victims are significantly more likely to avoid using overdose terminology (Atkins et al., 2024), a practice often undertaken to avoid a police response. These data suggest police facilities may not be acceptable places for PWOUD to seek help, especially in communities of color, leaving police in those communities less likely to engage in the initiative. Accordingly, PAARI's programs are more likely to be implemented in communities with less poverty and smaller Black populations, despite impoverished minoritized PWOUD experiencing the most acute need for linkages to care at the earliest intercepts (Donnelly et al., 2023).

Although police are often first responders for persons in behavioral health crisis and overdose, it is not within their purview or training to make the clinical assessments or recommendations necessary to identify the most promising non-enforcement response (Brinkley-Rubinstein et al., 2018), and their discretionary authority can be driven by lack of knowledge and bias (Belenko, 2000; del Pozo et al., 2021); such may limit their potential to effectively conduct LF, especially if officers have an aversion to the use of effective medications for treatment or prefer to rely on detoxification or abstinence-based measures that do not have a firm basis in evidence. There is a need for police to closely collaborate with and defer to clinically trained personnel regarding treatment determinations to ensure LF to appropriate type and level of evidence-based care; such collaboration would empower the police to make productive handoffs while preventing them from acting beyond their scope of training.

Other police-described barriers to providing diversion include PWOUD's prior negative experiences with the treatment system, police perceptions of the comparative complexity of diverting individuals to appropriate services, lack of availability of support services to target during LF, and prevailing norms of police culture about punitive responses to drug-related crime (Joudrey et al., 2021; Barberi & Taxman, 2019). Diversion is a complex, highly restricted practice that contends with arrest as a comparatively efficient and well-established practice with a clearer incentive and reward structure for officers (Reichert et al., 2023a). Police are more likely to support LF to treatment and harm reduction as alternatives to enforcement when their peers and supervisors support these approaches and when they perceive these approaches as not only reducing addiction and overdose, but also as enhancing their job safety and reducing crime (Baker et al., 2022; del Pozo et al., 2021; Marotta et al., 2023). This suggests that the success of diversion programs depends on a shared belief about the inherent connection between public health and public safety, which can require a significant shift in cultural norms, buy-in from police leadership, and ensuring services are available and/or accessible at the time of police encounters (Franco et al., 2021). Other data suggest that "person-centeredness" is an important element in the design and delivery of diversion programs and that an important component of police buy-in is to witness success stories among those served by the diversion program (Anderson et al., 2022).

Suggested research directions for linkage facilitation during police encounters

The advancement of police-involved LF needs research along two axes: police behavior and implementation science. The premises behind diversion, deflection, and post-overdose outreach have strong underlying bases in evidence; connection to treatment with MOUD has been shown to reduce both overdose (Santo et al., 2021) and arrests (Evans et al., 2019); and harm reduction services have been shown to slow the spread of infectious disease and prime people for treatment (Thakarar et al., 2020). Gaps in knowledge include how to effectively implement LF practices in a variety of police settings, and how to get police officers to view LF as an acceptable part of routine practice. Police need to understand the engagement barriers created by warrant checking practices during acute intoxication, overdose response and post-overdose outreach; the role of perceived legitimacy of police activities (particularly in communities of color) and how to build public trust and credibility of police-led linkages; how to integrate deflection and diversion into robust and well-resourced administrative systems; and ways to incentivize the acceptance and use of these practices among rank-and-file officers. Just as critically, future research should investigate ways to reduce police officers' negative attitudes toward MOUD (Kruis et al., 2021; Reichert et al., 2023b) and improve their recognition of MOUD as effective in reducing OUD-associated morbidity and mortality (Santo et al., 2021; Wakeman et al., 2020) and the criminal activities that can accompany addiction (Ball & Ross, 1991; Evans et al., 2019; Evans et al., 2022). Negative views of partial opioid agonist medications (e.g., substituting one addiction for another; not 100% recovery) are prevalent among the US population, its police officers included.

The courts: pre- and post-disposition (intercepts 2, 3)

Orientation to the courts

SIM approaches to *The Courts* (Intercepts 2, 3) describe strategies to link people with behavioral conditions to treatment during post-arrest court proceedings and the adjudication process, including diversion strategies to prevent progression toward incarceration. After an arrest and prosecutorial filing of criminal charges, a magistrate or judge issues a pretrial release and supervision decision at a bail or arraignment hearing, with input from the district attorney's office and defense attorney. Pretrial services agencies and community-based organizations that work with the CLS and PWOUD (e.g., Treatment Accountability for Safer Communities, TASC; Hub and Spoke models; other local organizations or government entities) provide input as well as behavioral health assessment, case management, treatment referral and monitoring, and related services on behalf of the court system (e.g., Anglin et al., 1999; Miele et al., 2020); linkage facilitators could potentially be used by such agencies. Release options vary by state and jurisdiction (Hernandez, 2023), but generally may include secure detention (i.e., local or county jail) pending trial or case disposition, cash bail or bond, pretrial release with supervision, or pretrial release on recognizance. In states and jurisdictions with cash bail or bond, persons unable to post bail or bond are detained in jail pending trial or bail payment.

In most jurisdictions, misdemeanor cases proceed quickly through the lower courts, typically resulting in guilty pleas or dismissal. Felony cases are initially heard in lower courts, adjudicated in a superior or upper court post-indictment, and progress slower than misdemeanors due to pretrial hearings and evidentiary disclosures (Ostrom et al., 2018). Stakeholders in the processing of misdemeanor and felony cases include judges or magistrates, prosecutors, defense attorneys (often public defenders), pretrial services agencies, jail staff, and community-based organizations or treatment providers.

Prosecutor's offices may divert cases from the courts, involving judicial approval and supervision by a pretrial services agency or probation, and pretrial services agencies may provide supervised release with a treatment component with judicial approval. Non-compliance with diversion and supervision requirements may result in criminal adjudication by the courts, while successful completion of requirements often results in dismissal or withdrawal of the charges. Examples of such diversion are drug treatment courts (though not all of these courts are pre-adjudication, some require a guilty plea for participation), which use a problem-solving, therapeutic jurisprudence approach for persons with SUD charged with drug or drug-related offenses (Drugs, Security, and Democracy [DSD] Program, 2018). Unlike traditional criminal courts (which may conduct no or very limited assessment), drug treatment courts use multi-domain assessments (e.g., mental health, substance use, housing, etc.) to inform judicially-supervised substance use treatment and facilitate non-adversarial collaboration across stakeholders (judge, prosecutor, public defender, case manager, clinician, probation officer) toward shared goals of promoting recovery and desistance to reduce recidivism (e.g., Belenko, 2019). Therapeutic jurisprudence models support the use of linkage facilitators (Hora et al., 1999; Wexler & Winick, 2009; Winick, 2003). More than 3,000 adult drug treatment courts exist in the United States (DeVall et al., 2022), with evidence of reduced recidivism and improved recovery for those who adhere to drug treatment court principles (e.g., Belenko, 2019; Mitchell et al., 2012; Wilson et al., 2006). It should be noted that adoption of MOUD-supportive practices has occurred slowly in all courts, including drug treatment courts. Only 7 states have laws prohibiting problem-solving

courts from excluding individuals who are prescribed MOUD or limiting the type, dose, or duration of their MOUD, while just 4 have laws to facilitate MOUD access in the courts (e.g., requirement to make MOUD available to court participants; Andraka-Christou et al., 2022). However, progress has been made to increase awareness among court actors of MOUD benefits, and positive actions to incorporate it into current practices (AllRise, 2023; Pivovarova et al., 2023).

Current state of linkage facilitation research in the courts

While LF research in court settings is limited, emerging research on the use of peer recovery support specialists for LF is encouraging. About 45% of drug courts report use of peer recovery support specialists (DeVall et al., 2022). In a pilot randomized clinical trial in an urban jurisdiction, drug court clients assigned a peer recovery support specialist had significantly lower rearrest rates and better drug court engagement than those without a peer (Belenko et al., 2021), although substance use recurrence and treatment attendance were unaffected. Court personnel and clients positively regarded the use of peer recovery support specialists in drug court and their role in assisting recovery (Gesser et al., 2022). Such linkage, of course, requires positive changes in court attitudes and practices toward MOUD, given the traditional antipathy toward such medications (Ahmed et al., 2022). Current surveys of court administrators indicate such progress, with many drug treatment courts actively seeking to improve MOUD practices (Pivovarova et al., 2023).

General barriers and facilitators to linkage facilitation in the courts

The overloaded court system, burdened by political pressure for convictions, focuses on punishment of criminalized behavior and retributive, incapacitative, or deterrence-based responses. Accordingly, linking PWOUD to treatment and other services is not a priority (Belenko et al., 2013; Belenko, 2019). Legal requirements for speedy trials may discourage courts from adopting health-related interventions that may prolong proceedings. Traditionally, U.S. criminal courts and prosecutors have embraced an abstinence model evincing biases against MOUD; a national survey found that half of drug treatment courts had policies *against* MOUD use (Matusow et al., 2013), though the U.S. Department of Justice recently issued guidance that barring access to MOUD violates civil rights (Civil Rights Division, 2022). Many judges and prosecutors have stigmatizing views of PWOUD and lack training on addiction, evidence-based treatment, and LF roles; as such, prosecutors and judges may be reluctant to support treatment diversion programs or allow LF to MOUD as a condition of pretrial release or sentencing (Andraka-Christou et al., 2019).

Court-based agencies also lack resources to hire non-legal staff (e.g., linkage facilitators) and train court stakeholders on health-related issues and evidence-based assessment, though there are some recent efforts to provide online training (e.g., Matusow et al., 2021). As such, court staff may not be comfortable working with health services staff and perceive these working relationships as difficult or complex (Taxman & Belenko, 2012). Differences in language, missions, and views about the court system's proper role impede effective interactions between court and health services staff, including linkage facilitators. Where support for LF exists, access to OUD treatment may be scarce, particularly in rural and small metropolitan areas (Mauro et al., 2022) and states without Medicaid expansion. An estimated 46% of U.S. counties lack MOUD access (Haffajee et al., 2019). Lack of formal service agreements between court agencies and community providers further limits LF. In addition, pretrial supervision raises ethical concerns for LF when treatment is enforced before adjudication of guilt. Court-based treatment determinations are not necessarily evidence-based; they may lack substance use assessment and staff for treatment referrals and progress monitoring, limiting LF to the appropriate level of care (Møllman & Mehta, 2017).

Progressive prosecutors and judges—many influenced by changes in the CLS like drug treatment court models, as well as other factors (e.g., the basic economics of incarceration, changing social conditions, recognition of injustice)—recognize the need for treatment-focused alternatives for defendants with SUD to reduce unnecessary incarceration and improve outcomes (Davis, 2019). The shift toward non-incarcerative sentences for persons with SUD-related charges both politically and legally aligns courts and prosecutors to embrace LF (McIvor, 2010). MOUD's effectiveness in reducing both recurrent drug use and recidivism also aligns with the courts' aims of due process and public safety. LF can assure courts that clients will be connected to treatment and resources, act as a liaison between courts and the treatment system, and help monitor treatment progress, therefore providing both public safety and public health benefits. Such information can contribute to pre-sentencing reports and help judges make appropriate sentencing decisions. The TASC model offers one example of an established framework for integrating treatment linkages into court processes, creating formal agreements with courts to provide assessment, treatment linkage and monitoring, and client support – all compatible with a LF role. Though drug treatment courts and other diversion programs contract with community treatment providers currently (National Association of Drug Court Professionals, 2018a, 2018b), a more formal relationship between these organizations can ensure successful linkages. Similarly,

pretrial services agencies aligned with the court system can establish supervised release programs and formal partnerships with community treatment providers for access to dedicated treatment slots and information sharing agreements.

Suggested research directions for linkage facilitation in the courts

At present, there is little empirical literature to guide the development of LF models in the courts, despite the clear potential of LF to reduce unnecessary pretrial incarceration and improve public health outcomes for people being adjudicated in criminal courts and despite a call for such measurement (e.g., Henry, 2018). JCOIN has funded a stepped-wedge type II hybrid trial to assess effectiveness and implementation of the opioid care cascade, including LF, in opioid treatment courts (Elkington et al., 2021). More formative research on the feasibility and acceptability of LF roles and approaches in varied court settings and at varied stages of the judicial process is needed to gauge the level of interest and support for LF among judges, prosecutors, public defenders, and pretrial services agency staff. Research can inform appropriate roles of linkage facilitators in court contexts, and LF's impact on the adjudication process, case outcomes, and client recovery. Empirical research should also assess the effect of state laws intended to facilitate MOUD access in the courts and inform the crafting of policies to ethically improve LF to MOUD and OUD services from the courts (Andraka-Christou et al., 2022).

Incarceration: pre-trial detention, jail, and prison (intercepts 2, 3)

Orientation to incarceration

SIM approaches to *Incarceration* (Intercepts 2, 3) consider services to link people with behavioral health needs to treatment in controlled CLS settings, like jails and prisons. Jail is a confinement facility operated by local executive or law enforcement agencies (e.g., county, city, municipal) and may include special facilities, such as medical treatment or release centers, halfway houses, and temporary holding or lockup facilities as part of the jail's combined function. Jails typically hold people with sentences of one year or less as well as those in pretrial detention (SAMHSA, 2019). Prison is a long-term confinement facility run by a state or federal government or private company, generally confining persons with felony convictions and sentences longer than one year (SAMHSA, 2019). Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont each combine jails and prisons into a unified system. Incarceration is complex, with operations varying by state, county, and facility based on policy, resources, funding, and cultural pressures.

Current state of linkage facilitation research during incarceration

Research has demonstrated improved recovery outcomes from MOUD provision throughout incarceration compared to forced detoxification (Rich et al., 2015; Green et al., 2018; Bovell-Ammon et al., 2024). Provision of all three forms of MOUD during incarceration has been shown to be a cost-effective strategy to significantly curb the post-release overdose risk (Chatterjee et al., 2023), as well as increase treatment engagement and promote desistance (Cates & Brown, 2023; Evans et al., 2022). Court rulings have established that the Americans with Disabilities Act obligates carceral facilities to provide all three forms of MOUD, yet such practice remains infrequent (NASEM, 2019; Scott et al., 2021a). Many facilities interpret this mandate to mean MOUD continuation only for people with prescriptions prior to incarceration (Sinkman & Dorchak, 2022) or time-limited treatment immediately before release (Scott et al., 2021a). Many facilities still enforce detoxification upon intake and throughout the sentence. When MOUD is offered, facilities may practice directive linkages only to opioid antagonist treatment (Grella et al., 2020; Staton et al., 2021), wait to initiate treatment near release (Scott et al., 2021a), or restrict continuous medication treatment to high-risk subgroups only (e.g., pregnant, HIV, chronic pain; Grella et al., 2020), though many fail to initiate or maintain MOUD for such patients as well (Sufrin et al., 2022). Forced detoxification from opioids upon incarceration, an often-traumatic experience, increases the risk of serious health complications, suicide, and death pre-release (Bureau of Justice Assistance, 2022), reduces the likelihood of patients restarting MOUD post-release (Rich et al., 2015), and can increase the risk of post-release overdose (Cates & Brown, 2023).

Research is scarce on LF approaches for incarcerated PWOUD. While research on peer support for SUD is an emerging field of study, studies have shown peer recovery support specialists effectively support linkage to and engagement in MOUD treatment and SUD services in community settings (Bassuk et al., 2016; Gormley et al., 2021; Reif et al., 2014). Limited studies suggest the potential for LF by incarcerated peers. For example, a health education program delivered by trained incarcerated peer supporters increased linkage to care in one study (e.g., HIV testing; Ross et al., 2006). Incarcerated peer recovery support for SUD (e.g., abstinence-based Therapeutic Community) is feasible (Bagnall et al., 2015). However, rigorous research is needed to examine the effectiveness (Cioffi et al., 2023), ethics, and impact on LF to evidence-based treatments and the use of peers in LF models.

General barriers and facilitators to linkage facilitation during incarceration

Healthcare financing poses a significant barrier to LF activities in carceral settings. The Medicaid Inmate Exclusion Policy prohibits federal reimbursement of non-inpatient healthcare and services during incarceration, which limits the extent to which community-based linkage facilitators can "reach in" to the CLS to serve PWOUD (Fiscella et al., 2017). Under this policy, states, counties, facilities—and often incarcerated persons themselves via copayments (Sawyer, 2017)—are financially responsible for the healthcare rendered during incarceration and exempt from external oversight mechanisms that make reimbursement contingent on maintaining healthcare quality standards (e.g., accreditation; Alsan et al., 2023). Thus, states, counties, and facilities have the authority to set their own care standards, which creates a perverse financial incentive to segregate carceral healthcare delivery systems, limit their scope of care (e.g., restrictive formularies; Morris et al., 2020), and resist the adoption of emerging evidence-based care practices (Scott et al., 2021a) like LF or treatments that may enhance LF (e.g., long-acting MOUD). Private prisons are uniquely motivated to maximize revenue (e.g., maintain population numbers at or near capacity) and reduce costs (e.g., lower amount or quality of healthcare delivered) to drive shareholder profits (Gotsch & Batsi, 2018). This carceral healthcare gap (i.e., insurance, quality) can impose care disruptions upon insurance termination or suspension during incarceration and delayed insurance reactivation during reentry (Fiscella et al., 2017). For PWOUD, care disruptions can be fatal and can prevent their ability to comply with court-mandated OUD treatments (e.g., treatment as probation/parole condition). Research suggests such care disruptions disproportionately impact racially/ethnically minoritized PWOUD (Pro et al., 2020).

LF in carceral settings may be limited by institutional hiring restrictions (e.g., disallowing persons with CLS histories entry to carceral facilities), intensive onboarding procedures, logistics and human resources (e.g., staffing to supervise client movement through a facility), staff resistance, emotional burden on linkage facilitators, and limited resources and evidence-based guidance for training and supportive supervision (South et al., 2016). For jail settings in particular, the lack of a uniform system and processes across jails within the same state means that LF services are unique within each jail; processes must be adapted for each facility, which requires significant resources (Krawczyk et al., 2022). LF in jails also must account for unpredictable release schedules, particularly for clients under pre-trial detention, which can disrupt linkage efforts (Krawczyk et al., 2022).

Notably, LF to methadone has unique legal, logistical, and attitudinal barriers. As a full agonist opioid, methadone treatment is tightly regulated to prevent the risk of diversion, misuse, and overdose. Given the arduous process to obtain a Drug Enforcement Agency license for internal medication dispensing, CLS facilities that allow methadone prefer to contract with community opioid treatment programs. This requires relationship with community treatment sites, commitment of financial and human resources to transport patients to/from treatment sites, and/or receipt and secure administration of methadone doses that are transported into the facility (Krawczyk et al., 2022). A survey of medical directors in state and federal prisons (Rich et al., 2005) suggested that stigma towards the use of methadone also impedes its use during incarceration and referral to methadone treatment upon release. Practitioners who did not think methadone was beneficial were less likely to provide this medication in their facilities. Linkage facilitators may support solutions to such barriers by educating CLS staff and advocating for treatment linkages during incarceration and in preparation for release. Linkage facilitators that span carceral facilities and the community may better support continuity of OUD care, particularly for individuals who cycle in and out of jail. In jail settings, adopting rapid universal intake, screening, and MOUD linkage processes, partnering with community services, and leveraging telehealth connection to community-based prescribers can alleviate the risk of MOUD linkages being disrupted by short stays (Krawczyk et al., 2022). LF can also be enhanced when conducted by persons with a history of incarceration, as incarcerated persons have reported a preference for working with those who directly understand their experience (Matthews, 2021). However, some peer recovery support specialists may bias LF to specific types of MOUD or recovery services based on their personal experiences and limit client autonomy to use approaches that differ from their own recovery process (Suzuki et al., 2023). For example, peers who have experienced success in particular recovery frameworks (e.g., Alcoholics/Narcotics Anonymous) may have internalized stigma against MOUD and enact bias toward abstinence-only services (Monico et al., 2015a). For LF to MOUD and recovery services to be successful in carceral settings, some of the important ingredients include policy alignment, institutional buy-in at all levels, resource commitment, and technical support (Grella et al., 2020) to address staff misconceptions, destigmatize MOUD, and operationalize support for

client self-determination, especially when utilizing peer support specialists (South et al., 2016).

Suggested research directions for linkage facilitation during incarceration

Research in recent decades has demonstrated the feasibility and effectiveness of delivering MOUD in prisons (e.g., Kinlock et al., 2008), jails (e.g., Lee et al., 2015), and unified systems (e.g., Green et al., 2018), particularly in preparation for release from prison. Research has also focused on examining the impact of expanding access to all forms of MOUD in jails and prisons (Chatterjee et al., 2023; Green et al., 2018; Macmadu et al., 2021). However, less research has explicitly examined processes for linking PWOUD to MOUD treatment and recovery-oriented behavioral services upon intake into jails and prisons and during entire periods of incarceration (i.e., prior to the structured reentry planning phase). For example, several JCOIN-funded trials test LF models during reentry (see the *Suggested research directions for linkage facilitation during reentry* section); these, however, do not include a focus on LF during jail intake or early phases of prison incarceration. National surveys have found variable implementation of evidence-based best practices in OUD screening and treatment initiation across jails (Scott et al., 2022) and state prisons (Scott et al., 2021a). Because intake is a critical period for MOUD linkage with predictive impact on post-release treatment engagement (Rich et al., 2015), studies are needed to develop effective LF models for jail intake and early prison incarceration. LF models at these phases also may support care continuity between community and carceral healthcare providers for incoming patients with preexisting care and promote care utilization for the many patients for whom carceral-based healthcare is the first point of healthcare access (Rich et al., 2014). Medicaid Reentry 1115 waivers allow approved states to temporarily waive the federal ban on accessing Medicaid in prisons and jails (i.e., Medicaid Inmate Exclusion Policy) and provide Medicaid coverage up to 90 days prior to release from incarceration (Tsai, 2023). Medicaid Reentry 1115 waivers are happening or likely to happen in several states (California Department of Health Care Services, 2023; Kaiser Family Foundation, 2023), presenting opportunities to develop and evaluate strategies to facilitate community-carceral healthcare linkages upon entry to jails and prisons and throughout entire sentences (e.g., community strategies to "reach in" to prisons and jails versus carceral strategies "reach out" to the community).

Research is needed on the acceptability, feasibility, and effectiveness of hiring linkage facilitators for OUD onto carceral teams versus alternatives (e.g., external linkage facilitators, expanded LF roles for existing staff, leveraging peer recovery support specialists). Studies should explore the ethical implications of *who* conducts LF in carceral settings (i.e., facilitator identity; Fig. 3), and the impact of a linkage facilitator's lived experience (e.g., CLS history and/or OUD history versus none; concordant versus non-concordant peer/client histories) on staff and client engagement. Given the high risk for coercion in carceral settings, research is needed to identify strategies to maximize self-determination in treatment and prevent coercion by linkage facilitators (i.e., rigid/directive facilitator-client relationships; Fig. 3). In addition to interpersonal factors, research should also consider interventions to address structural factors that drive coercive (i.e., rigid/directive) LF during incarceration (e.g., resource restrictions); for example, Vest (2023) describes how one resource-limited state prison only provides MOUD to individuals who overdose while in custody, setting a high non-evidence-based threshold for accessing evidence-based treatment and forcing detoxification, abstinence, and recurrent substance use as the only alternatives. Other health workers have faced moral injury, burnout, and ethical dilemmas working in confinement settings (Webb et al., 2024); studies must explore the risk of these outcomes among linkage facilitators that interface with or operate within jails and prisons, and identify effective strategies to prevent and treat work-related psychological distress.

Researchers also can evaluate linkage facilitators' role in promoting clinical guideline adoption in carceral spaces, given their potential to support the dissemination of evidence-based information on OUD treatment options and treatment planning inclusive of patient preference (Crotty et al., 2020). Linkage facilitators have effectively supported the development of inter-organizational linkages between CLS sites (e.g., probation, parole) and community MOUD providers at Intercept 5 (Friedmann et al., 2015), suggesting the potential to translate such LF roles to jail and prison settings. Such may be particularly relevant for LF to licensed opioid treatment programs for methadone. Studies should also examine policies that may impact implementation of LF in carceral settings (e.g., Medicaid Inmate Exclusion Policy, licensure requirements) and inform policy changes to support sustainable implementation and fidelity of LF (e.g., Medicaid 1115 waivers, elimination of Medicaid Inmate Exclusion Policy, training requirements, caseload guidance).

Reentry from jails, prisons, and unified systems (intercept 4)

Orientation to reentry

SIM approaches to *Reentry* (Intercept 4) describe services to link people with behavioral conditions to community

services upon release from incarceration. Such LF can be based in carceral facilities, community settings, or both. According to Taxman (2002), three reentry phases exist: (1) institutional (≥6 months before release), (2) structured reentry (within 6 months pre-release to 30 days post-release), and (3) integration (31+days post-release). As such, reentry activities can overlap with incarceration (Intercepts 2, 3), and, for many but not all, community supervision (Intercept 5). This section focuses on interventions targeting structured reentry.

Current state of linkage facilitation research during reentry

Reentry is a critical period for OUD linkages as 95% of incarcerated persons will reenter the community (Hughes & Wilson, 2004). Incarcerated PWOUD are at high risk of losing opioid tolerance due to forced opioid abstinence and limited MOUD access (White & Irvine, 1999). Upon reentry, PWOUD transition to fragmented care systems, often without clinical handoffs or record-sharing (Woods et al., 2019; Jennings et al., 2021). Many encounter barriers connecting to treatment (e.g., insurance delays, low availability of MOUD prescribers), particularly in resource-limited settings (e.g., rural communities; Hoover et al., 2023). Many return to opioid use and face up to 129-times greater risk of fatal opioid overdose than the general population during the first two weeks of release (e.g., Binswanger et al., 2007; Ranapurwala et al., 2022).

Pre-release delivery of MOUD significantly reduces the prevalence of overdose deaths post-release (Gisev et al., 2015; Green et al., 2018; Macmadu et al., 2021). Yet, research on the operationalization of LF to OUD treatment and services during reentry is limited. Grella et al. (2022) evaluated intervention components and outcomes of linkages to SUD/MOUD services during reentry after jail. Of the fourteen identified studies, four randomized controlled trials focused specifically on pre-release interventions to increase MOUD linkage and retention post-release. Patient navigation was associated with higher initiation of interim methadone than interim methadone alone (i.e., 80.3% versus 57.1%; Schwartz et al., 2021). Lee et al. (2015) found higher initiation among individuals offered physician linkage to extended-release naltrexone pre-release along with brief motivational counseling and a referral for community-based treatment post-release, compared to those only offered a referral. However, no significant differences in MOUD retention were found for studies with LF by research staff to methadone (McKenzie et al., 2012), patient navigators and case managers to methadone (Schwartz et al., 2021), or patient navigators and physicians to extended-release naltrexone (Farabee et al., 2020), compared to other treatment interventions.

General barriers and facilitators to linkage facilitation during reentry

Reentry requires ethical interactions among representatives of multiple systems: carceral (e.g., case managers, probation/parole), executive branch (e.g., parole board), carceral healthcare, community healthcare, social services, and families/social networks. Challenges include limited access to carceral facilities for linkage facilitators with felony records, establishing rapport with incarcerated clients (e.g., interpersonal and legislative limits of telemedicine), confidentiality, and developing pre-release plans amidst multiple unknowns often decided on short notice (e.g., release date, court-ordered treatments, housing), especially for jail releases (Tillson et al., 2022). As detailed in the *General barriers to linkage facilitation services across criminal legal system contexts* section, federal restrictions on insurance coverage during incarceration can create delays in insurance reactivation upon return to the community, limiting timely access to LF services (Fiscella et al., 2017). Clients' socioeconomic instability (e.g., inconsistent housing or communication tools) and urgent survival needs (e.g., housing, income, food) create the conditions for both physical and cognitive scarcity (Zhao & Tomm, 2018), which may hinder clients from following up post-release on linkages initiated pre-release. LF connections providing continuity that spans pre- and post-release may foster client trust and post-release engagement (Kendall et al., 2018). Qualities of the linkage facilitator, like consistency, non-judgment, and advocacy, support reentry program success (Schwartz et al., 2021; Tillson et al., 2022).

Suggested research directions for linkage facilitation during reentry

The high overdose risk for reentering PWOUD requires prioritization of clinical trials to identify the most effective reentry LF interventions. JCOIN is currently supporting several such trials (Howell et al., 2021; Pho et al., 2021; Scott et al., 2021b; Springer et al., 2022; Staton et al., 2021); however, additional future research will likely be required in this area. As interest grows in integrating LF into the CLS, interventions should explore the advantages and disadvantages of creating LF roles employed by carceral facilities versus outside agencies (e.g., impact on client trust and engagement). With two-thirds of formerly incarcerated persons reincarcerated within 3 years of release (Alper, 2018), interventions must also determine LF's impact on OUD outcomes during reentry and recidivism, as well as identify effective LF responses to client reincarceration (e.g., continuity versus handoff to linkage facilitators based within carceral facility). Once effective LF models are identified, dissemination and implementation research will be required to facilitate scale-up and ensure proper system integration. Research

is also needed to take advantage of real-world opportunities such as Medicaid Reentry 1115 waivers (described in the *Suggested research directions for linkage facilitation during incarceration* section). Future policy decisions will benefit from assessment of states' baseline LF strategies and evaluation of the pre- and post-release LF intervention models deployed across waivered states for Medicaid recipients with OUD.

Community supervision: probation and parole (intercept 5)

Orientation to community supervision

SIM approaches to *Community Supervision* (Intercept 5) consider strategies to connect individuals on probation or parole with behavioral and medical healthcare services to reduce recidivism, promote desistance, and improve quality of life, public health, and public safety. Over 3.7 million, or 1 in 69, adults were on community supervision at the end of 2021 (Kaeble, 2023). Given that most individuals on probation or parole have incarceration and substance use histories, their risk for OUD and opioid-related overdose mirrors those cited earlier. Estimates suggest those on community supervision are 15 times more likely to die from opioid-related mortality than the general population (Boulger et al., 2022).

Current state of linkage facilitation research during community supervision

Providing MOUD to individuals on probation or parole increases retention in treatment and decreases the rate of recurrent substance use and recidivism (Gordon et al., 2015; Clark et al., 2014). Linkage to treatment often occurs through referrals from probation/parole officers (i.e., PPOs or community corrections) to community programs (Taxman, 2012; Taxman & Belenko, 2012). Indeed, the CLS accounts for over a third of all substance use treatment referrals in the United States, largely initiated by PPOs (Smith & Strashny, 2016). However, studies examining the use of LF within community supervision are rare. One noteworthy study by O'Connell et al. (2020) developed the "Culture of Health" intervention, which involves embedding non-peer navigators in community corrections offices to assess needs and link persons on probation to primary care. A pilot randomized controlled trial demonstrated increased treatment engagement among those receiving the intervention relative to a control group (O'Connell et al., 2020).

General barriers and facilitators to linkage facilitation in community supervision

Studies aiming to improve collaboration between PPOs and treatment providers shed light on the barriers and facilitators that linkage facilitators are likely to face in a community supervision context (Friedmann et al., 2015; Welsh et al., 2016). One key barrier is the somewhat disparate priorities of PPOs and those working in the healthcare sector. That is, because PPOs focus primarily on promoting public safety and preventing recidivism, many favor abstinence-based treatment models and do not support the use of opioid agonist MOUD (Hawks et al., 2022; Mitchell et al., 2016; Reichert & Gleicher, 2019); this bias is bolstered by a lack of knowledge about MOUD's effectiveness. However, linkage facilitators are likely to prioritize services that best meet an individual's needs, including MOUD and other harm reduction approaches. Another barrier is differing norms about privacy and confidentiality. PPOs are not subjected to the provisions of HIPAA or subsequent liabilities and are regularly frustrated by the privacy concerns of those working in the healthcare sector, such as linkage facilitators (Welsh et al., 2016). A related barrier is the tendency for community corrections and treatment providers to have fragmented lines of communication and different expectations on information sharing. Even after treatment referrals are made, individuals on community supervision face numerous barriers to completing linkages to care. For example, those on probation have lower rates of health insurance than the general population (Hawks et al., 2020). Other common barriers are discrimination in healthcare settings (especially for women and people of color) and stigma of receiving MOUD, particularly in communities with limited confidentiality (e.g., rural settings; Hawks et al., 2022; Taweh et al., 2021; Bunting et al., 2018). Lower health literacy among those under CLS supervision is associated with reduced linkage to MOUD and other healthcare (Berkman et al., 2011; Hadden et al., 2018). Adopting LF within community supervision has potential to ensure individuals receive effective, equitable assistance.

Fortunately, studies indicate that several of these barriers might be overcome via an organizational linkage intervention (OLI) that promotes enhanced communication, trust, and goal setting among PPO staff and those in the treatment sector (Friedmann et al., 2013). The OLI approach has been shown to address MOUD stigma and referral intentions, while educating CLS employees about the effectiveness of MOUD (Friedmann et al., 2015). Additional strategies promoted by OLI that linkage facilitators could easily adopt to foster a harm reductionist collaboration with PPOs include (a) use of clear release of information forms that specify what information can and will be shared with whom and (b) providing PPOs with regular updates using mutually designed progress report templates (Monico et al., 2015b).

In qualitative research with recipients of LF services promoting methadone treatment following jail release (Mitchell et al., 2021), participants reported a higher likelihood to engage in methadone programs when their linkage facilitator engaged in specific behaviors. These

included (a) conveying nonjudgmental caring, persistence, and advocacy to promote treatment engagement; (b) brokering resources to address basic needs (e.g., food stamps, clothing, state medical assistance, housing); (c) helping those on probation stay organized via appointment setting, reminders, and appointment accompaniment; and (d) negotiating directly with PPOs and explaining CLS processes (and how treatment programs interact with it) to participants.

Suggested research directions for linkage facilitation in community supervision

As noted previously, research on the use of LF in a community supervision context is still in its infancy. Notably, two JCOIN-funded studies focus on LF during community supervision. One examines peer recovery support specialists' delivery of LF to MOUD and related support services for persons newly on probation (Martin et al., 2021). The second tests the implementation of an organizational intervention to improve access and retention in behavioral health and MOUD for persons at risk for opioid use during post-incarceration community supervision; this study trains communities to provide the Opioid Treatment Linkage Model, which includes OUD screening and assertive linkage strategies (e.g., "warm hand offs") (Knight et al., 2021). Given the different practice philosophies, functions, and goals of PPOs and linkage facilitators, studies should examine strategies for fostering effective, ethical partnerships. The aforementioned work on OLI is likely to provide helpful guidance in this regard.

Part 3: Opportunities for linkage facilitation practices in the criminal legal system

Benefits of linkage facilitation in criminal legal settings

The potential benefits outweigh the challenges of incorporating LF into legal systems. People experiencing CLS settings generally face a confusing, at times intimidating, set of institutional structures, including treatment services. Their experiences can foster self-stigma and preconceived notions about how they will be treated (Moore & Tangney, 2017), which can impact care engagement (Luoma et al., 2012). Recent research indicates LF services may not only provide more efficient connections to care, but also enhance self-determination by eliciting coproduction (Dewey et al., under review), a collaborative facilitator-client dynamic (Fig. 3). Although some of these findings are specific to peer support specialists, practitioners of LF could also support improved self-perception, self-efficacy, and self-determination (Bandura, 2012; Deci & Ryan, 1985; Fortuna et al., 2022) among PWOUD by modeling these behaviors, prioritizing healthy social networks and prosocial environments conducive to recovery as linkage targets, and supporting client development of a new sense of self in recovery. Successful LF to substance use treatment may reduce self-stigma and anticipated stigma post-incarceration (Moore et al., 2023).

Community partnership in designing linkage facilitation services

LF has both great potential and great burden to be the first step toward building PWOUD's trust in care systems that may have historically excluded or mistreated them (SAMHSA, 2020) or even participated in their criminalization (Paltrow & Flavin, 2013). As interest in LF along the SIM grows, it is imperative for researchers to understand the historical context of the communities they seek to serve and intentionally co-produce LF research and interventions with directly impacted persons. Such partnership ensures that research priorities are shaped by the expertise that is informed by lived experience, align with community-identified needs, and result in more effective, equitable, and trusted interventions delivered by community-embraced facilitators (SAMHSA, 2020). At every Intercept and in every stage of the research cycle, community expertise should be integrated into LF research. One excellent model of community-partnered LF research is the JEAP Initiative (JEAP Initiative, 2023), which includes researchers with lived experience of SUD and the CLS (one serving as an author of this article). Their advisory board of directly impacted persons drives their research priorities and informs research conduct and dissemination.

Linkage facilitator support and professional development in legal settings

Philosophical differences between a medical model where an expert knows best versus experiential knowledge and self-determination precludes integration of some linkage facilitators into systems (Mirbahaeddin & Chreim, 2022) like the CLS, which primarily emphasizes custody and control (Ellis & Alexander, 2017). Even in non-legal settings, linkage facilitators may not become integral to services if stakeholders are unwilling to integrate them into existing practice (Ibrahim et al., 2020). Integrating linkage facilitators into systems is enhanced by linkage facilitators having a peer network and organizational resources (e.g., internet access), preparing staff through training (e.g., how to interact with linkage facilitators) and role clarification, and attending to staff attitudes towards linkage facilitators (Ibrahim et al., 2020). Resistance to the integration of linkage facilitator roles or LF services due to stigma and discrimination can be mitigated via certification allowing formal recognition of LF practices (Mirbahaeddin & Chreim, 2022).

In contrast to other systems, linkage facilitators interfacing with the CLS may be privy to information that could jeopardize a client's liberty. For example, client

behaviors—such as recurrent drug use, missed treatment, travel to certain locations, or interaction with certain people—may trigger a probation or parole violation and subsequent reincarceration if disclosed to a PPO. CLS staff may pressure linkage facilitators to reveal such information about clients; clear supervision and ethical guidance are needed supports.

There is little, if any, data on how best to support the professional development of linkage facilitators operating in legal settings, whether they are hired into such settings or interface with them. What is known is that an important facilitator is having stakeholder buy-in and visibility (Adams & Lincoln, 2021). Recent JCOIN-funded work by Stein and colleagues (2023) assessed linkage facilitators ($N=30$) across four national CLS sites during four waves of data collection. Linkage facilitators consistently reported the usefulness of their training in motivational interviewing, MOUD, and overdose response; and they consistently used client engagement and retention strategies, provided emotional support, and assisted with linkage to medical and behavioral health services. In contrast, sharing recovery stories decreased over time, and efforts to advocate for LF as a service remained relatively infrequent. These preliminary data suggest professional development supporting what linkage facilitators find useful (e.g., motivational interviewing) and their frequent activities (e.g., retention) may be in order. Professional development supporting activities to educate the public and other service sectors on LF roles may be of use.

Addressing linkage facilitator credibility

Linkage facilitators operate in environments where their roles and responsibilities are often poorly defined (du Plessis et al., 2020), which can result in various challenges in providing services (Weikel et al., 2017) such as other staff not understanding the LF role, questioning the facilitator's credibility, and devaluing LF services (Scannell, 2021). This is likely exacerbated in the CLS, where staff roles have long been defined and tend to be more distinct than in other fields. Lack of role clarity can lead to feelings of exclusion, tokenism, and stigmatization among linkage facilitators (du Plessis et al., 2020). Staff training can build a shared understanding of LF's purpose, roles, and activities among linkage facilitators and other staff (Clossey et al., 2018; Kemp & Henderson, 2012). Varied LF roles require certification, regular professional development to enhance linkage facilitator skills, which also enhances role clarity (Mancini, 2018), and signals to other staff the importance of recognizing and investing in LF services.

Challenges of hiring persons with lived experience

Studies of LF indicate lived experience plays a crucial role in reentry services, however, it becomes a barrier to linkage facilitators' employment (Adams & Lincoln, 2021) and ability to navigate the thorny operational and confidentiality issues that can arise when helping people in the community under CLS supervision, such as those on parole or probation. Having lived experience may also limit the ability of a linkage facilitator to serve their clients. As noted above, many jail and prison systems do not allow persons with a felony conviction record to enter a carceral facility, making it impossible for some linkage facilitators to visit their clients prior to release to assist with reentry or discharge planning (Mitchell et al., 2022; Watson, 2015). Similarly, they may face bureaucratic hurdles in being hired by healthcare systems, universities, or research centers, which may also have discriminatory background check policies. LF research on the impact of lived experience may help to facilitate institutional and legislative policy changes (Hunt et al., 2018) to eliminate such hiring barriers.

For linkage facilitators with SUDs, recovery may be challenged by exposure to familiar substance use triggers while working with clients under CLS supervision. Linkage facilitators are also at risk of reactivated and vicarious trauma upon exposure to shared lived experiences and the high mortality risk of their clients with SUD (Mamdani et al., 2021). Initiatives like the Recovery Friendly Workplace show promise in enhancing recovery and workplace supports for employees with SUD (National Institute of Environmental Health Sciences, 2023). Evidence-based guidance is needed to inform trauma-responsive training and supervision of linkage facilitators.

Emerging frontiers to explore linkage facilitation in criminal legal contexts

Upward of 51% of youth in the juvenile legal system have SUD, yet only 26% of youth under community supervision who are in need of treatment are referred (Belenko et al., 2022), and only 33% receive appropriate treatment (Knight et al., 2022). Lack of coordination between juvenile legal and behavioral health systems (including OUD treatment) increases the risk of recidivism and/or more serious progression in addiction among youth (Weber & Lynch, 2021). Given the high prevalence of SUD among youth in the juvenile legal system and the limited data on MOUD treatment in adolescents in general, research is needed to characterize the LF needs of youth to develop tailored, effective interventions. Similarly, emerging adults (ages 18–26) are less likely to access MOUD (Pilarinos et al., 2022), and CLS involvement in young adults specifically relates to lower treatment utilization (Liebling et al., 2016). Improved cross-system collaboration and LF may facilitate linkage to treatment for youth with SUD in the juvenile legal system (Knight et al., 2022).

Recent approval of Pell Grants for incarcerated students suggests that in the next decade there will likely be a substantial increase in the number of scholars exiting prisons and wishing to continue their educational pursuits (Weisman, 2023). Collegiate recovery programs may be well positioned to support LF efforts to enhance recovery capital (e.g., education) for CLS-impacted persons. These programs offer refuge for students in recovery from SUDs (Vest et al., 2021). Collegiate recovery programs can build cooperation among college stakeholder groups and provide LF to student health center services to ensure medication treatment access and essential wrap-around services for students with SUD, including those impacted by the CLS (Vest et al., 2023). Inclusion of CLS-impacted students in recovery from SUDs in classrooms and on campus can combat societal stigma of these conditions and encourage colleges to provide training for the LF workforce serving in CLS contexts. Institutions that increase efforts to recruit, accept, and provide necessary health services to this student group may reduce our nation's addiction crisis.

The mass imprisonment of immigrants, like mass incarceration, is a direct consequence of the decades-long War on Drugs (Diaz et al., 2023). While the surveillance, policing, and imprisonment (i.e., detention) of immigrants falls under U.S. civil law, rather than criminal law, immigrants are often confined in criminal legal facilities that contract with Immigration and Customs Enforcement yet are exempt from the constitutional rights therein (e.g., access to healthcare; Diaz et al., 2023). Furthermore, a growing proportion of immigration enforcement cases are referred for criminal prosecution of immigration law violations and subject to incarceration upon sentencing (National Immigrant Justice Center, 2022). Limited research has considered the S/OUD care needs of U.S.-based immigrants (DeFries et al., 2022), yet detention experiences parallel those of U.S. citizens with S/OUD in jails and prisons, and are often worse. For example, advocacy organizations have reported lack of S/OUD screening, forced detoxification, and lack of medical treatment of withdrawal in detention centers, with preventable fatal outcomes (American Civil Liberties Union et al., 2024). Future research should consider opportunities to adapt the SIM to examine the barriers and facilitators to LF to S/OUD care for this subpopulation.

Finally, this primer has focused on in-person human-delivered LF as a linkage method (Fig. 3). Many aspects of LF to OUD services from CLS contexts could be conducted with technology (i.e., digital synchronous or asynchronous linkage methods), yet such digital intervention also poses the risk of deepening inequities (e.g., encoding discriminatory bias, extending the CLS's reach), particularly among racially/ethnically marginalized communities (Benjamin, 2019). Research should study the ethics, barriers, and facilitators to digital LF approaches from CLS contexts (e.g., interoperability, privacy rules, security, discriminatory bias); establish ethical standards and oversight mechanisms for digital LF approaches that involve CLS contexts; explore the acceptability, feasibility, and effectiveness of digital LF approaches from CLS contexts; and inform the implementation of emerging technologies. The ethical conduct of such research necessitates co-creative partnership with CLS-impacted communities (i.e., human-centered, participatory, co-production approaches) and multidisciplinary stewardship to ensure that the design, evaluation, and dissemination of CLS-interfacing digital health tools prioritize lived vulnerabilities and needs, are grounded in harm reduction and liberatory frameworks, are informed by critical understanding of the historical sociopolitical construction of structural inequality, and deliberately consider and prevent the potential for harm (Benjamin, 2019).

Conclusion

The entire CLS faces the call to adopt a major paradigm shift in its orientation and functioning away from a sole focus on legal deliberation, adjudication, and punishment toward the practice of evidence-based health services and harm reduction approaches, like LF. Such an approach may enhance public health, sense of belonging, and, thereby, public safety. However, the evidence for how to effectively usher such change into each CLS context is lacking. While this primer could not discuss all the myriad nuances implicated for LF in each CLS context, it has demonstrated that each CLS context has distinct players, stakes, purposes, priorities, funding constraints, and taxpayer expectations to consider. Rigorous studies of the effectiveness and implementation of LF to OUD services in each CLS context are needed. While such research can inform the tailoring of LF to account for the existing contours of each CLS context, more boldly, studies should inform LF interventions to obviate exposure to the CLS altogether and facilitate changes to the organization, culture, and behavior of the CLS itself. The study and delivery of LF has immense potential to advance the reimagination of U.S. policies toward people who use substances; instead of criminalization and punishment via physical and social isolation, LF advocates for connection and care as the effective, evidence-based, and ethical public health response. Researchers, clinicians, and legal practitioners have an opportunity to advance the field of LF and address key knowledge gaps; for example, funding sources like JCOIN have announced an intention to solicit proposals from multidisciplinary teams to test early Intercept interventions (National Institutes of Health, 2023). Additional funders should prioritize this field of study. As this article has argued,

LF has the potential at all stages of the CLS to increase access to MOUD and other health services for PWOUD, enhance recovery, and reduce the negative health and social impacts of CLS involvement. Understanding the contexts and challenges of LF to OUD treatment and services across the CLS helps to inform new research and policy development that will build a strong evidence base for LF and provide helpful guidance for effectively scaling up its use in these settings.

Abbreviations

CLS	Criminal legal system
CoARS	Consortium on Addiction Recovery
HIPAA	Health Information Portability and Accountability Act
JCOIN	Justice Community Opioid Innovation Network
JEAP	Justice-involved and Emerging Adult Populations
LEAD	Law Enforcement Assisted Diversion
LF	Linkage facilitation
MOUD	Medication for opioid use disorder
NIDA	National Institute on Drug Abuse
OLI	Organizational linkage intervention
OUD	Opioid use disorder
PAARI	Police Assisted Addiction and Recovery Initiative
PPO	Probation/parole officer
PWOUD	People with opioid use disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance use disorder
TASC	Treatment Accountability for Safer Communities
US	United States

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MFS, AH, TKD, AJS, SB, ACL, MM, NZ, AFB, AMS, and LARS conceptualized the study and participated in the design. MFS developed the outline with substantive feedback from co-authors. All authors contributed to the literature review, analysis, and interpretation of literature findings. All authors contributed to the drafting of the manuscript and provided critical feedback during the drafting phase of the manuscript. MFS, SB, AJS, AFB, NV, BdP, DPW, PFH, RS, and LARS provided critical revision of the completed manuscript. All authors read and approved the final version of the manuscript.

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Declarations

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